Agenda

NHS Medway NHS Foundation Trust

Trust Board Meeting in Public

Wednesday, 14 January 2026 at 10:00 – 12:30 - Trust Board Room, Gundulph Offices and via MS Teams

Item	Subject	Presenter	Type	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 **1.4a**	Minutes of (12 November 2025) and Actions		3 4	10.02	Approve
2.	**Opening Matters**				
2.1	Chief Executive Officer update	Chief Executive	18	10.05	Oversight
3.	**Stabilisation Plan (including IQPR and BAS)**				
3.1	**Culture** a) Cultural Review Actions b) Employee relations recovery c) Board Strengthening	Deputy Chief Executive/ Chief People Officer	IQPR -22 BAS – 64 Sta.Plan – 73 LfD - 82 & Verbal	10:10	Oversight
	Performance a) Delivery of Access Standards b) IQPR headlines	Chief Operating Officer			Oversight
	Governance and Quality a) SHMI – including Learning from Deaths Report b) IQPR headlines	Chief Medical Officer			Oversight
3.2	**Finance** a) Month 09 Report	Chief Financial Officer	103		Oversight
3.3	Board Assurance Framework	Dir. of Strategy and Partnership	106	10:40	Oversight
3.4	Trust Risk and Issues Report	Chief Nursing Officer	109	10:50	Oversight
4.	**Board Assurance**				
4.1	Reports of the Committee Chairs a) Audit & Risk b) Quality (Nov and Dec) c) People d) Finance, Planning & Performance	Chairs of Committees and Executive Leads	125 127 & 134 139 143	11:00	Oversight
4.2	Governance Review	Katie Goodwin and Fiona Wise	146	11:25	Briefing

Agenda

5.	**Other Board Business**				
5.1	Council of Governors Report	Lead Governor	Verbal	11:40	Assurance
5.2	Maternity a) Picker Survey Results b) Maternity CNST compliance Report c) Maternity Bi-Annual workforce report d) Perinatal Surveillance Quarterly report	Director of Midwifery	164 178 205 237	11:50	Oversight
5.3	Annual Fire Safety Audit	Director of Estates and Facilities.	240	12:10	Approval
6.	**Items to Note**				
6.1	Emergency Preparedness, Resilience and Response - Annual Assurance Rating	Chief Operating Officer	Appendix	-	Note
6.2	Modern Slavery Statement	Company Secretary		-	Note
7.	**Closing Matters**				
7.1	Questions from the Council of Governors and Public	Chair	Verbal	12.25	
7.2	Escalations to the Council of Governors				
7.3	Any Other Business and Reflections				
	Date and time of next meeting: 11 March 2026				

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	Revised version on agenda (item 3)	Green
23.07.25	**TB/2025/018**	**Standing Financial Instructions and Scheme of Delegation:** to be reviewed and amended following the establishment of the Kent and Medway Joint Committee.	12.11.25 ~~10.09.25~~	Matt Capper, Director of Strategy and Partnership/Company Secretary	The SFI have been reviewed and no amendment is necessary at this stage. **Propose to close**	Green
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~~ 18.02.26	Siobhan Callanan, Deputy Chief Executive	A mapped report will come to the Board in February 2026	White
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 Transformation Report - Details of responsibilities for the governance route to be decided and shared.	12.11.25	Sheridan Flavin, Chief People Officer	Document shared with Board members in December 2025	Green
10.09.25	**TB/2025/024**	Report on risks and responsibilities for Fire Safety	12.11.25	Neil McElduff, Director of Estates	Report on agenda (item 5.3)	Green
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	Report updated and on agenda (item 4.1)	Green
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/2025/028**	Maternity - Update from Regional South East Team visit to the next meeting.	14.01.26 ~~12.11.25~~	Alison Herron, Director of Midwifery	Report on agenda (item 5)	Green

Minutes of the Trust Board Meeting in Public

Wednesday, 12 November 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
	Jon Wade	Chief Executive Officer (Interim)
	Paulette Lewis	Non-Executive Director
	Mojgan Sani	Non-Executive Director – MS Teams
	Peter Conway	Non-Executive Director – MS Teams
	Gary Lupton	Non-Executive Director
	Helen Wiseman	Non-Executive Director
	Jenny Chong	Non-Executive Director
	Siobhan Callanan	Deputy Chief Executive
	Alison Davis	Chief Medical Officer
	Simon Wombwell	Chief Finance Officer (Interim)
	Steph Gorman	Chief Nursing Officer (Interim)
	Frances Woodrolf	Chief Operating Officer (Interim)
	Sheridan Flavin	Chief People Officer (Interim)
Attendees:	Victoria Moore	Deputy Trust Secretary – Dartford and Gravesham NHS Trust (DGT) (Minutes)
	Matt Capper	Director of Strategy and Partnership/Company Secretary
	Martina Rowe	Lead Governor
	Abby King	Director of Communications
	Alison Herron	Director of Midwifery
	Evonne Hunt	Chief Nursing Officer
	Tina Rowe	Lead Governor
	Jane Harsent	Chair, League of Friends
	Marion Cogger	Secretary, League of Friends
Observing:	Councillor George Crozer	Member of the Public

	Claire Leech	MGG Health
Apologies:	Fiona Wise	NHSE Board Advisor
	Jane Perry	Academic Non-Executive Director
	Katie Goodwin	NHSE Improvement Director

1. PRELIMINARY MATTERS

1.1 Chair's Introduction and Apologies

The Chair welcomed all present and noted apologies as recorded. He extended a warm welcome to Evonne Hunt, Chief Nursing Officer, on her return to the Trust and acknowledged Frances Woodroffe, Chief Operating Officer, attending her first public Board meeting in post. The Chair reflected on his attendance at the Trust's recent Memorial Day service, commending the moving contribution by the Lead Chaplain and thanking those involved.

The Chair reminded members of the importance of flu vaccination and encouraged staff to take up opportunities to receive one. He also urged completion of the staff survey to support engagement and improvement. The Chair highlighted the revised layout of Board and Committee agendas, confirming that these would be aligned to the Trust's Stabilisation Plan and adopted across all sub-committees.

1.2 Quorum

The meeting was confirmed as quorate.

1.3 Declarations of Interest

There were no declarations of interest

1.4 Minutes of the Last Meeting

The minutes of the meeting held on 10 September 2025 were reviewed and approved as a true and accurate record. Minor amendments were requested and would be incorporated prior to approval.

- 3.2c – Clarification that the Trust's financial position was on plan for June but off plan in July.

The Board formally approved the minutes and agreed they would be published in line with governance requirements.

1.5 Action Log

The Action Log was reviewed and updated. Several actions were marked for closure, including those relating to Freedom to Speak Up and Cultural Transformation governance. Outstanding items were linked to the Stabilisation Plan and would be tracked accordingly.

The Board noted the updates and requested that future logs clearly indicate progress against the Stabilisation Plan metrics.

Decision: All actions indicated for closure would be closed.

2 OPENING MATTERS

2.1 Chief Executive Officer Update

The Chief Executive Officer (CEO) provided a strategic update outlining key developments and challenges. The Board was informed that the Trust was expected to be placed in Segment 5 under the National Provider Improvement Programme, following its ranking of 130 out of 134 acute trusts in NHS England's league tables. This position reflected ongoing operational delays, financial pressures, and cultural concerns. The CEO confirmed that Ear Nose and Throat (ENT) service delays had been fully assessed and were considered isolated, with NHS England assured by the mitigation measures in place. Additional updates included the launch of a new palliative and end-of-life care service, recognition awards for maternity and breast care teams, and the onboarding of new Governors.

The CEO also highlighted preparations for upcoming industrial action, noting that plans were in place to maintain safe services and deliver approximately 95% of scheduled activity despite the disruptive nature of the strikes. The Board acknowledged the financial pressures associated with reliance on temporary staff and discussed the Mutually Agreed Resignation Scheme (MARS) as a mechanism to address cost challenges while mitigating capacity risks through a robust two-stage approval process.

The Board noted the update, agreed that continued oversight of operational recovery, cultural improvement, and industrial action planning was essential, and requested that progress on collaboration with Dartford and Gravesham NHS Trust (DGT) be reported at the next meeting.

3 STABILISATION PLAN

3.1 Integrated Quality Performance Report (IQPR)

The Board received the Integrated Quality and Performance Report (IQPR) as part of its review of the Stabilisation Plan. It was noted that all programmes within the plan were rated Amber or Red, reflecting significant challenges in delivery pace and operational pressures. The Executive Team confirmed that structured activity plans were being developed for each workstream, detailing key actions, ownership, milestones, and interdependencies. A coordinated communications strategy was also in progress to improve staff understanding and transparency regarding progress.

Check and Challenge

The Board was advised that strengthened governance and planning would be essential to move programmes toward greater stability. The IQPR would be refreshed to align with the Stabilisation Plan, and the Board was asked to maintain close oversight of delivery risks and provide feedback on reporting formats. No formal approval was required at this stage.

Action TB/2025/030: Executives to finalise activity plans and communications strategy.
Acton TB/2025/031: Board to review updated IQPR and reporting approach at a future meeting.

3.2 Culture

The Cultural Transformation Phase 1 Report was presented by the Chief Executive and Chief People Officer. The report, published in September, was acknowledged as a difficult but necessary read, highlighting negative behaviours experienced by staff. Apologies were issued to those affected, and the Board reaffirmed its commitment to creating a fair, inclusive,

and psychologically safe working environment. Weekly monitoring of incivility cases was underway, with 80 cases reported and red-rated issues escalated within 24 to 48 hours.

The Board commended the engagement of staff and Governors in the process and agreed that a sustainable cultural shift was essential.

Actions TB/2025/022 and TB/2025/023 were raised, requiring a Freedom to Speak Up update and clarification of governance responsibilities. The Board received the report and agreed to support the next phase of the programme, including the development of six workstreams and continued staff engagement.

3.2a Action 2 – Cultural Review Actions

The Deputy Chief Executive presented the report for oversight.

The Board received an update on the six workstreams developed under the "Rebuilding Trust" programme. It was noted that while some areas remained amber or red, significant progress was underway with a focus on achieving key milestones. The remit of the programme had been widened to include governors, stakeholders, and patient voice representation. A "Train the Trainer" toolkit had been implemented and used to prepare advocates, whose contribution was acknowledged as critical to the success of the rollout.

Work continued on refining the Terms of Reference to ensure compliance, inclusivity, and transparency, alongside the establishment of a Programme Board to review input from all workstreams before reporting to the Board. Staff had been surveyed regarding listening events, with results expected at the next meeting.

Action TB/2025/032: Programme leads to finalise Terms of Reference and ensure Programme Board governance arrangements are in place.

Action TB/2025/033: Results of staff survey following listening events to be presented at the next Board meeting.

3.2b Action 1 – Board Strengthening

The Director of Strategy and Partnership/Company Secretary presented the report for oversight.

Governance strengthening was recognised as a priority to support delivery of the Integrated Improvement Plan. The Board agreed that future agendas for both the Board and its Committees would be aligned to the Stabilisation Plan to ensure clarity of focus and improved assurance.

Programme leads were tasked with finalising Terms of Reference for the Programme Board and ensuring inclusive governance arrangements. It was anticipated that the action would move to green in January 2026.

3.2c Action 7 – Ward to Board

Chief Nurse (Interim) presented the report for oversight.

The Board received an update on governance development across all workstreams as part of the Stabilisation Plan. It was confirmed that work was underway to strengthen governance throughout the programme and maintain oversight of all streams. The integrated impact assessment panel was now operational, and benchmarking activity had been identified as the next step.

Programme leads were asked to provide indicative timelines for when their areas could move to green, noting that the culture element was expected to improve but remained amber due to outstanding business case challenges. Benchmarking and development of the accountability framework were to be prioritised, with progress updates scheduled for the next Board meeting. The Board acknowledged that this work would continue with further updates provided at the next meeting.

3.3 Performance

The Chief Operating Officer provided an update on performance.

3.3a Action 4 – Delivery of Access Standards

The Chief Operating Officer, presented the report for oversight.

The Board received an update on access standards and noted significant improvements in cancer care, with the Trust returning to plan and tracking positively against national benchmarks. Sustained progress was highlighted in 31-day cancer performance, with the Trust now within the top 20% nationally, and there were clear backlog reductions in 62-day pathways. However, elective care remained the most challenged area, primarily due to a large cohort of ENT patients. Recovery plans were in place for underperforming specialties, including gastroenterology, cardiology, rheumatology, and ENT, with a focus on eliminating 65-week waits for treatment by December and reducing 52-week waits to 1% by March 2026. Winter planning was underway, supported by Multi-Disciplinary Discharge (MADE) events and the virtual ward model to improve flow and mitigate bed deficits.

Check and Challenge

The Board requested continued monitoring of specialty performance and system-wide coordination. Programme leads were asked to circulate updated performance data to all Board members following the latest statistical review. Benchmarking and resilience planning were to be prioritised to sustain improvements, particularly in elective care and emergency flow. Progress updates, including RTT recovery and winter plan outcomes will be presented at the next meeting.

Action TB/2025/034: Programme leads were asked to circulate updated performance data to all Board members following the latest statistical review.

Action TB/2025/035: Progress updates, including RTT recovery and winter plan outcomes, will be presented at the next meeting.

3.4 Governance and Quality

3.4a Action 6 – Standardised Hospital Mortality Index (Learning from Deaths Annual Report)

The Chief Medical Officer presented the report for oversight.

The Board received the Annual Learning from Deaths Report. The report provided assurance on mortality governance, structured judgement reviews (SJRs), and key themes identified across the Trust. Improvements were noted in the Hospital Standardised Mortality Ratio (HSMR), now within the expected range, while the Summary Hospital-level Mortality Indicator (SHMI) remained high with an upward trajectory. Key areas for improvement included documentation quality, timely escalation of deteriorating patients, and end-of-life care planning. The Medical Examiner Service had successfully transitioned to the statutory model, increasing scrutiny and family engagement. The Board acknowledged examples of good care alongside areas requiring improvement, including handover robustness and coding accuracy.

The Board endorsed continued implementation of the Mortality Breakthrough Objective and agreed to focus on clinical pathways to ensure best care, embedding learning from deaths processes, and improving data accuracy through clinical validation and coding collaboration. Benchmarking and accountability frameworks will be developed, and progress on SHMI reduction, pneumonia audit findings, and coding improvements will be reported at the next meeting.

3.4b Action 10 – Decisions made on Existing Business Cases

The Board noted the action with no further update provided.

3.5 Finance

The Chief Finance Officer presented the Month 6 Finance Report, highlighting a year-to-date deficit of £13.6 million, which was £8 million adverse to plan.

Action TB/2025/029 was raised to ensure success metrics for sample processing are monitored. The Board acknowledged the financial risks and agreed to maintain close oversight of the efficiency programme, cash flow management, and strategic planning for medium-term recovery. The importance of triangulating financial, workforce, and operational data was emphasised.

3.5a Action 5 – Finance Delivery Plan – Month 06 Finance Report

Chief Finance Officer presented the report for oversight.

The Month 6 Finance Report confirmed a year-to-date deficit of £13.6 million, which was £8 million adverse to plan. The position reflected underperformance against savings targets, reduced income from Community Diagnostic Centres, and unplanned cost pressures including industrial action, increased clinical supplies, and maintenance costs. The Board noted that while costs were stabilising, they were not reducing as anticipated. Risks included the potential loss of Deficit Support Funding and the need for additional borrowing to maintain cash flow. VAT recovery assumptions of £3.5 million had crystallised as a loss following an HMRC appeal, and unrecovered debts were being managed with the Kent and Medway Integrated Care Board (ICB).

The Board previously ratified the Virtual Ward business case and approved the Kent and Medway Pathology Network contract, with Action TB/2025/029 having been raised to monitor success metrics for sample processing. The Chief Finance Officer (CFO) confirmed that monthly forecasting was now embedded and that the capital programme, currently behind profile, would require acceleration in the second half of the year. The Board emphasised the

importance of triangulating financial, workforce, and operational data to support decision-making and requested assurance that maternity works would be completed within the financial year.

The CFO would provide a revised year-end forecast and monthly capital spend profile to the Finance Committee on 27 November and report progress to the next Board. Executives were asked to ensure robust governance of savings plans and to escalate risks promptly. The Board noted that strategic planning for medium-term recovery must remain a priority and requested updates on VAT recovery, debt resolution, and winter cost mitigation at the next meeting.

Action TB/2025/036: Revised year-end forecast and monthly capital spend profile to be presented to the Finance Committee on 27 November.

Action TB/2025/037: Updates on VAT recovery, debt resolution, and winter cost mitigation to be presented to the next Board meeting.

3.5b Action 8 – Corporate Services

Chief Finance Officer presented the report for oversight.

The Board discussed the need to strengthen Business Partner capability to support divisional leadership and improve triangulation of performance, clinical, and financial intelligence. It was noted that current processes require greater clarity of roles, expectations, and collaborative working to ensure richer, more strategic conversations around performance. A facilitated approach was being developed to mature these capabilities, with an emphasis on sharing data and insights to provide a joined-up narrative for divisional colleagues. The Board acknowledged that this work would take approximately five months to embed before measurable outcomes were realised.

Programme leads were asked to ensure structured engagement between Business Partners and divisional teams, supported by training and collaborative forums. Benchmarking and capability assessments will be undertaken, with progress reviewed at Trust Leadership Team (TLT) and reported back to the Board. Opportunities for collaboration with external partners, including Dartford and Gravesham NHS Trust, will be explored to standardise roles and strengthen resilience.

3.5c Action 9 – Medium Term Business Plan and Financial Recovery

Chief Finance officer presented the report for oversight.

The Board noted the paper on national planning requirements, which outlined multi-year delivery plans with stringent targets for quality, safety, and financial sustainability. It was confirmed that the Board has a critical role as the first line of defence for regulatory assurance. Deadlines were highlighted as challenging, with an interim submission due in December and a final submission in February, although templates and guidance for the December return were still awaited. The Board acknowledged the need to balance performance, quality, and financial objectives, recognising that difficult decisions may be required to achieve a break-even plan while maintaining patient care standards.

The Board agreed to allocate time at its 17 December meeting to review templates, key assumptions, and required changes. A summary of priorities and recommendations will be presented at the January public meeting and shared with the Council of Governors. The January Finance Committee will be scheduled as a full Board session to align with the February submission. A working group, including divisional and finance leads, will continue to develop trajectories and options, ensuring triangulation of quality, performance, and financial plans. Progress updates will be provided regularly to maintain assurance.

Action TB/2025/038: Allocate time at 17 December Board meeting to review templates, key assumptions, and required changes.

Action TB/2025/039: Summary of priorities and recommendations will be presented at the January public meeting and shared with the Council of Governors.

Action TB/2025/040: All Board members to be invited to January Finance Committee to ensure alignment with February submission.

4. BOARD ASSURANCE

4.1 Board Assurance Statement

The Company Secretary presented the Board Assurance Statement, which summarised the Trust's current risk profile and governance alignment with the Stabilisation Plan. The statement reflected the Board's oversight of key domains including culture, performance, quality, and finance. It also incorporated feedback from sub committees and highlighted areas where assurance had been strengthened or required further development.

The Board noted the statement and agreed that quarterly reviews would be essential to maintain visibility of progress and risks. Members were asked to provide feedback on the format and content of future assurance reports to ensure they remain fit for purpose. The Board reaffirmed its commitment to robust governance and continuous improvement in line with national expectations.

Action TB/2025/041: The Trust Company Secretary to meet with Chair of Audit and Risk Committee to further review and refine Board Assurance Statement.

4.2 Assurance Reports from Board Committees

Committee Chairs and Executive Leads presented assurance reports from the Audit and Risk, Quality, People, and Finance Committees. Key escalations included safeguarding compliance, maternity standards, and controlled drug management. The Quality Committee reported concerns around missing equipment, antibiotic usage, and domestic violence trends. The People Committee highlighted statutory training gaps and cultural transformation progress. The Finance Committee noted underperformance in savings and approved the Virtual Ward for Board ratification.

The Board was assured by the reports and acknowledged the importance of triangulating findings across committees. Members agreed to continue deep dives into high-risk areas and ensure divisional engagement in assurance processes.

4.2a Audit and Risk Committee

Chair of the Audit and Risk Committee presented the report for oversight.

The Board were asked to note that there was limited assurance audit and that this was understood, with further work to be done in relation to controls in place.

The Board was **ASSURED** by the report.

4.2b Quality Assurance Committee

Chair of the Quality Assurance Committee presented the report for oversight.

The Board received the Quality Assurance Committee (QAC) assurance report, which highlighted key areas requiring attention and progress. The Committee noted the ongoing transition work to ensure reports presented to QAC and the Board provide meaningful assurance and add significant value. A deep dive into the National Major Trauma Registry backlog was scheduled for December, with urgent actions identified to address staffing, process gaps, and technology support to safeguard the Trust's trauma designation. The Committee also discussed the need to progress medical device issues, triangulating quality, delivery, and financial impacts, and agreed that the Director of Estates or an Executive lead would attend the next meeting to provide a comprehensive update. Improvements to QSPC reporting were requested to strengthen assurance and clarity.

The Board were **ASSURED** by the report.

4.2c People Committee

Chair of the People Committee presented the report for oversight.

The Board received an update from the People Committee on statutory and mandatory training, employee relations, staff engagement, and workforce initiatives. Compliance rates for statutory training had not improved, although a new trainer had commenced and improvement was expected. Employee relations remained a concern due to a backlog of cases, with additional support secured to accelerate resolution. The staff survey was underway, with a target response rate of 50%; current engagement was 32% for substantive staff and 18.3% for bank staff. The Board noted the Resident Doctor 10-Point Plan aimed at improving working conditions, facilities, and culture within a tight timeline. Staff safety was highlighted as a priority both within hospital settings and for those working in the community.

Staff survey engagement strategies, including drop-in sessions, were to continue, with results reviewed in the New Year. The Board also requested assurance on systems to support staff safety in community settings and endorsed continued engagement with external partners, including anti-racism initiatives.

The Board were **ASSURED** by the report.

4.2d Finance, Planning and Performance Committee

Chair of the Finance Committee presented the report for oversight.

The Board received an update from the Finance, Planning and Performance Committee on the Trust's financial position and recovery actions. It was noted that the loss of Deficit Support Funding (DSF) had created significant cash pressures, with forecasts indicating the Trust would fall below its minimum cash holding in November and face a substantial year-end

shortfall without intervention. The Committee approved submission of a Public Dividend Capital (PDC) application for cash support, subject to amendments, and stressed the need for accurate forecasting and contingency planning. The Board was advised that the efficiency programme remained behind plan, although momentum was building with PA Consulting supporting delivery of the Cost Improvement Programme (CIP). Triangulation of finance, activity, and performance data was highlighted as critical to underpin robust business planning and assurance.

The Committee agreed to maintain close oversight of cash management and CIP delivery. Executives were tasked with ensuring accurate and timely submission of the cash support application, strengthening grip and control measures, and accelerating savings delivery without compromising patient safety or quality. The Committee requested detailed reporting on CIP progress, including phased impacts on cost, workforce, and income/expenditure, and asked for assurance that lessons learned inform the 2026/27 business planning process. A formal Financial Recovery Plan would be submitted to NHSE by the end of November, and revised reporting aligned to the Stabilisation Plan would be presented at future meetings.

The Board were **ASSURED** by the report.

4.3 Medical Examiner – Annual Report

The Chief Medical Officer was joined by the Medical Examiner to present the Medical Examiner Annual Report, which outlined the transition to the statutory model under the Death Certification Reforms 2024. The report highlighted recurring themes including prolonged ED stays, poor documentation, delayed ceiling-of-care discussions, and increased nosocomial infections. The Medical Examiner Office had reviewed a higher proportion of hospital-based deaths compared to national averages, providing valuable insights into care quality and system pressures. It was noted that every death in the region must now be scrutinized, with 3,764 deaths reviewed in the past year and 29% referred to the coroner, consistent with national benchmarks.

The Board acknowledged improvements in governance and welcomed the integration of the Medical Examiner Service with the Learning from Deaths programme. Key areas for improvement included documentation standards, consultant identification, and family communication. The Board noted delays in meeting timeliness targets for referrals and practitioner responses, with mitigations in place including a proof-of-concept for electronic medical certificates to reduce delays. Assurance was provided that concerns raised through reviews are escalated via SHMI and mortality governance processes, and that recommendations are signposted to appropriate teams for follow-up.

The Board agreed to support improvements in documentation and escalation processes and requested continued monitoring of review quality and timeliness. A Trust action plan will be aligned with the report's recommendations and presented to the Quality Assurance Committee for assurance before returning to the Board. Progress on electronic certification, consultant identification, and bereavement engagement will be reported at future meetings.

The Board were **ASSURED** by the report.

4.4 Paediatrics Summit Report

The Board received the Paediatrics Summit Report, which outlined service developments, risks, and improvement actions. Key issues included ligature safety, fire compliance, and governance clarity. It was noted that new blinds were expected to mitigate ligature risks, while compartmentation challenges remained under review. The report also highlighted progress in divisional engagement and assurance processes, supported by strengthened committee oversight. Additional updates included the launch of Martha's Rule, pathway changes following the community paediatrics tender, and plans to deliver Level 2 and enhanced paediatric critical care services within the financial envelope.

The Board welcomed the proactive approach taken by the division, including cross-organisation dialogue with DGT to explore future collaboration opportunities. Members noted ongoing challenges relating to estates risks, mental health patients, and CAMHS, and emphasised the importance of consistent reporting and divisional accountability. The report recommended continued monitoring of performance, development of clinical strategy, and enhancement of governance structures to ensure sustainable improvements.

Further assurance will be sought through the Audit and Risk Committee and Quality Assurance Committee. Progress on ligature risk reduction, compartmentation compliance, and delivery of paediatric critical care services will be reported at future meetings. The Board endorsed continued collaboration with system partners and the development of a robust governance framework to support service resilience.

4.5 Maternity and CNST Compliance Assurance Report – Updates and Actions

The Director of Midwifery presented the CNST Year 7 update, confirming that the reporting period runs until 30 November 2025 with submission due by March 2026. The Board noted that Safety Actions 1 (Perinatal Mortality Review Tool), 5 (Midwifery Workforce), and 8 (Multi-professional Training) were off track or at risk. Safety Action 1 compliance stood at 87% against a 95% target, impacted by delays in receiving factual information. Safety Action 5 related to midwifery workforce budget alignment with Birthrate Plus recommendations, and Safety Action 8 concerned training compliance for new starters and anaesthetic staff. All other safety actions were reported as on track, and the Trust remained safely staffed.

The Board commended the maternity team for their engagement and commitment to improvement and agreed that future reports should include clearer trajectories and risk mitigation plans. It was noted that non-compliance could impact the CNST rebate, although there were no regulatory implications. The Board acknowledged the cultural improvement work underway, including targeted diversity initiatives, bespoke surveys, and enhanced governance through the Perinatal Quality Oversight Model. Assurance was provided that action plans for Safety Actions 1, 4, and 8 had been reviewed by the Trust Leadership Team and were ready for Board approval.

The Board formally

- Approved the action plans for Safety Action 1 (PMRT compliance), Safety Action 4 (NICU Nursing workforce), and Safety Action 8 (New starter training compliance).
- Recognised:
    - 100% compliance with RCOG guidance for short-term and long-term locums.
    - 99% compliance with RCOG consultant attendance guidance.
    - Neonatal medical staffing compliance with all relevant BAPM standards.

  - Neonatal Nursing Team compliance at 68.75% and approve the plan to achieve 70%.
- Were assured by the confirmation that new starters rotating from July 2025 would complete training within six months of start date.
- Noted the ongoing cultural improvement programme and support escalation from the Maternity and Neonatal Safety Champion Assurance Board.
- Agreed to track Action TB/2025/028 for January, pending the outcome of the Regional South East Team's visit.

The Board **APPROVED** the report.

5. OTHER BOARD BUSINESS

5.1 Council of Governors Report

Martina Rowe, Lead Governor gave the Board a verbal update.

The Lead Governor provided a verbal update to the Board, confirming that the Council of Governors' new appointments and that they continued to engage actively with Trust leadership and maintained oversight of key strategic developments. The Governors had received briefings on the Cultural Transformation Programme, the Stabilisation Plan, and recent performance challenges, and were assured that appropriate actions were being taken.

No formal escalations were raised at this meeting. The Board noted the assurance provided and agreed to continue fostering collaborative working with the Council of Governors, ensuring that feedback and concerns are incorporated into planning and governance processes.

The Board were **ASSURED** by the update.

5.2 Audit and Risk Committee (September 2025) – Revised Terms of Reference.

The Company Secretary presented the revised Terms of Reference for the Audit and Risk Committee. The updates aligned the Committee's remit with HFMA guidance and the 2025 Internal Audit standards, ensuring that the governance framework remained robust and fit for purpose. The revisions clarified responsibilities around risk management, internal controls, and financial oversight.

The Board reviewed and approved the revised Terms of Reference. It was agreed that the updated document would be circulated to Committee members and published in accordance with governance protocols. The Board also requested that future reviews continue to reflect evolving regulatory requirements and best practice.

The Board approved the revisions and requested they be published and circulated.

Decision: Audit and Risk Assurance Committee Terms of Reference APPROVED

5.3 League of Friends – Annual Report

The League of Friends presented their annual report, highlighting a total contribution of £364,135 in funded equipment and volunteer support across the Trust. The report showcased the impact of charitable donations on patient care, including the provision of specialist equipment and enhancements to ward environments.

Members noted that the League of Friends would be opening a location in Sheppey to further benefit our staff, patients and visitors and the Board looked forward to supporting the new location.

The Board received the report as a briefing and expressed appreciation for the continued support of the League of Friends. Members agreed to explore opportunities for future collaboration and to ensure that the contributions of volunteers and donors are recognised and integrated into service development plans.

The Board noted the report and expressed appreciation for the continued support.

6 ITEMS TO NOTE

6.1 Medical Education – Annual Report

The Medical Education Annual Report was provided in the appendices folder for Board reference. The report outlined progress in training compliance, postgraduate education, and workforce development. Key achievements included improvements in induction processes and alignment with national standards for clinical supervision and appraisal.

The Board noted the report and agreed that its findings would inform future workforce planning and quality improvement initiatives.

6.2 Infection Protection and Control Standard Contract

The Infection Protection and Control (IPC) Standard Contract was submitted for noting. The report confirmed compliance with national IPC standards and outlined the Trust's approach to managing infection risks, including audit outcomes, training compliance, and outbreak management protocols.

The Board noted the report and continued monitoring of IPC performance indicators.

6.3 Survey Results – Cancer Patient Experience and Inpatient CQC

Survey results from the Cancer Patient Experience and Inpatient CQC were provided in the appendices. The findings highlighted areas of strength in communication and care delivery, as well as opportunities for improvement in discharge planning and patient involvement.

The Board noted the results and plans to triangulate the findings with cultural and performance data. Divisional teams should incorporate survey feedback into local improvement plans and report progress through the Quality Assurance Committee.

7 Closing Matters

7.1 Questions from the Council of Governors and Public

The Chair invited questions from the Council of Governors and members of the public.

The Board noted comments from members regarding operational and workforce matters. Martina Rowe, expressed appreciation for the Trust's support of work experience opportunities, referencing her granddaughter's involvement with the League of Friends through the Duke of Edinburgh Award.

Concerns were raised about discharge delays caused by pharmacy medication availability and incomplete enablement assessments for care packages. The Chief Pharmacist

confirmed that work was underway to align rosters with peak discharge times and improve coordination with community partners, acknowledging that some factors were outside the Trust's direct control.

The Board supported continued efforts to optimise discharge processes and reduce delays, including pharmacy scheduling improvements and engagement with system partners on enablement assessments. It was agreed that progress updates would be provided at future meetings.

Additionally, the Board noted a request for clarification in relation to performance metrics. It was confirmed that these are triangulated with quality indicators to mitigate risks, and endorsed the implementation of the nationally approved MARs scheme, recognising affordability constraints and the exclusion of staff undergoing formal performance processes.

7.2 Escalations to the Council of Governors (COG)

The Chair summarised those items which would be escalated to the Council of Governors following the meeting. These would include the Committee Chairs' reports (formal) with the collaboration with DGT (informal) and a summary of the progress on the stabilization plan.

7.3 Any Other Business and Reflections

No additional items of business or reflections were raised by Board members. The Chair thanked all attendees for their contributions and reaffirmed the importance of maintaining momentum on the Trust's improvement priorities.

The Chief Executive thanked Steph Gorman, Interim Chief Nurse on behalf of the Board and Executive team for her work over the previous months.

7.4 Date and time of next meeting

The date of the next Trust Board meeting was confirmed as Wednesday, 14 January 2026.

The meeting was formally closed at 13.15

These minutes are agreed to be a correct record of the Board Meeting in PUBLIC of Medway NHS Foundation Trust held on Wednesday, 12 November 2025

Signed by the Chair …… Date:

Chief Executive's report: January 2026

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.

Establishing a Group with Dartford and Gravesham NHS Trust

The boards of Medway NHS Foundation Trust and Dartford and Gravesham NHS Trust recently approved the creation of a group between the two trusts, which is supported by our Council of Governors, the Kent and Medway Integrated Care Board (ICB) and NHS England South East.

The decision to form a group follows a review, commissioned by the ICB last year, which identified significant opportunities to improve patient care and strengthen services by establishing a formalised, governance-backed group between the trusts.

Group working is increasingly common in the NHS where two or more trusts work closely together under a shared leadership team while remaining independent organisations. Greater collaboration also underpins delivery of the transformational shifts in the NHS 10 Year Health Plan.

By working as a group, the trusts will be better placed to address shared challenges, learn from each other, build on what each do well, and drive innovation that improves patient care and strengthens services.

The trusts will establish a shared Board, starting with the appointment of a Group Chief Executive and, later this year, a Group Chair.

Once appointed, the Group Chief Executive will work with both boards, staff and stakeholders to agree how the Group will operate and develop shared priorities, and a future leadership structure. This will include strong senior leadership at both trusts who will remain separate organisations.

The Group's development will take place in phases over time while we remain focussed on delivering our immediate Stabilisation Plan priorities, which are to transform our culture, treat patients sooner, improve the quality of their care, stabilise our finances and improve our governance.

Industrial action and flu

I am pleased to report that thanks to careful planning and effort by staff, we were able to maintain most planned appointments and procedures during five days of Resident Doctor industrial action that took place before Christmas.

This latest round of strike action coincided with an early and rapid rise in flu cases in the community. We took the decision to introduce mandatory mask wearing in clinical areas in

December as part of a series of measures to protect patients and staff against flu and other winter viruses.

At the time of writing, inpatient numbers have followed a downward trend since Christmas. However, we remain vigilant should cases rise again, and continue to actively offer staff who had not yet had a free vaccine the opportunity to do so, so that they can protect themselves, their loved ones and our patients against what can be a very serious virus.

Bringing down cancer and elective waiting times

I am pleased to report that we have made significant progress in reducing waiting times for cancer and elective care standards over the last six months.

For cancer care, 76 per cent of patients were treated within 62 days of referral, up from 50 per cent in June, and 76 per cent of patients were seen in line with the 28-day faster diagnosis standard, up from 54 per cent in May.

The number of patients waiting longer than 52 weeks for elective treatment is down from five per cent to one and a half per cent of our total waiting list since the summer, with just 41 patients waiting longer than 65 weeks in December, mostly due to patient choice.

This progress is the result of a significant amount of focussed effort by teams across the hospital as we seek to treat more patients sooner, which is a key focus on our Stabilisation Plan.

Care Quality Commission inspection

In November the Care Quality Commission published its report following an inspection of our Emergency Department (ED) which took place in the previous April.

The overall rating remains requires improvement, with the well-led domain again rated good, and the safe domain upgraded from inadequate to requires improvement. Ratings for the caring, effective and responsive domains remain requires improvement.

Inspectors found improvements to patient care and staff culture since the previous inspection in February 2024, and the requirements of a warning notice, issued in April 2024, have since been met.

The report recognised a number of improvements and areas of good practice, including consistently turning around ambulances quickly, effective daily safety huddles, strong multi-disciplinary team working, and an improved culture and team working in ED.

The report also expressed concern about the service's ability to consistently provide safe care for all patients, and in ways that always maintain their privacy and dignity, particularly when the department is very busy.

Improvements have continued since the April inspection, with more ED nurses and doctors recruited, improved procedures to ensure patients receive specialist assessments, tests

and treatments sooner, and additional senior checks to ensure risk assessments are completed, and medications given, in a timely manner.

Virtual ward service expanded

To help reduce delays and improve care, we have recently expanded our virtual ward service from 80 to 120 beds, and made them available 24/7, so that more people who would otherwise be in hospital can be safely cared at home.

Expanding this service is already helping people leave hospital sooner, and means that some do not need to come into hospital at all, with care provided at home instead. It is also helping to relieve pressure on the hospital, by freeing up ward beds for those who need them most, reducing delays and overcrowding in ED.

This recent expansion is the first step in an exciting journey that will see our well-established virtual ward develop into a 200-bed virtual hospital later this year. This important work builds on the national direction set out in the NHS 10 Year Health Plan, which aims to end ‘hospital by default’ by delivering more care locally and at home.

Call for Concern extended to children’s’ services

A vital patient safety initiative that allows patients and families to request a rapid review if they feel that a patient's condition is deteriorating, has been extended to children’s wards and our neonatal unit, having been successfully introduced in our adult services in 2023.

Call 4 Concern (C4C) enables inpatients, friends and family to call a dedicated number, available 24/7, for immediate help and advice if they have ongoing concerns despite raising them with the nurse in charge or doctor.

A member of our Acute Response Team will assess the patient on the ward and liaise with the medical team to discuss further treatment options, if needed. This important initiative is part of the national rollout of Martha's Rule.

Formal opening for Sheppey Community Diagnostic Centre

Last month we officially opened the newly-completed Community Diagnostic Centre (CDC) at Sheppey Community Hospital. This marks a further step in improving timely access to diagnostic tests and scans for local people, and is part of the national programme to expand diagnostic capacity and improve early detection and treatment of disease.

The centre provides CT, MRI, ultrasound, X-Ray and other diagnostic services, reducing the need for Swale residents to travel to Medway, while also easing pressure on these services at our busy acute site.

Since opening its doors with a CT scanner in December 2024, followed by MRI, ultrasound and other important services last spring, radiology colleagues have delivered close to 50,000 diagnostics, including more than 5,000 CT scans and 3,000 MRI scans.

I am delighted that this service consistently receives positive patient feedback with quicker access to appointments, shorter travel times and the centre's calm environment all recognised.

National accreditation for liver service

Finally, I would like to acknowledge our Hepatology Team for achieving the Improving Quality in Liver Services (IQILS) accreditation. The team is one of 20 trusts to have achieved full IQILS accreditation nationwide and the only trust to do so in Kent.

This significant milestone is the result of a two-year journey, culminating in a successful external assessment in November 2025. The accreditation reflects the team's sustained commitment, collaborative working, and dedication to delivering high-quality, patient-centred care.

This national recognition highlights the exceptional standard of liver care provided by our hepatology service and reinforces our ongoing commitment to continuous quality improvement for the benefit of our local community.

NHS
Medway
NHS Foundation Trust

Integrated Quality & Performance Report

November - 2025

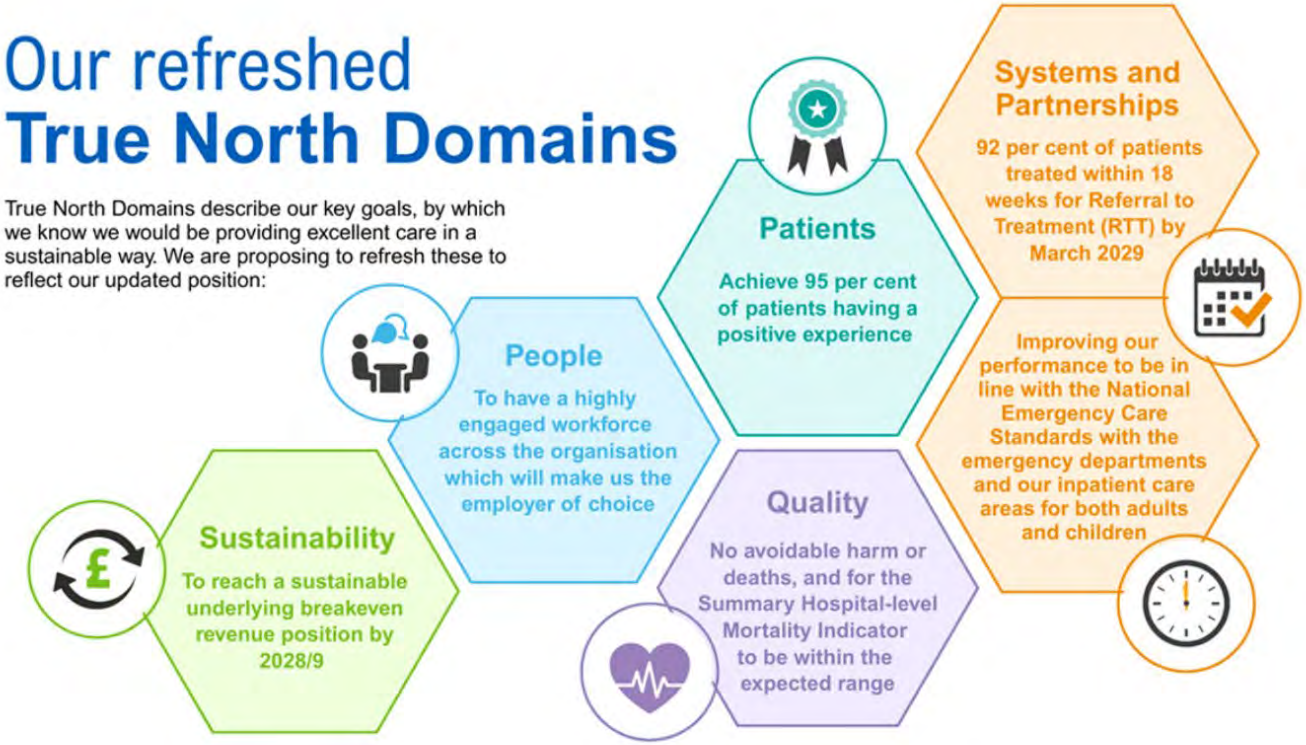
Patient FIRST

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	6	10	3	9	4	5
Quality	24	10	10	9	2	3
Systems & Partnerships	18	14	3	11	2	12
Patients	8	4	0	4	0	3
Sustainability	4	1	4	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		Crude Mortality Rate % Emergency Care FFT Recommend %	National Staff Engagement Score Total FFT Recommend % Type 1 LOS > 12 Hours in EC %	
No Significant Change	Low or No Harm Incidents %	Total EC 4 Hour Performance % WTE Actual vs Plan	Outpatient FFT Recommend % RTT 65+ Week Waiters RTT Incompletes Performance % Variance to CIP Target (£)	Deceased Patient – Clinical Coding Validation…
H / L – Concerning Variation		Total Pay Spend (£) vs Budget	Incivility Cases (Combined)	

Executive Summary

True North Strategy and Supporting Breakthrough Objectives

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
Siobhan Callanan, DCEO

Key Messages

- Culture is recognised as a critical enabler of stabilisation.
- Board and executive strengthening activity is underway.
- Phase 2 of the Cultural Transformation Programme has now commenced.
- Staff listening and advocacy activity is increasing.
- Action is being taken to address the Employee Relations (ER) backlog.

Issues, Concerns & Gaps

- Significant ER backlog, indicating historic process and capability weaknesses.
- Culture work risks being perceived as activity-led rather than outcome-led.
- Inconsistent management capability contributing to ER recurrence.
- Clear success measures for culture change beyond activity completion.

Actions & Improvements

- Complete and embed Phase 2 of the CT Programme with clear behavioural expectations.
- Strengthen managerial capability and accountability to prevent ER recurrence.
- Introduce outcome-based KPIs (e.g. ER reduction, staff confidence indicators).
- Maintain Board visibility through regular culture deep dives.
- Ensure CT actions explicitly support stabilisation priorities.

Governance & Quality
Alison Davis, CMO
Evonne Hunt, CNO

Key Messages

- Key leadership posts filled (Mortality Lead and Sepsis Lead)
- Governance and reporting structures are in place.
- A clearer programme–workstream–project structure is being established to create line of sight from delivery to Board.
- Work is underway to strengthen oversight, reporting and escalation, using standardised templates and rhythms.

Issues, Concerns & Gaps

- Quality improvements are not consistently articulated in terms of impact.
- Programme-level risks are not clearly articulated in the report. Clear programme KPIs demonstrating sustained improvement.
- Governance arrangements have historically been fragmented and inconsistent across the Trust.
- Limited clarity on decision rights, escalation routes, and ownership at programme and project level.

Actions & Improvements

- Define and report a small set of stabilisation-focused quality KPIs.
- Strengthen triangulation between quality, performance, and workforce data.
- Establish and embed a single stabilisation governance framework, clearly setting out roles, decision rights, and escalation routes.

Performance
Frances Woodroffe, COO

Key Messages

- Tangible performance improvements are emerging.
- Virtual Hospital expansion has delivered additional bed capacity.
- RTT performance is improving and now above national target.
- 52-week wait position improving ahead of plan.

Issues, Concerns & Gaps

- Improvements may not yet be fully resilient or sustainable.
- Continued dependency on operational initiatives rather than systemic change.
- Risk that performance gains could be undermined by workforce or financial pressures.
- .Alignment between performance recovery and productivity / workforce plans.
- Forward-looking risks and mitigation not fully developed.

Actions & Improvements

- Embed Virtual Hospital model as business-as-usual with clear ownership.
- Align performance initiatives with medical productivity and workforce plans.
- Strengthen trajectory management and early-warning indicators.
- Explicitly link performance delivery to RSP exit criteria.

Financial Recovery Plan
Simon Wombwell, CFO

Key Messages

- PA Consulting are supporting the Trust to refresh and write a new Financial Recovery Plan. An in-year recovery plan has been produced and socialised with Executives and submitted to NHSE as part of its cash support application.
- Significant financial challenge remains.
- Only 42.6% of the CIP target identified (29.8% risk-adjusted).
- Forecast outturn is materially below target.
- High proportion of schemes are recurrent, which is positive.
- Additional opportunities are being developed (spans & layers, productivity).

Issues, Concerns & Gaps

- FRP requires mature savings planning for the current financial year and beyond; 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.
- Large remaining financial gap with limited time to close it.
- Heavy reliance on schemes still in development or validation.
- Conversion of cost improvement schemes into productivity creates delivery risk.
- Financial grip remains fragile.
- Clear prioritisation of high-confidence, high-value schemes.

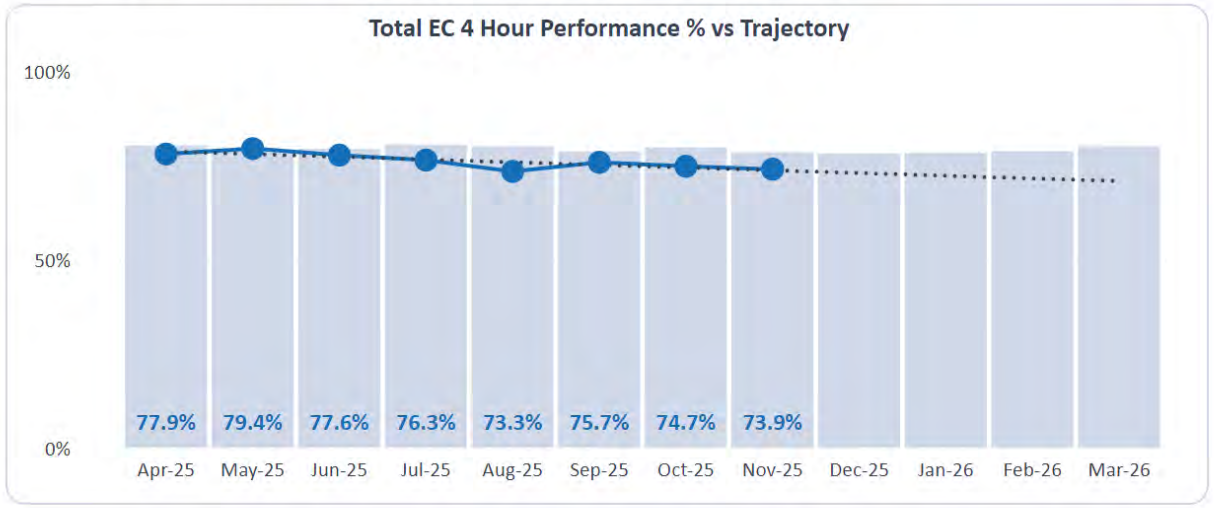
Actions & Improvements

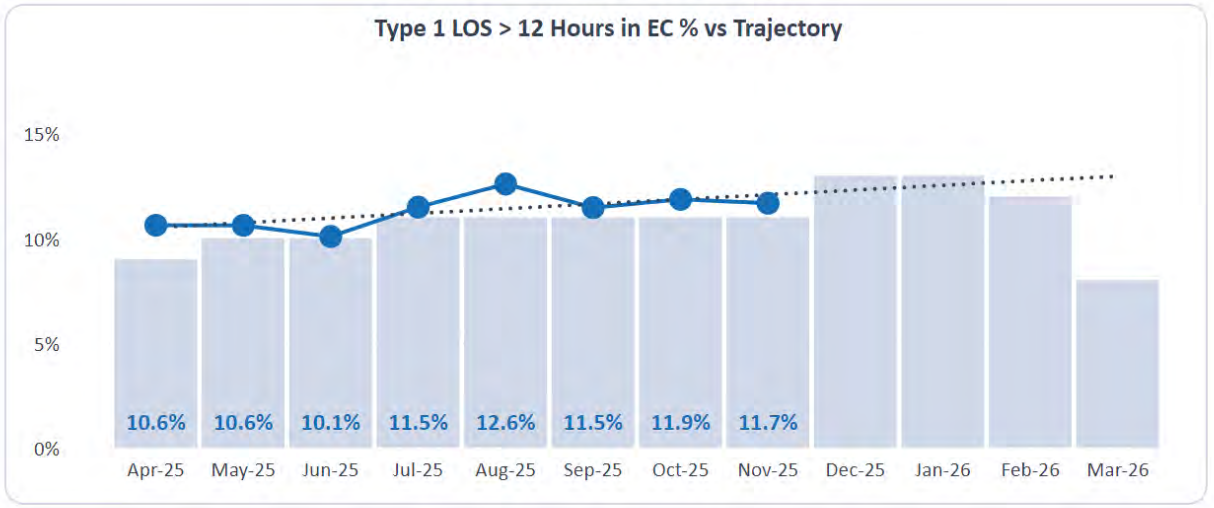
- Implementation of Group Model with Dartford & Gravesham NHS Trust.
- Continued drafting and evolution of FRP.
- Accelerate development and approval of high-value schemes.
- Strengthen ownership and accountability at divisional level.
- Tighten grip and control on pay and non-pay expenditure.
- Integrate finance recovery with workforce and performance programmes.

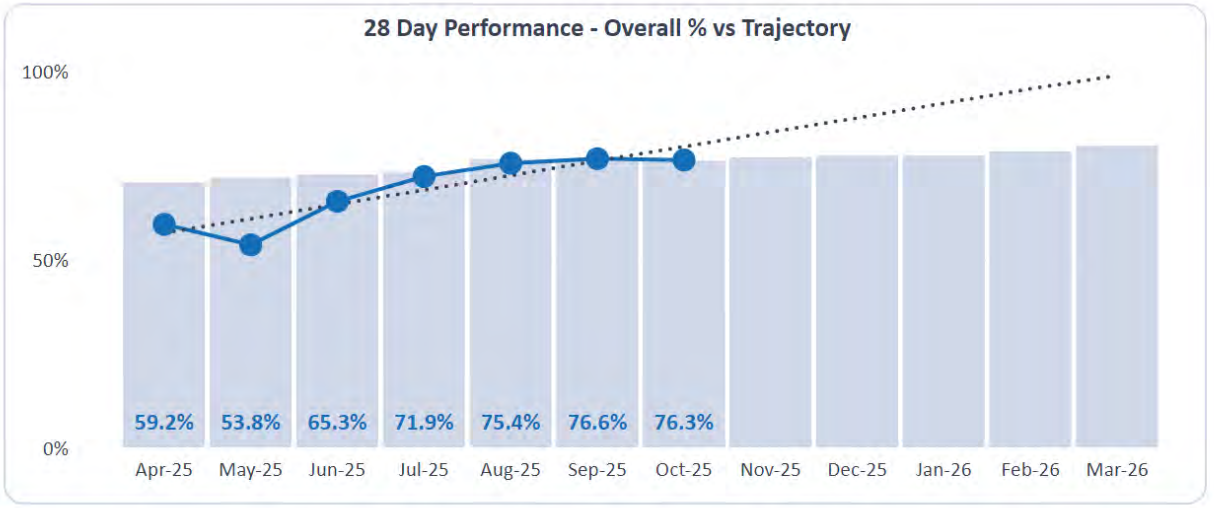
Executive Summary

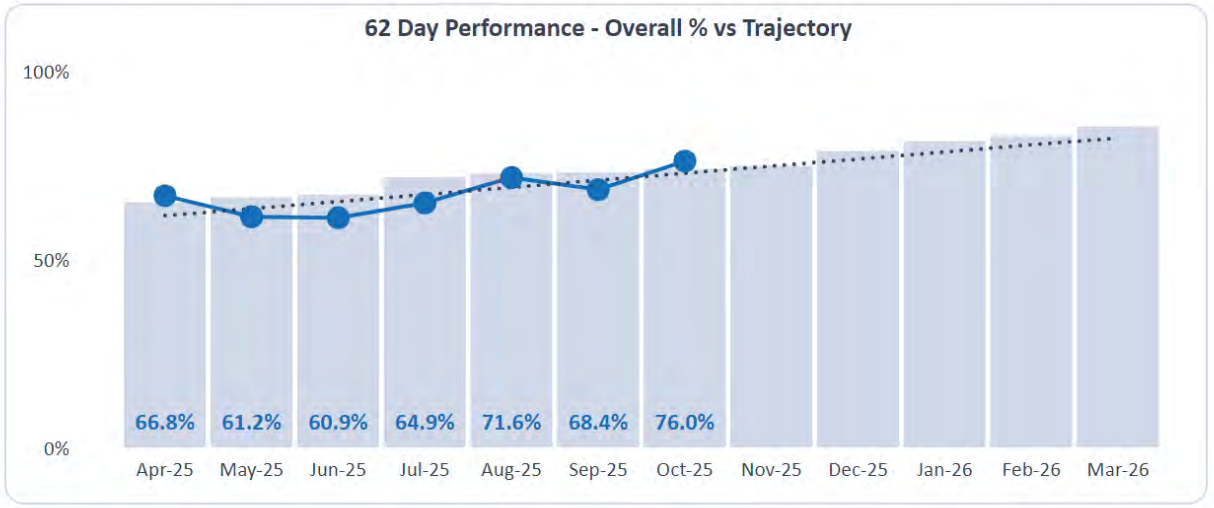
Stabilisation Plan - Performance vs Trajectory

Emergency Care and Cancer KPIs





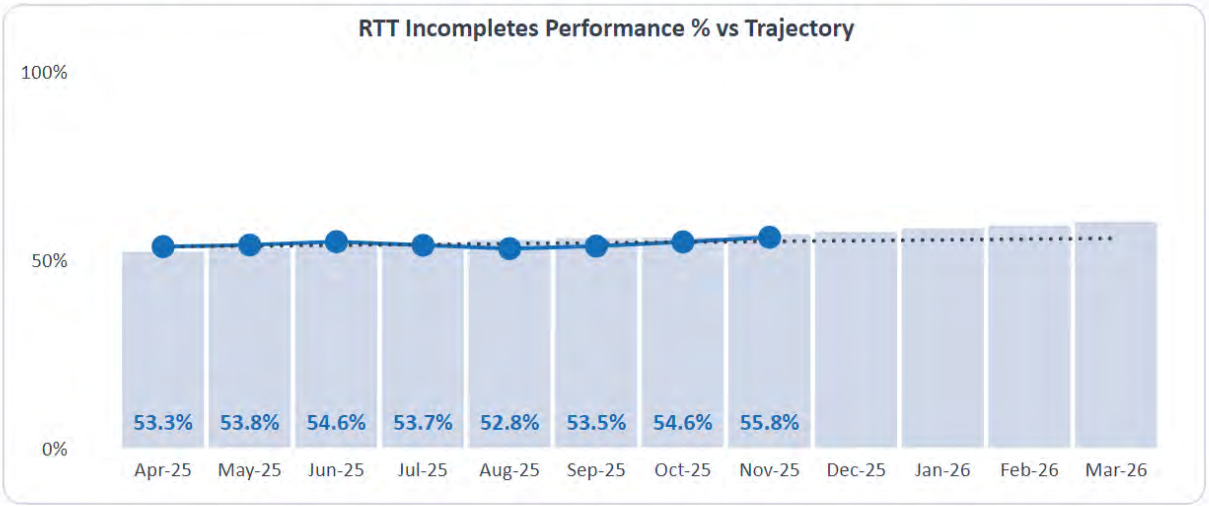


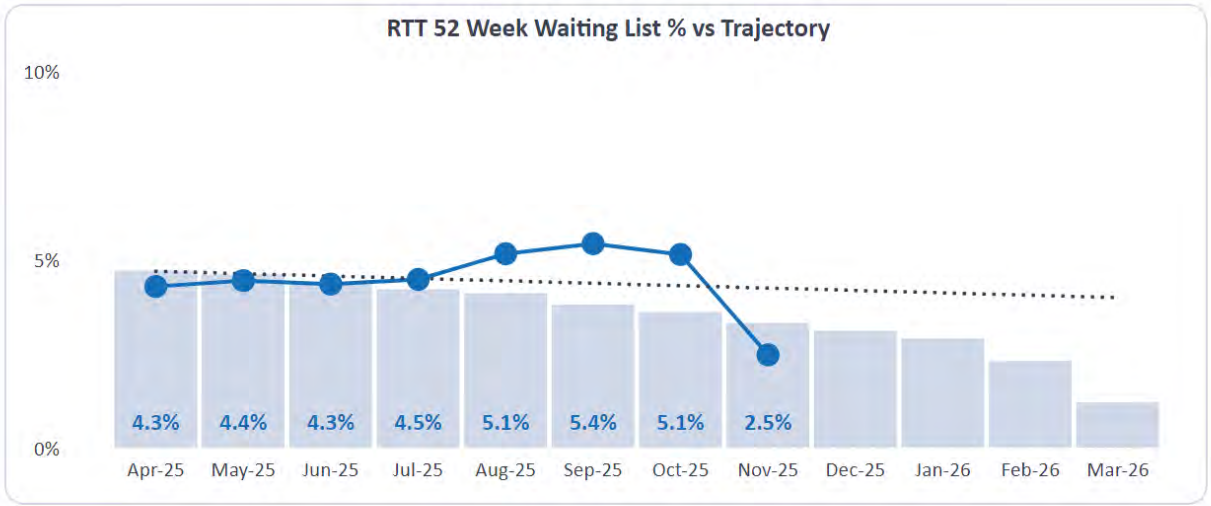


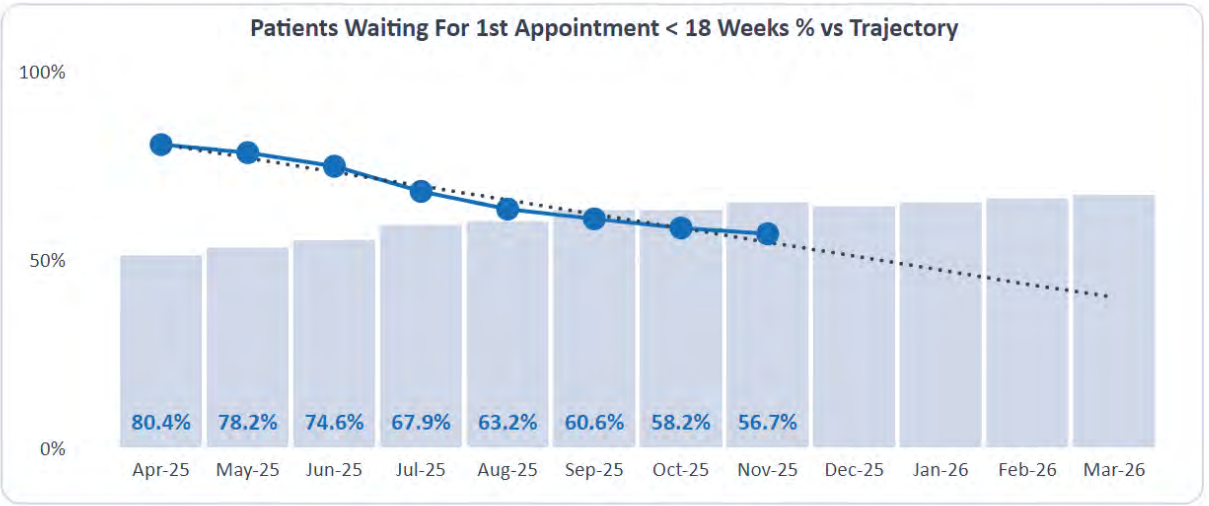
Executive Summary

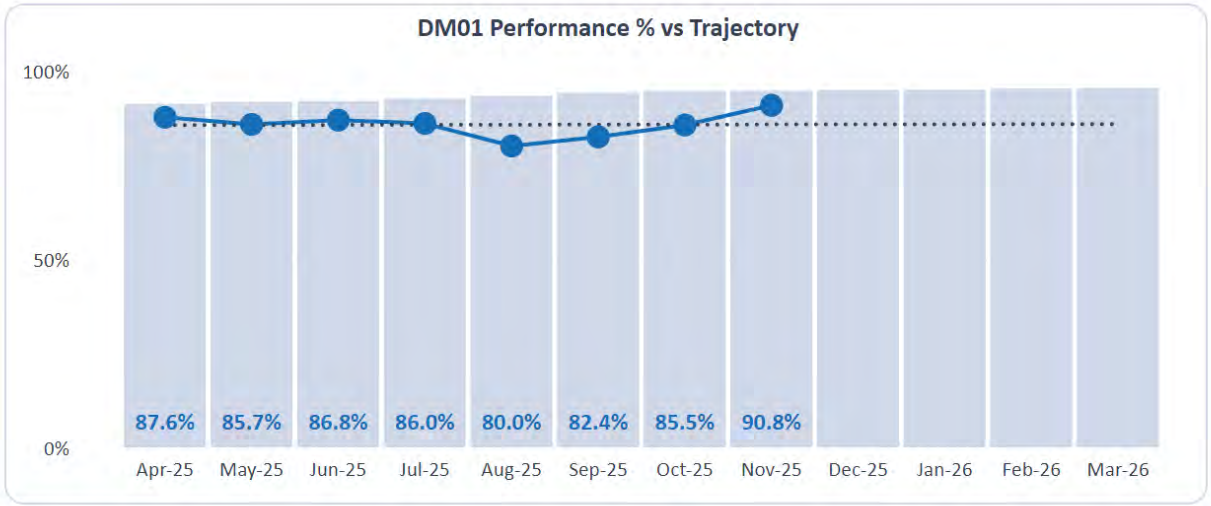
Stabilisation Plan - Performance vs Trajectory

RTT and Diagnostics KPIs









Patients

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

NHS Medway NHS Foundation Trust

Evonne Hunt
Chief Nursing Officer

Patient FIRST

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

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

Committees:
Quality Assurance Committee (QAC)

Patients Summary

Patient FIRST

BUSINESS INTELLIGENCE
Medway NHS Foundation Trust

NHS
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Watch KPIs Only
Patients Domain

Assurance

Variation	KPI consistently passing the threshold	KPI Inconsistently hitting, passing and falling short of the threshold	KPI consistently falling short of the threshold	No threshold Set for KPI
Improving Variation		Mixed Sex Accommodation Breaches	Complaints Breached %	
No Significant Change		Critical Care Admission Delays > 4Hrs Critical Care Discharge Delays > 4Hrs		Complaints Complaints Re-Opened PALS Closed % Parliamentary and Health Service Ombudsm... Patient Advice and Liaison Service (PALS) Co...
Concerning Variation				

Patients

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

FFT

Total FFT Recommend %

Type	Threshold	V	A	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
	95.0%	H	F	90.9%	92.0%	91.5%	90.5%	92.1%	91.9%	91.5%	91.5%	91.0%	90.7%	90.5%	90.9%

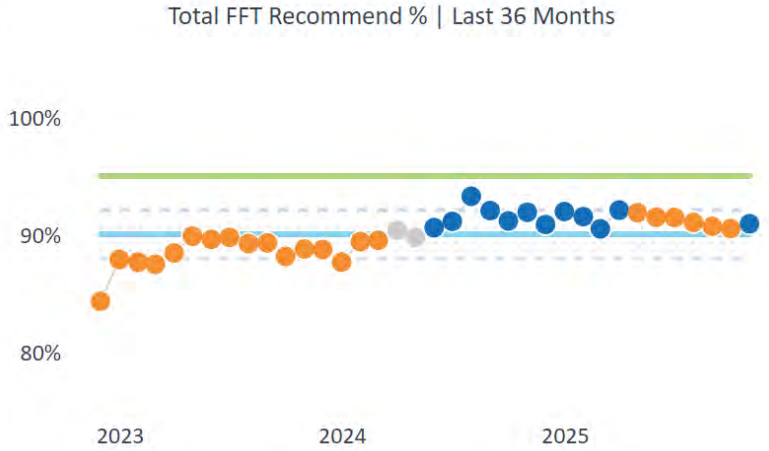
True North Domain: **Patients**

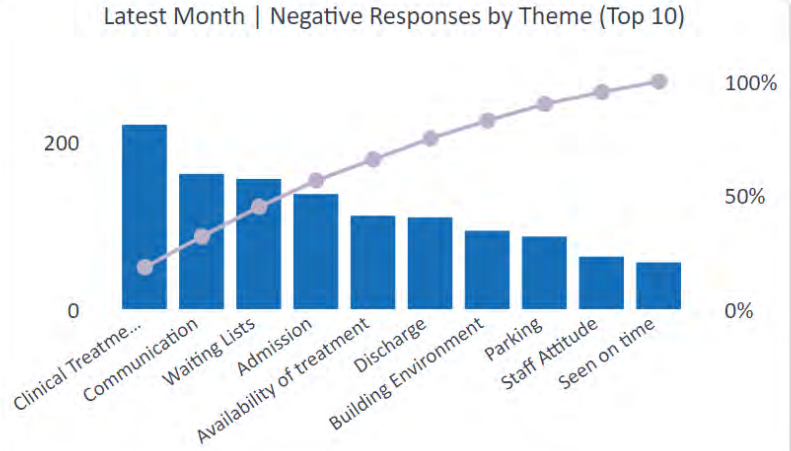
KPI Threshold: 95.0%

Sub Domain KPIs: 3

Variation Summary:

1	0	0	0	2





Key Messages

Positive experiences of care have remained over 90% for 12 consecutive months. Patient experience remains below Trust target.

Small improvement reported in November compared to the previous month.

Issues, Concerns & Gaps

Negative themes reported throughout FFT feedback consistently remain

- Negative experiences of clinical treatment
- Poor communication
- Long waiting times
- Admission and discharge delays/issues

Actions & Improvements

ED improvement plan developed in response to CQC assessment including actions to improve patient experience and FLOW.

Divisional refresh of PE A3 counter measures.

Triangulation of themes from FFT, complaints and PALs

Patients

Key Messages

- 100% complaints acknowledged
- Complaint themes include; delays in diagnosis and treatment, communication between staff and with patients and appropriateness of discharge.
- PALS themes include; queries on appointments, unable to contact department/Pathway Coordinator, verbal communication to patient/relatives and written communication to patient, concerns regarding mental capacity.
- 28 compliments registered.
- 2 PHSO enquiries closed – no investigation required.
- 2 complaints re-opened – both involved patients who had died.
- 60% of amber complaints were responded to within Trust target time of 40 working days due to late submission of comments/statements and changes to the sign off process.

Issues, Concerns & Gaps

- 81 complaints open at month end
- There continues to be a high number of enquires to PALS when switchboard cannot connect to a specialty administration team or the Patient Service Centre to manage the appointment enquiry.
- There is ongoing challenge in obtaining comments/statements from staff to progress the complaint investigation for Executive approval and sign off. This has resulted in an unusually high number of breached cases in November – 40%
- A change to the complaints sign off process was introduced in November

Actions & Improvements

- Following 2 investigations discussions were had in regard to the robustness of completing the falls investigation template. Consideration was given to the outcomes of the investigations and the language captured within the investigation. The falls investigation Swarm/AAR tool was revised and additional prompts were added to signpost the investigator to consider all options, for example the dementia pathway if the 4AT score is elevated.

Patients

KPI Scorecard

Patient FIRST

BUSINESS INTELLIGENCE
Medway NHS Foundation Trust

NHS
Medway
NHS Foundation Trust

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Patients	FFT			Total FFT Recommend %	95.0%	H	F	90.9%	92.0%	91.5%	90.5%	92.1%	91.9%	91.5%	91.5%	91.0%	90.7%	90.5%	90.9%
				Emergency Care FFT Recommend %	80.0%	H	?	72.9%	75.9%	77.9%	75.7%	80.9%	77.3%	76.5%	76.7%	78.2%	77.2%	76.8%	76.7%
				Outpatient FFT Recommend %	95.0%		F	92.2%	93.3%	92.5%	91.0%	92.1%	92.5%	92.3%	92.6%	92.9%	93.0%	91.9%	92.4%
	Patient Experience			Mixed Sex Accommodation Breaches	0	L	?	17	2	13	5	28	24	30	25	24	29	19	5
				Critical Care Admission Delays > 4Hrs	5.0%		?	9.3%	13.3%	12.5%	6.9%	3.2%	1.8%	4.3%	8.1%	4.1%	8.3%	8.1%	3.7%
				Critical Care Discharge Delays > 4Hrs	35.0%		?	57.1%	41.3%	46.5%	52.5%	54.3%	43.9%	45.8%	51.0%	52.4%	64.4%	37.2%	40.4%
	Complaints			Complaints	-			20	37	36	27	24	19	38	21	27	44	30	24
				Complaints Re-Opened	-			2	1	7	0	1	3	2	2	4	1	6	2
				Complaints Breached %	5.0%	L	F	16.7%	33.3%	20.0%	16.2%	14.6%	7.7%	8.3%	16.1%	13.3%	16.7%	17.1%	40.0%
	PALS			Patient Advice and Liaison Service (PALS) Concerns	-			463	470	447	321	453	460	475	533	302	510	617	506
				PALS Closed %	-			100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	PHSO			Parliamentary and Health Service Ombudsman (PHSO) Cases	-			0	0	2	1	0	0	2	1	2	0	3	0

Quality

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

NHS Medway NHS Foundation Trust

Evonne Hunt
Chief Nursing Officer

Alison Davis
Chief Medical Officer

Patient FIRST

Sub Domain	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
Incident Management	5	3	3	2	1	2
IPC	1	0	1	1	1	0
Falls	1	0	0	0	0	0
Health & Safety	0	2	0	0	0	0
Legal & Information Governance	1	0	0	0	0	0
Maternity	7	1	0	0	0	0
Mortality	8	3	4	4	0	1
Pressure Ulcer	1	0	2	1	0	0
VTE	0	1	0	1	0	0

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

Committees:
Quality Assurance Committee (QAC)

Quality Summary

Assurance

Watch KPIs Only
Quality Domain

Variation	KPI consistently passing the threshold	KPI Inconsistently hitting, passing and falling short of the threshold	KPI consistently falling short of the threshold	No threshold Set for KPI
Improving Variation		HSMR (12m) Never Events SJRs Completed % VTE Risk Assessment Completed %	EDNs Completed Within 24hrs %	Duty of Candour Compliance Stage 2 % Mental Capacity Act Training Compliance % Resuscitation Training Compliance % Total Number of Still Births Greater Than 24 ...
No Significant Change		Fractured NOF Within 36 Hours MRSA Cases - Hospital Acquired		After Action Review (AAR) Declared Assaults - Patient on Staff Caesarean Section % Deceased Patient – Clinical Coding Validation... Duty of Candour Compliance Stage 1 % Elective C-Section % Emergency C-Section % Falls per 1,000 Bed days +12
Concerning Variation		Pressure Ulcers - Total (Reportable) Violence & Aggression Incidents	Clinical Incidents with Harm (Moderate and ... SHMI (12m)	After Action Review (AAR) Open - Month End HSMR Expected Death Rate (12m) Pressure Ulcers per 1,000 Bed Days (Reporta... SHMI Crude Death Rate (12m) SHMI Expected Death Rate (12m)

Quality

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

Incident Management

Low or No Harm Incidents %

Type	Threshold	V	A	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
	95.0%		P	99.1%	98.7%	99.3%	99.5%	99.0%	99.4%	99.6%	98.9%	98.3%	98.5%	98.8%	98.3%

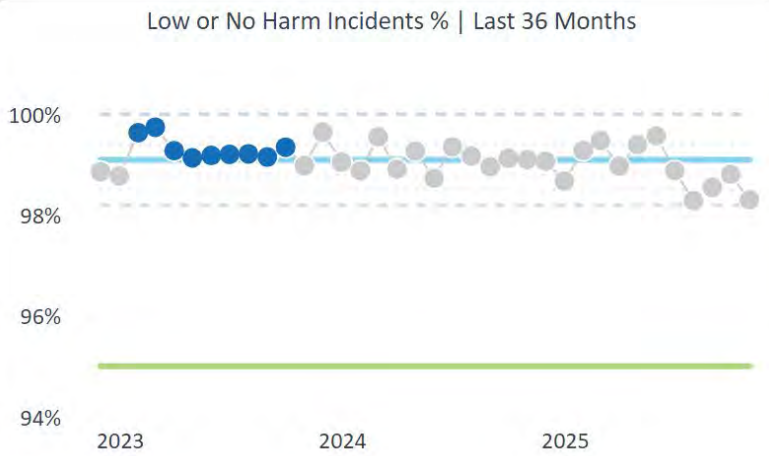
True North Domain: Quality

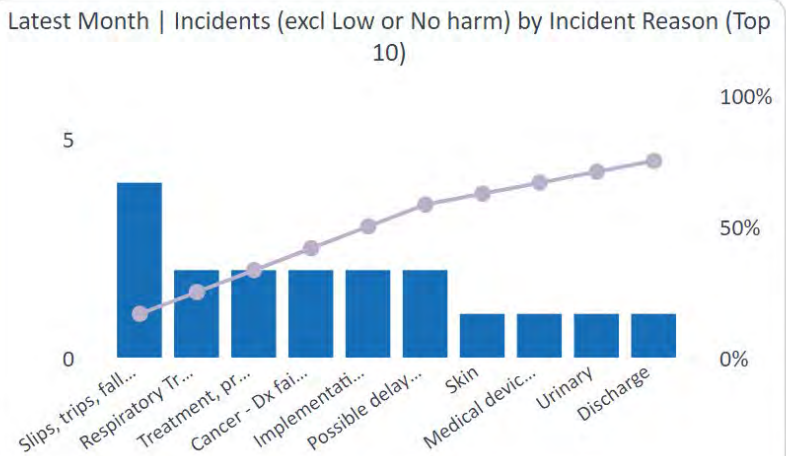
KPI Threshold: 95.0%

Sub Domain KPIs: 11

Variation Summary:

	L	H	L	H
5	0	3	1	2





Key Messages

- 98.2% of all incidents reported resulted in low or no harm.
- Clinical incidents with harm as moderate or above has increased
- 25 incidents in November (pre-validation) caused moderate harm or above. At time of writing, 5 have been validated via IRG, specialty or Care Group.
- 16 Incidents caused moderate harm: 3 validated, 13 tbc.
- 5 incidents caused severe harm: 1 validated, 4 tbc.
- 4 incidents were fatal: 1 validated, 3 tbc

Issues, Concerns & Gaps

- Delays in antimicrobial therapy for suspected high-risk sepsis patients
- Anticoagulation management
- Missed referral and follow up, delay in follow up leading to potentially avoidable admission, delay in diagnosis, missed reporting on imaging
- Cannula and Catheter care
- Transition to adult services and delay in epilepsy follow up
- Potentially avoidable 2222 calls
- Drug withdrawal management and correct instructions on TTO

Actions & Improvements

- Developing nutrition & hydration, Imaging, Mental Health and EOLC QIP.
- Medicines management and VTE QIPs in place.
- Deteriorating Patient QIP being refreshed
- Pathway co-ordinators to receive further training to prevent loss to follow-up incidents
- Learning from SWARMs to feed into nursing education programmes.
- Training being provided to medical staff on the use of US to help prevent delayed VBGs.
- Review of extubation checklist to taking place following identified learning

Quality

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

Mortality

Crude Mortality Rate %

Type	Threshold	V	A	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
	1.30%	L	?	1.80%	2.31%	1.90%	1.58%	1.46%	1.42%	1.12%	1.20%	1.42%	1.47%	1.41%	1.38%

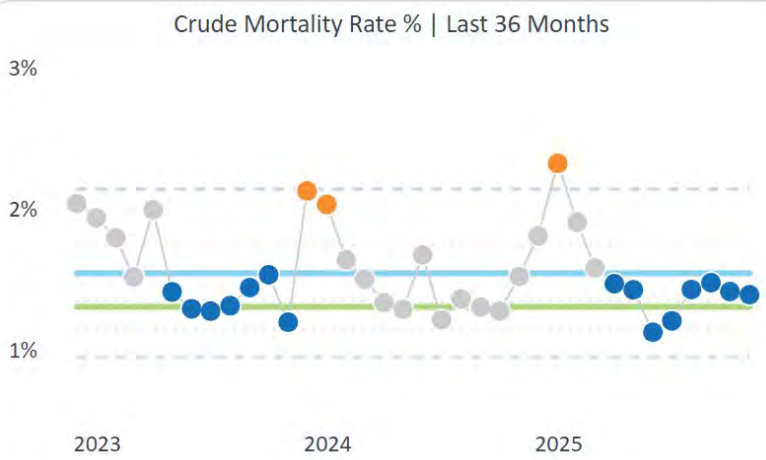
True North Domain: Quality

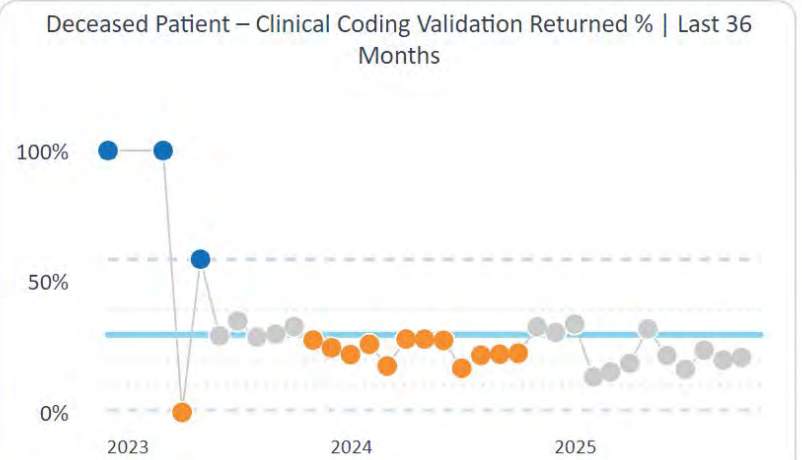
KPI Threshold: 1.30%

Sub Domain KPIs: 15

Variation Summary:

	L	H	L	H
8	0	4	2	1





Key Messages

- HMSR+ for Aug 24- Jul 25 is 94.37 and 'within expected'
- On a single month trend, July 25 performed 'lower than expected' driven by the low volume of in-hospital deaths and the higher number of expected deaths for July.
- The Trust continues to report strong quality of clinical coding with a rate of 44.7% for non-elective HSMR+ superspells with a comorbidity score of 20+ being the highest in the country.
- SHMI for the period of Jul 24- Jun 25 is 1.25 and 'higher than expected'- this is an improvement in SHMI value for the month.
- Pneumonia and UTI remain outlying diagnosis groups for SHMI
- 10.1% deaths were subject to SJR review. Three cases underwent a stage 2 SJR panel. No preventable deaths identified

Issues, Concerns & Gaps

- SHMI remains higher than expected
- UTI and Pneumonia remain outlying diagnosis groups
- There is a recurring theme of patients being admitted to the Trust on palliative or end of life care who die in the Trust.
- There is a concern that frail, elderly patients with prolonged stays in ED, prolonged hospital stays with No Criteria To Reside status, are contributing to increase deaths of patients on the frailty pathway

Actions & Improvements

- Work with community partners to investigate multifactorial challenges when patients are conveyed to MFT to die when a community setting was more appropriate particularly those on the frailty pathway. Community partners to contribute to stage 2 SJR panels
- Strengthened working with the Medical Examiner Office to provide assurance that ME concerns are addressed appropriately and to provide a higher level of scrutiny of deaths of concern.
- Assessing the impact NCTR deaths and avoidable admissions have on the SHMI

Maternity

Key Messages

Perinatal Quality – Incidents: 146 datix (↓)reported for maternity; 0 Incidents in maternity rated Moderate harm or above; 0 MNSI referrals in November, 2 made in October and accepted; 1 MNSI Report received in October 2025; PPH (dashboard) – Total over >1000mls 45 (↓) 14 (↓)1500mls; 4 (↑) > 2500mls; 25 Datix (↓) relating to PPH >1000mls (45 on dashboard); 2 (↓) datix relating to 3rd/4th degree tears (7 (-) recorded via Maternity Dashboard); 37 (↑) Incidents in NICU, 7(↑) relating to medication. All incidents no/low harm. **Staffing** – November 2025: 0.0(↓) WTE Band 5/6 vacancy available to advertise; 5.72 WTE recruited but not yet started; 0 leavers in next 3 months
Perinatal Quality – PMRT: Perinatal Losses (MRRACE reportable & PMRT): 2 Neonatal Deaths – 37+3 (known fetal anomaly), 23+1; 1 Stillbirth – 38+6 Placental Abruption; 4 TOP; 1 PMRT Meetings held in November: Maternity Led Graded at B.C. **Listening to Women and Families – Service Users and MNVP**: 15 Steps planning: Walk the patch planning; Ongoing Communication projects; Co-production involvement within the Trust - PPH, Previous CS pathway; Co-production of CQC Picker Survey Action plan arranged for December. **Staff Feedback**: Community connectivity continues to be a subject of staff feedback. The issue score has been increased. Purchase order has been approved to progress with work; USS quality of imaging in FMU affecting quality and length of appointments. Added to risk register and capital bids. Loan equipment in interim. **Training**: Achieved >90% compliance for all staff groups for PROMPT, CTG and NBLS training as per CNST requirements. **External**: Q1 25/26 Saving Babies Lives (SBL) 94% Compliance; NHSE Maternity Insight Visit completed September 2025; Awaiting formal report; Declaring compliance with 9 out of 10 CNST Safety Actions.

Issues, Concerns & Gaps

Perinatal Quality – Incidents: 3rd and 4th degree tears and PPH now ongoing QIPS; 3rd and 4th degree tears same as previous month. Datix not completed for all instances; Datix not completed for all PPH >1000mls. **Staffing**: 12.6 WTE (-) maternity leave; Full birthrate plus review required as part of CNST Year 8 at >£11,000 cost. **Risk**: Non-compliance with CNST Safety Action 1 (PMRT). Perinatal Quality - PMRT: Themes – Documentation, Communication, Staff attitude; Both neonatal deaths referred to coroner (parental referral). **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**: Ward clerks raised concerns regarding vacancy and impact on individual workloads. Interviews held 13.11.25. 2 WTE appointed. Request for additional vacancies to be filled by Bank; Continued intermittent loss of central monitoring connectivity on delivery suite, multiple fixes by IT. **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 to review service provision, prioritisation and business planning. SBL compliance will reduce, as this element will now move to partially implemented; Declaring non-compliance with CNST Safety Action 1 (PMRT reporting) due to 3 cases missing report started deadline. Awaiting MBRRACE verification for final position.

Actions & Improvements

Perinatal Quality – Incidents: VTE QIP meeting underway including process mapping, service user video, service user survey and patient information; Initial PPH QIP meeting held, data reviewed and preliminary actions agreed; Reminder to all staff to ensure all 3rd and 4th degree tears and PPHs are datixed. **Staffing**: Workforce action plan devised and aligned with key areas of enquiry from National Maternity and Neonatal Investigation; Bi-annual workforce paper completed. To be shared with Trust Board in January 2026; Include Birthrate plus in business planning for 26/27. **Perinatal Quality – PMRT**: Staff review and reflection on care and communication; Review of communication of bereavement team, including sharing of ashes. **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 part of working group for PPH QIP; MNVP to support coproduction of service user information and videos for VTE pathway; Picker Survey 2025 results received into organisation. Action plan to be co-produced with MNVP and key stakeholders once embargo lifted. **Staff Feedback**: Inability to support waterbirth requiring continuous fetal monitoring on delivery suite due to wireless CTG monitor no longer functioning. Added to risk register, capital bids and charity request. 1 to be purchased with support of league of friends. **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**: No harm or adverse impact on families due to delays in reports being started on PMRT system. All reports published within required timeframe and parents views and input sought in a timely manner; Action plan in place to support future compliance.

Quality

Key Messages

- FNoF/NAFF: Total admissions: 28 patients - NOF (Neck of Femur) fractures: 23 patients, NAFF (Non-Ambulatory Fragility Fractures, non-hip): 5 patients; Overall breaches: 11 / 28 (39.3%) - NOF breaches: 9 / 23 (39.1%), NAFF breaches: 2 / 5 (40.0%). Compliance: 60.7% overall, continuing an upward trend from 61.5% in October 2025, and significantly improved from 33.3% in August 2025
- TVN – increase in reportable PUs in October and November, causing increase in PU per 1000 bed day increases. 2 grade 4 PUs also reported in November.
- All new purchased equipment has been fully deployed for patient use
- Falls – to celebrate that all clinical areas achieved over the above requirement for the crash bundle audit.
- The number of falls per 1,000 bed days has remained below 5 for six consecutive months.
- Over 200 Violence and aggression incidents recorded for six consecutive months.
- VTE risk assessment compliance remains above target, compliance has improved in paediatric and lower performing areas

Issues, Concerns & Gaps

- FNoF/NAFF: The majority of delays occurred in weekdays during daytime lists, consistent with high elective pressure. Breaches occurred due to insufficient theatre capacity (55%), medical optimisation through complex comorbidities/infection/sepsis (36%) and subspecialty surgeon/equipment availability (9%)
- TVN reportable PUs rise, in part, attributed to staffing gaps within the corporate TVN team and a reduction in QI work in the top contributing clinical areas
- The dashboard to report VTE compliance remains outstanding as automated reporting on sectra cannot be established. The number of HAT's increased in November, identified themes are in relation to incorrect doses of thromboprophylaxis
- SHMI remains above expected whereas HSMR+ is within expected range

Actions & Improvements

- FNoF/NAFF: Insufficient theatre capacity remains the dominant theme. Medical optimisation delays are often unavoidable but could be reduced through earlier preoperative input and escalation
- Medical Examiner's Office trialling electronic medical death certificates, to enable any amendments that require to be made, can be rectified electronically, preventing delays and distress to families.
- TVN – intensive support and QI work to recommence in Harvey, Phoenix and Sapphire as the top contributing areas.
- Falls - programme to replace falls alarms ongoing with completion estimated by the end of 2025
- Through the fundamentals of care group a new handover process is being rolled out following positive initial results.
- VTE – the divisional leads and CNS for VTE are working with radiology to identify AI solutions to automate positive scan reporting
- The VTE CNS and clinical lead have established a programme of education for clinical staff, however VTE training is not mandatory. The VTE policy has been socialised with all clinical staff and will be taken through governance for ratification

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Quality	Incident Management			Low or No Harm Incidents %	95.0%		P	99.1%	98.7%	99.3%	99.5%	99.0%	99.4%	99.6%	98.9%	98.3%	98.5%	98.8%	98.3%
				Clinical Incidents with Harm (Moderate and above)	0	H	F	7	11	8	6	10	6	5	13	14	15	15	23
				Patient Safety Incident Investigations (PSII) Declared	-				1	1	1		2		2		1	1	
				After Action Review (AAR) Declared	-			2	6	5	1	4	5	4	5	5	2	4	3
				After Action Review (AAR) Open - Month End	-	H		7	11	12	8	9	13	14	15	18	19	19	21
				Never Events	0	L	?	0	0	0	0	0	0	0	0	0	0	0	0
				Duty of Candour Compliance Stage 1 %	-			100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	90.0%	100.0%	92.3%
				Duty of Candour Compliance Stage 2 %	-	H		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
				EDNs Completed Within 24hrs %	90.0%	H	F	84.8%	83.1%	82.4%	82.9%	84.4%	84.5%	86.2%	87.3%	84.3%	87.1%	85.8%	85.4%
				Violence & Aggression Incidents	126	H	?	123	116	172	247	220	167	237	221	265	214	267	230
				Assaults - Patient on Staff	-			53	56	66	73	48	48	65	72	120	54	82	79
	Falls			Falls per 1,000 Bed days	-			5.08	6.69	5.94	4.24	4.45	5.96	4.46	4.65	4.63	4.72	4.73	4.13
	Pressure Ulcer			Pressure Ulcers - Total (Reportable)	24	H	?	26	34	39	30	22	23	28	21	23	23	40	38

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Quality	Pressure Ulcer			Pressure Ulcers - Grade 4	-			0	1	2	2	1	1	2	1	2	0	0	2
				Pressure Ulcers per 1,000 Bed Days (Reportable)	-	H		1.59	1.99	2.57	1.82	1.42	1.41	1.76	1.27	1.38	1.43	2.43	2.42
	IPC			C-Diff Cases - Hospital Acquired YTD (Cumulative)	53			48	54	58	64	3	6	13	19	23	25	26	29
				MRSA Cases - Hospital Acquired	0		?	2	0	0	0	0	0	0	1	0	1	0	0
	Mortality			Crude Mortality Rate %	1.30%	L	?	1.80%	2.31%	1.90%	1.58%	1.46%	1.42%	1.12%	1.20%	1.42%	1.47%	1.41%	1.38%
				Deceased Patient – Clinical Coding Validation Returned %	-			30.5%	33.8%	13.6%	15.5%	18.8%	31.9%	21.7%	16.5%	23.8%	20.0%	21.1%	-
				Deceased Patient – Clinical Coding Validation Sent %	-			98.3%	93.3%	96.7%	97.3%	99.0%	95.9%	93.2%	94.0%	92.3%	91.3%	18.6%	-
				HSMR (12m)	100	L	?	97.42	97.53	96.70	97.14	97.58	97.02	96.01	94.40	96.72			
				HSMR Expected Death Rate (12m)	-	H		5.3%	5.4%	5.5%	5.6%	5.6%	5.7%	5.7%	5.8%	5.8%			
				HSMR Expected Death Rate (Month)	-			6.5%	6.0%	6.8%	6.3%	5.4%	6.0%	5.5%	6.0%	5.9%			
				SHMI (12m)	1	H	F	1.21	1.23	1.25	1.25	1.26	1.26	1.25	1.26				
				SHMI Expected Death Rate (12m)	-	H		3.2%	3.3%	3.3%	3.4%	3.4%	3.5%	3.5%	3.5%				
				SHMI Crude Death Rate (12m)	-	H		3.9%	4.0%	4.1%	4.2%	4.3%	4.4%	4.4%	4.4%				

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Quality	Mortality			Fractured NOF Within 36 Hours	92.0%			83.3%	70.7%	60.9%	70.0%	48.7%	71.9%	78.8%	66.7%	31.6%	58.8%	88.9%	
				Number of Deaths Reviewed via SJR	-			14	13	10	18	15	13	12	19	17	16	16	11
				SJRs Completed %	12.5%	H		9.2%	6.5%	7.2%	14.6%	14.3%	11.9%	14.1%	19.6%	16.8%	14.3%	13.8%	10.3%
				Total Number of Deaths Due to Failings in Care	-			0	1	0	2	0	0	0	0	1	0	0	0
				Number of LD Deaths Reviewed via SJR	-			0	0	1	4	0	0	1	0	1	1	1	1
				Total Number of LD Deaths Due to Failings in Care	-					0	0			0		0	0	0	0
	VTE			VTE Risk Assessment Completed %	95.0%	H		99.1%	98.9%	97.6%	94.5%	99.5%	97.0%	96.1%	97.9%	95.6%	98.3%	97.6%	97.1%
	Maternity			Caesarean Section %	-			48.1%	46.5%	51.1%	45.1%	53.0%	50.1%	48.7%	50.0%	52.2%	44.4%	50.8%	52.1%
				Elective C-Section %	-			21.8%	19.8%	22.3%	21.2%	22.3%	20.4%	20.3%	23.9%	19.2%	20.9%	21.9%	19.2%
				Emergency C-Section %	-			26.3%	26.6%	28.7%	23.9%	30.7%	29.7%	28.4%	26.1%	33.0%	23.5%	28.9%	33.0%
				PPH greater than or equal to 1500mls	-			20	18	12	15	18	12	14	17	16	15	21	14
				Total Number of Still Births Greater Than 24 weeks Gestation	-	L		0	2	2	1	1	1	0	1	0	1	1	1
				Neonatal Deaths	-			2	3	3	3	1	2	2	1	3	3	3	2

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Quality	Maternity			Maternity and Newborn Safety Investigations (MNSI) Declared	-			0	2	1	0	0	0	0	0	0	0	0	1
				Number of cases of Hypoxic Encephalopathy (HIE) grades 2 & 3	-			1	0	0	0	0	0	0	0	0	1	1	0
	Health & Safety			Resuscitation Training Compliance %	-			84.5%	84.0%	84.0%	83.7%	83.5%	85.0%	83.5%	84.0%	84.1%	83.0%	82.9%	83.3%
				Mental Capacity Act Training Compliance %	-			86.9%	86.1%	86.0%	85.3%	85.6%	86.2%	86.8%	86.4%	86.5%	86.6%	86.6%	85.7%
	Legal & Information Governance			Regulation 28 Reports	-			-	-	-	-	-	-	-	-	-	-	-	-

Systems & Partnerships

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

NHS Medway NHS Foundation Trust

Frances Woodroffe
Chief Operating Officer

Patient FIRST

Sub Domain	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
Access	10	9	3	8	1	8
Emergency Care	8	5	0	3	1	4

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

Committees:
Finance & Performance Committee

Systems & Partnerships

Assurance

Watch KPIs Only
Systems & Partnerships

Variation	KPI consistently passing the threshold	KPI Inconsistently hitting, passing and falling short of the threshold	KPI consistently falling short of the threshold	No threshold Set for KPI
Improving Variation	30 Day Readmission Rate	Ambulance Handover Delays (> 60 mins) Cancer USC Performance % DM01 Performance % RTT 52 Week Breaches	62 Day PTL Backlog Average Time in EC Department - Excl. Type ... Outpatient DNA Rate % PIFU % RTT 52 Week Waiting List %	IP Discharged Before Noon % (Inc transfers t... OP First to Follow Up Ratio RTT Waiting List Size
No Significant Change		28 Day Performance - Overall % 31 Day Performance - Overall % Average Elective Length of Stay (days) Operations Cancelled by Hospital on Day Total EC 4 Hour Performance - Non-Admitted... Urgent Operations Cancelled for 2nd Time	62 Day Performance - Overall % Total EC 12 Hour DTAs Type 1 EC 4 Hour Performance %	104 Day Cancer Waits Ambulance Handover Delays (> 30 mins) Bed Occupancy - NCTR % (G&A) Day Case Rate % Number of ED Arrivals by Ambulance The Number of Patients in TES within ED
Concerning Variation	Average Non-Elective Length of Stay (days)		OP Average Time to First Appointment (days)	Patients Waiting For 1st Appointment < 18 ...

Systems & Partnerships

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

Access

RTT Incompletes Performance %

Type	Threshold	V	A	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
	60.0%		F	50.3%	50.6%	51.5%	53.0%	53.3%	53.8%	54.6%	53.7%	52.8%	53.5%	54.6%	55.8%

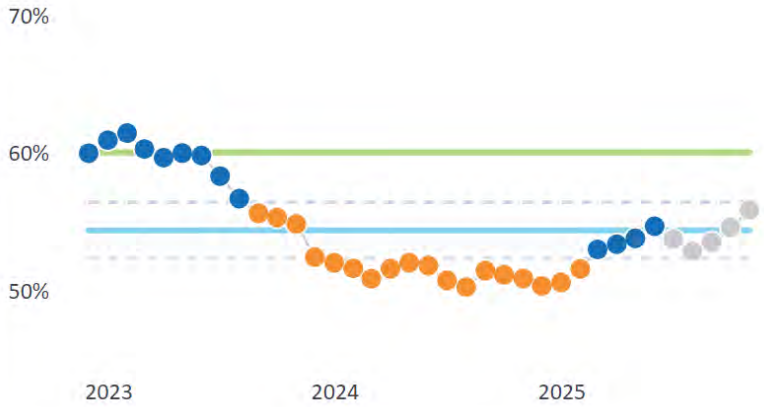
True North Domain: Systems & Partnerships

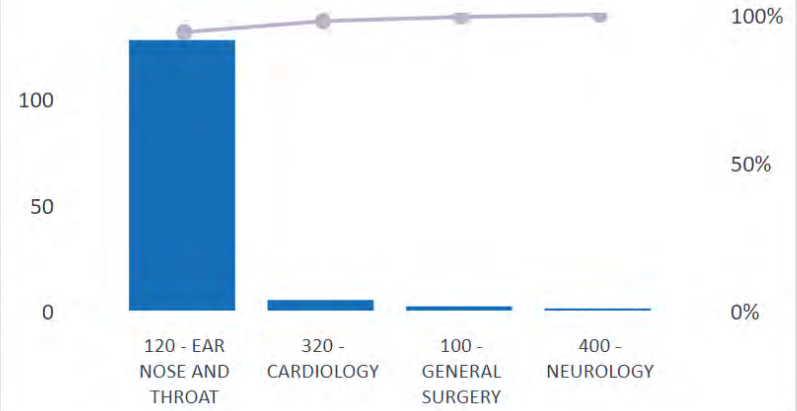
KPI Threshold: 60.0%

Sub Domain KPIs: 22

Variation Summary:

	L	H	L	H
10	1	2	6	3





Key Messages

Incomplete performance has improved this month to 55.8%, however adverse variance of -0.8% against plan of 56.6%.

Patients waiting >52wks at end of November is 2.5%. This is an improvement from previous month, and delivery better than plan of 3.3%

Overall waiting list size stands at 37,127 against a plan of 39,917 a positive variance.

Issues, Concerns & Gaps

65 week position currently at 141 at end of November, which is expected to improve to 138 with validation. The trust is expected to have ~40 reportable 65 week breaches for 21/12

All but 9 specialities are delivering RTT performance >60%, and elective recovery plans have been developed for 7 of these areas (Endocrine performance has declined over the last five months, due to change in triaging referrals process).

Actions & Improvements

Fortnightly Tier 1 meetings remain with NHSE and ICB to oversee elective and cancer performance improvement.
Targeted recovery plans have been compiled for 7 challenged specialities with additional oversight and support from NHSE RSP .
Development of improved forecasting and modelling at specialty level
Maximisation of additional ENT capacity to eradicate 65 week waits prior to 21st December .
Weekly exec elective oversight meeting to be implemented in January 26

Systems & Partnerships

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

Emergency Care

Total EC 4 Hour Performance %

Type	Threshold	V	A	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
	80.0%			73.8%	75.8%	77.6%	77.4%	77.9%	79.4%	77.6%	76.3%	73.3%	75.7%	74.7%	73.9%

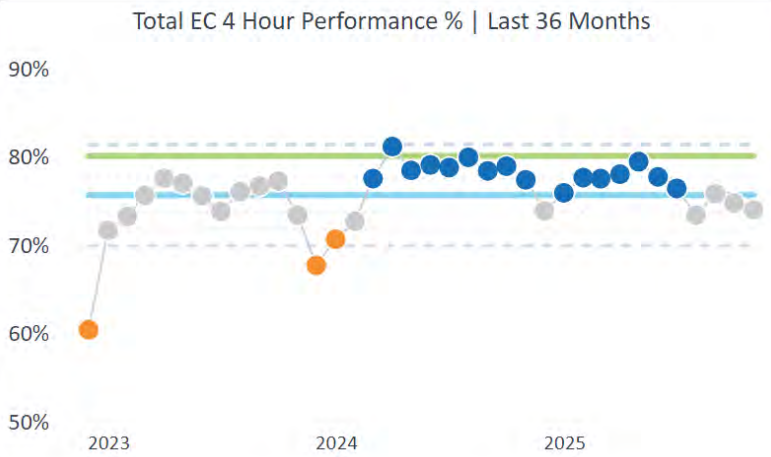
True North Domain: Systems & Partnerships

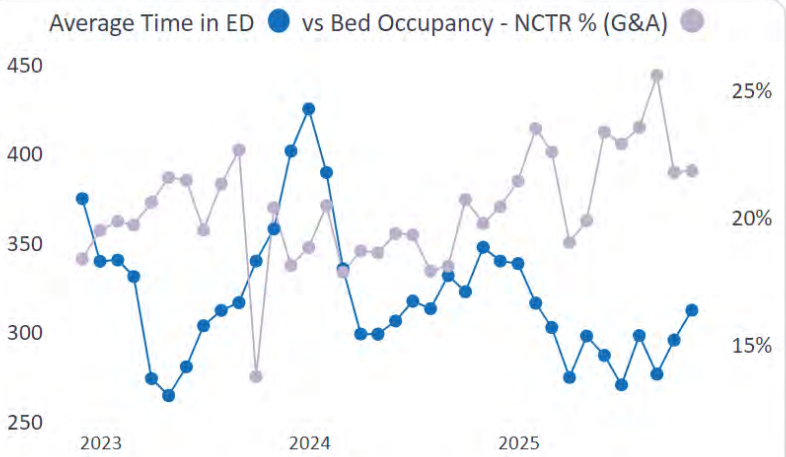
KPI Threshold: 80.0%

Sub Domain KPIs: 13

Variation Summary:

	L	H	L	H
8	0	0	4	1





Key Messages

4 hour performance deteriorated in November by -0.8% to 73.9%
12 hour performance has however remained stable, at 11.7%, with a reduction in the volume of patients over 12 hours (284 compared with 340 In October).

The Trust declared FCP for 7 days in November.

Particular focus is needed in driving down long waits in ED, ensuring there is visibility and action for patients remaining in the department for over 24 hours.

Issues, Concerns & Gaps

The winter modelling identifies a significant gap in capacity at peak.

The focus remains on improving flow, and reducing harm, and the Trust is working across the HCP to close the gaps in the BAS.

Actions & Improvements

BCF funding approved to support the additional of an Acute Consultant in ED overnight Mon-Fri and 24/7 over weekends to support the reduction of DTAs from ED.

MADEs in November, December and January supported by system partners to reduce NCTR patients focusing on both internal and system delays.

Virtual ward increased capacity in November to 120, increase to 160 expected in December/January.

Access

Key Messages

RTT - 9 specialties where performance is < 60 %; ENT – 38.9% (↑6%), Pain Management 39.8% (↑5%), Rheumatology 38.5% (⍰1.5%), Cardiology 47% (↑2%), Sleep 46.7% (↑0.7%), Neurology 43.4% (⍰3.5%), Respiratory 49% (↑1%), Gastroenterology 53%, Endocrinology 47.8% (⍰10%) (recovery plans have been developed for all of these specialties (apart from endocrine supported by RSP colleagues) with progress being monitored through revised governance process / oversight meetings.
DM01 – Performance 90.8% (5.3% improvement from last month and highest performance since March 2025)
Imaging 89.4% (3.8% improvement from last month), underperformance in NOUS and MRI. NOUS driven by staffing vacancies and MRI capacity used to prioritise cancer diagnostic demand.
Endoscopy 90.6% (highest performance seen), physiological measurements 95.6% (8.5% improvement from last month)
Cancer October (published data) - 28D performance for October was 76.3% against 76.1% plan; 31D performance was 100%, consistently above target of 96%; 62D performance was 76% against a 74.5% plan; 62D backlog position decreased to 6.8%.

Issues, Concerns & Gaps

Access - 65 week position currently at 141 at end of November, which is expected to improve to 138 with validation. Of these, 130 – ENT, 5 – Cardiology, 2 – General Surgery, 1 - Neurology
DM01 - Challenges with NOUS capacity and workforce continue. Improved position again in November with 10% increase in performance from October since June 2025. MRI performance remained static with October position due to prioritisation of capacity for cancer demand.
Cancer - 28D – Lower GI and Head & Neck/Thyroid are our tumour sites remain the two areas 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 have been compiled for 7 challenged specialities with additional oversight and support from NHSE RSP. Interim Deputy Director of Elective Reform now in place to drive progress of actions; Regular Exec oversight meetings to be arranged in January to monitor RTT and Cancer compliance and access standards.
DM01 - Rochester CDC MRI opened at end of November, creating the additional capacity required to meet DM01 target
Cancer - Head & Neck pathway – challenges with timely diagnostics, working with Imaging at MFT and DGT; Gynaecology – met with Clinical Lead ad review of STT pathway underway; Further funding available from KMCA, additional schemes have been identified and approved.

Emergency Care

Key Messages

- November performance was 73.9%, which was a deterioration on the previous two months. This is 4.7% adverse to the 78.6% plan for the month
- Ambulance handover delays - 30-60 mins were 1.6%
- Type 1 attendances >12 hours were 11.7%, 0.5% adverse to the plan of 11.2%
- The Trust declared FCP for 7 days over November

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 – November recorded 1,151 breaches compared with 1,236 in October. 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 51.9%, remaining 18.1% below target and representing a increase from October of 2.1%. 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) has been delayed due to unresolved issues within EPR and is due to start in January (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 increase in capacity in place from the 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. Initial data is positive with around 50% of the patients admitted to virtual ward in November being admitted directly from 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
- 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.

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Systems & Partnerships	Access			RTT Incompletes Performance %	60.0%		F	50.3%	50.6%	51.5%	53.0%	53.3%	53.8%	54.6%	53.7%	52.8%	53.5%	54.6%	55.8%
				RTT 65+ Week Waiters	0		F	192	249	181	80	86	111	101	75	384	555	496	136
				RTT Waiting List Size	-	L		40,697	39,894	39,959	39,949	40,171	40,086	39,993	39,335	39,907	39,089	38,102	37,104
				RTT 52 Week Breaches	1,250	L	?	1,754	1,807	1,767	1,695	1,718	1,777	1,735	1,756	2,053	2,116	1,953	914
				RTT 52 Week Waiting List %	1.0%	L	F	4.3%	4.5%	4.4%	4.2%	4.3%	4.4%	4.3%	4.5%	5.1%	5.4%	5.1%	2.5%
				Patients Waiting For 1st Appointment < 18 Weeks %	-	L		67.3%	73.4%	79.0%	81.7%	80.4%	78.2%	74.6%	67.9%	63.2%	60.6%	58.2%	56.7%
				OP Average Time to First Appointment (days)	60	H	F	107.53	118.17	121.02	120.69	115.51	117.42	119.58	122.84	180.68	154.94	130.80	154.49
				Outpatient DNA Rate %	5.0%	L	F	6.4%	5.5%	5.2%	5.7%	6.1%	6.0%	6.3%	5.9%	6.4%	6.3%	6.3%	6.4%
				OP First to Follow Up Ratio	-	L		1.76	1.77	1.76	1.69	1.79	1.78	1.73	1.79	1.76	1.80	1.79	1.67
				PIFU %	5.0%	H	F	2.1%	2.4%	2.5%	2.4%	2.4%	2.5%	2.4%	2.8%	2.9%	3.8%	3.6%	4.0%
				Operations Cancelled by Hospital on Day	13		?	8	17	10	4	5	4	13	10	8	21	30	14
				Urgent Operations Cancelled for 2nd Time	0		?	1	1	0	0	1	1	0	1	2	1	0	0
				Day Case Rate %	-			88.7%	86.2%	86.3%	88.0%	88.7%	88.0%	87.9%	87.8%	86.8%	87.4%	87.0%	86.2%

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Systems & Partnerships	Access			Average Elective Length of Stay (days)	3			2.86	2.57	2.08	2.16	2.14	2.19	2.97	3.18	3.65	2.59	2.70	3.41
				Average Non-Elective Length of Stay (days)	10	H	P	6.30	6.43	6.60	6.43	6.36	6.48	6.01	6.50	6.22	6.25	6.87	6.34
				104 Day Cancer Waits	-			9	18	11	17	17	12	20	19	11	18	13	
				Cancer USC Performance %	93.0%	H		94.0%	82.2%	82.4%	77.4%	77.7%	69.2%	87.5%	89.1%	90.8%	95.3%	97.0%	
				28 Day Performance - Overall %	75.0%			70.1%	67.1%	67.5%	66.2%	59.2%	53.8%	65.3%	71.9%	75.4%	76.6%	76.3%	
				31 Day Performance - Overall %	96.0%			99.3%	91.4%	99.4%	97.1%	94.2%	98.6%	96.3%	98.0%	98.6%	98.0%	100.0%	
				62 Day Performance - Overall %	85.0%		F	65.6%	61.2%	69.5%	69.8%	66.8%	61.2%	60.9%	64.9%	71.6%	68.4%	76.0%	
				62 Day PTL Backlog	6.0%	L	F	14.7%	14.9%	12.8%	11.7%	13.0%	13.9%	11.9%	10.9%	11.3%	10.7%	9.9%	8.0%
				DM01 Performance %	73.1%	H		78.3%	82.5%	87.4%	91.1%	87.6%	85.7%	86.8%	86.0%	80.0%	82.4%	85.5%	90.8%
	Emergency Care			Total EC 4 Hour Performance %	80.0%			73.8%	75.8%	77.6%	77.4%	77.9%	79.4%	77.6%	76.3%	73.3%	75.7%	74.7%	73.9%
				Type 1 LOS > 12 Hours in EC %	6.0%	L	F	15.2%	15.9%	14.2%	13.2%	10.6%	10.6%	10.1%	11.5%	12.6%	11.5%	11.9%	11.7%
				Total EC 4 Hour Performance - Non-Admitted %	85.0%			79.2%	81.5%	82.9%	83.3%	83.8%	84.9%	82.7%	81.6%	78.5%	81.4%	79.7%	79.4%
				IP Discharged Before Noon % (Inc transfers to ADL)	-	H		17.6%	21.1%	20.0%	21.3%	18.5%	19.1%	19.1%	21.0%	19.6%	19.3%	19.3%	18.7%

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Systems & Partnerships	Emergency Care			Type 1 EC 4 Hour Performance %	75.0%		F	58.3%	61.1%	64.7%	65.8%	67.0%	67.5%	67.1%	65.7%	61.6%	66.6%	66.0%	64.6%
				Total EC 12 Hour DTAs	0		F	771	756	706	688	412	533	454	614	696	632	728	593
				Average Time in EC Department - Excl. Type 5 (mins)	240	L	F	339.45	338.03	315.86	302.25	274.26	297.45	286.62	270.09	297.68	276.13	295.21	311.90
				The Number of Patients in TES within ED	-			1,783	1,811	1,376	1,277	737	975	870	1,268	1,389	1,286	1,633	1,423
				Number of ED Arrivals by Ambulance	-			3,248	3,210	2,722	3,021	2,977	3,022	2,947	3,120	3,063	3,058	3,215	3,193
				Ambulance Handover Delays (> 30 mins)	-			145	137	86	77	48	49	28	47	69	53	82	61
				Ambulance Handover Delays (> 60 mins)	0	L	?	10	8	1	0	3	1	0	2	2	2	1	2
				Bed Occupancy - NCTR % (G&A)	-			20.4%	21.4%	23.5%	22.5%	19.0%	19.8%	23.3%	22.9%	23.5%	25.5%	21.7%	21.8%
				30 Day Readmission Rate	13.0%	L	P	7.8%	7.4%	7.9%	8.1%	7.1%	8.1%	8.3%	8.2%	7.6%	7.4%	7.8%	6.5%

People

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

NHS Medway NHS Foundation Trust

Sheridan Flavin
Chief People Officer

Patient FIRST

Sub Domain	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
StatMan	1	2	0	1	2	0
Workforce	4	7	2	6	2	5
Safe Staffing	1	1	1	2	0	0

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

Committees:
People Committee

People

Watch KPIs Only
People Domain

Assurance

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
Improving Variation	Agency Spend % StatMan Training Compliance % StatMan: Patient Safety L1 Compliance % Vacancy Rate %	Bank Spend % Time to Hire - AfC Voluntary Turnover % - First 2 Years Employ...	Voluntary Turnover %	Staff Fill Rate % (Total) - Registered Nurse
No Significant Change		Sickness Absence Rate - Short Term % Staff Fill Rate - Total % StatMan: Patient Safety L2 Compliance % Time to Hire - Medical	Sickness Absence Rate - Long Term % Sickness Absence Rate - Total %	
Concerning Variation		Care Hours per Patient Day (CHPPD) Staff Appraisal Rate %		

People

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

Workforce

National Staff Engagement Score

Type	Threshold	V	A	Dec-24	Jan-25	Feb-25
	6.93	H	F	6.74	6.74	6.74

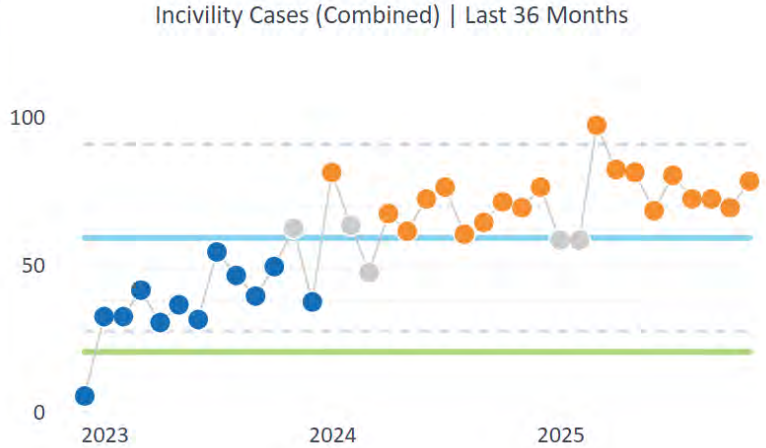
True North Domain: People

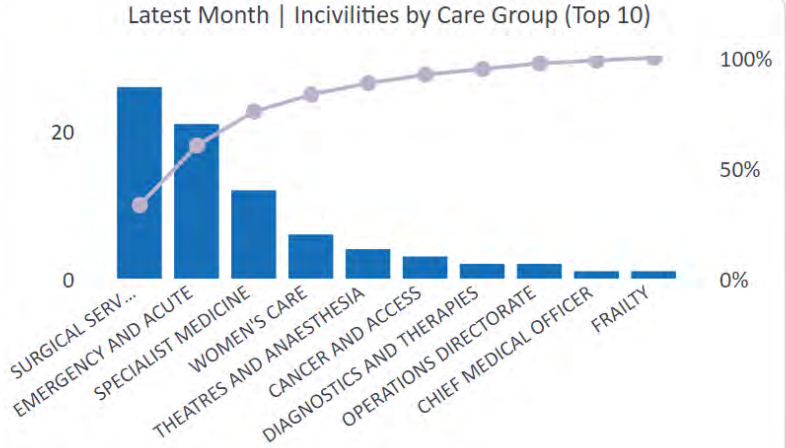
KPI Threshold: 6.93

Sub Domain KPIs: 13

Variation Summary:

4	1	1	6	1





Key Messages

The number of incivilities combined reporting through Friends and Family Test (FFT) and Datix reported in November has slightly increased from 72 to 78 . Reporting cases continues, reflecting greater awareness and confidence in reporting and addressing behaviours. The Trust continues its commitment to addressing incivility as a systemic issue impacting team cohesion, psychological safety, and overall organisational culture.

Issues, Concerns & Gaps

- The level of incivilities, whilst a concern is a good indicator that staff feel psychology safe to speak up
- High demand in the hospital is causing pressure on staff.
- Staff on staff rudeness, lack of courtesy to one another and taking time to communicate effectively with colleagues is a key area of incivility reported.
- Incivility by reception staff to patients is a concern.
- Customer service training Interest and enrolments has greatly improved with all classes fully booked. Overbooking has been advised to mitigate the high DNA rate that continues.

Actions & Improvements

- Customer services training for all staff has been commissioned and dates continue to be published
- Attendance reports have been provided to the divisional leads to try and improve attendance, offering overbooking
- Weekly huddles to discuss incivilities has ben strengthened with a week 4 action learning set approach to share good practice. Feedback continues to be positive with this approach
- All incivilities reported are followed up and staff discussions are completed to provide feedback and implement improvements

People

Key Messages

- Incivility cases reported in November have slightly increased from 72 to 78.. As this high number is still of concern, it may also demonstrates that staff are feeling psychologically safe to speak up and raise concerns
- Staff Appraisal completion rates is continuing to deteriorate over the period of 6 months.
- Customer service training available to all staff attendance has improved. All sessions are fully booked. Overbooking has been implemented to mitigate high Did not attend rate (DNA)
- Sickness absence total rate and long term remain above the threshold
- Management Essentials training addresses how to manage sickness absence.
- Occupational Health are working with Employee relations and managers to assist with getting staff back to work with support if required.

Issues, Concerns & Gaps

- Customer service training did not attend rate is high.
- Appraisal completion compliance rates continue to fall over a 6 month period, although stat mand training compliance has increased and compliance is above the 85% target.
- Sickness absence continues to be monitored via Employee Relations teams and Occupational Health with Stress, anxiety and MSK the highest cause.

Actions & Improvements

- Customer service training is now available to all staff
- The mandated Appraisal training continues and should assist to improve the experience and appraisal compliance rate.
- Employee Relations (HRBPs) and Occupational Health are working closely together to assist managers with staff who have met the triggers in sickness absence. Managers are provided with training as part of the statmand Management Essentials programme on how to manage sickness absence. This will assist with improving staff returning to work in a timely way.

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
People	Workforce			National Staff Engagement Score	6.93	H	F	6.74	6.74	6.74									
				Incivility Cases (Combined)	20	H	F	76	58	58	97	82	81	68	80	72	72	69	78
				Voluntary Turnover % - First 2 Years Employment	1.00%	L	?	0.8%	1.9%	1.0%	1.4%	1.2%	0.8%	0.9%	1.1%	1.1%	0.7%	1.1%	0.9%
				Staff Appraisal Rate %	90.0%	L	?	90.4%	90.4%	89.9%	89.7%	90.3%	90.4%	89.9%	89.1%	89.0%	88.5%	87.5%	86.1%
				Vacancy Rate %	9.0%	L	P	6.2%	7.1%	6.6%	6.1%	0.6%	4.4%	4.2%	4.1%	4.2%	4.7%	5.1%	5.2%
				Voluntary Turnover %	8.0%	L	F	8.2%	8.4%	8.4%	8.2%	8.3%	8.2%	8.1%	7.9%	7.8%	7.6%	7.3%	7.0%
				Sickness Absence Rate - Total %	4.0%		F	5.3%	5.6%	5.1%	4.5%	4.6%	4.5%	4.7%	4.9%	4.8%	5.1%	5.5%	5.2%
				Sickness Absence Rate - Short Term %	2.0%		?	2.6%	3.2%	2.6%	2.0%	2.2%	2.0%	2.0%	2.1%	2.1%	2.4%	2.7%	2.8%
				Sickness Absence Rate - Long Term %	2.0%		F	2.7%	2.4%	2.5%	2.4%	2.4%	2.5%	2.7%	2.8%	2.7%	2.7%	2.8%	2.4%
				Time to Hire - AfC	42	L	?	45.40	55.60	63.80	54.90	64.40	55.05	56.50	49.10	35.70	50.60	44.40	52.90
				Time to Hire - Medical	70		?	60.90	61.70	65.90	58.10	56.90	68	76.70	85.40	80.10	68.10	57.50	81.90
				Agency Spend %	3.7%	L	P	1.2%	0.9%	1.1%	0.6%	1.2%	1.2%	0.9%	0.8%	0.9%	0.9%	0.9%	1.1%
				Bank Spend %	10.0%	L	?	9.6%	9.9%	9.7%	6.6%	8.8%	8.2%	9.1%	9.8%	9.7%	9.7%	8.8%	10.1%
	Safe Staffing			Staff Fill Rate - Total %	85.0%		?	85.2%	85.5%	87.4%	91.1%	91.3%	89.6%	87.6%	87.5%	87.8%	87.2%	89.7%	91.9%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
People	Safe Staffing			Staff Fill Rate % (Total) - Registered Nurse	-	H		88.1%	88.6%	90.0%	92.5%	91.6%	89.4%	88.9%	88.4%	87.6%	89.4%	92.6%	92.9%
				Care Hours per Patient Day (CHPPD)	9.50	L	?	9.20	8.77	9	9.19	9.65	9.48	9.35	9.29	9.23	9.20	9.08	9.07
	StatMan			StatMan Training Compliance %	85.0%	H	P	87.9%	88.9%	89.1%	89.1%	89.9%	89.7%	89.5%	89.8%	89.4%	89.2%	89.4%	89.3%
				StatMan: Patient Safety L1 Compliance %	85.0%	H	P	92.6%	93.3%	93.4%	93.6%	94.3%	94.7%	94.5%	94.0%	94.3%	94.8%	94.8%	95.0%
				StatMan: Patient Safety L2 Compliance %	85.0%		?	-	-	-	-	-	-	-	-	-	-	-	-

Sustainability

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

NHS Medway NHS Foundation Trust

Simon Wombwell
Chief Finance Officer

Patient FIRST

Sub Domain	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
Financial Position	4	1	4	5	0	2

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

Committees:
Finance & Performance Committee
Audit & Risk Committee

Sustainability

Watch KPIs Only
Sustainability Domain

Assurance

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				Total Temporary Staffing Worked FTE
No Significant Change		Total Non-Pay Spend (£) vs Budget		Total Temporary Staffing Spend (£)
H / L: Concerning Variation		Income (£) vs Budget	WTE Actual	

Sustainability

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

Financial Position

Surplus / (Deficit) (£) Variance to Plan YTD

Type	Threshold	V	A	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
	£0.00m			-10.86m	-16.69m	-21.33m	-19.55m	-2.04m	-3.44m	-5.57m	-9.18m	-13.60m	-17.05m	-28.66m	-38.07m

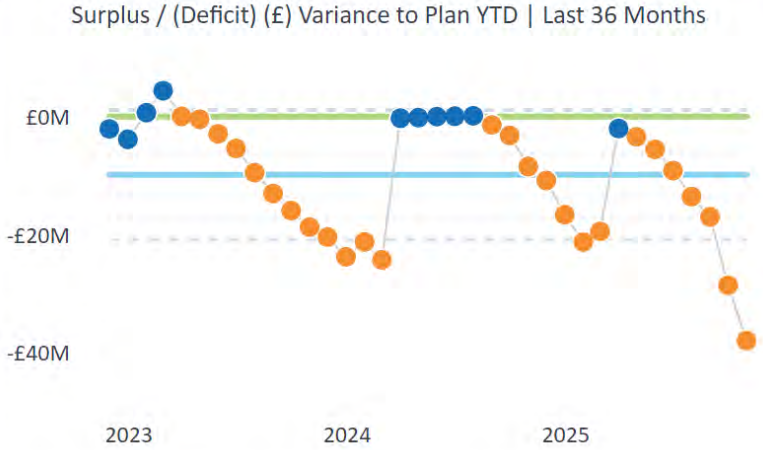
True North Domain: **Sustainability**

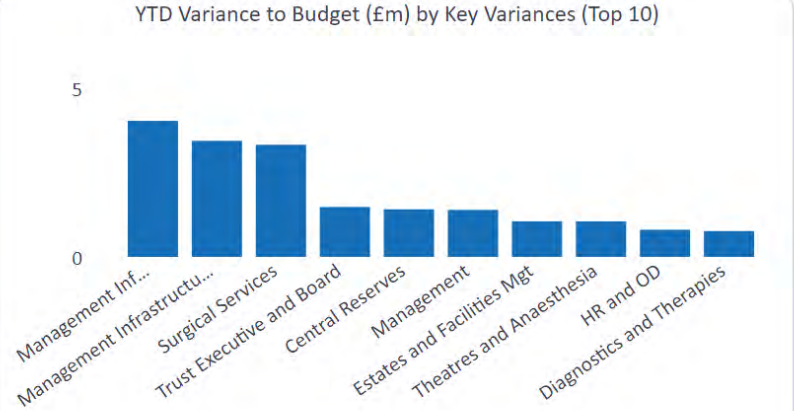
KPI Threshold: £0.00m

Sub Domain KPIs: 9

Variation Summary:

4	2	2	1	0





Key Messages

The Trust reports a YTD deficit at month 8 (November 2025) of £26.8m, adjusting to a control total deficit excluding Deficit Support Funding ("DSF") of £54.5m; this is adverse to plan by £19.6m.
The key driver causing us to move away from Plan is that our savings plans remain below target (adverse by £18.8m YTD).
This is having a detrimental impact on our cash (partially offset by the capital plan being behind at this time) – the Trust has made a cash support application and is deploying cash management techniques which could affect supplies.
DSF has been withdrawn form the Trust in Q3, equating to £2.7m pcm / £5.5m YTD.

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. 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.
The Brockenhurst (car park VAT) claim has now been ruled on by the Supreme Court and found in favour of HMRC. The Trust therefore recognised the £3.5m adverse impact in month

Actions & Improvements

Our efficiencies programme YTD is meeting less than 25% of the target (£6.2m vs £25.0m target).
Supported by PA Consulting, we need to see accelerated and increased reductions in our cost base.

Sustainability

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The Brockenhurst (car park VAT) claim has now been ruled on by the Supreme Court and found in favour of HMRC. The Trust therefore recognised the £3.5m adverse impact in month 7 (October 2025).
Industrial action remains a cost pressure.

The Trust's run-rate gives rise to a substantial planning gap to the 2026/27 revenue plan limit.

Actions & Improvements

Our efficiencies programme YTD is meeting less than 25% of the target (£6.2m vs £25.0m target).
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Sustainability

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Sustainability	Financial Position			Surplus / (Deficit) (£) Variance to Plan YTD	£0.00m			-10.86m	-16.69m	-21.33m	-19.55m	-2.04m	-3.44m	-5.57m	-9.18m	-13.60m	-17.05m	-28.66m	-38.07m
				Total Pay Spend (£) vs Budget	£0.00m	H	?	0.74m	1.68m	1.68m	19.85m	0.25m	-0.16m	0.88m	1.01m	2.40m	3.20m	3.51m	3.85m
				WTE Actual vs Plan	0		?	52.83	-1.98	60.59	157.89	329.36	93.18	171.36	216.61	170.44	172.94	114.43	124.82
				Variance to CIP Target (£)	£0.00m		F					-0.26m	-0.77m	-1.24m	-2.36m	-3.53m	-3.84m	-4.08m	-2.67m
				WTE Actual	5,155	H	F	5,556.27	5,552.05	5,618.26	5,705.64	5,576.22	5,533.26	5,616.48	5,697.79	5,658.10	5,678.19	5,634.10	5,642.45
				Total Temporary Staffing Worked FTE	-	L		582.46	584.79	610.15	687.55	557.06	508.99	589.93	622.10	601.07	634.38	574.09	594.66
				Total Temporary Staffing Spend (£)	-			2.94m	3.02m	3.01m	3.31m	2.97m	2.72m	2.89m	3.20m	3.08m	3.16m	2.87m	3.37m
				Total Non-Pay Spend (£) vs Budget	£0.00m		?	2.60m	1.46m	1.19m	1.96m	-0.40m	-0.64m	-0.56m	0.31m	0.17m	1.05m	1.57m	1.23m
				Income (£) vs Budget	£0.00m	L	?	0.18m	-1.73m	-1.55m	22.13m	-0.21m	-0.50m	0.44m	-0.65m	-0.10m	1.03m	-4.71m	-3.24m

Stabilisation Plan	**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		The trust is not effectively managing its in-year budgets, run rate, CIP and cash reserves resulting in the non-delivery of the agreed in year control totals and the removal of deficit support funding.	**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	Trajectory
Initial score	4	3	12	
Current score (ISSUE)	-	-	5	–
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. Vacancy and enhanced non-pay controls. 4. NHSE Improvement Director support. 5. System finance and recovery forum (CFO attending).	1. High – Formal governance structure with clear accountability. 2. Moderate – Tactical oversight with visible outputs. 3. Moderate – Direct cost containment with governance checks 4. High – On-sight oversight with strategic input. 5. Moderate – A forum for strategic alignment across ICB partners
Gaps in control and assurance	**Actions to address risk**
a. Immature stabilisation plan implementation plan. b. Immature business planning and budget setting process. c. Developing business partner support provision d. Immature set of triangulated metrics/KPIs	a. Approved stabilisation plan being implemented. Monthly progress reported and actions tracked. CIP performance support governance now operational. Mar 26 b. Opening submission was made in December, next submission due 12th Feb c. Revised business partner arrangements being implemented and will be fully operational from Apr 26. d. IQPR and stabilisation plan reporting now revised and operational. Weekly TLT's now aligned to the stabilisation plan.

Stabilisation Plan	**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	Trajectory
Initial score	5	4	20	
Current score (ISSUE)	-	-	5	–
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 risk**
a. Lack of an approved Estates and Facilities strategy. b. Immature capital planning and budget setting process. c. No Estate business partner support provision to divisions d. Immature set of triangulated metrics/KPIs e. Developing annual capital programme review process (Inc. medical devices)	a. Draft estates strategy to be presented to Board. Feb 26 b. Planning group in place and aligned with finance governance. Reports monthly. Complete c. Revised business partner arrangements being implemented and will be fully operational from Apr 26. d. IQPR and stabilisation plan reporting now revised and operational. Complete e. Establish formal governance with oversight and audit trail. Reported to FPPC. Compete f. Exploring avenues for external/national funding. Feb 26

Stabilisation Plan	**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	Trajectory
Initial score	3	4	12	
Current score (ISSUE)	-	-	4	
Target score	3	3	9	
Lead – Chief People Officer		**Appetite – 6** (3x2)		

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 risk**
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 are taking forward complex ER cases completion date now a month delayed (originally Jan 26). b. 85% management essential (inc. Advanced) trained staff (in the stabilisation plan). Mar 26 c. Rapid Case Reviews progressing and updates provided to Trust Board monthly and People Committee. Complete d. Action plan in place to mitigate sexual safety risks. Plan being reviewed. Mar 26

Stabilisation Plan	**Culture**	Risk – 4 (mapped to BAF 6)	Target date – March 2026
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 of patient care could be 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	Trajectory
Initial score	4	3	12	
Current score (ISSUE)	-	-	4	–
Target score	4	2	9	
Lead – Chief People Officer		**Appetite – 3** (3x1)		

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.	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
Gaps in control and assurance	**Actions to address risk**
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. complete b. Introduction of trained mediators and facilities to support local dialogue. Feb 26 c. Continued service reflection and embedding service. d. Cultural transformation programme actions for phase 2.

Stabilisation Plan	Quality	Risk – 6 (mapped to BAF 8)	Target date – September 2026

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	Trajectory
Initial score	5	4	20	
Current score (ISSUE)	-	-	5	–
Target score	4	2	8	
Lead –Chief Medical Officer		**Appetite – 3** (3x1)		

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 risk**
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.	a. Focus on supporting the development of robust action plans SJR panel review. b. EOL team work with community providers and SECAMB to improve the clinical decision process and pathway. Mar 26 c. As point 1. d. Focussed internal programme to support the EOL decision process. Mar 26 e. Clinical pathway review against NCEPOD/ national standards for SHMI outlier groups

Stabilisation Plan	Performance	Risk – 7 (mapped to BAF 10)	Target Date – March 2026
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	Trajectory
Initial score	4	3	12	
Current score (ISSUE)	-	-	4	
Target score	4	3	12	
Lead – Chief Operating Officer		**Appetite – 3** (3x1)		

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. Waiting list maintenance and review process. 5. 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. High – Good data quality and reviewed by clinicians. 5. National initiative but limited take up in most areas.
Gaps in control and assurance	**Actions to address risk**
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.	a. Roll-out of the trusts LoS programme. Mar 26 b. Completion of the job planning and rostering programme. Dec 25 c. Implementing Winter Plan 2025 and embedding medical models. Complete d. Programme 'go-live' November 2025. Complete e. Undertake first MADE. Complete f. Stabilisation plan reporting templates, IQPR and governance designed and implemented. Complete

Stabilisation Plan	Performance	Risk – 8 (mapped to BAF 12)	Target Date – March 2026
Cause		**Risk**	**Impact ∆ - 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	Trajectory
Initial score	4	4	16	
Current score (ISSUE)	-	-	4	–
Target score	3	3	9	
Lead – Chief Operating Officer		**Appetite – 6** (3x2)		

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. 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 risk**
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. 5. Lack of HaCP Discharge planning, Efficiencies Group and LAEDB.	a. Roll-out of the trusts LoS programme and monitor through TLT. Ongoing and performance reported to board and committees. Mar 26 b. Undertake first MADE event. Further events planned through January and February 26 c. Review effectiveness of tools. Complete d. Virtual hospital ‘go-live’. Complete

Stabilisation Plan	Culture	Risk – 9 (mapped to BAF 14)	Target Date – March 2026

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	Trajectory
Initial score	4	3	12	
Current score	4	3	12	–
Target score	2	3	6	
Lead – Chief Medical Officer		**Appetite – 9** (3x3)		

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. 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 – Job Planning programme yet to be completed.
Gaps in control and assurance	**Actions to address risk**
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.	a. Compile a tracking scorecard for each of the 10 points. Complete b. Procurement a new digital rota tool. Complete c. Introduce a pre-arrival onboarding checklist that includes ESR setup, IT access, and mandatory training completion. Mar 26 d. Assign a lead to each point/ measurable indicator. Complete

Stabilisation Plan theme	Performance	Risk – 10 (mapped to BAF 13)	Target Date – September 2026
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	Trajectory
Initial score	4	4	16	
Current score	4	4	16	–
Target score	3	3	6	
Lead – Director of Strategy and Partnership		**Appetite – 6** (3x2)		

Controls	Assurance on controls
1. Digital and data (DDaT) strategy and implementation plan. 2. IT investment summary (business planning item) 3. Annual maintenance programme. 4. Server upgrade programme. 5. Local Cyber security audit and action plan. 6. 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. Moderate – Limited by availability of capital. 4. Moderate – reduces risks but does not eliminate them. 5. High – Identifies vulnerabilities and drives remediation. 6. Enhances threat intelligence and access to national capital funds.
Gaps in control and assurance	**Actions to address risk**
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. Feb 26 3. Map all digital programmes (e.g. infrastructure upgrades, cybersecurity, innovation pilots) into a single delivery roadmap – Jan 26.

Medway Foundation Trust's – Stabilisation Plan

(first stage of our Integrated Improvement Plan)

14th January 2026

Executive Summary

Current Position

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

Proposed Plan

- **January 2026 – Establish Control**
  - Delivery plans agreed and signed off across the majority of workstreams
  - KPIs established with initial monitoring underway
  - Programme interdependencies identified, with finalisation in progress
- **February 2026 – Drive Pace & Grip**
  - Delivery accelerated against agreed plans
  - Enhanced controls introduced where progress lagged
  - Dependencies actively managed to minimise slippage
- **March 2026 – Escalation & Transition**
  - Non-delivery escalated promptly with recovery actions agreed
  - Executive decisions sought where delivery could not be achieved
  - Programme prepared for transition to next performing phase

Overall Assessment

- The programme is progressing broadly as planned, with improved grip and control now being established across the majority of workstreams.
- Delivery plans and KPIs are in place and active monitoring has commenced, providing increased visibility of progress and risk.
- While some elements of delivery and interdependencies continue to be finalised, appropriate controls, escalation routes, and recovery actions are in place. No material risks have been identified that cannot be managed within existing governance arrangements.

Programme	RAG
Culture	
Governance	
Quality	
Performance	
Finance	

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

The ICB report and recommendations have now been reviewed by Trust Board and Council of Governors in the last reporting period. Which proposed the creation of a group model with Dartord and Gravesham NHS Trust with a joint Chair and CEO. A Trust briefing for all staff took place on the 27/11/25.
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.
Compliance with Management Essentials and Advanced Management Essentials has not increased in the last reporting period due to a significant number of staff not attending planned training. The primary reason for this is due to sickness. There is now a risk that compliance with the agreed plan for Management Essentials of 85% for December will not be met.
ER backlog status is contained in the adjoining slides to the TLT pack for 16/12/25. There remains a number of original cases still to be outcomed. All cases, with one exception, have been allocated to the external HR support team

Milestones Completed this Period

ICB report and recommendations reviewed at Trust Board and all-staff briefing completed in the last reporting period

Staff Listening Events Advocacy training

ER backlog remedial actions are underway - updated position has been advised

Milestones to be Completed next Period

Progress agreed recommendations and milestones for the creation of the Group Model with DGT including the progression of Executive Level recruitment.

Progress programme mobilisation 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 and establish the Phase 2 Steering Group following stakeholder mapping, confirm Programme resourcing and complete Programme Workbook

Undertake mitigating actions to reduce risks related to 1) DNA rates in Management Essentials and Advanced Management Essentials Training and 2) Progression of ER case backlog.

Performance - KPI Profile

Current measures of performance	Nov-25 Latest	Nov-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
2 80% of middle managers completing the TLT development programme (Advanced Management Essentials for B8a and above / Management Essentials for B7) (Lead: DCEO / CPO)	51.6% (AME) 51.7% (ME)	TBC	43% (AME) 46.7% (ME)	TBC	51.6% (AME) 51.7% (ME)	TBC	51.6% (AME) 51.7% (ME)	TBC		85% (ME)						80% (AME)
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 - TBC	Four w/streams active - TBC	N/A	N/A	3	4										
4 100% of backlog cases in Employee Relation (ER) have been reviewed and outcomed (Lead: CPO)	33/51 cases closed 50 cases allocated	TBC	50 cases allocated - 22 outcomed (Aug &	TBC	Cum. total = 27 cases outcomed (5 in month)	TBC	Cum. total = 33 cases outcomed (6 in month)			100%						
5 Improvement in performance related to disciplinary and grievance investigations completed within 6 weeks (non MHPS) - on stream from Jan 2026	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		TBC		TBC		TBC
6 Improvement in performance related to disciplinary and grievance hearings held within 3 weeks of the report being submitted (non MHPS) - on stream from Jan 2026	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		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	DNA rates for Management and Advanced Management Essentials training have been significant in the past month due to staff sickness. Off plan to deliver Management Essentials by end December 2025
2	Delayed launch of Phase 2 of the Cultural Transformation Programme
3	ER backlog cases off plan to be outcomed by the end of December 2025.

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

Rag status	Amber

Description:

Develop and implement ward to board "Golden thread" governance structure with accountability and assurance framework

Decision to be made on 3 existing business cases

Carnell Farrer ICB report - review recommendations and implement .

RAG justification:

Currently on Track for all 3 business cases to have decision by 31/12/2025
QIA panel implemented Novemeber 2025 but still requires further development on process and wider communications
Delays with confirmation on using IQPR within PRMs for all divisions

Milestones completed this period:

QIA panel established and runs every Wednesday (PMO/ Clinician/ Nurse)
Decision made not to continue with elective business case on Debenhams
Cath lab business case taken to TLT in Nov 2025 -approved and awaiting funding from ICB

Milestones to be completed next period:

Governance structure review and mapping complete
Revised governance structure (committee map) and escalation routes and framework agreed.
Refresh all TORs for the Committee from the ward to the Board.
Define and complete divisional governance standards (governance maturity self-assessment/audit)
Executive agreement of programme scope refresh
Establish a single integrated governance calendar
Baseline risk registers
Identify top 10 organisation-wide risks
Confirm required Board assurance products (for example IQPR, Monthly Board Quality report

Current measures of performance:

Oct-25		Sep-25		Oct-25		Nov-25		Dec-25		Jan-26		Feb-26		Mar-26	
Lastest	Plan	Delivered	Plan	Delivered	Plan	Delivered	Plan	Target	Plan	Target	Plan	Target	Plan	Target	Plan
50%	50%	0	0	0	0	50%	50%	0	60%	0	75%	0	90%	0	100%
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	100%
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	100%
70%	3	0	0	0	0	100%	70%	1	100%						

Development of QIA panel and number of QIA's completed and approved
Performance reporting mapped correctly to Board / committee routes.
All divisions using revised IQPR and escalation routes.
A unitary Board decision taken on all three business cases.

Key Barriers to success:

1.Inconsistent leadership behaviours, capability and accountability
-Variability leads to weak follow-through on governance actions.
-Governance structure with over-complex architecture
2.Poor data quality and fragmented systems and sources across Quality, Finance, Operations and Workforce
-Limits board assurance and affects decision-making.
3.Staff burnout and low psychological safety
- Impacts incident reporting, escalation, engagement.
-Siloed working
4.Cultural inertia and "work-arounds"
-Reliance on informal behaviours rather than structured governance.
5.Unclear ownership of risks and actions
-Causes delays, duplication, or failure to resolve issues.
6.Divisional variation
-Different standards of governance maturity and capability.
7.Competing operational pressures
-Winter, bed capacity issues, staffing gaps disrupt governance attendance and focus.
8.Lack of standardisation

Outline project plan: (Description / Action)

An agreed accountability and assurance performance review meeting framework embedded within organisation
Increase % of divisional teams using revised IQPR and escalation routes
Develop QIA panel and process (Track completed and approved)
Ensure all existing business cases are taken to the approapriate governance forum for timely decision-making, providing clear accountbility and alignment with strategic priorities

Interdepencies:

Culture programme - exec board strengthening work
Patient Safety (PSIRF) and Patient Experience
Workforce
Performance & Operations
Financial Governance
Digital & Data
ICS Partners
Education & Training Governance
Research & Innovation Governance

Key Risks:

Failure to embed fragmented governance processes	Capacity constraints
Data quality failures	Weak mortality oversight
Inconsistent escalation	Poor documentation/governance record keeping
Divisional non-compliance	Financial pressures
Staff disengagement	Understanding of QIA process

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. Action plans from deepdive of UTI and Pneumonia will require EPR update for Ca
2. Mortality Lead appointed and commenced 1st December.
3. Coding for October has just been completed and Clinical validation start dates ar
4. Sepsis lead appointed and start date was 8th December

Milestones to be Completed next Period
1. Work underway for Palliative care team to improve early discharges for Palliative care patients.
2. Pneumonia care bundle to be prioritised onto EPR
3. Electronic sepsis care bundle is under testing and will ready for deployment very soon.
4. To set up clinical documentation Trustwide quality improvement project.

Performance - KPI Profile

Current Measures of Performance:		Latest	Plan	Jun Delivered	Jun Plan	Jul Delivered	Jul Plan	Aug Delivered	Aug Plan	Sep Delivered	Sep Plan	Oct Delivered	Oct Plan	Nov Delivered	Nov Plan	Dec Delivered	Dec Plan	Jan Delivered	Jan Plan	Feb Delivered	Feb Plan	31-Mar Delivered	31-Mar Plan
1	Mortality - A downward trajectory of the Trust SHMI by September 2026. (CMO)	1.26		1 1.2512	TBC	1.256																	1.15%
2	Crude mortality rate in month to be less than the same time period 12 months previously (CMO)	1.4		2 1.1	TBC	1.2		1.4		1.5		1.4		1.4									1.10%
3	95% compliance in NICE Guideline Sepsis care compliance using monthly audit data (CMO)	100%		3	TBC							85%		100%									90%

Key Barriers to Success:
1 As the SHMI data is 6 months arrears in reporting, we have the risk of the improvement not being realised before March 2026
2 The SHMI methodology lacks congruence with Medway patients characterist
3 Community partners and services to help with bed blockages due to limited rehabilatation beds and packages of care in care homes

Outline Project Plan:

	Description / Action	Deadline	Lead
1	Mortality - A downward trajectory of the Trust SHMI by September 2026.	31-Mar	CMO

Key Risks:
1 Capacity & resourcing
2 Insufficient capacity of frontline managers in engaging their frontline teams due to operational pressures due to winter period
3 ED overcrowding and bed capacity issues during winter period

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**, based on KPI - latest month vs Plan. Amber : In the delivery of : 95.3% of DM01 Delivery of Diagnostics within 6 weeks

Milestones Completed this Period
1. Stabilisation plan shared across the organisation and requested for ideas from front line to sustain delivery of objectives
2. Final preparations for EM5 are underway for admissions avoidance
3. MADE Event held from 15 - 24 December to support 'Home for Christmas' campaign to suitably and safely discharge patients home for the holiday period
4. SMART Virtual Hospital released capacity equivalent to 13 in-hospital beds. In November, a total of 102 Medicine patients were admitted to the Virtual Hospital; this figure has already been exceeded in December, with 104 patients admitted as of 24 December and seven days remaining in the month

Milestones to be Completed next Period
1. Fortnightly Tier 1 meetings remain with NHSE and ICB to oversee elective and cancer performance improvement.
2. Follow up MADE Event planned for January 2026
3. Targeted recovery plans from NHSE RSP have been compiled for 8 challenged specialties with additional oversight and support
4. Meeting to agree a realignment of the GIRFT Steering Group with the two Steering Groups operational for UEC & Flow and Elective Reform to ensure wider clinical and operational engagement focused on key deliverbale in the Stabilisation Plan
5. To confirm and initiate the use of EM5 for Patient flow - Jan 2026
6. Increasing capacity within Virtual hospital in line with agreed occupancy rate. Currently taking 50 more patients from Medicine (from the inception of 24 hour Virtual hospital support) with a current LoS of 8 days

Performance – KPI Profile

Current Measures of Performance:	Nov-25		30-Sep		31-Oct		30-Nov		31-Dec		31-Jan		28-Feb		31-Mar	
	Latest	Plan	Delivered	Plan	Delivered	Plan	Delivered	Plan	Delivered	Plan	Delivered	Plan	Delivered	Plan	Delivered	Plan
1 Patients are seen and treated within 18 Weeks	55.80%	56.60%	53.40%	55.60%	54.60%	55.80%	55.80%	56.60%		57.30%		58.20%		58.90%		60.00%
2 No more than 1% of patients to be waiting >52 weeks seen & treated	2.50%	3.6%	5.40%	3.80%	5.10%	3.60%	2.50%	3.30%		3.10%		2.90%		2.30%		1.00%
3 ED 4hr Performance	73.90%	80.0%	75.70%	79.00%	74.70%	80.00%	73.90%	78.00%		78.00%		78.00%		79.00%		80.00%
4 ED >12hr LOS Type 1	11.70%	11.0%	11.10%	11.00%	11.90%	11.00%	11.70%	11.00%		13.00%		13.00%		12.00%		9.40%
5 95.3% of DM01 Delivery of Diagnostics within 6 weeks.	90.80%	94.6%	82.40%	93.00%	85.50%	94.60%	90.80%	94.70%		95.00%		94.90%		95.30%		95.30%
6 28 day FDS (80%) - October	76.30%	76.1%	76.70%	76.00%	76.30%	76.10%	Unvalidated	76.99%		77.00%		77.43%		78.55%		80.07%
7 62 day (75%) Cancer waits - October	76.00%	74.5%	71.00%	73.00%	76.00%	74.47%	Unvalidated	74.74%		73.03%		71.59%		74.16%		75.00%

Key Barriers to Success:
1 Staffing with Virtual Hospital and Preadmission lounge space for Virtual hospitals

Outline Project Plan:

	Description / Action	Deadline	Lead
1	CDC Opening Hours 12 hours per day, 7 days per week	Mar-26	COO
2	Rolling out at least 10 straight-to-test pathways	Mar-26	COO
3	Go live of the EM5	Jan-26	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 seasonal trends
4 Increase in ED attendances (due to seasonal variance - winter)
5 Virtual hospital staffing

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 Due to adverse position to Plan and RAFOT; Medium Term Plan sign-off high risk.

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 was adverse in month 7 & 8 including adverse performance against CIP Board to review the medium term plan, Current position untriangulated and not expected to deliver against all national priorties

Milestones Completed this Period
1. Issued in year Financial Recovery Plan (FRP) to Executives
2. Demand and Capacity work developed and discussed with Divisions
3. Provisional Budget position developed, Subject due to activity from D&C

Milestones to be Completed next Period
1. Deliver Month 9 (December) RAFOT
2. Submit draft planning documents to NHSE

Current Measures of Performance:	Latest	Plan
1 2025/26 In Year Plan	(£44m)	(£4.9m)
2 2025/26 CIP Target (excluding share of System-wide savings target)	£16.1m	£27m
3 2025/26 CIP Target (including share of System-wide savings target (£18m))	£17.8m	£45m
4 Board sign-off, with updates and direction for Board each Month	17-Dec	17-Dec
5 Submission to national timetable	17-Dec	17-Dec

Performance - KPI Profile

	30-Sep		31-Oct		30-Nov		31-Dec		31-Jan-25		28-Feb		31-Mar	
	Delivered	Plan	Delivered	Plan	Delivered	Plan	Delivered	Plan	Delivered	Plan	Delivered	Plan	Delivered	Plan
1	(£13.6m)	(£13.6m)	(£22.7m)	(22.7m)	(£29.8m)	(27.6m)		(32.4m)		(36.8m)		(41.1m)		(47.4m)
2	£3.1m	£27m	£3.8m	£4.3m	£6.2m	6.2m		£8.4m		10.8m		13.5m		16.1m
3	£3.1m	£45m	£3.8m	£4.3m	£6.2m	6.4m		£8.9m		11.7m		14.8m		17.8m
4	02-Oct	02-Oct		22-Oct		12-Nov	S	17-Dec						
5		-		-		-		17-Dec				03-Feb		

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	Draft Plan with balance between capacity/resource, activity & performance	17-Dec	CFO>FPPC
2	Board to sign off Medium Term Plan for submission to NHSE (TBC)	17-Dec	CFO>FPPC
3	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 staffing levels.
3 Pace of financial improvement is constrained by lack of restructuring or investment funding

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

Financial Performance Summary - Month 9 / December 2025

Key messages:

Headline: Overall position in line with revised control total, but some unexpected pressure from non pay costs despite the reduced number of working days in December. Pay costs remain flat after allowing for further industrial action this month.

1. The December (in-month) position is a **£9.0m deficit; £38.8m deficit year to date (YTD).** This is line with the formal forecast exercise to deliver a £56.9m deficit outturn (See seperate paper on forecast outturn).
2. The **in-month deficit** is worse than prior month; this is mainly due to an increase in clinical supplies and drugs due to activity e.g. additional clinics to meet demand and RTT, as well as a ~£0.4m reduction / correction of income for the MIU due to service non-provision of the GP service. These pressures have been partially offset by benefits from reassessing the dividend calculation.
3. **CDC income** remains a concern; whilst December activity/income was in line with plan it is ~£2.6m adverse YTD; we have made a provision of ~£1.5m in the December position but the balance of ~£1.1m is at risk of a claw back by the commissioner (they may only pay for activity delivered). We are preparing a case to receive 100% of the contracted income.
4. Overall **Clincal Income, including ERF (variable) income** is reporting to plan, this is consistent to the previous month. However, delays in clinical coding due to capacity constraints mean we have higher levels of uncoded activity at the month end.
5. No **Deficit Support Funding** has been recognised in-month/for Q3. This is critical as DSF is cash-backed (see risks opposite).
6. **Pay costs have remained flat** in month, although there has been an increase in the number of arrears payments costing ~£0.1m. Industrial action costs recognised in December total £0.6m.

Risks:

1. The position below reports run-rate and changes thereon against the most recent risk adjusted fore
NHSE of a £56.9m deficit. This forecast position **may not be accepted by NHSE** and the Trust may
improvement.
2. The revised RAFOT assumes £3m of further CIP/efficiency and £3m of non-recurrent technical acc
a positive impact on the Trust run-rate, i.e. **costs must reduce**.
3. **CDC income** recognised in the YTD position is at risk of 'claw back' if activity and services coming
revised RAFOT requires the contract value to be paid in full. Confirmation of income claw back has n
this was enacted in prior years.
4. The Board have been apprised of the risks around MCH debt, NHS debts (continues to be assume
to NKPS charges. We must also remain cautious around further Industrial Action, Elective Recovery
5. We were notified that we/the system would not receive **Deficit Support Funding** (DSF) in Q3. If t
can deliver the rest of its plan and full year control total this can be earned back in Q4. Performance
6. **Cash** balances remain an issue to ensure the Trust can meet its commitments - failure to address
factors. The Trust's cash support application made in December has been approved (£30m), with a f
Failure to receive cash support could impact on supplier payments and delivery of the capital

Current Month

£m	Actual									Commentary
	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	
Clinical income	40.4	38.6	38.1	38.6	37.7	39.2	36.6	34.7	33.8	December reduction in clinical income arises due to reversal of contracted MIU income as services are not being provided by the Trust. The balance of the movement reflects the activity/plan phasing.
High cost drugs	2.3	2.1	2.3	2.7	2.2	2.2	2.4	2.3	2.4	Passthrough income related to expenditure below. The main commissioner contract is a block and thus the Trust carries the risk of HCD expenditure above that value (~£0.4m YTD, being the net HCD income vs expenditure variances).
Other operating income	2.9	2.8	2.9	2.9	2.7	2.6	(0.1)	3.1	2.9	October balance reflects the reversal of the Brockenhurst VAT.
Total patient care and other operating income	**45.6**	**43.6**	**43.3**	**44.2**	**42.6**	**44.0**	**38.8**	**40.1**	**39.1**	
Donated asset income	0.1	0.4	0.1	0.3	0.3	1.9	0.1	0.0	0.3	Mainly relates to the Salix decarbonisation grant and timing of the capital works. This income is excluded for the purpose of performance against control total.
Total income	**45.8**	**44.0**	**43.4**	**44.5**	**42.9**	**45.9**	**38.9**	**40.2**	**39.4**	
Nursing	(11.6)	(11.5)	(11.8)	(11.8)	(13.4)	(12.4)	(12.4)	(12.1)	(12.4)	Arrears claims/payments increased in December due to recognition of non-NHS service of international nurses; a review by the CNO's office will ensure it has been correctly applied.
Medical	(9.1)	(8.9)	(8.9)	(9.5)	(10.9)	(9.3)	(9.3)	(10.2)	(9.9)	December costs include ~£0.6m of costs due to industrial action, in line with November and July. Additional sessions reductions have otherwise brought the overall cost down in month.
Other	(8.9)	(8.5)	(8.3)	(8.8)	(4.7)	(8.0)	(7.9)	(7.8)	(7.8)	The **pay inflation reserve cost** was reported against other pay until the point of payment/actual cost was incurred (August 2025), at which point and thereafter this cost is reported against nursing/medical/other as applicable.
Efficiency target	-	-	-	-	-	-	-	-	-	Balance in the plan values (right) are unidentified/not transacted against individual budget lines.
Total pay	**(29.7)**	**(28.9)**	**(29.0)**	**(30.1)**	**(29.0)**	**(29.7)**	**(29.6)**	**(30.1)**	**(30.1)**	
Clinical supplies	(4.7)	(5.1)	(5.9)	(7.3)	(5.5)	(5.5)	(5.6)	(5.9)	(6.3)	Increased insourcing costs (S&A division), additional clinics (MEC division) and blood product costs have contributed to an in-month run-rate increase.
Drugs	(1.0)	(1.2)	(1.6)	(1.6)	(1.0)	(1.2)	(1.4)	(1.1)	(1.3)	-
High cost drugs	(2.4)	(2.3)	(2.1)	(2.4)	(2.2)	(2.4)	(3.0)	(2.2)	(2.4)	See HCD income above.
Other	(6.1)	(5.8)	(4.2)	(3.7)	(5.4)	(5.4)	(5.9)	(6.4)	(5.2)	Due to lease capitalisation in December the lease costs for 2025/26 have been reversed from other non-pay and recognised as a depreciation charge.
Efficiency target	-	-	-	-	-	-	-	-	-	Balance in the plan values (right) are unidentified/not transacted against individual budget lines.
Total non-pay	**(14.2)**	**(14.3)**	**(13.8)**	**(15.0)**	**(14.1)**	**(14.5)**	**(15.9)**	**(15.6)**	**(15.2)**	
Contribution	**1.9**	**0.7**	**0.6**	**(0.6)**	**(0.2)**	**1.8**	**(6.6)**	**(5.5)**	**(5.9)**	
Depreciation	(1.7)	(1.7)	(1.7)	(1.6)	(1.7)	(1.8)	(1.7)	(1.7)	(2.0)	Additional charges for lease capitalisation in month (cost transfer from other non-pay as above).
Donated assets depreciation	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	-
Interest	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.0	(0.1)	-
Impairment	-	-	-	-	(0.0)	-	-	-	(0.5)	In December we have impaired the endoscopy modular planning works.
Gain/loss on disposal	-	-	-	0.1	(0.0)	-	-	-	-	-
PDC dividend	(0.8)	(0.8)	(0.8)	(0.8)	(0.8)	(0.8)	(0.8)	0.1	(0.7)	A recalculation of estimated charges for the year in November, the YTD cost was revised downwards.
Non-operating exp.	**(2.5)**	**(2.5)**	**(2.5)**	**(2.3)**	**(2.5)**	**(2.6)**	**(2.5)**	**(1.6)**	**(3.3)**	
Reported surplus/(deficit)	**(0.6)**	**(1.7)**	**(1.9)**	**(3.0)**	**(2.7)**	**(0.8)**	**(9.1)**	**(7.1)**	**(9.2)**	
Adjustment to control total	(0.1)	(0.4)	(0.0)	(0.3)	(0.3)	(1.9)	(0.0)	(0.0)	0.2	This line remove donated asset income, depreciation on donated assets, impairments and gains/losses on disposal of assets to report a control total (including DSF).
Control total surplus/(deficit)	**(0.7)**	**(2.1)**	**(1.9)**	**(3.2)**	**(3.0)**	**(2.6)**	**(9.1)**	**(7.1)**	**(9.0)**	

Meeting of the Trust Board in Public

Meeting Date: 14 January 2026

Title of Report	Quarter 1 and Quart 2 2025/26- Learning from Deaths report			**Agenda Item**	3.1.3
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	Sofia Power- Learning from Deaths Manager				
Lead Executive	Alison Davis- Chief Medical Officer				
Purpose	**Approval**		**Briefing**		**Noting X**
Proposal and / or key recommendation:					
Executive Summary	This report provides an overview of mortality outcomes, review activity and learning from deaths across Quarters 1 and 2 of 2025/26 (April–September 2025). It summarises findings from Structured Judgement Reviews (SJRs), key themes, improvement actions and the Trust's current performance against national mortality indicators. **Mortality Overview** Across the first half of 2025/26, the Trust recorded: • 553 adult inpatient deaths and 70 deaths in ED. • 92 Stage 1 SJRs were completed, representing 14.8% of all deaths. • 17 cases were escalated for Stage 2 review. • One death was judged possibly/probably preventable (>50:50). This was escalated to the Incident Review Group and further investigation revealed blood test results that were not previously available to the SJR reviewer. The case was downgraded and was shared for learning with the speciality team involved. The SJR programme continues to provide rich insights into care quality across the patient pathway. High-quality practice was consistently demonstrated in: • Strong teamwork and communication in ED.				

- Early completion of Treatment Escalation Plans (TEPs) and DNAR decisions.
- Effective involvement of palliative care and allied health professionals.

However, recurring concerns were identified in several key areas:

- **End of life care** – delays in recognition, pathway initiation and anticipatory prescribing.
- **Diagnostic and treatment delays**, including prolonged stays in ED due to capacity issues.
- **Documentation and communication failures** affecting decision-making, discharges, and family engagement.
- **Medication and clinical management errors**, including incorrect prescribing, dosing and delayed antibiotics.
- **Operational pressures**, including staffing gaps, equipment shortages, handover issues and IT failures.

These themes reflect system-wide challenges that impact care continuity, timely escalation, and patient experience.

Learning Disability Reviews

Three deaths involved patients with learning disabilities, all assessed as largely good/excellent care with some gaps in end-of-life processes.

All three LD cases reviewed scored good or excellent care. A SWARM review identified an IT-related failure in prescribing end-of-life injectables; corrective actions have now been implemented including checklists, education, and improved discharge coordination.

Actions and Improvement Work

Significant improvement activity is underway, including:

- Implementation of a Learning from Deaths audit for additional oversight and early escalation of concerns.
- Enhanced Trust-wide education on clinical documentation and its impact on coding, finance, and mortality indicators.
- Strengthening of communication and documentation processes through PSIRF-aligned workstreams.
- Targeted action on end-of-life care, including early recognition tools, audits, pathway redesign and enhanced discharge processes.
- A series of medication safety initiatives, including EPMA alerts, anticoagulant safety measures, national QI collaboratives, and improved visibility of critical medications.

	• Cross-specialty work to address delays in referrals, ED flow, handovers, and availability of essential equipment.
	
	Mortality Indicators
	
	Although HSMR+ is stable and within expected limits, SHMI remains higher than expected. Drivers include:
	
	• Rising palliative care rates and longer length of stay particularly for frail patients.
	• Late identification of palliative status.
	
	The Trust is progressing deep-dives, coding reviews, and enhanced specialty feedback loops to address documentation accuracy and diagnostic coding issues that influence SHMI.
	
	Strategic Priorities and Forward Planning
	
	Key forward priorities include:
	
	• Strengthening the Learning from Deaths process and ensuring systematic response to concerns raised by Medical Examiners.
	• Improving early identification and management of frailty and end-of-life care needs.
	• Trust-wide implementation of the new sepsis improvement programme, including policies, dashboards, and education.
	• Delivery of the Patient First Mortality Breakthrough Objective, focusing on:
	  ○ Care continuity in emergency pathways
	  ○ Documentation accuracy
	  ○ Best-practice-aligned mortality reviews
	  ○ Strengthening end-of-life care
	
	These actions aim to reduce avoidable harm and return the Trust's SHMI to the expected range by 2026/27.

Issues for the Board / Committee Attention:	
Committee / Meetings at which this paper has been discussed / approved: **Date:**	
Board Assurance Framework / Risk Register:	

Financial Implications:				
Equality Impact Assessment and / or patient experience implications				
Freedom of Information status:	Disclosable		Exempt	X

Learning from deaths- Quarter 1 and Quarter 2 (2025/26)

1. Excutive Summary

This report presents a retrospective overview of the deaths occurring between April 25 and September 25, alongside the learning identified through structured case reviews. The purpose of this section is to highlight themes, share learning from patient care, and outline actions taken to improve safety and quality across the organisation during the quarter 1 and quarter 2 reporting period (2025/26).

2. Mortality overview in Q1 and Q2 (2025/26)

Table 1: Overview of deaths and review processes Q1 and Q2 (25/26)

	2025/2026									YTD
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Total no. of adult inpatient deaths	98	98	75	85	92	105				553
Total no. of deaths in ED	8	14	12	13	13	10				70
Total number of deaths reviewed by SJR (stage 1)	15	13	12	19	17	16				92
% of deaths reviewed by SJR.	14.2%	11.6%	13.8%	19.4%	16.2%	13.9%				14.8%
Number of deaths referred for stage 2 SJR panel	4	2	1	4	3	3				17
Total number judged as possibly/probably preventable (over 5050)	0	1	0	0	0	0				1
Total number of LD deaths reviewed	0	0	1	0	1	1				3
Total number of LD deaths judged as possibly/probably preventable	0	0	0	0	0	0				0
Crude mortality %	1.5%	1.4%	1.1%	1.2%	1.4%	1.5%				
SHMI	1.26	1.26	1.25	1.26						
HSMR+	97.95	97.45	96.49	94.99	94.55	95.87				

3. Learning from Deaths

Structured Judgement Reviews (SJR)

This report provides a summary of mortality review activity undertaken using the Structured Judgement Review (SJR) methodology. The SJR process forms a core element of the Trust's mortality governance arrangements, supporting the identification of learning, quality improvement opportunities, and actions to strengthen patient safety.

Between April 2025 and September 2025 (Quarters 1 and 2, 2025/26), 92 deaths were reviewed through Stage 1 SJRs. Stage 1 reviews are undertaken by an independent, trained reviewer and provide an initial assessment of the quality of care delivered throughout the admission.

Cases where significant concerns are identified, such as problems in care, evidence of potential patient harm, or an overall quality of care rating of *poor* or *very poor* are escalated to a Stage 2 review. Escalation also occurs where reviewers judge there to be a degree of preventability associated with the death.

Stage 2 reviews are completed by a multi-disciplinary oversight panel, which collectively evaluates the level of concern, determines the appropriate escalation route, and ensures that learning is disseminated across relevant specialties or, where appropriate, referred to the Patient Safety Incident Review Group. This two-stage process provides consistent scrutiny and assurance that concerns are considered with appropriate clinical oversight and governance.

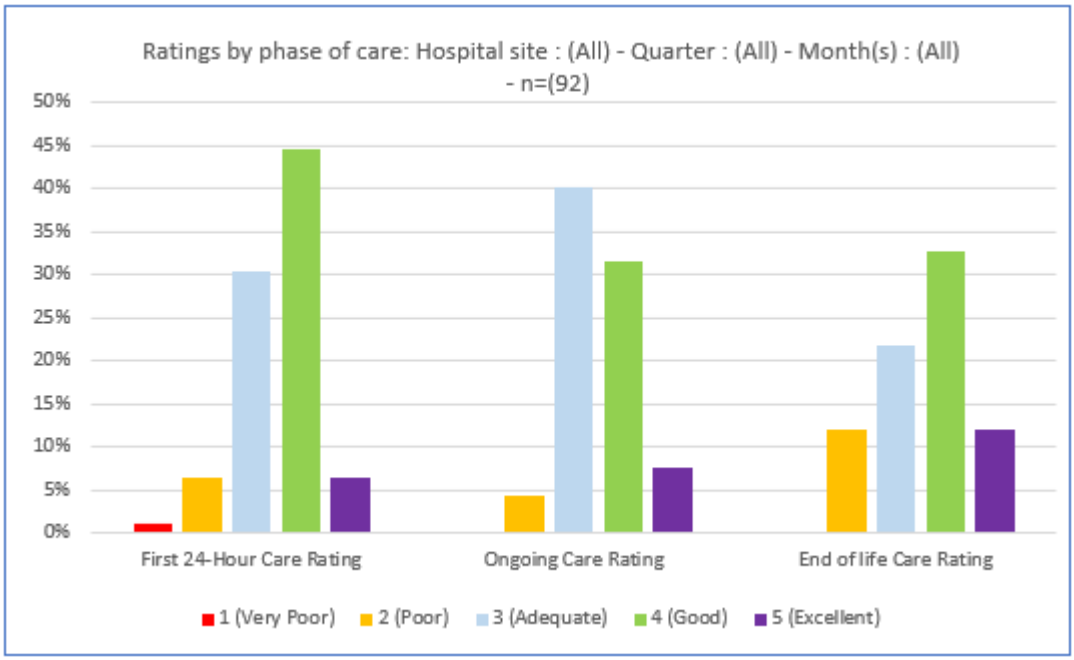
The SJR methodology requires reviewers to assess and score the quality of care across defined phases of the patient pathway, including:

- the first 24 hours of admission
- ongoing inpatient care
- procedural care
- care during the final days of life
- overall care assessment

Each phase is rated against a standard five-point scale (*very poor* to *excellent*). This approach enables the Trust to identify where high standards of care are consistently achieved and where targeted improvement may be required.

Learning arising from SJRs is routinely shared with clinical specialties and discussed at Mortality and Morbidity (M&M) meetings to ensure feedback is embedded within teams and informs service-improvement activity. Aggregated phase-of-care scores for Quarters 1 and 2 are illustrated in Figure 2 and highlight themes and trends that will inform forthcoming quality improvement priorities.

Figure 1 : Q1 and Q2 2025-26 deaths: SJR phases of care



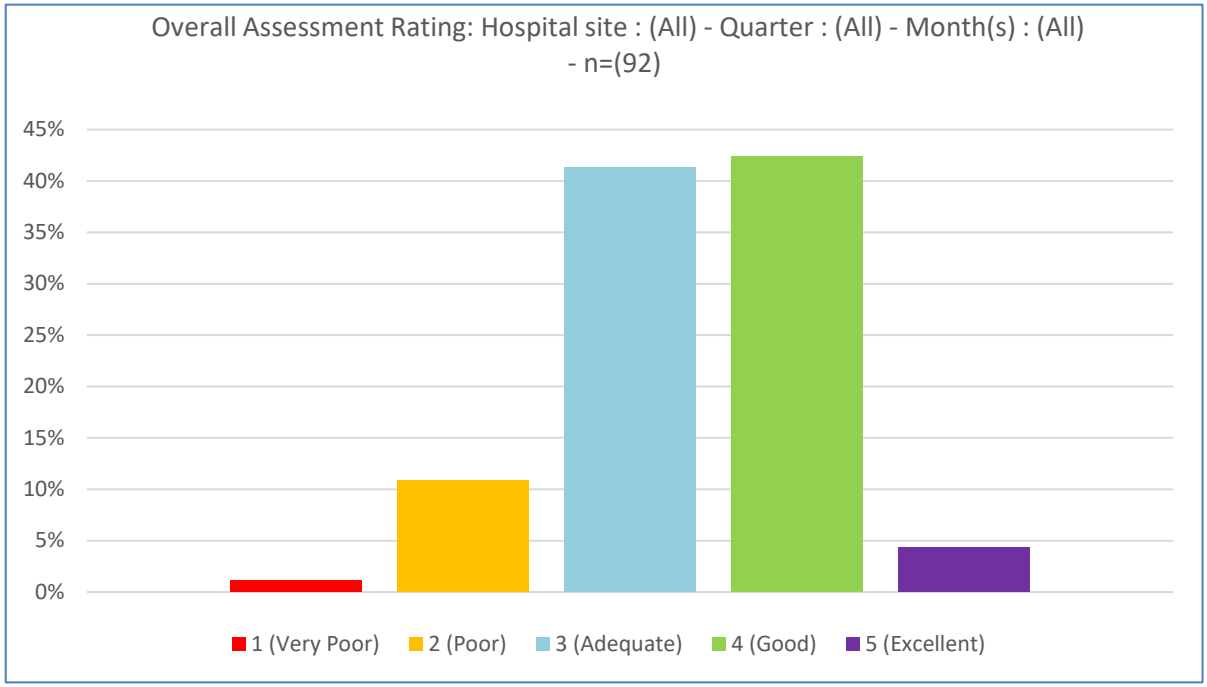
Some of the good and excellent care identified:

- Excellent collaboration across multiple teams for complex patients in ED.
- Good, clear communication and family involvement
- Effective escalation planning with Treatment Escalation Plans (TEP) and Do Not Attempt Resuscitation (DNAR) completed early on in admissions
- Good involvement of palliative and ART teams for acute deterioration.
- Good use of supportive services including SALT, dieticians, therapies, TVN and Respiratory for NIV support.

Some of the poor care identified:

- Professionalism, culture and system factors- breakdown in communication with families
- Lack of ownership between clinical teams
- Bleep and IT failures
- Confusion amongst nursing staff about anticipatory meds usage when patient is not formally end of life care
- Prolonged stays in ED
- Documentation issues- incomplete, not completed or lack of details and discrepancies
- Medication errors- delayed antibiotics, dosing errors, inadequate fluid management

Figure 2: Q1 and Q2 2025-26 deaths: SJR Overall Assessment of Care Rating

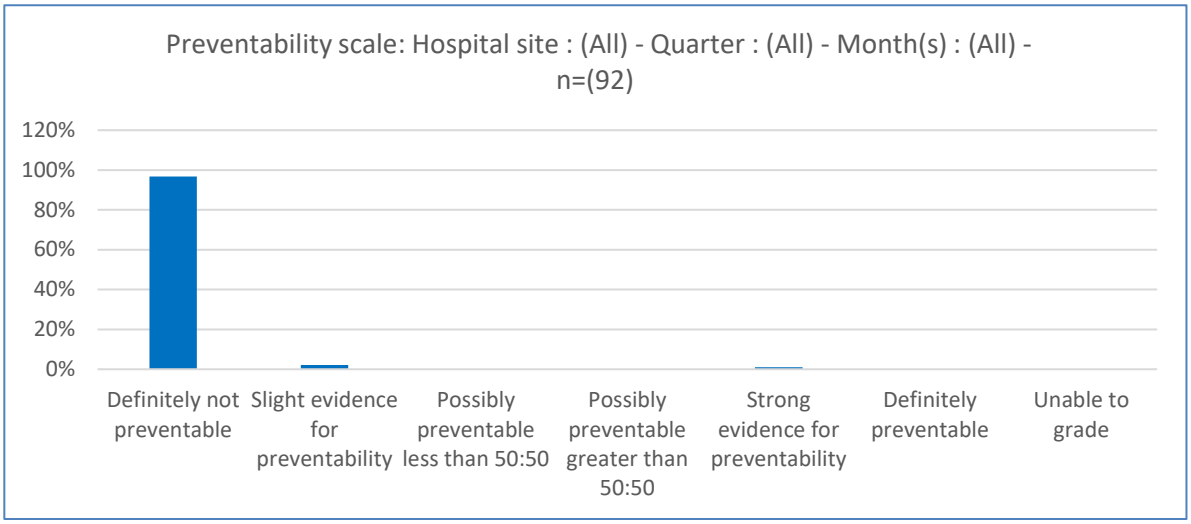


Preventable deaths

The SJR plus tool uses the terms ‘preventable’ rather than ‘avoidable’ as Aqua and Better Tomorrow agreed that a softer use of the term to describe deaths that may have been due to issues in care would make the reviewer feel more confident in making a judgement if there had been suboptimal care. Preventable deaths refer to deaths judged to have been more likely than not (>50:50) due to a problem in healthcare.

With the SJR approach, the preventability of death is assessed at the point of review. This provides a strong/clear steer for which cases should receive further robust investigation via our patient safety incident framework.

Figure 3: Q1 and Q2 2025/26 deaths: SJRs judged as possibly preventable



Thematic Analysis and escalations

Thematic reviews of SJRs are completed on a quarterly basis to allow sufficient data to review what issues are reoccurring. The table below gives an overview of the top five themes that were identified over quarter 1 and quarter 2 (2025-26), that is, issues that have been identified a number of times from different reviews. The table include the current status around ongoing improvement work.

Table 2: Q1 and Q2 2025/26: SJR themes and actions

Theme	Issues identified	Actions
End of life care gaps	There were widespread issues with end of life care, with numerous patients experiencing delays in the recognition that they were approaching end of life. In several cases, EOLC pathways were not initiated in a timely manner, resulting in patients remaining in hospital beds when a community or hospice setting might have been more appropriate. Additionally, there were repeated failures to prescribe anticipatory medications, both during inpatient care and at discharge, leaving patients vulnerable to	• Work has commenced with palliative and end of life care to find a suitable early recognition tool. • Amber care bundle and the Support and Palliative Care Indicators Tool (SPICT) being explored. • NACEL audit ongoing with live current data to look at time from recognition of dying to the time of referral to specialist palliative/end of life care teams. Data being used to

	unmanaged symptoms at a critical time.	benchmark against national data • A3 for RESPECT from completion in progress • QIP for end of life and palliative care in place • Audit undertaken by SECAMB to explore reasons why patients are conveyed to Medway. Next steps are to develop a new model of care for end of life care patients with updates expected in the next coming months.
Delays in diagnostics, referrals and treatment	Across several cases, there was evidence of significant delays in obtaining diagnostic investigations, securing specialist reviews, and commencing appropriate treatments. Patients often experienced prolonged waits in the Emergency Department, sometimes spanning multiple days, due to capacity issues or misdirected referrals (e.g. surgical patients being referred to medical teams). Such delays potentially impacted outcomes and contributed to patient distress.	• PSIRF priority- including delays in patients diagnosis and treatment, patients lost to follow up and where opportunities to improve escalation to monitoring of patients who decondition. • 12 hour ED breach quarterly harm review- actions will be implemented going forward as not previously addressed • Training provided in ED via drop in sessions and class room training. • Ongoing A3 to progress the move from 'its not my patients' to 'this is our Medway patient' • Guidance for ED transfer to specialties now available on the intranet. • Linked teams where this has been an issue: ED and critical care joint M&M with interdepartmental simulations and consultant to consultant referral process

Documentation and communication failures	There were persistent failures in documentation and communication, undermining continuity of care and clinical decision-making. Records were often incomplete, disorganised, or lacked critical detail about major decisions such as DNAR status, management plans, and discussions with patients and families. Communication gaps extended to interactions with patients' next of kin, and there were missed opportunities to use interpreting services for patients with language barriers.	• Lack of interpreting services identified as a risk. Detailed action plan in place based on national guidance with potential joint tender options with KMPT. • Mitigation of risk include AI pocket devices in emergency situations, mainly in maternity. • Communication is a PSIRF priority and encompasses issues where communication failures contributed to the event/incident and where opportunities have been identified to enhance handovers, access translation services, team and cultural collaboration both within MFT and across organisations, communication with patients and families, and quality of documentation. • Continued education delivered by coding and learning from death to all specialties on quality of documentation and the impact on coding, finances and mortality indicators.
Medication and clinical managements failures	Frequent errors in medication and clinical management were noted, ranging from incorrect prescriptions and dosing errors to failures to adjust medications for comorbidities such as renal dysfunction. Patients sometimes remained on treatments longer than necessary, while antibiotic regimens were not always reviewed in line with	• ED improvement plan in place which include introduction of alerts on EPMA to alert staff to any new prescriptions that have been added to prevent medication administration • Medications is a PSIRF priority- issues related to timely delivery of critical medications, availability

	microbiology results, leading to avoidable exposure and risk.	of drugs, staff skills and training, following medication polices and accuracy or timing in prescribing and administrating medications. • Anticoagulant safety: Improving visibility of LMWH and other anticoagulants on EPMA (grouped together at top of Drug chart, warning message if 2 anticoagulants are prescribed concurrently, development of new oral anticoagulants policy (not yet completed), review of current VTE policy, VTE working group) • Opioid safety: Improving prescribing at discharge to reduce the length of time patients are taking opioid medication, and to reduce misuse in primary care, working with surgical and anaesthetic teams to create a patient info leaflet regarding the use of pain killers post-surgery, reducing the use of Oxycodone (which is stronger than morphine) • Critical medication: MFT were successful in being part of a National critical meds QIP which started last week, increasing stock holding of medication for epilepsy to reduce the incidence of omitted doses. • Increasing incident reporting: Training and engagement of

		pharmacy team, and setting up of QR code reporting for near misses (in dispensary) and near misses (spotted on wards when prescribing was incorrect and medics were approached to correct before any harm to a patient) • 9 month collaborative for safer use of time critical medications- first meeting last week, next scheduled this week and next few weeks. Explore with other organisations on how to manage time critical medications- specific to Parkinson and antiepileptic but can be used across all medications.
Systemic and operational pressures impacting on care	Finally, there were numerous examples where systemic and operational pressures compromised the quality and timeliness of patient care. These included staff shortages during bank holidays, lack of space or equipment in ED, delays in securing community care placements, and inadequate handover systems. Such issues often prolonged hospital stays and contributed to gaps in patient monitoring and follow-up.	• Handovers forms part of PSIRF priority under communication to ensure that incidents where handovers have contributed due to handover issues are investigated. • Bleep system A3 underway • TEP form on epR • MDT QI group- action to buy scales to weigh vomit and VGB/ABG on ePR in September • Prompt added to ePR to ensure imaging is reviewed before discharge. Added to ServiceDesk and proposal to go to epR clinical workstream.

		• Trauma checklist for equipment- formal protocol being introduced including visual map of equipment and walkthrough as part of ED induction. • More trainings planned with ED PDN's. NG ESR E-Learning created for staff which gives them theoretical knowledge on types of NG tubes, difference of the tube used for feeding and drainage purposes, safe insertion techniques and its management. • Email sent to ED team requesting all their nursing staff to complete this NG ESR E-learning course before the end of this month. Face to face NG training started for those who wish to get NG insertion competency, first batch completed their training on 24/04/2025.

Learning Disability

Every patient with a learning disability and autism is subject to an SJR. SJRs are forwarded to the Learning from Lives and Deaths of people with a Learning Disability and Autism for LeDeR review. Over quarter 1 and 2 (25/26), there were a total of three SJRs for patients with learning disabilities. A member of the Learning Disabilities Team attends the SJR panel where LD patients are discussed to provide input into the care given to the patients and to highlight any concerns.

All three cases reviewed through SJR scored good or excellent care for the majority of the admission however, there were gaps identified with the end of life care process. Learning identified included end

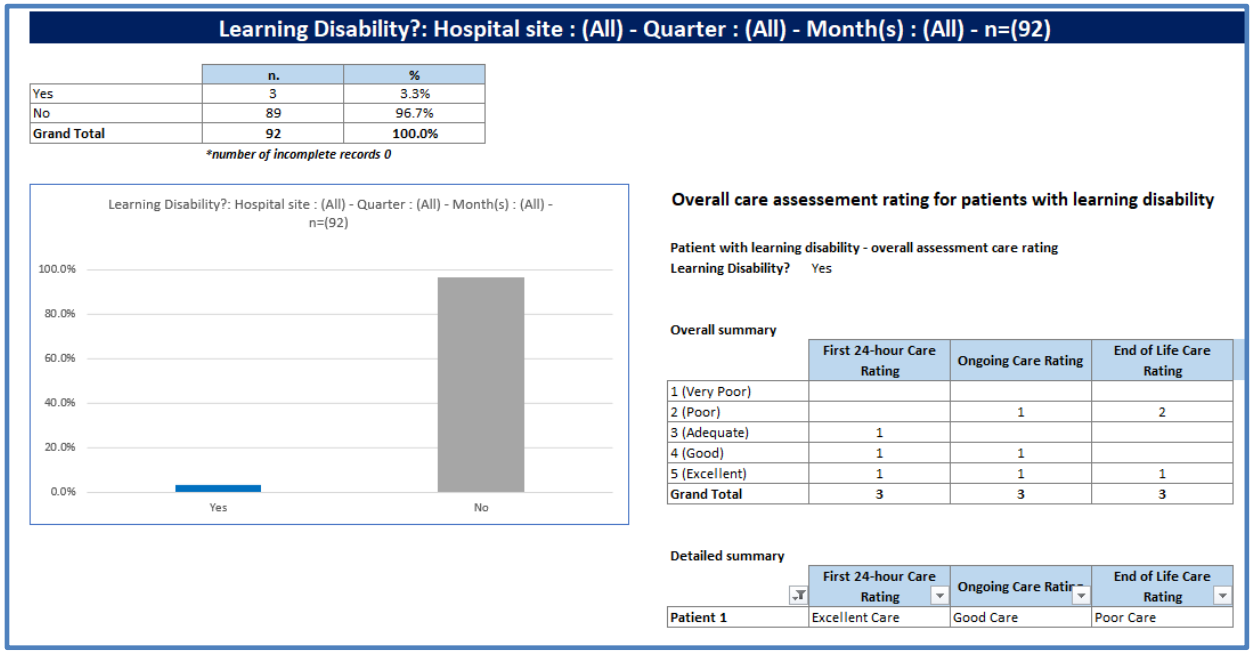
of life injectables that were not provided at discharge and had to be arranged urgently after the patient was discharged.

A SWARM was undertaken and established that two syringe drivers were prescribed to go home with the patient however, due to an IT fault, the referral to Medway Community Healthcare for the prescription did not go through. This was quickly identified and medications were urgently arranged.

Actions included:

- Ward meeting with end of life care team to share learning
- Education to all staff and booklets given for end of life preferences
- End of life checklist to go live in September to provide safety netting to stop patients being discharged without everything in place
- Discharge coordinator on the ward will be responsible for coordinating fast track discharge check lists
- Medway Community Healthcare to send hospital end of life care team a list of syringes used at MCH to ensure the patient have them when discharged

Figure 4: Q1 and Q2 2025/26: SJRs for patients with learning disabilities



Learning Disability?: Hospital site : (All) - Quarter : (All) - Month(s) : (All) - n=(92)

	n.	%
Yes	3	3.3%
No	89	96.7%
Grand Total	92	100.0%

*number of incomplete records 0

Overall care assessement rating for patients with learning disability

Patient with learning disability - overall assessment care rating
Learning Disability? Yes

Overall summary

	First 24-hour Care Rating	Ongoing Care Rating	End of Life Care Rating
1 (Very Poor)			
2 (Poor)		1	2
3 (Adequate)	1		
4 (Good)	1	1	
5 (Excellent)	1	1	1
Grand Total	3	3	3

Detailed summary

	First 24-hour Care Rating	Ongoing Care Rati...	End of Life Care Rating
Patient 1	Excellent Care	Good Care	Poor Care

Learning from deaths – key actions

- A learning from deaths audit was instigated, looking at each patient death, highlighting cases for SJR reviews, raising incidents for immediate concerns and adding an extra layer of oversight of deaths. The LFD audit data will be presented at the Resuscitation and Deterioration Group (RADG).

- Clinical coding and Learning from deaths have presented at the Acute Medicine, General Medicine, Diabetes, Critical Care, ED, General Surgery, Elderly Care and Haematology on the importance of clinical documentation and the impact this has on coding, finance and mortality indicators. The presentation receives positive feedback and is an educational forum for clinicians to understand what can and can't be coded and an introduction into the mortality indicators and what this means for the Trust.
- LFD attending all M&M where SJRs are discussed to ensure learning is shared

- Mortality Matters is a monthly newsletter that is circulated to clinicians that shares learning and provide valuable updates- the past few months have included medical examiner updates. The newsletter received really positive feedback and LfD were asked to support Medicines Group to produce similar to share learning.

- Cases that undergo a stage 2 review but do not require referral to Patient Safety are sent to the Divisional Governance Leads. Cases discussed at the stage 2 highlighted learning for both Doctors and Nurses in ED and Acute Medicine around clinical monitoring issues, delays in hyperkalaemia treatment and communication around end of life care decisions. ED, Acute Medicine and the Matron on Pembroke ward have all be forwarded the specific learning points for their areas and learning from cases will be shared with Doctor and Nursing.

Forward plans and next steps

- National benchmarking indicates that organisations with a well-embedded safety and learning culture typically identify potentially preventable factors in approximately 4–5% of deaths per year. Current internal review data suggests that we may be identifying fewer cases than expected, which could indicate gaps in our learning approach. To address this, the forward plan will focus on strengthening the Learning from Deaths process by ensuring that concerns

raised by the Medical Examiner are systematically reviewed and acted upon, with clear feedback loops in place. Additionally, escalation pathways will be reinforced to ensure that all cases where deaths may have been preventable are appropriately identified, investigated and learned from.

- Data from SJR reviews and the learning from deaths audit indicates that we review predominantly frail and elderly patients, many of whom have prolonged stays in ED. Forward plans include looking at the frailty pathway for patients and the impacts prolonged stays, coupled with issues with end of life care and the impact on mortality.

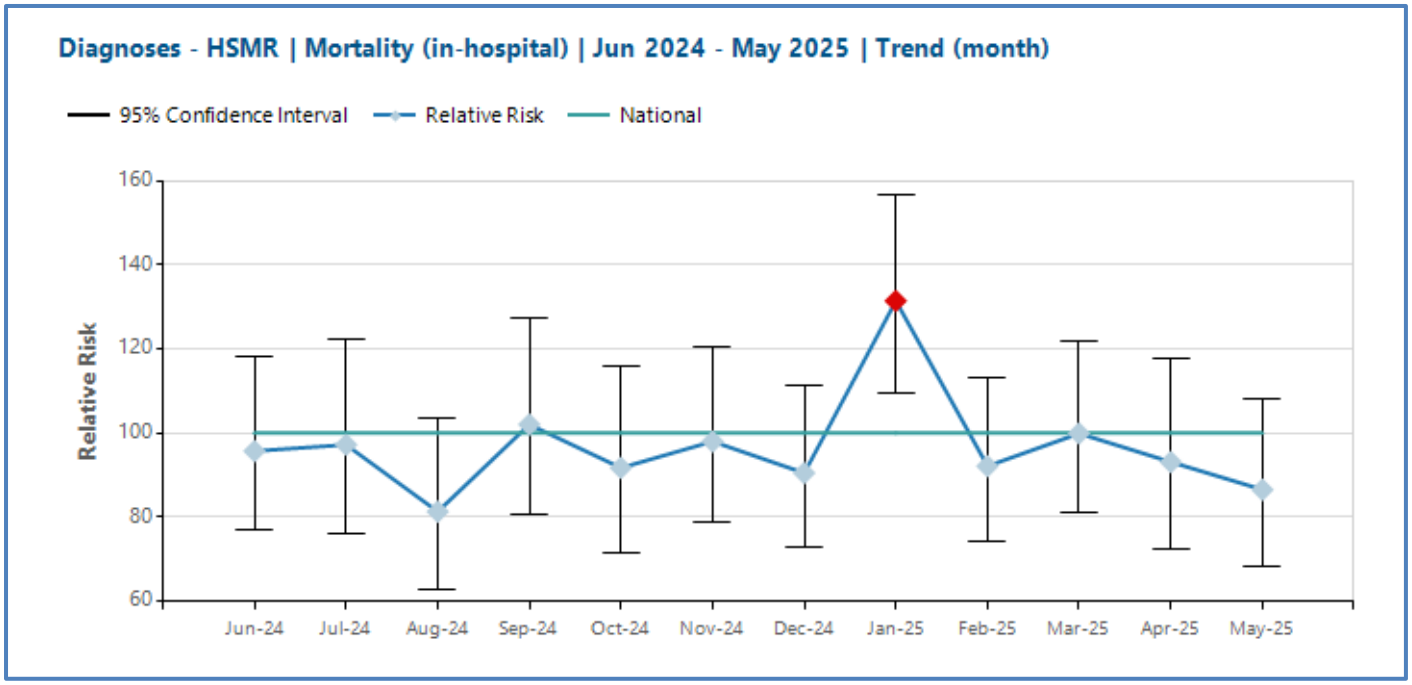
Mortality

Hospital Standardised Mortlaity Ratio (HSMR+)

The HSMR+ value reported for Quarters 1 and 2 of 2025/26 covered the period June 2024 to May 2025 and was 86.56, which sits comfortably within the ‘as expected’ range.

The Trust has continued to remain well within this banding. Improvements have also been noted in coding quality, including greater coding depth, with data reflecting a higher proportion of patients recorded with a richer comorbidity profile, contributing to more accurate risk adjustment and mortality modelling.

Figure 5: HSMR+ 12 month rolling trend June 24- May 25



Summary Hospital- Level Mortality Indicator (SHMI)

The Trust’s SHMI performance, which is the NHSE recognised metric for mortality, and in contrast to the HMSR+ data, has continued to deteriorate over the reporting period. The crude rate and in-hospital deaths have continued to increase, with both in hospital and post discharge deaths increasing.

The SHMI value reported for Quarter 1 and 2 of 2025/26 covered the period May 2024 to April 2025 and was 1.26, and higher than expected.

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 care 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).

Figure 6: SHMI SPC chart

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+). 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. 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+ we triangulate both measures with structured case record reviews and clinical judgement to provide a more accurate assessment of mortality outcomes and supports meaningful learning.

Actions to address the increase in SHMI include:

Deep dives into outlying diagnosis groups: Deep dive reviews have consistently identified documentation accuracy as a key driver of apparent mortality outlier, rather than care quality issues. The following Trust wide actions have been implemented:

- Inclusion of SHMI and documentation accuracy in Resident Doctor Inductions
- Learning from deep dives included in monthly 'Mortality Matters' newsletter to share learning, circulated to clinicians.
- Regular education to specialty teams
- Introduction of quarterly specialty feedback loops (targets to Acute Medicine and frailty- with a higher volume of deaths).
- Oversight of outlying diagnosis groups continually monitored through the Mortality and Morbidity Surveillance Group (MMSG)
- Deep dives into Pneumonia and UTI to be undertaken to establish the root causes into the persistent SHMI outlying diagnosis groups.

Next Steps and Ongoing Improvement Work

- Appointment of a Trust Sepsis Lead (1 PA/week funded via CMO budget , recruitment commenced.
- Development of a Trust-wide Sepsis Policy, with shared learning from Dartford and Gravesham NHS Trust (DVH).
- Implementation of a Sepsis 6 bundle, risk assessment tool, and tag within EPR (draft by end October 2025; completion by end of Q4).
- Launch of a Sepsis Dashboard and improved BI reporting for timely, accurate Trust-wide data.
- Establishment of a Sepsis Working Steering Group, jointly led by CCOT and RADG, supported by the Transformation Team.
- Comparative Trust-wide audit to determine the quality of sepsis care, aligned to the National Standard Contract (50 ED and 50 inpatient cases per quarter).
- Continued improvement work via the A3 methodology, with regular monthly review through the Sepsis Working Group.

- Exploration of adding sepsis as a specific agenda item within the mortality huddle to ensure continued oversight and learning

Patient First Mortality Breakthrough Objective

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. The key focus areas of the Breakthrough Objective are:

- Care continuity and speciality review for patients on the emergency admission pathway
- First time data documentation accuracy and subsequent clinical coding
- Learning from deaths process aligning with best practice
- End of life care process

The breakthrough objective is a 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 meeting is attended by key stakeholders including Divisional representation, End of Life Care, Clinical coding, Business Intelligence, Nursing and Medical representation, Learning from Deaths, Patient Safety and Clinical Governance. Themes from the teams are presented with immediate actions to the group.

Meeting of the Trust Board in Public

Date: 14th January 2026

Title of Report	Finance Flash Report Month 9 / December 2025			**Agenda Item**	3.2
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	Paul Kimber, Deputy Chief Financial Officer				
Lead Executive	Simon Wombwell, Chief Finance Officer (Interim)				
Purpose	**Approval**		**Briefing**	X	**Noting**
Proposal and/or key recommendation:	None				
Executive Summary	Overall financial position in December is in line with the revised RAFOT projection, but some unexpected pressures experienced against non pay costs despite a reduced number of working days in December. Pay costs remain flat after allowing for industrial action costs of ~£0.6m in December. The key challenge is for the management team to contain costs, increase savings in the final quarter of the financial year to meet the new control total of £57m deficit (pending application to NHSE on 8th January) – see separate paper.				
Issues for the Board/Committee Attention:	See Risks section.				
Committee/ Meetings at which this paper has been discussed/ approved: **Date:**	A financial report is presented to the FPPC and Board on a monthly basis.				
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 and the removal of deficit support funding.				
Financial Implications:	None				
Equality Impact Assessment and/or patient experience implications	None undertaken for the forecast, however all efficiency proposals undergo an impact assessment.				
Freedom of Information status:	Disclosable	X	Exempt		

Meeting of the Board

Meeting Date: 14 January 2026

Title of Report	**Board Assurance Framework**			**Agenda Item**	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**
					X
Author and Job Title	Matthew Capper, Director Strategy and Partnership				
Lead Executive	Deputy Chief Executive				
Purpose	**Approval**	X	**Briefing**	X	**Noting**
Proposal and / or key recommendation:	The Committee is requested to consider the contents of the Board Assurance Framework.				

Executive Summary

This report provides an overview of the current board assurance framework (BAF) which is designed to describe the strategic risks and issues facing the trust. The trusts stabilisation plan is aligned with the BAF.

In line with the actions from the trusts Audit and Risk Committee, the BAF risk appetite ratings have been recalibrated to align with the Board approved Risk Management Framework.

There have been two amendments to the BAF from the December 2025 version, these are:

- Risk 2, action 1 – the Estates Strategy is due to be presented to the Board in February 2026 (previously December 2025).
- Risk 8, target date for achievement has been amended to September 2026 (Previously March 2026)

There are currently 4 active risk, distributed as follows:

Risk Rating	Score Range	Number of Risks	% of Total
Extreme	15+	2	50%
High	8-12	2	50%
Moderate	4-6	0	0%
Low	1-3	0	0%

The following risks are rated **Extreme (score ≥15):**

ID	Risk Title	Score	Exec Lead
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.	16	Deputy Chief Executive
14	Without continual investments and maintenance (including cyber security) the trust will not be able to deliver on its core	16	Dir Strategy and Partnership

	responsibilities and duties as well as being able to deploy innovative systems to support the delivery of the trusts aims, objectives and strategic intentions.	

As agreed by the Board in December 2025 risk number 9 (patient experience) has been closed on the BAF.

There are currently 8 active issues, distributed as follows:

Priority Rating	Number of Issues	% of Total
5 – Significant	4	50%
4 – High	4	50%
3 – Moderate	0	0%
2 – Low	0	0%
1 – Insignificant	0	0%

Issues for the Board / Committee Attention:	• There has been no recorded movement of a risk or issue rating in this reporting period.
Committee / Meetings at which this paper has been discussed / approved: **Date:**	The Board Assurance Framework is presented to each Board and Board-Sub-Committee, monthly
Board Assurance Framework / Risk Register:	See attached document.
Financial Implications:	N/A
Equality Impact Assessment and / or patient experience implications	N/A

Freedom of Information status:	Disclosable	✓	Exempt	

Board Assurance Framework – January 2026

					Initial Risk Rating				Current Rating					Appetite Rating							
Risk ID	Added Date	Theme	Risk Description	Risk / Issue	Consequence	Likelihood	Score	Controls in place	Consequence	Likelihood	Score	Risk Movement	Actions	Action Due Date	Consequence	Likelihood	Score	Risk Treatment	Target Date for Closure	Confidence in achieving closure date	Exec Lead	BAS item ?
1	April 25	Sustainability	The trust is not effectively managing its in-year budgets, run rate, CIP and cash reserves resulting in the non-delivery of the agreed in year control totals and the removal of deficit support funding.	Issue	4	3	12	• Finance, Performance and Planning Committee oversight. • Weekly sustainability recovery group. • Vacancy and enhanced non-pay controls. • NHSE Improvement Director support. • System finance and recovery forum (CFO attending).	Issue	Issue	5	-	1. Approved stabilisation plan being implemented. Monthly progress reported and actions tracked. CIP performance support governance now operational. 2. Dedicated business planning support secured, draft plan to be completed by 17 Dec 25. 3. Revised business partner arrangements being implemented and will be operational from Dec 25. 4. IQPR and stabilisation plan reporting now revised and operational. Revised version went to FPPC in Nov 25. Some amendments to performance metrics will be made in Dec 25.	Mar 26 Complete Dec25 Complete % complete – 50%	4	3	12	Treat	31 Mar 2027 (financial balance)	Low	Chief Finance Officer	Yes
2	April 25	Sustainability	Limited capital money is impacting the Trust's ability to tackle its backlog maintenance requirements.	Issue	5	4	20	• Trust prioritisation matrix for estates. • Annual Place surveys and Ward Accreditation programme • Six-Facet survey recovery programme. • System strategic estates group (member). • Estates and IPC walk around • Links to quality and performance agendas	Issue	Issue	5	-	1. Draft estates strategy to be presented to Board. 2. Planning group in place and aligned with finance governance. Reports monthly. 3. Revised business partner arrangements being implemented. 4. IQPR and stabilisation plan reporting now revised and operational. 5. Establish formal governance with oversight and audit trail. Reported to FPPC. 6. Exploring avenues for external/national funding.	Feb 25 Complete Dec 25 Complete Complete Feb 26 % complete – 50%	4	3	12	Treat	Mar 26 (annual)	Low	Deputy Chief Executive	Yes
3	July 23	Sustainability	Independent audits into the drivers of deficit at the Trust have identified the financial culture of the organisation as a contributory factor in the performance. Failure to address this as an issue will impact the Trust's exit from a recovery regime.	Issue	4	4	16	• Monthly budget holder meetings • Budget holder training (stat man) • Mandatory objective in appraisal • Communication via senior managers meetings and Trust Management Board • Compliance reporting to FPPC (as part of payables update) and to the Audit and Risk Committee.	Issue	Issue	5	-	1. Revised business partner arrangements being implemented. 2. Dedicated business planning support secured for divisions. 3. Budget holder training part of Stat and Man training. 4. Communication from CEO and CFO outlining staff responsibilities 5. Link through to the trust cultural transformation programme.	Dec 25 Dec 25 Ongoing Complete Monthly % complete – 20%	4	3	12	Treat	31 Mar 26	Low	Chief Finance Officer/ Deputy Chief Executive	No (linked to risk 1)
4	April 25	Quality	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.	Risk	4	3	12	• Trust Leadership Team and performance oversight governance. • Board Sub-Committee oversight. • Trust combined impact assessments (quality, equality and finance) included in all sustainability focused areas and business planning. • IQPR dashboard. • External regulator audits.	4	4	16	-	1. Produce triangulated reporting mechanism and revise trust governance to ensure effective flow of big data. 2. Embed combined IAA in all aspects of decision making across the trust. 3. Revise the IQPR. 4. Deliver the trust stabilisation plan.	Nov 25 Nov 25 Complete Mar 26 % complete – 25%	3	1	3	Treat	31 Mar 26	High	Deputy Chief Executive	No (linked to risk 1)
5	April 25	Culture	The Trust's current organisational culture will continue to negatively impact staff and patients' experience and the trusts reputation.	Issue	3	4	12	• Annual staff survey and routine Pulse surveys • Monthly FTSU review meetings. • Cultural Transformational phase 2 plan and monitoring metrics. • WRES/WDES indicator collection and reporting. • Stabilisation Plan programme.	Issue	Issue	4	-	1. Dedicated investigation & resolution team are taking forward complex ER cases. 2. 85% management essential (inc. Advanced) trained staff (in the stabilisation plan). 3. Rapid Case Reviews progressing and updates provided to Trust Board monthly and People Committee. 4. Action plan produced to mitigate risk from the sex discrimination assessment.	Jan 26 Mar 26 Mar 26 To be confirmed % complete – 0%	3	2	6	Treat	Mar 26 (Phase 2)	Medium	Chief People Officer	Yes

					Initial Risk Rating				Current Rating						Appetite Rating							
Risk ID	Added Date	Theme	Risk Description	Risk / Issue	Consequence	Likelihood	Score	Controls in place	Consequence	Likelihood	Score	Risk Movement	Actions	Action Due Date	Consequence	Likelihood	Score	Risk Treatment	Target Date for Closure	Confidence in achieving closure date	Exec Lead	BAS item ?
6	Jul 25	Culture	Quality of patient care could be 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.	Issue	4	3	12	• Freedom to Speak Up service, strategy and implementation plan. • Cultural Transformation programme, phase two implementation. • Staff networks programme • People Strategic Initiative focussing on leadership behaviours. • National staff survey dashboard with local survey results links.	Issue	Issue	4	-	1. Redesigned approach to pre-disciplinary panel to reduce number of formal investigations and suspension. 2. Introduction of trained mediators and facilities to support local dialogue. 3. Continued service reflection and embedding service. 4. Cultural transformation programme actions for phase 2.	Complete Complete Monthly review Monthly review % complete – 50%	3	1	3	Treat	Mar 26	High	Chief People Officer	Yes
8	Aug 24	Quality	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.	Issue	5	4	20	• Board-level oversight of mortality through the stabilisation plan • Mortality surveillance dashboards. • Emergency Admission pathway and medical model. • Learning from Deaths process, End of life care pathway • Speciality Morbidity and Mortality meetings Medical Examiners process and reporting	Issue	Issue	5	-	1. Focus on supporting the development of robust action plans SJR panel review. 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/ national standards for SHMI outlier groups	Ongoing Mar 26 Ongoing Mar 26 Complete % complete – 60%	3	1	3	Treat	Sept 26	Medium	Chief Medical Officer	Yes
10	Jul 23	Performance	High levels of 'no criteria to reside' patients and a lack of operational performance (e.g. RTT) impacts patient care, patient experience, finances.	Issue	4	3	12	• Weekly internal RTT meetings. • Monthly reporting to TLT as part of the performance management review. • Acute Medical and Frailty Model • Waiting list maintenance and review process. • Patient initiated Follow-up (PIFU) initiative.	Issue	Issue	4	-	1. Roll-out of the trusts LoS programme. 2. Completion of the job planning and rostering programme. 3. Implementing Winter Plan 2025 and embedding medical models. 4. Programme 'go-live' November 2025. 5. Undertake first MADE. 6. Stabilisation plan reporting templates, IQPR and governance designed and implemented.	Mar 26 Dec 25 Complete Complete Complete Complete % complete – 66%	3	1	3	Treat	Mar 26	Medium	Chief Operating Officer	Yes
12	Jul 23	Performance	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.	Issue	4	4	16	• Daily site and management meetings to monitor and support progress on improving discharge processes throughout the Trust. • Flow and Discharge Corporate project. • Tele Tracking tool. • Virtual Ward initiatives • SHMI improvement programme (BAS 8)	Issue	Issue	4	-	1. Roll-out of the trusts LoS programme and monitor through TLT. Ongoing and performance reported to board and committees. 2. Undertake first MADE event. 3. Review effectiveness of tools 4. Virtual hospital 'go-live'.	Mar 26 Ongoing Complete Mar 26 Complete % complete – 60%	3	2	6	Treat	Mar 26	Medium	Chief Operating Officer	Yes
13	Sept 24	Performance	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.	Risk	4	4	16	• Digital and data (DDaT) strategy and implementation plan. • IT investment summary (business planning item) • Annual maintenance programme. • Server upgrade programme. • Local Cyber security audit and action plan. • Local and national IT partnership working (e.g. CSOC).	4	4	16	-	1. Create a regular report for TLT. 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 Feb 26 Jan 26 % complete – 0%	3	2	6	Treat	Sept 26	Medium	Dir Strategy and Partnership	Yes
14	Sept 25	Culture	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.	Risk	4	3	12	• NHSE baseline survey monitoring.as requested by NHSE. • The GMC and National Education and Training survey. • Routine CMO and DME meetings with resident doctors. • Payroll control measures. • Job Planning process and annual leave policies.	4	3	12	-	1. Compile a tracking scorecard for each of the 10 points. 2. Procurement a new digital rota tool. 3. Introduce a pre-arrival onboarding checklist that includes ESR setup, IT access, and mandatory training completion. 4. Assign a lead to each point/ measurable indicator.	Complete Complete Mar 26 Complete % complete – 75%	3	3	9	Treat	Mar 26	High	Chief medical Officer	Yes

The Board approved Risk Management framework risk appetite ratings.

Domain	Risk Appetite	Score
Safety of patients, staff or public (physical / psychological harm)	Low	1-3
Quality/Complaints/Audits	Low	1-3
Human Resources/Staffing/OD/Competence	High	8-12
Statutory Duty/Inspections	Low	1-3
Reputation/Adverse Publicity	Moderate	4-6
Corporate/Business Interruption	Moderate	4-6
Environmental Impact	High	8-12
Business Objectives/Projects	Moderate	4-6
Finance (Including Claims)	High	8-12

Meeting of the Trust Board

Meeting Date: 14 January 2026

Title of Report	Trust Risk Register and Issues Log Report			**Agenda Item**	
Stabilisation Plan Domain	**Culture**	**Performance**	**Governance and Quality**	**Finance**	**Not Applicable**
			✓		
CQC Reference	**Safe**	**Effective**	**Caring**	**Responsive**	**Well-Led**
	✓	✓			✓
Author and Job Title	Claire Cowell, Integrated Governance Lead				
Lead Executive					
Purpose	**Approval**		**Briefing**		**Noting** ✓
Proposal and / or key recommendation:	Note the current profile of Trust-wide risks and issues, including the number and distribution of Extreme risks and Significant issues. Review the Extreme risks and Significant issues set out in this report, with particular attention to those affecting patient safety, statutory compliance, and operational resilience. Seek assurance that mitigating actions, trajectories to target scores, and closure dates are realistic, resourced, and subject to active oversight by Executive leads and Divisions.				

Executive Summary

Risk Register

There are currently **94 active and approved risks**, distributed as follows:

Risk Rating	Score Range	Number of Risks	% of Total
Extreme	15+	10	10%
High	8-12	65	69%
Moderate	4-6	17	18%
Low	1-3	2	2%

Key themes across the Trust Risk Register

The predominant themes across Extreme and High-rated risks are:

- **Clinical safety and quality:** including mortality indicators, ligature and environmental safety for children and young people, and reliability of critical clinical systems (EPR/EPMA, Metavision, imaging and diagnostic capacity).
- **Workforce capacity and competence:** including specialist pharmacy, therapy, midwifery, ED/critical care medical staffing, and key single-point-of-failure roles (e.g. trauma, VTE, digital clinical safety, specialist CNS roles).
- **Digital, estates and infrastructure resilience:** including cyber security, ageing IT platforms, non-compliance with key HTMs (fire, water,

ventilation, medical gases), backlog maintenance, and end-of-life clinical equipment.
- **Regulatory and statutory compliance:** including IRR/IR(ME)R, CNST, HTA, CQC requirements, and information governance (SARs, GDPR, data quality and document control).
- **Financial sustainability and delivery risk:** including corporate cash-flow risk, budget setting gaps in clinical services, and capital constraints affecting replacement of critical equipment.

Summary of Extreme Risks (Current Score ≥15)

1) **Risk of patient safety and care quality impact due to EPR/EPMA system limitations (Risk 2068)**
   Risk: If the Electronic Patient Record (EPR) system continues to have limitations, including lack of interoperability, then user experience, clinical workflows, and staff efficiency will be adversely affected, leading to compromised patient safety, reduced quality of care, delayed decision-making, and decreased overall service efficiency. This risk impacts patients, clinical staff, and operational teams.
   Current score: 16 (4 Major x 4 Likely)
   Key mitigation: Prescription of blood components and products not on EPMA supported by paper-based processes and mandatory training. Vendor engagement to update EPMA system functionality.
   Target score and ambition: Reduction to 4 Major x 1 Rare = 4 by 31 December 2026, subject to completion of system upgrade and training.

2) **Risk of elevated SHMI mortality indicator impact Trust reputation and patient confidence (Risk 1684)**
   Risk: If the Trust's SHMI remains higher than expected, public, patient, and staff confidence may be affected, leading to reputational damage, reduced stakeholder assurance, and increased regulatory and media scrutiny.
   Current score: 16 (4 Major x 4 Likely)
   Key mitigation: Quality Breakthrough initiatives, Mortality & Morbidity process improvements, validation of deaths process, and strengthened reporting to the Board.
   Target score and ambition: Reduction to 1 Negligible x 3 Possible = 3 by 31 March 2026, contingent on full implementation of quality and reporting improvements.

3) **Risk of patient harm and operational disruption due to obsolete and condemned surgical equipment (Risk 2600)**
   Risk: If surgical and critical care equipment remains obsolete or condemned and capital funding is insufficient, patient harm may increase, surgeries may be delayed or cancelled, and operational strain on staff may grow, leading to reputational damage and regulatory consequences.
   Current score: 16 (4 Major x 4 Likely)
   Key mitigation: Routine inspections, use of loaned/shared equipment, escalation to Trust Board, and weekly capacity planning meetings.

Target score and ambition: Reduction to 4 Major x 2 Unlikely = 8 by 1 April 2026, as new equipment is procured and operational practices stabilised.

4) **Risk of Inadequate Care Provision for 16–17 Year Olds (Risk 2274)**
Risk: Gaps in staff expertise, differing paediatric/adult protocols, limited electronic prescribing, and inconsistent pathways for 16–17 year olds create safety, mental health, and operational risks, with potential impact on outcomes, regulatory compliance, and reputation.
Current score: 16 (4 Major x 4 Likely)
Key mitigation: Implementation of a Trust-wide Policy for the Care of 16–18 year olds and development of an SOP for supervision and safety netting. The Policy is approved and will go live 1 March 2026; SOP is being developed to underpin operational practice.
Target score and ambition: Reduction to Moderate (3 x 2 = 6) by 31 March 2026, subject to full operationalisation of the new policy and SOP.

5) **Risk of infrastructure failure and compromised clinical safety due to delayed maintenance (Risk 2158)**
Risk: If backlog maintenance continues to grow with limited funding, infrastructure will progressively deteriorate, leading to unsafe clinical environments and compromised healthcare delivery.
Current score: 16 (4 Major x 4 Likely)
Key mitigation: Condition surveys and asset registers completed, proactive maintenance by Estates team, and prioritisation of high-risk sites.
Target score and ambition: Reduction to 4 Major x 1 Rare = 4 by 31 July 2030, subject to delivery of backlog maintenance programme.

6) **Risk of compromised patient safety and care quality due to Financial Efficiency Targets (Risk 2453) Women, Children, and Young People Division**
Risk: Achieving mandated financial efficiency targets creates funding gaps, forcing service reviews without adequate risk assessment, increasing likelihood of adverse patient outcomes, medication incidents, staff burnout, and regulatory non-compliance.
Current score: 16 (4 Major x 4 Likely)
Key mitigation: Finance review to correct establishment numbers and align cost centres, enabling accurate budget identification and operational oversight.
Target score and ambition: Reduction to 3 Moderate x 2 Unlikely = 6 by 31 March 2026, dependent on resolution of budget and staffing gaps.

7) **Risk of harm due to ligature points in Paediatric Areas (Risk 2304)**
Risk: Absence of a clear ligature assessment policy and incomplete assessments leave paediatric areas with potential ligature points, increasing risk of self-harm incidents, serious patient harm, regulatory scrutiny, and reputational impact.
Current score: 15 (5 Catastrophic x 3 Possible)
Key mitigation: Ligature-free/low-risk rooms for at-risk patients, RMN

supervision, staff awareness, and escalation procedures.
Target score and ambition: Reduction to 2 Unlikely x 1 Negligible = 2 by 2 February 2026, contingent on full ligature risk mitigation implementation.

8) **Risk of Patient Harm: Metavision System Failure due to unsupported IT Systems (Risk 1979)**
Risk: If the Metavision EPR software remains outdated and IT compatibility issues persist, combined with a non-functional backup system, then there is a high likelihood of patient harm, medication errors, and compromised critical care, leading to risks for patients, critical care staff, and the Trust's operational and regulatory compliance. This risk will continue until the urgent upgrade to Metavision 6 is completed.
Current score: 15 (5 Catastrophic x 3 Possible)
Key mitigation: Revert to BCP/paper records if system fails, daily prescription audits, and critical care oversight; urgent upgrade to Metavision 6 underway.
Target score and ambition: Reduction to 5 Catastrophic x 1 Rare = 5 by 31 March 2026, following system upgrade and staff training.

9) **Risk of Fire Safety Breach due to Non-Compliance with HTM 05-01 (Risk 2166)**
Risk: If established fire safety protocols, standards, and guidance are not fully adhered to across healthcare buildings, then the likelihood and potential severity of fire-related incidents will increase, leading to loss of life, injury, property damage, disruption to patient care, reputational harm, and financial consequences such as legal claims, fines, or recovery costs.
Current score: 15 (5 Catastrophic x 3 Possible)
Key mitigation: Mandatory fire training, 24/7 response capability, routine inspections, capital investment in fire infrastructure, and ongoing fire alarm upgrades.
Target score and ambition: Reduction to 5 Catastrophic x 1 Rare = 5 by 2 October 2028, dependent on completion of fire safety improvements.

10) **Risk of Cyber Attack impacting Trust Information Systems and IT Infrastructure (Risk 1965)**
Risk: If the Trust's IT estate is targeted by cyber-attacks (ransomware, malware, phishing, DoS), operations could be disrupted, patient data compromised, and financial losses incurred, affecting patients, staff, and Trust reputation.
Current score: 15 (5 Catastrophic x 3 Possible)
Key mitigation: Funding secured for system improvements, monthly Cyber Security Group oversight, firewalls, anti-virus, vulnerability detection, and regular reporting to Board.
Target score and ambition: Reduction to 5 Catastrophic x 2 Unlikely = 10 by 27 March 2026, with full implementation of cyber security measures.

Issues Log

There are **221 open and validated issues**, of which 39% are rated High or above in priority.

Priority Rating	Number of Issues	% of Total
5 – Significant	3	1%
4 – High	84	38%
3 – Moderate	112	51%
2 – Low	22	10%

High and Significant issues are predominantly associated with:

- **Equipment and estates constraints:** condemned or obsolete equipment in theatres, diagnostics, maternity and paediatrics; environmental risks (ward condition, estates footprint, temperature control, storage).
- **Patient safety and flow:** diagnostic delays (US, CT, EEG, radiology reporting, follow-up booking), emergency department capacity, delayed discharges, and transport delays.
- **Workforce and leadership gaps:** specialist nurses (e.g. cancer, epilepsy, Parkinson's, antimicrobial, diabetes in pregnancy), pharmacy and therapy staffing, senior nursing leadership in key areas (CHED, paediatrics, neonatal/AIP).
- **Regulatory and statutory risk:** IRR/IR(ME)R exposure (radiopharmaceutical storage, Radiopharmacy eye dose, fluoroscan data), screening programme compliance, cancer pathway performance, and IT system support for key clinical functions.

Summary of Significant Issues:
The following Significant issues (priority 5) are highlighted for Board attention:

1) **Condemned Ultrasound Machines in Theatres (Issue 2288 – Priority 5 Significant)**
   Issue: Three theatre ultrasound machines (two condemned, one obsolete) have been removed from service. This constrains imaging capacity for theatre, ED and critical care, increasing risk of diagnostic delay, procedural complications and cancelled elective activity, with income and productivity impact.
   Controls: Limited imaging capacity maintained via two remaining machines (main theatres and SDCC) with active daily reallocations, theatre huddles and scheduling adjustments. Incidents and delays are being captured via Datix and governance routes.
   Actions/trajectory: Equipment bid submitted for three replacement machines; existing machines maintained as far as possible. Multiple Datix entries evidence impact. Capital unavailability remains the critical constraint, so risk is not yet reducing.

	2) Condemned Theatre Trolleys affecting operational delivery (Issue 2296 – Priority 5 Significant) **Issue:** Eight theatre trolleys have been formally condemned, reducing the number of safe, functional trolleys at a time of increased surgical throughput. This is driving delays, reduced capacity, and increased risk of on-the-day cancellations, with quality, flow and income implications. **Controls:** Daily theatre huddles, operational oversight, reallocation of remaining trolleys between lists, active monitoring of equipment, and engagement with procurement and Infection Prevention & Control to maintain safety of the remaining fleet. **Actions/trajectory:** Capital bid submitted for replacement trolleys; however, lack of capital funding has resulted in persistent turnaround delays and constrained productivity, with no substantive reduction in risk at this stage. **3) Non-Compliance with Records Management Code: Medical Records Not Properly Culled or Destroyed (Issue 2083 – Priority 5 Significant)** **Issue:** The Trust is not currently culling or destroying patient records in line with the Public Records Act or the NHS Records Management Code of Practice due to insufficient resources. This creates a risk of regulatory intervention, potential ICO sanctions, and an inability to evidence that the Trust operates a satisfactory records management regime. **Controls:** A Health Records Handbook has been implemented to reflect national requirements. A site visit has been completed, and the Chief People Officer has contacted staff with documents stored at Regal to review their holdings. Early indications suggest most stored documents may be eligible for destruction, pending confirmation. **Actions/trajectory:** Further review of stored documents is underway to confirm destruction eligibility. Full compliance will require resourcing to support ongoing culling and destruction processes. The issue remains significant until a sustainable, compliant records management process is in place.
Issues for the Board / Committee Attention:	To note progress with the actions to mitigate the organisation's highest operational risks and issues.
Committee / Meetings at which this paper has been discussed / approved: **Date:**	N/A
Board Assurance Framework / Risk Register:	See separate agenda item.
Financial Implications:	N/A
Equality Impact Assessment and / or patient experience implications	N/A

Freedom of Information status:	Disclosable	✓	Exempt	

Appendix 1: Extreme Risks

				Initial				Current					Target						
Risk ID	Added Date	Division	Risk Description	Consequence	Likelihood	Rating	Key Existing Controls	Consequence	Likelihood	Rating	Actions	Action Due Date	Consequence	Likelihood	Rating	Risk Treatment	Target Date for Closure	Confidence in achieving Target Date	Exec Lead
1684	31/05/2023	Corporate (Medical)	**Risk of elevated SHMI mortality indicator impact Trust reputation and patient confidence** If the Trust's Summary Hospital-level Mortality Indicator (SHMI) remains higher than expected, partly due to a decrease in the expected mortality rate, then public, patient, and staff confidence may be affected, leading to reputational damage, reduced stakeholder assurance, and increased scrutiny from regulators and the media. This risk impacts patients, staff, and the wider community and may result in operational and governance consequences.	4 - Major	2. Unlikely	8	• Variability of SJR process- over medicalised, process not in line with RCP guidance, lack of centralised database- process is now aligned with RCP guidance, reviewers and both medical and nursing backgrounds and SJR+app used to hold SJR data and reviews. • Limited LFD visibility at Board level- LFD report monthly to QAC and quarterly to Trust Board. LFD reports are shared with specialities and included in Quality Care Group and Divisional level reporting • M&M Process- structural issues, absence of responsibility to report M&M outcomes, lack of engagement and compliance. Teaching provided to specialties and best practice guide with minute template and action log circulated to all teams. Escalation process in place to ensure compliance. Mortality and Morbidity Review Group (MMRG) for specialties to report on M&M themes and trends. • Validations of deaths process variable and not fully optimised- job planning/PA for MEC specialty with higher volume of deaths. Responsibility for Patient Safety Leads/Mortality leads in lower volume specialties to review all deaths. Business case developed to resource the process. VCP to be approved and target of respiratory related deaths to be implemented. • Medical staff not clear on EOL escalation as no criteria for deterioration in the notes.	4 - Major	4. Likely	16	1) A3 Mortality Refresh looking at root causes for the high SHMI value with a focus on the validations of deaths for Respiratory. *Progress Update:* *The Mortality A3 workstream has transitioned into the organisation's Mortality Breakthrough Objective (BO). Oversight and coordination of this work now take place through the weekly BO huddle, which provides a structured forum to review and advance improvements across clinical pathways, end-of-life care, and the Learning from Deaths (LfD) processes.* *The huddle brings together all key stakeholders, enabling collective monitoring of key performance indicators and timely escalation or mitigation of risks. It also incorporates review of Structured Judgement Reviews (SJRs), including those highlighted by Medical Examiner concerns, to ensure immediate learning and action planning. In addition, the group oversees the findings and resultant recommendations from deep-dive analyses, such as the recent review of the pneumonia care pathway, ensuring that identified learning is translated into operational practice.*	31/03/2026	1 - Negligible / Insignificant	3. Possible	3	TREAT	31/03/2026	Red	Chief Medical Officer

				Initial				Current				Target						
Risk ID	Added Date	Division	Risk Description	Consequence	Likelihood	Rating	Key Existing Controls	Consequence	Likelihood	Rating	Actions	Action Due Date	Consequence	Likelihood	Rating	Risk Treatment	Target Date for Closure	Confidence in achieving Target Date	Exec Lead
2068	13/05/2024	Information Technology	**Risk of patient safety and care quality impact due to EPR/EPMA system limitations** If the Electronic Patient Record (EPR) system continues to have limitations, including lack of interoperability, then user experience, clinical workflows, and staff efficiency will be adversely affected, leading to compromised patient safety, reduced quality of care, delayed decision-making, and decreased overall service efficiency. This risk impacts patients, clinical staff, and operational teams.	4 - Major	4. Likely	16	• Prescription of blood components and products NOT on EPMA: Drug charts still being used in most areas. If unable to access the drug charts, a Blood Transfusion Integrated Care Pathway is available as an alternative which can be downloaded from the Intranet QPulse. • Covered in Blood Training – Prescription and Administration which is mandatory for all staff who are involved in the transfusion process. • POCT Database correctly records results (incorrect capillary blood glucose ranges on EPR). • Prescribers are trained to know that the EPMA/EPR clinical decision support tool will only alert for interactions between medications and allergies/intolerances. • For certain medications such as paracetamol the maximum dose limit within 24 hours is stated in the medications administration information which displays at the point of prescribing, when reviewing the prescription and when the medication is administered. For Gentamicin for Endocarditis, the dose range is stated within the order set. • Working with the vendor to update the system to support dose range limits on EPMA. • Removed the inpatient discharge summary from the ED in light of EPMA order reconciliation manager not transferring between ED and inpatient.	4 - Major	4. Likely	16	1) Solution for ED EPR Bed Allocation. 2) Review Lack of Dose Range Limits when Prescribing on EPMA. 3) Verify ED Bed Allocation. 4) POCT integration into EPR. 5) Blood Transfusion implementation. 6) Dose range limits to be implemented post-system upgrade. 7) ED Location against patient records. 8) Request for ORM enhancements to be made and discussed with Altera directly. 9) Results Acknowledgement. 10) Strategic direction is needed to manage how OP will be implemented. *Progress Update:* *Met with CMO and Chief Pharmacist to progress recruitment of EPMA pharmacist, which is a key resource for EPMA risk mitigations* *The Blood Transfusion activity has been tested however, the team has asked for more changes so this will delay the deployment date due to competing pressures. Point of Care Testing (Blood Gas) only, is going through final design decisions to support incorrect results appearing in the EPR based on human error - no date known yet. Point of Care Blood Glucose/ketone project has been approved but there have been no technical discussions in place yet.* *EPR ORM is a project forming part of the EPR business case.* *EPR Dose range limits is on-hold.*	Complete Complete Complete Complete 30/06/2025 18/08/2025 30/09/2025 27/10/2025 31/03/2026 31/03/2026	4 - Major	1. Rare	4	TREAT	31/12/2026	Amber	Director of Strategy and Partnership

				Initial				Current					Target						
Risk ID	Added Date	Division	Risk Description	Consequence	Likelihood	Rating	Key Existing Controls	Consequence	Likelihood	Rating	Actions	Action Due Date	Consequence	Likelihood	Rating	Risk Treatment	Target Date for Closure	Confidence in achieving Target Date	Exec Lead
2158	31/07/2024	Estates and Facilities	**Risk of infrastructure failure and compromised clinical safety due to delayed maintenance** If the Trust's backlog maintenance of £120m (£107m under ERIC criteria) continues to grow while capital funding remains at only 20% of what is required over five years, then the infrastructure will progressively deteriorate, leading to unsafe or unsuitable clinical environments and compromising the delivery of essential healthcare services.	4 - Major	5. Almost Certain	20	• A condition survey using the NHS's approved 'A risk-based methodology for establishing and managing backlog' completed in January 2024 by NIFES Consulting. • A condition-based asset register completed in March 2024 by NIFES Consulting. An established Estates maintenance team with detailed site knowledge who proactively and reactively manage maintenance failures.	4 - Major	4. Likely	16	1) Identify backlog items. 2) Establish Capital Pipeline for 2024/25. 3) NHSE Funding Bid Submission to address funding shortfall; reliance on capital allocations. 4) Establish Backlog Prioritisation Group. 5) Create Model for Maintenance Priorities and Capital Pipeline Tracking. 6) Critical Asset Register Update. 7) Completion of resurvey to address lack of updated condition data; gaps in assurance. *Progress Update:* *Meeting with NHSE December 2025 to discuss potential sources of funds to backlog maintenance.* *Resurvey underway, report expected Feb 2026.*	Complete Complete Complete 30/01/2026 30/01/2026 27/02/2026 27/02/2026	4 - Major	1. Rare	4	TREAT	31/07/2030	Amber	Chief Operating Officer
2274	30/12/2024	Women, Children and Young People	**Risk of Inadequate Care Provision for 16–17 Year Olds** There is an increased risk of adverse events for 16–17-year-olds due to gaps in staff expertise, differing paediatric and adult care protocols, limited electronic prescribing, and inconsistent care pathways. Placement and transfer challenges, alongside variations in Early Warning Systems, create potential safety, mental health, and operational risks. Delays in treatment and extended stays may impact patient outcomes, increase costs, and affect the Trust's reputation and regulatory compliance. Implementation of mitigation measures is ongoing but progress is slow.	4 - Major	4. Likely	16	• 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 on OH support that are affected by this cohort of patients.	4 - Major	4. Likely	16	1) Policy for the Care of 16 to 18 year olds at MFT to be agreed across all Divisions. 2) Develop a short Standard Operating Procedure (SOP) to ensure robust safety-netting of clinical supervision for 16–17 year olds. Once drafted, circulate the SOP for approval and implementation. *Progress Update:* *Policy approved and will be launched March 2026 to minimise the impact on the adult services this winter.*	Complete 27/02/2026	3 - Moderate	2. Unlikely	6	TERMINATE	31/03/2026	Amber	Chief Medical Officer

				Initial				Current					Target						
Risk ID	Added Date	Division	Risk Description	Consequence	Likelihood	Rating	Key Existing Controls	Consequence	Likelihood	Rating	Actions	Action Due Date	Consequence	Likelihood	Rating	Risk Treatment	Target Date for Closure	Confidence in achieving Target Date	Exec Lead
2453	30/05/2025	Women, Children and Young People	**Risk of compromised patient safety and care quality due to Financial Efficiency Targets (WCYP Division)** There is a critical risk that the Women, Children, and Young People's (WCYP) Division will be unable to deliver safe, high-quality care if the mandated £3.287 million financial efficiency target is achieved. The target is driving an incomplete 2025/26 budget-setting process, with essential roles unfunded, forcing service reviews without adequate risk assessment. For example, the complex care team cannot deliver vital community care packages to children with complex conditions, resulting in preventable inpatient admissions. Historical unclear and opaque budgets, combined with proposed staffing reductions and cost savings, create an unsustainable environment and conflict with CQC Regulation 18 (Staffing) and NMC professional standards. This increases the likelihood of adverse patient outcomes, medication safety incidents, staff burnout, and regulatory non-compliance. The risk affects patients, families, clinical staff, and the Trust's operational and regulatory performance.	4 - Major	4. Likely	16	• There has been a request to finance to ensure incorrect establishment numbers are being corrected by the finance business partner and that cost centres are being scrutinised to ensure they are correctly matched to the areas of service. This is an issue that predates the outturn budget. This will enable accurate identification of the gaps in funding linked to the outturn budgets. Until this is corrected the budget sign off cannot be completed	4 - Major	4. Likely	16	1) Clarifying cost centres, reviewing and correcting establishments. *Progress Update:* *Business planning underway.* *Line by line work on budgets continues.* *Realignment of cost centres with rotas continues.*	Complete	3 - Moderate	2. Unlikely	6		31/03/2026	Red	Chief Operating Officer
2600	30/09/2025	Surgery and Anaesthetics	**Risk of patient harm and operational disruption due to Obsolete and Condemned Surgical Equipment** If surgical and critical care equipment remains obsolete or condemned and capital funding for replacements is insufficient, then patient harm may increase, surgeries may be delayed or cancelled, and operational strain on staff will grow, leading to reputational damage, regulatory consequences, and reduced capacity to deliver safe and timely care. This risk directly affects patients, theatre and critical care staff, and the Trust's overall service delivery.	4 - Major	4. Likely	16	• Routine inspections of condemned equipment. • Use of loaned or shared equipment. • Escalation to Trust Board and inclusion in capital funding bid. • Weekly capacity planning meeting where services prioritise patients for the week. • Review surgical scheduling to ensure availability of suitable equipment.	4 - Major	4. Likely	16	1) Orthopaedic Power Tools: Equipment Bid for funding. 2) Equipment bid for replacement Atlan Anaesthetic Machines. 3) Equipment Bid for Diathermy Machines 4) Equipment Bid for three replacement ultrasound machines. 5) Equipment Bid to purchase 7 new theatre trollies. 6) PID for new Multidebrider Drills for ENT FESS Procedures 7) Equipment Bid for upgrade of spinal drills. 8) Equipment Bid for replacement of old table. 9) Image Intensifier: PID for the additional equipment and staff. *Progress Update:* *There has been a total of 31 incidents linked to this risk dating back to March 2025. Each individual piece of equipment listed on the Issues Log.*	Complete Complete Complete Complete Complete Complete Complete Complete 30/01/2026	4 - Major	2. Unlikely	8	TREAT	01/04/2026	Amber	Chief Operating Officer

				Initial				Current					Target						
Risk ID	Added Date	Division	Risk Description	Consequence	Likelihood	Rating	Key Existing Controls	Consequence	Likelihood	Rating	Actions	Action Due Date	Consequence	Likelihood	Rating	Risk Treatment	Target Date for Closure	Confidence in achieving Target Date	Exec Lead
1965	14/02/2024	Information Technology	**Risk of Cyber Attack impacting Trust Information Systems and IT Infrastructure** If the Trust's extensive IT estate is targeted by cyber-attacks, including ransomware, malware, phishing, denial-of-service (DoS), or other malicious activity—then hospital operations could be disrupted, patient data compromised, and financial losses incurred, leading to risks for patients, staff, and the Trust's operational, financial, and reputational standing. The Trust's reliance on digital systems for patient care and administration, combined with its public sector profile, increases vulnerability to these threats.	5 - Catastrophic	3. Possible	15	• The Trust has been awarded funding from NHSE. Orders have been raised for implementation prior to end of March 2025. • The Trust has a monthly Cyber Security Group that reports into the IGG. • The Trust provides cyber security summaries as part of their monthly board reports. • The Trust utilises firewalls, MDE, Avast AV, Lansweeper Dashboarding and Armis vulnerability detection to support cyber security.	5 - Catastrophic	3. Possible	15	1) NHSE Cyber Funding. 2) Cyber Security Strategy. *Progress Update:* • *Findings arising from the Cyber Audit/Review close-out meeting held on Thursday, 11 December 2025. No ring-fenced / dedicated Cyber resource. Currently at 0.2FTE and is way below baseline (should be b/w 2 - 4FTE)* • *Absence of a Cyber strategy. Currently in draft; working progressing via external resource and strategy team. Should be linked to ICS/ICB.* • *Absence / Uncertainty of a Formal Group for Cyber risk reporting and appraisal. ARC suggested Re AB.* • *Lack / Inadequate Centralised Security Monitoring (tools / process).* • *Cyber training (lack of specific cyber training and lack of Phishing exercise). Not just for IT staff but all staff. For all staff (outside of IT staff), priority could be made for staff with higher / privileged access and/or information asset owners/administrators (senior managers / service leads).*	28/03/2026 28/03/2026	5 - Catastrophic	2. Unlikely	10	TRANSFER	27/03/2026	Green	Director of Strategy and Partnership
1979	01/03/2024	Surgery and Anaesthetics	**Risk of Patient Harm: Metavision System Failure due to unsupported IT Systems** If the Metavision EPR software remains outdated and IT compatibility issues persist, combined with a non-functional backup system, then there is a high likelihood of patient harm, medication errors, and compromised critical care, leading to risks for patients, critical care staff, and the Trust's operational and regulatory compliance. This risk will continue until the urgent upgrade to Metavision 6 is completed.	5 - Catastrophic	5. Almost Certain	25	• Revert to BCP and use paper records if live system fails. • In case of failure of back-up system, print summary of care from MetaVision to be placed at patient bedside. Written paper drug charts – to be updated when changes are made on MetaVision and reviewed/compared with MV on the ward rounds. • Ward clerks will print MV patient prescription after the daily ward round. Critical Care audit nurses checking prescriptions routinely through week to ensure no 7 day cycle drop off. • ICU consultants and nursing teams all aware of issue and support with the above. • In discussion with IT to support current infrastructure and reviewing of 7 day cycle report. • Nurses will print MV patient prescription at the end of each shift.	5 - Catastrophic	3. Possible	15	1. IT support - advice and urgent meeting required from IT following initial meeting with GM, as to next steps. 2. IT team to raise POs for Metavision 6 upgrade as Capital funds approved 3. Timeline for Metavision upgrade to be shared with Execs 4. Retrieval of patient notes by IT team 5. IMDsoft to retrieve 1 patient record 6. Metavision archive split by IMDsoft *Progress Update:* *Risk remains the same whilst the metavision 6 programme is transferred on to the new server. Metavision works ongoing.*	Complete Complete Complete Complete Complete Complete	5 - Catastrophic	1. Rare	5	TREAT	31/03/2026	Amber	Chief Operating Officer

				Initial				Current				Target						
Risk ID	Added Date	Division	Risk Description	Consequence	Likelihood	Rating	Key Existing Controls	Consequence	Likelihood	Rating	Actions	Action Due Date	Consequence	Likelihood	Rating	Risk Treatment	Target Date for Closure	Confidence in achieving Target Date	Exec Lead
2166	05/08/2024	Estates and Facilities	**Risk of Fire Safety Breach due to Non-Compliance with HTM 05-01: Managing Healthcare Fire Safety** If established fire safety protocols, standards, and guidance are not fully adhered to across healthcare buildings, then the likelihood and potential severity of fire-related incidents will increase, leading to loss of life, injury, property damage, disruption to patient care, reputational harm, and financial consequences such as legal claims, fines, or recovery costs. Inadequate controls across detection systems, compartmentation, suppression systems, emergency lighting, staff training, governance, and site housekeeping directly affect patients, staff, visitors, and the Trust's operational and regulatory compliance.	5 - Catastrophic	3. Possible	15	• Mandatory fire safety training: Annual fire safety training for all staff, with optional fire warden training available Trust wide. • 24/7 in house fire response capability: Dedicated team attending all detector and call point activations around the clock. • Routine fire risk assessments: Departmental fire risk assessments undertaken to identify and manage local hazards. • Fire door inspection and maintenance programme: Annual inspections, with repair or replacement carried out as required. • Fire safety involvement in capital planning: Fire safety team embedded in the design and planning stages of all capital projects. • Regular fire alarm testing and engineering presence: Weekly alarm tests and a five day on site presence from fire alarm engineers. • Systematic installation of a new fire alarm system: Ongoing upgrade programme to replace outdated panels and improve reliability. • Fire damper inspections completed: Inspections undertaken to ensure compliance and functionality. • Post Grenfell cladding replacement: All cladding on site replaced to meet updated fire safety standards. • Fire safety walkarounds: Regular checks by the fire safety team to verify controls and identify issues. • Capital investment in fire safety infrastructure: Funding allocated for compartmentation, fire doors, fire alarm replacement, and emergency lighting. • HBN compliant ED build with misting system request noted: Ensures compliance despite changes during construction. • Smoking reduction group established: Reduces ignition risks associated with smoking behaviours. • Completed ward level fire safety works: Pembroke works complete; Nelson Ward fire alarm fully operational.	5 - Catastrophic	3. Possible	15	1) Compartmentation works to Pembroke ward as a capital project, due to commence mid October 2024. This will address only the compartmentation issues with the ward but should reduce the risk rating as this represents the highest risk to the Trust. 2) Smoking Group. 3) Capital program to continue fire works in the Trust, and in particular to address Panel 5, Red Zone. This will improve the reliability of the fire alarm and remove a weak panel which has many faults. 4) Compartmentation site wide. 5) Fire Paper and Strategy. *Progress Update:* *Commissioning report received from Fire Engineer for a compartmentation report. This is being commissioned over two FYs for a complete strategy on Compartmentation that will inform the FSSG to direct capital.*	Complete Complete 24/12/2025 20/03/2026 21/06/2030	5 - Catastrophic	1. Rare	5	TREAT	02/10/2028	Amber	Chief Operating Officer

				Initial				Current				Target						
Risk ID	Added Date	Division	Risk Description	Consequence	Likelihood	Rating	Key Existing Controls	Consequence	Likelihood	Rating	Actions	Action Due Date	Consequence	Likelihood	Rating	Risk Treatment	Target Date for Closure	Confidence in achieving Target Date	Exec Lead
2304	22/01/2025	Women, Children and Young People	**Risk of harm due to ligature points in Paediatric Areas** Due to the absence of a clear and implemented ligature assessment policy, and incomplete ligature assessments, there is no documented oversight of identified ligature anchor points in paediatric areas. Several potential ligature anchor points exist, and safety processes are unclear, increasing the risk of self-harm incidents. This risk affects paediatric patients, clinical staff, and the Trust's duty of care, with potential consequences including serious patient harm, regulatory scrutiny, and reputational impact.	5 - Catastrophic	3. Possible	15	• 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.	5 - Catastrophic	3. Possible	15	1) To escalate the need of overarching Trust ligature policy. 2) Estates Review: To have ligature anchor points reviewed and assessed by the estates team to give assurance that national NPSA alerts and estates and facilities alerts have been actioned and are adhered to. If alert recommendations not met then estates / trust representatives to provide an action plan. *Progress Update:* *Installation of blinds has reduced the risk of accidental injury to our very young patients. However other sources of ligature points remain a risk to our older patients and those with mental health issues.*	Complete 30/01/2026	1 - Negligible / Insignificant	2. Unlikely	2	TREAT	02/02/2026	Green	Chief Nursing Officer

Appendix 2: Significant Issues

Issue ID	Added Date	Division	Issue Description	Issue Priority Rating	Existing Controls	Action	Action Due Date	Exec Lead	Target Date for Closure
2083	20/05/2024	Information Technology	**Non-Compliance with Records Management Code: Medical Records Not Properly Culled or Destroyed** Due to the lack of resources available, the Trust is not currently culling or destroying patient records in line with the Public Records Act and retention schedules as set out in the Records Management Code of Practice. The impact is that organisations may be asked for evidence to demonstrate that they operate a satisfactory records management regime. There is a range of sanctions if satisfactory arrangements are not in place i.e. regulatory intervention leading to conditions being imposed upon the organisation, or monetary penalty issued by the ICO.	5 – Significant	• There is now a Health Records Handbook in place that reflects the requirements of the NHS Records Management Code of Practice. • A site visit has been undertaken and the Chief People Officer has contacted the individuals that have documents stored at Regal for them to review what they have. The view is that most of the documents stored can be destroyed but to be confirmed.	1) Business Case. 2) Tight process to be implemented around files being destroyed. 3) Review of documents located at Regal (off site storage). *Progress Update:* *Workforce plan for health records not approved at Trust Leadership Team Meeting. Unable to progress until approach for resources agreed.* *HR files previously stored at Regal are currently being held securely within a closed ward. We have engaged HR to lead the review of these records, with a clear remit to assess whether they should be disposed of or archived in accordance with Information Governance requirements.*	Complete Complete 30/01/2026	Chief Operating Officer	05/11/2026
2288	06/01/2025	Surgery and Anaesthetics	**Condemned Ultrasound Machines in Theatres** Three ultrasound machines essential for venous access and diagnostic imaging have been removed from service after failing safety and performance standards: two theatre machines have been condemned and permanently withdrawn, and one machine has been declared obsolete and beyond repair. These devices support theatre procedures, Emergency Department activity, and critical care; therefore, their removal is currently limiting imaging capacity across multiple clinical areas. The lack of available ultrasound increases the risk of delays to emergency access, procedural complications, and cancelled elective activity, which may result in lost income and disruption to planned care. The issue is ongoing and unresolved due to the inability to secure capital funding for replacement equipment. Workarounds rely on reallocating the limited remaining machines, which is affecting patient flow and clinical efficiency.	5 – Significant	• Remaining ultrasound machines still operational. One machine in main theatres and one in SDCC continue to provide limited imaging capacity. • Clinical teams actively reallocating machines. Consultants and theatre staff coordinate access to the remaining machines to minimise delays and maintain safe workflows. • Escalation and reporting of condemned equipment. Faults and failures have been formally identified, escalated, and logged through appropriate governance routes. • Use of alternative imaging methods where clinically appropriate. • Operational adjustments to theatre scheduling. Lists are being paced, staggered, or reorganised to align with the limited availability of ultrasound equipment. • Clinical risk awareness and prioritisation. Teams prioritise ultrasound access for emergency cases and high-risk procedures to reduce patient safety impact. • Procurement engagement and equipment bid submitted. A formal bid for three replacement machines has been completed and is progressing through approval routes. • Ongoing maintenance of remaining machines. The two machines still in use are maintained to ensure they remain safe and functional despite age related limitations.	1) Equipment Bid required for 3 replacement machines. 2) Monitor and maintain remaining machines: Implement rigorous preventive maintenance to prevent further breakdowns. 3) Document incidents and delays: Continue logging impact to patient care for governance and future funding justification. *Progress Update:* *Business Case and funding not approved for replacement machines.* *Awaiting Capital Funds.* *Multiple Datix incidents completed regarding the lack of ultrasound affecting patient quality and theatre productivity.*	Complete 31/03/2026 31/03/2026	Chief Operating Officer	31/03/2026

Issue ID	Added Date	Division	Issue Description	Issue Priority Rating	Existing Controls	Action	Action Due Date	Exec Lead	Target Date for Closure
2296	13/01/2025	Surgery and Anaesthetics	**Condemned Theatre Trolleys affecting operational delivery** Eight surgical theatre trolleys have reached end-of-life and been formally condemned, leaving them unfit for clinical use. This has reduced the number of safe, functioning trolleys available to support theatres, at a time of increased surgical throughput and productivity expectations. The lack of operational trolleys is currently disrupting theatre workflows, contributing to delays, reduced capacity, and risk of case cancellations. This is negatively affecting key performance indicators, income generation, and the quality and efficiency of patient care. The issue remains unresolved because replacement trolleys cannot be procured owing to capital funding constraints, and current workarounds rely on reallocating a limited number of remaining assets between lists and theatres.	5 – Significant	• Daily theatre huddles and operational oversight. • Active equipment monitoring and reporting. • Use of remaining functional trollies. • Short term reallocation of trollies between theatres. • Contingency planning within theatre scheduling. • Escalation to divisional leadership. • Procurement engagement for replacement trollies. • Infection prevention and safety checks on remaining trollies.	1) Equipment Bid for Capital Funds. 2) Reallocate trollies efficiently: Share functional trollies between theatres based on case priority. 3) Escalate ongoing operational risks: keep Divisional leadership informed about delays or safety risks. *Progress Update:* *No capital funds to purchase new trollies.* *Delays in turnaround consistent due to lack of trollies.*	Complete 31/03/2026 31/03/2026	Chief Operating Officer	31/03/2026

ARC Report to MFT Board - Meeting Date: 11.12.2025

Risk Management

Topic	Summary	Assurance	Items for Board discussion/agreement
BAS	New dashboards being further improved. Fit for purpose	Moderate	Use for the period of the Stabilisation Plan
BAF/TRR	Significant data inaccuracies, articulation of risks, coherence of information and future action/outcome orientation. Work underway to address these but it will take time to improve the quality of the information and change behaviours KMPG Report on BAF - *''Partial Assurance with Improvements Required''*	Limited	Tolerate pending treatment targeting 31.3.2026 coincidental with Stabilisation Plan
Clinical Data Quality	Opaque information, assurance and evidence. To be reviewed again at March ARC in conjunction with clarity on safety risks being tolerated for premises backlog remediation and medical devices	Limited	Tolerate until 31.3.2026
Cyber Security	Governance, strategy, and dashboard all work-in-progress. Digital Security Protection Toolkit provides reasonable but not sufficient assurance.	Limited	KMPG audit due end of December. A cyber-resilience assurance dashboard to be provided to FPPC in January and recommend Board consideration in February
Triangulation of issues raised by Medical Examiner in their report to Board (11.2025) with RRs	Quality of SJRs, Prolonged stays in ED, MFFD dying, Delays in discussing ceilings of care, Poor Documentation, Electronic drug documentation	Moderate	

Audit and Assurance

IA (KMPG)	Plan on track but several key reports due - core financial systems (accounts receivable), cyber, governance (budget reporting) and AI (advisory not audit)	Limited	

Internal Controls

Gifts & Hospitality Register	1 item reported for the period. Unclear whether this is normal, an outlier or how it benchmarks	No assurance	To come back to ARC in March
Financial Limit Change Approval	Ultra vires so item not taken. Similar to e.rostering issue below	No assurance	SFIs and delegated authorities to be amended

Governance, Legal and Regulatory Compliance

e.Rostering unauthorised spend	Result of opacity of approval process, and individuals either not understanding or not providing clarity at key decision points	Limited	Limits and processes need to be simplified and easier for staff to understand/adhere to
Adequacy/effectiveness of policy and procedures for compliance with legal/regulatory obligations	No report received	No Assurance	To come back to next ARC

Meeting of the Board of Directors in Public
Wednesday, 14 January 2026

Title of Report	Quality Assurance Committee Friday, 07 November 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, 07 November 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				
	No Assurance	There are significant gaps in assurance or actions			
	Partial Assurance	There are gaps in assurance			

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

ASSURANCE AND ESCALATION HIGHLIGHT REPORT

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

Declarations of Interest Made
None

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

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

Items/risks/issues for escalation

Escalations to note:

- Medical Gases – concerns
- Learning from Pathology and Rheumatology Deep Dive – Assurance of embedded learning
- Medical Devices – Robust reporting required for assurance

Implications for the corporate risk register or Board Assurance Framework
None recorded

Key Headlines	**Assurance Level**
1. QPSSC Governance Structure Proposal The committee were advised of a revised oversight and assurance model that aligns more closely with Dartford and Gravesham NHS Trust (DGT) The Committee **APPROVED** the transition to a new quality governance structure and to stand down QPSSC with immediate effect. The new model will have a 3-month review.	
2. Learning from Deaths Report and Summary 1) For Quarter 2, the Structured Judgement Review (SJR) completion rate exceeded target at 16.9% (target 12.5%), reflecting sustained engagement from clinical reviewers. 2) Delays in Assessment, Escalation, and Treatment – Issues with timely recognition of deterioration, sepsis management and diagnostic imaging. Action - Trust wide QI programme in place. 3) Poor Documentation and Communication – Incomplete records, unclear working diagnoses and inconsistent handovers. Action - Targeted training, weekend audit, improved EPR and enhanced visibility of clinical pathways. 4) End of Life Care Deficiencies – Miss or delayed palliative recognition and inconsistent communication with families. Action – updated prescribing	Assured

guidance, simulation training, enhanced RESPECT documentation and communication training. 5) System and Process Issues – Persistent difficulties in specialty referrals, on call access, and ED delays. Action – Regional collaboration on 12-hour ED breach reviews and creation of intranet-based referral guidance. 6) Medication and Monitoring Errors – Errors in dosing, anticoagulation, and monitoring. Action – Update VTE policy, staff education, near miss reporting, strengthened governance and thematic reviews. 7) Cross Trust Learning and Assurance 8) Clinical Coding Assurance 9) Deep Dive – Diabetes with Complications 10) Medical Examiner Update 11) Mortality Indicators – HSMR within expected range, SHMI higher than expected. The Committee requested an update on the Pneumonia Audit Results for the December meeting	
3. ENT Backlog Issue Update 1) As of 30 July 2025: • 4279 patients waiting for new appointments • 4570 patients waiting follow up appointments, diagnostic test or procedures in the same area. • Cancer pathways not impacted 2) Independent investigation from NHSE Regional 3) Additional clinics to address the waiting lists 4) 1172 patients waiting over 52 weeks have been seen in clinics and have had a clinical harm review undertaken. 1138 patients unimpacted. No patients assessed as coming to moderate harm. 5) As of 15 August 2025 • 464 patients have been identified deceased • 18 patients identified as requiring clinical review, to be completed by 31.10.25 6) GIRFT has been engaged to explore best practice in ENT. The Committee requested a further update for the December meeting, future reporting to be delivered only if there are issues to report.	Assured
4. Surgery and Anaesthetics Divisional Report 1) Risks: 2 extreme risks for the division: • 2600 Obsolete and Condemned Surgical Equipment not replaced due to Funding Constraints • 1979 Risk of Patient Harm: Metavision failure due to unsupported IT systems 2) Status Update: • Tailored training for theatre staff around incivilities • Improvement work around staff sickness and hand hygiene compliance 3) Safe: • Focused improvement on EDN completion within 24 hours • Increase in avoidable 2222 incidents • Hand hygiene and stool documentation remain below target • MRSA Bacteraemia (Phoenix ward) learning identified around Category 2 pressure sore not being swabbed and VIP score not correctly assessed.	Assured

• Reducing the EDN backlog remains a priority for the division, SAU no longer a top contributor. Gaps identified around duplicate EDN's and patients who have self-discharged. Process is being looked into. • Increase in reportable pressure ulcers over the quarter, learning identified and shared at monthly meeting with TVN team and ward managers presenting incident on a page 4) Effective: • Ensuring that ward accreditation actions are on track 5) Caring: • Delayed discharges from Critical care remain high, now a divisional driver. This also impacts on high numbers of MSA for the division • Patients in recovery overnight continues, primarily non-elective patients, this is being worked on as a metric for T&A • Reduction in response rate for FFT due to link taking patients to another feedback source • Increase in complaints for Surgical Services over August and September 6) Well led: • Appraisal compliance has dropped for Surgical services • Overall statman compliant • Critical Care peer review visit was positive in September, delayed discharges was highlighted as an issue • Reduction in overall sickness absence is a divisional driver metric 7) Responsive: • Number of incidents awaiting review has reduced. Slight increase in incidents awaiting review • Currently 2 open PSII • Good collaboration with CCCS to support interventional radiology refurbishment 8) Mortality and Morbidity: • Learning identified from M and M meetings • Working with the Learning from Death team to ensure the correct template is used, so themes can be identified and start tracking actions The Committee were **ASSURED** by the report and thanked the division for the update	
5. Medical Devices and Equipment Update Report The paper demonstrates the following pillars of 1compliance with the management of Medical Devices at Medway Maritime Hospital. Overall Medical Devices at Medway Maritime Hospital show a good level of compliance with: 1) Policy and regulatory compliance are documented and current. Compliance with Policy is good. 2) Clinical Engineering maintaining its status as ISO9001:2015 accredited. 3) Planned Maintenance compliance is high with difficulties in locating equipment and man power. 4) Clinical Engineering shows a high output with a large number of interventions for Clinical Equipment Compliance with ISO9001:2015 is demonstrated and a high level of pass was achieved at the March annual external audit. 5) Field Safety Notices are monitored by the Patient Safety Team with high levels of compliance.	Gaps in Assurance

6) LOLER inspections for Patient Lifting Equipment shows a high level of compliance. 7) DATIX shows low numbers of incidents with Medical Devices and compliance with Field Safety Notices is good. 8) Training shows a good level of Compliance. 9) All Test and Calibration equipment in use is calibrated to the appropriate standard 10) Capital Requirements and the 2025-26 Medical Equipment Bid Lists show a requirement of £2.1M. this is compared against Bid Risk Score and is also included for the years 2025-2029. The Committee were **PARTIALLY ASSURED** by the report, requesting the following for future reporting: • Impact of medical devices on patient care. • Report links with the Medical Devices Group, capital spillage and a focus on theatres • The number of devices requiring replacement • The number of devices vulnerable to cyber security	
6. Annual Legal Services Report 1) In 2024/25, the Trust received 58.5% more new Clinical Negligence Scheme for Trusts (CNST) claims, compared to the previous financial year. The total paid for CNST matters on behalf of the Trust by NHS Resolution was less that the Trust's CNST contribution for the financial year in question. The proportion of the Trust CNST claims that are settled remains above the national average. The Trust CNST contribution for the next financial year rose by 35.6%. 2) In 2024/25, the Liabilities to Third Parties Scheme (LTPS) was an asset for the Trust as the total paid for Trust's LTPS matters increased the Trust's contribution by 75.2%. The Trust experienced a 40% decrease in the number of new LTPS claims in the financial year. 3) During the 2024/25 financial year, the amount of new Coronial matters in which the Trust was involved increased by approximately 4.6%. 32.6% more Coronial cases involving the Trust were concluded in 2024/25 compared to the previous year. Further, the Trust had Interested Person at 34% more Inquests. No Prevention of Future Deaths reports were issued to the Trust. 4) A significant decrease of 57.2% was achieved in external legal expenditure from the Legal Services budget compared to the previous financial year, with total external legal spend at £25,229.	Assured
7. Rheumatology Report 1) Following a Royal College of Physicians review of rheumatology services at Darent Valley Hospital (DVH) in 2010, one of the key recommendations advised the Dartford and Gravesham NHS Trust to link the rheumatology services across all Medway Foundation Trust locations. 2) An assessment of the merger between the two Trust's Rheumatology services identified a number of key learning points. **3)** The reviews into shared services in Pathology and Rheumatology between DGT and MFT have shown that the learning from the mergers/joint ventures were distinctly different in nature, however there	

were five key learning themes that were apparent across both which should be considered ahead of any future shared services arrangements The Committee **NOTED** the report	
8. Getting It Right First Time (GIRFT) Update The report consolidates divisional GIRFT updates from August to October 2025. The period demonstrated significant improvement in day case surgery performance, enhanced multidisciplinary collaboration, and notable pathway redesigns (notably in cardiology, respiratory, and neurology).	
9. IQPR, Board Assurance Statement, Risk Register The Committee **NOTED** the reports	
10. Maternity and Neonatal Safety Champion Assurance and Escalation Report 1) Key risks for escalation: Non-compliance with CNST Safety Action 1. 2) Key items for escalation: Challenges to achieve 90% compliance for each eligible staff group for Obstetric Emergency Training and Fetal Monitoring Training. 3) Perinatal Surveillance and Clinical Governance: 1 MNSI referral, 4 MBRRACE reportable deaths in August, 20 NICU incidents. 4) Maternity and NICU Risk and Issues Register: Womens – 4 risks, 25 Issues. NICU 1 risk, 3 issues. 5) Maternity and Perinatal Incentive Scheme (CNST) Year 7 – non-compliance with Safety Action 1 due to missing target date for 3 cases in reporting period. Safety Action 8 – off track. Mitigations in place. 6) Work force: 4 WTE Band 5 vacancies. BAPM Compliant with Qualified in Speciality Nurses. Midwifery – 2.51 WTE bank 5/6 Midwifery vacancy. 7) Maternity Dashboard: Sustained reduction in 3rd and 4th degree tears. Postpartum haemorrhage remains above national average (4.4%). Increasing Induction of Labour rate. Consistently high in CS rate. The Committee **NOTED** the report	
11. Maternity - National Investigation Update 1) On 23 June 2025, the Secretary of State for Health and Social care announced a rapid independent investigation into maternity and neonatal services, along with an independent taskforce and immediate actions to improve care. 10 Trusts were identified for review 2) The Maternity and Neonatal Team responded to this and presented an assurance report to QAC in July and September 2025 3) MFT have identified the key actions in response to these updates and added them to the action plan formulated in response to the initial letter. There are currently 32 actions identified against the two letters, with 100% of these being on track or completed. The Committee **NOTED** the report	
12. Organ and Tissue Donation Annual Report 1) 9 Patients donated their organs after death at MFT in 2024/25 leading to 27 patients receiving lifesaving organ transplants. 2) 100% of potential DBD donors and 96% of potential DCD donors 3) 22 Tissue donation referrals in 2024/25 with 13 patients donating tissue resulting in 20 corneal donations, 4 bone donations, 5 tendon donations and 5 hearts for heart valves.	

4) 1 missed opportunity for organ donation referral during 2024/25 5) Families invited to celebrate the names displayed on the hero wall. 6) The OTDC continues to co-ordinate educational and public awareness. 7) Support from colleagues for clear intent of reconfirmation of organ donation from families The Committee **NOTED** the report	
13. Clinical Audit Annual Report 1) National Clinical Audits: 97% participation in 2024/25. One audit not completed. National Clinical Audit 90-day compliance rose from 26% to 79%. 2) NICE guidance: Compliance increased from 79% to 90% 3) Local Audits: A total of 343 audits conducted across all divisions. 4) Medical Devices Outcome Registry (MDOR): Launched to track procedures involving high-risk devices. 5) National Joint Registry: MFT awarded Gold status for the fifth consecutive The Committee **NOTED** the report	

Meeting of the Board of Directors in Public
Wednesday, 14 January 2026

Title of Report	Quality Assurance Committee Monday, 08 December 2025		**Agenda Item**		
Executive Lead	Alison Davis, Chief Medical Officer Evonne Hunt Chief Nursing Officer				
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, 08 December 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				
	No Assurance	There are significant gaps in assurance or actions			
	Partial Assurance	There are gaps in assurance			

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

ASSURANCE AND ESCALATION HIGHLIGHT REPORT

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

Declarations of Interest Made
None

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

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

Items/risks/issues for escalation

Escalations to note:

- ED CQC Report and Action plan to be presented to January 2026 Trust Board meeting

Implications for the corporate risk register or Board Assurance Framework
None recorded

Key Headlines	**Assurance Level**
1. Updated Work Plan in line with Refreshed Governance Structure The Committee considered and approved a revised governance model for quality oversight, effective January 2026. The proposal aimed to reduce duplication, streamline reporting, and improve assurance of priority issues. Key changes included standing down QPSSC, expanding QAC membership to include divisional triumvirates and specialty leads, and increasing meeting duration to three hours. Transitional arrangements were agreed to ensure continuity of oversight during the change period. The Committee agreed to revisit membership arrangements and provide assurance on operational versus assurance oversight. Further iterations of the work plan would be presented at the next meeting.	
2. Learning from Deaths Report and Summary The Committee noted ongoing risks, including elevated SHMI (1.26, higher than expected) and recent requests for SJRs for legal purposes, which raised concerns about the integrity of the learning process. Forward plans included enhanced coding education, RESPECT training, and targeted audits.	Significant Assurance

The Committee agreed to monitor SHMI reduction through breakthrough objectives and pneumonia/UTI audits, and confirmed a review of SJR disclosure processes with legal and governance teams. Forward plans included enhanced coding education and RESPECT training.	
3. Pneumonia Audit Initial Findings The Committee acknowledged the urgency of the findings and agreed that the proposed pathway and digital prompts would support quality improvement and patient safety. Funding for the pneumonia nurse had been secured internally, and the initiative was aligned with the Trust's stabilisation plan and mortality breakthrough objectives.	
4. ENT Backlog Issue Update The Committee were assured that governance processes were robust and that no significant harm had been identified to date, but recognised the reputational and operational risks posed by the backlog. It was confirmed that progress updates would continue to be reported through the Patient Safety Group and escalated to QAC as appropriate.	
5. Accreditations Assurance Report The Committee was assured by the current position and emphasised the need for proactive engagement with external bodies to maintain high standards of care and compliance.	
6. Medical Group Assurance Report The committee recognised that the group would continue monitoring risks related to job planning systems and medication safety, escalating the impact of industrial action and performance expectations to regional bodies, and incorporating medication safety actions into the Trust-wide improvement plan. The Committee confirmed that these issues would be tracked through its action log and escalated to the Chief Medical Officer's team for resolution. The Committee was assured by the report but recognised the importance of maintaining visibility on these areas through future updates.	
7. QPSSC Assurance and Escalation Report The Committee noted escalations in relation to operational and patient safety risks. These included gaps in medical representation at RADG and related subgroups, which continued to delay decision-making and concerns regarding the bleep system upgrade, with only 11 docking stations procured for 300 devices and a compressed training window before the current system expires on 31 December. Assurance was requested on the bleep system transition, with a briefing note to be provided to TLT outlining implementation timelines and mitigations	Partial Assurance
8. Maternity Dashboard The Committee noted that actions would include maintaining focus on reducing caesarean section rates and PPH through quality improvement initiatives, continuing targeted training for junior midwives, and monitoring demographic-specific interventions. Members emphasised the importance of sustaining improvements in clinical outcomes while addressing workforce challenges linked to the transition from experienced midwives to newer staff. The Committee agreed that future dashboards would include RAG ratings to improve clarity and oversight and were assured by the dashboard however recognised the need for continued vigilance and improvement in areas where performance remained above national averages.	
9. Maternity and Neonatal Safety Champion Assurance and Escalation Report The Committee was assured by the actions taken and noted that CNST compliance risks would be monitored closely.	
10. Maternity and Neonatal 3 Year Delivery Plan	

The Committee noted that all actions on the Board Assurance Framework are now aligned to the delivery plan themes, ensuring continuous oversight.	
11. Maternity - Survey Result The Committee noted next steps included coding free-text responses, co-producing an action plan with stakeholders, and presenting a detailed report to the Trust Board. Members noted the survey findings and endorsed the development of an action plan for improvement.	
12. ED CQC Report The Committee acknowledged the progress made but emphasised the need for sustained improvement in patient flow and privacy standards. Actions agreed included submitting a comprehensive improvement plan to the CQC by 12 December 2025 to address breaches in dignity and respect and safe care, and maintaining oversight of ED performance through QAC and Tier 1 meetings. Members discussed systemic factors contributing to ED pressures, including limited GP provision and late-stage presentations, and noted the positive impact of initiatives such as the virtual hospital. The Committee was assured by the improvements achieved but recognised that further work was required to meet regulatory standards and deliver consistent patient experience.	Partial Assurance
13. Cancer and Core Clinical Services Divisional Report The Committee noted that patient experience indicators, including Friends and Family Test response rates, were stable, with positive comments on staff communication and care. Key risks highlighted included delays in diagnostic imaging due to equipment obsolescence and workforce gaps in radiology. Mitigation plans were in place, including recruitment initiatives and capital bids for equipment replacement. Future actions would include maintaining focus on cancer performance and diagnostic capacity and continuing targeted audits for hand hygiene compliance, The Committee was assured by the improvement trajectory but emphasised the need for sustained oversight of workforce and equipment risks to ensure service resilience**.**	Partial Assurance
14. Safeguarding (Key Issues and Challenges) The Committee acknowledged the statutory responsibilities under Regulation 13 and discussed the need for stronger data collection to enhance reporting quality. Future activity would include reviewing safeguarding policies to ensure they are streamlined and fit for purpose, strengthening allegations management within safeguarding training, and providing a further update on MARAC process improvements and safeguarding audits in Quarter 3. Members welcomed progress but emphasised the importance of continued focus on communication, conduct, and staff awareness of their impact on safeguarding risks. The Committee was assured by the mitigations in place but recognised that systemic improvements were required to sustain compliance and resilience.	
15. Trauma Update The Committee agreed that a more detailed written report would be provided at a future meeting to give assurance on progress and outcomes. Further to this a deep dive report would be scheduled for February 2026 Members welcomed the update and acknowledged the importance of addressing delays and ensuring robust governance for trauma care. The Committee was assured by the initial steps taken but recognised that further work was required to deliver sustainable improvements.	
16. Integrated Quality Performance Report The Committee acknowledged progress but noted areas requiring sustained focus, including patient feedback response rates and cultural change initiatives. Members recognised plans to map these priorities into future IQPR iterations to ensure visibility and accountability, further to this member requested consideration be given to improving readability of the report by adding clear targets and consistent colour coding, and addressing anomalies such as the recent increase in pressure ulcers despite investment	

in new mattresses. Members welcomed improvements in mortality governance and VTE compliance but emphasised the need for continued monitoring of ED performance and elective recovery trajectories. The Committee was assured by the report but recognised that further refinements were necessary to strengthen assurance and clarity.	
17. Board Assurance Statement The Committee welcomed the strengthened triangulation of assurance and the clarity provided by the revised format and supported continuing monthly updates to monitor stabilisation progress, refining metrics and reporting templates in early 2026, and embedding cultural transformation programmes alongside operational improvements. Members noted that performance risks were being addressed through initiatives such as the Length of Stay programme, winter planning, and virtual ward expansion, while quality risks focused on SHMI improvement and enhanced mortality governance. The Committee endorsed the approach and confirmed that the BAS would serve as a key tool for supporting Board-level decision-making and tracking delivery against stabilisation objectives.	
18. Risk Register The Committee emphasised the importance of aligning risk management with stabilisation objectives and embedding assurance processes into divisional reporting. While no new risks were introduced during the meeting, members acknowledged that systemic challenges such as equipment obsolescence and digital resilience would require sustained focus and capital prioritisation. The Committee was assured by the current reporting arrangements but recognised the need for ongoing scrutiny to ensure timely mitigation of extreme risks.	

Meeting of the Board of Directors in Public
Wednesday, 14 January 2026

Title of Report	People Committee Thursday, 27 November 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, 27 November 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 s.flavin1@nhs.net				
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions			
	Partial Assurance	There are gaps in assurance			
	Assurance	Assurance with minor improvements needed.			
	Significant Assurance	There are no gaps in assurance			

	Not Applicable	No assurance required.

ASSURANCE AND ESCALATION HIGHLIGHT REPORT

Number of Member Attendees	Number of apologies	Quorate	
		Yes	No
4	0	X	

Declarations of Interest Made

None

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

Item	Group, Subcommittee, Committee	Date
None		

Reports not received as per the annual workplan and action required

None	

Items/risks/issues for escalation

Escalation and Highlights to the Board:

- Risk of staff shortages and capacity impact on staff wellbeing and burnout.
- MSK (Musculoskeletal) referrals increasing. A deep dive for short and long term MSK illness to be done
- Employee Relations backlog. – this work continues and progress is reported at People Committee and Board through the stabilisation plan update
- Use of Apprenticeship levy can be improved across all divisions for staff training, career development and retention.
- Freedom to Speak Up – Improved staff engagement seen. Estate and Facilities are reporting the highest for Culture issues
- Succession planning and cover required to maintain a resilient service. Lack of planning and process by line managers to arrange cover for sickness and maternity leave, resulting in key person risk.

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 Statement Risk and Issue Register: 1) No current extreme risks, 8 high risks. 2) 13 active and approved risks. 3) 32 active and approved issues. 7 high issues. 4) BAS Risk 3 (mapped to BAF 5): The Trust's current organisational culture will continue to negatively impact staff and patients' experience and the trusts reputation. Current Score: 16. 5) BAS Risk 4 (mapped to BAF 6): Quality of patient care could be 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. Current Score: 16 6) Current challenges with organisation changes and the impact on current staff.	There are gaps in assurance

The Committee requested future reporting risk threshold of 15 and above. Enriched narrative for Risks 2500 (Uplift of CSW Bands 2–3 in Theatre Services) and 2438 (Prolonged Lack of Repairs Poses Risk to Nursery Environment Condition). Board Assurance Statement: On BAS for Performance Risk 10 (mapped to BAF13), provide feedback to the relevant team/owner on cyber awareness and cyber culture, for consideration in the actions/controls Integrated Quality Performance Report: 1) 6 workstreams for Cultural Diversity in Phase 2. This will be monitored through the People Committee. 2) Incivility Breakthrough Objective is monitored on a weekly basis with learning identified. 3) Management Essentials Training enables skills to effectively manage staff. 4) Staff appraisal numbers have deteriorated. 5) Sickness at 5.4% 6) StatMand training compliance at 89.4% The Committee requested data for levels of engagement of surveys from Estates and Facilities; and level of detail for work force information including training compliance. The Committee **NOTED** the IQPR, BAF and Risk Register	
2. HR and OD Performance Group The report summarised HR and OD teams' performance in the last two months and providing assurance to the Committee. Updates on the enhanced workforce controls, impact of recruitment freezes, backlog in employee relations cases, and effort to extract learning from investigations. The Committee requested an update on Enhanced Workforce Controls for the next meeting. The Committee were **ASSURED** by the report	Significant Assurance
3. Recruitment, Retention and Education Assurance Report The Committee requested the wording is reviewed for clarity, including the secondment length of time. The CNO to provide a paper on sponsorships and nursing staff retention. The Committee were **ASSURED** by the report	Significant Assurance
4. Policies and Terms of Reference for Ratification 1) Equality Steering Group Terms of Reference 2) Joint Staff Committee Terms of Reference The Committee **RATIFIED** both Terms of Reference.	ToR Ratified
5. Modern Day Slavery and Anti-Trafficking Statement **1)** The Policy 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. The statement publicly demonstrates the Trusts ongoing commitment to protecting vulnerable individuals, promoting ethical practice,	Statement Approved

and ensuring that modern slavery has no place in our organisation or its supply chains The Committee **APPROVED** the statement	
6. Health and Wellbeing Guardian 1) The National Health and Wellbeing (HWB) Framework dashboard, alongside key performance indicators from NHS Staff Survey and metrics from contracted services, combine to provide an overview of progress against the Trust People Strategy. 2) Workshop wellbeing into action – trust values. Four completed to date 3) There have been three engagement awareness stands: Alcohol, Blood Pressure and Infant Feeding. Rising MSK referrals to be followed up with a deep dive. Good engagement noted on the Menopause training for different staff groups. The Committee **NOTED** the report	Significant Assurance
7. Apprenticeship Funding and Implementation The report provided an update on the progress made in the management of apprenticeship funding and delivery across the Trust for both new and existing staff. The update outlined recent changes to the levy share scheme and the positive impact these developments will have on maximising apprenticeship investment and supporting workforce development. The Committee **NOTED** the report	Significant Assurance
8. Freedom to Speak Up Annual Report 1) Between April and September 2025, a total of 71 concerns were raised via the independent Guardian service. 2) There remains an ongoing perception that staff concerns would not be appropriately addressed, along with a fear of potential repercussions, and having raised matters before with no actions undertaken by the Trust. 3) Trust has increased its responsiveness in a timely and effective approach to concerns related to patient and staff safety, marking a significant improvement from April 2025 to September 2025. 4) Since April 2025 there have been 7 concerns raised anonymously. The Committee **NOTED** the report	Significant Assurance

Meeting of the Board of Directors in Public
Wednesday, 14 January 2026

Title of Report	Finance, Planning and Performance Committee Thursday, 27 November 2025		**Agenda Item**	4.1d
Committee Chair	Helen Wiseman, Chair of Committee/NED			
Executive Lead	Simon Wombwell, Chief Financial Officer (Interim)			
Executive Summary	Assurance report to the Trust Board from the Finance, Planning and Performance Committee (FPPC), ensuring all nominated authorities have been reviewed and approved. The report includes key headlines from the Committee.			
Proposal and/or key recommendation:	This report is to provide ASSURANCE to the Trust Board			
Purpose of the report (tick box to indicate)	Assurance	X	Approval	
	Noting		Discussion	
Committee/Group at which the paper has been submitted:	Finance, Planning and Performance Committee, 27 November 2025			
Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:			
	Priority 1: (Sustainability) X	Priority 2: (People) X	Priority 3: (Patients) X	Priority 4: (Quality) X	Priority 5: (Systems) X
Relevant CQC Domain:	Tick CQC domain the report aims to support:			
	Safe:	Effective: X	Caring:	Responsive: X	Well-Led: X
Integrated Impact assessment:	Where applicable, individual considerations are provided at the FPPC Committee.			
Legal and Regulatory implications:	Individual legal and regulatory implications are provided at the FPPC Committee.			
Appendices:	None			
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act.			
For further information or any enquires relating to this paper please contact:	Simon Wombwell, Chief Finance Officer (Interim) simon.wombwell@nhs.net			
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions		
	Partial Assurance	There are gaps in assurance		

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

ASSURANCE AND ESCALATION HIGHLIGHT REPORT

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

Declarations of Interest Made

None

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

Item	Group, Subcommittee, Committee	Date
None		

Reports not received as per the annual workplan and action required

None	

Items/risks/issues for escalation

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

Implications for the corporate risk register or Board Assurance Framework

None recorded

Key Headlines	Assurance Level
1. Financial Report Month 07 The Trust reported an October deficit of £9.1m and a year-to-date deficit of £22.7m, driven largely by efficiency programme risks, high drug charges VAT claim reversal and removal of deficit support funding. The Committee requested that variances of the Risk Adjusted Forecast Outturn (RAFOT) for divisions be reported in the next meeting to improve oversight. The Committee considered the delivery of a £47m projected outturn to be high risk due to the slower than expected progress on CIPs.	There are significant gaps in assurance or actions
2. CIP Progress Report and Update from PA Consulting The revised RAFOT target stands at £17.8m. Key areas of focus identified included implementing control panels to manage bank and agency spend and action was taken to schedule a deep dive into other key schemes for December to ensure financial targets for the current and upcoming years are reachable. The Committee recognises the challenge in identifying cash releasing savings in light of the operational challenges and performance requirements, but slow progress against target does raise concerns for our ability to achieve our sustainability goals.	There are significant gaps in assurance or actions

3. Cash and Cash Support Following the rejection of its initial cash application by NHSE, the Trust is preparing a formal in-year financial recovery plan to address constraints and potential payment delays. **This was circulated to the Board by email on 3rd December 2025** The Committee approved a resubmission of the cash support application to NHSE for December.	There are significant gaps in assurance or actions
4. Business Planning and Budget Setting A delivery framework was proposed for the 2026/27–2029/30. A Medium-Term Planning Framework had been compiled with an assumption for a break-even position and zero agency spend by 2030. The Committee approved the framework for onward Board ratification, emphasising the need for "Star Chamber" sessions to enforce difficult prioritisation choices. The Committee wish to reinforce the extremely tight timescales for what will be a challenging planning round for MFT, not least given our financial and operational targets for improvement to meet Government expectations.	Assurance with minor improvements needed.
5. Capacity and Demand Review The first stage of the review indicated that significant capacity could be released through improved clinical productivity, with Rheumatology identified as the initial focus. The Trust is now integrating these findings into wider improvement initiatives and has appointed a new lead for elective recovery. The Committee were assured by the report.	Assurance with minor improvements needed.
6. Board Assurance Statement (BAS), and Risk Register and Issue Log The Committee was only partially assured, requesting improvements in triangulation and the inclusion of quality and culture risks within the statement. A refreshed BAS with improved formatting and a supporting coversheet is to be presented at the next meeting. Risk Register and Issue Log - Concerns were raised regarding the sufficiency of mitigation actions for specific risks and the need for a forward-looking perspective in reporting. Action was assigned to ensure DATIX evidence is captured to support capital bids for the January meeting.	There are gaps in assurance
7. Integrated Quality Performance Report (IQPR) Performance remains challenged in urgent care and elective waits, with the Trust currently positioned in the bottom ten for 52-week waits and RTT. The Committee requested that future reports include a forward look and prognosis, and that stabilisation plan areas be integrated into IQPR graphs.	There are gaps in assurance
8. MFT eRostering Business Case The proposal aims to replace fragmented medical workforce systems with a single integrated solution from Patchwork Health covering job planning and temporary staffing. Despite concerns regarding prior virtual approval processes, the Committee ratified the business plan for onward approval by the Trust Board.	There are no gaps in assurance

Meeting of the Trust Board

Date: Wednesday, 14 January 2026

Title of Report	What is good governance?			**Agenda Item**	4.2
Stabilisation Plan Domain	**Culture**	**Performance**	**Governance and Quality**	**Finance**	**Not Applicable**
	x	x	x	x	
CQC Reference	**Safe**	**Effective**	**Caring**	**Responsive**	**Well-Led**
					x
Author and Job Title	Fiona Wise, Strategic Board Advisor and Katie Goodwin, NHSE Improvement Director				
Lead Executive	Jon Wade, Chief Executive Officer				
Purpose	**Approval**		**Briefing** x		**Noting**
Proposal and/or key recommendation:	This paper is intended to remind the Board of the principles of good governance, provide a set of questions for Board members to consider (as a unitary Board and individually), as well as a set of strategic recommendations to feed into the governance improvement plan. We recommend that the Board continues to revisit this paper, in the coming months, to evaluate progress and define what success looks like (outcomes). The Board's view is sought on current governance arrangements, using this paper as a prompt. The Board is then asked to agree the development of a formal action plan and next steps, to address the requirements of the Undertakings. This should include the development of a formal Governance Framework, linked to a Behaviours and Accountability Framework, and a Board Development Programme.				
Executive Summary	The paper has been written as an initial response to address a key part of the Independent Strategic Adviser's brief to "review the organisation's governance structure and processes, assess their impact and effectiveness and advise on any improvements and amendments required which ensures the evidence of golden thread from ward to Board, including the role of Divisions as well as taking account of the proposed transition to a Group Model".				
Issues for the Board/Committee Attention:	As a guide to key issues for Board attention, you should consider commenting (as appropriate) on: • How far / near to the Board consider themselves to be to the principles of good governance set out in this paper. • Whether there is agreement across all Board members, particularly committee chairs, that this is the case or are there differences?				

	• How the Board proposes to address any deficiencies?			
Committee/ Meetings at which this paper has been discussed/ approved: Date:	N/A			
Board Assurance Framework/Risk Register:	Part of the discussion			
Financial Implications:	N/A			
Equality Impact Assessment and/or patient experience implications	N/A			
Freedom of Information status:	Disclosable x		Exempt	

What is good governance?

Author: Fiona Wise / Katie Goodwin

Date: January 2026

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1. Introduction

1.1 This paper is intended to remind the Board of the principles of good governance, provide a set of questions for Board members to consider (as a unitary Board and individually), as well as a set of strategic recommendations to feed into the governance improvement plan. We recommend that the Board continues to revisit this paper, in the coming months, to evaluate progress and define what success looks like (outcomes).

1.2 The paper has been written as an initial response to address a key part of the Independent Strategic Adviser's brief to "review the organisation's governance structure and processes, assess their impact and effectiveness and advise on any improvements and amendments required which ensures the evidence of golden thread from ward to Board, including the role of Divisions as well as taking account of the proposed transition to a Group Model ".

1.3 Furthermore the authors are reminded of the Board's responsibility to meet its Licence Conditions and the Enforcement Undertakings which were updated in the Summer of 2025.

These covers: Leadership, Well Led and Governance

Financial Management

Programme Management

RSP Transition Criteria

Reporting Requirements on compliance with the undertakings

The Trust's Stabilisation Plan addresses these headline requirements, but further review is required to ensure complete alignment

This paper is not a detailed review of the organisations structure and processes but, rather, seeks to stimulate discussion and ownership of the principles of good governance. It does, however, raise questions for consideration. Once discussed, these should be used to facilitate planning of the Board Agendas and areas for development and enable the next step of the Strategic Adviser's brief to be taken forward - especially in the context of the emerging steps regarding the Group Model.

It will also assist the response to the specific requirements of the Trust Enforcement Undertakings in respect of clear organisation wide governance being in place.

2. Principles of good governance

From **the Healthy NHS Board: Principles for Good Governance**, the **three core roles of an NHS board** are to:

2.1 Formulate Strategy

- Develop a compelling vision and clear strategic objectives.
- Ensure strategy is shaped by evidence, external context, and stakeholder engagement.
- Make transparent, evidence-based strategic decisions.

2.2 Ensure Accountability

- Hold the organisation to account for delivering the strategy.
- Seek assurance that systems of control are robust and reliable, covering:
    - **Quality assurance and clinical governance**
    - **Financial stewardship**
    - **Risk management**
    - **Legality and probity**
- Avoid "false reassurance"—focus on real assurance and decisive action.

2.3 Shape Culture

- Create and embed a positive, open, and patient-centred culture.
- Promote NHS values (respect, dignity, compassion, quality of care).
- Model transparency and integrity in board behaviour.

2.4 These roles are supported by **three "enablers" / sources of assurance**:

Context (understanding policy, regulation, and environment),

Intelligence (using reliable performance and quality data), and

Engagement (active dialogue with patients, staff, and stakeholders).

2.5 While not legally mandated, **NHS England's Code of Governance** (2022) and the **NHS Providers** guide recommend that both NHS trusts and foundation trusts should have, at minimum, the following **assurance-focused board sub-committees**:

- Audit Committee

- Remuneration and/or Nominations Committee
- Quality Committee
- Finance and Performance Committee

These are viewed as essential for robust oversight and board assurance, even if not all are legally mandated.

3. How close do we think we are to this?

Questions to consider, as follows

3.1 Formulate Strategy

- Does the board have a **clear, compelling vision** and strategic objectives that put **quality and patient safety at the heart**?
- Is there evidence of **regular strategic discussion** (not just annual planning)?
- Has the strategy been shaped by **intelligence** (performance trends, external context, patient needs)?
- Were **clinicians, staff, and stakeholders** actively involved in shaping the strategy?
- Does the board have a **long-term financial and workforce model** aligned to strategic goals?

3.2 Ensure Accountability

- Does the board receive **clear, timely, and integrated intelligence** on quality, finance, and risk?
- Are **quality dashboards** and **Board Assurance Framework** actively used to drive decisions?
- When performance issues arise, does the board act **swiftly and decisively**, or is it easily reassured?
- Are **audit, quality, and remuneration committees** functioning effectively with proper independence?
- Does the board periodically **validate assurance through direct engagement** (e.g., walk rounds, patient stories)?

3.3 Shape Culture

- Is the board visibly **championing NHS values** (respect, dignity, compassion, openness)?

- Does the board model **candour and constructive challenge** in its own behaviour?
- Are patient safety and quality **prominent on the agenda** (at least 20% of board time)?
- Does the board engage directly with **staff and patients** to understand lived experience?
- Is there evidence of **innovation-friendly culture** (not just risk-averse compliance)?

3.4 Enablers

- **Context:** Do board members understand the policy, regulatory, and economic environment?
- **Intelligence:** Is performance data meaningful, benchmarked, and linked to strategic goals?
- **Engagement:** Is there a systematic approach to stakeholder engagement beyond formal reports?

4. Key recommendations for Board agreement

Principles of governance need to be incorporated into both clinical and corporate governance arrangements, however, the following recommendations, principally apply to corporate arrangements and the role of the unitary board. As the organisation moves towards a group model, developing consistency across the two organisations should be considered where appropriate. The recommendations also seek to specifically incorporate the requirements set out in The Trusts Enforcement undertakings

1) Develop a Trust governance framework, aligned with a leadership development / behaviour framework (as per the cultural transformation workstream). Please see appendices for skeleton content. Evidence of this framework will need to be in place and reported on to NHSE by the end of Q1 2026/27
2) Specifically, review the current accountability arrangements for digital, in light of it being one of the three pillars of the NHS 10-year plan.
3) Review the current the Board and Sub -committee schedule to ensure it is fit for purpose. For example, the frequency of public Board meetings (currently bi-monthly), given high level scrutiny as a RSP / NPIP trust.
4) Implement a standardised digital Board pack and paper etiquette; this should include minute writing training (and shadowing) for the board secretariat team and the monitoring / follow-up of actions.
5) Review alignment of ToR, BAF and risk register and the Board's position re risk appetite (linked to point 7 – Board development).

6) Review individual executive governance accountability arrangements and ensure they align with any revised governance framework and attendance at Board sub-Committees
7) Implement a robust Board development programme for executive and non-executive members, focused on the key roles / expectations of unitary Board working (strategy, accountability – including performance – and culture)
8) Receive a progress report on the actions taken at the Trust Board meeting in March 2026

5. Next Steps

Subject to the outcome of the Board discussion, and decision on initial recommendations, work can commence on the next steps of the review, alongside the development of the Group Model.

Appendix a) [potential to form the skeleton for the Trust governance framework]

Good governance in an acute district general NHS hospital is the system of leadership, accountability, assurance, and continuous improvement that enables safe, effective, compassionate, and sustainable care. It rests on five pillars:

(1) **clear board leadership and purpose**;

(2) **robust risk management and internal control**;

(3) **comprehensive quality and safety assurance**;

(4) **effective information and financial stewardship**; and

(5) **collaborative, transparent system working** within Integrated Care Systems (ICS).

Governance is enacted through a unitary board model, supported by well-functioning committees, integrated governance domains (clinical, financial, workforce, information, and research), and a culture rooted in NHS constitutional values and the Nolan principles of public life. Requirements are codified by NHS England's **Code of Governance for NHS Provider Trusts**, provider licence conditions, the **CQC Well-Led** expectations, as well as statutory frameworks for information standards and data governance.

High-performing acute hospitals demonstrate:

- clear roles and delegation,
- strong board assurance frameworks (BAFs),
- timely and reliable information flows,
- rigorous clinical governance (including audit, incident learning, and mortality review),
- prudent financial control, and
- proactive engagement with patients, staff, and partners.

They also align their governance with ICS priorities (noting that the role of the ICS will change in coming months and reflecting this in the development of a governance framework), reduce unnecessary bureaucracy, and leverage digital standards to safeguard information. The result is improved outcomes, equity, resilience, and public trust.

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1. Introduction

Governance in the NHS is "***a framework for assurance, decision-making, accountability, and optimal use of resources***" that provides a safe, supportive environment for high-quality care and for meeting strategic objectives.

It encompasses culture, vision, values, structures, policies, processes, and the overarching assurance framework that supports an organisation to take decisions and deliver agreed outcomes. Good governance enables leaders to provide assurance around quality, safety,

and use of resources, reinforced in law by the Health and Social Care Act and **Regulation 17: Good Governance**. In modern NHS practice, it is inseparable from partnership working across ICS footprints and must reduce unnecessary bureaucracy through clear, streamlined assurance routes and data-sharing agreements.

Acute hospitals face distinctive governance challenges: complex case-mix, high patient volumes, multi-specialty interfaces, constrained estates and capital, digital interoperability issues, and workforce pressures. Consequently, governance must be both **unitary** (a single board accountable for strategy, risk, and performance) and **integrated** (clinically, financially, and operationally aligned across divisions and with system partners).

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2. Core Principles of Good Governance (*Purpose*)

2.1 Accountability and Transparency

Clear lines of accountability from ward to board are essential. Boards must operate openly, publish decisions and outcomes where appropriate, and maintain constructive challenge through independent non-executive oversight. Scheme of delegation, standing orders, and standing financial instructions should be current and accessible.

2.2 Patient-Centred Quality and Safety

Clinical governance assures continuous improvement in quality and safeguards high standards of care, grounded in the CQC domains (safe, effective, caring, responsive, well-led). Matrons and clinical leaders provide real-time assurance through audits, patient experience measures, and learning from incidents.

2.3 Ethical Leadership and Culture

NHS Constitution principles and values, and the Nolan principles of public life, underpin behaviours. Culture should promote candour, inclusion, diversity, psychological safety, and learning, with visible clinical and managerial leadership.

2.4 Integrated System Working

Hospitals must collaborate consistently in **shared planning and decision-making**, take collective responsibility with partners for quality and sustainability across system and place footprints, and deliver agreed system improvements. NHS England’s guidance under the provider licence sets explicit expectations and characteristics of governance to support collaboration.

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3. Governance Architecture in an Acute Hospital (*Process*)

An organisation that has accountability embedded in its culture relies on the quality of the relationship between those who are accountable for outcomes of something and those who are responsible for its delivery.

There is an equal and even responsibility on both to ensure the effectiveness of this relationship and to escalate where additional support is required, or a risk or conflict of interest has been identified that would impact the credibility and integrity of the accountability framework.

3.1 Unitary Board and Committee Structure

- **Unitary Board**: Executive and Non-Executive Directors share collective responsibility for strategy, risk, and performance. Chairs enable constructive challenge and alignment to purpose.
- **Assurance Committees** (typical):
    - **Audit & Risk Committee**: Oversees internal control, risk, and audit plans.
    - **Quality Assurance Committee**: Provides systematic assurance over safety, effectiveness, and patient experience.
    - **Remuneration Committee**: Ensures fair and transparent executive remuneration aligned to outcomes.
    - **Clinical Governance Groups** (e.g., Patient Safety, Clinical Outcomes and Effectiveness, Patient Experience and Engagement) provide specialty and divisional assurance routes feeding upward to the board.

3.2 Integrated Governance Domains

High-functioning frameworks cover: **clinical governance**, **financial governance** (including capital planning), **workforce governance**, **education**, **information governance**, **research governance**, and **performance & divisional governance**—with clear reporting and onward assurance to the board.

3.3 System Interfaces and External Accountability

Governance aligns with ICS partner arrangements, provider collaboratives, commissioners, and regulators. Boards demonstrate how local governance contributes to system objectives and equity.

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4. Key Components and Practices (*Performance*)

4.1 Board Leadership, Purpose, and Strategy

The **Code of Governance for NHS Provider Trusts** expects boards to set clear purpose, values, and strategic priorities, supported by transparent decision-making and performance oversight; succession planning and periodic board evaluation are required.

Good practice includes:

- Annual cycle of business mapped to strategic objectives and regulatory requirements.
- Regular board development and external evaluation.
- Clear role descriptions, competency frameworks, and targeted succession planning for executives and clinical leaders.

4.2 Risk Management and Internal Control

Boards should maintain a **Board Assurance Framework (BAF)** linking principal risks to strategic objectives, controls, assurances (internal and external), gaps, and action plans. Audit & Risk Committees test control effectiveness, supported by internal audit, counter-fraud, and clinical risk systems (incident reporting, serious incident investigation, and learning).

4.3 Quality and Safety Assurance

A mature clinical governance system spans: risk management; incident reporting and investigation; **Duty of Candour**; clinical audit; mortality and morbidity reviews; education and professional development; evidence-based practice; and learning from complaints and patient feedback. Routine use of ward/unit accreditation tools, PLACE, and nursing metrics benchmarking (e.g., Model Hospital) is encouraged. Outcomes feed into the Quality Committee and inform improvement plans.

4.4 Information Governance and Digital Standards

Hospitals must comply with **national information standards** and the governance structure led by the Data Alliance Partnership Board (DAPB) and Data Assurance Board (DAB). The NHS Standards Directory provides a single entry point to mandated and widely used standards (including ISNs), enabling safer interoperability and reducing duplicative data burdens.

Governance should ensure lawful, ethical handling of data, alignment with target data architectures, and adoption of approved standards and APIs.

4.5 Financial Stewardship and Sustainability

Standing financial instructions, effective budgeting, capital planning, and rigorous financial reporting support value for money and sustainability. Guidance on corporate governance and financial management standards (including for independent providers of CRS) illustrates good practice principles transferable to NHS acute settings: prudent oversight, early warning indicators, and continuity planning.

4.6 Workforce Governance and Culture

Workforce plans should integrate safe staffing, skills mix, retention, leadership development, and wellbeing, aligned with the **NHS People Promise**. Governance mechanisms need to surface culture indicators (freedom to speak up, staff survey results), ensure psychological safety, and embed equality, diversity, and inclusion in decision-making.

4.7 Stakeholder Engagement and Public Accountability

Patients, carers, staff, governors (for foundation trusts), and community partners should be meaningfully engaged. Openness and transparency build trust; complaints and PALS insights should be systematically analysed and reported to the board, with visible actions and learning.

4.8 Characteristics of a Well-Governed Acute District General Hospital

i. **Clarity of Roles and Delegations**: Documented schemes of delegation and committee terms of reference; board and divisional responsibilities understood and enacted.

ii. **Reliable Information Flows**: Timely, triangulated data (quality, operational, finance, workforce) with clear dashboards and narrative analysis; alignment to national standards for data and interoperability.

iii. **Strong Assurance Frameworks**: BAF linked to strategic objectives, with clear gaps and actions; internal audit and clinical audit programmes that drive improvement.

iv. **Culture of Learning and Improvement**: Active incident learning, mortality review programmes, and improvement science embedded in pathways and wards; visible support for Duty of Candour.

v. **Financial Prudence and Resource Optimisation**: Effective planning and oversight of revenue and capital; readiness for continuity and resilience; transparent reporting to committees and board.

vi. **System Collaboration and Equity Focus**: Participation in provider collaboratives and ICS forums; shared priorities (e.g., urgent and emergency care flow, elective recovery, health inequalities); coherent governance across organisational boundaries.

vii. **Information Governance Maturity**: Compliance with ISNs, robust data protection, and modern cyber practices; clear accountability for data quality and analytics.

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5. Roles (*people*)

5.1 Council of Governors

The role of the Council of Governors (the council) is to hold the non-executive directors individually and collectively to account for the performance of the board of directors. The role of the council is not to duplicate the functions of the non-executive directors or to repeat the decisions taken by the board, but rather it is to ensure that the assurance received by the non-executive directors is well-founded and that the standard of decision-making is suitably high.

5.2 The Trust Board

The board has overall responsibility for the safe and effective running of the trust, and its members are collectively accountable for the trust's performance. The board exercises all the powers of the trust except those exercised by the council of governors, or in the instances where powers have been passed to others in statute.

The role of the board is to:

- provide effective and proactive leadership of the trust within a framework of processes, procedures and controls which enables risk to be assessed and managed.
- take responsibility for making sure the trust complies with the conditions of its licence, its constitution, guidance issued by its regulators, relevant statutory requirements and contractual obligations.
- set the trust's strategic aims at least annually, taking into consideration the views of the council of governors.
- be responsible for ensuring the quality and safety of health care services, education, training and research delivered by the trust.
- ensure that the trust exercises its functions effectively, efficiently and economically.

- set the trust's vision, values and standards of conduct and ensure the trust meets its obligations to its members, patients and other stakeholders and communicates them to these people clearly.
- take decisions objectively in the interests of the trust.
- take joint responsibility for every board decision, regardless of their individual skills or status.
- share collective accountability as a unitary (single) board.
- constructively challenge the decisions of the board and help develop proposals on priorities, risk mitigation, values, standards and strategy.

5.3 Non-Executive Directors

Non-executive directors are collectively, with the executive directors, accountable for the performance and actions of the trust. The role of the non-executive directors is to hold the executive directors to account for the performance of the trust and for the way in which the executive team discharges its responsibilities for the operational running of the trust. Non-executive directors focus on providing challenge, support, seeking assurance and adding value.

5.4 Statutory roles

A statutory role is one that is defined in law and as such is a legal requirement to have within our governance structure. Statutory roles include both functions (e.g. council of governors), and positions (e.g. chief finance officer).

Statutory governance functions:

All foundation trusts have a statutory requirement to have a council of governors and a unitary board of directors that includes both non-executive directors and voting executive members. The board must always have more non-executive directors than voting executive directors.

The board must include the following board sub-committees within its constitution: audit committee and remuneration committee.

Statutory positions:

The law (statute) describes which roles within the trust must also have voting rights as a member of the trust board, and in some instances goes further to describe the specific activities for which they are responsible. The board roles with specific responsibilities are:

Role	Activities
Accountable Officer / Chief Executive Officer (CEO)	The accountable officer has responsibility for the overall organisation, management and staffing of the trust and for its procedures in financial and other matters. The accountable officer must ensure that: • there is a high standard of financial management in the trust as a whole. • the trust delivers efficient and economical conduct of its business and safeguards financial propriety and regularity throughout the organisation. • financial considerations are fully taken into account in decisions by the trust.
Chief Finance Officer (CFO)	• Sets financial strategy. • Sets operational and capital expenditure budgets for the group. • Is responsible for overall financial performance. • Sets financial standards and processes that the health units are expected to adhere to.
Chief Medical Officer (CMO)	• Jointly responsible for key clinical governance arrangements with the chief nursing officer (e.g. group-wide quality and patient safety committees). • Fulfils the statutory role of the chief medical officer on the trust board, providing medical oversight, expertise and leadership and is the professional line of accountability for all doctors.
Chief Nursing Officer (CNO)	• Oversees regulatory arrangements (e.g. CQC) and jointly responsible for key clinical governance arrangements with the chief medical officer. • Fulfils the statutory role of the chief nursing officer on the trust board (e.g. provides nursing oversight, expertise and leadership; is the professional line of accountability for all nurses and allied health professionals; leads safeguarding arrangements). • Defines and sets standards for the patient experience. • Oversees the trust risk register.

In addition, there are some other roles that have statutory (legally defined) responsibilities that must report to the chief executive officer and trust board, but are not necessarily required to be voting members of the board.

Appendices b) terminology and definitions

Much of the language that we use in everyday life has a more precise or specific definition in a corporate governance context. Developing a shared language is critical to the effectiveness of the accountability framework.

Included below are the key definitions that are at the core of the accountability framework and good governance practices.

	What it is	**What it's not**
Accountable	To be answerable for a specific set of outcomes or area of work. Accountability is held at an individual level and cannot be shared. However, in a distributed leadership model such as at the trust, a number of people may be individually accountable for different deliverables or outcomes that will collectively contribute to a shared goal. This is collective accountability. We may at times describe meeting 'A' being accountable to meeting 'B'. In this instance, it is the Chair of meeting 'A' who is ultimately accountable (answerable) to meeting 'B'.	To be accountable for something does not necessarily mean you are responsible for its delivery, though you will remain ultimately responsible for the outcomes of the work.
Responsible	To hold the duties of delivering a specific role, task or set of deliverables for an area of work. This will often include holding control of the resources required to discharge this set of duties, and to be given delegated authority for some or all aspects of decision-making. Responsibility can be shared e.g. the local executive teams in each hospital share responsibility for the day-to-day operations of that hospital.	To be accountable for something does not necessarily mean you are responsible for its delivery, though you will remain ultimately responsible for the outcomes of the work.
Autonomy	Autonomy describes the conditions within which authorised groups or individuals are able to exercise good judgement and have the freedom to act within the scope of their responsibilities or in the delivery of an agreed strategy or plan.	Autonomy is not sovereignty (full independence), or freedom from accountability. The delegation of authority or responsibility does not in itself enable someone to operate with autonomy. The principle of autonomy needs to be agreed, and the conditions to support it created.

To hold to account	To ask someone to explain, or answer for, their decisions and actions. Holding to account is a proactive opportunity to bring transparency to decision-making, and to add value, professionalism, and rigour through regular and active challenge. As members of a public body, we should all have a reasonable expectation to be held to account for the work that we do. This should be done in a way that is constructive, transparent and relevant to the role, responsibility and accountabilities that we individually hold. • The person who is responsible should expect to be held to account for the way in which they have discharged their duties. • The person who is accountable should expect to be held to account for the expected outcomes to the expected standards. • Both should expect to be held to account for the effectiveness of the relationship between the person who is accountable and person(s) who are responsible if there is a delineation.	Holding someone to account is not blaming or pointing the finger. It should happen by default rather than exception and recognise successes and examples of best practice as well as areas of poor practice or concern.
Assurance	Assurance is the confidence gained through evidence that what is said to be happening is happening. The Good Governance Institute describes that best practice assurance is the triangulation between what is observed (e.g. walk-arounds, case studies etc.); what is said (e.g. patient and staff testimonials); and the data / information that is reported. **Management assurance**: this is sometimes described as operational assurance and relates to the regular production, analysis and scrutiny of data, risk management, and planning – these functions will typically be carried out at team / ward / divisional level. **Internal assurance**: is the oversight of evidence provided with the aim of ensuring that it is complete, accurate, reliable and timely. This will typically be carried out through a speciality focus forum such as an Infection Prevention Control or Risk meeting. Or by an executive or non-executive led committee such as a board committee. **External assurance**: will be sought by people who are external and independent of the Trust. This will most typically be via a regulator such as CQC, external auditor or commissioner, and gained through inspections, reviews and audits. Whilst the specific data and activity required may vary between the different tiers of assurance, each should be verifiable, accurate and consistent.	Assurance is not reassurance. Reassurance is typically descriptive and based on opinion, e.g. a report confirming that all risks are being managed is reassurance, the provision of the risk register is assurance. Providing assurance is also not about 'putting your best foot forward'. Good assurance will include providing the evidence that a risk / issue / challenge has been appropriately identified, understood and that the correct steps are in place (or are being put in place) to address it.

Delegated authority	Delegated authority is giving a group or individual the right to decide on a specific set of decisions or area of work. Delegated authority will be written in one of five places: the Trust Scheme of Delegation; the Trust Standing Financial Instructions; the meeting's Terms of Reference; the individual's job description; the minutes of the delegating meeting (typically for a short-term piece of work).	Holding delegated authority will often, but not, always transfer responsibility for delivery. Delegated authority will not transfer accountability for the outcomes of the decisions taken, e.g. TLT may hold delegated authority to approve business cases up to a defined financial or risk threshold. The relevant members of TLT will remain collectively accountable for the outcome of the business case. ARC will typically manage this through seeking assurance on the quality and effectiveness of decision-making in how it approves business cases. Or in the cases of more complex or contentious business cases, may request a higher level of visibility of the content of the business case being considered.

Meeting of the Public Trust Board

Date: 14 January 2026

Title of Report	Maternity CQC Picker Survey – 2025 Survey Headlines			**Agenda Item**	5.2a
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	X
Author and Job Title	Alison Herron, Director of Midwifery				
Lead Executive	Chief Nursing Officer				
Purpose	**Approval**		**Briefing**		**Noting X**
Proposal and/or key recommendation:					
Executive Summary	• This report summarises the findings from the Maternity Survey 2025 carried out by Picker. • The fieldwork was carried out between 22nd April and 15th July 2025. • A total 55 questions were asked in the 2024 survey, of these 40 can be positively scored, with 19 of these which can be historically compared. • A total of 89 questions were asked in the 2025 survey, of these 61 can be positively scored, with 58 of these which can be historically compared. The results include every question where our organisation received at least 30 responses (the minimum required). • Full publication of report was November 2025 and free text comments received in division. **Next steps:** • Complete coding of responses and the free text to identify key areas for improvement. • Co-produce action plan along with key stakeholders, including MNVP lead, and PE & EDI Midwife. • Detailed report and action plan to be presented through MNSCAG, QAC and Trust board in Feb/March 2026				

Issues for the Board/Committee Attention:	No issues currently identified.			
Committee/ Meetings at which this paper has been discussed/ approved: Date:	Maternity and Neonatal Safety Champion Assurance Board, October 2025. QAC – 8 December 2025			
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	

CQC Surveys - Headlines

Maternity Survey

November 2025

Maternity Survey 2025

Medway NHS Foundation Trust

Headlines

- This report summarises the findings from the Maternity Survey 2025 carried out by Picker.
- The fieldwork was carried out between 22nd April and 15th July 2025.
- A total 55 questions were asked in the 2024 survey, of these 40 can be positively scored, with 19 of these which can be historically compared.

A total of 89 questions were asked in the 2025 survey, of these 61 can be positively scored, with 58 of these which can be historically compared. Your results include every question where your organisation received at least 30 responses (the minimum required).

316	314	34%	38%	35%
Invited to complete the survey	Eligible at the end of survey	Completed the survey (108)	Average response rate for similar organisations	Your previous response rate

		Historical comparison*	Comparison with average*
99%	C17. Treated with respect and dignity (during labour and birth)		
96%	C18. Had confidence and trust in staff (during labour and birth)		
95%	C16. Involved enough in decisions about their care (during labour and birth)		

*Chart shows the number of questions that are better, worse, or show no significant difference

Respondents

NHS Medway Foundation Trust

34%

of patients responded to the survey

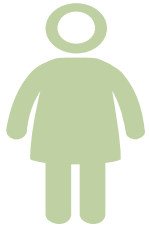
31%

of respondents said they had a long-term condition

9% 16-25 year olds	21% 26-30 year olds
31% 31-35 year olds	38% 36+ year olds

57%

of mothers who have previously given birth



4%	Asian/ Asian British
13%	Black/ African/ Caribbean/ Black British
3%	Mixed/ Multiple ethnic groups
0%	Other ethnic groups
79%	White

Responses

Medway NHS Foundation Trust

Top performing areas

Top 5 scores vs Picker Average	Trust	Picker Avg
D6. Found partner was able to stay with them as long as they wanted (in hospital after birth)	91%	80%
G15. If needed it, received support or advice about feeding their baby during evenings, nights or weekends	84%	73%
B12. Provided with relevant information about feeding their baby	93%	86%
F4. Felt about the length of time waited before seen in person by a midwife during triage	98%	91%
D2. Discharged without delay	70%	62%

Lower performing areas

Bottom 5 scores vs Picker Average	Trust	Picker Avg
B1. Offered a choice of where to have baby	79%	86%
G18. Felt GP talked enough about mental health during postnatal check-up	70%	76%
G17. Felt GP talked enough about physical health during postnatal check-up	65%	71%
C8. Professionals did everything they could to help manage pain during labour and birth	83%	87%
C19. Able to ask questions afterwards about labour and birth	73%	78%

Most improved scores	Trust 2025	Trust 2024
D2. Discharged without delay	70%	55%
D4. Given enough information (in hospital after birth)	95%	82%
D3. Able to get help when needed (after the birth)	95%	85%
G15. If needed it, received support or advice about feeding their baby during evenings, nights or weekends	84%	76%
C14. Felt that the midwives and / or doctors looking after them worked well together during labour and birth	95%	89%

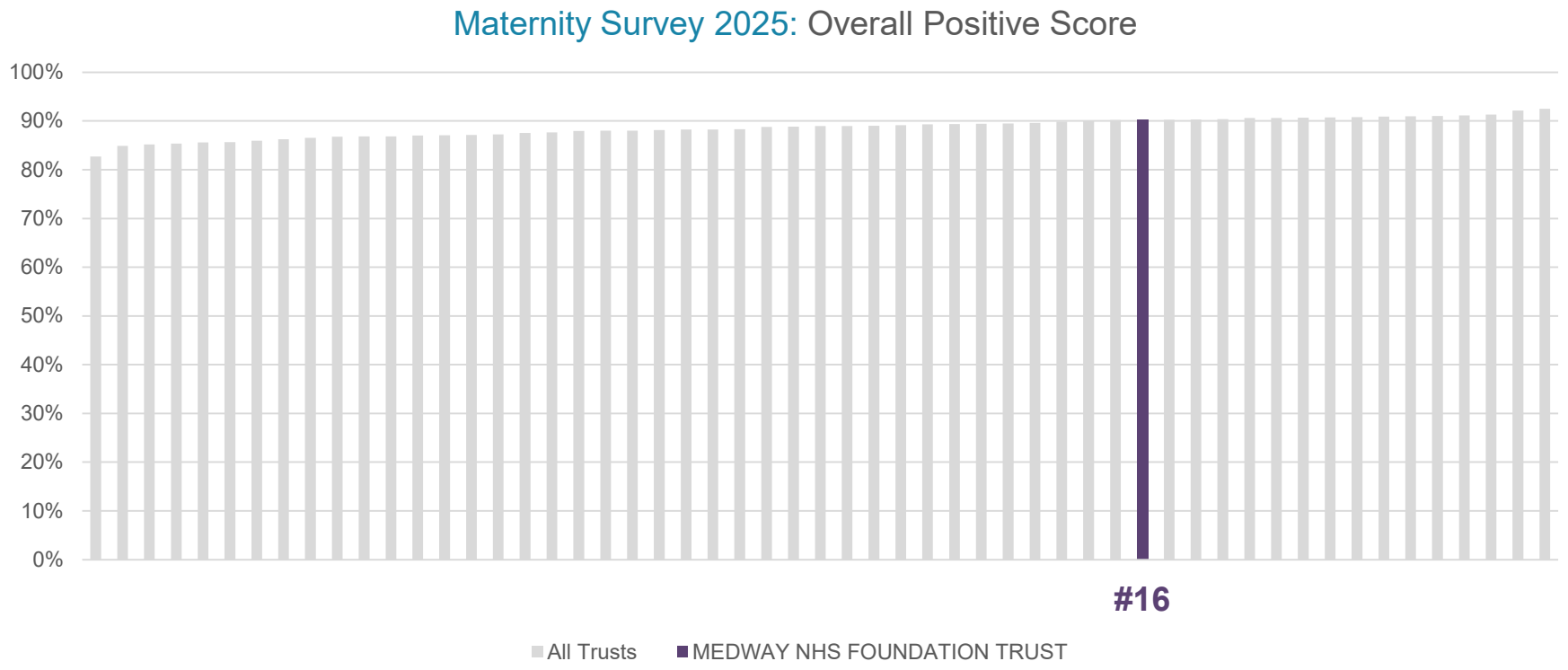
Most declined scores	Trust 2025	Trust 2024
G17. Felt GP talked enough about physical health during postnatal check-up	65%	74%
D6. Found partner was able to stay with them as long as they wanted (in hospital after birth)	91%	99%
G5. Felt midwives aware of medical history (postnatal)	76%	83%
B8. Given enough support for mental health during pregnancy	87%	93%
G4. Saw the midwife as much as they wanted (postnatal)	67%	72%

Key Messages;

- The survey asked 61 questions
- 108 respondents completed the survey which is similar to 2024
- 4 new questions asked this year
- An improvement in score for 35 questions
- Slight decline in score for 15 questions
- No change in score for 6 questions
- Positively we score above the Picker average for 45 questions
- Postnatal care was a focus for 2024 Picker survey action plan. Positively, all questions relating to postnatal care in the 2025 survey (with the exception of one) improved in rating from last year and all questions scored above the national average.

League table: overall positive score

The league table shows your overall positive score's ranking in comparison to the overall positive score of every other organisation that ran the Maternity Survey 2025 with Picker. The overall positive score is the average positive score for all positively scored questions in the survey.



Next Steps

- Full publication of report was end of November 2025 and free text comments received by the service.
- Complete coding of responses and free text to identify key areas for improvement.
- Co-produce action plan along with key stakeholders, including MNVP lead, and PE & EDI Midwife.
- Detailed report and action plan to be presented through MNSCAG, PEG, QAC and trust board in Feb/March 2026

CQC Surveys - Headlines

Maternity Survey

November 2025

Maternity Survey 2025

Medway NHS Foundation Trust

Headlines

- This report summarises the findings from the Maternity Survey 2025 carried out by Picker.
- The fieldwork was carried out between 22nd April and 15th July 2025.
- A total 55 questions were asked in the 2024 survey, of these 40 can be positively scored, with 19 of these which can be historically compared.

A total of 89 questions were asked in the 2025 survey, of these 61 can be positively scored, with 58 of these which can be historically compared. Your results include every question where your organisation received at least 30 responses (the minimum required).

316	314	34%	38%	35%
Invited to complete the survey	Eligible at the end of survey	Completed the survey (108)	Average response rate for similar organisations	Your previous response rate

		Historical comparison*	Comparison with average*
99%	C17. Treated with respect and dignity (during labour and birth)		
96%	C18. Had confidence and trust in staff (during labour and birth)		
95%	C16. Involved enough in decisions about their care (during labour and birth)		

*Chart shows the number of questions that are better, worse, or show no significant difference

Respondents

NHS Medway Foundation Trust

34%

of patients responded to the survey

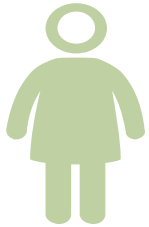
31%

of respondents said they had a long-term condition

9% 16-25 year olds	21% 26-30 year olds
31% 31-35 year olds	38% 36+ year olds

57%

of mothers who have previously given birth



4%	Asian/ Asian British
13%	Black/ African/ Caribbean/ Black British
3%	Mixed/ Multiple ethnic groups
0%	Other ethnic groups
79%	White

Responses

Medway NHS Foundation Trust

Top performing areas

Top 5 scores vs Picker Average	Trust	Picker Avg
D6. Found partner was able to stay with them as long as they wanted (in hospital after birth)	91%	80%
G15. If needed it, received support or advice about feeding their baby during evenings, nights or weekends	84%	73%
B12. Provided with relevant information about feeding their baby	93%	86%
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D2. Discharged without delay	70%	62%

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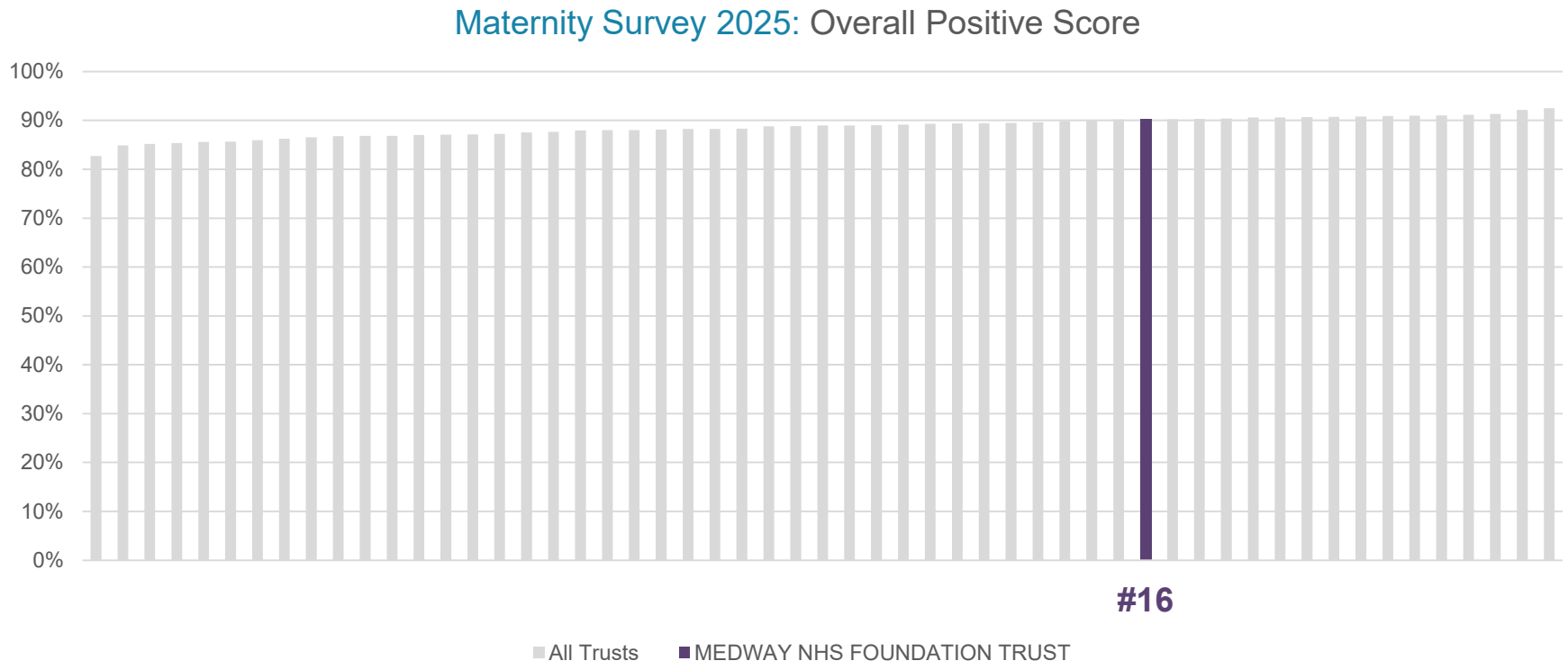

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Meeting of the Trust Board in Public

Date: Wednesday 14th January 2026

Title of Report	Maternity CNST Safety actions Year 7 Final Report			**Agenda Item**	5.2b	
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	Evonne Hunt, Chief Nursing Officer					
Purpose	**Approval**	X	**Briefing**	X	**Noting**	X
Proposal and/or key recommendation:	• Approval – Request Board approval for the CEO to sign the declaration form prior to submission to NHSR.					
Executive Summary	• CNST Year 7 Published 2 April 2025 with reporting period ending 30 November and submission due 3 March 2026. • The report indicates the Maternity and Neonatal Services plan to declare compliance with 9 out of 10 Safety Actions. • Safety Action 1 remains non-compliant due to 3 cases missing the required review start date. No delay was experienced by families as a result of this, nor was there any delay in conducting the Multidisciplinary Review Meeting or publishing the report. • An action plan to address this has been developed and has been approved by Trust Board. Full detail of this mitigation will be included in the declaration form as advised by NHSR. • Full evidence archive for all 10 Safety Actions available on shared drive.					
Issues for the Board/Committee Attention:	**The Report requests the following actions from Trust Board:** • Record compliance with Safety actions 2 to 10. • Note the evidence of all eligible cases for Safety Action 10 shared with Trust Board. • Approve the report and agree for the CEO to sign the declaration form on the Trust's behalf. **Issues:** • Non-compliance with CNST Safety Action 1 • Robust action plan in place to address non-compliance.					

	• Await MBRRACE verification of position post declaration submission.			
Committee/ Meetings at which this paper has been discussed/ approved: Date:	Maternity and Neonatal Safety Champion Assurance Group - 1st December 2025 Trust Leadership team meeting – 9 December 2025			
Board Assurance Framework/Risk Register:				
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. This does not impact the overall Trust CNST premium.			
Equality Impact Assessment and/or patient experience implications				
Freedom of Information status	Disclosable	X	Exempt	

Maternity (and perinatal) Incentive Scheme – Year 7 Final Compliance Report
1 December 2025

NHS Medway NHS Foundation Trust

MNSCAG 1 December 2025
Quality TLT 9 December 2025
Public Trust Board 14 January 2026

Patient FIRST

Executive Summary

Action No.	Maternity safety action	Action met? (Y/N)	Met	Not Met	Info	Check Response	Not filled in
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	No	6	1	0	0	0
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes	2	0	0	0	0
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes	5	0	0	0	0
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes	13	0	1	0	0
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes	6	0	1	0	0
6	Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes	4	0	0	0	0
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes	4	0	0	0	0
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes	20	0	1	0	0
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?	Yes	9	0	0	0	0
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?	Yes	8	0	0	0	0

CNST Year 7 Self-Assessment

True North	Safety Action	Description	May 2025	June 2025	July 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	1 Dec 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 – Non-Compliant
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 No. 1
Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?

From 1 December 2024 to 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all eligible perinatal deaths from 1 December 2024 onwards been notified to MBRRACE-UK within seven working days? (If no deaths, choose N/A)	Yes
2	For at least 95% of all deaths of babies who died in your Trust from 1 December 2024, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Yes
3	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 1 December 2024 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	No
4	Were 75% of all reports completed and published within 6 months of death? MIS verification period: Dec 2024 to April 2025 60% of cases. 2 April 2025 to 30 Nov 2025 75% of cases	Yes
5	For a minimum of 50% of the deaths reviewed, was an external member present at the multi-disciplinary review panel meeting and was this documented within the PMRT? MIS verification period: 2 April 2025 - 30 Nov 2025	Yes
6	Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 1 December 2024 including reviews and consequent action plans.	Yes
7	Were quarterly reports discussed with the Trust Maternity Safety and Board level Safety Champions?	Yes

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, December 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.
- Non-compliant with 3 cases for requirement 3 – reviews not commenced within 2 months.
    - All reporting and surveillance for these cases completed within the required timeframe.
    - Reviews all commenced within 3 weeks of original deadline.
    - However, completed review not fully submitted electronically within the time frame
    - 1 case was delayed due to antenatal factual questions
    - 2 reports published within the required timeframe and one on track to be published within timeframe. No delays for families, or delays in multidisciplinary review and learning.
- Declaring non-compliance and await MBRRACE verification of final position as advised by NHSR.

True North: Quality

Safety Action 1: PMRT – Non-Compliant
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.

	Reporting Compliant	Standard b parents informed	Standard b parents input sought	Standard c - Review Started Compliant	Standard c- Report published Compliant	External Member present
Met	55	40	39	34	25	27
Not Yet Met	0	1	2	1	11	9
Not Met	0	0	0	3	1	0
Not Applicable	5	19	19	19	19	20
Total Eligible Cases	55	41	41	38	37	36
Total Compliant Cases	55	40	39	34	25	27
Compliant Trajectory Numbers	55	41	41	35	36	36
Current Compliance	100%	98%	95%	89%	68%	75%
Compliance Trajectory	100%	100%	100%	92%	97%	100%

Actions and Improvements :

- Improved processes now in place to monitor compliance:
  - Weekly review meetings with perinatal bereavement team ensuring all deadlines are met and any barriers to achieving deadlines are escalated.
  - Spreadsheet now calculates compliance automatically, with correct numerator and denominator for each standard.
- Perinatal reporting SOP being developed with Key Stakeholders.
- Action plan approved by Trust Board in November 2025. To submit to NHSR as part of Board Declaration form.
- Confident in achieving compliance with remaining standards as all deadlines are monitored weekly.

True North: Quality

Safety Action 1: PMRT – Non- Compliant
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 – Compliant

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

Medway NHS Foundation Trust

Safety action No. 2
Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No)
1	Did July 2025's data contain valid birthweight information for at least 80% of babies born in the month? This requires the recorded weight to be accompanied by a valid unit entry. (Relevant data tables include MSD401; MSD405)	Yes
2	Did July 2025's data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	Yes

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 Year 7 – Compliant
Ambition: Preventing avoidable admissions to the Neonatal Unit by supporting mothers and babies on the Transitional Care Pathway.

NHS Medway NHS Foundation Trust

Safety action No. 3
Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Are pathway(s) of care into transitional care in place which includes babies between 34+0 and 35+6 in alignment with the BAPM Transitional Care Framework for Practice?	Yes
2	**Or** Can you evidence progress towards a transitional care pathway from 34+0 in alignment with the BAPM Transitional Care Framework for Practice, and has this been submitted this to your Trust Board and the Neonatal Operational Delivery Network (ODN) on behalf of the LMNS Boards?	N/A
Drawing on insights from themes identified from any term or late preterm admissions to the neonatal unit, undertake or continue at least one quality improvement initiative to decrease admissions and/or length of infant/mother separation.		
For units commencing a new QI project		
3	By 2 September 2025, register the QI project with local Trust quality/service improvement team.	N/A
4	By 30 November 2025, present an update to the LMNS and Safety Champions regarding development and any progress.	N/A
Or **For units continuing a QI project from the previous year**		
5	Demonstrate progress from the previous year within the first 6 months of the MIS reporting period, and present an update to the LMNS and Safety Champions.	Yes
6	By 30 November 2025, present a further update to the LMNS and Safety Champions regarding development and any progress at the end of the MIS reporting period	Yes

Key Messages:

- Pathways of care into transitional care are in place, which includes babies between 34+0 and 35+6 and is aligned with the BAPM Transitional Care Framework for Practice.
- 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.
- Data collection and analysis ongoing to assess full impact of QI project.
- Regular updates of QI project to Maternity and Neonatal Safety Champions and ICB colleagues throughout the reporting period, with final update in November 2025.

True North: People

Safety Action 4: Clinical Workforce – Compliant

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

Safety action No. 4

Can you demonstrate an effective system of clinical workforce planning to the required standard?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Obstetric medical workforce		
1	Has the Trust ensured that the following criteria are met for employing all short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology, demonstrated through audit of any 6-month period from February 2025 and before submission to Trust Board (select N/A if no short-term locum doctors were employed in this period): Locum currently works in their unit on the tier 2 or 3 rota OR They have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progression (ARCP)? OR They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	Yes
2	Has the Trust ensured that the RCOG guidance on engagement of long-term locums has been implemented in full for employing long-term locum doctors in Obstetrics and Gynaecology, demonstrated through audit of any 6-month period from February 2025 to 30 November 2025 (select N/A if no long-term locum doctors were employed in this period)	Yes
3	**For information only:** RCOG compensatory rest (not reportable in MIS year 7) Have you met, or are working towards full implementation of the RCOG guidance on compensatory rest where Consultants and Senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day.	Yes
4	Is the Trust compliant with the Consultant attendance in person to the clinical situations guidance, listed in the RCOG workforce document: 'Roles and Responsibilities of the Consultant providing acute care in obstetrics and gynaecology' into their service. Trusts should demonstrate a minimum of 80% compliance through audit of any 3-month period from February 2025 to 30 November 2025.	Yes
5	Do you have evidence that the Trust position with the above has been shared with Trust Board?	Yes
6	Do you have evidence that the Trust position with the above has been shared with Board level Safety Champions?	Yes
7	Do you have evidence that the Trust position with the above has been shared with the LMNS?	Yes

True North: People

Safety Action 4: Clinical Workforce – Compliant

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

Safety action No. 4

Can you demonstrate an effective system of clinical workforce planning to the required standard?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
b) Anaesthetic medical workforce		
8	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) Representative month rota acceptable for evidence.	Yes
c) Neonatal medical workforce		
9	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing?	Yes
10	Is this formally recorded in Trust Board minutes?	Yes
11	If the requirements are not met, has Trust Board agreed an action plan with updates on progress against any previously developed action plans? This should be monitored via a risk register.	N/A
12	Was the above action plan shared with the LMNS?	N/A
13	Was the above action plan shared with the Neonatal ODN?	N/A
d) Neonatal nursing workforce		
14	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing?	No
15	Is this formally recorded in Trust Board minutes?	Yes
16	If the requirements are not met, has Trust Board agreed an action plan with updates on progress against any previously developed action plans? This should be monitored via a risk register.	Yes
17	Was the above action plan shared with the LMNS?	Yes
18	Was the above action plan shared with the Neonatal ODN?	Yes

True North: People

Safety Action 5: Midwifery Workforce – Compliant

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

Safety action No. 5

Can you demonstrate an effective system of midwifery workforce planning to the required standard?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed in the last three years? (If this process has not been completed within three years due to measures outside the Trust's control, you can declare compliance but evidence of communication with the BirthRate+ organisation (or equivalent) MUST demonstrate this.)	Yes
2	Has a midwifery staffing oversight report that covers staffing/safety issues been submitted to the Board every 6 months (in line with NICE midwifery staffing guidance) on an ongoing basis. This must include at least one report in the MIS period 2 April - 30 November. Every report must include an update on all of the points below: ● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall. ● The midwife to birth ratio ● Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty at the start of every shift. ● Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with the provision of one-to-one care in active labour ● Is a plan is in place for mitigation/escalation to cover any shortfalls in the points above?	Yes
3	**For Information Only:** We recommend that Trusts continue to monitor and include NICE safe midwifery staffing red flags in this report, however this is not currently mandated, This includes: • Redeployment of staff to other services/sites/wards based on acuity. • Delayed or cancelled time critical activity. • Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing). • Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication). • Delay of more than 30 minutes in providing pain relief. • Delay of 30 minutes or more between presentation and triage. • Full clinical examination not carried out when presenting in labour. • Delay of two hours or more between admission for induction and beginning of process. • Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output). • Any occasion when one Midwife is not able to provide continuous one-to-one care and support to a woman during established labour. Other midwifery red flags may be agreed locally.	Yes

True North: People

Safety Action 5: Midwifery Workforce – Compliant

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

Safety action No. 5

Can you demonstrate an effective system of midwifery workforce planning to the required standard?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
4	Can the Trust Board evidence that the midwifery staffing budget reflects establishment as calculated? Evidence should include: ● Midwifery staffing recommendations from Ockenden and of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. ● The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.	Yes
5	Where Trusts are not compliant with a funded establishment based on the above, 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.	N/A
6	Where deficits in staffing levels have been identified must be shared with the local commissioners.	N/A
7	Evidence from an acuity tool (may be locally developed) that the Midwifery Coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.	Yes
8	**For Information Only:** A workforce action plan detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Development of the workforce action plan will NOT enable the trust to declare compliance with this sub-requirement.**	N/A
9	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with the provision of one-to-one care in active labour	Yes
10	A workforce action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Development of the improvement plan will enable the Trust to declare compliance with this sub-requirement. This improvement plan does not need to be submitted to NHS Resolution**	N/A

Saving Babies Lives Care Bundle v. 3.2 – Compliant

Medway NHS Foundation Trust

Safety action No. 6
Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you agreed with the ICB that Saving Babies' Lives Care Bundle, Version 3.2 is fully in place, and can you evidence that the Trust Board have oversight of this assessment?	No
2	Where full implementation is not in place, has the ICB been assured that all best endeavours and sufficient progress has been made towards full implementation, in line with the locally agreed improvement trajectory?	Yes
3	Have you continued the quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 6, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 7 to track compliance with the care bundle? These meetings must include: ● Initial agreement of a local improvement trajectory against these metrics for 25/26, and subsequently reviews of progress against the agreed trajectory. ● Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. ● Evidence of sustained improvement where high levels of reliability have already been achieved. ● Regular review of local themes and trends with regard to potential harms in each of the six elements. ● Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate.	Yes
4	Following these meetings, has the LMNS determined that sufficient progress has been made towards implementing SBLCBv3, in line with the locally agreed improvement trajectory?	Yes
5	If the available Implementation Tool is not being utilised to show evidence of SBL compliance, has a signed declaration from the Executive Medical Director been provided declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB	N/A

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

NHS 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	BRAG Oct 2025	BRAG Nov 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 – Compliant

Key Messages:

- Q1 25/26 assessed by ICB and 94% compliant. Reduction in compliance from last quarter due to changes in SBL in version 3.2.
- Review and Quality Improvement meeting to be held in November. All CNST requirements met within this meeting.
- 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.
- Working with leads to develop audits to review outcomes alongside interventions.
- Use of implementation tool well embedded in Trust and ICB.

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.
- Improvement in Quit rates noted in Q2 25/26.
- Confirmation that Very Brief Advice training compliance will only be monitored for Maternity Staff.
- Improvements noted in Compliance with HbA1c laboratory readings in quarter.
- Sharing at LMNS Learning and Sharing Forums in November and December 2025.

True North: Patients

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

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.

NHS Medway NHS Foundation Trust

Safety action No. 7
Listen to women, parents and families using maternity and neonatal services and coproduce services with users
From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Do you have evidence of an action plan co-produced following joint review of the annual CQC Maternity Survey free text data which CQC have confirmed is available to all trusts free of charge	Yes
2	● Has progress on the co-produced action above been shared with Safety Champions?	Yes
3	● Has progress on the co-produced action above been shared with the LMNS?	Yes
4	**Do you have evidence of MNVP infrastructure being in place from your LMNS/ICB, in full as per national guidance, and including all of the following:** • Job description for MNVP lead • Contracts for service or grant agreements • Budget with allocated funds for IT, comms, engagement, training and administrative support • Local service user volunteer expenses policy including out of pocket expenses and childcare cost	No
5	**If MNVP infrastructure is not in place and evidence of an MNVP, commissioned and functioning in full as per national guidance, is unobtainable (and you have answered N to Q4):** Has this has been escalated via the Perinatal Quality Oversight Model (PQOM) at trust, ICB and regional level? In this event, as long as this escalation has taken place the Trust will not be required to provide any further evidence as detailed below to meet compliance for MIS for this safety action.	Yes
6	**If MNVP infrastructure is in place as per national guidance (and you have answered Y to Q4):** Terms of Reference for Trust safety and governance meetings, showing the MNVP lead as a quorate member of trust governance, quality, and safety meetings at speciality/divisional/directorate level including all of the following: • Safety champion meetings • Maternity business and governance • Neonatal business and governance • PMRT review meeting • Patient safety meeting • Guideline committee	N/A
7	**If MNVP infrastructure is in place as per national guidance (and you have answered Y to Q4):** Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.	N/A

True North: Patients

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

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:

- MNVP well established at MFT and an integral part of maternity and neonatal services, including regular attendance and MNSCAG.
- Not currently resourced inline with national guidance.
- All relevant escalation and updates completed to Trust Board regarding resourcing. No further action required for CNST Year 7.
- ICB currently working to secure additional funding to increase resource in line with CNST requirements for CNST Year 8,

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.
- Continue 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: Compliant

Medway NHS Foundation Trust

Safety action No. 8
Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

From 1 December 2024 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Can you demonstrate the following at the end of 12 consecutive months ending 30 November 2025? Rotational medical staff in posts shorter than 12 months can provide evidence of applicable training from a previous trust within the 12 month period using a training certificate or correspondence from the previous maternity unit.		
	Fetal monitoring and surveillance (in the antenatal and intrapartum period)	
1	90% of Obstetric consultants?	Yes
2	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2025) contributing to the obstetric rota? (without the continuous presence of an additional resident tier obstetric doctor)	Yes
3	For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	N/A
4	90% Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank midwives employed by Trust and maternity theatre midwives who also work outside of theatres)?	Yes

Fetal Monitoring Training and Assessment	Obstetric Consultants	Obstetric Residents	Midwives
Current Compliance	93.33%	100.00%	94.95%
CNST Trajectory	93.33%	100.00%	94.95%

True North: People

Safety Action 8: Compliant

Safety action No. 8

Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

From 1 December 2024 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Can you demonstrate the following at the end of 12 consecutive months ending 30 November 2025? Rotational medical staff in posts shorter than 12 months can provide evidence of applicable training from a previous trust within the 12 month period using a training certificate or correspondence from the previous maternity unit.		
	Maternity emergencies and multiprofessional training	
5	90% of obstetric consultants?	Yes
6	90% of all other obstetric doctors including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows, foundation year doctors and GP trainees contributing to the obstetric rota?	Yes
7	For rotational obstetric staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
8	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres), maternity theatre midwives and bank midwives employed by Trust?	Yes
9	90% of maternity support workers and health care assistants? (to be included in the maternity skill drills as a minimum).	Yes
10	90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors?	Yes
11	90% of all other obstetric anaesthetic doctors (commencing with the organisation prior to 1 July 2025) including any anaesthetists in training, SAS and LED doctors who contribute to the obstetric anaesthetic on-call rota. This requirement is supported by the RCoA and OAA?	Yes
12	For rotational anaesthetic staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
13	Can you demonstrate that at least one multidisciplinary emergency scenario is conducted in any clinical area or at point of care during the whole MIS reporting period? This should not be a simulation suite.	Yes

Medway NHS Foundation Trust

Staff Group	Current Compliance	CNST Compliance Trajectory	New starter Compliance by March 25
Obstetric Consultants	93.33%	93.33%	N/A
Obstetric Residents	100%	100%	100%
Midwives	96.49%	96.49%	N/A
MSWs	93.85%	93.85%	N/A
Anaesthetic Consultants	100%	100.00%	100%
Anaestehtic Residents	100%	100.00%	100%

Actions & Improvements:

- 4 Obstetric new starters who joined the Trust in October 2025 will complete PROMPT Training in January and February 2025
- 4 Anaesthetic doctors who joined the Trust in August 2025 will complete PROMPT training in January 2025.

True North: People
Safety Action 8: Compliant

Medway NHS Foundation Trust

Safety action No. 8
Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

From 1 December 2024 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Can you demonstrate the following at the end of 12 consecutive months ending 30 November 2025? Rotational medical staff in posts shorter than 12 months can provide evidence of applicable training from a previous trust within the 12 month period using a training certificate or correspondence from the previous maternity unit.		
	Neonatal resuscitation training	
14	90% of neonatal Consultants or Paediatric consultants covering neonatal units?	Yes
15	90% of neonatal junior doctors (commencing with the organisation prior to 1 July 2025) who attend any births?	Yes
16	For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	N/A
17	90% of neonatal nurses? (Band 5 and above)	Yes
18	90% of advanced Neonatal Nurse Practitioner (ANNP)?	Yes
19	**For Information Only:** 90% of maternity support workers, health care assistants and nursery nurses? (dependant on their roles within the service - for local policy to determine)	No
20	90% of midwives? (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres), maternity theatre midwives and bank midwives employed by Trust)	Yes
21	In addition to the above neonatal resuscitation training requirements, a minimum of 90% of neonatal and paediatric medical staff who attend neonatal resuscitations unsupervised must have a valid Resuscitation Council (RCUK) Neonatal Life Support (NLS) certification or local assessment equivalent in line with BAPM basic capability guidance? Staff that attend births with supervision at all times will not need to complete this assessment process for the purpose of MIS compliance.	Yes

Staff Group	Current Compliance	CNST Compliance Trajectory
Neonatal Consultants	100%	100%
Neonatal Residents	100%	100%
ANNP	92.44%	96.00%
Neonatal Nursing	93.26%	93.26%
Midwives	94%	94%
MSWs	81%	81%

True North: Quality

Safety Action 9: Perinatal Quality - Compliant
Ambition: Demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

Safety action No. 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?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Are all Trust requirements of the Perinatal Quality Surveillance Model (PQSM) fully embedded with evidence of working towards the Perinatal Quality Oversight Model (PQOM)?	Yes
2	Has a non-executive director (NED) been appointed and is visibly working with the Board safety champion (BSC)?	Yes
3	Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) using a minimum data set as outlined in the PQSM/PQOM at least quarterly, and presented by a member of the perinatal leadership team to provide supporting context?	Yes
4	Does the regular review include a review of thematic learning informed by PSIRF, training compliance, minimum staffing in maternity and neonatal units, and service user voice and staff feedback and review of the culture survey or equivalent?	Yes
5	Do you have evidence of collaboration with the local maternity and neonatal system LMNS/ODN/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM/PQOM?	Yes
6	Ongoing engagement sessions should be being held with staff as per previous years of the scheme. Is progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2025?	Yes
7	Is the Trust's claims scorecard reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period 2 April - 30 November)?	Yes
8	Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period 2 April - 30 November) and that any support required of the Trust Board has been identified and is being implemented? **Where the infrastructure is in place, this should also include the MNVP lead as per SA7.**	Yes
9	Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented?	Yes

True North: Quality

Safety Action 10: MNSI and NHSR EN reporting – Compliant
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.

NHS Medway NHS Foundation Trust

Safety action No. 10
Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?

From 1 December 2024 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you reported of all qualifying cases to MNSI from 1 December 2024 until 30 November 2025?	Yes
2	Have you reported all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 until 30 November 2025?	Yes
3	Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme in a format that is accessible to them?	Yes
4	For any occasions where it has not been possible to provide a format that is accesible for eligible families, has a SMART plan been developed to address this for the future?	N/A
5	Has there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour?	Yes
6	Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution?	Yes
7	Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme. This needs to include reporting where families required a format to make the information accessible to them and should include any occasions where this has not been possible with the SMART plan to address this?	Yes
8	Has Trust Board had sight of evidence of compliance with the statutory duty of candour?	Yes
9	When reporting EN cases, have you completed the field showing whether families have been informed of NHS Resolution's involvement? Completion of this will also be monitored, and externally validated.	Yes

True North: Quality

Safety Action 10: MNSI and NHSR EN reporting – Compliant

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:

- 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:

- Need to develop SOP/Flow chart to ensure clear lines of reporting and accountability with move to new system.

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.

True North: Quality

Safety Action 10: MNSI and NHSR EN reporting – Compliant

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.

NHS Medway NHS Foundation Trust

Ref No	Date of incident	NHS ER Date Sent	MNSI Notified Date	MNSI Number	Family Information leaflet given	DoC	Verbal Duty of Candour	Ethnicity	Peferred Language	Interpreter Required (Y/N)	Accessible Information needs? (Y/N)	Accessible information Provided (Please give detail eg. Translated leaflet, visual information)	If Accessible information required and not provided - why not?
160487	07/12/2024	13/12/2024	13/12/2024	MI-039147	12/12/2024	Y	12/12/2024	Black Nigerian	N/K	N	N	N/A	N/A
161862	16/01/2025	N/A	22/01/2025	MI-039329	22/01/2025	Y	21/01/2025	White British	English	N	N	N/A	N/A
162169	23/01/2025	N/A	24/01/2025	MI-039340	23/01/2025	Y	23/01/2025	White British	English	N	N	N/A	N/A
165385	07/04/2025	N/A	09/01/2025	MI-041227	09/06/025	Y	08/04/2025	White British	English	N	N	N/A	N/A
/	11/07/2025	N/A	14/07/2025	MI-044224	N/A	N/A	N/A	White British	English	N	N	N/A	N/A
171327	16/08/2025	N/A	01/09/2025	Rejected	01/09/2025	N/A	N/A	White British	English	N	N	N/A	N/A
172603	15/09/2025	07/10/2025	26/09/2025	Rejected	26/09/2025	Y	26/09/2025	White British	English	N	N	N/A	N/A
173557 173586	06/10/2025	08/10/2025	06/10/2025	MI-047422	06/10/2025	Y	06/10/2025	White British	English	N	N	N/A	N/A
174133	17/10/2025	N/A	22/10/2025	MI-047984	21/10/2025	Y	17/10/2025	Black African	English	N	N	N/A	N/A

Actions and Next Steps

NHS Medway NHS Foundation Trust

- Request Trust Board approval and CEO sign-off of Declaration Form
- Request ICB approval and CEO sign-off of Declaration Form.
- Submit to NHSR by March deadline with full details of Safety Action 1 Mitigations and Actions.

Meeting of the Trust Board in Public

Date: Wednesday 14th January 2026

Title of Report	Midwifery Bi-Annual Workforce Report			**Agenda Item**	5.2c
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	Evonne Hunt, Chief Nursing Officer				
Purpose	**Approval**	X	**Briefing**	X	**Noting** X
Proposal and/or key recommendation:	• Approval – The Board's approval of the Workforce Action plan. • Noting- The Board to note that the current midwifery staffing budget is in line with the 2023 Birth Rate Plus assessment. • Request Trust Board support for formal Birthrate Plus establishment review in 2026. To be included in Divisional business planning with a PID to be completed and presented through Trust financial governance process.				
Executive Summary	• CNST Year 7 continues the requirement for a bi-annual midwifery workforce paper to be presented to Trust Board. • The aim of this report is to provide assurance to the Trust Board that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels • This maternity staffing report will highlight frequency of maternity safer staffing red flags and the reasons for the red flags • The report also provides an accurate account of the current workforce status and includes an update from recommendations within the paper presented to Trust Board in July 2025. • Gaps within the clinical midwifery workforce are highlighted with mitigation in place to manage this. • Monthly monitoring of workforce embedded into practice • New starter/preceptorship package is now in place with dedicated member of the education to support. • Current vacancy of 0.72 Band 5/6 Midwives. Skill mix now added to risk register and monitored via Trust Governance processes. • Unable to accurately complete Tabletop birth rate plus exercise due to changes to MSW banding, increased acuity and staffing skill mix. This requires a formal 3 yearly full Birth rate plus review which is due in 2026 at cost of >£11,000. To be included in Business planning alongside considering external funding				

	opportunities across the ICB. Risk of non-compliance with CNST year 8 if funding not approved to complete this. • Canterbury Christchurch received reaccreditation in reporting period, first cohort of students anticipated for placement in coming months. Increased numbers of staff being supported to complete RN to RM conversion course and Midwifery Apprenticeship • Future Workforce Pipeline impact of apprenticeships, RN-to-RM conversions, and MDA student cohorts expected to have a +ve impact on workforce stability over the next 12–24 months. • Stress and anxiety absence reviewed by senior team and improvement strategies implemented, including standardised reporting, collaboration with occupational health and return to work process. • Work ongoing to gather information from internationally educated and midwives from BAME backgrounds to identify actions and next steps. • Formal feedback from NHSE Insight visit recently received in Trust. Action plan to be developed and enhanced support meetings to be commenced in Jan 2026. • The Delivery Suite acuity tool data shows that unit was adequately staffed 70% of the time which is consistent with the previous reporting period. Need formal birth rate plus assessment to fully understand mitigations required to achieve 85% staffed to acuity. • 100% compliance with 1:1 care in labour and supernumerary status of Labour Ward Coordinator as per CNST requirements. • Achieved >90% compliance with PROMPT and CTG training and positive overall training position. • Workforce Action plan for 2025/26 in place, aligned with key areas of focus from National Investigation into Maternity and Neonatal Services. • Report will be included within the Trust wide annual Safer staffing paper
Issues for the Board/Committee Attention:	**Issues:** • Formal Birthrate Plus Review required in 2026, quotation received >£11,000. PID to be completed in business planning and funding opportunities from the ICB being explored.
Committee/ Meetings at which this paper has been discussed/ approved: Date:	Maternity and Neonatal Safety Champion Assurance Group, 1st December 2025 Trust Leadership Team 9 December 2025
Board Assurance Framework/Risk Register:	

Financial Implications:	Birthrate Plus assessment quoted at >£11,000 for 2026.			
Equality Impact Assessment and/or patient experience implications				
Freedom of Information status	Disclosable	X	Exempt	

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Maternity Bi-Annual Workforce Report

MNSCAG December 2025

ICB December 2025

Trust Board January 2026

Patient FIRST

Executive Summary

- CNST Year 7 continues the requirement for a bi-annual midwifery workforce paper to be presented to Trust Board.
    - The aim of this report is to provide assurance to the Trust Board that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels
    - This maternity staffing report will highlight frequency of maternity safer staffing red flags and the reasons for the red flags
    - The report also provides an accurate account of the current workforce status and includes an update from recommendations within the paper presented to Trust Board in July 2025.
    - Gaps within the clinical midwifery workforce are highlighted with mitigation in place to manage this.
- Monthly monitoring of workforce embedded into practice
- New starter/preceptorship package is now in place with dedicated member of the education to support.
- Current vacancy of 0.72 Band 5/6 Midwives. Skill mix now added to risk register and monitored via Trust Governance processes.
- Unable to accurately complete Tabletop birth rate plus exercise due to changes to MSW banding, increased acuity and staffing skill mix. Full Birth rate plus due in 2026 at cost of >£11,000. To be included in Business planning alongside considering external funding opportunities across the ICB. Risk non-compliance with CNST if unable to complete.
- Canterbury Christchurch received reaccreditation in reporting period, first cohort of students anticipated for placement in coming months. Increased numbers of staff being supported to complete RN to RM conversion course and Midwifery Apprenticeship
- Future Workforce Pipeline impact of apprenticeships, RN-to-RM conversions, and MDA student cohorts expected to have a +ve impact on workforce stability over the next 12–24 months.
- Stress and anxiety absence reviewed by senior team and improvement strategies implemented, including standardised reporting, collaboration with occupational health and return to work process.
- Work ongoing to gather information from internationally educated and midwives from BAME backgrounds to identify actions and next steps.
- Formal feedback from NHSE Insight visit not received in Trust. Action plan to be developed once received in Trust, with particular focus on staff feedback sessions.
- The Delivery Suite acuity tool data shows that unit was adequately staffed 70% of the time which is consistent with the previous reporting period. Need formal birth rate plus assessment to fully understand mitigations required to achieve 85% staffed to acuity.
- 100% compliance with 1:1 care in labour and supernumerary status of Labour Ward Coordinator as per CNST requirements.
- Achieved >90% compliance with PROMPT and CTG training and positive overall training position.
- Workforce Action plan for 2025/26 in place, aligned with key areas of focus from National Investigation into Maternity and Neonatal Services.

True North: People
Planned vs Actual Midwifery Staffing levels

Medway NHS Foundation Trust

Ambition: Achieving safe and appropriate midwifery staffing through implementation of Birth Rate Plus

Goal: Outline the findings from the internal Birth-rate Plus review

Key Messages:

- 0.72 Band 5/6 Vacancy in October 2025
- Significant recruitment in past 12 months with reduction in vacancy from 18.28 WTE band 5/6 vacancy in September 2024 to 0.72 WTE in October 2025.
- Positive retention figures across all bands.
- Overall positive trend in births to worked ratio – achieving 1:26 in August.
- Births have decreased slightly since the last Birth rate + assessment, which was based on 4617 births. MFT had 4415 births in 2024/25 and a predicted 4456 for 2025/26. However, despite this decrease, acuity and complexity has increased with both IOL and CS rates increasing in the period.

Issues, Concerns & Gaps:

- Full Birth-rate plus assessment due in 2026 (as per CNST requirements) across ICB. Quotation received from Birth Rate plus for >£11, 000.
- Due to financial position of Trust and ICB limited scope for funding. Risk of non-compliance with CNST requirements and accurate understanding of safe staffing position if unbale to undertake formal 3 year assessment.
- Unable to complete tabletop Birth rate Plus exercise due to significant changes to acuity (including increased CS rates and IOL rates since last assessment) and changes to MSW roles from band 2 to band . Need full exercise to accurately assess staffing levels.
- Significant recruitment has resulted in uneven skill mix across service.
- Trust-wide recruitment freeze from November 2025, including clinical posts.

Actions & Improvements:

- Include Birth-rate plus assessment in business planning for 26/27. If Trust funding not successful escalate through ICB.
- Continue with enhanced preceptorship programme and targeted training and support for staff as required.
- Skill mix added to the risk register and monitored through governance meetings.
- Continue to review staffing daily and support escalation and mitigation of clinical staffing concerns.

True North: People
Planned vs Actual Midwifery Staffing levels

Ambition: Achieving safe and appropriate midwifery staffing through implementation of Birth Rate Plus
Goal: Outline the findings from the internal Birth-rate Plus review

Medway NHS Foundation Trust

BIRTHRATE PLUS

	Funded	In post	Gap
Clinical B7	22.00	23.40	-1.40
Clinical B5/6	154.17	149.68	4.49
B5 Nurses	5.47	5.68	-0.21
Band 7 Specialists	14.86	13.90	0.96
Band 6 Specialists	5.92	6.03	-0.11
	202.42	**198.69**	**3.73**
Band 8 & above	7	7	0
Total funded Registrants	**209.42**	**205.69**	**3.73**
Band 3 Contribution	19.85	19.85	0
Total funded	**229.27**	**225.54**	**3.73**

Measure	Goal	May	Jun	July	Aug	Sep	Oct
Midwife to Women Ratio - Funded	1:25	01:25	01:25	01:25	01.25	01.25	01:25
Actual Worked ratio		01:30	01:30	01:28	01.26	01:29	01:28

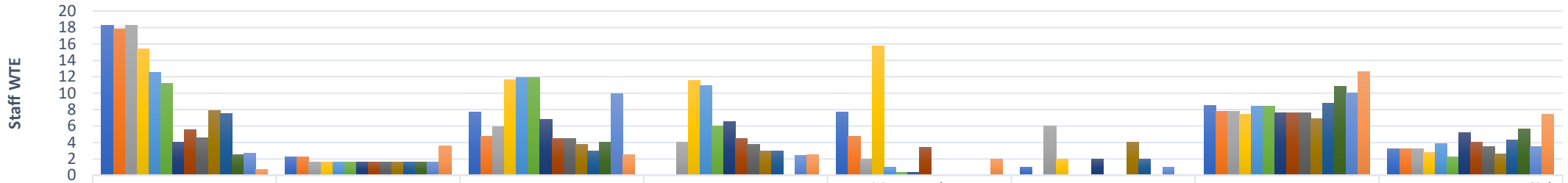
True North: People
Workforce Data Nov 24-Oct 25

Medway NHS Foundation Trust

Ambition: to ensure that we recruit and retain the required workforce to deliver safe, high-quality care to our service users.

Goal: to ensure that MFT is a great place to work by prioritising staff support and wellbeing.

Midwifery Staffing Nov 24 - Oct 25



	True vacancy	Secondments	Recruited	Start dates agreed	Awaiting employment checks	Leavers	Maternity Leave	Average Long Term Sick across month
Sep-24	18.28	2.24	7.72	0	7.72	1	8.56	3.23
Oct-24	17.81	2.24	4.72	0	4.72	0	7.76	3.23
Nov-24	18.24	1.64	5.92	4	1.92	6	7.76	3.23
Dec-24	15.37	1.64	11.68	11.57	15.8	2	7.4	2.78
Jan-25	12.51	1.64	11.88	10.92	0.96	0	8.44	3.87
Feb-25	11.15	1.64	11.88	6	0.32	0	8.44	2.26
Mar-25	4.03	1.64	6.84	6.52	0.32	2	7.64	5.16
Apr-25	5.56	1.64	4.52	4.52	3.36	0	7.6	3.99
May-25	4.54	1.64	4.52	3.76		0	7.6	3.48
Jun-25	7.88	1.64	3.76	3		4	6.85	2.62
Jul-25	7.52	1.64	3	3		2	8.76	4.31
Aug-25	2.51	1.64	4			0	10.8	5.62
Sep-25	2.65	1.64	9.96	2.39		1	10.04	3.5
Oct-25	0.72	3.56	2.48	2.48	2	0	12.6	7.47

True North: People

Ambition: to ensure that we recruit and retain the required workforce to deliver safe, high-quality care to our service users.

Goal: to ensure that MFT is a great place to work by prioritising staff support and wellbeing.

NHS Medway NHS Foundation Trust

Key Messages:

- Between March and August 2025, 4.8 WTE midwives left within the 2-5 year tenure band, representing the majority of departures in the period while retention beyond 10 years remains strong, early attrition poses a risk to workforce stability and service resilience. This trend reflects national concerns, with NHSE reporting that up to 50% of midwives leave the profession within five years of qualifying.

Issues, Concerns & Gaps:

- Staff leaving between 2-5 years of tenure limits ability to build an experienced workforce.
- High percentage of leavers leave for work/life balance. Challenge to continue to accommodate all flexible working requests and meet the needs of the service.

Actions & Improvements:

- Work with Matrons, Education Team and ICB to identify training and development opportunities for midwives to support career progression and prolong length of service.
- Ensure management team are available for regular 1:1s and have supportive discussions with staff regarding flexible working and career development.
- Continue to promote RN-to-RM conversion and apprenticeship pathways.
- Enhanced Preceptorship & Mentorship
- Continue structured preceptorship programme with dedicated education support.
- Maintain regular engagement sessions and feedback forums.
- Strengthen mental health support and signposting.
- Review flexible working requests systematically.
- Continue to explore innovative rostering solutions to accommodate part-time patterns.
- Celebrate service milestones (e.g., 2-year and 5-year).

True North: People
Workforce Data Nov 24-Oct 25

NHS Medway NHS Foundation Trust

Ambition: to ensure that we recruit and retain the required workforce to deliver safe, high-quality care to our service users.

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Midwifery Leaving Data March 2025-Aug 2025 (Data Source NHSESE Maternity Dashboard)								
AGE GROUP								
KM LMNS Average	34.1	47.5	18.5	100				
MFT %	31.3	68.7	0	100.1				
MFT WTE	2.0	4.3	0	20.07				
	<35	**35-54**	**55+**					
TENURE								
KM LMNS Average	12.3	6.3	48.2	11.9	12.1	9.2	100	
MFT %	12.8	0.0	77.0	O	10.2	0	100	
MFT WTE	0.8	0	4.8	0	0.6	0	6.2	
	< 1 Year	**1-2 Years**	**2-5 Years**	**6-10 Years**	**10-20 Years**	**>20 Years**		
REASON 1								
KM LMNS Average	**28.9**	**32.2**	**21.0**	**14.4**	**3.6**	**0**	100.1	
MFT %	**25.5**	**31.9**	**42.6**	**0**	**0**	**0**	100	
MFT WTE	1.6	2	2.7	0	0	0	6.3	
	Resign Destination Unknown	**Resign Move IN NHS/HC**	**Resign - Move out NHS**	**Retire**	**EoC/Redundancy/Dismissal**	**Unknown**		

True North: People

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NHS Medway NHS Foundation Trust

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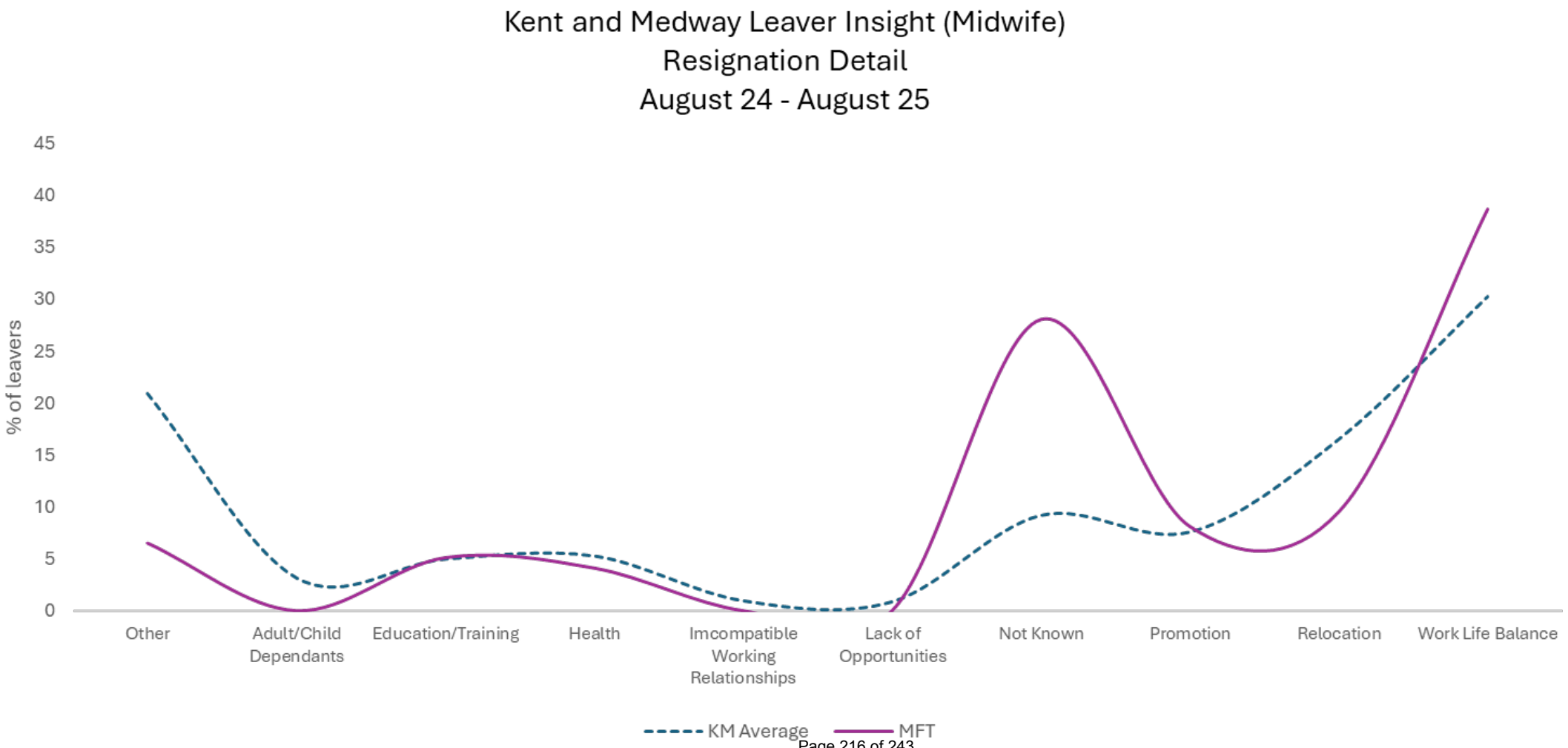
Medway NHS Foundation Trust



True North: People
Workforce Data Nov 24-Oct 25

Medway NHS Foundation Trust

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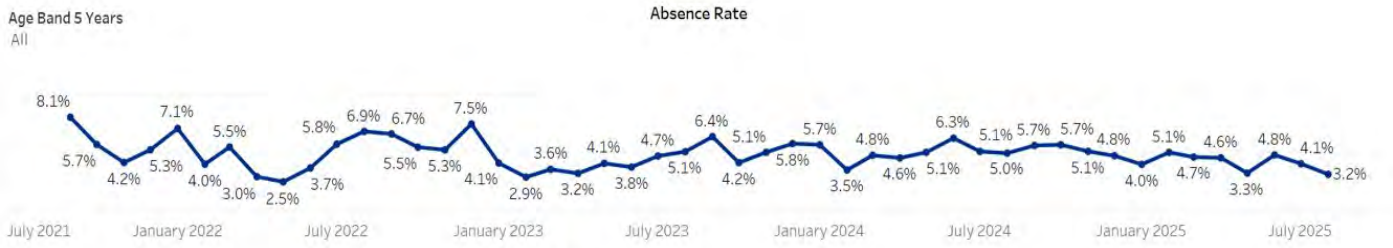


Key Messages:

- 48% of sickness and absence reasons for Anxiety/stress/depression/other psychiatric illness (S10).
- Deep dive completed on S10 absences from October 24-Jun 25 identified 72% of these absences were not work related.
- 14% of the non-work related absences were related to bereavement.
- The majority of the work-related absences were attributed to one member of staff, with a further 2 being attributed to staff who had resigned and were in their notice period.

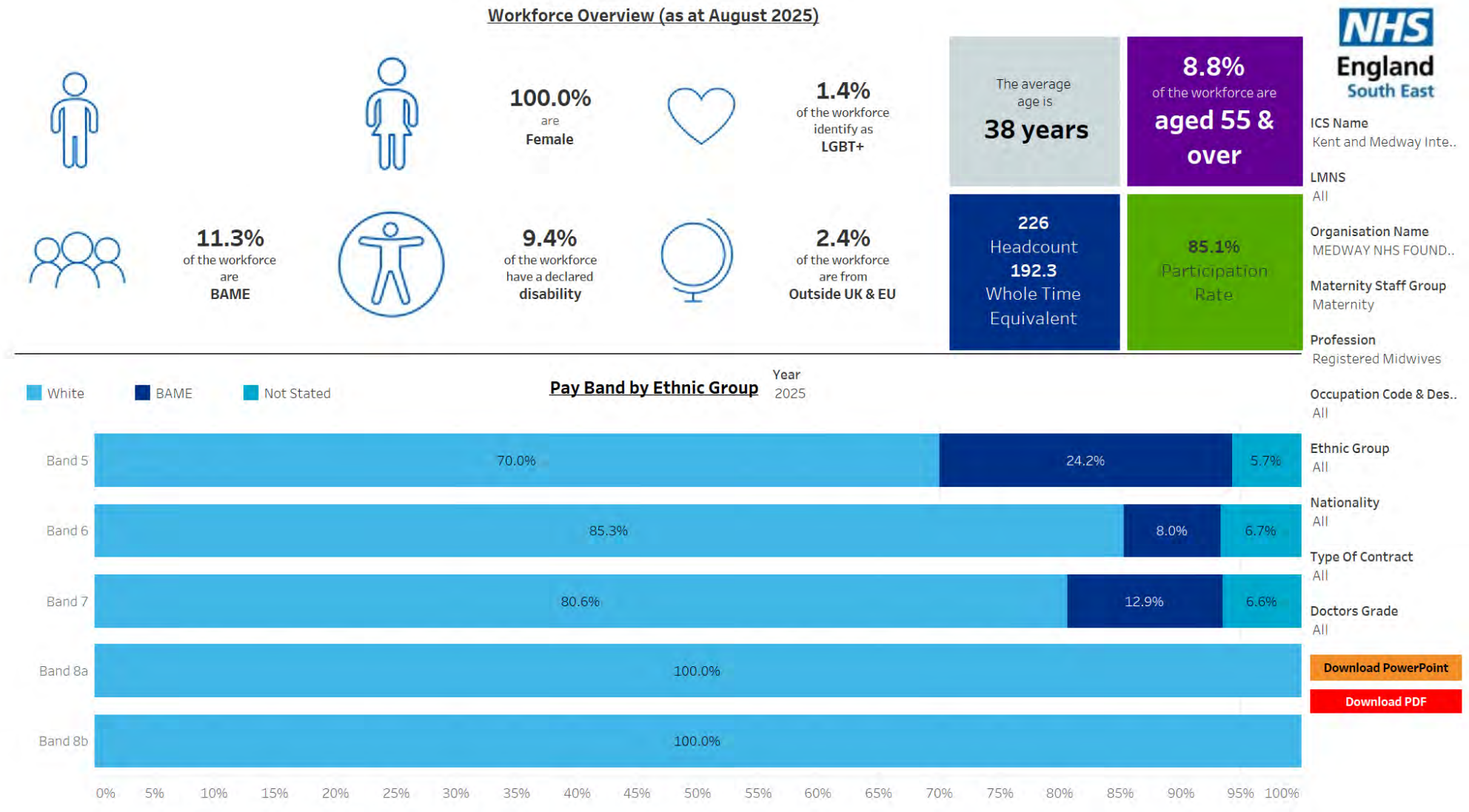
Issues, Concerns & Gaps:

- Documentation and process gaps were identified, particularly around long-term sickness management and return-to-work procedures.

Actions & Improvements:

- Strengthen bereavement support and ensure appropriate sign-posting to Trust counselling and peer support services.
- Managers to be proactive in managing long-term sickness and engage HR and Occupational health early for tailored support.
- Reiterate to all managers the importance of accurate documentation relating to sickness absence and offer training on Return to work procedures.
- Managers to monitor exit-related sickness trends during notice periods and ensure exit interviews capture wellbeing concerns.

True North: People



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True North: People – Diversity

Key Messages:

- Our midwifery workforce has demonstrated a positive trend in diversity, with BAME representation now at 11.3%, almost doubling over the past four years. While this progress is encouraging, further work is required to ensure equitable progression and representation across all roles, particularly within community teams
    - Year on year increase in BAME currently at 11.3% midwifery staff.
    - 12% of band 7 roles are BAME
    - 24% of band 5 midwives are BAME

Issues, Concerns & Gaps:

- Despite sustained increase in BAME midwifery staff, almost doubling in the past 4 years, further work needs to be done to support and develop BAME colleagues within the midwifery workforce.

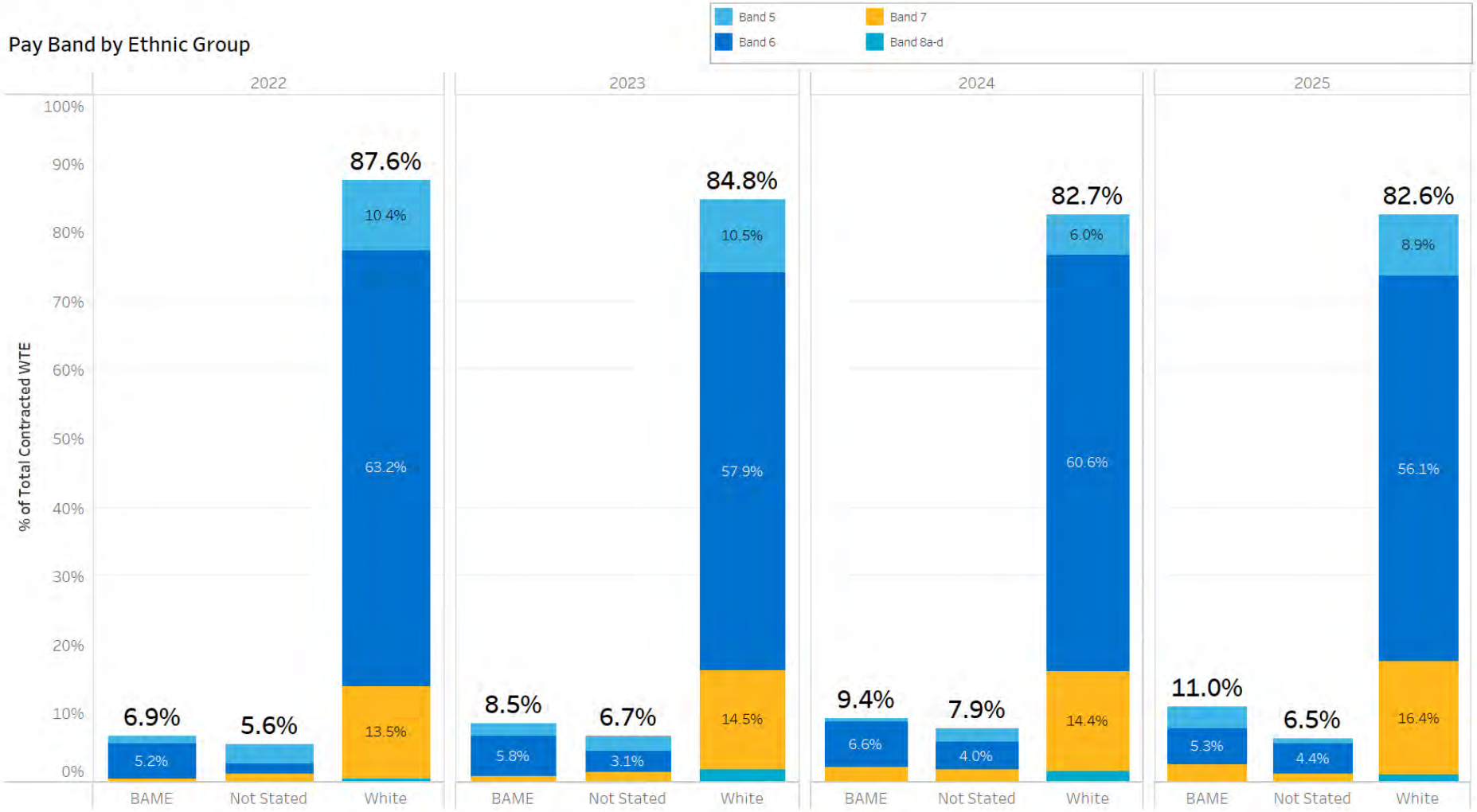
Actions & Improvements:

- Targeted Development: Identify and support BAME and internationally educated midwives to access leadership and specialist training opportunities, in line with NHSE's anti-discrimination programme (as outlined in the NHSE letter dated 16 October 2025).
- Inclusive Leadership- All senior leaders will undertake culture coach training to foster an inclusive environment and address inequalities.
- Collaborative Approach: Continue engagement with Trust-wide and ICB equality workstreams to ensure recruitment and retention strategies reflect the population we serve.
- Monitoring & Accountability- Embed EDI metrics into workforce reviews and audits, ensuring transparency and alignment with CNST Year 7 and national maternity safety recommendations
- Ensure all initiatives support the NHS Long-Term Workforce Plan and national ambitions to create a workforce that is representative, inclusive and responsive to the needs of our diverse community

True North: People

Maternity Service Workforce Profile as at: March 2025, April 2025, May 2025 and 3 more
System: Kent and Medway Integrated Care System **Organisation:** MEDWAY NHS FOUNDATION TRUST
Staff Group: Maternity **Occupation:** All

Medway
NHS Foundation Trust



Recruitment and Retention

Ambition: to ensure that we recruit and retain the required workforce to deliver safe, high-quality care to our service users.

Goal: to ensure that MFT is a great place to work by prioritising staff support and wellbeing.

NHS Medway NHS Foundation Trust

Key Messages:

- Positive retention noted, with minimal leavers over past 6 months.
- Future Workforce Pipeline impact of apprenticeships, RN-to-RM conversions, and MDA student cohorts expected to have a +ve impact on workforce stability over the next 12–24 months.
- The service is currently working with the HEE Midwifery Apprentice Programme and have 2 recently qualified and 7 ongoing apprentices.
- 5 RN on the RN to midwifery shortened course programme (18mth), including 2 Internationally Education Midwives. .
- Bank shift renumeration incentive has been reduced, with no apparent impact on fill rate.
- Underpinning for Midwifery Continuity of Carer commenced with recruitment of COC MSW.
- Ongoing work to gather information and feedback from Internationally educated and BAME midwives in order to develop an action plan to improve their experience across the unit.
- Actively engaged in Trust-wide work on incivility, with all datix incidents reported reviewed by senior team and addressed.
- Working with Trust to support ongoing culture work.
- CCCU achieved reaccreditation in reporting period. First cohort of students to commence placement in coming months.

Issues, Concerns & Gaps:

- Anxiety/stress/depression/other psychiatric illness highest reason for absence (S10)
- 100% of the Midwifery workforce are female and over 80% of child-bearing age so maternity leave will, at times, be disproportionately higher than other workforce groups
- Concerns raised regarding University of Greenwich student recruitment, onboarding and placement support.
- Formal Feedback from NHSE not received.
- Trust-wide recruitment freeze from November 2025.

Actions and Improvement.

- Targeted actions identified to address S10 sickness/absence.
- Offering fixed term contracts to mitigate significant maternity leave.
- Ongoing work with HEE providers to support selection and onboarding of students.
- Continue to support staff to access training and development opportunities.
- Access CPD funding to support staff through training.
- Management essential and appraisal training for all managers to strengthen leadership skills and support staff wellbeing.
- Re-launch of staff engagement/feedback sessions.
- Monitor impact of recruitment freeze to ensure this does not affect continuity of care and skill mix.

True North: People
Birthrate Plus 4- hourly acuity tool

Medway NHS Foundation Trust

Ambition: To ensure adequate staffing resource to adequately meet need of women
Goal: To deliver safer maternity care as required by the CNST maternity incentive scheme

Key Messages:

- The pie chart shows Acuity RAG status for November 2024 to April 2025 and May 2025 to October 2025
- The Intrapartum tool currently uses Red, Amber, and Green as determinants of acuity.
- A target of 85% for Green, when there is an adequate number of midwives available to provide the clinical care required by the women depending upon their needs, is considered to be appropriate
- The Delivery Suite acuity tool data shows that unit was adequately staffed 70% of the time which is consistent from the previous reporting period.

Issues, Concerns & Gaps:

- Staff are moved from other areas to mitigate against the risk of staffing shortfalls however this may create red flags in these areas.
- Did not achieve 85% meets acuity targets set for this quarter.
- Data entry into regional SHREWD system is not meeting the expected levels.

Actions & Improvements:

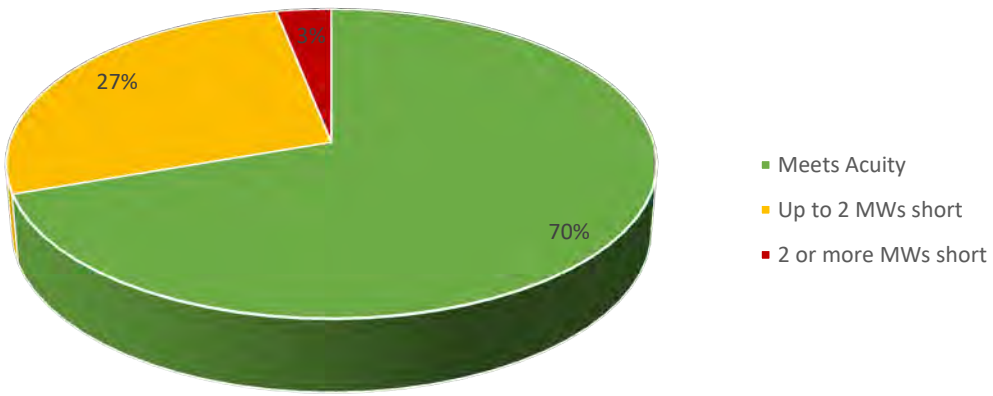
- A clear and robust escalation policy is in place and twice daily oversight of the maternity unit's acuity verses staffing being monitored. Early interventions can be taken to maintain safety and activate deployment of staff to ensure care needs are maintained and safety remains the priority for the service
- Increasing acuity and complexity of patients contributing to not achieving staffing target. Await formal Birth-rate plus assessment to identify whether additional establishment is needed to meet current patient acuity.

True North: People
Birthrate Plus 4- hourly acuity tool

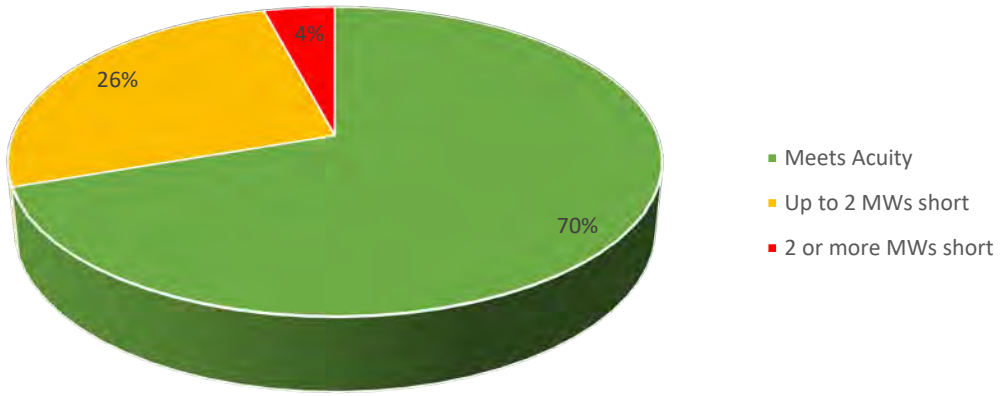
Medway NHS Foundation Trust

Ambition: To ensure adequate staffing resource to adequately meet need of women
Goal: To deliver safer maternity care as required by the CNST maternity incentive scheme

Delviery Suite Acuity/Staffing - Nov 24-April 25



Delivery Suite Acuity/Staffing - May 25-Oct 25



True North: People
Birthrate Plus 4- hourly acuity tool

Medway NHS Foundation Trust

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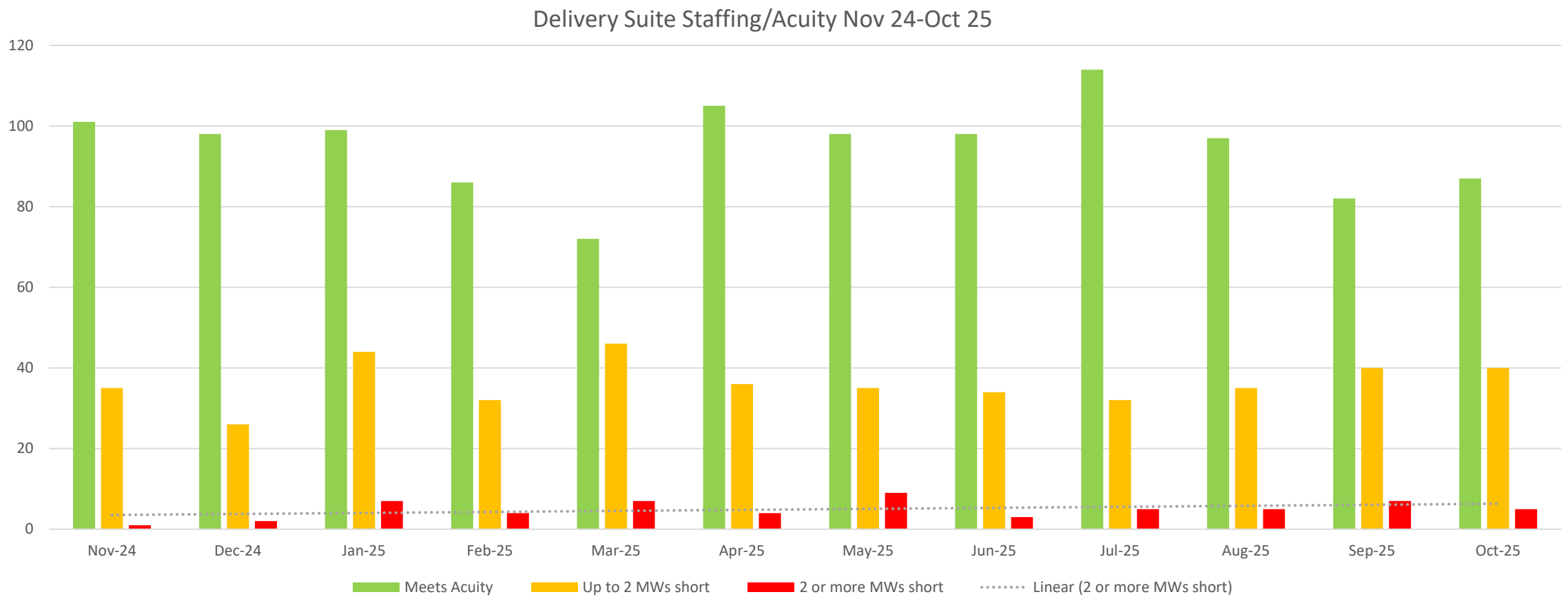


True North: People
Birthrate Plus 4- hourly acuity tool – Red Flags

Medway NHS Foundation Trust

Ambition: To ensure adequate staffing resource to adequately meet need of women
Goal: To deliver safer maternity care as required by the CNST maternity incentive scheme

Key Messages:

- Red flags are recorded every 4 hours by the delivery suite coordinator on the birth-rate plus acuity tool. The same red flag may be recorded multiple times per shift (eg. Delay in induction of labour).
- The red flags for delay in commencing IOL have has reduced in this reporting period (May to October 2025) to 67%of red flgas, reduced from 74/73% in previous two reporting periods.
- 25% of red flags relate to delay or cancelled time critical actives, which is a slight increase from 22% within the previous reporting period.
- 12% of the clinical actions in response to red flags were declining in-utero transfers, which is a slight increase from the previous 6 months (10%) and is a necessary action to ensure safety of patients already admitted into our maternity service.
- 2 red flag raised for inability to provide 1:1 care in labour, however, however, this was immediately mitigated by staffing factors and both mothers had continuous 1:1 care in established labour. This is also confirmed via the data validation completed by the digital midwives.

Issues, Concerns & Gaps:

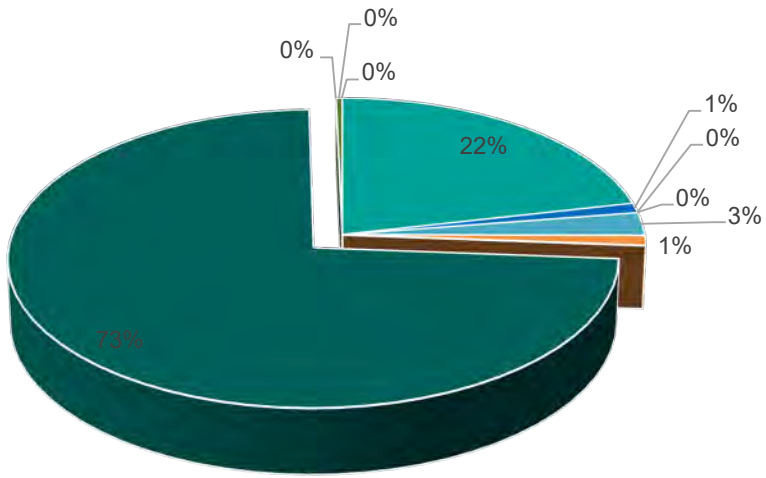
- IOL delays continue to raise red flags, but this data does not quantify the number of women affected or the length of delay. 81% of clinical actions taken to mitigate red flags were for delay of commencing IOL in line with Trust Guidance.
- Slight upward trend of redeploying staff from other areas noted across the pervious 12 month period.

Actions & Improvements:

- Ongoing QI work progressing regarding the IOL pathway, with a new induction agent has been commenced. Audit is now ongoing to evaluate whether it has reduced the length-of-stay for mothers on the antenatal ward and improve flow through the IOL pathway.
- Staffing factors contributing to red flags/acuity have also significantly improved over the previous 12 months, of particular note, inability to fill vacant shifts has reduced from across the 12 month period.
- Redeploying staff may be necessary to maintain skill mix and in response to acuity. Positive staffing position means that redeploying

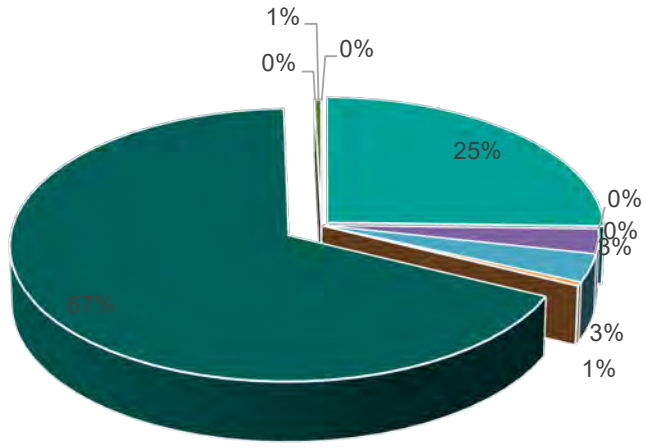
True North: People
Birthrate Plus 4- hourly acuity tool – Red Flags

Maternity Red Flags - Dec 24-April 2025



- Delayed or cancelled time critical activity
- Missed or delayed care (for example delay of 60 minutes or more in washing and suturing
- Missed medication during admission to hospital or MLU
- Delay in providing pain relief
- Delay between presentation and triage
- full clinical examinaination not carried out when preseting in labour
- Delay between admission for induction and beginning of process
- delayed recognition of and action on abnormal vital signs.
- Any occasion where 1 midwife is not able to provide continuous 1:1 care during established labour
- Coordinator unable to maintain supernumerary status

Maternity Red Flags May 25-Oct 25



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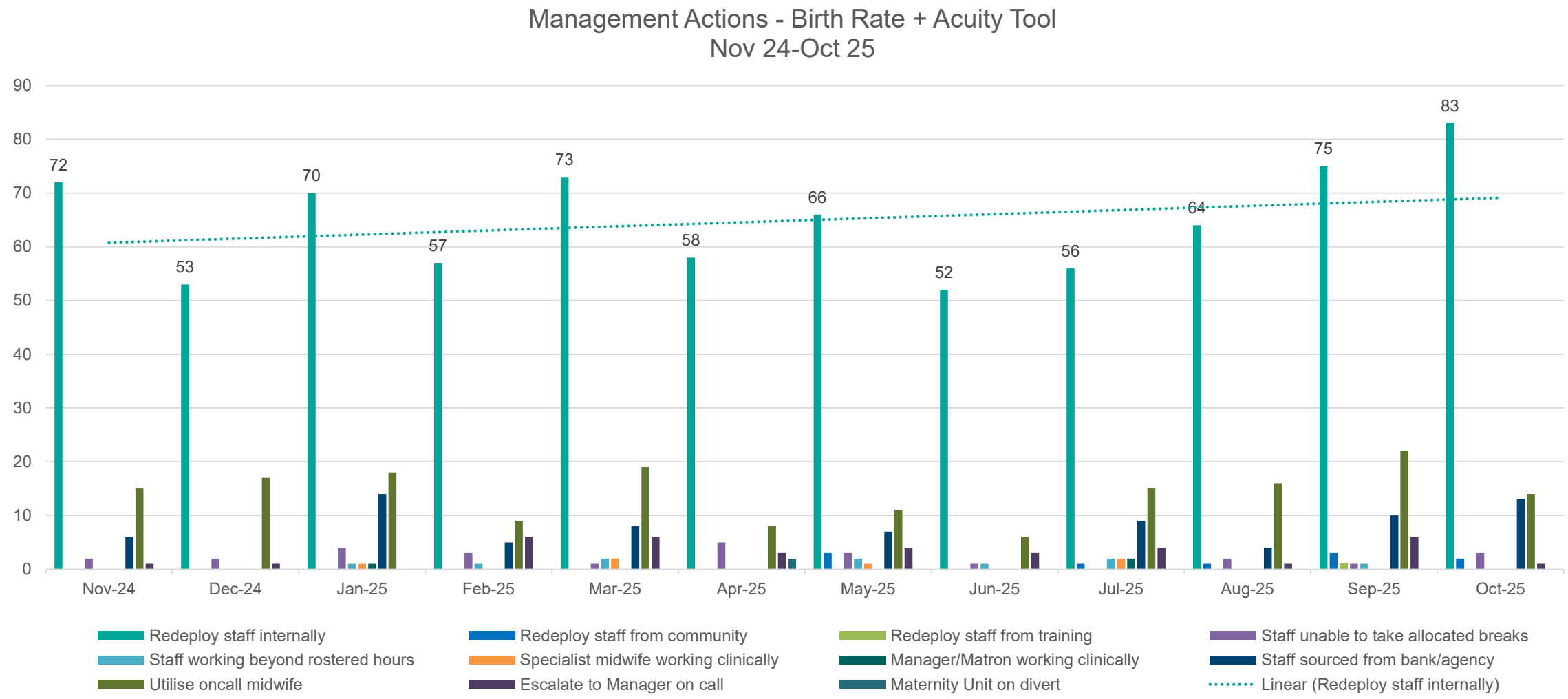
True North: People
Birthrate Plus 4- hourly acuity tool – Red Flags

Medway NHS Foundation Trust



True North: People
Birthrate Plus 4- hourly acuity tool – Red Flags

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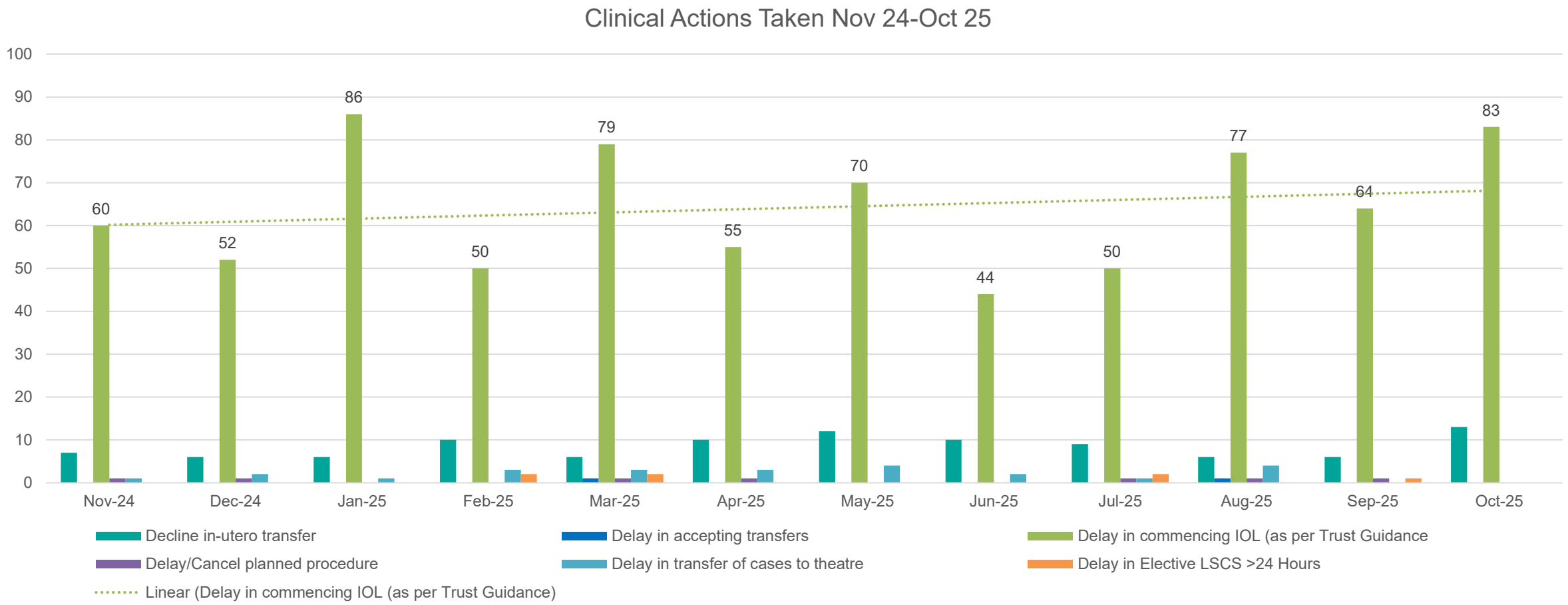

True North: People
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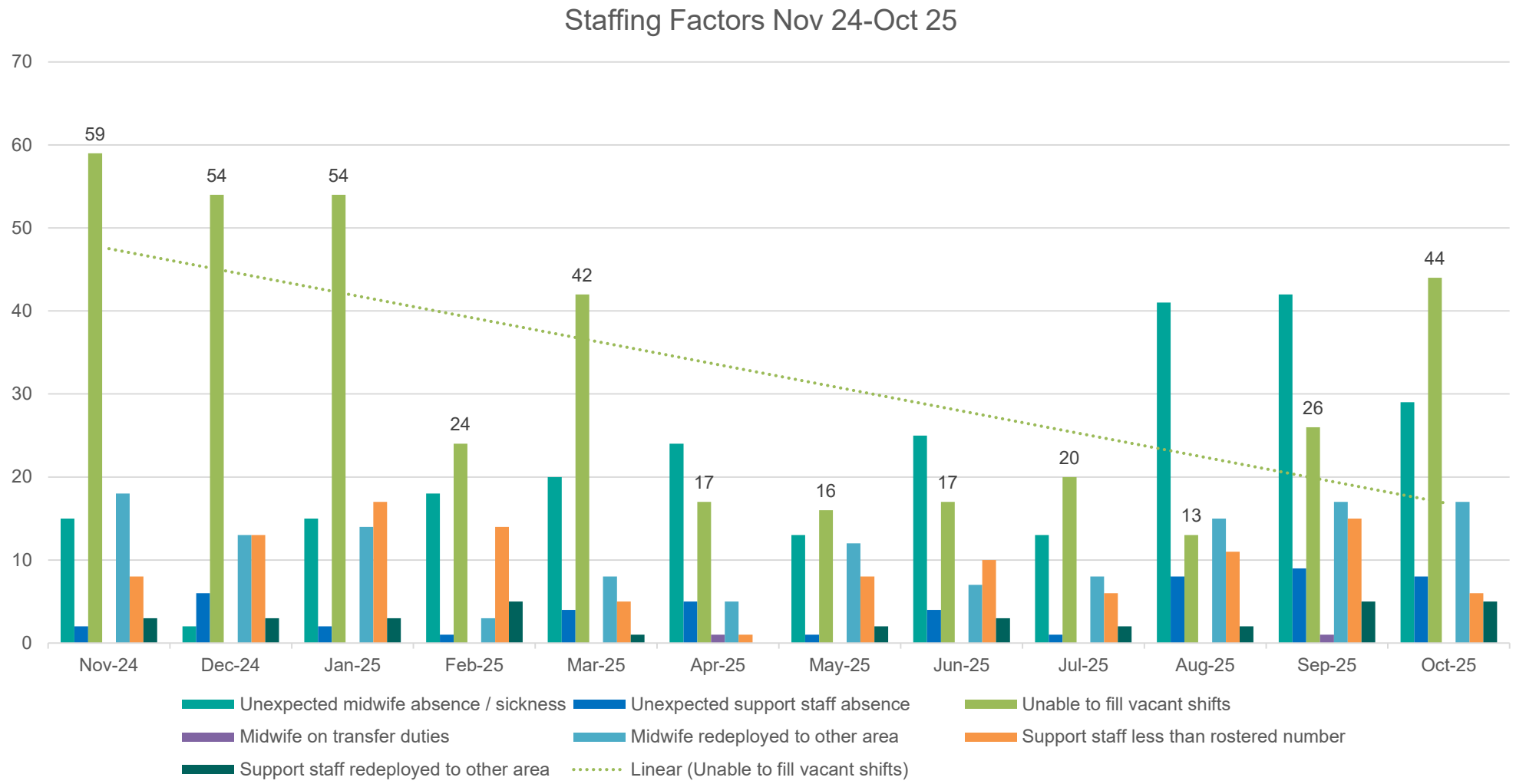

True North: People
Delivery Suite Co-ordinator supernumerary status

Ambition: To ensure supernumerary status of the delivery suite co-ordinator.
Goal: To monitor compliance of supernumerary status and ensure there is an action plan in place of how the maternity service intends to achieve this .

	Compliance with Supernumerary status of coordinator as per CNST Guidance	Compliance with 1:1 Care in Labour as per CNST Guidance
Nov-24	100%	100%
Dec-24	100%	100%
Jan-25	100%	100%
Feb-25	100%	100%
Mar-25	100%	100%
Apr-25	100%	100%
May-25	100%	100%
Jun-25	100%	100%
Jul-25	100%	100%
Aug-25	100%	100%
Sep-25	100%	100%
Oct-25	100%	100%

Key Messages:

- Labour Ward Coordinator (LWC) supernumerary status at start of the shift is a core element of CNST Safety Action 5. This is reflected on the rota with a LWC scheduled and booked as supernumerary for every shift.
- The twice daily bed state monitors the supernumerary status of the delivery suite co-Ordinator throughout the shift to ensure that they have oversight of all activity within the service.
- If there is an occasion where the delivery suite co-ordinator does not have supernumerary status for more than 1 hour, this is escalated to the Midwifery Manager on call
- All occasions of coordinator not supernumerary have been reviewed, and these are very brief periods of caring for postnatal women whilst waiting for staff to mobilise to delivery suite, and therefore meet the requirements of CNST allowing the service to declare 100% compliance with supernumerary status.
- Compliance with 1:1 care in labour remains at 100% and this has been validated on a case by case basis by the digital midwives. Data issues have now been resolved due to work of digital midwives and BI team and 100% compliance is reflected on the dashboard.

Training –

Ambition: To ensure the maternity and neonatal workforce have the skills and knowledge to provide safe and evidence based care.
Goal: To ensure all staff are trained to the required compliance.

Staff Group	Current Compliance	CNST Compliance Trajectory
Obstetric Consultants	93.33%	93.33%
Obstetric Residents	100%	100%
Midwives	96.49%	96.49%
MSWs	93.85%	93.85%
Anaesthetic Consultants	100%	100.00%
Anaestehtic Residents	100%	100.00%

Fetal Monitoring Training and Assessment	Obstetric Consultants	Obstetric Residents	Midwives
Current Compliance	93.33%	100.00%	94.95%
CNST Trajectory	93.33%	100.00%	94.95%

ALL TRAINING REQUIREMENTS

	Compliance		Compliance (%)	
STATUTORY SUBJECTS	Yes	No	Yes	No
ABLS L2	204	31	86.81%	13.19%
Conflict Resolution	207	10	95.39%	4.61%
Equality, Diversity & Human Rights	224	11	95.32%	4.68%
Fire Safety	193	42	82.13%	17.87%
Health, Safety & Welfare	211	24	89.79%	10.21%
Infection Prevention L2	212	23	90.21%	9.79%
Information Governance	217	18	92.34%	7.66%
MCA	200	33	85.84%	14.16%
Moving & Handling L1	205	30	87.23%	12.77%
Moving & Handling L2 (2yr)	164	68	70.69%	29.31%
NBLS L2	189	32	85.52%	14.48%
PBLS L2	0	1	0.00%	100.00%
Safeguarding Adults L3	211	18	92.14%	7.86%
Safeguarding Children L2	8	2	80.00%	20.00%
Safeguarding Children L3	188	37	83.56%	16.44%

Key Messages:

- Achieved >90% for all staff groups for PROMPT and CTG.
- Reduction in Safeguarding Children level 3 compliance for midwifery staff due to large numbers of new starters.
- Moving and handling below Trust target due to lack of trainer across Trust.
- Managers working to complete newly mapped advanced management and management essentials.
- All staff to be released to attend Oliver McGowan Training incrementally.
- Monthly monitoring of resuscitation training across division Positive improvements noted.

Issues, Concerns, Gaps:

- Moving and handling training below desired target.
- Newly mapped training courses require significant staff time with no additional uplift available to release staff.

Actions & Improvements:

- Improved oversight of booking and attendance records for PROMPT and CTG training with early escalation of non-attendance.
- 2 local moving and handling trainers now in place and supporting staff to complete training and monthly pick and mix sessions.
- Managers to prioritise appraisal and management essential training.
- All new starters to be allocated Safeguarding training session.

Training –

Ambition: To ensure the maternity and neonatal workforce have the skills and knowledge to provide safe and evidence based care.
Goal: To ensure all staff are trained to the required compliance.

Medway NHS Foundation Trust

MANDATORY SUBJECTS	Compliance		Compliance (%)	
	Yes	No	Yes	No
Advanced Management Essentials	2	4	33.33%	66.67%
Anaphylaxis	225	10	95.74%	4.26%
Appraisal Training	16	5	76.19%	23.81%
Blood Collection	4	4	50.00%	50.00%
Blood Collection, Prescription, Admin & Sampling	15	3	83.33%	16.67%
Blood, Prescription, Admin & Sampling	148	31	82.68%	17.32%
Cultural Competence	191	30	86.43%	13.57%
Freedom to Speak Up (All)	325	5	98.48%	1.52%
Freedom to Speak Up (Managers)	5	0	100.00%	0.00%
Insulin Safety	181	42	81.17%	18.83%
Local Induction	225	10	95.74%	4.26%
Management Essentials	4	12	25.00%	75.00%
Maternal Smoking	208	18	92.04%	7.96%
NEWS2	106	14	88.33%	11.67%
Patient Safety L1	330	8	97.63%	2.37%
Prevent WRAP	221	6	97.36%	2.64%
Prevention and Management of Violence and Aggression	12	2	85.71%	14.29%
Reducing Antimicrobial Resistance	1	1	50.00%	50.00%
Sepsis	185	30	86.05%	13.95%
The Oliver McGowan Mandatory Training P1	225	10	95.74%	4.26%
The Oliver McGowan Mandatory Training P2	25	203	10.96%	89.04%
Understanding sexual misconduct in the workplace	228	7	97.02%	2.98%

Action Plan

NHS Medway NHS Foundation Trust

No	Key lines of enquiry	Evidence Available	Gaps in Evidence/Assurance	Mitigating Actions /Comments	Action Due Date	Implementation Lead	BRAG
Workforce Action Plan 2025/2026							
1	Undertake full formal Birth Rate Plus Assessment in 2026 as per CNST requirements		Quote for Full Birth rate + Assessment is > £11,000.	* Include Birthrate plus in 25/26 Business Planning. * Seek funding from ICB for Regional Assessment * If Business planning not approved escalate via Trust Board and ICB	Jun-26	DOM	
2	Work with Matrons, Education Team and ICB to identify training and development opportunities for midwives to support career progression and prolong length of service.				Jun-26	HOM	
3	Work with PE&EDI Midwife and Education team to identify aspiring leaders in band 5 and 6.				Jun-26	HOM	
4	Be rigorous in tackling poor behaviour where it exists. Where there are examples of poor team cultures and behaviours these need addressing without delay			See Actions 1-6 in National Investigation into Maternity and Neonatal Care Action Plan			
5	Retain a laser focus on tackling inequalities, discrimination and racism within your services, including tracking and addressing variation and putting in place key interventions. A new anti-discrimination programme from August will support our leadership teams to improve culture and practice. This also means accelerating our collective plans to provide enhanced continuity of care in the most deprived neighbourhoods, providing additional support for the women that most need it.			See actions 25-32 in National Investigation into Maternity and Neonatal Care Action Plan			

Action Plan

Staff Culture							
1	Be rigorous in tackling poor behaviour where it exists. Where there are examples of poor team cultures and behaviours these need addressing without delay	Incivility is a Divisional Driver and the maternity and Neonatal services are being supported by the transformation team to reduce and address incivility across the services. Completion of the SCORE survey for maternity and neonatal services in 2022 with robust staff developed action plan completed throughout 2023. Regular senior team engagement sessions with staff with a focus on psychological safety to raise concerns. Regular Board Level Safety Champion Walk arounds to support staff in being able to raise concerns to Board level. The importance of collaborative working between Maternity and Neonatal Services celebrated through the "Maternity and Neonatal Collaborative Hour" and support through MDT incident review meetings, PMRT and ATAIN reviews. Patient Experience and Equality and Diversity Midwife (PE&EDI) in post to support both staff and service users to challenge inappropriate behaviours. Professional Midwifery Advocates provide support for all staff to raise concerns and reflect on incidents. Monthly student forums held to seek feedback from midwifery students, allowing them a safe forum to raise any concerns, including those regarding culture and behaviour. Maternity and Neonatal training includes simulations and learning from incidents, including poor behaviour or culture, to support staff how to recognise and escalate concerns in real time regarding inappropriate behaviour and culture. Service user feedback from complaints, incidents, Family and Friends tests and Maternity and Neonatal Voices partnership fed into team meetings, Maternity and Neonatal Safety Champion Assurance Board (MNSCAG), Governance meetings, staff newsletters, audit meetings and within staff training to ensure learning and improvements can be made following service user feedback. Strong leadership team across maternity and neonatal services to ensure staff have clear and appropriate routes to escalate any concerns. Robust check and challenge from Board Level Safety Champions at monthly MNSCAG. Monthly reporting of staff, student and service user feedback to Trust Board, with action plans in place to address any concerns and ensuring outcomes of feedback are shared to demonstrate a transparent and accountable leadership team.	•Need to ensure that all staff groups, particularly those that are internationally educated or BAME are supported and have a positive experience across maternity and neonatal services.	Work with the PE&EDI midwife to hold focused engagement session with all BAME staff to understand any concerns they may have, particularly around culture and behaviour, and develop targeted actions with the support of the Non-Executive Director and Trust Culture lead to address any concerns raised.	Nov-25	DOM/ADOM	
2			•There is a significant number of newly qualified staff within the midwifery workforce. It will be important to seek their feedback on culture and behaviour as part of the workforce.	Seek funding and release time for staff to attend culture training.	Dec-25	ADOM/Education Lead	
3				Repeat targeted culture survey for Maternity and Neonatal Staff to understand the current cultural climate within the services and co-produce an action plan with staff and key stakeholders to address any concerns.	Mar-26	DOM/MD	
4				Review 2025 GMC trainee survey feedback and develop action plan for any actions that fall below IQR. **1.9.25** All responses sit within on above IQR range. No immediate actions for 2025 survey.	30/09/2025	College Tutor	
5				Weekly monitoring incidents of incivility as part of Divisional Driver to assign actions and improve outcomes.	30/12/2025	DOM/MD	
6			Awaiting laucnh of Clinical leadership training for perinatal multi-disciplinary clinic leadesr such as labour ward coordinators, resident obstetricians and neonatologists and lead neonatal nurses.	* Support release of staff for clinical leadership training across maternity and neonatal services.	30/03/2026	DOM/MD	

Action Plan

NHS Medway

Equality and Diversity							
25	Retain a laser focus on tackling inequalities, discrimination and racism within your services, including tracking and addressing variation and putting in place key interventions. A new anti-discrimination programme from August will support our leadership teams to improve culture and practice. This also means accelerating our collective plans to provide enhanced continuity of care in the most deprived neighbourhoods, providing additional support for the women that most need it.	Addressing inequalities, discrimination and racism is fundamental to maternity and neonatal services in line with our commitment to the 3 year delivery plan. With the support of the PE&EDI midwife, the maternity service has been able to undertake deep dives into outcomes for service users from BAME and deprived groups. This has supported the development of focused targets and objectives for the PE&EDI midwife and the service as a whole. PE&EDI midwife annual objectives have been set with a view to reduce inequalities, discrimination and racism within the service, by supporting and training staff and engaging and empowering service users. Successfully achieved LMNS funding for an enhanced COC Maternity Support worker. This role has recently been appointed to and will be piloted in the most deprived areas of the service. Review of health and social inequalities is being integrated into all audits and reviews, including reviews of claims, incidents and complaints in line with CNST Year 7. This was recently presented at NHS Resolution as positive example of utilising data on inequalities to drive service improvement and address variation. Senior team engagement in Trust-wide and LMNS workstreams. Benchmarking against all national reports, including MBRRACE, to understand the outcomes of our service users and any variances that require targeted interventions. Neonatal regional quality improvement project to improve the detection of jaundice in non-white babies has been led by MFT improving patient experience and outcomes for families. The neonatal unit has joined the Poverty Proofing project, which aims to reduce socio-emotional and financial barriers to healthcare for families experiencing poverty.	•Understanding of EDI data for our population has improved significantly in recent years, but this needs to be further embedded in all processes, reviews and audits	Source baseline data for deprivation score, ethnicity and language now available for booking/birthing population to support an understanding of outcomes for vulnerable groups compared to the whole population, and in turn drive improvement.	30/08/2025	Compliance manager	
26			•Funding for enhanced COC MSW is only for 6 months and additional roles would require additional external funding.	Update CRIG form to include deprivation score, ethnicity and health inequality information for all MDT reviews to support identification of variances in outcomes and experience.	30/07/2025	Risk Midwife	
27				Develop working group to review findings of quarterly reviews including PPH and ATAIN based on equality and equity information to drive improvement.	30/12/2025	Compliance manager	
28				ADOM, Compliance manager and obstetric audit lead to support staff to fully embed the use of equality and ethnicity data in all service reviews and audit.	30/03/2026	ADOM/Audit Lead/Compliance Manager	
29				MNVP and senior team to support the PE&EDI midwife to achieve objectives to ensure that EDI is integral to service delivery.	30/04/2026	ADOM	
30				Poverty awareness training is being organised for all NICU staff to improve understanding and support for families affected by poverty.	30/03/2026	NICU Education leads	
31				Seek to extend funding for enhanced COC MSW with consideration to extend and expand pilot	30/04/2026	PE & EDI Midwife	
32			Awaiting launch of Perinatal Quality and Antidiscrimination Programme	Letter from NHSE dated 16/10/25 outlined further detail of Antidiscrimingation programme to be rolled out nationally. MFT await details of Trust joining programme and relevant onboarding.	30/06/2026	DOM	

Next Steps:

- Continue to support staff development through apprenticeship schemes and RN to RM courses.
- Continue to monitor red flags and supernumerary coordinator status and 1:1 care in labour.
- Continue to seek staff feedback and provide staff with regular updates on outcomes following actions.
- Request Board support for formal Birthrate Plus establishment review in 2026 (3 yearly requirement), PID to be completed and included in divisional business planning.
- Develop 25/26 workforce action plan following NHSE Insight visit.
- Share report with Trust Board and LMNS in compliance with CNST Year 7 requirements.

Meeting of the Trust Board in Public

Date: Wednesday 14th January 2026

Title of Report	Perinatal Quality Surveillance, perinatal Leadership and claims, incidents and complaints triangulation report			**Agenda Item**	5.2d
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	Evonne, Hunt Chief Nursing Officer				
Purpose	**Approval**		**Briefing**	**Noting**	X
Proposal and/or key recommendation:	Request the Trust Board note the detail of the report and the improvement work being undertaken across the service with regards to perinatal quality, leadership, claims, incidents and complaints triangulation, and staff and service user feedback.				

Executive Summary	• CNST Year 7 continues the expectation that Trust Boards will receive quarterly reports on Perinatal Quality in line with the minimum data set of the Perinatal Quality Oversight Model (PQOM). (Safety Action 1 and Safety Action 9)
	• Monthly updates aligned with the minimum dataset of the PQOM are submitted monthly to QAC along with to every Trust Board.
	• This report provides quarterly oversight for Q2 25/26 and includes the following:
	  • Incidents
	  • Investigations
	  • PMRT
	  • Complaints
	  • Claims Scorecard
	  • Staff and Service User Feedback
	  • Perinatal Leadership
	  • Safeguarding
	
	• This quarter has demonstrated continued progress in our commitment to delivering safe, high-quality perinatal care.
	• Key improvements in clinical outcomes, compliance with national standards, and service user feedback reflect the dedication of our multidisciplinary teams.
	• Multidisciplinary reviews of key incidents continue within the quarter and work to identify learning and actions at the time of				

	incidents, demonstrating our commitment to learning and continuous improvement.
	• Review of data with regards to Ethnicity and deprivation scores has identified further work in particular with regards to rate of PPH experienced by black women and this is being reviewed in detail as part of the PSIRP QIP.
	• All eligible MBRRACE reportable/PMRT cases have been included in the report, including details of actions and learning.
	• Service user and staff feedback continue to drive service improvement and development.
	• Perinatal Leadership and Culture Programme relaunched in Q2 with the following objectives:
	  • Integration with Wider Safety Programmes
	  • Embedding Everyday Culture Tools
	  • Quality Improvement Coaching
	  • Link to National Safety Priorities.
	• Continue with monthly reporting to MNSCAG and Trust Board via the IPQR slides which contain all the key information required as part of the PQOM minimum data set.
	• Report for onward reporting to Trust Board as per CNST year 7 requirements.

Issues for the Board/Committee Attention:	**Issues:** **PPH** • Percentage of PPH rates remain above national average – Focused QIP work underway as part of PSIRP with key actions identified including: • Staff training • Risk Assessment • Deep dive of PPH data including risk factors, ethnicity, deprivation score, management. • Staff survey **Claims** • The Trust Legal team have advised that the full claims scorecard including details of open claims cannot be shared with the maternity team to complete the triangulation report due to concerns about adversely impacting ongoing claims. • The scorecards are affected by a significant data quality issue, whereby the speciality is incorrectly coded in a proportion of claims, and the cause ("fail/delay diagnosis", "fail/delay treatment" etc.) is also not always accurate. This is a national issue, that in large part perpetuates due to absence of national guidance on identifying speciality of claims. This has been raised with NHSR, GIRFT and the panel firms. • Without access to full scorecard, service cannot identify emerging themes and trends in claim and cannot understand what learning has already taken place or identify any further

	learning that may be identified from a claim, even if it does not result in settlement. • This has been escalated to NHSR who are consulting with their panel firm to advise of next steps.			
Committee/ Meetings at which this paper has been discussed/ approved: Date:	Maternity and Neonatal Safety Champion Assurance Group, 1st December 2025 Reported via MNSCAG assurance and escalation report – QAC 8 Jan 2026			
Board Assurance Framework/Risk Register:				
Financial Implications:				
Equality Impact Assessment and/or patient experience implications				
Freedom of Information status	Disclosable	X	Exempt	

Meeting of the Trust Board in Public

Date: 14 January 2026

Title of Report	Annual Fire Safety Audit			**Agenda Item**	5.3
Patient First Domain	Sustainability	People	Patients	Quality	Systems
	X	X	X	X	X
CQC Reference	**Safe**	**Effective**	**Caring**	**Responsive**	**Well-Led**
	X				X
Author and Job Title	Neil McElduff, Director of Estates and Facilities				
Lead Executive	Siobhan Callanan, Deputy CEO				
Purpose	**Approval** X		**Discussion**		**Noting**
Proposal and/or key recommendation:	The Board is asked to note and approve the report				
Executive Summary	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 safe ty 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 11h and 15th August 2025 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. 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. 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 safe ty 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.

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

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.

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.

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.

There are limited scenarios which would necessitate the evacuation of High dependency areas such as the NCU and ICU wards, however, when need ed 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 ‘table top’ and ‘Toolbox’ talks. As a starting point it recommended that a timescale for evacuation preparation is established particularly for the intensive care nursery.

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 ou t before any patients or residents can occupy.

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

Issues for the Board/Committee Attention:	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.
Committee/ Meetings at which this paper has been discussed/ approved: Date:	Fire Safety Group
Board Assurance Framework/Risk Register:	Risk Description: If established fire safety protocols, standards, and guidance are not fully adhered to across healthcare buildings, then the likelihood and potential severity of fire-related incidents will increase, leading to loss of life, injury, property damage, disruption to patient care, reputational harm, and financial consequences such as legal claims, fines, or recovery costs. Inadequate controls across detection systems, compartmentation, suppression systems, emergency lighting, staff training, governance, and site housekeeping directly affect patients, staff, visitors, and the Trust's operational and regulatory compliance.

Actions (incomplete):

1971	Risk Register	2166	Fire Mitigation - Alarm	Capital program now approved to continue fireworks in the Trust, and in particular to address Panel 5, Red Zone. This will improve the reliability of the fire alarm and remove a weak panel which has many faults.	Brian Edwards	24/12/2025	Ongoing			
2669	Risk Register	2166	Compartmentation Site Wide	Recent surveys have revealed serious breaches in fire walls across the site. A new Project for Passive Fire Prevention is required to survey and remediate compartmentation issues across the site. A risk based approach is required to prioritise the projects attention on site areas at the most risk from long evacuation times and fire wall absence.	Neil Adams	20/03/2026	Ongoing	[20/03/2025 08:52:03 Neil Adams] FSSG to be held in April 2024 to finalise action.		
3033	Risk Register	2166	Fire Paper and Strategy	Fire alarm and compartmentation risks persist and are being deal with through the Fire Strategy paper. Fire Alarm is around 60% complete and recent works hae shown defects in compartmentation which extend into the past. Green zone may have some issues which a survey to be commissioned in 2025/26, to be implemented as a project in the same way as the fire alarm project. Existing information shows hot spots and provides a prioritisation for the survey.	Neil Adams	21/06/2030	Ongoing	[14/07/2025 11:56:01 Neil Adams] Capital Plan approved to spend 60% on Detection, 30% on Compartmentation adn the setting up of the multi-year project. 10% is allocated to Emergency Lighting. [14/07/2025 11:54:50 Neil Adams] Capital plan allocation is £1.6M for 2025-26		

Current risk score: 15

Risk Number: 2166

Financial Implications:	There is an automatic allocation of capital from previous board decisions. Additional funds may be sought after the compartmentation survey completion. The fire team is understaffed by 1 WTE.			
Equality Impact Assessment and/or patient experience implications	None			
Freedom of Information status:	Disclosable	X	Exempt	