Medway Hospital NHS Trust Annual Audit 2025

11th to 15th August 2025

BB7

Revision History

Version	Date	Author	Comments
01	10/12/25	John McLean	First draft

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Contents

1. Introduction

1.1 Background and scope

Health Technical Memorandum (HTM) 05-01: Managing Healthcare Fire safety, refers to the use of an Authorising Engineer (Fire). This person or persons will be an independent professional adviser to the healthcare organisation, an assessor who may make recommendations as appropriate, monitor the performance of fire safety management, and provide an annual audit to the Board Level Director (with fire safety responsibility). This document provides for the latter and has been prepared by the authorising engineer(s) from BB7 Consulting.

The audit was undertaken on between 11th and 15th August 2025

The audit involved a review of all relevant fire safety and fire engineering documents, logs and records, documentation and the control of documentation. In addition, interviews were held with relevant persons responsible for the subjects discussed.

A site inspection was carried out which involved a tour of all levels of the premises with specific attention paid to:

- All 'Hospital Streets'
- Pembroke Ward
- Neonatal care Unit
- Emergency Department

Judgement has then been made based of published technical standards and in relevant Health Technical Memoranda. Any notable issue has been identified and recommended actions listed separately using the priority rating system is described below.

Actions

Actions/Recommendations		
Definition of priorities (where applicable):		
Urgent	**High**	Immediate actions required or if it is not feasibly practical to immediately resolve the issue, it is strongly recommended that a written programme be put in place for resolving the issue and remedial measures put in place to control risk in the meantime. Considerable resources should be provided to resolve this as soon as reasonably practicable.

Strongly recommended	**Medium**	It is essential that efforts are made to reduce the risk in the short/medium term. Risk reduction measures, which should take cost into account, should be implemented within a defined time period.
Recommended	**Low**	No immediate action necessary. However, this will be best practice, so the item should be addressed when time or resources allow.
Advisory	**Advisory**	Advisory only.

The above table relates to the risk to allow the responsible person a guide to determine which risks should be addressed first and the best allocation of resources. Regardless of the severity of the rating, easy actions to resolve, (i.e. closing propped open fire doors), should be rectified as soon as practically possible. More difficult actions to resolve that may result in alteration to building fabric etc, should be programmed in depending on their severity and difficulty to resolve. The amount of resources allocated to an action is dependent on risk.

The responsible person may decide that the consequence, resources required and the practicality of resolving the risk, may be too high compared to their perception of the risk. These observations should be recorded. It is obviously strongly recommended that the higher risk recommendations are resolved and not just 'justified'.

BB7 do not routinely prescribe indicative timescales for the completion of actions as budgetary priorities of the client do not form part of this assessment. However, should the client require assistance, then BB7 would be happy to assist with prioritisation accordingly.

2. Executive summary

2.1.1 The funding for fire safety works is determined by the score identified in the Risk Register, (currently 15). This equates to a budget of £1.6 million for the year. How this is spent is the job of the fire Safety Group. This Group is well led and focused, all relevant interested parties are represented. The inclusion of those who oversee carrying out the works allows for realistic timescales and outcomes to be discussed.

2.1.2 The control of documentation was judged to be very good. Like last year an action in respect of fire risk assessments remains in place. With such many FRAs to be carried out may be unrealistic to expect annual inspections by the fire safety adviser, unless additional resources are provided.

2.1.3 There are ongoing significant challenges with the fire alarm replacement program Currently there are two systems in place which means a mix of warning signals. While this issue is dealt with during fire safety training sessions, the less time the different systems are in place the better. Now is the time for the fire alarm engineers to produce cause and effect documentation for the new fire alarm.

2.1.4 Smoking in wards is extremely hazardous; the provision of Oxygen massively increases the likelihood of a fire starting and aids its development. It is very important that all cases are reported to the senior fire safety advisor. And that the control of this behaviour is maintained

2.1.5 A hospital street is a special type of compartment that may be used to evacuated via to parts of the hospital not affected by the fire; and it will serve the fire-and-rescue service as a fire-fighting bridgehead. During the site visit all ‘Streets’ were inspected and this issue appears to have significantly improved since last year.

2.1.6 Concerted efforts have been made to identify the state and location of fire dampers, the testing of emergency lighting and to program of fire door checking and maintenance. In a large hospital that has grown in phases over decades these are not easy tasks. The next stage is to decide on the exact approach to remedial actions.

2.1.7 Breaches to compartmentation are often caused by contractors working on data, electrical or other systems which cross compartment lines. The adoption of the ‘Bolster system is a significant step forward in controlling that damage, its use could also provide information on the existing situation on compartmentation in the surrounding areas.

2.1.8 There are limited scenarios which would necessitate the evacuation of High dependency areas such as the NCU and ICU wards, however, when needed the actions in respect of horizontal evacuation should be timely and efficient. Local approaches to this process require specialist knowledge and need to be practiced. Clearly not in a live situation, but good training can take place by ‘tabletop’ and ‘Toolbox’ talks. As a starting point it recommended that a timescale for evacuation preparation is established particularly for the intensive care nursery.

2.1.9 Hospitals and care homes are excluded from the building safety Act 2022 once in occupation, because prior to the BSA, there were already in place safety regulatory regimes, including under the Regulatory Reform (Fire Safety) Order 2005 and a mandatory Quality Care Commission inspection which must be carried out before any patients or residents can occupy.

2.1.10 All staff involved in the audit process were helpful and supportive of the process and clearly appreciated the importance of issues raised

3. Action Plan

Action Plan

No.	Section	Description	Action	Priority
1.	4.1.2	Top management should show documented support with the Fire Policy.	A person authorized by top management should sign and authorize the Fire Policy	Low
2.	4.3.4	There may be areas which have not been fire risk assessed for some time, and as a result unknown risks may be developing	It is acknowledged that a new electronic FRA may be introduced to speed up the process, also it's expected that the fire safety team will be expanded to allow more scope for the senior fire safety advisor to conduct the fire risk assessments	Medium
3.	4.3.2	Pembroke Ward – Located in the highest section of the hospital there is limited scope for progressive Horizontal Evacuation, alternative escapes are via one external and one internal staircase and flat roofs. it has been in use as an Acute ward for a maximum of 30 persons for eight months following a period of refurbishment. Its location puts an onus on the need to use Evac type mats for non-ambulant patients. While some of the patients may be able to walk in the event of an evacuation, some would not, for this reason the policy was not to use the location as a bedded ward.	Consider enforcing the policy of only allowing ambulant patients to stay in Pembroke Ward.	Medium
4.	4.5.1	Each FRA area should have a fire logbook, which assist the Ward Manager in managing the fire risk in their area by providing guidance on routine testing. The contents of these varied,	if a physical book is to be used consistency should be applied	Low
5.	4.11.2	Discussions in the Fire Safety Group have recently taken place around the need for a fire strategy for the whole site. A Fire Safety Retrospective Strategy Report was produced by Trenton Fire in 2018. Strategy reports tend to describe compliance recommendations. It is more difficult to determine the state and provision of the existing fire safety features and understand how these affect the expected escape provisions. That said, the document is helpful and could form the basis of future reporting.	The recent investigations on the systems such as fire doors, compartmentation/ dampers etc are essential before moving forward with this project	Advisory

No.	Section	Description	Action	Priority
6.	4.11.3	To maintain the 'Golden Thread' of fire safety information and comply with the Building Safety Act, relevant information should be recorded and maintained.	While the fire alarm is being replaced cause and effect documents should be provided as part of commissioning process	Medium
7.	4.3.3	Babies in intensive care are unable to breath for themselves and therefore if disconnected during an evacuation require bag and mask ventilation. The HVAC systems provided to intensive care areas are designed so that the pressure within the department is maintained at slightly above that of the adjacent areas. In a fire emergency, the continuing operation of these systems will assist in preventing smoke and other products of combustion entering the intensive care area. Although it is accepted that some occupants, because of their condition or treatment, should not be moved, provision must still be made for external evacuation. The need for a vertical movement strategy for such occupants must be recognised, and appropriate measures must be installed to reduce the risk associated with such an action.	As a starting point it recommended that a timescale for evacuation preparation is established particularly for the intensive care nursery.	Medium
8.	8.3	Smoking remains an ongoing issue, although designated as a non-smoking site this is clearly not being addressed. Enforcement is an option and may work to some extent, however where individuals receive difficult news enforcement is likely to prove challenging and seem heavy handed. More concerning is the smoking by patients in wards, notwithstanding the disruption to the comfort and health of other patients the Oxygen present in both mobile and piped form massively increases the likelihood of a fire starting and aids its development.	Some form of external smoking area at least outside may be the solution to deal with those smoking outside the buildings. It is understood that there are sanctions against patients who are found smoking, the ultimate sanction being refusal of treatment. It is very important that all cases are reported to the senior fire safety advisor.	Medium
9.	4.3.3	A hospital street is a special type of compartment that occupants of the department affected may be evacuated via this hospital street to parts of the hospital not affected by the fire. It will also serve the fire-and-rescue service as a fire-fighting bridgehead. Currently the only area compromised was in the vicinity ED	Most of the obstruction were caused by trollies carrying consumable supplies. The nearest storeroom was almost full which might suggest that a timelier ordering process might deal with this issue.	Low

No.	Section	Description	Action	Priority
10.		Senior facilities staff are not content that conditions described could last for up to 4 more years. Discussions at the meeting centred around speeding up the fire alarm replacement process by moving funds from another project, for example emergency lighting upgrades.	It is recommended that this approach is adopted	Medium

4. The audit

4.1 Leadership

In addition to guidance contained in HTM 05-01, guidance has been published by the BSI. BS9997: 2019 provides overall guidance on fire risk management systems. It lists the expectations of top management and how they can demonstrate leadership and commitment regarding the fire risk management (FRM):

In pure auditing terms the two guidance documents are closely aligned in that they use the 'Plan Do Check Act' Model as a framework for Fire risk management systems. Clearly there are specific guidance documents applicable to Hospitals, and these are referenced as part of the process.

Figure 1

4.1.1 Audits are performed to ascertain the validity and reliability of information as well as to provide an assessment of the fire safety management system's internal control.

4.1.2 The Chief Executive delegates to a Board level Director who is responsible for championing fire safety issues at board level; this to include proposing programmes of work relating to fire safety for consideration as part of the Annual Business Plan. The Director of Finance has been delegated with this responsibility. The Director of Estates and Facilities is designated as the 'Fire Safety Manager' in accordance with the Department of Health, Fire code 05–01 'Managing healthcare fire safety', and 05-03-Operational Provisions.

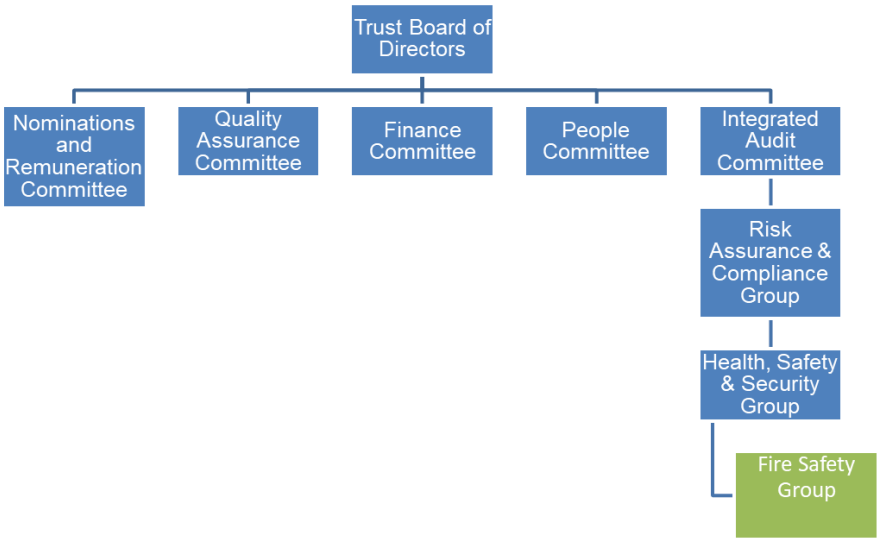
4.1.3 The principal document in respect of leadership is the corporate Fire Safety Policy, originally issued in 2017.This has been superseded by Corporate Policy: Fire Safety document LPOLCS024 dated November 2023. In addition to affirming the commitment to supporting fire safety strategies in the Trust the document identifies key positions and responsibilities; Management systems guidance defines Policy as intentions and direction of an organization, in respect of fire safety, as formally expressed by its top management. In this respect the policy document is very effective.

4.1.4 A person authorized by top management should sign and authorize the fire policy

4.1.5 The funding for fire safety works is determined by the score identified in the Risk Register, (currently 15). This equates to a budget of £1.6 million for the year. How this is spent is the job of the fire Safety Group. This Group is well led and focused, all relevant interested parties are represented. The inclusion of those who oversee carrying out the works allows for realistic timescales and outcomes to be discussed.

4.2 The structure of communications

The position of the Fire Safety Group in the trust's structure appears well placed for audit and finance purposes and exceeds the scope shown as an exemplar in HTM 05-01 in which there are four management tiers.



4.2.1 The Fire Safety Group arrangement continues to work well. The inclusion of all interested parties in the meetings means that all the factors which impinge on the issues are dealt with by Individuals who are best position to provide professional guidance

Fire Safety Strategy – STRCS001

Fire Response Plan

FIRE - Completing of Fire Logbook - GUCS005

FIRE - Fire Logbook - OTCS059

FIRE - Constructing a Fire Evacuation Plan – GUCS006

Smoke Free Policy POLCS011

4.2.2 Four areas were chosen to insect as part of the audit. They were selected for the comparative high-risk nature of the occupancy or the potential to impact on means of escape. They were:

- All 'Hospital Streets'
- Pembroke Ward
- Neonatal care Unit
- Emergency Department

5. Site visits

5.1.1 **Hospital Street** - is a special type of compartment that occupants of the department affected may be evacuated via this hospital street to parts of the hospital not affected by the fire. It will also serve the fire-and-rescue service as a fire-fighting bridgehead. The site visit involved an inspection of all areas designated as Hospital streets; the last audit found that they were being used to store beds, which in the event of a fire will significantly affect the functions described above. The situation was much improved during this year's audit.

5.1.2 **Pembroke Ward** – Located in the highest section of the hospital there is limited scope for progressive Horizontal Evacuation, alternative escapes are via one external and one internal staircase and flat roofs. it has been in use as an Acute ward for a maximum of 30 persons for eight months following a period of refurbishment. Its location puts an onus on the need to use Evac type mats for non-ambulant patients. While some of the patients may be able to walk in the event of an evacuation, many would not for this reason the policy was not to use the location as a bedded ward.

5.1.3 **Emergency department –** The FRA, was reviewed in Q2 2024. Its' purpose is to assess the effect of additional pressures. This is also referred to as TES (Temporary Escalation Spaces,) by NHS England. The principle in ED is that "No-one gets turned away." This is understandable but has safety considerations (Fire, H&S, Security;) plus, issues with patient dignity; confidentiality; patient distress; patient privacy; relatives' distress, etc. There is the added burden of stress upon the incumbent staff. Initially the FRA was to deal with winter pressures however increasingly these pressures occur at other times of the year. At the time of the visit there were 17 'lodgings. Lodgings are beds in which patients are treated which located outside treatment bays. As a minimum lodging should be positioned so they don't restrict the width of exit doors or access to fire extinguishers.

5.1.4 The Hospital Street next to ED was being used to store trolleys containing medical consumables, generally it is assumed that these are awaiting a move to the nearest storeroom. However, the nearest store appeared to be almost full, and it would be some time before the trollies would be moved. It may be that changing the timing to the ordering routine would reduce amount of storage in the hospital Street.

5.1.5 Oliver Fisher ward – Is divided into three levels of care

- Intensive Care nursery
- High dependency
- Special care

Babies in intensive care are unable to breath for themselves and therefore if disconnected during an evacuation require bag and mask ventilation.

The HVAC systems provided to intensive care areas are designed so that the pressure within the department is maintained at slightly above that of the adjacent areas. In a fire emergency, the continuing operation of these systems will assist in preventing smoke and other products of combustion entering the intensive care area. Although it is accepted that some occupants, because of their condition or treatment, should not be moved, provision must still be made for external evacuation. The need for a vertical movement strategy for such occupants must be recognised, and appropriate measures must be installed to reduce the risk associated with such an action.

As a starting point it recommended that a timescale for evacuation preparation is established particularly for the intensive care nursery.

6. Fire Risk Assessments

6.1.1 Compartment boundaries (60 minutes fire resistance) are designed to protect hospital streets and the secure horizontal escape; they also help to denote different departments allowing for clear management delineation, it is for this reason they mark the boundaries of fire risk assessment areas.

6.1.2 Fire risk assessments in previous years were carried out annually. Guidance in HTM 05-01 echoes fire safety law in not specifying a time frame for fire risk assessment reviews. It states that the fire risk assessment should be a dynamic document that is maintained under constant review. The following are typical examples of reasons to review the validity of the current fire risk assessment:

- changes to the work process, the way work is organised or the introduction of new equipment.
- alterations to the premises.
- changes in use or occupation of the premises.
- substantial changes to furnishings and fixings that may affect fire safety.
- the failure of fire precautions/fire protection systems.

6.1.3 Currently FRAs are being carried out following one or more of the changes outlined above, and are therefore, for the most part dealing with changing risk. However, this leaves the operational issues such as wedging open of fire doors and blocking exits etc. This behaviour is ideally managed locally, not least because the fire safety advisor cannot be expected to carry out constant patrols.

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6.2 Fire Logbook (Local)

6.2.1 Each FRA area should have a fire logbook, which assists the Ward Manager in managing the fire risk in their area, the logbook provides guidance on routine testing etc. The contents of these are designated in the Fire safety Handbook. If a physical book is to be used consistency should be applied.

6.3 Training

6.3.1 The trust employs approximately 4400 persons on the Medway site; this figure increases to over 5000 if employees from other organisations based on the site are considered. In addition to the Induction training. the Trust has a well-structured protocol which provides clear advice and guidelines on the methodology of training. The training matrix is particularly helpful in detailing the type and frequency of training to be provided to each Trust employee.

6.3.2 HTM 05-01 states that video- and computer-based training should only be used to enhance the training delivered by the Fire Safety Adviser and should not be used in isolation for induction or any other form of training. Face-to-face sessions continue to take place; sessions are arranged around hospital shift patterns even if this means carrying out the training out of office hours. Staff receive well timed pre notification.

6.4 Fire alarm

6.4.1 At the Fire Safety group Meeting (FSG) meeting dated 11th August 2025 it was stated that the replacement of the existing (Minerva) fire alarm system is projected to take between 2 and 4 years to complete.

6.4.2 It is accepted that the process of fire alarm replacement will lead to a situation where there are two different systems in use, this is unavoidable. However, acceptance is predicated on the fact that staff are made familiar the meaning of the different warnings in their area and are advised of the situation in other parts of the hospital.

6.4.3 Senior facilities staff are not content that conditions described in 6.4.1 could last for up to 4 more years. Discussions at the meeting centred around speeding up the fire alarm replacement process by moving funds from another project, for example emergency lighting upgrades. It is recommended that this approach is adopted

6.5 Emergency Lighting

6.5.1 New lighting purchased for LED replacement programme in plantrooms and the laundry includes MyMesh technologies allowing lighting to be controlled and tested remotely, including emergency light testing.

6.5.2 The Trust is introducing a self-testing system of emergency lighting. The self-test feature replaces the manual tests carried out monthly and annually. The removal of the need for manual testing makes self-test emergency lighting a more cost-effective solution and creates less disruption in the building.

6.6 Compartmentation

6.6.1 The Trust has invested in the 'Bolster' system which is designed to capture, preserve and maintain any changes to fire stopping digitally, removing duplication and inaccuracy to establish a 'single source of truth'. It went live in September 2023, ensuring designated contractors digitally confirm their respective compliance as part of project documentation.

6.6.2 Contractors drop a dedicated coloured pin onto a plan, depicting its requirement colour, some pictures and a short description, to then track, observe and report the fire stopping throughout the entire hospital site.

6.6.3 Using the 'Golden Thread' concept to record the levels of action needed within the hospital from penetration to FIRAS Certification.

6.6.4 A survey of the higher risk compartment lines (Hospital streets and escape stairs) using the bolster system is programmed to take place towards the end of the year. The results will assess level of risk and therefore the comparative risk associated with compartmentation.

6.6.5 Under Capital Projects, Bolster is now included in the tender process for every project.

6.7 Fire Doors

6.7.1 The current regime of fire door testing and maintenance was designed to ensure that each existing fire door is checked at least every six months. This is in line with Annex I of BS9999. Each door is identified by an individual number which is appended to plan drawing.

6.7.2 There is potential for the fire doors to be included in the 'Bolster' system. it is acknowledged that the barrier to compliance is not necessarily systems based, more resourcing.

6.8 Fire Dampers

6.8.1 The various stages of development of the hospital over the years would have been constructed in line with fire safety guidance at the time and, therefore, it is likely that there is not a homogeneous approach to compartmentation across the site. This is reflected in the approach to dampers, where some ventilation trunking is provided with dampers in sub compartments and other are not.

6.8.2 Fusible dampers on contract and now networked except for two older panels in maternity and the birthplace that will need replacing.

6.8.3 A strategy document providing guidance on the risk associated with management of fire dampers has been produced by BB7 and should help with identifying where they should be located and maintained.

7. Funding choices

7.1.1 When distributing the budget, the Fire Safey Group are guided by the relative risk posed by each of the issues described above. The 2 ‘big players’ in this respect are compartmentation and the fire alarm system which between them form the core of the means of escape strategy. Both are in the throes of investigation and or upgrade. Currently the focus for works is the fire alarm replacement, however further investigations into the state of the compartmentation may reveal the need for urgent remedial measures. The Group will then have to decide if there is a need to reallocate the funding. Clearly the ideal situation would be that both work streams could be fully funded, however realty dictates otherwise

8. Fire Strategy

8.1.1 Discussions in the Fire Safety Group have recently taken place around the need for a fire strategy for the whole site. A Fire Safety Retrospective Strategy Report was produced by Trenton Fire in 2018. Strategy reports tend to describe compliance recommendations. It is more difficult to determine the state and provision of the existing fire safety features and understand how these affect the expected escape provisions. That said the document is helpful and could form the basis of future investigations. The recent investigations on the systems such as fire doors, compartmentation/ dampers etc are essential before moving forward with this project

8.1.2 While the fire alarm is being replaced cause and effect documents should be provided as part of commissioning process. It could be argued that this information is required by the Building Safety Act 2022.

8.2 Emergency Planning and Fire Response Plan

8.2.1 Pre-planning for a fire is key to the success of safeguarding the occupants and the fabric of the building. Pre-planning will also include testing the proposed measures to ensure they achieve their intended objectives. The overall aim is to ensure that all occupants can escape unharmed to a place of safety either: within the building (progressive horizontal evacuation) or outside the building. In order to achieve this, there must be a prompt response to the alarm and an effective strategy for evacuation.
At Medway Hospital planning is split into three approaches

1. Fire Response Plan
2. Local Fire Evacuation Plan
3. Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity Policy

8.2.2 The Fire Response plan is a clear comprehensive and well produced document which provides structure and guidance for staff in the event of a fire. The local plan includes guidance specific to the ward/ area. Identified as a Category One responder under the Civil Contingencies Act (2004), the Trust has special duties and standards which need to be met in relation to Emergency Preparedness, Resilience and Response EPRR and Business Continuity. Policy has been produced to help the Trust to be prepared to deal with a critical incident, this means any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical functions. Although the disruption may be caused by variety of functions a serious fire will be amongst one of them.

8.3 Smoking

8.3.1 Smoking remains an ongoing issue, although designated as a non-smoking site this is clearly not being addressed. Enforcement is an option and may work to some extent, however where individuals receive difficult news enforcement is likely to prove challenging and seem heavy handed it maybe that some form of smoking area, at least outside may be the solution.

8.3.2 More concerning is the smoking by patients in wards, notwithstanding the disruption to the comfort and health of other patients the Oxygen present in both mobile and piped form massively increases the likelihood of a fire starting and aids its development. It is understood that there are sanctions against patients who are found smoking, the ultimate sanction being refusal of treatment. It is very important that all cases are reported to the senior fire safety advisor.

8.4 Reducing unwanted fire signals.

8.4.1 Health Technical Memorandum 05-03 Part H – 'Reducing false alarms in healthcare premises' provides guidance in respect of the measures necessary to identify, control and reduce false alarms in healthcare premises. The guidance is intended to reduce the burden placed on NHS organisations and fire services by avoidable, unnecessary fire calls (false alarms and unwanted fire signals). Ongoing monitoring and record keeping is taking place.

8.4.2 There are 5800 devices in the hospital, and, to remain within the acceptable level of false alarms the performance level grading charts indicate that the X factor should not exceed 59. In the last 12 months this figure has not been exceeded. Which, given the continual building works taking place, is to be commended.

9. Conclusion

To carry out an audit effectively the auditor must have access to all relevant information, and to all parts of the hospital. This cannot be achieved without the assistance of the trust staff. My thanks go to Phil Williams (Senior Fire Safety Advisor) who facilitated my visit.

This audit has provided a comprehensive review of fire safety management at Medway Hospital NHS Trust, assessing compliance with statutory requirements and best practice guidance. While significant progress has been made in areas such as hospital street management, compartmentation control, and emergency lighting upgrades, several critical challenges remain. Chief among these are the ongoing replacement of the fire alarm system and the persistent issue of patient smoking within wards, both of which present heightened risks that require continued prioritisation.

The Fire Safety Group demonstrates strong leadership and collaboration, ensuring that decisions on resource allocation are informed and pragmatic. However, the complexity of the site, coupled with phased development over decades, necessitates sustained focus on maintaining the 'Golden Thread' of fire safety information and implementing robust strategies for evacuation, particularly in high-dependency areas.

To maintain momentum, it is essential that the recommendations outlined in this report are implemented in full, supported by clear timelines and adequate resourcing. Continued engagement from senior management and adherence to the principles of HTM 05-01 and BS 9997 will be critical to achieving a resilient fire safety framework that safeguards patients, staff, and visitors.

In a hospital which has been constructed over a such a long period of time under different regulatory guidance criteria it would be difficult to identify a homogeneous approach to significant issues. Some of the issues from the last audit report remain in place this year, e.g. the fire alarm system and patient smoking. Estates team members are making moves to expedite solutions which will take time to work through.

The individuals involved in the management of fire safety are knowledgeable and focussed and strive to achieve constant improvement. The Fire Safety Group operates effectively to bring forth issues decide on an approach and oversee implementation.

We create safe spaces where people, businesses and communities thrive.

Meeting of the Trust Board
Date: Wednesday 14th January 2026

Title of Report	Assurance Report for Emergency Preparedness Resilience & Response Group			**Agenda Item**	6.3
Stabilisation Plan Domain	**Culture**	**Performance**	**Governance and Quality**	**Finance**	**Not Applicable**
		x	x		
CQC Reference	**Safe**	**Effective**	**Caring**	**Responsive**	**Well-Led**
	x	x		x	x
Author and Job Title	Brian Williams Head of EPRR				
Lead Executive	Frances Woodroffe COO				
Purpose	**Approval**		**Briefing**	**Noting** X	
Proposal and/or key recommendation:	**Noting** – The Board/Committee is requested to formally receive this report. It is provided for information purposes only and does not require discussion or decision. This document is a data report that will be published externally with the Integrated Care Board and NHSE and no further input or action is required from the Board/Committee.				
Executive Summary	This report provides assurance on the Trust's Emergency Preparedness, Resilience and Response (EPRR) preparedness. Medway NHS Foundation Trust (MFT) remains fully compliant with National Health Service (NHS) EPRR Core Standards, as confirmed by the 2024 and 2025 self-assessments. Business Continuity compliance improved to 90%, a significant rise from 68% in July 2024. The Trust received positive feedback during a recent South East Coast Ambulance Service (SECAmb)-led peer review of Chemical, Biological, Radiological and Nuclear (CBRN) arrangements. Training provision is robust but currently not integrated into the Electronic Staff Record (ESR) system. The primary risk is the unfilled Band 7 Emergency Preparedness, Resilience and Response (EPRR) Officer post, which presents operational and regulatory challenges.				
Issues for the Board/Committee Attention:	For noting – Ongoing establishment challenges.				
Committee/ Meetings at which this paper has been discussed/ approved: Date:	Chief Operating Officer (COO) – Senior Operations Team meeting – Nov 25 Central Operations Governance Group – Nov 25				

Board Assurance Framework/Risk Register:	This report aligns with the Trust's Board Assurance Framework and supports oversight of corporate risks. The relevant risk recorded on the corporate risk register is: • **Risk ID:** DATIX 2498 • **Issue Title:** Failure to Maintain EPRR Compliance and Operational Resilience Due to Vacant Band 7 Post • **Summary:** The Band 7 Senior EPRR Officer post has been removed from the 2025/26 budget following a vacancy in July 2023. This has led to a significant reduction in EPRR capacity, impacting the Trust's ability to meet its statutory duties under the Civil Contingencies Act 2004 and NHS EPRR Core Standards. The absence of this post presents critical risks to on-call resilience, incident response, training delivery, and internal assurance processes. This risk is actively monitored and mitigated through ongoing improvements in data quality, reporting mechanisms, and assurance processes. The Board/Committee should note this linkage for context and oversight.			
Financial Implications:	There is a potential adverse impact on the Trust's financial position in the 2025/26 financial year due to the removal of the Band 7 budget allocation. This change may affect service delivery capacity, resource planning, and operational resilience within the affected area. Mitigation strategies and alternative funding options should be considered to minimise disruption and maintain continuity of service.			
Equality Impact Assessment and/or patient experience implications	N/A			
Freedom of Information status:	Disclosable	x	Exempt	

Reports to committees will require an assurance rating to guide the Committee's discussion and aid key issues reporting to the Board	
The key headlines and levels of assurance are set out below:	
No assurance	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans
Partial assurance	Amber/ Red - there are gaps in assurance
Assurance	Amber/ Green - Assurance with minor improvements required
Significant Assurance	Green – there are no gaps in assurance
Not Applicable	White - no assurance is required

ASSURANCE AND ESCALATION HIGHLIGHT REPORT

Meeting	Meeting Date	Group Chair
EPRR Group	19/05/2025	**Brian Williams**

Number of attendees	Number of apologies	Quorate	
		Yes	No
9	22	x	

Declarations of Interest Made

Nil.

Assurance received at the Group meeting

(overview of key points/issues/matters on the agenda discussed at the Group meeting, including anywhere the group was unable to obtain assurance or there may be an adverse impact for the Trust (e.g. potential impact on: strategic progress, compliance or patient safety). Consider whether the agenda was fit for purpose – e.g. linked to the terms of reference and the work plan for that month)

Annual EPRR Assurance Improvements plan

EPRR Core Standards Assessment

- MFT achieved **Full Compliance for 2024/25**.
- Self-assessment for 2025 is complete and remains **fully compliant**.
- Submission due: **12 September 2025**.

Decisions and Actions made by the Group

(Bullet points describing the key decisions made and the responsible owner)

N/A

Highlights from sub-groups reporting into this group

(Short description of any key successes / risks highlighted by the sub-groups. Outline any key projects delegated, e.g. task and finish exercises on a specific issue)

The Trust Business Continuity Network is managed by the Head of EPRR in the absence of a Band 7. This network has an agreed Terms of Reference and aligns with the Trust's BCM Framework 2024.

The Service-level Business continuity plans tracker is held by Integrated Governance to ensure oversight of all service-level Business Continuity plans and details of state – ownership, in development, endorsed, published and socialised, exercised and review.

This is now an element of the Senior EPRR Officer's work plan to maintain the Business Continuity Network to expedite progress with developing and reviewing these plans. It is being managed by the Head of EPRR until B7 role is again filled supported by one of our Band 5's
The Business Continuity Network will convene as a sub-group of the EPRR group, providing updates to the RCAG, as part of the reporting timetable.

Items to come back to the Group

(Items the Group is keeping an eye on outside its routine business cycle)

N/A

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

Item	Group, Subcommittee, Committee	Date
Nil.		

Reports not received as per the annual work plan and action required

Nil

Items/risks/issues for escalation

(Describe the reason for the item being escalated, where it has been escalated to and what action the group needs to take as a result. This may be include for example outstanding action where limited progress has been made)

1) **EPRR risks for Escalation**

The loss of the Band 7 Senior EPRR Officer budget presents a regulatory and staffing risk that may impact the planning and delivery of critical exercises, including the upcoming Outpatients and ED incident exercises scheduled for later this year. A Risk has been raised and business case in draft form for approval prior to escalation.

2) **EPRR Training**

- The 2025 EPRR Training Prospectus is in circulation and has been advertised to all staff once endorsed by the EPRR group and Senior Leadership team. The Training being offered is fully aligned to the NHS EPRR core standards assurance requirements and the Trust's Training needs analysis. The EPRR Training remains standalone and not integrated with ESR for access, recording competency or easily reportable data.

- Incident Commander Training

In line with the Training needs analysis included as part of the Trust Tactical and Strategic Policy, all Senior Managers on Call and Directors on call should undertake this training before commencing

in the On-Call rotas. New Strategic and Tactical Command training was delivered as required. Consolidation of validation will follow.

- CBRN Training

The agreed standard of ensuring MFT have staff trained to respond to a CBRN incident, using a training package consistent with the SECAmb SORT / HART models. We run course internally monthly supported by ED. We are also looking to expand to include non-clinical staff for training.

ED have nominated a member link staff (awaiting 2nd) to ensure the CBRN equipment storage area and equipment is jointly audited and maintained with the MFT EPRR Team.

- Loggist Training

The Trust Loggist list has been updated. There are currently 25 staff trained across the Trust. There is a fully reviewed Training package available on the shared drive which can be informally delivered by the EPRR Officer. We are also sourcing train the trainer courses for the EPRR team.

3) EPRR Risk Register

The current EPRR risk Register will have full review in March. There are risks which require closing and possible new Risks which are not yet articulated.
This review will be informed by:

- the Kent Community Risk Register maintained by our Kent Resilience Forum (accessible via the KRF RD page)
- the Local Health Resilience Partnership EPRR Risk Register

4) CBRNI Peer review and Audit.

Our recent peer review and audit of our CBRNe (Chemical, Biological, Radiological, Nuclear, and Explosive) preparedness, conducted by SECAmb, was a resounding success.
The review team commended our operational readiness, inter-agency coordination, and the professionalism of our staff. Particular praise was given to our robust protocols, training standards, and the clarity of our response framework. This outcome reflects the hard work and dedication of everyone involved and reinforces our commitment to excellence in this critical area of emergency preparedness.

Implications for the corporate risk register or Board Assurance Framework

Nil.

Examples of outstanding practice or innovation

1) EPRR Exercising and Debriefing sessions – Lessons Identified reports

EPRR & ED currently in planning stages for a further live exercise at their request. This will likely be Sept/Oct and will involve support from representatives from Resus teams, Simulation, Estates, Porters, and Site etc.
This is in addition to a Table top in September.

2) **Partnership working and networking.**
HM Coastguard and HM Coroner's Office.
Operation Joinville – CBRN Exercise with London Ambulance Service and the Metropolitan Police.
Operation Melville – Led by MFT in partnership with Kent & Medway EPRR—first-of-its-kind regional evacuation exercise testing mutual aid protocols and cross-agency coordination.
Medway Council including Table top attendance.
LHRP and North West Kent EPRR Team
NHSE SE EPRR Conference.
University of Kent – Guest tutor for Incident Command module for MSc Forensics.

3) **Consultant/Resident Doctors IA**

EPRR stood up Incident command in support of all of the Resident Doctor industrial action.

4) **Trust Business Continuity (BCP) Status**

- Total Plans: 79
- In-Date Plans: 71 (90%), improved from 68% in July 2024.
- Plans Due for Review (Next 3 Months): 2 (2.5%), significantly reduced from 29% in July 2024.
- Overdue Plans: 8 (10%), down from 32% in July 2024.

5) **Trust Network Downtime**

A scheduled network downtime occurred from **20:00 on 27th June 2025 until 07:00 on 28th June 2025**. All operational IT systems were inaccessible. This essential maintenance is to improve reliability and security. The approach was to safely manage a Trust-wide shift to business continuity (BC)/paper operations during a planned network outage, ensuring minimal disruption and safe care delivery.

Despite delays in the new Network becoming fully active the overall event was a success given the size and potential impact of the downtime.

Assurance Levels

Area	Assurance Level
EPRR Core Standards Compliance	**Green** – Full Assurance
BCP Compliance	**Green** – Significant Improvement
Training & Competency	**Green** – Significant Improvement
Risk Register Management	**Green** - Significant Improvement
Staffing Resilience	**Red** – Band 7 post unfilled

REPORT ENDS

Meeting of the Trust Board in Public

Date: 14 January 2026

Title of Report	Modern Day Slavery Statement			**Agenda Item**	6.8
Stabilisation Plan Domain	**Culture**	**Performance**	**Governance and Quality**	**Finance**	**Not Applicable**
			X		
CQC Reference	**Safe**	**Effective**	**Caring**	**Responsive**	**Well-Led**
	X		X		X
Author and Job Title	Matt Capper, Director of Strategy and Partnerships and Company Secretary				
Lead Executive	Chief People Officer				
Purpose	**Approval**	X	**Briefing**		**Noting**
Proposal and/or key recommendation:	The Trust Board is asked to ratify the update to the Modern-Day Slavery Statement for publication on the Trust website as is required by law.				
Executive Summary	The UK Modern Slavery Act 2015 requires every organisation with an annual turnover of £36m or more to publish an annual statement highlighting the steps they are taking to prevent modern slavery in their operations and supply chains. At Medway NHS Foundation Trust, this is supported by our Modern-Day Slavery Policy that clearly outlines steps for Staff to undertake to ensure appropriate due diligence in recruitment and procurement. The public statement provides transparent accountability to our community of the steps that we are taking to proactively identify, assess and mitigate the risks of modern-day slavery. This statement publicly demonstrates our ongoing commitment to protecting vulnerable individuals, promoting ethical practice, and ensuring that modern slavery has no place in our organisation or its supply chains.				
Issues for the Board/Committee Attention:	None				
Committee/ Meetings at which this paper has been discussed/ approved:	People Committee – 27 November 2025 – approved.				

Date:				
Board Assurance Framework/Risk Register:	None			
Financial Implications:	None			
Equality Impact Assessment and/or patient experience implications	None			
Freedom of Information status:	Disclosable	X	Exempt	

Modern Day Slavery and Human Trafficking Statement 2025 - 2026

Introduction

This statement is made pursuant to Section 54 of the Modern Slavery Act 2015 and outlines the steps taken by Medway NHS Foundation Trust to ensure that modern slavery and human trafficking do not occur within our organisation or supply chains. We adopt a zero-tolerance approach to all forms of modern slavery and are committed to acting ethically and with integrity in all our business dealings.

About Medway NHS Foundation Trust

Medway NHS Foundation Trust is an acute hospital serving the population of Medway and surrounding areas. We employ approximately 5000 staff and have an annual turnover exceeding £36 million, which brings us within the scope of the Modern Slavery Act.

Our services include inpatient, outpatient, emergency care, and specialist clinical services. We also deliver services such as pharmacy, catering, cleaning, and facilities management.

Our Commitment

- Support the Government's objective to eradicate modern slavery and human trafficking.
- Ensure compliance with the Modern Slavery Act 2015, Health and Care Act 2022, and NHS England guidance.
- Promote awareness among staff and suppliers of their responsibilities.

Governance and Accountability

- The Board of Directors approves this statement annually.
- The Chief Executive holds ultimate accountability.
- Oversight is provided through the People Committee and Procurement Governance Group.

Policies and Procedures

We have policies in place that support our commitment, including:

- Safeguarding Adults and Children Policy (includes modern slavery indicators and referral pathways).
- Recruitment and Employment Checks Policy (right-to-work verification, fair pay, NHS terms and conditions).
- Procurement Policy (due diligence on suppliers, compliance with NHS Standard Contract and Crown Commercial Service frameworks).

- Freedom to Speak Up Policy (staff can raise concerns confidentially).

Due Diligence in Supply Chains

- All suppliers must confirm compliance with the Modern Slavery Act during procurement.
- Use of NHS-approved frameworks and Labour Standards Assurance System (LSAS) for high-risk categories.
- Risk assessments and supply chain mapping for high-risk goods (e.g., PPE, textiles).
- Contract clauses allow termination for non-compliance.

Training and Awareness

- Mandatory safeguarding training includes modern slavery awareness.
- Procurement and HR teams receive enhanced training on identifying and mitigating risks.

Reporting and Escalation

- Concerns about modern slavery are escalated through safeguarding processes and reported to relevant authorities.
- Staff can report anonymously via the Freedom to Speak Up Guardian.

Future Actions

- Continue to strengthen supplier due diligence in line with PPN 02/23 (Tackling Modern Slavery in Government Supply Chains).
- Expand training to cover all staff groups.
- Annual review of high-risk contracts and supply chains.