Agenda

NHS Medway NHS Foundation Trust

Trust Board Meeting in Public

Wednesday, 11 March 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
1.4a **1.4b**	Minutes of (14 January 2026) and Actions		3 11	10.02	Approval
2.	**Opening Matters**				
2.1	Chairman's report	Chairman	Verbal	10.05	Assurance
2.2	Chief Executive Officer update	Chief Executive	12	10.15	Assurance
3.	**Stabilisation Plan and Strategy, including the IQPR**				
3.1	**Culture** a) Cultural Review Actions b) Employee relations recovery c) Board Strengthening	Deputy Chief Executive/ Chief People Officer	15	10:30	Assurance
	Performance a) Delivery of Access Standards b) IQPR headlines	Chief Operating Officer			Assurance
	Governance and Quality a) SHMI – including Learning from Deaths Report b) IQPR headlines c) CQC ED report	Chief Medical Officer/Chief Nursing Officer			Assurance
3.2	**Finance** a) Month 10 Report b) Governance Review Report c) Finance function progress update	Chief Financial Officer/ Intensive Support Improvement Director	98		Assurance
3.3	Board Assurance Framework	Dir. of Strategy and Partnership	125	11:00	Assurance
3.4	Trust Risk and Issues Report	Chief Nursing Officer	132	11:15	Assurance
3.5	Health and Safety Strategy	Chief Nursing Officer	165	11:25	Approval
4.	**Board Assurance**				

Agenda

NHS Medway NHS Foundation Trust

Item	Subject	Presenter	Type	Time	Action
4.1	Reports of the Committee Chairs a) Quality b) People c) Finance, Planning & Performance	Chairs of Committees	Verbal	11:35	Assurance /Decision
5.	**Regulatory and Corporate Governance**				
5.1	Governance Framework update and Scheme of Delegation amendment proposal	Company Secretary	184	11:55	Assurance
5.2	Gender Pay Report	Head of Equality and Inclusion	193		Assurance
5.3	Maternity a) Perinatal Surveillance Quarterly report b) Claims, Incidents, Complaints Triangulation report c) Homebirth Services d) Maternity Enhanced Support and Oversight Programme	Director of Midwifery	203		Assurance
5.4	Lead Governor's report	Lead Governor	Verbal		Assurance
6.	**Closing Matters**				
6.1	Questions from the Council of Governors and Public	Chair	Verbal	12.25	Assurance
6.2	Escalations to the Council of Governors				
6.3	Any Other Business and Reflections				
	Date and time of next meeting: 6 May 2026				

Minutes of the Trust Board Meeting in Public

Wednesday, 14 January 2026 at 10:00 – 12:30

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

Gundulph Boardroom and via MS Teams

PRESENT		
	Name:	**Job Title:**
Members:	John Goulston	Trust Chair
	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)
	Evonne Hunt	Chief Nursing Officer
	Frances Woodroffe	Chief Operating Officer (Interim)
	Sheridan Flavin	Chief People Officer (Interim)
	Fiona Wise	NHSE Board Advisor
	Jane Perry	Academic Non-Executive Director
	Katie Goodwin	NHSE Improvement Director
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
Observing:	Jackie Craissati	
Apologies:	Jon Wade	Chief Executive Officer (Interim)

1. PRELIMINARY MATTERS

1.1 Chair's Introduction and Apologies

The Chair opened the meeting by welcoming all attendees and noting apologies as recorded. He acknowledged the recent appointment of the substantive Lead Governor and expressed appreciation for the efforts of staff across the organisation during the festive period, noting the positive impact this had on morale under challenging winter conditions. The Chair also highlighted the significant increase in violence and aggression toward staff compared with previous years and confirmed that a dedicated staff safety summit would be convened in February to determine further organisational actions.

He reminded members of the ongoing pressures faced by the Trust, referencing pre-Christmas joint discussions between Chairs and CEOs about the forthcoming financial recovery submission. The Chair reiterated the need to remain mindful of the operational environment as the Board progressed through the agenda.

1.2 Quorum

The meeting was confirmed as quorate in accordance with Standing Orders, enabling formal business to proceed.

1.3 Declarations of Interest

There was one declarations of interest

- Helen Wiseman, Non-Executive director reported her appointment as Non-Executive Director at Dartford and Gravesham NHS Trust on 1 December 2025.

1.4 Minutes of the Last Meeting

The minutes of the meeting held on 12 November 2025 were reviewed and approved as a true and accurate record.

1.5 Action Log

The Action Log was reviewed and updated.

The Board received the updated Action Log, noting that actions were either completed, on today's agenda, or progressing in line with agreed timescales. No additional matters arose from the log requiring discussion.

2 OPENING MATTERS

2.1 Chief Executive Officer Update

The Chief Executive's report was presented, noting that it provided a comprehensive overview of operational performance, quality developments and organisational priorities. The paper set out progress in cancer and elective care, the continuation of winter flu precautions, and the expansion of the virtual ward service. It also summarised improvements in the Emergency Department highlighted in recent CQC reviews, developments in children's safety initiatives under Call for Concern, and the formal opening of the Sheppey Community Diagnostic Centre.

Members discussed the operational pressures described in the report, including industrial action and persistent emergency care demand. Clarification was sought regarding SECAMB

ambulance flow, ED staffing and induction, and the sustainability of improvements in waiting times. The Chief Nurse explained that while temporary redeployment from wards occasionally occurred, this was managed safely with strengthened induction processes. The Board noted the report and the assurances provided.

3 STABILISATION PLAN

3.1.1 Culture

a) Cultural Review Actions

Siobhan Callanan updated the Board in line with the Stabilisation Plan.

The report on cultural improvement was presented, noting that it set out progress within Phase 2 of the Cultural Transformation Programme. The paper highlighted ongoing work to refine the programme pillars, commence staff listening events, and strengthen methodology and governance. It also described significant progress in reducing the employee relations backlog, which had fallen from 51 cases to 16, though several complex matters and tribunal cases continued to present challenges.

Members discussed those actions underway to embed consistent leadership behaviours, improve accountability and align cultural work with the wider Stabilisation Plan. The Chief Nurse described strengthened governance frameworks and clearer alignment with NHSE's governance expectations. The Board emphasised the need for cultural outcomes to be evidenced and sustainable, and noted the update.

b) Employee Relations Recovery

Evonne Hunt updated the Board.

Members noted this presentation and recognized that work was being undertaken to review and close open cases.

c) Board Strengthening

Siobhan Callanan and Matt Capper presented the update on Board Strengthening.

Members noted this update

3.1.2 Performance

a) Delivery of Access Standards

Frances Woodroffe updated the Board.

This report summarised improvements in cancer pathways, with performance now positioned among the top thirty trusts nationally, and described continued reductions in 52-week waits, which had fallen to 1.4% with a planned trajectory to reach 1% by March. The Board also noted progress in diagnostics, although endoscopy remained short of its stretch ambition, and recognised the persistent challenges within urgent and emergency care, where four-hour performance remained below target despite improvements in twelve-hour breaches.

During discussion, members reflected on the pressure on operational capacity and the need for strengthened forecasting and modelling. Queries were raised about the sustainability of referral to treatment (RTT) recovery, Did not Attend (DNA) rates following digital initiatives, and the management of winter demand. The Board acknowledged the improvements

delivered to date and the requirement to maintain pace through strengthened governance and divisional ownership.

Members further considered the proposals relating to the urgent care center (UTC) at the Medway Hospital site and recognized that a Business Case would be developed for presentation to the Board in March.

Action : Business Case for UTC on Medway Hospital site to be presented to the Board in March.

b) IQPR Headlines
Frances Woodroffe updated the Board.

Members noted this presentation.

3.1.3 Governance and Quality
a) SHMI – including Learning from Deaths Report
Alison Davis presented the Learning from Deaths Report to the Board.

The Learning from Deaths report set out mortality trends across Q1 and Q2 2025/26, showing HSMR within expected parameters but SHMI remaining above expected, driven by frailty, delays in end-of-life recognition, pathway variation and documentation inconsistencies affecting coding. It highlighted examples of good practice, including early use of treatment escalation plans, strengthened multidisciplinary working, and improved Medical Examiner engagement.

Members discussed the relationship between pathway delays and mortality indicators, and sought assurance about actions to strengthen pneumonia and UTI pathways. The Chief Medical Officer described work underway to enhance coding, documentation and escalation processes, alongside improvements in frailty and sepsis pathways. The Board noted the need to sustain focus in this area and the assurance provided through the Trusts Quality Committee.

b) IQPR Headlines
Alison Davis updated the Board.

Members noted this presentation.

3.2 Finance
Month 09 Report
Simon Wombwell updated the Board in line with the paper submitted.

The Month 9 financial position as introduced. The paper highlighted a deteriorating financial outlook shaped by rising non-pay spending, dependency on temporary staffing, industrial action costs, and an underlying deficit compounded by withdrawal of Q3 Deficit Support Funding. It also reported the approval of a £30m loan and the need for further monthly cash support applications, while noting capital underspend and the risk to CDC income.

Members discussed the implications of the financial trajectory and sought clarity on the assumptions underpinning the medium-term plan and the CIP programme. The Chief Finance Officer explained that planning work continued at pace with FPPC oversight. The Board noted the position, the cash challenges, and the continued emphasis on robust forecasting and budgetary discipline.

3.3 Board Assurance Framework

Matt Capper updated the Board in line with the paper submitted.

The Board Assurance Framework (BAF) update, noting amendments to risk appetite and the inclusion of several extreme risks relating to financial stability, estates concerns and digital/cyber vulnerability. The report included feedback from Audit and Risk Committee confirming gaps in data integrity, triangulation and accuracy of some risk ratings.

Members discussed the need for a clearer articulation of risk interdependencies and emphasised the importance of the forthcoming February Board Development Day, where risk appetite would be further examined. The Board noted the update and the need for continued maturity in assurance processes.

` **Action: Board Assurance Framework and Risk appetite to be included on the February 2026 Development day agenda.**

3.4 Trust Risk and Issue Report

Evonne Hunt updated the Board.

The risk and issues update, summarised the Trust's eight active risks and ten active issues relevant to the committee's remit. The report highlighted risks relating to staffing, diagnostics capacity, income protection and estates.

Members discussed the need for improved clarity between operational risks and longer-term systemic issues, and for more explicit escalation routes. The Board noted the update and requested that the format be refined to improve transparency and distinction between risks and issues.

4. BOARD ASSURANCE

4.1 Reports of the Committee Chairs

Board members acknowledged the breadth of assurance and the importance of cross-committee triangulation in strengthening organisational oversight. The Chair thanked Committee Chairs for their work and noted the reports.

a) Audit and Risk

Peter Conway updated the Board.

Audit and Risk Committee highlighted limited assurance in several areas, particularly data quality and cyber security.

b) Quality Assurance (November and December)

Mojgan Sani updated the Board.

Quality Assurance Committee confirmed strengthened oversight of mortality, medical devices and maternity, while emphasising the need for continued pathway improvements.

c) People

Jenny Chong updated the Board.

The People Committee outlined progress in workforce initiatives but noted ongoing challenges in sickness, training compliance and the employee relations backlog.

d) Finance, Planning and Performance

Helen Wiseman updated the Board.

Finance Planning and Performance reported ongoing scrutiny of the financial recovery plan, business planning and the triangulation of activity, workforce and finance.

4.2 Governance Review

Katie Goodwin and Fiona Wise updated the Board in line with the paper submitted.

The governance review update was presented, noting that the paper outlined the need to revise the governance framework in line with NHSE undertakings. The review recommended refinements to Board and committee structures, strengthened digital oversight, and increased transparency through more frequent publication of public Board items.

Members discussed the recommendations and supported the direction of travel. The Board requested a further update in March, with a draft forward plan setting out immediate and longer-term improvements.

Action: Governance review Update to be presented in March with a draft forward plan setting out immediate and longer-term improvements.

5. OTHER BOARD BUSINESS

5.1 Council of Governors Report

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

The Chair invited an update from the Lead Governor, who reflected on recent governor activities and ongoing engagement with the Trust. The Board noted the supportive approach of the Council of Governors at a time of organisational pressure.

5.2 Maternity

Alison Herron updated the Board in line with the papers submitted:

The Committee received the maternity reports, which included the Picker Survey, CNST compliance update, bi-annual workforce report and perinatal surveillance data. The papers highlighted significantly improved postnatal care scores, strong performance across most survey domains and progress against ten CNST Safety Actions, with compliance achieved

in nine. Workforce metrics remained broadly positive, though acuity pressures and maternity leave rates required continued monitoring.

Members discussed the implications of non-compliance with Safety Action 1 and sought assurance regarding workforce resourcing and red-flag monitoring. The Director of Midwifery confirmed ongoing actions and anticipated submission timelines. The Board approved the CNST declaration and noted the remaining maternity updates.

a) Picker Survey Results

This report was presented for noting

b) Maternity CNST Compliance Report

This report was presented seeking approval of compliance with 9 out 10 conditions.

Decision: The Board approved the CNST declaration and noted the remaining maternity updates.

c) Maternity Bi-Annual Workforce Report

This paper is presented to the Board twice annually. Members noted and supported the content.

d) Perinatal Surveillance Quarterly Report
Q2 report, paper for noting

This report was presented for noting

5.3 Annual Fire Safety Audit
Siobhan Callanan updated the Board in line with the paper submitted.

The annual fire safety audit report was presented. It outlined areas of progress, such as improvements in alarm systems and compartmentation, but also highlighted outstanding risks including infrastructure limitations and patient smoking behaviours.

Members sought clarity on capital requirements and interim mitigations. Estates confirmed a phased programme of works aligned with the capital plan. The Board noted the report and requested a further update at the next meeting.

Action: Fire Safety Audit update to be presented to the March Board meeting.

6 ITEMS TO NOTE

6.1 Emergency Preparedness, Resilience and Response – Annual Assurance Rating
Frances Woodroffe presented the report.

The Board noted the annual assurance rating provided within the EPRR Report.

6.2 Modern Slavery Statement

Matt Capper presented the report.

The Modern Slavery Statement was noted.

7 Closing Matters

7.1 Questions from the Council of Governors and Public

The Chair invited questions from those observing. These related to delays in discharge processes, pharmacy turnaround times and the correlation between operational performance and quality metrics. The Board acknowledged the concerns raised and confirmed that relevant actions were being pursued through operational and strategic programmes.

7.2 Escalations to the Council of Governors (COG)

- Committee chairs reports on the agenda for the next Council Of Governors meeting
- Summary stabilisation plan to the next Council Of Governors meeting
- Refreshed governance statement once approved by Board to the May meeting.

7.3 Any Other Business and Reflections

No further items were raised. The Chair thanked members for their contributions and acknowledged the ongoing pressures faced by staff

7.4 Date and time of next meeting

The date of the next Trust Board meeting was confirmed as Wednesday, 11 March 2026.

The meeting was formally closed at 13.00

These minutes are agreed to be a correct record of the Board Meeting in PUBLIC of Medway NHS Foundation Trust held on Wednesday, 14 January 2026

Signed by the Chair …… Date:

Public Trust Board
Action Log

Actions are RAG Rated as follows:

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

Meeting Date	Minute Ref / Action No	Action	Action Due Date	Owner	Current position	Status
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	11.03.26 ~~12.11.25~~	Siobhan Callanan, Deputy Chief Executive	**Update to come to March meeting**	Amber
12.11.25	**TB/2025/034**	Programme leads were asked to circulate updated performance data to all Board members following the latest statistical review.	14.01.26	Programme Leads	No update received.	Amber
14.01.26	**TB/2026/001**	Business Case for UTC on Medway Hospital site to be presented to the Board in March.	05.03.26	COO		Amber
14.01.26	**TB/2026/002**	Board Assurance Framework and Risk appetite to be included on the February 2026 Development day agenda.	Feb-26	Matt Capper, Dir of Strategy and Partnership	Completed	Green
14.01.26	**TB/2026/003**	Governance review Update to be presented in March with a draft forward plan setting out immediate and longer term improvements.	05.03.26	CNO	On agenda	
14.01.26	**TB/2026/004**	Fire Safety Audit update to be presented to the March Board meeting	05.03.26	Estates and Facilities	No update received.	Amber
			.			

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.

Group with Dartford and Gravesham NHS Trust

The Boards of Medway NHS Foundation Trust and Dartford and Gravesham NHS Trust are progressing the early development of a new hospital Group designed to strengthen services and improve long-term sustainability.

Both Boards have reviewed the leadership capacity required in light of significant operational and financial pressures facing the Trust and wider Kent and Medway system and have agreed that, for now, each trust will retain its own Chief Executive. I will continue to lead both organisations until 31 March, after which I will focus fully on Dartford and Gravesham while Medway begins the process of appointing a substantive Chief Executive.

A joint committee of the Boards, supported by a dedicated Programme Director, will guide the next phase of Group development, ensuring the right approach, pace, and structure. Both trusts remain confident that forming the Group is the right strategic direction, creating significant opportunities for innovation, improvement, and long-term sustainability. It will enable the trusts to address shared challenges more effectively, strengthen clinical services, and deliver better outcomes for patients and staff.

Performance update

We have continued to make progress in improving patient care despite a very challenging start to the year, driven by rising demand and sustained operational pressures.

Thanks to continued improvement over the past six months in both the 28-day and 62-day cancer standards, the Trust recently exited tiered oversight for cancer care. In its notification to the Trust, NHS England said: "*The sustained and diligent efforts of your team in delivering pathway transformation and improving performance are greatly appreciated, with a demonstrable and positive impact on both patient care and patient experience*."

Teams have also made significant progress in reducing the number of patients waiting over 52 weeks for elective care to 1.4 per cent of our total waiting list in December (327 patients), down from 5.4 per cent in September (2,116 patients). We remain on track to exceed the one per cent target ahead of the end-March deadline.

We have also secured additional funding to accelerate improvements in meeting the 18-week target for starting planned treatment following a GP referral. This investment is enabling us to run additional clinics that will further reduce waiting times. Performance has already improved from 52.8 per cent in August to 57.9 per cent in December, and thanks to

this additional support, we remain on track to meet the 60 per cent target by the end of March.

Diagnostic performance has also continued to improve. The proportion of patients waiting longer than six weeks for a diagnostic test has reduced significantly, improving from 80 per cent in August to 91.9 per cent in January. I'm also pleased to report that the second phase of the Rochester Community Diagnostic Centre has completed, further expanding local diagnostic capacity for patients.

Significant work continues to strengthen the environmental sustainability of the site. Newly installed solar panels are now generating renewable energy to power part of the estate for the first time, and the programme to replace a substantial number of windows with energy-efficient alternatives is nearing completion.

Finance update

We have maintained strict controls on recruitment, temporary staffing and non-essential spending throughout this year but our latest forecast shows we will be significantly off plan by March. Rising costs, inflation, national funding changes and the challenge of delivering our £45m savings target are the main drivers.

This reflects wider system pressures, with Kent and Medway carrying an underlying £400m deficit. We are working closely with system partners on a financial improvement plan to ensure services remain effective and sustainable, including progressing the NHS 10-Year Plan's shifts from treatment to prevention, hospital to community, and analogue to digital.

System transformation update

Work is underway to develop a Kent and Medway Neighbourhood Health implementation plan that sets out the immediate actions, governance, and engagement needed to establish a consistent system-wide approach. The plan draws on learning from early implementers and will be aligned with wider transformation pillars.

The system Acute Services Transformation Programme is progressing in line with the System Improvement Plan, with partners agreeing early priority areas including referral management and endoscopy improvements. The programme is preparing for Phase 1 delivery, subject to investment approval, and remains on track to initiate early test areas while shaping the longer-term Phase 2 model.

A proposed contracting framework and oversight model has been developed to strengthen system grip, clarify roles, and align commissioning and assurance processes with the new NHS operating model.

New technology to boost breast cancer detection

I am pleased to report that we have significantly strengthened our diagnostic capability in our Breast Care Unit with the introduction of two advanced technologies – the GE Pristina

Mammography Machine and Contrast-Enhanced Spectral Mammography (CESM) – enabling faster, more accurate detection of breast cancer and reducing the need for repeat imaging or unnecessary biopsies. By improving the clarity and accuracy of breast imaging, we can identify concerns earlier, provide answers sooner, and reduce the need for unnecessary procedures.

Lung ultrasound study boosts care for premature babies

Colleagues at Medway have played a key role in a major UK study showing that lung ultrasound is a reliable, quick and safe way to assess breathing difficulties in premature babies. The national SLURP study, involving our Oliver Fisher Neonatal Unit and two other neonatal units, found that with structured training clinicians can accurately use lung ultrasound to predict which babies will need surfactant, a vital treatment that helps newborns' lungs function effectively. The findings support wider adoption of lung ultrasound in neonatal care, reducing reliance on X-rays and enabling faster, more targeted treatment. The study has already trained many clinicians, with results published in leading journals and presented internationally.

New sensory equipment improving children's experience before surgery

I'm pleased to report that children awaiting surgery are now supported by new sensory and play equipment that helps reduce anxiety and create a calmer pre-operative experience. Arcade-style games, sensory tools and a new child-friendly information video provide age-appropriate reassurance, and strengthen our commitment to delivering high-quality children's surgery in a safe, supportive and child-friendly environment.

Inspiring the next generation of Medway healthcare professionals

I would like to acknowledge Kelly Ochonogor who works in theatres, whose experience shows the impact of high-quality placements and apprenticeships in developing our future workforce. As our first T-Level student, her placement in theatres inspired a career change from clinical psychology to the Operating Department Practitioner (ODP) role.

After gaining experience as a Clinical Support Worker, she successfully secured a three-year ODP apprenticeship and is now training alongside theatre teams, growing in confidence and skills. Colleagues describe her enthusiasm and aptitude as exceptional, and her journey highlights how apprenticeships are creating accessible routes into clinical careers and strengthening our future workforce.

A final thank-you

As this is my final Board meeting, I want to express how proud I am of the progress our staff have achieved over the past year. Their commitment to improving care, strengthening services, and supporting one another has been impressive. While challenges remain, I have every confidence that the dedication and determination I have seen across the Trust will continue to drive meaningful improvements for both patients and colleagues. It has been a privilege to serve alongside them.

Meeting of the Trust Board Meeting in Public

Date: Wednesday, 11 March 2026 at 10:00 – 13:30 - Trust Board Room and via MS Teams

Title of Report	Stabilisation Plan			**Agenda Items**	3.0
Stabilisation Plan Domain (please mark X, if necessary, select multiple boxes)	**Culture**	**Performance**	**Governance and Quality**	**Finance**	**Not Applicable**
	X	X	X	X	
CQC Reference	**Safe**	**Effective**	**Caring**	**Responsive**	**Well-Led**
Author and Job Title	Jennifer Butler – cPMO Programme Manager				
Lead Executive	Siobhan Callanan				
Purpose	**Approval**		**Briefing** X		**Noting**
Proposal and/or key recommendation:	The Board is asked to note this report, which provides an update on the current status of the Stabilisation Plan and its associated programmes. This paper is presented for noting only and does not require approval or discussion at this stage. Its purpose is to formally inform the Board of programme progress, current risks, and the actions underway to strengthen delivery foundations across all workstreams.				
Executive Summary	The programme is now in a more stable position, with strengthened programme controls, governance arrangements and reporting structures established across all workstreams. This has significantly improved visibility of delivery progress, interdependencies and programme risks, enabling a more consistent and assured view of performance. Since the previous update, further work has been undertaken to clarify workstream scope and strengthen programme management arrangements. Resources have been realigned in some areas to better support priority programmes and ensure appropriate expertise is focused on key delivery areas. While overall progress remains positive, several constraints continue to require active management. These include the pace of decision-making in some areas, capacity pressures across priority programmes and the need to finalise KPI frameworks to ensure delivery can be effectively monitored and assured.				

	The programme outlook remains positive. Elective Reform is already delivering against agreed KPIs and the Culture Programme has established strong foundations for delivery. Over the coming period, the focus will be on finalising detailed delivery plans across all workstreams, embedding KPIs and governance frameworks and strengthening programme assurance to support continued progress. With these elements in place, the programme has been able to move fully into a delivery-focused phase, providing increased confidence in delivery trajectory and benefits realisation.
Issues for the Board/Committee Attention:	The Executive Summary at the commencement of this submission details the areas of focus and the key performance position of the stabilisation plan.
Committee/ Meetings at which this paper has been discussed/ approved: Date:	Content in this paper – in the areas of Culture, Performance and Finance, have been discussed at: Trust Board (Cultural Transformation) FPPC (Performance, Finance) QAC (Quality)
Board Assurance Framework/Risk Register:	
Financial Implications:	Please see summary in the Finance area of the Stabilisation Plan.
Equality Impact Assessment and/or patient experience implications	There are no significant equality or patient experience implications to report at this stage. The Stabilisation Plan is currently focused on strengthening programme governance, planning, and delivery processes. Impact on Patient Experience - No direct impact has been identified. Any downstream service changes arising from future phases of the programme will be subject to appropriate quality and equality assessments. Controls in Place - Existing Trust governance processes, including Quality Impact Assessments (QIAs) and Equality Impact Assessments (EIAs), will be applied to any future changes to ensure no adverse impact on patients, staff, or protected groups. Consideration of Health Inequalities - Health inequalities have been considered; however, no specific impacts have been identified at this early stage of programme planning. Health Inequalities Potentially Impacted - None identified at this stage. Controls to Prevent Adverse or Unintended Implications - All programme workstreams will continue to review equality and health

	inequality implications as proposals develop. Any changes with potential impact will be escalated through the Trust's governance framework for assessment and mitigation.			
Freedom of Information status:	Disclosable	x	Exempt	

Overall Stabilisation Plan Update

(last updated 13/02/2026)

Overall Programme Position:-

Stabilisation Plan	
Exec Lead	Siobhan Callanan
Programme Director	Linda Longley
Date	22/01/2026
Programme RAG Status	
RAG Justification	The overall RAG status is Amber. This reflects the scale and complexity of the programme, alongside the need to fully embed governance arrangements and confirm delivery plans across all areas. Overall progress is being made across the programme. Elective Reform has achieved its agreed KPIs and is contributing positively to the Trust's overall performance metrics. The Culture Programme is being established, with appropriate programme and project management support in place, a steering group formed and stakeholders engaged and communicated. Quality milestones are being developed to define what can be delivered by March, recognising the overall programme timeline to August. Existing governance structures are also under review to confirm inputs, outputs and any additional requirements needed to support delivery and assurance. Further clarity across these areas will support progression to a Green status.

Overall Position

The programme is now in a more stable position, with consistent programme controls established across all workstreams. Governance, reporting cadence and assurance mechanisms are in place, providing a clearer and more consistent view of progress and delivery confidence.

What's Changed Since Last Update

- Improved visibility across the programme, with clearer understanding of workstream scope, status and interdependencies.
- Programme controls have been implemented, providing a consistent approach to planning, reporting and risk management.
- Re-alignment of some resources to better balance workload and align expertise to priority areas, improving delivery focus and resilience.

Key Risks & Constraints

- Pace of decision-making impacting momentum in some workstreams
- Capacity pressures across priority programmes limiting ability to accelerate delivery
- Agreeing KPIs in a timely fashion to ensure effective delivery

Programme Control and Path to Green

Next Control Point
- All programmes having detailed delivery plans which are actively being tracked and monitored.

Outlook
The outlook for the programme is positive. Programme controls are now in place, visibility has improved and there is demonstrable progress across key workstreams. Delivery focus over the coming period will be on finalising detailed delivery plans and embedding governance and KPI frameworks. With Elective Reform already delivering against KPIs and the Culture Programme establishing strong foundations, the programme is well positioned to move into a more delivery-focused phase. Continued engagement with executive stakeholders will support timely decision-making and assurance as the programme progresses.

Criteria for Movement to Green
- Detailed delivery plans agreed across all workstreams.
- Governance and KPI frameworks finalised and embedded.
- Demonstrable upward trajectory against agreed KPIs, providing confidence in delivery and benefits realisation.
- Ongoing evidence of consistent programme control, with risks and issues actively managed and mitigated.

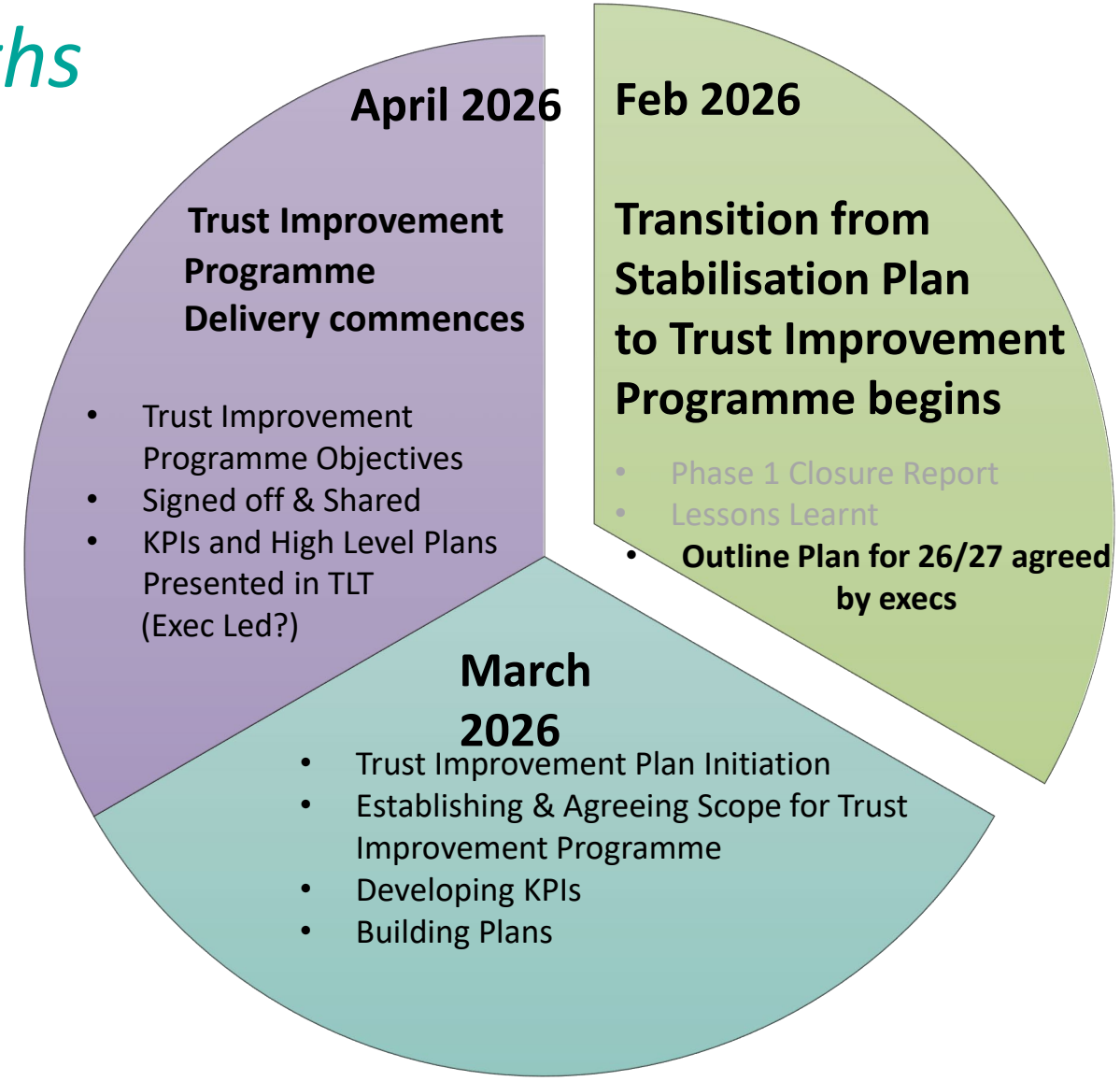
Key Activity over next 2-4 weeks
Over the next two weeks, activity will focus on consolidating assurance and preparing for transition into the next phase. This will include:
- Completion of lessons learnt across Phase 1 delivery.
- Development of a programme closure report, clearly setting out achievements, outcomes and residual risks.
- Formal escalation of any areas of non-delivery, with supporting evidence.
- Development of recovery plans where required, to address gaps and mitigate impact on overall delivery.

To support effective mobilisation of the next phase, executive direction is required on the approach to scoping, underpinned by a clear and agreed set of objectives and KPIs. This will ensure Phase 2 is appropriately sized, prioritised and aligned to Trust expectations and capacity.
The proposed Phase 2 scope, objectives, KPIs and delivery approach will be presented to TLT in April, with delivery planned to commence in April, subject to agreement.

Programme Timeline …. the next three months

Transition from Stabilisation Plan into our
Trust Improvement Plan

Objectives for new Improvement Plan - tbc



Programme KPIs

	Data published 12 February 2026	Trend	Data published 15 January 2026
Elective proportion waiting within 18 weeks	**57.1%** 91/118	↑	**55.8%** 97/118
Elective proportion waiting over 52 weeks	**1.4%** 49/118	↑	**2.5%** 78/118
Cancer faster diagnosis 28 day	**75.8%** 86/118	↓	**78.9%** 50/118
Cancer 62 day combined	**73.8%** 52/118	↓	**82.1%** 17/118
Diagnostics proportion waiting over six weeks	**11.9%** 30/118	↓	**9.2%** 27/118
Emergency Department four hour performance	**70.1%** 51/118	↑	**69.9%** 69/118
Emergency Department 12 hour performance	**14.2%** 63/118	↓	**12.9%** 79/118
	Emergency care: January Elective, cancer and diagnostics: December		Emergency care: December Elective, cancer and diagnostics: November

An example KPI table has been included here, aligned to the Trust's communications approach as an example of good practice. This is intended as a placeholder to demonstrate the proposed standard for reporting KPIs across both the Stabilisation and Trust Improvement Plans, and how data will be presented consistently going forward. We would welcome any thoughts or suggestions before this approach is embedded

Governance

Governance	
Exec Lead	Evonne Hunt
Programme Manager/ SRO	Steph Gorman/ Molly Marcu /Louise Furlong
Date	February 2026
Programme RAG Status	
RAG Justification	Confirmed Board development date to discuss the trust vision and strategic commitment. On track with all confirmed actions.

Programme Description:

1. The Ward-to-Board Governance Stabilisation Programme aims to rapidly restore confidence, safe, reliable, and high-performing governance systems across all domains of an NHS acute trust. It strengthens the entire assurance chain by creating a single well-functioning integrated governance framework covered under the following 3 pillars:

- ***Clinical quality governance;*** *this includes Divisional governance and health & safety.*
- ***Corporate governance****; this includes workforce, education & training, research, programme management operational performance and Digital/ information Governance, including NHS oversight framework.*
- ***Financial governance*** Standing Financial Instructions (SFIs) & Scheme of Delegation, Financial policies suite, Fit-for-purpose internal controls.

Programme Objectives:

1. Strengthen to ensure a consistent governance "golden thread" that connects patient care from ward → divisional/corporate → executive, and Board assurance.
2. Standardise governance structures, reporting, decision-making, accountability, oversight and escalation to eliminate variation, duplication, or blind spots.
3. Improve visibility of all risks across the organisation, ensuring triangulated reliable validation including early warning triggers.
4. Ensure Trust Governance framework reflect best practice framework for example NHS Code of Governance, CQC Well-Led framework

NHS Medway NHS Foundation Trust

Milestones planned: Commence before 31st March 2026

Governance Framework:

- The Trust Vision & strategic objectives identified from the Trust board development day to be reflected within the revised Medway governance Framework.
- End to end review of the Trust risk register to be completed.
- Executive leadership portfolio including responsibility to be identified
- Submit draft of the governance framework- TLT, relevant board committees prior to the Board for Approval in April 2026
- Map Board annual cycle of business to strategic commitments and regulatory requirements
- Put in place a Board development programme that is aligned to strategic priorities
- Review Risk Appetite Statement of the Trust for Board in Q1
- Clarity on timelines for Divisional structure review as this will have direct impact on Governance framework 3 pillars.
- Revise BAF to align principle risks and strategic objectives
- Define role & duties of board committees, sub committees and groups, ensuring we have appropriate templates for TOR
- PSIRF review completed with the focus on being on the implementation of recommendations from review.
- Clarity on the SJR process and how this aligns to the Trust PSIRF process. Implementation of robust QIA process
- Understanding of how the National Provider Improvement Programme (NPIP) will feed into the overarching Governance Framework

Progress Update

- Identified current Medway Framework, commencing review to identify gaps for improvement
- We have agreed the monitoring undertakings via this Governance stabilisation plan
- We have grouped and identified the 3 key pillars for Governance – Clinical / Corporate/ Finance
- 1st Board development session agreed for 18th February – focus on Trust vision and Strategy, further action to identify the BAF following this session
- Identified gaps around the framework for COG (Council of Governors)
- Identified the regulations the Trust needs to be compliant with as a NHS foundation Trust. Next step will be to align these regulations to relevant board committee, Trust leadership and Divisional Governance to ensure implementation and monitoring.

Celebrations:

Clarity around the focus on the 3 pillars for Medway's Integrated Governance Framework.
Discussion and agreement that the undertakings will be monitored by the Governance Stabilisation plan.

Project Workstreams

NHS Medway NHS Foundation Trust

Clinical	Corporate	Finance
Patient Safety (PSIRF) and Patient Experience • Decision-making algorithms • Incident response • Thematic learning • Mortality improvement • Complaints, PALS, FFT, CQC surveys, equality and inclusion • Safeguarding adults and children, infection prevention, winter pressures governance	**Workforce** • Staffing levels • Rostering • Education & training • Culture and psychological safety • HR casework and leadership behaviours • Vacancy, sickness, rostering, capability.	• Investment in governance capacity • PMO resources • Ward accreditation and training needs • CIP, budget control, cost pressures, financial risk, decision-making controls.
Divisional Governance **Performance & Operations** • Flow • Escalation levels and protocols • IPC and deteriorating patient pathways • ED, RTT and elective performance pressures • Diagnostics, theatre utilisation, escalation protocols	**Education & Training Governance** • Mandatory training • Clinical competencies, Professional standards • career development	
	Digital & Data • Quality surveillance groups • Shared risks • Regulatory oversight • Regulatory reporting, quality surveillance groups, partner assurance	
	ICS Partners • Quality surveillance groups • Shared risks • Regulatory oversight • Regulatory reporting, quality surveillance groups, partner assurance	
	Research & Innovation Governance	

Current Governance Programme Risks :

Medway NHS Foundation Trust

Risk	Likelihood	Consequence	Risk score	Impact	Mitigation (Suggested mitigations)
Fragmented & over-complicated Governance structures and processes could lead to inconsistent escalation from Ward to board.	3	4	12	Regulatory escalation; poor quality outcomes Variability leads to weak follow-through on governance actions Different standards of governance maturity and capability. Meeting overload/ burden Harm Goes unnoticed Understanding relevance of respective meetings Limits board assurance and affects decision-making.	Mandatory governance training; exec enforcement; monthly audit Data validation rules; single dashboard; informatics oversight
Divisional non-compliance with governance	2	3	6	Breakdown of the golden thread	Divisional accountability meetings chaired by COO/CNO/CMO Escalation policy, accountability reviews
Capacity constraints due to competing operational and financials pressures (Winter, bed capacity issues, staffing gaps disrupt governance attendance and focus)	4	3	12	Slower programme delivery Staff disengaged with the governance framework work.	Programme PMO, prioritisation of high-impact actions
Poor documentation/governance record keeping due to lack of standardisation	3	2	6	Lack of assurance Different templates, methods, assurance styles	Standard templates and digital repository
Understanding of QIA process	3	2	6	Delays to change process	Review of process/ training and communication trust wide
Incomplete/ assurance reporting to the committees and board resulting in decision making				TBC	TBC

Programme & Project KPIs

To be determined following board development day on 18th Feb, which is focusing on governance. Previous KPIs socialised at TLT on 27th January will be amended at recirculated.

However, the programme is reporting as green as all identified actions are on track, to be delivered against plan

Proposed Governance Programme Key Performance Indicators	Current	Owner
% of extreme risks with each executive owner	Exec Lead / Extreme (15+) Chief Financial Officer 0% Chief Medical Officer 29% Chief Nursing Officer 0% Chief Operating Officer 14% Chief People Officer 0% Deputy Chief Exec 29% Director of Strategy & Partnership 29%	**Integrated Governance**
# of PSII declared *(update to % of PSII per 1000 bed days when data available)*	**7 (unvalidated)**	**Patient safety improvement Team**
# of Learning actions open *(update to % of PSII learning actions when data available)*		**Patient safety improvement Team**
% of risks without controls	**26%**	**Integrated Governance**
% of risks with overdue actions.	**7% (over 6months)**	**Integrated Governance**
% of overdue board assurance frame actions		**TBC**
# of QIAs completed	**13**	**PMO**
# of QIAs submitted for every change	**15**	**PMO**

Governance Framework (Golden Thread) – Programme scope

-Develop actions under each Pillar and track progress on Gantt charts as KPI measure

Ward Level	Divisional Level	Executive	Board	Corporate Actions
• Daily Safety Huddle (staffing, incidents, deteriorating patient, IPC) • Ward Governance Meeting (monthly) • Ward Accreditation & Quality Standards • Ward Risk Log (local risks & mitigations) • Incident Reporting (Datix), Complaints, FFT, Observations • Escalation Trigger Framework (Green/Amber/Red) • Escalation of risks, incidents, staffing & quality themes • Weekly Improvement huddles	• Divisional Quality & Governance Board (monthly) • Divisional Performance Review (weekly/fortnightly) • Monitoring of Divisional KPIs (safety, quality, finance, workforce) • Divisional Risk Register (aligned to corporate scoring matrix) • Learning from Incidents & Mortality (themes, actions, compliance) • Accountability for PSIRF/SIRIs & SJR completion • Workforce governance: sickness, vacancy, rostering, culture • Escalation of red themes, high risks & regulatory concerns • Divisional to complete Governance assurance self assessment tool	• Executive Quality & Performance Reviews (weekly) • Trust-wide Integrated Performance Report (IPR) • Corporate Risk Register • PSIRF Oversight Group, Mortality Oversight Group • Workforce & Culture Review (People & OD) • Finance & Productivity Governance • Executive Sign-off on escalations, actions & recovery plans • NED/Exec Safety Walkarounds • Strategic oversight & assurance escalation	• Quality Assurance Committee (QAC) • People Committee / Finance Committee / Performance Committee • Board Integrated Assurance Report • Board Assurance Framework (BAF) • Board-to-Ward engagement • Independent Scrutiny (NEDs, Internal Audit, External Review) • Final accountability, decision-making & organisational risk oversight	• Refresh terms of reference for all committees (ward governance, divisional boards, QAC, People Committee, Finance & Performance, etc.). • Clarify decision-making and escalation rights. • Align to NHS England “Good Governance” maturity model. • Clear process for IRG, PSIRG, SJR, and mortality oversight. • Unified risk register with risk scoring consistency. Corporate & divisional risk registers, risk controls, escalation standards, Executive ownership of risks and controls. • Clear corporate KPI dashboard tied to the Board priorities • Re-design of Board subcommittee packs. • Ward accreditation scheme refreshed or implemented. • Research & Innovation governance: Study approvals, governance oversight, research capacity, NIHR compliance
Care Group • Care group Performance review • Monitoring of care group KPIs				
Actions				
• Standardised ward governance packs (harm prevention, IRG/PSIRG, incidents, deteriorating patients, complaints, mortality themes, IPC, staffing, workforce). • Staff engagement, psychological safety, and improvement capability building.	• Mandatory monthly divisional governance boards with a standard agenda. • Divisional boards, risk management, improvement accountability	• Traffic light escalation protocol ward to division to exec on: i. Safety events ii. Operational pressures iii. Workforce issues Iiii. Culture/human factors concerns • Reinforced accountability for actions, decision logs, and follow-ups. • Sightline from Board to ward through data, walkarounds, and triangulation.	• Board structures, committees, assurance framework (BAF), annual governance • Quarterly deep dives: mortality, workforce culture, IPC, patient experience, safeguarding. • Executive and NED “Governance WalkRounds”. • Decisions have been made on all 3 outstanding business cases.	
What success looks like				
• All wards run reliable monthly governance meetings with standard data. • Staff report increased psychological safety.	• Divisional governance boards operate to schedule with clear actions.	• Real-time visibility of patient safety, quality, staffing and mortality.	• Clear escalation pathways with timely resolution of risks. • Board receives meaningful, triangulated assurance.	• A single, trusted, triangulated trust-wide dashboard is used. • Governance is no longer dependent on individuals—processes are institutional.

Culture

Culture	
Exec Lead	Siobhán Callanan
Programme Manager	Adam Walton
Date	13/02 /2026
Programme RAG Status	
RAG Justification	Programme Board is now set up with Monthly Cadence for Cultural Transformation Overall, the programme is active, engaged and aligned to its stated objectives. Continued focus on delivery discipline, impact measurement, and visible leadership sponsorship will be key to maintaining momentum and achieving high-impact outcomes by the April and October 2026 milestones. TLT development programme training is not delivering to target due to a number of factor (see report)

Programme Workstreams

1. Delivery of management competency through the Management and Advanced Management Essentials training for all staff B7 and above;
2. Workstreams 1 - 6 of the Cultural Transformation Programme;
3. Management of Employee Relations backlog;

Milestones Achievements this Period:

1. Cultural Transformation Programme Boards scheduled and Terms of Reference approved
2. Listening model and advocacy training established and advocates trained. Further training on Hold pending agreement on SOP.
3. Workstreams 4 & 5 of the programme commenced, realigned to Stabilisation Plan objectives

Milestones Planned:

1. **Mobilise workstream governance and reporting across all workstreams**
2. **Finalise programme and workstream plans, reporting and delivery structures in newly mobilised workstreams (WS2, WS3, WS 4 /5 and WS 6)**
3. **Completion of listening events for January 2026 following approval of SOP**
4. **Development of an evidence-based work safety plan for WS 3 of the CT Programme**
5. **SOP to be developed and agreed to support further training and processes for Listening advocates**
6. **Agree SRO and further stakeholders for Workstream 4/5**
7. **Understand Risk and Issues for Cultural transformation programme and how they link with Trust Board Assurance Framework**

Celebrations:

1. **Cultural Transformation Programme Board up and running with first board meeting commenced.**
2. **Engagement across all workstreams and CT Programme Board**

Progress Update

Phase 2 of the Cultural Transformation Programme has successfully moved from design into structured implementation, with all 5 high-impact workstreams now active.

Cultural Transformation Board is now set up with Monthly Cadence with confirmation from Executive members, SRO. ToR has been agreed. Overall, the programme is active, engaged and aligned to its stated objectives. Continued focus on delivery discipline, impact measurement, and visible leadership sponsorship will be key to maintaining momentum and achieving high-impact outcomes by the April and October 2026 milestones.
Listening advocacy training has taken place and Staff Listening events have commenced, however further training is on hold whilst a Standard Operating Procedure has been agreed.

TLT development activity has been impacted by staff capacity to attend training due to operational pressure.

Programme Milestones

NHS Medway NHS Foundation Trust

Project	Milestones	Target Date	RAG	Status
CT: Workstream 1: Rebuilding Trust	Listening model and capability established Listening events underway	Jan 2026		On track
CT: Workstream 2: HR Case Review	Milestone deadlines are being re-phased following change in membership	TBC		Delayed
CT: Workstream 3: Work Safety	Embedding Cultural Competence and Accountability into Trust-Wide Values and Behaviours Building a Real-Time View of Safety Risks Across All Staff Groups Strengthening Early Action and Reporting Channels Launching Trust-Wide Anti-Racism and Anti-Discrimination Charter	End Feb. 2026 End Mar. 2026 End Apr. 2026 End May. 2026		On track
CT: WS4: Leadership Accountability aligned with WS5: Fixing the Middle (Aligned)	Joint management proposed for this workstream	TBC		Delayed
CT: WS6: Gender Equality (GenderWise)	Workstream meeting established	16/02/2026		On track
Employee Relations Backlog	To be advised by CPO	31/12/2025		TBA
TLT Development Programme (Management Essentials and Advanced Management Essentials)	Compliance is running averse to plan due to risks stated in risk report. Trajectories for compliance revised to 80% (ME) & 80% (AME) by March 2026	AME- 31/03/26 ME - 31/12/25		Off track

Programme & Project KPIs

Programme KPIs	Latest (Dec)	Plan	Trend	Justification for Variance	Nov25 Actual	Nov 25 Planned	Dec 25 Actual	Dec 25 Planned	Jan 26 Actual	Jan 26 Planned
80% of middle managers completing the TLT development programme (Advanced Management Essentials for B8a and above / Management Essentials for B7)	66% (AME) 53.4% (ME)	TBC (AME) 85% (ME)	▲	Industrial action and FCP are highest linked reason for cancellation of attendance at training. Staff reporting they have been requested to provide cover on planned training day so DNA rates have not improved	58.6% (AME) 55.3% (ME)		66% (AME) 53.4% (ME)	85% (ME)	72.5% (AME) 55.3% (ME)	
Deliver to the six workstream timescales linked to Phase 2 of the Cultural Transformation Programme (completion of Phase 2 by October 2026)	6 workstreams mobilised	6 workstreams	▲	All workstreams now mobilised although some are behind in terms of milestone delivery for this point in the Phase 2 plan.	4 workstreams mobilised	6	4 workstreams mobilised	6	5	5
100% of backlog cases in Employee Relation (ER) have been reviewed and outcomed (Lead: CPO)	TBA	100% cases outcomed	TBC		Cum. total = 33 cases outcomed (6 in month)		To be advised	100% cases outcomed	72.5% cases outcomed	100% cases outcomed
Improvement in performance related to disciplinary and grievance investigations completed within 6 weeks (non MHPS) - on stream from Jan 2026	N/A	N/A		Not yet due to report	N/A	N/A	N/A	N/A	N/A	N/A
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		Not yet due to report	N/A	N/A	N/A	N/A	N/A	N/A

Project KPIs – *detailed updates to be provided on return of Programme Manager*	Latest	Plan	Trend	Justification for Variance	Jan 26 Actual	Jan 26 Planned	Feb 26 Actual	Feb 26 Planned	Mar 26 Actual	Mar 26 Planned

Interdependencies & Risk

Interdependencies
Closer collaboration with Dartford and Gravesham NHS Trust following announcement of the group model and Executive structure
Governance Programme activities
Recruitment timescales for Executive core roles
Programme of recruitment to build capacity within HR to manage Employee Relations activity
NHS National Leadership Framework implementation in Spring 2026 will impact local TLT development programme in Management Essentials and Advanced Management Essentials.

Key Barriers to Success
Operational pressures, such as FCP which reduce capacity of staff to attend development activities in line with the TLT Development Programme i.e. Management and Advanced Management Essentials
Operational Pressures such as FCP which reduce capacity of staff to lead and deliver workstream activity within each workstreams. CT Programme board structure designed to support and understand these pressures

Project	Risk	Mitigation	RAG	Owner
Further updates to be provided once risk assessment of the programme and workstreams has been completed				

Quality

Quality	
Exec Lead	Alison Davis
Programme Manager	Chris Parokkaran
Date	13/02/2026(TLT)
Programme RAG Status	
RAG Justification	The Trust SHMI is outside the expected range. It correlates with frailty admissions, ED performance and hospital admissions for palliative care. National Data published in a paper from 2022 shows that every time a patient stays in ED for more than 5 hours the standardised mortality rate will increase in a dose dependant relationship. Areas of concern include community and in- hospital frailty pathways, community and in hospital palliative care pathways, avoidable deconditioning and deterioration particularly in ED and inpatients who are **NCTR**. The clinical pathway outlier group for the trust in the SHMI dataset 12.02.26 is Pneumonia.

Progress Update

All five workstreams are focused on reducing in-hospital deaths. We have also identified gaps in community services for dying patients, leading to avoidable hospital admissions and contributing to SHMI. Strengthening community provision will be essential to improving SHMI.

Milestones Achievements this period: (Jan 2026)

1. Initial meeting for establishing frailty community pathway has taken place. Leads for work identified.
2. Learning from deaths pathway refresh- initial meeting has taken place and next meeting scheduled for 11th Feb. Estimated completion date 1st of March.
3. Palliative care and avoidable admission and delays to discharge- Initial meeting with community PELOC to identify themes and support required from community to reduce unwarranted admissions for palliative care. 4.
4. Deconditioning and deteriorating patient initial meetings commenced. Outcome measures discussed. KPI now being identified.
5. Sepsis/ Pneumonia order set has now gone live on EPR. Staff training underway.

Programme Workstreams:

1. Frailty Pathways.
2. Palliative Care Pathways
3. Nursing and therapies to prevent deconditioning and deterioration whilst in ED/ NCTR
4. Learning from Death Process and Governance (Improve avoidable death reporting, actions and learning).
5. Clinical Pathways (Pneumonia & Sepsis)

NHS Medway NHS Foundation Trust

Milestones Planned: (Feb 2026)

1. Community Frailty Pathway work to be developed further as leads are established. Initial meeting booked for 26th Feb. PMO resource to be identified. KPI'S to be established. System Partners Workshop planned for 25th Feb and Medway representatives to attend.
2. Refresh learning from deaths pathway to ensure robust investigations of learning and communication between patient safety, medical examiners, complaints and mortality team takes place. Completion of BO huddle refresh.
3. Monthly meeting with community palliative care established and need to discuss the themes that impact the avoidable admissions further. Building end of life dashboard and further discussions to establish KPI.
4. Deconditioning patient group to finalise outcome measure by 6th March and discuss time frame to upload on EPR. KPI to be established. Deteriorating patients work needs to start after establishing resource that can lead this work
5. Sepsis/ Pneumonia group to make sure 50 % staff trained to complete order set. Sepsis group to progress work to now establish paediatric sepsis order set. Pneumonia group to scope project plan and establish meetings and finalise KPI.

Celebrations:

1. Mortality workshop went well last month and completed the Quality True North refresh.

Project Milestones

NHS Medway NHS Foundation Trust

Workstream Update	Milestones	Target Date	RAG	Status
Community and Hospital Frailty Pathways	Lead established. PMO support to be established. Initial meeting booked for 26th Feb. Workshop on 25th Feb. Initial phase can take up to 4 months. Awaiting ICB business case.	April 2026		On track. Initial meeting went well. Awaiting ICB business case to decide on KPI'S. Can go off track if ICB business plan not received.
Community Palliative care pathways	Monthly meeting with community palliative care established and need to discuss the themes that impact the avoidable admissions further. Building end of life dashboard and further discussions to establish KPI.	March 2026		Awaiting ICB business case. Track themes e.g. care homes /GP practices.
Learning from Deaths Pathway	Awaiting option papers from LFD team to start pathway change work and establish how to monitor KPI to improve avoidable death reporting	March 2026		On track to provide option papers and then pathway changes in few months.
Clinical Pathways	Sepsis order set is now live and staff testing the order set currently. Working group has been set and KPI'S agreed. To have a comms plan once review of order set is complete. Part of Pneumonia order set is now live and staff are testing this currently. Pneumonia nurse has been identified and need to set up working group now and agree KPI's that are going to be monitored.	Oct 2025		Off Plan expected to be completed in Oct. New agreed date is Feb 26.
Deteriorating and deconditioning work.	Deconditioning working group set up to meet once a month and feedback to Quality BO huddle. KPI's in discussion to be agreed after outcome measure is decided and uploaded on EPR. Deteriorating patient work resource need to be finalised.	March 2026		Ontrack for deconditioning but off track for deteriorating as resource for this work need to be finalised soon for this working group to start.

Programme KPIs

KPI	Latest (Jan -26)	Trend	Justification for Variance	Dec 25 Actual	Dec 25 Planned	Jan 26 Actual	Jan 26 Planned
A downward trajectory of Mortality of the Trust SHMI by September 26 (Data set available with a six months lag. Next data set available for Aug 25 in mid-January 2026)	1.26 (Sep 24 – Aug 25)			1.26 (August 24- July 25)	1.15	1.26 (Sep 24- Aug 25)	1.15
Crude Mortality Rate (%) in the month to be less than the same time period 12 months previously	2.2% (Jan 25 -2.3%)			1.8%	1.1	2.2%	1.1
95% Compliance in NICE guidelines SEPSIS care compliance using monthly audit data (Data set based on 50 patients for old compliance)	91%			75%	90%	91%	90%

Project KPIs & Risk

Project	KPI	Baseline Sept 25	Trend	Dec 25	Jan 26	Jan 26 Planned
Community and Hospital Frailty Pathways	ED length of stay for patients over 75 years old proposed as KPI. Understanding if this data is available with BI.					
Community Palliative care pathways	Number of avoidable palliative care admissions per month proposed as KPI. Analysing data availability. Also awaiting ICB business case for themes. Awaiting End of Life dashboard to be build so KPI can be decided.					
Sepsis NICE Compliance	90% compliance to the NICE guidelines. Currently ED data not included to check compliance. Understanding data availability with BI.			75%	91%	90%
Pneumonia Pathway Compliance	Pneumonia working group initial meeting done. KPIs discussed but not agreed.					

Project	Risk	Mitigation	RAG	Owner
ED Sepsis Data	ED Sepsis data not available for audit . Escalation done to BI team to get ED Sepsis data	To organise a meeting with ED/ BI teams together to get the data.		Sarah
Deteriorating Patient	Project recourse not available to start the work.	Evonne Hunt to discuss with Divisional leads and confirm project resource.		Evonne
Frailty pathways and palliative care	Projects dependent on ICB Business case which is expected to include community frailty, single point of access and palliative care.	Not able to mitigate as not within our gift. Dependent on community partner's.		Sanjay

Performance

Performance	
Exec Lead	Frances Woodroffe
Programme Manager	Darren Palmer
Date	11/02/2026
Programme RAG Status	
RAG Justification	Overall RAG status for the programme is Amber, primarily based on being behind schedule and risks associated with delivering key milestones to time.

Programme Objectives

1. Delivery of access standards, as per the revised forecast outturn
2. Exiting from Tier 1 for Cancer and RTT

Milestones Achievements this Period:

1. Exceeded the expected RTT improvement trajectory to support specialties in their respective improvement paths.
2. Additional funding secured for additional sessions to support with RTT performance improvement to increase target from 57% to 60%.
3. DM01 Working Group Established – For better data oversight
4. Rescoping and agreement of NCTR workstream with clear milestones in place
5. EM5 Go live date and plan agreed
6. Patients being referred directly from ED to Virtual Hospital

Milestones Planned:

1. Decision to be made on Frailty SDEC
2. Recruitment of additional virtual hospital staff to enable the expansion
3. Plans developed for Ward Closures
4. Outpatient dashboard specification developed
5. Commencing next steps for PIFU following Gran Round presentation
6. Plan for clinical RTT training

Celebrations:

1. DM01 performance reported as achieving 91.9%. Improvement of 4.2% from last month
2. Patients being referred directly from ED to Virtual Hospital
3. EM5 Go live date and plan agreed

Progress Update

1. Elective Reform continues to move at pace with milestones supporting the stabilisation plan on target to achieve their KPIs at the end of March. Additional funding secured due to success of improvements made in RTT.
2. Virtual hospital capacity is behind scheduled due to the recruitment timeline, VCPs, interviews and notice periods will determine when this can happen.
3. UEC Performance remains challenged with significant pressure being held in ED
4. NCTR remains a significant challenge, however, a plan has now been agreed to implement key work initiatives on a pilot ward. This will generate valuable data to inform further rollout across other wards.

Milestones

Project	Milestones	Target Date	RAG	Status
Elective Reform	Training - Deliver RTT training to all staff within the trust. Outpatient Optimisation - Increase Clinic utilisation, Increase PIFU uptake to 5% of all outpatient appointments. WL/PTL - Dashboard launch, ensure we deliver a minimum five percent point improvement in RTT performance. Diagnostics - Extend CDC Opening Hours 12 hors per day 7 days per week and Deliver optimal tests per hour (improving capacity for diagnostics), Complete DM01 Review and DM01 Dashboard launch (improved data visibility).	March 2025 March 2026 March 2026 March 2026		Milestones are currently delivering expected planned improvements the project is confident that this will continue to improve. 90.8% currently target is 95.3% on trajectory to achieve this by end of March – Improved from a baseline of 75.7%
UEC/Flow	EM5 – Go live	March 2026		Plan developed with key milestones and go live date approved for 4th March 2026 – RAG's as Amber as discussions between COO and ICB are currently taking place over ward classification which may impact on go live date.
	Frailty Workstream	Mar 2026		Significant delays with this workstream. Currently on hold whilst decisions are being made on scope and objectives. Possible dependency for Quality whose objectives are on community and system the need for an SDEC is a big dependency.
	NCTR Implement Criteria Led Discharges (Pilot Ward – Sapphire) Behavioural Chart Improvements (Pilot Ward - Sapphire) Safer Patient Flow Bundle Implementation (Pilot Ward - Sapphire)	April 2026 March 2026 March 2026		Workstream has been rescoped and plan drafted. Baseline reset and RAG'd amber due to volume of work and risk around achievement to time.
	Virtual Hospital – Project Medical Patient Referrals from ED Expansion to 150 Patients Ward 1 Closure Ward 2 Closure	Feb 26 March 26 TBC		Pause was lifted – 29th January with patients now being referred directly from ED (based on capacity). Currently have capacity for 120 – Staffing required to match the model for 150 patients. Recruitment of roles at varying timeline for completion depends on recruitment timeline. Patients not lodging in ED corridors or discharge lounge achieved Behind schedule – Consultation process to begin no dates confirmed

Programme KPIs

NHS Medway NHS Foundation Trust

Current Measures of Performance:		30-Sep		31-Oct		30-Nov		31-Dec		31-Jan		28-Feb		31-Mar	
		Delivered	Plan	Delivered	Plan	Delivered	Plan	Delivered	Plan	Delivered	Plan	Delivered	Plan	Delivered	Plan
1	Patients are seen and treated within 18 Weeks	53.40%	55.60%	54.60%	55.80%	55.80%	56.60%	57.0%	57.30%	**60.9%**	58.20%		58.90%		60.00 %
2	No more than 1% of patients to be waiting >52 weeks seen & treated	5.40%	3.80%	5.10%	3.60%	2.50%	3.30%	1.3%	3.10%	**0.9%**	2.90%		2.30%		1.00%
3	ED 4hr Performance	75.70%	79.00%	74.70%	80.00%	73.90%	78.00%	69.9%	78.00%	**70.1%**	78.00%		79.00%		80.00 %
4	ED >12hr LOS Type 1	11.10%	11.00%	11.90%	11.00%	11.70%	11.00%	13%	13.00%	**14.4%**	13.00%		12.00%		9.40%
5	95.3% of DM01 Delivery of Diagnostics within 6 weeks.	82.40%	93.00%	85.50%	94.60%	90.80%	94.70%	87.7%	95.00%	**91.9%**	94.90%		95.30%		95.30 %
6	28 day FDS (80%)	76.70%	76.00%	76.30%	76.10%	78.9%	76.99%	75.8%	77.00%	**71.3%**	77.43%		78.55%		80.07 %
7	62 day (75%) Cancer waits	71.00%	73.00%	76.00%	74.47%	82.1%	74.74%	73.8%	73.03%	**82.1%**	71.59%		74.16%		75.00 %

Project KPIs & Risk

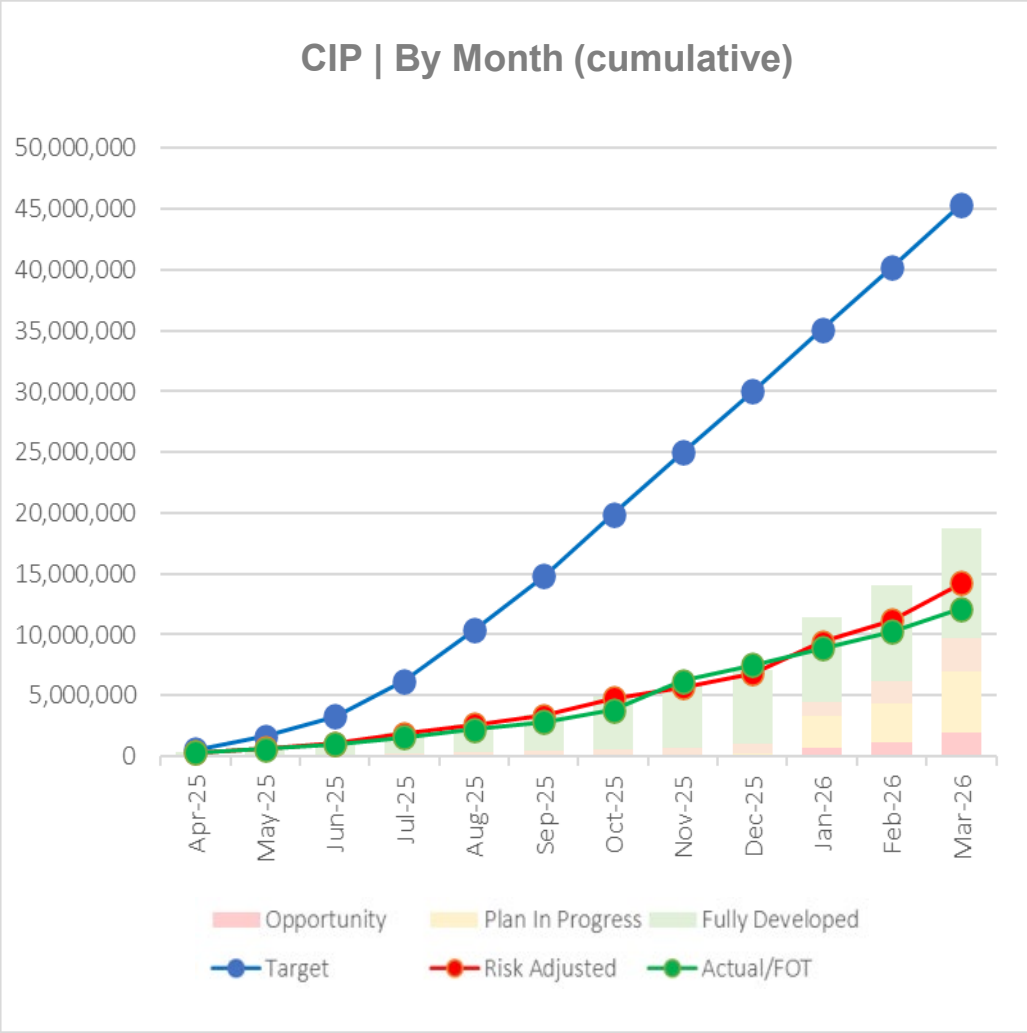
Project	KPI	Baseline Sept 25 (Actual)	Plan	Trend	Nov 25 Planned	Nov 25 Actual	Dec 25 Planned	Dec 25 Actual
UEC/Flow	Specific metric around reduction of over 12-hour LoS in ED for Type 1 patients	11.5%	(TBC)					
Elective recovery-RTT and Cancer	Refer to Programme KPIs on the previous slide. (Given the high number of KPIs within each workstream, we should decide how to present this information for the next meeting.)	TBC			N/A	N/A	TBC	TBC

Project	Risk	Mitigation	Consequence	Likelihood	Risk Score	Owner
Elective reform	1. Risk to RTT delivery due to ENT backlog and cost to deliver recovery	Activity is being outsourced to OMNES	4	3	12	DDoER
Elective reform	2. Risk to delivery of diagnostics due to limited Imaging reporting capacity at external organisations	To be agreed	3	4	12	Sam Chapman
Elective reform	3. Risk to RTT delivery due to potential winter cancellations illustrated by seasonal trends	To be agreed	5	4	20	
UEC/Flow	4. Increase in ED acuity and attendances (due to seasonal variance - winter)	Admission avoidance project currently underway for initiation Increased capacity within virtual ward More senior review in ED (Acute consultant)	4	3	12	Dr Da Costa
UEC/Flow	5. Increase in NCTR patients	Increase of community capacity (limited) Expedition of pathway zero discharges and MADE events	3	4	12	IDT
UEC/Flow	6. Virtual hospital staffing to accommodate the increase in beds	Discussions underway with Execs to ensure availability of staffing for existing bed base and recruitment is in progress in order to accommodate the expansion.	3	3	9	Tracy Stocker

Finance

25/26 programme: actual and forecast delivery overview

Against initial 25/26 target



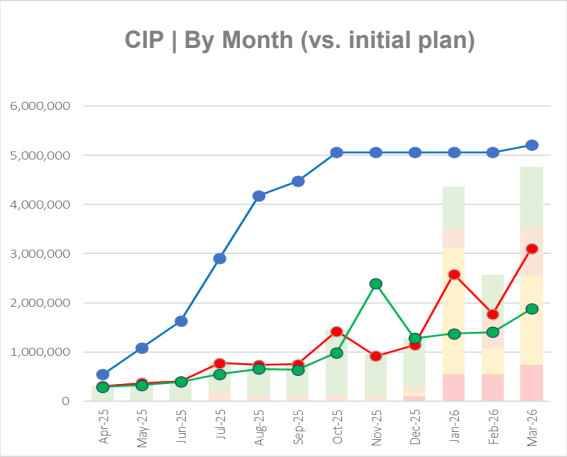
Target	Identified (not adjusted)	Identified (risk adjusted)	FYE (identified)
£45.36m	**£18.79m**	**£14.28m**	**£30.93m**
Forecast Outturn	Change since last SRG	Change since last SRG	Change since last SRG
£12.15m	**-£0.10m**	**-£0.03m**	**-£6.27m**
Remaining gap (vs FOT)	Remaining gap (identified not adjusted)	Remaining gap (identified – risk adj.)	26/27 plan (FOT + plans in delivery)
£33.21m	**£26.57m**	**£31.08m**	**£13.35m**

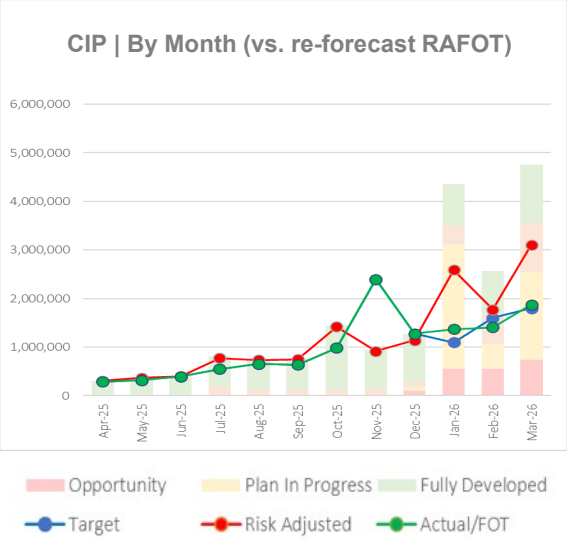
- We have identified 41.4% of the target (31.5% of the target based on the risk adjustments (considering plan maturity))
- Forecast outturn is 26.8% of the target (£12.16m) – this dropped by £0.11m since last SRG
- 91% of the schemes in delivery (i.e. forecast outturn) are recurrent

Note: the reduction in FYE is due to (a) the removal of the remaining outpatient productivity schemes (i.e. template standardisation) to productivity as opposed to cost out. This takes the value of schemes relating to elective productivity (i.e. theatres, imaging) which have been converted to productivity to support RTT to ~£3.3m FYE and (b) the reduction of the FYE impact of MARS from £4.5m to £0.2m.

There are additional opportunities relating to the spans & layers review to be included – these are being worked through from opportunities. **Work is continuing to review all controllable spend for 25/26 to identify further opportunity to generate cost out (i.e. outsourcing, insourcing, non-substantive pay) through exec-led check and challenge sessions (incl. the offsetting impact to income / external funding secured).**

25/26 programme: monthly trajectory





25/26 (£'000)	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	YTD	FYE
Initial CIP target	0.54	1.08	1.63	2.91	4.18	4.48	5.07	5.07	5.07	5.07	5.07	5.21	30.03	45.38
RAFOT CIP target	0.12	1.23	0.01	0.33	0.62	0.82	1.22	2.12	2.47	2.82	3.02	3.02	8.92	17.80
Re-forecasted RAFOT CIP target	0.29	0.32	0.40	0.55	0.65	0.64	0.98	2.39	1.28	1.10	1.60	1.80	7.50	12.00
Planned (not risk adjusted)	0.31	0.37	0.40	0.81	0.76	0.77	1.45	0.95	1.28	4.37	2.57	4.79	7.10	18.80
Opportunity	-	-	-	-	-	-	-	-	0.10	0.55	0.55	0.74	0.10	1.94
Plan in Progress	-	-	-	-	-	-	0.01	0.02	0.07	2.57	0.52	1.80	0.10	4.99
Fully Developed	0.31	0.37	0.40	0.81	0.76	0.77	1.44	0.93	1.11	1.25	1.50	2.22	6.89	11.87
Gap vs. initial CIP target	(0.23)	(0.71)	(1.23)	(2.10)	(3.42)	(3.71)	(3.62)	(4.12)	(3.79)	(0.70)	(2.50)	(0.42)	(22.93)	(26.55)
Gap vs. RAFOT CIP target	0.19	(0.86)	0.39	0.48	0.14	(0.05)	0.23	(1.17)	(1.19)	1.55	(0.45)	1.77	(1.84)	1.03
Gap vs. re-forecasted RAFOT CIP target	0.02	0.05	-	0.26	0.11	0.13	0.47	(1.44)	-	3.27	0.97	2.99	(0.40)	6.83
Actual / FOT	0.29	0.32	0.40	0.55	0.65	0.64	0.98	2.39	1.28	1.37	1.44	1.88	7.50	12.16
Gap vs. initial CIP plan	(0.25)	(0.76)	(1.23)	(2.36)	(3.53)	(3.84)	(4.09)	(2.68)	(3.79)	(3.70)	(3.63)	(3.33)	(22.53)	(33.19)
Gap vs. RAFOT CIP plan	0.17	(0.91)	0.39	0.22	0.03	(0.18)	(0.24)	0.27	(1.19)	(1.45)	(1.58)	(1.11)	(1.44)	(5.61)
Gap vs. re-forecasted RAFOT CIP target	-	-	-	-	-	-	-	-	-	0.27	(0.16)	0.08	-	0.19

25/26 programme: summary (overview vs. original target)

Medway NHS Foundation Trust

		Forecast Outturn			Identified (all schemes)		Identified (full value by stage)			
Divisions	Lead	Target	Actual	Gap to target	# of schemes	Total Value (unadj.)	Opportunity	Plan in Progress	Fully Developed	Value (risk adjusted)
CCCS	Sam C	£5.97m	£2.30m	(£3.67m)	22 (-3)	£1.63m (-)	- (-)	£0.09m (-)	£1.55m (-)	£1.58m (-)
MEC	Nicola C	£6.87m	£2.29m	(£4.58m)	18 (-)	£3.62m (-)	£0.05m (-)	£0.62m (-)	£2.95m (-)	£2.85m (-)
S&A	Stewart N	£6.02m	£2.64m	(£3.38m)	28 (-)	£2.49m (-£0.10m)	- (-£0.10m)	£0.03m (-)	£2.47m (-)	£2.42m (-£0.03m)
WC&YP	Karen K	£3.29m	£0.99m	(£2.30m)	18 (-)	£1.21m (-)	£0.08m (-)	£0.05m (-)	£1.08m (-)	£1.12m (+£0.15m)
E&F	Neil M	£2.18m	£0.75m	(£1.43m)	19 (-)	£0.93m (-£0.01m)	£0.05m (-)	£0.06m (-)	£0.83m (-)	£0.79m (-£0.02m)
Corporate (excl. EAF)	Simon W	£2.87m	£2.09m	(£0.78m)	72 (-1)	£2.98m (-)	£1.22m (-)	£0.06m (-)	£1.69m (-)	£2.03m (-)
Central	N/A	N/A	£1.10m	£1.10m	14 (-3)	£5.92m (-)	£0.53m (-)	£4.09m (-)	£1.30m (-)	£3.48m (-)
System-level efficiencies	N/A	£18.18m	-	(£18.18m)	- (-)	- (-)	- (-)	- (-)	- (-)	- (-)
Total		**£45.38m**	**£12.16m**	**(£33.23m)**	**191 (-7)**	**£18.78m (-£0.11m)**	**£1.93m (-£0.10m)**	**£5.00m (-)**	**£11.87m (-)**	**£14.27m (+£0.10m)**

Cross-cutting projects	Lead	Target	Actual	Gap to target	# of schemes	Total Value (unadj.)	Opportunity	Plan in Progress	Fully Developed
Elective Reform (Outpatients)	Frances W	N/A	TBC	N/A	0	Opportunity being delivered as productivity (not cost-out)			
Elective Reform (Theatres)	Frances W	N/A	TBC	N/A	0	Opportunity being delivered as productivity (not cost-out)			
UEC & Flow	Darren P	N/A	TBC	N/A	1	£1.00m	£1.00m	-	-
Medical Productivity (workforce)	Alison D	N/A	TBC	N/A	6	£1.16m	-	-	£1.16m
Virtual Wards / hospital	Tracy S	N/A	TBC	N/A	2	£1.50m	£0.50m	£1.00m	-
Corporate services review	Simon W	N/A	TBC	N/A	1	£2.03m	£1.80m	£0.23m	-

* Risk adjustments are made based on status of scheme in the approval process: opportunity (25% of total value), plan in progress (50% of total value) and fully developed (100% of total value).

Medical Productivity

Opportunity	Core KPI Driving Opportunity	Target	Trend	Oct-25	Nov-25	Dec-25	Jan-26
Job Planning							
Job Planning PID - Reduction in PA's	£ opportunity delivered	£1m	—	£0	£112k	£112k	
	KPI: Team job plans signed off	100%	—	90%	97%	97%	
	KPI: Individual job plans signed off	100%	▲	65%	73%	85%	
	KPI: PAs reduced from job plans	75	—	26	26	26	
Increasing DCC to 85%	£ opportunity delivered	£0	—	£0	£0	£0	
Allocate/payroll review	£ opportunity delivered	£0	—	£0	£0	£0	
Medical Rostering Review							
MEC	£ opportunity delivered	£0.164m	—	£0	£0	£0	
S&A, CCCS, WCYP	£ opportunity delivered	£0.028m*	—	£0	£0	£0	
System procurement	£ opportunity delivered	£0	—	£0	£0	£0	
Medical Leave	£ opportunity delivered	£0	—	£0	£0	£0	
Additional Sessions grip and control							
Governance and rate review	£ opportunity delivered	£0	—	£0	£0	£0	
	KPI: # requests received	NA	TBC	TBC	TBC	TBC	
	KPI: # requests approved	NA	TBC	TBC	TBC	TBC	

** to be validated*

Key Achievements

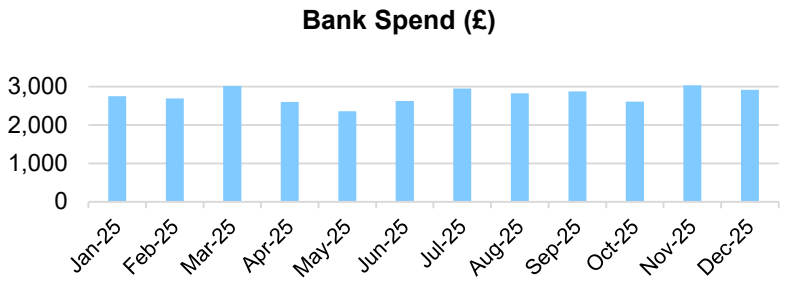
- Position in January shows 100% of team job plans are agreed and 89% of individual job plans are signed off.
- Analysis undertaken to understand PA change excluding new starters and leavers – net 27.5 PA reduction between April and January (to be discussed at next SRG)
- M1-8 additional session run rate reduction confirmed at £982k ex. IA
- Bank check and challenge approach agreed with Divisional leadership

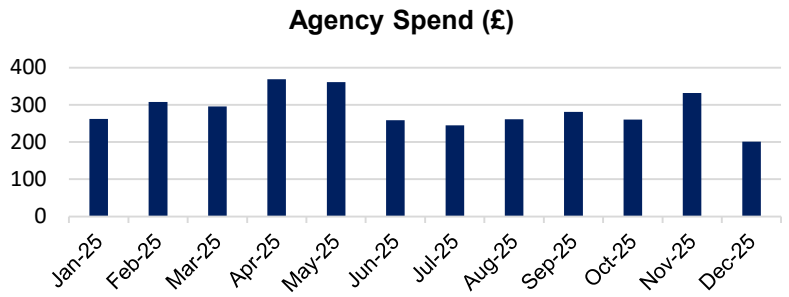
Focus areas for next two weeks

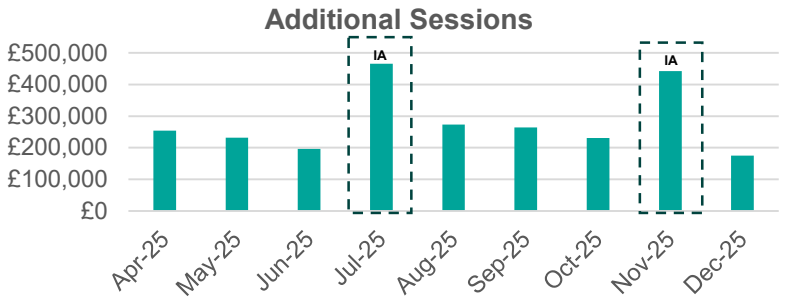
- Sign off additional sessions SOP
- Implement enhanced bank controls
- Finalisation of allocate/payroll review
- Continue mediations and job plan deep dives

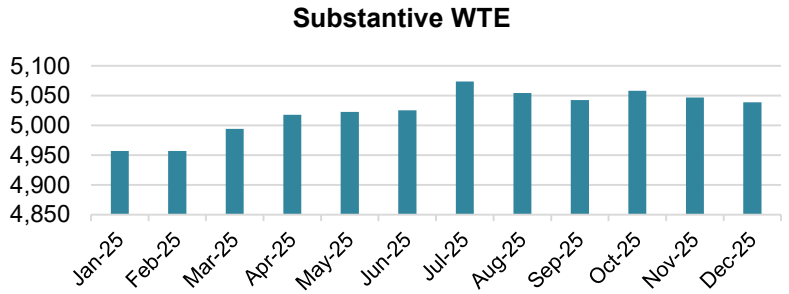
Key Risks / Issues	Mitigating actions	RAG	Owner
Capacity within the Organisation to move forward with improvement work is limited due to demand on services / people / annual leave	Diary management. Executive decision on Prioritisation		All
PA's increase rather than reduce as per the PID that has been approved at panel	PA Consulting to support with a granular analysis of job plans – objective to ensure plans are fair and transparent. Further process enhancements to be developed to support ongoing tracking		Chris P / Chez F
Divisions failing to deliver job plans which are in line with the job planning policy, within the deadlines.	Provide additional support from DCMO and External Job Planning Expert and regular progress reviews		Chris P / Chez F
Divisional engagement with rostering opportunity review	Focused engagement with PMO and PA support to expedite opportunity review		Matt R / Chez F

Workforce: Grip & Control









Opportunity	Core KPIs	Baseline (Sep'25)	Trend	Oct-25	Nov-25	Dec-25	Jan-26
Workforce KPIs							
Temporary Staffing	Bank Spend	£2,879k	▼	2,613	3,036	2,923	
	Bank Spend as % Pay Spend	10.9%	▼	8.8%	10.1%	9.7%	
	Agency Spend	£281k	▼	260	332	201	
	Agency Spend as % Pay Spend	1.1%	▼	0.9%	1.1%	0.7%	
	Additional Sessions Spend	£239k	▼	204	439	175	
Substantive	Substantive WTE	5,043	▼	5,058	5,047	5,039	

Key Risks / Issues	Mitigating Actions	RAG After Mitigation	Owner
Winter/ Operational pressures limiting ability to reduce temporary staffing in areas with high sickness/ limiting senior time available to provide effective oversight	Continued meeting of G&C meetings to ensure effective oversight/ staffing levels aligned to safe staffing requirements		SG

Key Achievements

Nursing, Midwifery, CSWs and AHPs:

- Sickness absence management best practice process mapped, policy updated, governance drafted for review and deep dives in progress;
- Establishment review working group continues with options development for headroom recruitment and management;
- Enhanced Care daily huddle continues with weekly tracking of impact;
- Ongoing development of roster review approach and best practice training and guidance.

Focus for Next 2 Weeks

Nursing, Midwifery, CSWs and AHPs:

- Rostering guidelines updated and signed-off;
- Absence management policy in sign off process (TBC sign off)
- Absence management governance process drafted – to be reviewed and signed off for implementation;
- First draft of automated absence report;
- Agreed preferred way forward for headroom recruitment and management;
- Enhanced Care 1-month impact review.

END

NHS
Medway
NHS Foundation Trust

Integrated Quality & Performance Report

January - 2026

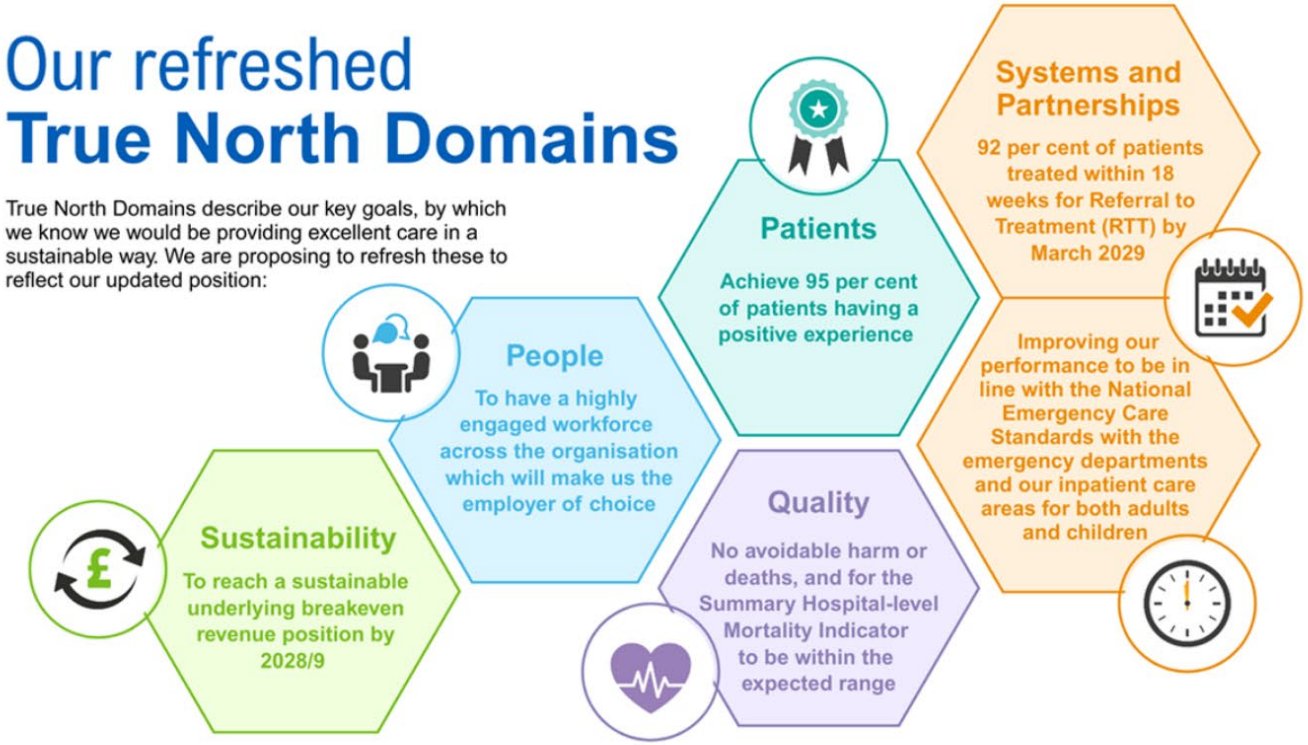
Patient FIRST

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:



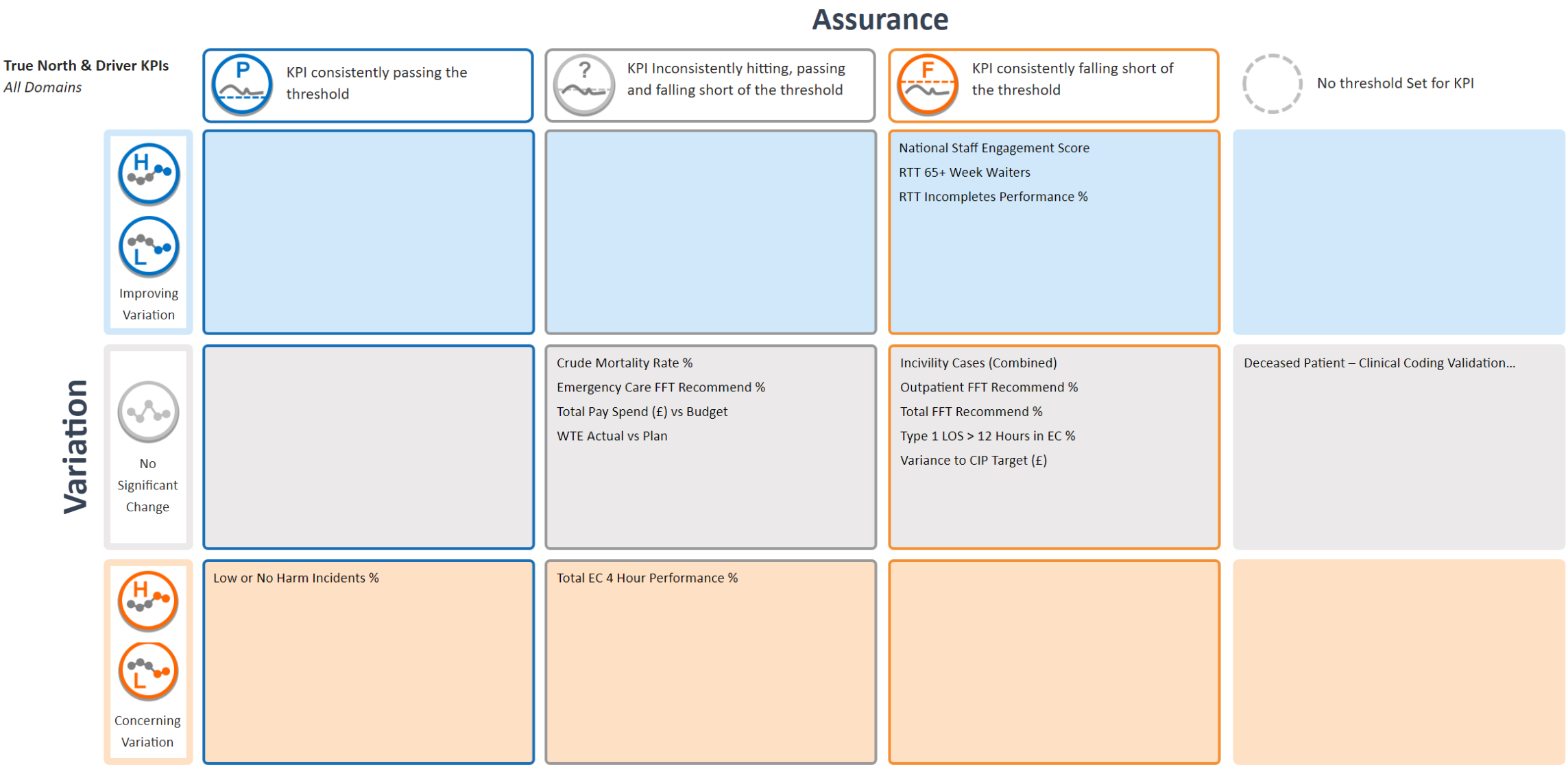
True North

	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
People	7	9	3	9	4	5
Quality	23	8	13	9	2	3
Systems & Partnerships	16	11	8	12	2	11
Patients	10	1	1	4	0	3
Sustainability	5	1	3	4	0	3

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



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

- Phase 2 of the Cultural Transformation Programme has successfully moved from design into structured implementation,
- Cultural Transformation Board is now set up with Monthly Cadence with confirmation from Executive members, SRO. ToR has been agreed.
- X2 Listening advocacy training have taken place along with specific workstream listening events

Issues, Concerns & Gaps

- TLT development activity has been impacted by staff capacity to attend training due to operational pressure.
- Listening events have commenced, however further training is on hold whilst a Standard Operating Procedure has been agreed.

Actions & Improvements

- Agree SRO and further stakeholders for Workstream 4/5
- Continue to build programme management structure
- Understand Risk and Issues for Cultural transformation programme and how they link with Trust Board Assurance Framework
- Confirm Listening Advocacy SOP to support further Training

Governance & Quality
Alison Davis, CMO
Evonne Hunt, CNO

Key Messages

- Identified current Medway Framework, commencing review to identify gaps for improvement
- We have agreed the monitoring undertakings via this Governance stabilisation plan
- We have grouped and identified the 3 key pillars for Governance – Clinical / Corporate/ Finance
- Identified the regulations the Trust needs to be compliant with as a NHS foundation Trust
- Frailty pathway, Palliative care, Pneumonia and Sepsis, Deterioration and Deconditioning of patients Learning from Deaths process and Clinical Documentation

Issues, Concerns & Gaps

- Identified gaps around the framework for COG (Council of Governors)
- End-to-end review of the Trust risk register to be completed.
- Executive leadership portfolio including responsibility to be identified
- Define role & duties of board committees, sub committees and groups, ensuring we have appropriate templates for TOR
- Lack of Community pathway

Actions & Improvements

- To align these regulations to relevant board committee, Trust leadership and Divisional Governance to ensure implementation and monitoring.
- The Trust Vision & strategic objectives identified from the Trust board development day to be reflected within the revised Medway governance Framework.
- Put in place a Board development programme that is aligned to strategic priorities
- Mortality work steams will be assessed for impact as part of the weekly mortality break through objective

Performance
Frances Woodroffe, COO

Key Messages

- RTT Performance slightly off plan in December and January due to Christmas and New Year. However, Q4 trajectories remain good with additional sprint activity planned across challenged areas.
- Tiering status now officially received to come out of Tier 1 for RTT and move to monthly Tier 2 oversight.
- Out of Tiering now completely for Cancer
- Virtual Hospital capacity continues to increase in Q4 to deliver further impact

Issues, Concerns & Gaps

- UEC performance remained challenged throughout January with extended periods in Full Capacity Protocol. Bed occupancy and NCTR numbers remain high.
- Christina Rossetti has been a point of escalation in periods of extremis although this is likely to close and remain closed throughout the remainder of Q4.
- Type 1 4 hour and 12 hours improvement initiatives being worked up with Divisional leadership

Actions & Improvements

- Programme to support virtual hospital remains a priority to step up further the occupancy in Q4
- Proposal to inhouse and redesign walk in pathways in ED due to board in February
- Performance sprints on elective care in train

Financial Recovery Plan
Simon Wombwell, CFO

Key Messages

- PA Consulting are supporting the Trust to refresh and write a new multi-year Financial Recovery Plan.
- System Drivers of Deficit work underway and provisional findings reported to FPPC.
- Forecast outturn is materially below target, largely caused by non-delivery of efficiencies.
- 3-year plan submitted as part of national planning – breakeven (after Deficit Support Funding) each year.

Issues, Concerns & Gaps

- FRP requires mature savings planning for all financial years; 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.
- Significant risks in achieving breakeven (after DSF) in 3-year plan submitted to NHSE.
- Financial grip remains fragile.

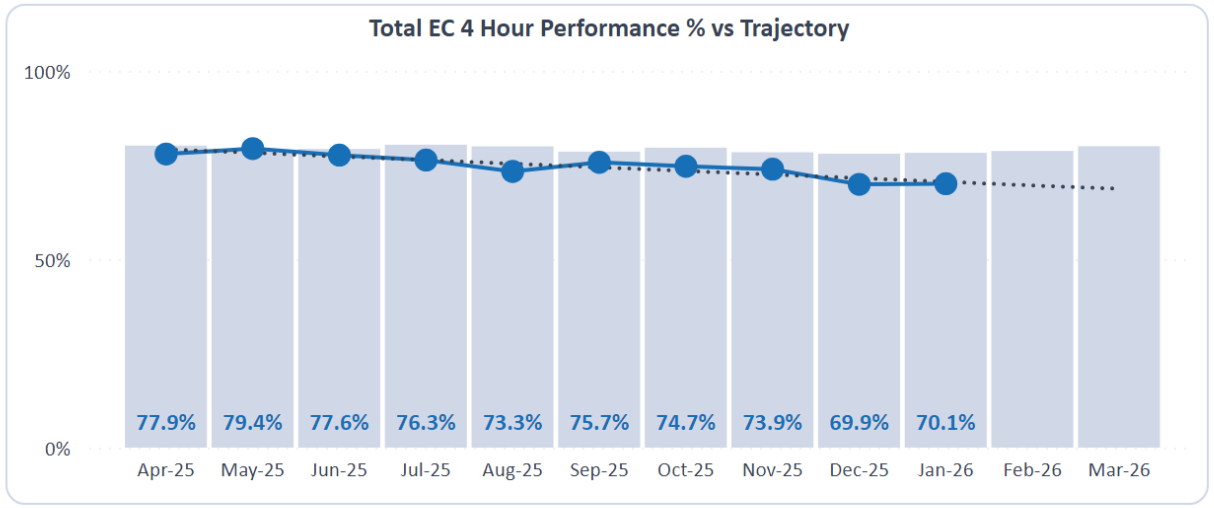
Actions & Improvements

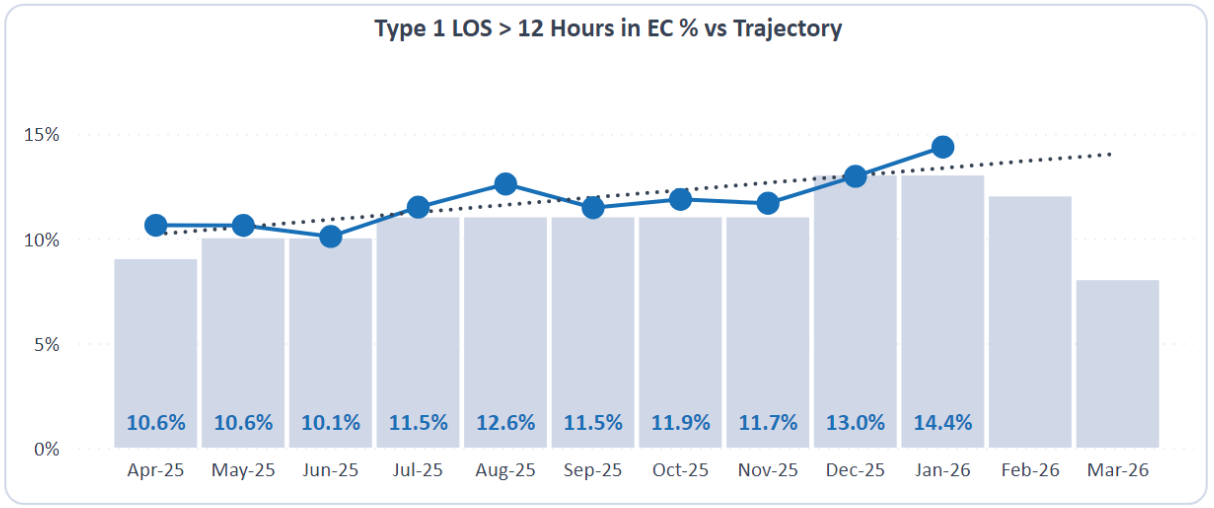
- Implementation of Group Model with Dartford & Gravesham NHS Trust.
- Continued drafting and evolution of FRP.
- Full engagement and influence over System Drivers of Deficit work.
- Accelerate development of thematic CIPs for 2026/27.
- Strengthen ownership and accountability of Divisions.
- Integrate finance recovery with workforce and performance programmes.

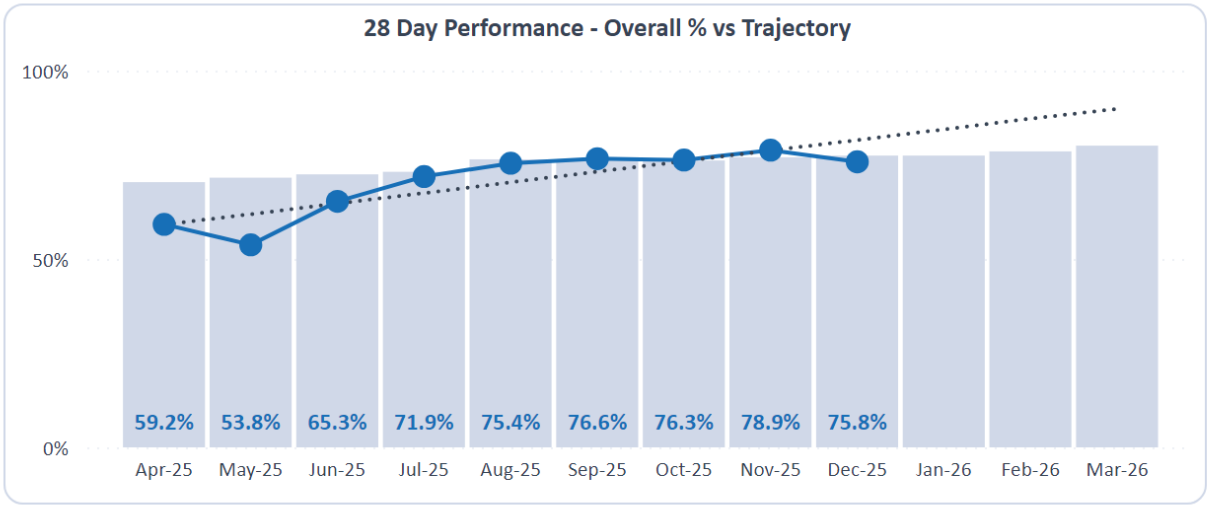
Executive Summary

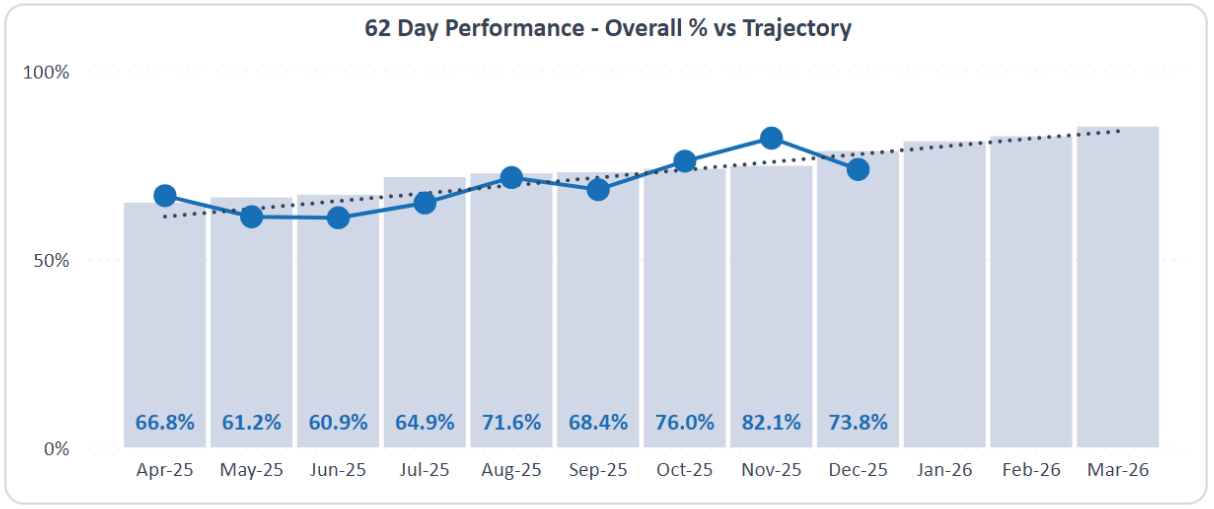
Stabilisation Plan - Performance vs Trajectory

Emergency Care and Cancer KPIs







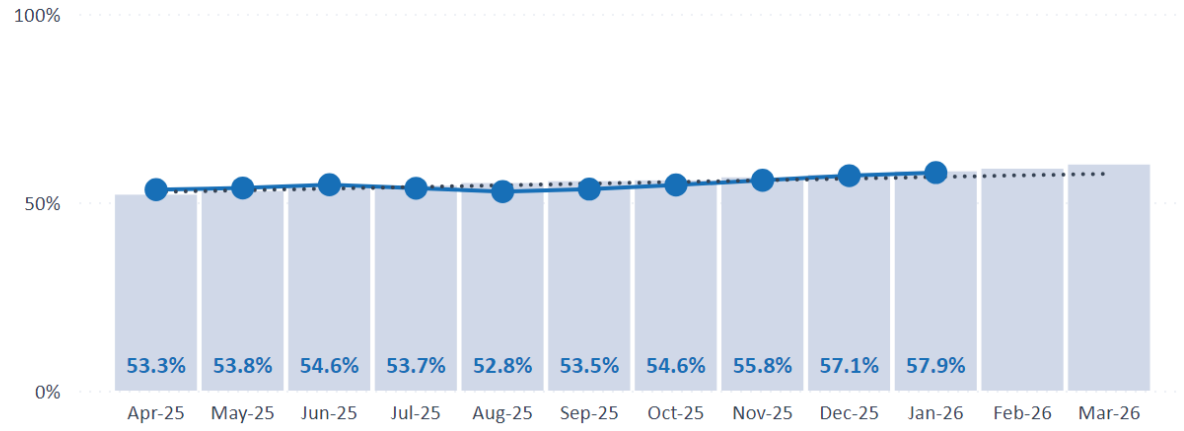


Executive Summary

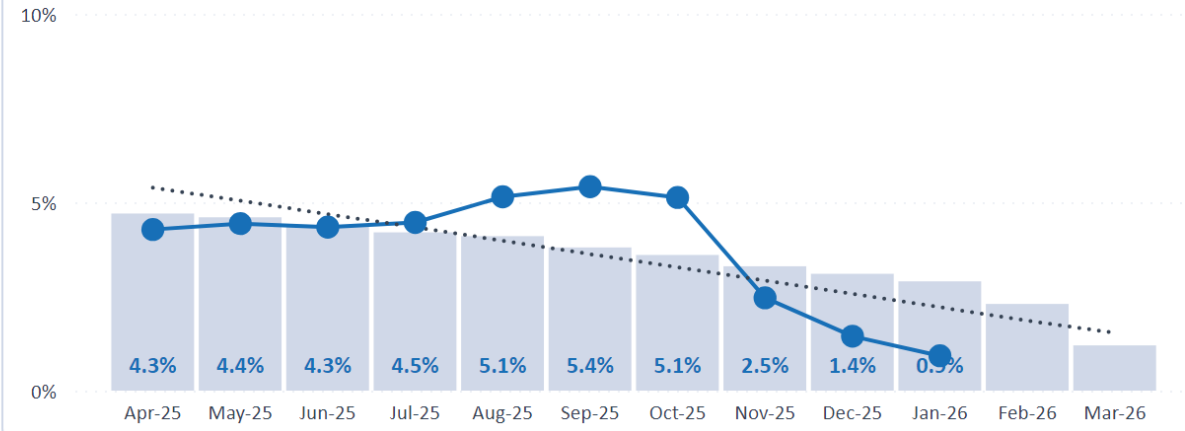
Stabilisation Plan - Performance vs Trajectory

RTT and Diagnostics KPIs

RTT Incompletes Performance % vs Trajectory

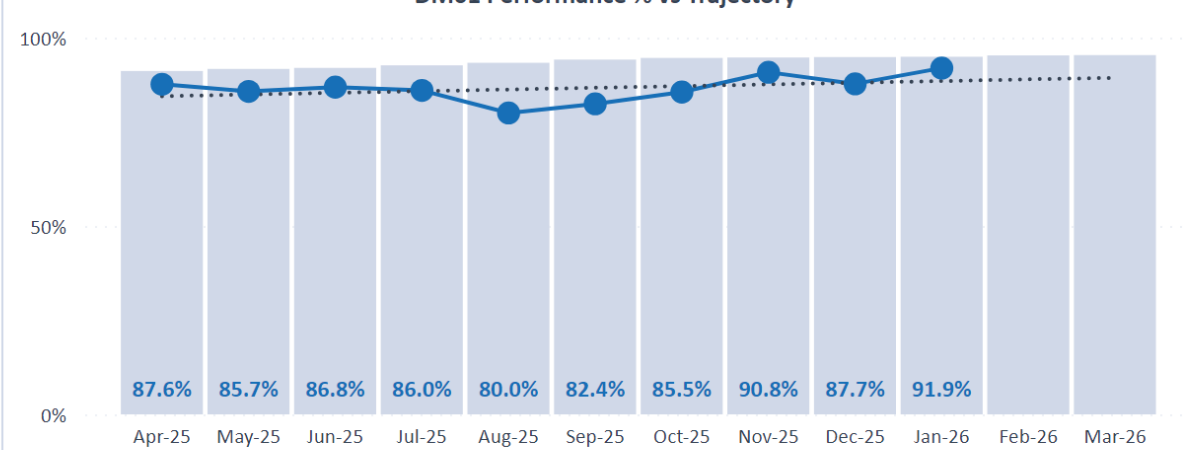


RTT 52 Week Waiting List % vs Trajectory



RTT Waiting List Size vs Trajectory

DM01 Performance % vs Trajectory



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	0	1	0	0	1
FFT	3	0	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*

Committees:
Quality Assurance Committee (QAC)

Patients Summary

Patients

Patient FIRST

BUSINESS INTELLIGENCE
Medway NHS Foundation Trust

NHS
Medway
NHS Foundation Trust

Watch KPIs Only
Patients 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		Mixed Sex Accommodation Breaches		
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...
H / L: Concerning Variation			Complaints Breached %	

Patients

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

FFT

Total FFT Recommend %

Type	Threshold	V	A	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
	95.0%			91.5%	90.5%	92.1%	91.9%	91.5%	91.5%	91.0%	90.7%	90.5%	90.9%	90.1%	90.7%

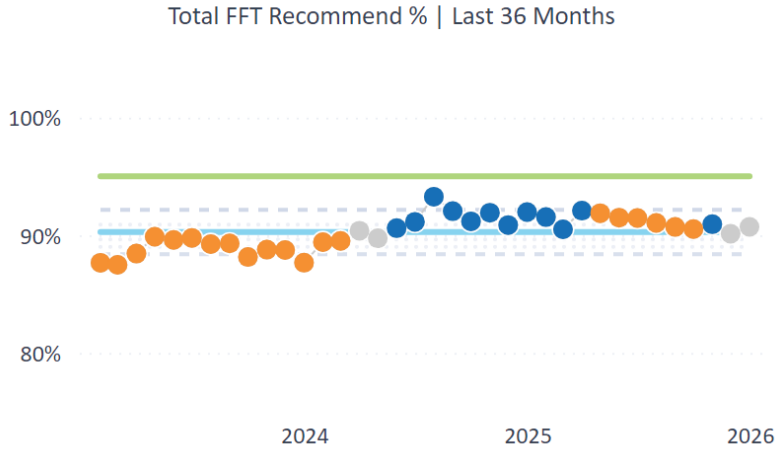
True North Domain: **Patients**

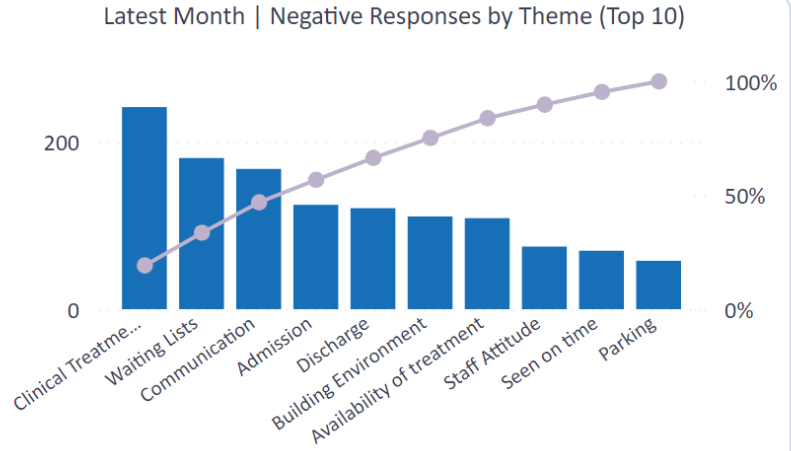
KPI Threshold: 95.0%

Sub Domain KPIs: 3

Variation Summary:

3	0	0	0	0





Key Messages

- Positive experiences of care have remained over 90% for 12 consecutive months. Patient experience remains below the Trust target.
- There continue to be small improvements
- ED FFT recommend rates continue to be over 75% and are just below target of 80%
- OP FFT recommend rates have been over 90% for 12 months and remain just below the target of 95%

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
- Divisions creating QIPS focusing on a key theme from their data

Patients

Key Messages

- 100% new complaints acknowledged.
- 23 new complaints registered. Themes include; delay in treatment,, general dissatisfaction with medical care, appropriateness of discharge
- PALS themes include; appointment queries, written & verbal communication to patients and families, delays with medication, delays in receiving results, delays with treatment, 20 enquiries related to entries in medical records.
- PALS team were less responsive due to staff absence causing a delay in responding to enquires, reduced number of enquiries handled; including just 6 compliments
- Increasing number of breached complaints.23 due to be responded to, 17 breached – 9 breached still awaiting comments, 8 breached during sign off process.
- 3 new PHSO enquiries for assessment – 1 complaint relates to 2022 and urology care, 2 are from 2025 and relate to nursing care on Emerald and Nelson ward
- MSA - Reduction from last month (18)

Issues, Concerns & Gaps

- 76.9% breach rate for responding to amber complaints KPI – causes include::
- Delay in receiving timely comments/statements from staff to progress the complaint investigation to prevent breaching KPI
- Additional stages in the complaint sign off process focusses on meaningful learning but has delayed closing the complaint
- Ongoing short staffing in the complaints team
- Lack of identified learning from patient feedback and complaints where it is identified that something has gone wrong
- A high number of patients remain unable to successfully contact the specialty department direct regarding appointment queries and result enquiries resulting in an additional stage in their enquiry with the calls being passed to PALS.
- Absence within the PALS team has impacted on responsiveness
- MSA - Awaiting automated MSA reporting to go live on Teletracking (Risk 1647)

Actions & Improvements

- Complaints linked to ongoing QIP work wherever possible or contributes to the QIP work if new issue
- Complaint timeframes and KPI's currently being reviewed
- Complaint report for PEG has been reviewed with additional emphasis on learning.
- Action linking via Datix is being explored to highlight the open actions for the divisions
- MSA - Data manually collected

Patients

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Patients	FFT			Total FFT Recommend %	95.0%		F	91.5%	90.5%	92.1%	91.9%	91.5%	91.5%	91.0%	90.7%	90.5%	90.9%	90.1%	90.7%
				Emergency Care FFT Recommend %	80.0%		?	77.9%	75.7%	80.9%	77.3%	76.5%	76.7%	78.2%	77.2%	76.8%	76.7%	75.1%	76.2%
				Outpatient FFT Recommend %	95.0%		F	92.5%	91.0%	92.1%	92.5%	92.3%	92.6%	92.9%	93.0%	91.9%	92.4%	91.3%	92.3%
	Patient Experience			Mixed Sex Accommodation Breaches	0	L	?	13	5	28	24	30	25	24	29	19	5	18	10
				Critical Care Admission Delays > 4Hrs	5.0%		?	12.5%	6.9%	3.2%	1.8%	4.3%	8.1%	4.1%	8.3%	8.1%	3.7%	8.4%	9.3%
				Critical Care Discharge Delays > 4Hrs	35.0%		?	46.5%	52.5%	54.3%	43.9%	45.8%	51.0%	52.4%	64.4%	37.2%	40.4%	38.7%	39.8%
	Complaints			Complaints	-			36	27	24	19	38	21	27	44	30	25	31	23
				Complaints Re-Opened	-			7	0	1	3	2	2	4	1	6	2	1	1
				Complaints Breached %	5.0%	H	F	20.0%	16.2%	14.6%	7.7%	8.3%	16.1%	13.3%	16.7%	17.1%	40.0%	72.7%	76.9%
	PALS			Patient Advice and Liaison Service (PALS) Concerns	-			447	321	453	460	475	533	302	510	617	506	506	357
				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	-			2	1	0	0	2	1	2	0	3	0	2	3

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	4	2	5	2	1	2
IPC	0	0	2	1	1	0
Falls	0	1	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	9	2	4	4	0	1
Pressure Ulcer	1	0	2	1	0	0
VTE	1	0	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)	EDNs Completed Within 24hrs %	Duty of Candour Compliance Stage 2 % Falls per 1,000 Bed days Mental Capacity Act Training Compliance % Resuscitation Training Compliance % Total Number of Deaths Due to Failings in Care Total Number of Still Births Greater Than 24 ...
No Significant Change		Fractured NOF Within 36 Hours Never Events SJRs Completed % VTE Risk Assessment Completed %		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 % HSMR Expected Death Rate (Month) +9
Concerning Variation		MRSA Cases - Hospital Acquired 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) Patient Safety Incident Investigations (PSII) D... 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	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
	95.0%	L	P	99.3%	99.5%	99.0%	99.4%	99.5%	98.9%	98.6%	98.8%	98.8%	99.1%	98.0%	96.5%

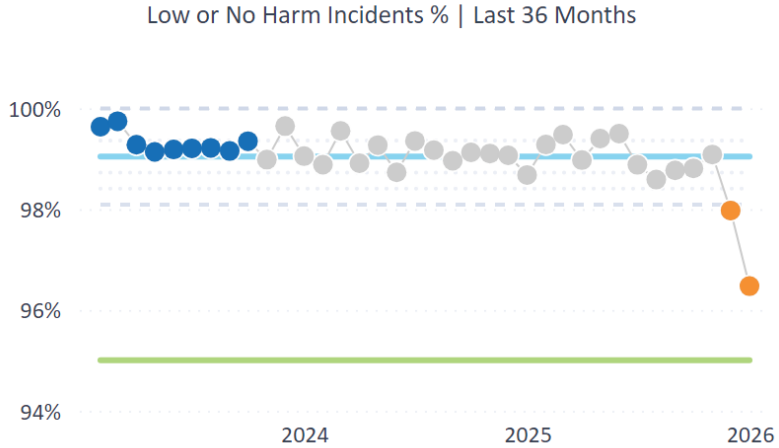
True North Domain: Quality

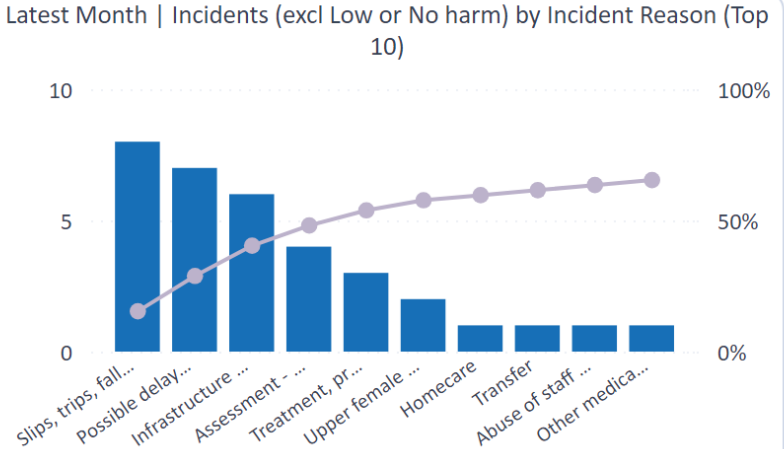
KPI Threshold: 95.0%

Sub Domain KPIs: 11

Variation Summary:

	L	H	L	H
4	1	4	0	2





Key Messages

- 96.4% of all incidents reported resulted in low or no harm.
- Clinical incidents with harm as moderate or above has increased by 54.54% compared to December.
- 34 incidents in January caused moderate harm or above. At time of writing, 15 have been validated via IRG, specialty or Care Group.
- 27 Incidents caused moderate harm: 12 validated, 15 tbc.
- 5 incidents caused severe harm: 2 validated, 3 tbc.
- 2 incidents were fatal: 1 validated, 1 tbc
- Duty of Candour is showing as not 100% compliant on the dashboard. Validation was delayed due to site pressures but has been updated. The dashboard applies a 10-day timeframe, although this is not a formal requirement.

Issues, Concerns & Gaps

- Medication management, including subtherapeutic anticoagulation, EOL medications and delays in antibiotics
- Patient broke window restrictors
- Delay in transfer to ITU
- Falls and PUs
- Incorrectly calculated NEWS2 scores, issues with confusion and alert
- Delay in OGD – no clear management/ownership
- Bleeps not answered
- Surgical/treatment complications. Transfusion Reaction
- EOL care

Actions & Improvements

- Providing support to create nutrition, diabetes, imaging, MH and EOL QIP.
- Medication and VTE QIP now in place.
- Completion of audit of documentation/care plans following failed first line of induction within 6 month period; sample of 10 patient case notes were reviewed.
- Case and findings were discussed in Endoscopy User Group (EUG) to share identified learning and to re-iterate the correct pathway and escalation routes to follow.
- Policy updated to incorporate the management of a peripheral venous thrombosis for the trust – the updated policy is awaiting CMO approval then will be made available to staff via Intranet.

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	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
	1.30%			1.90%	1.58%	1.46%	1.42%	1.12%	1.20%	1.42%	1.47%	1.41%	1.37%	1.84%	2.14%

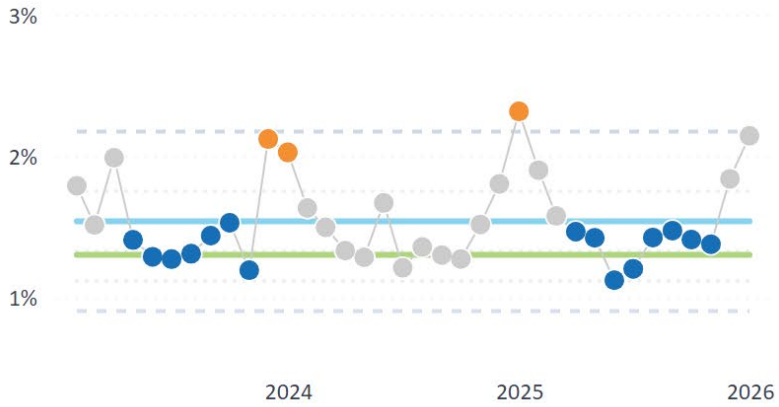
True North Domain: Quality

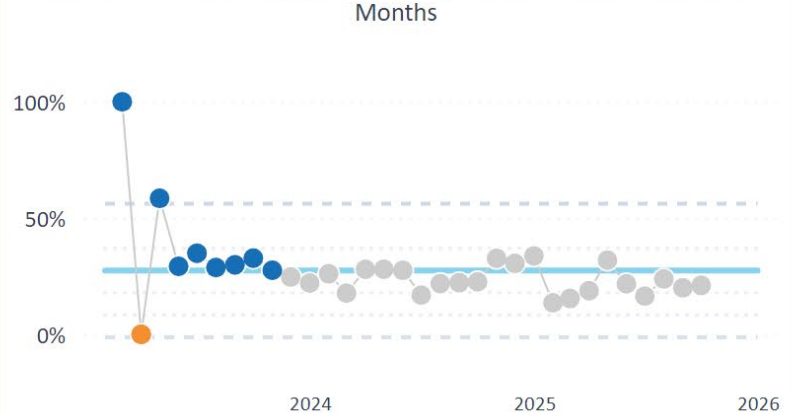
KPI Threshold: 1.30%

Sub Domain KPIs: 15

Variation Summary:

9	0	4	2	0





Key Messages

- HSMR+ for the period of Oct 24- Sept 25 is 95.63 and within expected
- SHMI for the period of Oct 24- Sept 25 is 1.27 and higher than expected
- Pneumonia remains an outlying diagnosis group from the SHMI methodology
- 14cases were subject to a stage 1 SJR review in January. None of these deaths were judged as possibly preventable (over 5050) .
- The current SJR platform is under administration and SJRs will move over to Gather. This will facilitate easier reporting between LFD and BI to access data around SJR outcomes and preventable deaths data, which was previously manually inputted.

Issues, Concerns & Gaps

- SHMI remains higher than expected
- The Learning from Deaths pathway needs to be revised to agree proportionate, sustainable and standards aligned Learning from deaths pathway that strengthens operational oversight, triangulates intelligence and delivers demonstrable improvements in care.
- The current SJR platform has undergone administration. SJRs have been recreated on Gather and will undergo a PDSA cycle to assess suitability of the platform and to ensure it supports the SJR process.

Actions & Improvements

- Mortality workshop in progress to agree key focus areas for the Quality Breakthrough Objective refresh
- Initial Meeting between Medical Examiner Office, LFD, complaints and Patient Safety to revise the Learning from Deaths pathway and ensure clear visibility across all teams with a defined pathway of review or investigation for deaths which are graded as preventable.
- Initial meeting for establishing frailty community pathway has taken place and leads established
- Palliative care and avoidable admission – initial meeting with community PEOLC to identify themes and establish support required from community to reduce avoidable admissions for palliative patients
- Deconditioning initial meeting commenced. Outcome measures discussed- KPIs being identified
- Sepsis/pneumonia order-set live on ePR - staff training underway

Maternity

Key Messages

Perinatal Quality – Incidents - 128 datix (↓)reported for maternity, 0 Incidents in maternity rated Moderate harm or above, 0 MNSI referrals in January, 0 maternal death, 0 Adverse homebirth incidents; Action plan to be developed and agreed from MNSI report. To go to PSIRG in February 2026; PPH (dashboard) – Total over >1000mls 41 (↓) 10 (↓)1500mls, 2 (↓) > 2500mls; 19 Datix (↑) relating to PPH >1000mls (30 ↓ on dashboard, 12> 1500mls); 2 (↑) datix relating to 3rd/4th degree tears (5 (-) recorded via Maternity Dashboard) 21 (↓) Incidents in NICU, (2↓) relating to medication. All incidents no/low harm. Staffing – 0.0(-) WTE Band 5/6 vacancy available to advertise; 2.92 WTE recruited but not yet started; 1 leavers in next 3 months Perinatal Quality – PMRT – Perinatal Losses (MRRACE reportable & PMRT): Stillbirth 39+4, Neonatal death 23+2 weeks gestation ex-utero transfer, day 8 of life; PMRT Meetings held in January 2026: 1 Neonatal Led – B,B,A, ; 2 Maternity Led PMRTs D,B (D grading based on care and transfer by neighbouring Trust) and B, C (also an MNSI case). Listening to Women and Families – Service Users and MNVP – 15 Steps completed January 2026; Walk the patch planning; Ongoing Communication projects; Co-production of CQC Picker Survey Action plan completed in January; Working with chief pharmacist at ICB to review halal options for non-halal medications eg. Fragmin; Service users missing scan appointments due to queuing to access carpark. Staff Feedback - Listening event held January 2026 with all BAME maternity staff. Positive feedback received and additional actions identified; Staffing pressures in community maternity team assistants who have now commenced cross cover to ensure no gaps; New starters at the B5 day report feeling well-supported during induction and orientation; Staff valued first working group for K2- new maternity system. External –Q2 25/26 Saving Babies Lives (SBL) Submitted; NHSE Enhanced Support and Oversight onboarding meeting held in January; Declaring compliance with 9 out of 10 CNST Safety Actions; 0 Maternity Outcomes Signal System (MOSS) Level 1 or Level 2 Signals 1 event meeting MOSS criteria (Term Stillbirth); National PFD (not for MFT) received following maternal and neonatal death at a homebirth in Manchester – Assurance response submitted to the ICB; MNOPS– daily national reporting of maternity and neonatal NOPEL/MOPEL Scores continues and embedded into daily practice; Maternity Care Bundle (MCB) Published January 2026 – 5 elements for Trusts to implement.

Issues, Concerns & Gaps

Perinatal Quality – Incidents - 3rd and 4th degree tears and PPH now ongoing QIPS ; 3rd and 4th degree tears consistent from December. Datix not completed for all instances; Datix not completed for all PPH >1000mls. Staffing - 14.75 WTE (↑)maternity leave with a further 7.03 WTE due to go off on maternity leave in coming months; 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 - Currently cases graded C or D not routinely escalated/reviewed at PSIRG meetings; In appropriate referral and transfer pathway from neighbouring Trust – escalated to relevant Trust's Clinical Director; C grading resulted from communication from an individual member of the multidisciplinary team – this has been addressed directly with the member of staff. Listening to Women and Families – Service Users and MNVP - No maternity and neonatal directorate within ICB restructure. Lack of oversight and support for MNVP leads. Staff Feedback – Incivility survey circulated to all staff; Staff identified a need for clearer escalation pathways during peak activity times- working with SS to develop flow chart; Suggestions from staff include streamlining documentation- options being worked up. External – Declaring non-compliance with CNST Safety Action 1 (PMRT reporting) due to 3 cases missing report started deadline. Awaiting MBRRACE verification for final position; MCB implementation will require MDT and multi-agency working to implement across all 5 elements. Trust Board review and sign-off of implementation plan will be required in due course.

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; Work ongoing with Governance and clinical leads to remind staff to ensure all 3rd and 4th degree tears and PPHs are datixed, and review any missed cases to ensure no missed CRIG reviews. Improvement noted in month. Staffing - Bi-annual workforce paper completed and shared with Trust Board in January 2026; Include Birthrate plus in business planning for 26/27. Training - Achieved >90% compliance for all staff groups for PROMPT, CTG and NBLS training as per CNST requirements; All staff mapped to fetal monitoring and PROMPT Training throughout the year. Reflected on e-roster for all staff. Perinatal Quality – PMRT - Update the SOP for PMRT to send all cases graded C or D to PSIRG for review; All PMRT recommendations to be reviewed with key stakeholders/ MDT following the meeting and action plan agreed and logged centrally and reviewed thematically in line with PSIRF and QIPs. 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 coproduced. Staff Feedback – Purchase order for community connectivity approved and process to install commenced; Staff Picker Survey Link shared across Maternity and Neonatal. 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; Weekly monitoring now well established and SOP being developed; Homebirth PFD assurance report completed for QAC and response and evidence submitted to ICB. Action plan developed to strengthen service. Awaiting feedback from ICB; Key stakeholders attending MCB webinars and completing benchmarking and action planning for each element. Task and finish groups to be established to support.

Quality

Key Messages

- TVN - 43 reportable PUs
- Data: 15 (35%) were EOL, Key learning identified continues to be repositioning
- Falls 4.67 OBD
- Data: Maintain QIP target <5.5 OBD consistently for 3 months, 3 falls with harm
- VTE - 95% national target
- Data: National target achieved
- IPC – Below trajectory for C.Difficiles however have had 3 MRSA bacteraemia cases in 1 month, 2 are likely cross-contamination on 1 ward
- FNoF/NAFF: FNoF breaches were 20/44 (45.5%). NAFF breaches were 2/3 (66.7%, small numbers).

Issues, Concerns & Gaps

- TVN -Issues/ Risks: Training not mandated
- Falls - 3 types of call bell system across Trust. Only option on some wards is to have emergency alarm sound when falls alarm activated. Risk of becoming desensitised to alarm due to potential increased frequency of use (Risk 2733)
- VTE - Training not mandated
- IPC – Although good nose and groin screening for MRSA staff not screening wounds and likely sources in the 2 linked cases is through wounds. Also wards not treating with decolonisation therapy
- FNoF/NAFF - The primary driver was insufficient theatre capacity, accounting for 12 of 22 breaches (54.5%). Clinical factors (medical optimisation and awaiting investigations) accounted for 7 breaches (31.8%). Workforce/equipment issues and a complex blood crossmatch case reason for the remainder.

Actions & Improvements

- TVN -Collaborative QI work with EOL care team. Training is offered to support identified learning. QI focus on the top 3 wards (Harvey, Sapphire, Phoenix)
- Falls - Roll out of OSKA Falls equipment with training and raise awareness of alarm sound
- VTE - Awaiting approval for mandated training
- IPC – Intensive support to the ward in this case however working on PGD for nurses to prescribe decolonisation therapy. Education on wound screening

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Quality	Incident Management			Low or No Harm Incidents %	95.0%	L	P	99.3%	99.5%	99.0%	99.4%	99.5%	98.9%	98.6%	98.8%	98.8%	99.1%	98.0%	96.5%
				Clinical Incidents with Harm (Moderate and above)	0	H	F	8	6	10	6	6	13	14	13	15	12	22	34
				Patient Safety Incident Investigations (PSII) Declared	-	H		1	1		2		2		1	1		3	7
				After Action Review (AAR) Declared	-			5	1	4	5	4	5	5	2	4	3	3	2
				After Action Review (AAR) Open - Month End	-	H		12	8	9	13	14	15	18	19	19	21	21	23
				Never Events	0		?	0	0	0	0	0	0	0	0	0	0	1	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%	100.0%	100.0%	93.3%
				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	82.4%	82.8%	84.4%	84.5%	86.2%	87.3%	84.3%	87.1%	85.8%	85.4%	84.8%	85.0%
				Violence & Aggression Incidents	126	H	?	172	247	220	167	237	221	265	214	267	230	184	241
				Assaults - Patient on Staff	-			66	73	48	48	65	72	120	54	82	79	56	63
	Falls			Falls per 1,000 Bed days	-	L		5.94	4.24	4.45	5.96	4.46	4.65	4.63	4.72	4.73	4.13	3.58	4.67
	Pressure Ulcer			Pressure Ulcers - Total (Reportable)	24	H	?	39	30	22	23	28	21	23	23	40	38	32	43

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Quality	Pressure Ulcer			Pressure Ulcers - Grade 4	-			2	2	1	1	2	1	2	0	0	2	1	0
				Pressure Ulcers per 1,000 Bed Days (Reportable)	-	H		2.57	1.82	1.42	1.41	1.76	1.27	1.38	1.43	2.43	2.42	1.97	2.57
	IPC			C-Diff Cases - Hospital Acquired YTD (Cumulative)	53			58	64	3	6	13	19	23	25	26	29	31	34
				MRSA Cases - Hospital Acquired	0	H	?	0	0	0	0	0	1	0	1	0	0	0	3
	Mortality			Crude Mortality Rate %	1.30%		?	1.90%	1.58%	1.46%	1.42%	1.12%	1.20%	1.42%	1.47%	1.41%	1.37%	1.84%	2.14%
				Deceased Patient – Clinical Coding Validation Returned %	-			13.6%	15.5%	18.8%	31.9%	21.7%	16.5%	23.8%	20.0%	21.1%	-	-	-
				Deceased Patient – Clinical Coding Validation Sent %	-			96.7%	97.3%	99.0%	95.9%	93.2%	94.0%	92.3%	91.3%	18.6%	0.0%	0.0%	-
				HSMR (12m)	100	L	?	97.22	97.74	98.23	97.74	96.78	95.56	95.12	94.25	95.28			
				HSMR Expected Death Rate (12m)	-	H		5.5%	5.5%	5.6%	5.7%	5.7%	5.8%	5.8%	5.9%	6.0%			
				HSMR Expected Death Rate (Month)	-			6.8%	6.2%	5.4%	6.0%	5.3%	5.8%	6.3%	6.2%	4.4%			
				SHMI (12m)	1	H	F	1.25	1.25	1.26	1.26	1.25	1.26	1.26					
				SHMI Expected Death Rate (12m)	-	H		3.3%	3.4%	3.4%	3.5%	3.5%	3.5%	3.6%					
				SHMI Crude Death Rate (12m)	-	H		4.1%	4.2%	4.3%	4.4%	4.4%	4.4%	4.5%					

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Quality	Mortality			Fractured NOF Within 36 Hours	92.0%			60.9%	70.0%	48.7%	71.9%	78.8%	66.7%	31.6%	58.8%	88.9%	60.0%	78.6%	
				Number of Deaths Reviewed via SJR	-			10	18	15	13	12	19	17	16	16	11	9	14
				SJRs Completed %	12.5%			7.2%	14.6%	14.3%	11.9%	14.1%	19.6%	16.8%	14.3%	13.7%	10.2%	6.7%	8.1%
				Total Number of Deaths Due to Failings in Care	-			0	0	0	0	0	0	0	0	0	0	0	0
				Number of LD Deaths Reviewed via SJR	-			1	4	0	0	1	0	1	1	1	1	1	1
				Total Number of LD Deaths Due to Failings in Care	-			0	0			0		0	0	0	0	0	0
	VTE			VTE Risk Assessment Completed %	95.0%			97.6%	94.5%	99.5%	97.0%	96.1%	97.9%	95.6%	98.3%	97.6%	97.1%	94.5%	95.8%
	Maternity			Caesarean Section %	-			51.1%	45.1%	53.0%	50.1%	48.7%	50.0%	52.2%	44.4%	50.8%	52.1%	58.1%	52.1%
				Elective C-Section %	-			22.3%	21.2%	22.3%	20.4%	20.3%	23.9%	19.2%	20.9%	21.9%	19.2%	25.1%	20.4%
				Emergency C-Section %	-			28.7%	23.9%	30.7%	29.7%	28.4%	26.1%	33.0%	23.5%	28.9%	33.0%	33.0%	31.7%
				PPH greater than or equal to 1500mls	-			12	15	18	12	14	17	16	15	21	14	10	12
				Total Number of Still Births Greater Than 24 weeks Gestation	-			2	1	1	1	0	1	0	1	1	1	0	1
				Neonatal Deaths	-			3	3	1	2	2	1	3	3	3	2	2	1

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Quality	Maternity			Maternity and Newborn Safety Investigations (MNSI) Declared	-			1	0	0	0	0	0	0	0	0	1	1	0
				Number of cases of Hypoxic Encephalopathy (HIE) grades 2 & 3	-			0	0	0	0	0	0	0	1	1	0	0	0
	Health & Safety			Resuscitation Training Compliance %	-			84.0%	83.7%	83.5%	85.0%	83.5%	84.0%	84.1%	83.0%	82.9%	83.3%	84.4%	83.3%
				Mental Capacity Act Training Compliance %	-			86.0%	85.3%	85.6%	86.2%	86.8%	86.4%	86.5%	86.6%	86.6%	85.7%	85.9%	86.2%
	Legal & Information Governance			Regulation 28 Reports	-			-	-	-	-	-	-	-	-	-	-	-	-

Systems & Partnerships

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

Frances Woodroffe
Chief Operating Officer

Sub Domain	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
Access	10	10	2	9	1	7
Emergency Care	6	1	6	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

Watch KPIs Only
Systems & Partnerships

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

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	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
	60.0%	H	F	51.5%	53.0%	53.3%	53.8%	54.6%	53.7%	52.8%	53.5%	54.6%	55.8%	57.1%	57.9%

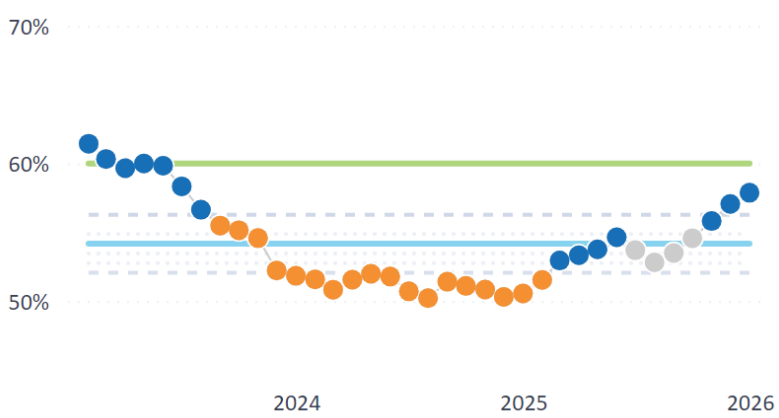
True North Domain: **Systems & Partnerships**

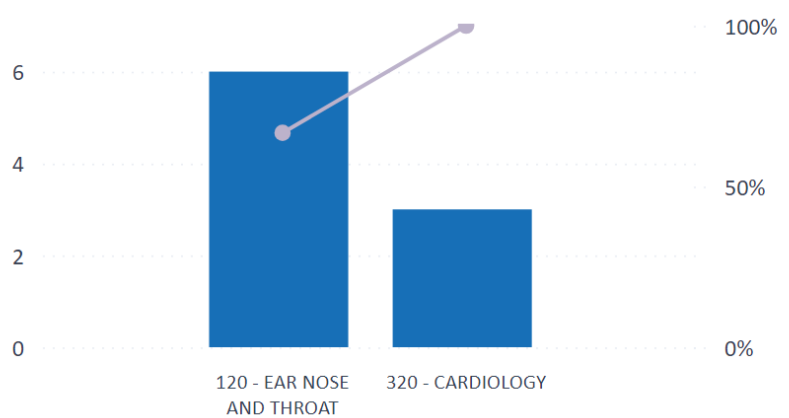
KPI Threshold: 60.0%

Sub Domain KPIs: 22

Variation Summary:

	L	H	L	H
10	0	2	6	4





Key Messages

- RTT performance 57.6%, which is 0.6% worse than plan; further validation has increased performance to 57.9% (0.3% worse than plan)
- 338 >52 week waits (0.9%), following further validation this has reduced number of >52 week waits to 328
- 52+ Weeks, % of 52+ weeks wait and PTL size position remain better than plan
- PTL size 35,869 against a plan of 39,584, further validation has reduced the waiting list size to 35,480
- We have received confirmation from NHSE we have been stepped down to Tier 2 for Elective for quarter 4 2025/26.

Issues, Concerns & Gaps

- 65 week position currently at 9 at end of January; 6 x ENT (3 x patient choice/ 3 capacity) and 3 x cardiology (2 x CMRI / 1 x patient choice delayed MPS scan)

Actions & Improvements

- Moving to monthly Tier 2 meetings for continued oversight
- The agreed improvement plan for 7 challenged specialties are progressing.
- Executive oversight meetings are now in place to review and monitor performance standards

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	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
	80.0%	L	?	77.6%	77.4%	77.9%	79.4%	77.6%	76.3%	73.3%	75.7%	74.7%	73.9%	69.9%	70.1%

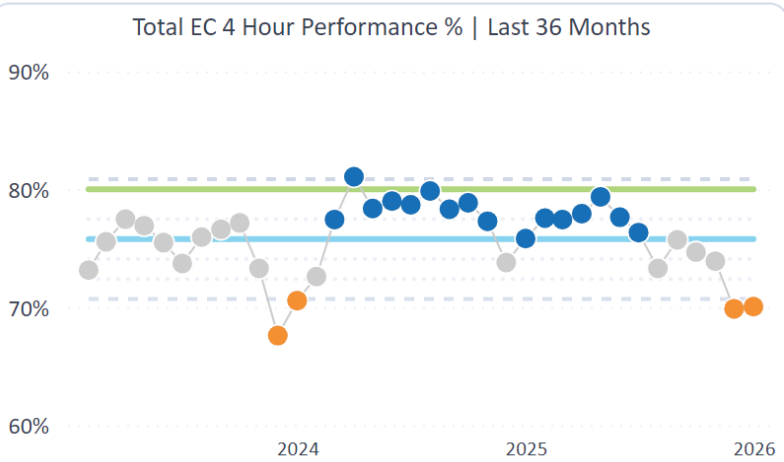
True North Domain: **Systems & Partnerships**

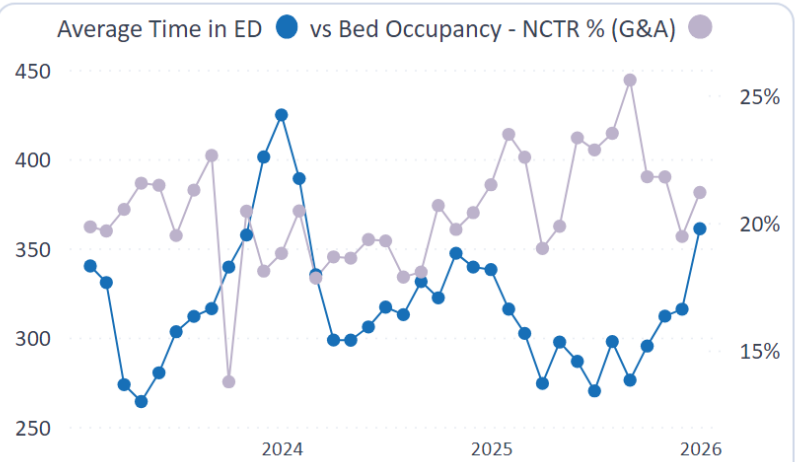
KPI Threshold: 80.0%

Sub Domain KPIs: 13

Variation Summary:

	L	H	L	H
6	2	4	1	0





Key Messages

- 4 hr performance saw a slight improvement (0.2%) in January compared to December
- Type 1 Patients spending >12 hours in ED increased by 1.4% to 14.4% in January.
- Whilst attendances were lower in January compared to December the acuity of patients increased. Patients with a DTA within the department increased significantly in January by 196 with 876 compared with 680 in December due to significant increase in acuity
- Delays in ambulance handovers increased in January with 20 >60 minute delays due to the department being over capacity on multiple occasions and the acuity of patients. This was managed well with our partners SECAmb and was turned around at the earliest opportunity. Remained top of region for handovers

Issues, Concerns & Gaps

- January remained challenging with the majority of month seeing the Trust in Full Capacity Protocol.
- Christina Rossetti (CR) was open providing 8 escalation beds over the most challenging month of winter. Patients identified were medically fit for discharge and had a planned discharge date within a day of taking the bed on CR to provide beds on the acute medical wards
- ED continued to be over capacity throughout January requiring use of additional beds in areas of undesignated care in the corridor. All patients were medically reviewed for the appropriateness of being in those areas to ensure patient safety at all times.

Actions & Improvements

- Commencement of EM5/true CDU (End of February) to improve initial assessment/treatment times for non-admitted patients and increase performance
- Review of AMU model on Lister (to commence 16.02.2026) to convert 8 bed bay back to functioning AMU to reduce long LOS in ED

Access

Key Messages

- RTT - 9 specialties where performance is < 60 % -
- ENT – 68.8% (↑14.8%), Pain Management 36.5% (1.3%), Rheumatology 35.5% (1.4%), Cardiology 47.1% (↔), Sleep 46.3% (↔), Neurology 40% (↔), Respiratory 51% (↔), Gastroenterology 50% (↔), Endocrinology 50.6% (↑2.6%) (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 91.9% (4.2% increase in performance from last month)
- Imaging 94.2% (4.3% improvement from last month)
- Endoscopy 93.1%, highest performance reported to date
- Physiological measurements 85% (4.2% improvement in performance from previous month)

Issues, Concerns & Gaps

Access

- 65 week position currently at 9 at end of January, 6 x ENT (3 x patient choice/ 3 capacity) , 3 x Cardiology (2 x CMRI / 1 x patient choice delayed MPS scan)

DM01

- Challenges with NOUS capacity and workforce continue. Performance improved in January to 92.6%, 7.2% compared with December and highest performance seen this financial year.
- MRI performance improved again in January to 92.3%, 3.8% improvement.
- Physiological measurements – have seen increased performance across board apart from audiology where performance reduced by 7.3% compared with December.

Actions & Improvements

RTT

- Moving to monthly Tier 2 meetings for continued oversight
- The agreed improvement plan for 7 challenged specialties are progressing.
- Executive oversight meetings are now in place to review and monitor performance standards

DM01

- Endoscopy improvement in performance continues; on track to be fully recovered by March 2026
- MRI performance on track to be fully recovered by March 2026.
- NOUS recovery plan in place

Emergency Care

Key Messages

- 4 hr performance saw a slight improvement (0.2%) in January compared to December. January was 8.2% off plan at 70.05% against a plan of 78.25%
- Type 1 Patients spending >12 hours in ED increased by 1.4% to 14.4% in January against a plan of 13.00% .
- Whilst attendances were lower in January compared to December the acuity of patients increased. Patients with a DTA within the department increased significantly in January by 196 with 876 compared with 680 in December due to significant increase in acuity
- Delays in ambulance handovers increased in January with 20 >60 minute delays due to the department being over capacity on multiple occasions and the acuity of patients. This was managed well with our partners at SECAmb and was turned around at the earliest opportunity. We remained top of the region for handovers.

Issues, Concerns & Gaps

- January remained challenging with the majority of month seeing the Trust in Full Capacity Protocol. Bed occupancy was consistently higher than the same period on 24/25
- Christina Rossetti was open in January providing 8 escalation beds over the most challenging month of winter. Patients identified were medically fit for discharge and had a planned discharge date within a day of taking the bed on Christina Rossetti to provide beds on the acute medical wards
- ED continued to be over capacity throughout January requiring use of additional use of beds in areas of undesignated care in the corridor. All patients were medically reviewed for the appropriateness of being in those areas to ensure patient safety at all times.

Actions & Improvements

- Commencement of EM5/true CDU (End of February) to improve initial assessment/treatment times for non-admitted patients and increase performance
- Review of AMU model on Lister (to commence 16.02.2026) to convert 8 bed bay back to functioning AMU to reduce long LOS in ED

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Systems & Partnerships	Access			RTT Incompletes Performance %	60.0%	H	F	51.5%	53.0%	53.3%	53.8%	54.6%	53.7%	52.8%	53.5%	54.6%	55.8%	57.1%	57.9%
				RTT 65+ Week Waiters	0	L	F	181	80	86	111	101	75	384	555	496	136	30	9
				RTT Waiting List Size	-	L		39,959	39,949	40,171	40,086	39,993	39,335	39,907	39,089	38,102	37,104	36,921	35,480
				RTT 52 Week Breaches	1,250	L	?	1,767	1,695	1,718	1,777	1,735	1,756	2,053	2,116	1,953	914	533	328
				RTT 52 Week Waiting List %	1.0%	L	F	4.4%	4.2%	4.3%	4.4%	4.3%	4.5%	5.1%	5.4%	5.1%	2.5%	1.4%	0.9%
				Patients Waiting For 1st Appointment < 18 Weeks %	-													58.9%	60.9%
				OP Average Time to First Appointment (days)	60	H	F	121.02	120.69	115.51	117.34	119.36	122.82	180.45	154.51	130.77	154.55	123.03	126.92
				Outpatient DNA Rate %	5.0%		F	5.2%	5.7%	6.1%	6.0%	6.3%	5.9%	6.4%	6.3%	6.3%	6.4%	6.6%	6.3%
				OP First to Follow Up Ratio	-	L		1.76	1.69	1.79	1.78	1.73	1.79	1.76	1.80	1.79	1.68	1.83	1.77
				PIFU %	5.0%	H	F	2.5%	2.4%	2.4%	2.5%	2.4%	2.9%	2.9%	3.8%	3.6%	4.0%	4.1%	4.3%
				Operations Cancelled by Hospital on Day	13		?	10	4	5	4	13	10	8	21	30	18	2	14
				Urgent Operations Cancelled for 2nd Time	0		?	0	0	1	1	0	1	2	1	0	0	2	0
				Day Case Rate %	-			86.3%	88.0%	88.7%	88.0%	87.9%	87.8%	86.8%	87.5%	87.0%	87.7%	88.5%	86.2%

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Systems & Partnerships	Access			Average Elective Length of Stay (days)	3			2.08	2.16	2.14	2.19	2.97	3.18	3.65	2.60	2.70	3.43	3.45	2.14
				Average Non-Elective Length of Stay (days)	10	H	P	6.60	6.43	6.36	6.48	6.01	6.50	6.22	6.26	6.87	6.34	6.63	6.76
				104 Day Cancer Waits	-			11	17	17	12	20	19	11	18	13	15	13	
				Cancer USC Performance %	93.0%	H		82.4%	77.4%	77.7%	69.2%	87.5%	89.1%	90.8%	95.3%	97.0%	95.2%	97.4%	
				28 Day Performance - Overall %	77.0%			67.5%	66.2%	59.2%	53.8%	65.3%	71.9%	75.4%	76.6%	76.3%	78.9%	75.8%	
				31 Day Performance - Overall %	96.0%			99.4%	97.1%	94.2%	98.6%	96.3%	98.0%	98.6%	98.0%	100.0%	99.1%	96.2%	
				62 Day Performance - Overall %	80.0%			69.5%	69.8%	66.8%	61.2%	60.9%	64.9%	71.6%	68.4%	76.0%	82.1%	73.8%	
				62 Day PTL Backlog	6.0%	L	F	12.8%	11.7%	13.0%	13.9%	11.9%	10.9%	11.3%	10.7%	9.9%	8.0%	10.8%	11.2%
				DM01 Performance %	73.1%	H		87.4%	91.1%	87.6%	85.7%	86.8%	86.0%	80.0%	82.4%	85.5%	90.8%	87.7%	91.9%
	Emergency Care			Total EC 4 Hour Performance %	80.0%	L		77.6%	77.4%	77.9%	79.4%	77.6%	76.3%	73.3%	75.7%	74.7%	73.9%	69.9%	70.1%
				Type 1 LOS > 12 Hours in EC %	6.0%		F	14.2%	13.2%	10.6%	10.6%	10.1%	11.5%	12.6%	11.5%	11.9%	11.7%	13.0%	14.4%
				Total EC 4 Hour Performance - Non-Admitted %	85.0%	L		82.9%	83.3%	83.8%	85.0%	82.7%	81.6%	78.5%	81.4%	79.7%	79.4%	75.3%	75.1%
				IP Discharged Before Noon % (Inc transfers to ADL)	-			20.0%	21.3%	18.5%	19.1%	19.1%	21.0%	19.6%	19.3%	19.3%	18.7%	17.2%	19.7%

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Systems & Partnerships	Emergency Care			Type 1 EC 4 Hour Performance %	75.0%		F	64.7%	65.8%	67.0%	67.5%	67.1%	65.7%	61.6%	66.6%	66.0%	64.6%	59.9%	57.6%
				Total EC 12 Hour DTAs	0		F	706	688	412	533	454	614	696	632	728	593	680	876
				Average Time in EC Department - Excl. Type 5 (mins)	240		F	315.86	302.27	274.26	297.41	286.62	270.07	297.68	276.12	295.21	311.94	315.84	360.91
				The Number of Patients in TES within ED	-	H		1,376	1,277	737	975	870	1,268	1,389	1,286	1,633	1,423	1,628	2,246
				Number of ED Arrivals by Ambulance	-	H		2,722	3,021	2,977	3,022	2,947	3,120	3,063	3,058	3,215	3,193	3,463	3,381
				Ambulance Handover Delays (> 30 mins)	-	H		86	77	48	49	28	47	69	53	82	61	116	180
				Ambulance Handover Delays (> 60 mins)	0	H	?	1	0	3	1	0	2	2	2	1	2	4	20
				Bed Occupancy - NCTR % (G&A)	-			23.5%	22.6%	19.0%	19.9%	23.3%	22.9%	23.5%	25.6%	21.8%	21.8%	19.5%	21.2%
				30 Day Readmission Rate	13.0%	L	P	7.9%	8.1%	7.1%	8.1%	8.3%	8.2%	7.5%	7.4%	7.7%	7.0%	7.9%	6.8%

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	5	6	2	6	2	5
Safe Staffing	1	1	1	2	0	0

Operational Leads:
Steve McGowan - *Deputy Chief People Officer*

Committees:
People Committee

People

Assurance

Watch KPIs Only
People Domain

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	Agency Spend % StatMan Training Compliance % StatMan: Patient Safety L1 Compliance % Vacancy Rate %	Bank Spend % Time to Hire - AfC	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 Voluntary Turnover % - First 2 Years Employ...	Sickness Absence Rate - Long Term %	
H / L Concerning Variation		Care Hours per Patient Day (CHPPD) Staff Appraisal Rate %	Sickness Absence Rate - Total %	

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	Feb-25
	6.93	H	F	**6.74**

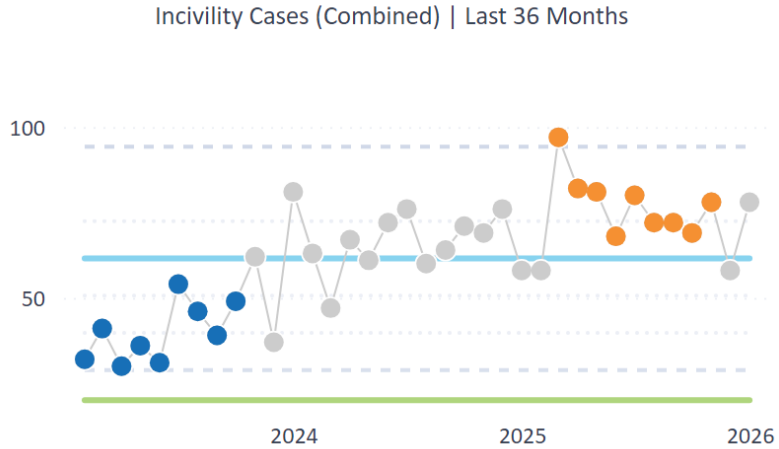
True North Domain: **People**

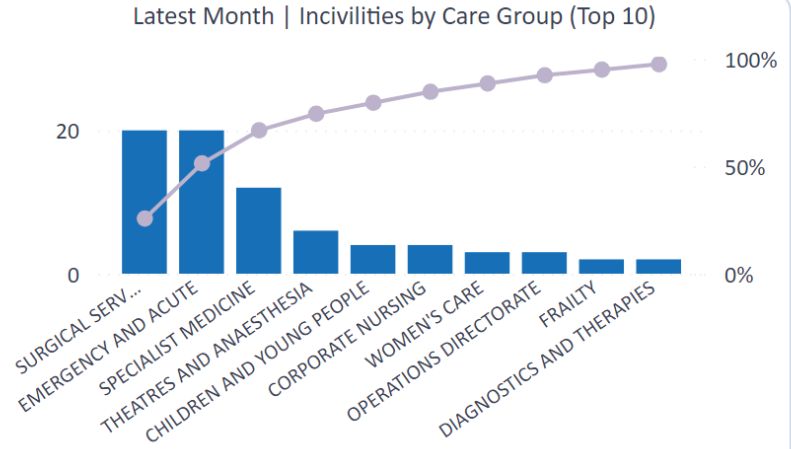
KPI Threshold: 6.93

Sub Domain KPIs: 13

Variation Summary:

	L	H	L	H
5	1	1	5	1





Key Messages

The number of incivilities combined reporting through Friends and Family Test (FFT) and Datix reported in January increased from 58 to 79.
The Trust continues to address incivility as a systemic issue impacting team cohesion, psychological safety, and overall organisational culture. The management of cases has moved into business as usual and is discussed and reported into the Equality Steering Group (ESG);
The recent staff survey information has been made available to divisional managers to allow early focus and attention (whilst also adhering to the embargo)

Issues, Concerns & Gaps

- The level of incivilities, whilst a concern, can be seen as an indicator that staff are feeling increasingly confident and psychology safe to speak up
- Vacancies have increased (as a result of workforce controls) this coupled with high demand across the hospital, could be resulting in increased pressure on staff, which may in turn result in more incivilities.

Actions & Improvements

- Customer services training continues to be rolled out .
- Breakthrough huddle now part of the Equality Steering Group as business as usual
- Wellbeing sessions around values and behaviours have commenced for staff
- Reporting mechanism for incivilities to be reviewed
- All incivilities reported are followed up and staff discussions are completed to provide feedback and implement improvements

People

Key Messages

- Following a decline in December (58), incivility cases reported in January (79) returned to levels consistent with before December.
- Sickness absence remains above target, although the in month figure for January 26 is lower than January 25 at 5.4% compared to 5.63%. Long term sickness is at its lowest percentage this financial year.
- The Occupational Health and Employee Relations teams continue to support managers with getting staff back to work.
- Vacancies increased to 5.3%, reflecting the impact of the workforce controls introduced in late 2025 start to have.

Issues, Concerns & Gaps

- Sickness absence remains above target, with a rolling 12 month figure of 5.01%, marginally better than the corresponding time last year (5.02%). In January the most common reason for sickness was Stress related illness, accounted for 20.8% of all sickness. Stress related illness has been the highest reason for sickness every month of this financial year.
- Voluntary turnover for staff in their first two years with the organisation for January was the highest this financial year and 0.8% above target.
- Staff appraisal's are below target, and the percentage completed is marginally worse than at the same time in December. A reminder to managers will be delivered as part of trust leadership team (TLT) meetings.

Actions & Improvements

- The increased focus on sickness for quarter 4 continues, as Employee Relations (HRBPs) and Occupational Health continue to work closely together to assist managers with staff who have met the triggers in the sickness absence policy;
- Customer services training continues to be rolled out.
- The People Team are working with the BI Team to look at ways of improving the reporting and access to workforce management information, to help managers address issues in the most timely manner possible.
- Wellbeing sessions around values and behaviours have commenced roll out to staff.
- The reporting mechanisms for incivilities to be reviewed.
- The trust bullying and harassment policy and grievance policy have both been reviewed and revised. Following consultation with managers and staff side colleagues, the new policies are expected to be launched during April.

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
People	Workforce			National Staff Engagement Score	6.93	H	F	6.74											
				Incivility Cases (Combined)	20		F	58	97	82	81	68	80	72	72	69	78	58	78
				Voluntary Turnover % - First 2 Years Employment	1.00%		?	1.0%	1.4%	1.2%	0.8%	0.9%	1.1%	1.1%	0.7%	1.1%	0.9%	1.6%	1.8%
				Staff Appraisal Rate %	90.0%	L	?	89.9%	89.7%	90.4%	90.4%	90.0%	89.1%	89.1%	88.7%	87.9%	87.3%	86.7%	86.2%
				Vacancy Rate %	9.0%	L	P	6.6%	6.1%	0.6%	4.4%	4.3%	4.1%	4.2%	4.8%	5.0%	5.3%	5.0%	5.3%
				Voluntary Turnover %	8.0%	L	F	8.4%	8.3%	8.3%	8.2%	8.1%	7.9%	7.8%	7.6%	7.3%	7.1%	7.2%	7.2%
				Sickness Absence Rate - Total %	4.0%	H	F	5.1%	4.5%	4.6%	4.5%	4.7%	4.9%	4.8%	5.1%	5.5%	5.3%	5.6%	5.4%
				Sickness Absence Rate - Short Term %	2.0%		?	2.6%	2.0%	2.2%	2.0%	2.0%	2.1%	2.1%	2.4%	2.7%	2.5%	2.9%	3.1%
				Sickness Absence Rate - Long Term %	2.0%		F	2.5%	2.4%	2.4%	2.5%	2.7%	2.8%	2.7%	2.8%	2.9%	2.8%	2.7%	2.3%
				Time to Hire - AfC	42	L	?	63.80	54.90	64.40	55.05	56.50	49.10	35.70	50.60	44.40	52.90	40.40	39.60
				Time to Hire - Medical	70		?	65.90	58.10	56.90	68	76.70	85.40	80.10	68.10	57.50	81.90	72.60	61
				Agency Spend %	3.7%	L	P	1.1%	0.6%	1.2%	1.2%	0.9%	0.8%	0.9%	0.9%	0.9%	1.1%	0.7%	0.6%
				Bank Spend %	10.0%	L	?	9.7%	6.6%	8.8%	8.2%	9.1%	9.8%	9.7%	9.7%	8.8%	10.1%	9.7%	8.8%
	Safe Staffing			Staff Fill Rate - Total %	85.0%		?	87.4%	91.1%	91.3%	89.6%	87.6%	87.5%	87.8%	87.2%	89.7%	91.9%	90.4%	91.1%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
People	Safe Staffing			Staff Fill Rate % (Total) - Registered Nurse	-	H		90.0%	92.5%	91.6%	89.4%	88.9%	88.4%	87.6%	89.4%	92.6%	92.9%	91.6%	93.3%
				Care Hours per Patient Day (CHPPD)	9.50	L	?	9	9.19	9.65	9.48	9.35	9.29	9.23	9.20	9.08	9.07	9.01	8.84
	StatMan			StatMan Training Compliance %	85.0%	H	P	89.1%	89.1%	89.9%	89.7%	89.5%	89.8%	89.4%	89.2%	89.4%	89.3%	89.3%	88.9%
				StatMan: Patient Safety L1 Compliance %	85.0%	H	P	93.4%	93.6%	94.3%	94.7%	94.5%	94.0%	94.3%	94.8%	94.8%	95.0%	95.1%	94.7%
				StatMan: Patient Safety L2 Compliance %	85.0%		?	-	-	-	-	-	-	-	-	-	-	-	-

Sustainability

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

Simon Wombwell
Chief Finance Officer

Sub Domain	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
Financial Position	5	1	3	4	0	3

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

Committees:
Finance & Performance Committee
Audit & Risk Committee

Sustainability

Assurance

Watch KPIs Only
Sustainability Domain

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	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
	£0.00m			-21.33m	-19.55m	-2.04m	-3.44m	-5.57m	-9.18m	-13.60m	-17.05m	-28.66m	-38.07m	-48.48m	-53.88m

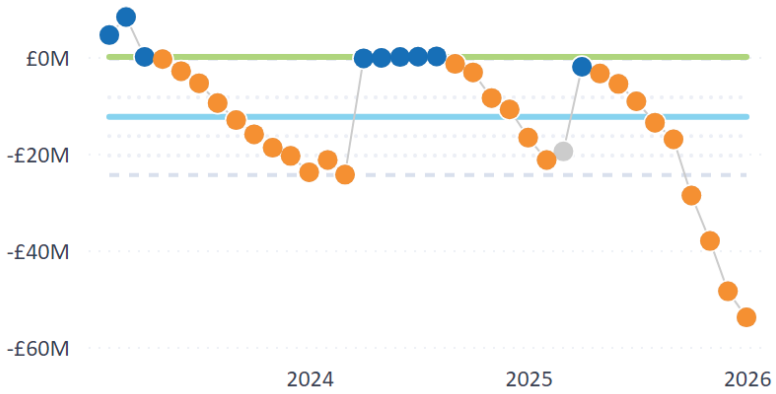
True North Domain: **Sustainability**

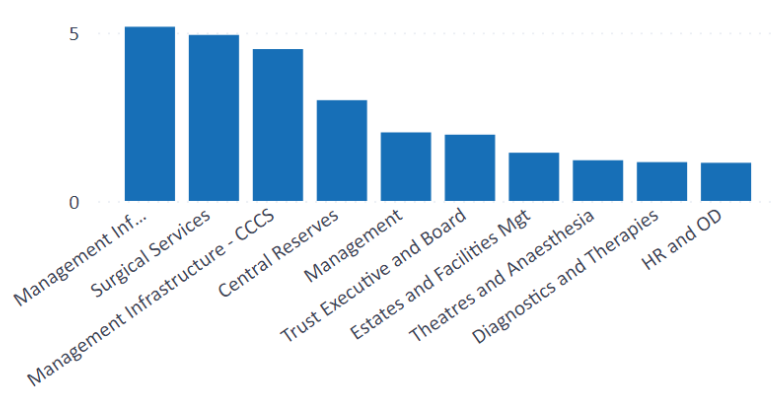
KPI Threshold: £0.00m

Sub Domain KPIs: 9

Variation Summary:

5	2	1	1	0





Key Messages

The Trust reports a YTD deficit at month 10 (January 2026) of £39.6m, adjusting to a control total deficit excluding Deficit Support Funding ("DSF") of £67.6m; this is adverse to plan by £26.4m.
The key driver of the variance is that our savings delivery remain below target (adverse by £26.2m YTD).
This is having a detrimental impact on our cash (partially offset by the capital plan being behind at this time) and has required the Trust to make cash support applications; this support comes at an additional cost.
The deficit is in line with the reforecast £55m deficit outturn for this financial year.

Issues, Concerns & Gaps

Key risks to delivering the £55m forecast include:
1. Delivery of the efficiencies programme, particularly ward closures
2. CDC activity underperformance
3. Further industrial action (if unfunded)
4. Incremental underlying spend increasing the run-rate

Cash remains an area of focus to ensure the Trust can meet its commitments, especially if CIPs do not deliver.
The Trust's current run-rate must improve in advance of the start of 2026/27.

Actions & Improvements

Our efficiencies programme YTD is ~5% of the target (£8.9m vs £35.1m target).
Supported by PA Consulting, we need to see accelerated and increased reductions in our cost base, together with schemes ready to launch for 2026/27.

Sustainability

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Sustainability

KPI Scorecard

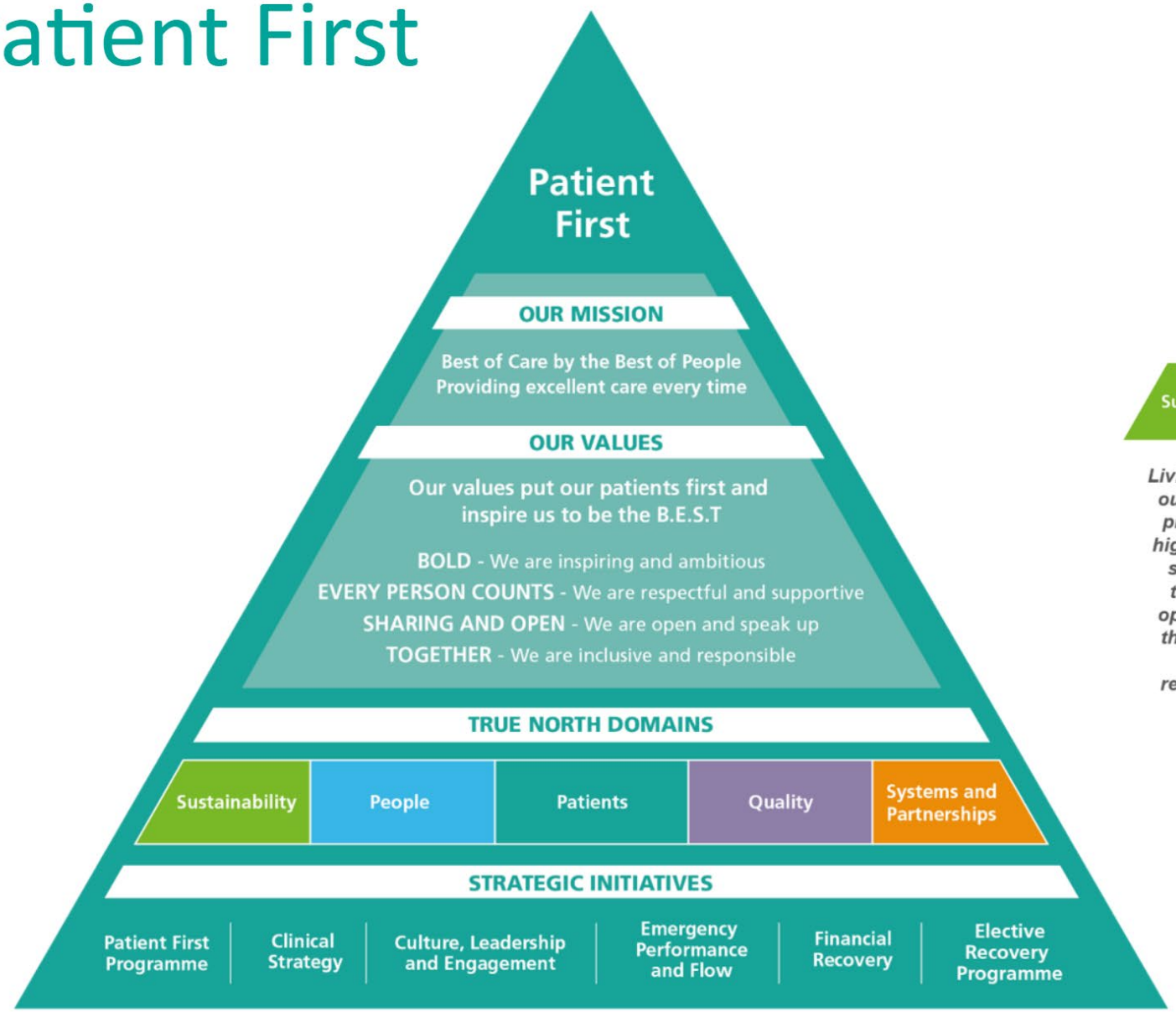
Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Sustainability	Financial Position			Surplus / (Deficit) (£) Variance to Plan YTD	£0.00m			-21.33m	-19.55m	-2.04m	-3.44m	-5.57m	-9.18m	-13.60m	-17.05m	-28.66m	-38.07m	-48.48m	-53.88m
				Total Pay Spend (£) vs Budget	£0.00m		?	1.68m	19.85m	0.25m	-0.16m	0.88m	1.01m	2.40m	3.20m	3.51m	3.85m	4.23m	2.86m
				WTE Actual vs Plan	0		?	60.59	157.89	329.36	93.18	171.36	216.61	170.44	172.94	114.43	124.82	103.33	-1.85
				Variance to CIP Target (£)	£0.00m		F			-0.26m	-0.77m	-1.24m	-2.36m	-3.53m	-3.84m	-4.08m	-2.67m	-3.91m	-3.56m
				WTE Actual	5,155	H	F	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	5,624.51	5,518.56
				Total Temporary Staffing Worked FTE	-	L		610.15	687.55	557.06	508.99	589.93	622.10	601.07	634.38	574.09	594.66	584.11	503.71
				Total Temporary Staffing Spend (£)	-			3.01m	3.31m	2.97m	2.72m	2.89m	3.20m	3.08m	3.16m	2.87m	3.37m	3.12m	2.72m
				Total Non-Pay Spend (£) vs Budget	£0.00m		?	1.19m	1.96m	-0.40m	-0.64m	-0.56m	0.31m	0.17m	1.05m	1.57m	1.23m	0.92m	0.64m
				Income (£) vs Budget	£0.00m	L	?	-1.55m	22.13m	-0.21m	-0.50m	0.44m	-0.65m	-0.10m	1.03m	-4.71m	-3.24m	-2.88m	-0.61m

NHS
Medway
NHS Foundation Trust

Useful Information

Patient FIRST

Patient First



Sustainability	People	Patients	Quality	Systems and Partnerships
Living within our means providing high quality services through optimising the use of our resources	*To be the employer of choice and have the most highly engaged staff within the NHS*	*Providing outstanding, compassionate care for our patients and their families, every time*	*Excellent outcomes ensuring no patient comes to harm and no patient dies who should not have*	*Delivering timely, appropriate access to acute care as part of a wider integrated care system*

Patient First - Guidance

NHSI 'Plot the Dots' Guidance

Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Variation icons: **Orange** indicates concerning **special cause variation** requiring action; **Blue** indicates where improvement appears to lie, and 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. A grey icon 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.

Meeting of the Trust Board Meeting in Private

Date: Wednesday 14 January 2026

Title of Report	**CQC report**			**Agenda Item**	3.1d
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	Wayne Blowers, Interim Director of Quality				
Lead Executive	Siobhan Callanan, Deputy CEO Evonne Hunt, Chief Nursing Officer				
Purpose	**Approval**		**Briefing**	x	**Noting**
Proposal and/or key recommendation:	For TB to be appraised of the findings from the April 2025 CQC assessment of MFT's Emergency Department and plans for improvement.				
Executive Summary	The CQC undertook an unannounced assessment of MFT's Emergency Department on 29 and 30 April 2025 to assess improvements against a Warning Notice issued to the Trust in April 2024. Following this assessment, significant improvements had been made, and the Warning Notice had been met. The service was previously in breach of the legal regulations in relation to dignity and respect (Regulation 10) and safe care and treatment (Regulation 12). Improvements were found at this assessment, but the service remained in breach of these legal regulations. The overall rating for the service remains requires improvement. Well-led remains good, and safe has received an improved rating from inadequate to requires improvement. Ratings for caring, effective and responsive remain requires improvement.				

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent Care 2025	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Good	Requires improvement

The CQC's report recognises improvements in patient care and staff culture since the February 2024 inspection. The report also recognises a number of improvements and areas of good practice:

- Ambulance turnaround times are regularly among the best in the country, quickly releasing ambulances to help others in need.
- Effective daily safety huddles have been established to escalate and address capacity and staffing issues.
- Improved culture and team working in the Emergency Department (ED), with staff feeling able to raise concerns, incidents thoroughly investigated, and a focus on improving staff wellbeing.

	• Effective multi-disciplinary team working, and strong partnerships with specialist in-house teams, and community, mental health and ambulance partners. The CQC report also highlights ongoing concern about our ability to consistently provide safe care to all our patients, and in ways that maintain their privacy and dignity, particularly when ED is busy. The report also highlights the need for further improvements in the following areas: • Inconsistent monitoring of patients whilst in the ED, including people with mental health needs • Patient risk assessments not always being completed • Clear explanations to patients and discussions regarding care plans • Medicines optimisation and safety The Trust submitted its responses to the two regulatory breaches to the CQC on 12 December 2025 setting out the actions being taken to achieve regulatory compliance. The 46 improvement actions being taken are captured and tracked in the refreshed ED improvement plan (attached).			
Issues for the Board/Committee Attention:	The emergency department remains in breach of two legal regulations - Dignity and Respect - Safe Care and Treatment			
Committee/ Meetings at which this paper has been discussed/ approved: Date:	Elements of this topic have been discussed at the Trusts Quality Assurance Committee.			
Board Assurance Framework/Risk Register:	BAF risks 10 and 12.			
Financial Implications:	Linked to staffing levels.			
Equality Impact Assessment and/or patient experience implications	Patient experience and patient harm implications.			
Freedom of Information status:	Disclosable	x	Exempt	

Meeting of the Trust Board in Public

Date: 11th March 2026

Title of Report	**Finance Report Month 10 / January 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	Matt Chapman, Head of Financial Management Isla Fraser, Financial Controller Paul Kimber, Deputy Chief Financial Officer				
Lead Executive	Simon Wombwell, Chief Finance Officer (Interim)				
Purpose	**Approval**		**Briefing**	X	**Noting** X
Proposal and/or key recommendation:	The Board is asked to note January (Month 10) financial performance and review the forecast to meet or better a £55m deficit for the year.				
Executive Summary	The January (in-month) position is a £4.2m deficit; taking us to a £42.9m deficit year to date (YTD). This remains on-track to meet the revised Risk Adjusted Forecast Outturn ("RAFOT") deficit of £54.9m (as reported to last month's FPPC). The in-month deficit is £4.8m better than the prior month (December); the improvement is a combination of increased income in January: income phasing (Jan better than Dec), the inclusion of £2m NHSE funding for past industrial action and a one-off worsening of the December position from a reduction in the MIU contract, adjusting for the fact MFT is not fulfilling the GP provision. CDC income is ~£2.6m adverse to YTD Plan; we have made a provision of ~£1.5m in the YTD position, but the balance of £1.1m continues to be included in our reported position and is at risk of a claw back by the commissioner (they may only pay for activity delivered). Overall ERF income is reporting to Plan; this is consistent to the previous month. However, delays in clinical coding (capacity constraints) means we have higher estimates for the last two months. No Deficit Support Funding (DSF) has been recognised since the end of quarter 2 (£11.0m lost in H2 YTD). The supplementary cash support application of £30m in January 2026 was agreed by NHSE and drawn, with £8.7m (of £12.2m requested) approved for February. Our March application has been submitted and the value increased from £6.1m to £9.6m to reflect the unapproved element from February. Our total borrowing will be ~£48m.				
Issues for the Board/Committee Attention:	We have plans to achieve the £55m deficit revised RAFOT; our biggest risks to achieving this are non-payment of the MCH triage service debtor and CDC contract clawback. The Trust set a £45.4m efficiency plan for FY26; the revised RAFOT (£54.9m deficit) includes savings delivery of £15m, which requires further work to ensure delivery in February and March to meet our revised target.				

	The Board should note the approval of the £30m cash application (drawn in January 2026). The cash application made for a February drawn down was for £12.2m; of this, £8.7m was approved. The feedback received was that an adjustment was made in respect of Brockenhurst (being one of the drivers of the adverse in-year deficit); we believe this has been misinterpreted from a cash perspective and hence have adjusted the March drawdown application value accordingly. The overall requested support therefore remains at £48.4m for the year. Cash support (unlike DSF) increases our Public Dividend Capital (PDC) and thus attracts interest at 3.5%; this increases the Trust cost base in perpetuity (higher PDC dividend payments of >£1.5m per annum).			
Committee/ Meetings at which this paper has been discussed/ approved: **Date:**	○ Forecast Outturn Paper (*revised* RAFOT / £57m* deficit) presented to Trust Board in January Monthly reports to Trust Board and FPPC. [Item 2.1] ○ Monthly reports to Trust Board and FPPC, including analysis and discussion on £47m deficit forecast outturn at December Board (November results). [Item 2.3(b)] ○ Financial performance discussed at Trust Leadership Team and the February Finance, Planning and Performance Committee. **£57m reduced to £55m following issue of £2m central funding for the cost of industrial action.*			
Board Assurance Framework/Risk Register:	BAF 1: There is a risk that the trust does not effectively manage its in-year budgets, run rate, CIP and cash reserves resulting in the non-delivery of the agreed in year control totals BAF 4: There is a risk that if not properly managed the Trust's financial position will lead to compromises in patient safety, health and safety and staff morale.			
Financial Implications:	As described. The Board will recognise the increased regulatory intervention and reinforcement of the need for financial sustainability. We await the detailed implication of being in Oversight Category 5, with provider intervention(s).			
Equality Impact Assessment and/or patient experience implications	Adverse financial performance could directly and indirectly impact patient experience/safety, for example: • Decisions to contain financial losses (and cash shortfalls) could reduce available capacity (and reduce pace of performance target improvements). • Significant losses could result in decisions being made over sustainability/continuity of service provision in medium to long term. • Limiting or delays to capital spend could impact on the physical environment and equipment; impacting on productivity and business continuity risks. • Cash constraints could lead to supplier tensions, withholding of supplies and higher prices for supplies and services.			
Freedom of Information status:	Disclosable	X	Exempt	

Finance Report

For the period ending 31st January 2026 (M10)

Contents

1. Executive Summary – Trust Level

The financial results to **January 2026** (Month 10) are summarised below. Performance is measured against the *revised* forecast, which sets a Year End target of £54.9m deficit (to 31 March 2026). The original Plan was a £4.9m deficit.

£m	Plan	Actual	Var.	Commentary
Income and Expenditure (I&E) Surplus / (Deficit)				
In-month vs RAFOT	**(4.2)**	**(4.2)**	**(0.0)**	The Trust reported in line with its forecast deficit for January and YTD; this includes recognition of £2m of (one-off) Industrial Action (IA) funding issued during January. The in-month deficit is better than December due to the IA funding, together with planned phasing of income, and recognising that there was a reduction in the prior month for the MIU contracted income (exaggerating the gap between the positions reported in the two months). Several risks have been identified, along with corresponding actions and mitigations that must be implemented to achieve the £54.9m forecast. We continue to work through all these issues and continue to expect to meet the ~£55m deficit ceiling.
In-month vs control total excl. DSF	(2.9)	(4.2)	(1.3)	
YTD vs RAFOT	**(42.9)**	**(42.9)**	**(0.0)**	
YTD vs control total excl. DSF	(41.2)	(67.6)	(26.4)	
RAFOT	**(54.9)**	**(54.9)**	**0.0**	
Efficiencies Programme				
In-month	5.1	1.5	(3.6)	The Trust continues to work with PA Consulting to support identification, implementation and delivery of efficiencies. Our revised RAFOT requires savings of £15m, including non-recurrent. We also continue our drive on cost controls, including discretionary spend reduction.
YTD	35.1	8.9	(26.2)	
Cash				
Month end	13.6	13.7	0.1	£30.1m cash support was received in January; the support has enabled all approved NHS and Non-NHS accounts payable invoices to be brought up to date including a payment to £11m to Dartford and Gravesham NHS Trust for NKPS joint venture debt.
Capital				
YTD				At month 10 the YTD programme underspend is £21m; £15.9m relates to the externally funded (Salix grant) decarbonisation project, whilst the remaining £5.1m relates to projects that are behind plan mainly for procurement/contractor reasons. Overall, ~£5.1m of schemes are forecast to defer into 2026/27 & £1.5m of additional (UEC award & sale of assets) funds were awaiting allocation; £2.3m has been utilised to offset CFO approved over planning, leaving £4.3m for re-allocation. A plan for reallocating capital slippage is in full flow, with orders being placed & delivery dates agreed for substitute schemes before 31 March. As at the time of writing, £3.4m has been allocated to priorities as agreed with Trust Leadership Team, £0.3m for revenue to capital transfers, leaving a balance for allocation of ~£0.5m, notably for IT equipment.
Capex (Internal)	11.1	8.4	(2.7)	
Capex (external)	22.7	5.1	(17.6)	
Leases	4.2	3.5	(0.7)	
Total	**38.0**	**17.0**	**(21.0)**	
FORECAST				
Forecast	**49.1**	**49.1**	**0.0**	

2. Income and Expenditure Profile / Run-rates and Risk Adjusted Forecast Outturn (RAFOT)

£m	Actual										Forecast		Full Year
	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	
Clinical income	40.4	38.6	38.1	38.6	37.7	39.2	36.6	34.7	33.8	37.0	34.3	32.4	**441.6**
High cost drugs	2.3	2.1	2.3	2.7	2.2	2.2	2.4	2.3	2.4	2.4	2.3	2.3	**28.0**
Other operating income	2.9	2.8	2.9	2.9	2.7	2.6	(0.1)	3.1	2.9	3.2	2.9	2.9	**31.7**
Total patient care and other income	**45.6**	**43.6**	**43.3**	**44.2**	**42.6**	**44.0**	**38.8**	**40.1**	**39.1**	**42.6**	**39.5**	**37.7**	**501.3**
Donated asset income	0.1	0.4	0.1	0.3	0.3	1.9	0.1	0.0	0.3	0.6	1.0	16.1	**21.3**
Total income	**45.8**	**44.0**	**43.4**	**44.5**	**42.9**	**45.9**	**38.9**	**40.2**	**39.4**	**43.2**	**40.6**	**53.8**	**522.6**
Nursing	(11.6)	(11.5)	(11.8)	(11.8)	(13.4)	(12.4)	(12.4)	(12.1)	(12.4)	(12.1)	(12.3)	(12.3)	**(146.1)**
Medical	(9.1)	(8.9)	(8.9)	(9.5)	(10.9)	(9.3)	(9.3)	(10.2)	(9.9)	(9.2)	(9.4)	(9.4)	**(114.1)**
Other	(8.9)	(8.5)	(8.3)	(8.8)	(4.7)	(8.0)	(7.9)	(7.8)	(7.8)	(7.8)	(7.4)	(4.4)	**(90.3)**
Total pay	**(29.7)**	**(28.9)**	**(29.0)**	**(30.1)**	**(29.0)**	**(29.7)**	**(29.6)**	**(30.1)**	**(30.1)**	**(29.1)**	**(29.1)**	**(26.1)**	**(350.5)**
Clinical supplies	(4.7)	(5.1)	(5.9)	(7.3)	(5.5)	(5.5)	(5.6)	(5.9)	(6.3)	(6.1)	(5.6)	(5.6)	**(69.2)**
Drugs	(1.0)	(1.2)	(1.6)	(1.6)	(1.0)	(1.2)	(1.4)	(1.1)	(1.3)	(1.1)	(1.2)	(1.2)	**(15.0)**
High cost drugs	(2.4)	(2.3)	(2.1)	(2.4)	(2.2)	(2.4)	(3.0)	(2.2)	(2.4)	(2.4)	(2.5)	(2.5)	**(28.8)**
Other	(6.1)	(5.8)	(4.2)	(3.7)	(5.4)	(5.4)	(5.9)	(6.4)	(5.2)	(5.7)	(5.5)	(5.0)	**(64.3)**
Total non-pay	**(14.2)**	**(14.3)**	**(13.8)**	**(15.0)**	**(14.1)**	**(14.5)**	**(15.9)**	**(15.6)**	**(15.2)**	**(15.3)**	**(14.9)**	**(14.4)**	**(177.3)**
Contribution	**1.9**	**0.7**	**0.6**	**(0.6)**	**(0.2)**	**1.8**	**(6.6)**	**(5.5)**	**(5.9)**	**(1.2)**	**(3.4)**	**13.3**	**(5.2)**
Depreciation	(1.7)	(1.7)	(1.7)	(1.6)	(1.7)	(1.8)	(1.7)	(1.7)	(2.0)	(1.7)	(1.7)	(1.7)	**(20.4)**
Donated assets depreciation	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	**(0.3)**
Interest	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.0	(0.1)	0.1	0.1	0.1	**0.7**
Impairment	-	-	-	-	(0.0)	-	-	-	(0.5)	-	-	-	**(0.5)**
Gain/loss on disposal	-	-	-	0.1	(0.0)	-	-	-	-	-	-	-	**0.1**
PDC dividend	(0.8)	(0.8)	(0.8)	(0.8)	(0.8)	(0.8)	(0.8)	0.1	(0.7)	(0.7)	(0.7)	(0.7)	**(8.7)**
Non-operating exp.	**(2.5)**	**(2.5)**	**(2.5)**	**(2.3)**	**(2.5)**	**(2.6)**	**(2.5)**	**(1.6)**	**(3.3)**	**(2.4)**	**(2.4)**	**(2.4)**	**(29.2)**
Reported surplus/(deficit)	**(0.6)**	**(1.7)**	**(1.9)**	**(3.0)**	**(2.7)**	**(0.8)**	**(9.1)**	**(7.1)**	**(9.2)**	**(3.6)**	**(5.8)**	**10.9**	**(34.4)**
Adjustment to control total	(0.1)	(0.4)	(0.0)	(0.3)	(0.3)	(1.9)	(0.0)	(0.0)	0.2	(0.5)	(1.0)	(16.1)	**(20.5)**
Control total surplus/(deficit)	**(0.7)**	**(2.1)**	**(1.9)**	**(3.2)**	**(3.0)**	**(2.6)**	**(9.1)**	**(7.1)**	**(9.0)**	**(4.2)**	**(6.8)**	**(5.2)**	**(54.9)**
£54.9m RAFOT deficit	**(0.7)**	**(2.1)**	**(1.9)**	**(3.2)**	**(3.0)**	**(2.6)**	**(9.1)**	**(7.1)**	**(9.0)**	**(4.2)**	**(6.8)**	**(5.2)**	**(54.9)**
Variance	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Deficit Support Funding ("DSF")	6.4	4.0	4.0	3.4	3.4	3.4	-	-	-	-	-	-	**24.7**
Deficit adjusted for DSF	**(7.1)**	**(6.1)**	**(5.9)**	**(6.7)**	**(6.4)**	**(6.1)**	**(9.1)**	**(7.1)**	**(9.0)**	**(4.2)**	**(6.8)**	**(5.2)**	**(79.6)**
Control total excluding DSF	(6.9)	(6.3)	(5.9)	(4.7)	(3.6)	(2.8)	(2.1)	(2.5)	(3.4)	(2.9)	(2.3)	(2.6)	**(46.1)**
Variance to control total excl. DSF	**(0.2)**	**0.2**	**0.0**	**(1.9)**	**(2.8)**	**(3.3)**	**(7.0)**	**(4.6)**	**(5.6)**	**(1.3)**	**(4.5)**	**(2.6)**	**(33.5)**

Withdrawal of DSF in O3.

Brockenhurst VAT reversed.

Pay award applied

Industrial action

Rheumatology backlog prescribing

NKPS historic debt recoded to supplies

PDC dividend reforecast and YTD correction

3. Risks to headline RAFOT and mitigating actions:

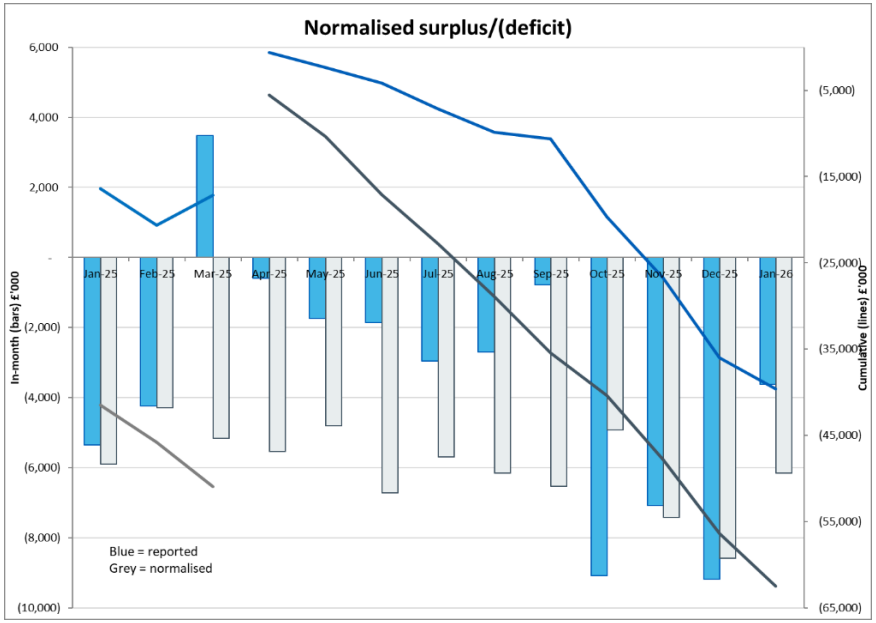
The following are the key risks (considered as a range) to delivery of the £54.9m deficit outturn. “Expect” is the assessment of impact on RAFOT allowing for the mitigating action.

#	Worst	Med	Expect	Further potential risks	Mitigation / action
1	(3.0)	(1.0)	-	Delivery of efficiencies. (excluding virtual hospital below)	Continuation of Vacancy Control Panel, work with PA Consulting and Executive governance arrangements to deliver the full value of efficiencies included within the forecast. Review of mitigations underway daily between CFO, DCFO and senior finance team.
2	(1.2)	(0.6)	-	Industrial action - potential future action	Minimise operational disruption. Claim national funds should these be made available. This has been communicated to NHSE. Outlook suggests IA is low risk in Q4.
3	(2.0)	(1.0)	-	Harsher winter than phasing in RAFOT financially allows	Careful and fully costed winter plan. Current spending in the run rate and pressures being managed in the forecast.
4	(1.8)	(0.9)	-	Debt “arbitration” found against the Trust	Principle of triage charging supported by ICB; legal action. Awaiting meeting with new ICB CFO.
5	(1.1)	(1.1)	-	CDC activity risk crystallises and income is clawed back	Review activity at each location to determine overall quantum; develop case to evidence costs incurred in readiness for service launch. Seek agreement from NHSE that claw-back will not be enacted (with support from ICB and NHSE regional team).
6	(1.5)	(0.8)	-	Virtual Hospital	Risk that the Virtual Hospital initiative does not enable closure of wards but simply increases baseline cost. This has crystallised, identifying reductions elsewhere.
7	(1.0)	(0.5)	-	Pensions auto-enrolment costs remain high	Assess opt-outs moving forwards and continue to drive workforce efficiency programmes. Potential opt-outs continue.
	(11.6)	**(5.9)**	**-**	**Total range of net risk against RAFOT**	

4. Normalised performance

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

£'000	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Reported surplus/(deficit)	**(5,347)**	**(4,242)**	**3,482**	**(590)**	**(1,735)**	**(1,861)**	**(2,956)**	**(2,696)**	**(775)**	**(9,080)**	**(7,080)**	**(9,188)**	**(3,617)**
Technical adjustments	424	(200)	(3,032)	(96)	(378)	(48)	(276)	(282)	(1,872)	(38)	(16)	205	(538)
Control total surplus/(deficit)	**(4,923)**	**(4,442)**	**450**	**(686)**	**(2,113)**	**(1,909)**	**(3,232)**	**(2,978)**	**(2,647)**	**(9,118)**	**(7,096)**	**(8,983)**	**(4,155)**
Deficit support funding	(2,191)	(989)	(1,948)	(6,412)	(3,996)	(3,996)	(3,429)	(3,429)	(3,429)	-	-	-	-
Control total surplus/(deficit) before deficit support funding	**(7,115)**	**(5,431)**	**(1,498)**	**(7,098)**	**(6,109)**	**(5,905)**	**(6,661)**	**(6,407)**	**(6,076)**	**(9,118)**	**(7,096)**	**(8,983)**	**(4,155)**
Normalisation adjustments:													
Non-recurrent adjustments	1,214	1,140	(295)	113	36	101	18	83	(632)	512	(171)	(86)	-
NKPS Debt provision				1,351	1,176	(1,010)	188	60	60	60	60	60	60
Industrial action costs / (Income)	-	-	-	-	-	-	555	-	-	-	617	550	(2,000)
Annual leave accrual cost	-	-	147	-	-	-	-	-	-	-	-	-	-
Pension 9.4% Costs	-	-	17,984	-	-	-	-	-	-	-	-	-	-
Pension 9.4% Income	-	-	(17,984)	-	-	-	-	-	-	-	-	-	-
Pay Award	-	-	-	(212)	(212)	(212)	635	-	-	-	-	-	-
Pay Award Income	-	-	-	184	184	184	(552)	-	-	-	-	-	-
Winter pressures funding	-	-	-	-	-	-	-	-	-	-	-	-	(50)
Backlog funfing (Sprint)												(119)	-
PDC dividend adjustment	-	-	-	119	119	119	119	119	119	119	(830)	-	-
Car Parking VAT - Claim Recognised	-	-	(3,508)	-	-	-	-	-	-	3,508	-	-	-
Recurrent surplus/(deficit)	**(5,901)**	**(4,291)**	**(5,154)**	**(5,543)**	**(4,807)**	**(6,722)**	**(5,699)**	**(6,145)**	**(6,529)**	**(4,919)**	**(7,419)**	**(8,578)**	**(6,145)**
Recurrent surplus/(deficit) - cumulative in-year	*(41,478)*	*(45,769)*	*(50,923)*	*(5,543)*	*(10,350)*	*(17,072)*	*(22,771)*	*(28,916)*	*(35,444)*	*(40,363)*	*(47,782)*	*(56,360)*	*(62,505)*



Commentary:

- The normalised/recurrent position removes technical items, e.g. income and spend relating to charitable donations and one-off impacts such as industrial action.
- The January normalised I&E position is an improvement on the previous month, in-month recurrent deficit - this is mainly driven by the phasing of block income and a reduction in clinical supplies costs.
- Based on the year-to-date average run rate, the annualised performance is projected to be ~**£75m** (or £78m based on £6.5m/month * 12), representing a deterioration of the underlying deficit compared to 2024/25. This variance is primarily driven by:
  - Ongoing growth in staffing levels following decisions made in mid-2024/25.
  - Non-delivery of planned efficiency measures to reduce the monthly run rate.
- Enhanced controls have been implemented to the end of the financial year (these will continue into 2026/27), including exit of all agency staff.

5. Statement of Financial Position

31 March 2025	£m	Month end Actual	Movement vs Prior Year
289.7	**Non-current assets**	**289.7**	**0.0**
6.7	Inventory	6.9	0.2
38.6	Trade and other receivables	43.4	4.8
0.4	Assets held for sale	0.0	(0.4)
13.3	Cash	13.7	0.4
59.0	**Current assets**	**64.0**	**5.0**
(0.2)	Borrowings	(0.7)	(0.5)
(61.0)	Trade and other payables	(62.6)	(1.6)
(1.1)	Other liabilities	(4.8)	(3.7)
(62.3)	**Current liabilities**	**(68.1)**	**(5.8)**
(3.3)	**Net current liabilities**	**(4.1)**	**(0.8)**
(2.8)	Borrowings	(5.4)	(2.6)
(1.3)	Other liabilities	(2.3)	(1.0)
(4.1)	**Non-current liabilities**	**(7.7)**	**(3.6)**
282.3	**Net assets employed**	**277.9**	**(4.4)**
511.3	Public dividend capital	546.4	35.1
(292.5)	Retained earnings	(332.1)	(39.6)
63.6	Revaluation reserve	63.6	0.0
282.3	**Total taxpayers' equity**	**277.9**	**(4.4)**

Key messages:

Non-current assets are essentially the same as year-end, being the net impact of investment expenditure, depreciation and impairments.

Net current liabilities (*current assets less current liabilities*) at the end of December are £4.1m (major favourable shift since the previous month end due to the receipt of cash support).

- **Trade and other receivables** are £43.4m (~108% of one-month's income)
- **Cash** as at 31st January is £13.7m; whilst all approved invoices have been brought up to date there is ~£4m unapproved well overdue with key suppliers that needs to be paid. Cash has been held to enable this to happen.
- **Trade and other payables** have decreased by £17.6m in month due to cash support enabling supplier to be paid.
- **Borrowings** – both current and non-current - have increased following recognition of the capitalised lease assets.
- **Other liabilities** relate to deferred income, materially being education income received quarterly in advance.

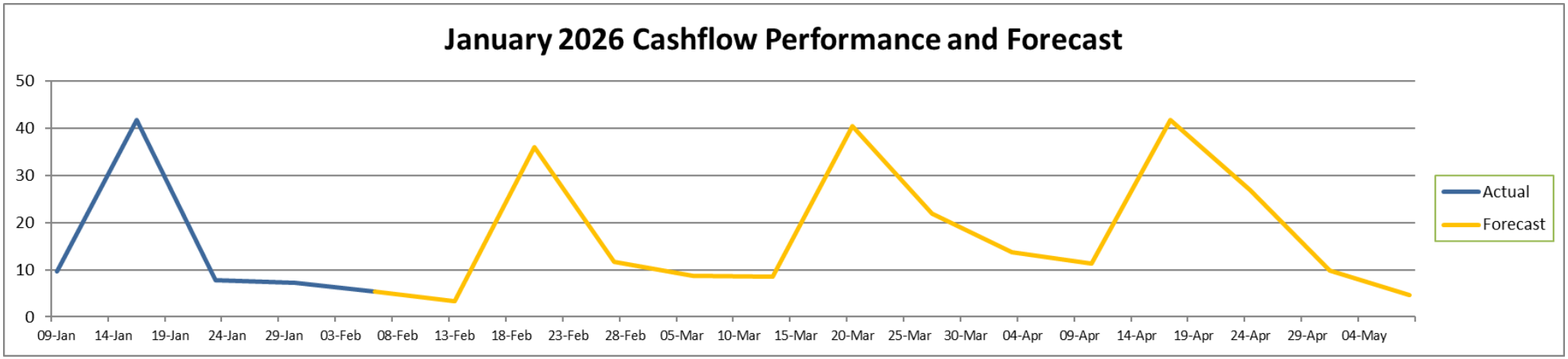
Public Dividend Capital has been received in year for capital projects (£5.0m) and revenue support (£30.1).

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

6. Cash

13-week cashflow

	Actual					Forecast												
£m	09/01/26	16/01/26	23/01/26	30/01/26	06/02/26	13/02/26	20/02/26	27/02/26	06/03/26	13/03/26	20/03/26	27/03/26	03/04/26	10/04/26	17/04/26	24/04/26	01/05/26	08/05/26
BANK BALANCE B/FWD	**13.4**	**9.6**	**41.7**	**7.8**	**7.2**	**5.3**	**3.4**	**35.9**	**11.8**	**8.8**	**8.5**	**40.4**	**21.8**	**13.6**	**11.3**	**41.8**	**26.8**	**9.7**
Receipts																		
NHS Contract Income	0.5	33.7	0.0	0.1	0.4	0.0	36.3	0.3	0.4	0.0	37.2	0.8	0.0	0.4	39.6	0.0	0.0	0.0
Other	0.2	0.3	0.2	0.5	0.2	0.2	0.2	0.4	0.2	0.2	0.2	0.4	0.1	0.3	0.6	0.2	0.5	0.3
Total receipts	**0.7**	**34.0**	**0.2**	**0.6**	**0.6**	**0.2**	**36.5**	**0.7**	**0.5**	**0.3**	**37.3**	**1.2**	**0.1**	**0.7**	**40.2**	**0.2**	**0.5**	**0.3**
Payments																		
Pay Expenditure (excl. Agency)	(0.4)	(0.4)	(28.4)	(0.5)	(0.4)	(0.5)	(4.5)	(23.5)	(0.8)	(0.4)	(0.4)	(28.3)	(0.4)	(0.4)	(0.5)	(13.6)	(15.5)	(0.5)
Non Pay Expenditure	(3.6)	(1.2)	(6.1)	(2.0)	(2.0)	(0.9)	(3.3)	(1.4)	(2.6)	(0.1)	(4.7)	(20.6)	(7.9)	(2.6)	(6.9)	(10.0)	(1.2)	(2.0)
Capital Expenditure	(0.5)	(0.2)	(0.0)	(0.2)	(0.1)	(0.8)	(0.3)	0.0	(0.2)	0.0	(0.3)	(0.9)	(1.2)	0.0	(2.2)	(5.0)	(1.9)	(2.8)
Total payments	**(4.6)**	**(1.8)**	**(34.5)**	**(2.7)**	**(2.5)**	**(2.1)**	**(8.1)**	**(24.9)**	**(3.5)**	**(0.5)**	**(5.5)**	**(49.9)**	**(9.4)**	**(3.1)**	**(9.6)**	**(28.6)**	**(18.6)**	**(5.3)**
Net Receipts/ (Payments)	**(3.8)**	**32.1**	**(34.2)**	**(2.1)**	**(1.9)**	**(1.9)**	**28.4**	**(24.2)**	**(3.0)**	**(0.3)**	**31.9**	**(48.7)**	**(9.3)**	**(2.4)**	**30.5**	**(28.3)**	**(18.1)**	**(5.0)**
Funding Flows																		
DH Revenue Support	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	30.1	0.0	0.0	0.0	8.7	0.0	0.0
Working Capital Support	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PDC Capital	0.0	0.0	0.0	1.4	0.0	0.0	3.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.2	1.0	0.0
Grant Capital	0.0	0.0	0.4	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0	0.0	1.1	0.0	0.0	3.4	0.0	0.0
Loan Repayment/Interest payable	0.0	0.0	(0.1)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Dividend payable	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Funding	**0.0**	**0.0**	**0.3**	**1.4**	**0.0**	**0.0**	**4.2**	**0.0**	**0.0**	**0.0**	**0.0**	**30.1**	**1.1**	**0.0**	**0.0**	**13.3**	**1.0**	**0.0**
BANK BALANCE C/FWD	**9.6**	**41.7**	**7.8**	**7.2**	**5.3**	**3.4**	**35.9**	**11.8**	**8.8**	**8.5**	**40.4**	**21.8**	**13.6**	**11.3**	**41.8**	**26.8**	**9.7**	**4.7**



12 months rolling

	Actual										Forecast									
£m	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26
OPENING CASH (REVENUE)	(0.8)	0.8	1.6	1.0	5.1	2.3	(6.8)	(3.7)	(12.6)	(15.1)	(11.1)	(13.2)	(10.5)	(7.3)	(7.3)	(7.9)	(7.9)	(3.9)	(8.3)	(8.1)
OPENING CASH (CAPITAL)	14.1	10.6	12.2	13.8	14.8	15.7	16.0	17.2	19.7	24.3	24.7	23.0	15.5	15.7	16.1	16.3	16.5	16.7	17.1	17.3
OPENING TOTAL CASH	**13.2**	**11.4**	**13.8**	**14.8**	**19.9**	**18.1**	**9.2**	**13.4**	**7.2**	**9.2**	**13.6**	**9.7**	**5.0**	**8.4**	**8.8**	**8.4**	**8.6**	**12.8**	**8.9**	**9.2**
Receipts																				
NHS Contract Income (Revenue)	39.4	43.2	38.4	44.7	45.7	38.9	44.6	32.6	35.2	36.6	38.3	42.1	37.5	33.6	33.6	38.6	35.1	33.5	37.9	33.0
NHS Contract Income (Capital)	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0
Other	1.7	1.0	1.6	1.4	2.0	1.1	0.9	1.2	1.2	0.9	1.6	1.7	1.4	1.2	1.1	1.7	1.5	1.3	1.0	1.2
Total receipts	**42.9**	**45.9**	**41.7**	**47.9**	**49.4**	**41.8**	**47.3**	**35.5**	**38.1**	**39.3**	**41.6**	**45.5**	**41.0**	**36.9**	**36.7**	**42.2**	**38.6**	**36.8**	**41.0**	**36.3**
Payments																				
Pay Expenditure (excl. Agency)	(27.4)	(28.2)	(27.9)	(28.3)	(30.9)	(31.0)	(29.5)	(29.7)	(28.9)	(30.3)	(30.0)	(30.0)	(30.7)	(30.1)	(30.1)	(30.5)	(30.1)	(30.1)	(30.5)	(30.1)
Non Pay expenditure prior year CR	0.0	0.0	0.0	0.0	0.0	(0.7)	(0.3)	0.0	0.0	(8.7)	(4.0)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Non Pay Expenditure	(12.1)	(15.1)	(12.7)	(13.8)	(19.6)	(13.2)	(12.6)	(12.9)	(10.0)	(24.6)	(20.9)	(17.8)	(16.6)	(15.3)	(16.6)	(16.6)	(16.6)	(15.3)	(16.6)	(16.6)
Efficiencies delivered	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.6	2.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Cost pressures (winter pressures)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.5)	(0.3)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Cost pressures (other)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(1.3)	(0.5)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Creditor Stretch	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.4	(0.0)	(4.3)	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Capital Expenditure	(6.6)	(2.2)	(0.5)	(0.7)	(1.1)	(1.8)	(0.8)	(1.0)	(1.4)	(2.4)	(9.1)	(13.7)	(11.9)	(1.6)	(1.8)	(1.8)	(1.8)	(1.6)	(1.8)	(1.8)
Total payments	**(46.1)**	**(45.5)**	**(41.0)**	**(42.8)**	**(51.6)**	**(46.7)**	**(43.3)**	**(43.5)**	**(40.3)**	**(66.1)**	**(59.9)**	**(59.8)**	**(63.5)**	**(47.0)**	**(48.5)**	**(48.9)**	**(48.5)**	**(47.0)**	**(48.9)**	**(48.5)**
Net Receipts/ (Payments)	**(3.2)**	**0.4**	**0.7**	**5.1**	**(2.2)**	**(4.9)**	**4.0**	**(8.0)**	**(2.2)**	**(26.8)**	**(18.2)**	**(14.2)**	**(22.6)**	**(10.1)**	**(11.8)**	**(6.7)**	**(9.9)**	**(10.2)**	**(8.0)**	**(12.2)**
Funding Flows																				
DH Revenue Support	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	30.1	8.7	9.6	15.9	10.6	11.4	6.9	14.0	10.5	8.3	12.1
DH working capital support	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PDC Capital	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.4	3.6	0.0	2.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Grants - Capital	1.4	2.1	0.3	0.1	0.3	0.4	0.3	0.4	0.5	1.1	3.4	4.5	10.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Loan Repayment/Interest payable	0.0	(0.1)	0.0	0.0	0.0	0.0	0.0	(0.1)	0.0	0.0	0.0	0.0	0.0	(0.1)	0.0	0.0	0.0	0.0	0.0	(0.1)
Dividend payable	0.0	0.0	0.0	0.0	0.0	(4.3)	0.0	0.0	0.0	0.0	0.0	(4.7)	0.0	0.0	0.0	0.0	0.0	(4.3)	0.0	0.0
Total Funding	**1.4**	**2.1**	**0.3**	**0.1**	**0.3**	**(3.9)**	**0.3**	**1.8**	**4.2**	**31.3**	**14.3**	**9.5**	**26.0**	**10.5**	**11.4**	**6.9**	**14.0**	**6.2**	**8.3**	**12.0**
NET INFLOW / (OUTFLOW) REVENUE	1.7	0.8	(0.6)	4.1	(2.8)	(9.1)	3.1	(8.8)	(2.6)	4.0	(2.1)	2.7	3.2	0.0	(0.6)	(0.0)	4.0	(4.3)	0.1	(0.4)
NET INFLOW / (OUTFLOW) CAPITAL	(3.5)	1.7	1.6	1.0	0.9	0.3	1.1	2.6	4.5	0.5	(1.8)	(7.5)	0.2	0.4	0.2	0.2	0.2	0.4	0.2	0.2
TOTAL NET INFLOW / (OUTFLOW)	**(1.8)**	**2.4**	**1.0**	**5.1**	**(1.9)**	**(8.9)**	**4.2**	**(6.2)**	**2.0**	**4.5**	**(3.9)**	**(4.8)**	**3.4**	**0.4**	**(0.4)**	**0.2**	**4.2**	**(3.9)**	**0.3**	**(0.2)**
OPENING CASH (REVENUE)	0.8	1.6	1.0	5.1	2.3	(6.8)	(3.7)	(12.6)	(15.1)	(11.1)	(13.2)	(10.5)	(7.3)	(7.3)	(7.9)	(7.9)	(3.9)	(8.3)	(8.1)	(8.6)
OPENING CASH (CAPITAL)	10.6	12.2	13.8	14.8	15.7	16.0	17.2	19.7	24.3	24.7	23.0	15.5	15.7	16.1	16.3	16.5	16.7	17.1	17.3	17.5
CLOSING TOTAL CASH	**11.4**	**13.8**	**14.8**	**19.9**	**18.1**	**9.2**	**13.4**	**7.2**	**9.2**	**13.6**	**9.7**	**5.0**	**8.4**	**8.8**	**8.4**	**8.6**	**12.8**	**8.9**	**9.2**	**9.0**
Cash flow forecast in NHSE plan	19.6	12.7	14.0	16.5	16.1	11.0	13.0	10.8	8.9	13.6	15.8	11.8	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Variance	(8.2)	1.1	0.8	3.4	2.0	(1.8)	0.4	(3.6)	0.3	0.0	(6.1)	(6.8)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
M6 Baseline CFF reported to FPPC	11.4	13.8	14.8	19.9	18.1	9.2	10.1	5.3	9.0	9.4	12.1	8.6	8.1	5.3	5.1	15.7	12.3	5.7	N/A	5.3
Variance	0.0	0.0	0.0	0.0	0.0	0.0	3.3	1.9	0.2	4.2	(2.4)	(3.6)	0.3	3.5	3.3	(7.1)	0.5	3.2	N/A	N/A
M6 NOSUPPORT CFF reported to FPPC	11.4	13.8	14.8	19.9	18.1	9.2	10.1	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	N/A	N/A
Variance	0.0	0.0	0.0	0.0	0.0	0.0	3.3	(0.3)	1.7	6.1	2.2	(2.5)	0.9	1.3	0.9	1.1	5.3	1.4	N/A	N/A

7. Conclusions

As reported through the year, there have been a number of issues and key risks to delivery of the annual plan; most notably the **material shortfall in achievement of efficiencies and cost base reduction** (whilst maintaining activity levels and performance target delivery – in contrast we are seeing improvements in waiting times). Cost pressures (e.g. VAT recovery loss), loss of Deficit Support Funding and prior year debt recovery are linked and exacerbate the in-year deficit. The result was a revised forecast outturn of £56.9m deficit (with further cost reduction action required); following receipt of industrial action funding (£2m) the **forecast reduces to £54.9m deficit**. FPPC and Board members will recognise this has significant regulatory implications (Category 5 Oversight meaning Provider Improvement Programme interventions), cash borrowing (increasing administration and scrutiny and increases to our cost base, as a result of the 'interest') and implications for system, including the system moving into 'turnaround'.

The Board / FPPC is asked to note this report and the financial performance to the end of January 2026 (Month 10), which is a £42.9m deficit and aligned to the formal reforecast of £54.9m.

There remain ongoing actions to deliver the forecast, including continued further delivery of the efficiency programme; any **risks must be fully managed and mitigated**.

The Trust's **exit run-rate** will directly impact the setting of a plan for 2026/27.

Current actions, with the support of our partners and PA Consulting, include the following:

1. In addition to tightening the recruitment freeze, the Trust continues to review and exit all agency staff, unless there is a clear patient safety risk. Furthermore, the process for approval of additional sessions, vacancy controls and in-/outsourcing moves to weekly reporting. At the same time reduce Bank spend i.e. avoid cost switching from perm/agency to bank. We are monitoring the non-clinical advertised vacancy position in line with K&M peers and we are lowest in the System most weeks. We also have a Non Pay Controls.
2. The implementation of Virtual Hospital is progressing, with an additional ~40 virtual beds on top of the existing ~80 already operated. We are targeting ~200 beds in total by the end of the implementation in order to reduce the physical on-site capacity (delayed slightly for the CMO and CNO to review clinical governance processes and protect patient safety). However, we note that closure of the physical capacity during winter will prove extremely challenging. We are targeting a Ward closure before year end, underpinned by lower cost virtual care.
3. Work on the corporate services review continues, with executive-led decision panels now held for all areas; this work, including a review of 'spans and layers' (hierarchies), require the implementation of proposals to release cost.

As a consequence of the adverse financial performance and significant deficit, a **revenue support application to secure additional cash** was made to NHSE; the requested support of £30m in January 2026 has been agreed together with a further £8.7m in February, **but**, this comes at an additional cost to the Trust by way of dividend/interest charges. Application for a £9.6m drawdown in March has been be made in line with previous endorsement from the Board of £48.4m this financial year.

The Board is asked to acknowledge, clarify understanding, discuss and support the position and actions outlined; and to request any further actions required for consideration.

Simon Wombwell
Chief Finance Officer
February 2025

Progress update: Margaret Pratt Financial Governance Review

Medway Foundation NHS Trust

February 2026

(note this is an updated report based on what that presented at Trust Board in November 2025)

Authors:

Katie Goodwin, Improvement Director (RSP)

Context

The Trust commissioned the Recovery Support Programme (RSP) to reassess progress against the 15 recommendations from the Margaret Pratt Financial Governance Review undertaken in December 2024. Recent updates to Board have demonstrated activity against the actions, but progress remains uneven and fragile. Leadership arrangements are highly transitional, with recent changes to the CEO, a highly interim executive team, and continued uncertainty about the group model. As such, collective ownership of the financial governance agenda is not yet secure. While cultural openness and challenge have improved, the organisation remains some distance from effective unitary board working, and decision-making structures have yet to be consistently embedded.

Margaret Pratt's review, alongside the 2024 KPMG assessment and the 2023 Niche Well-Led review, highlighted systemic issues in governance, accountability, financial grip, and the lack of a "golden thread" aligning actions, risks and delivery. Since then, the Trust has implemented a stabilisation plan, as well as implementing the Trust Leadership Team to strengthen transparency and engagement (including divisional triumvirates and heads of department, as well as the executive team). New NEDs have increased the level of scrutiny and rigour at FPPC and ARC. However, substantial operational and governance challenges persist: divisional financial ownership is weak, business partnering capacity is insufficient, triangulation across finance, workforce and operational data is inconsistent, and forecasting discussions remain largely confined to committees rather than the wider organisation. As such, the Trust's financial governance arrangements remain in a formative stage and are not yet sufficiently mature to provide reliable assurance to the Board. A new interim Board Secretary has been recently appointed to help drive this forward.

Overall, while the direction of travel is positive, progress does not yet meet the spirit or letter of the review. Key issues include:

1. **Fragile leadership and unclear accountability**: high turnover, interim arrangements and the paused group-model development have left executive and Board leadership unsettled. Unitary Board working has not yet been tested through difficult financial or operational decisions.
2. **Lack of a functional "golden thread":** escalation and decision-making routes have become clearer but remain inconsistent. Despite the stabilisation plan, the volume of business cases, projects and new initiatives continues to dilute focus, and there is limited follow-through from challenge to action.
3. **Over-reliance on PA Consulting and weak divisional ownership**: CIP delivery, grip and control, and budget reviews are currently reliant on external consultants rather than embedded divisional structures. Finance business partnering is immature and capacity-constrained, with limited triangulation of data and weak divisional accountability.
4. **Governance processes remain under-developed**: Board and committee debate has strengthened, but actions are not consistently SMART, risks are not always triangulated, and forecasting, workforce and operational data are not presented in an integrated way. The BAF remains more descriptive than dynamic, hence the work being undertaken to strengthen this.
5. **Divisional accountability and PRMs are not yet effective**: PRMs lack comprehensive finance packs and data triangulation, divisional forecasting is limited, and ownership of finance, outside of finance, remains weak. Cross-corporate business partnering working (ie PMO/finance/HR/BI) is at an early stage

The Trust should prioritise restoring stability and clarity in leadership and decision-making, using the arrival of the new Board Secretary to strengthen governance flow, action-tracking, agenda planning and assurance. Divisional accountability must be reinforced rapidly—with strengthened business partnering, comprehensive performance packs and clear expectations around forecasting and triangulation. Finally, the Board should narrow its organisational focus through visible leadership, embedding an improvement plan (based on the NPIP assessment) and ensuring that all committees and divisions operate to a shared financial and operational "golden thread".

Appendix

Assessment on the 15 specific recommendations

Ref	Recommendation, as per report	RSP progress assessment (Jan 26)
1)	The Trust reviews its financial reporting and forecasting to Board, to ensure that: • Concerns including the forecast outturn are escalated and debated at Board, with firm recommendations for SMART actions going forward; and • A "golden thread" is developed anchoring actions and deliverables to the delivery of sustainable finances. These actions should be tracked for effectiveness through the Board's Action log and incorporated within Trust communications. Actions should be tracked for effectiveness through the Board's Action log; and should demonstrate that there are no "orphan" activities agreed that do not have oversight from a Board Committee. Review outcomes should be explicitly endorsed by the CEO; lead executives and non-executive Chairs	Financial reporting and forecasting is now reported as a standard agenda item at public Board and reporting is consistent and provides more constructive narrative than . However, most of the debate still takes place at Finance, Planning and Performance Committee (FPPC). Whilst the debate at FPPC is considerably more robust than has been the case previously, the actions arising are not always explicit. This is made harder by the continued lack of a financial "golden thread" through the organisation (see progress assessment against recommendation 5 and 6) and the lack of follow-through on committee / Board discussion.
2)	Consideration should be given in agenda planning to ensure that the Board considers in public its most up-to-date financial position, with associated actions; and that the Trust's communications reflect actions to address issues and risks arising. Consideration should be given to circulating to all members of the Unitary Board the reports submitted to the ICB and NHSE in the months when the Board does not meet.	Due to the timing of reporting with FPPC and Board, it is not unusual for reporting to go directly to these forums without discussion at the Trust Leadership Team meeting; Board sometimes receives updated reporting prior to FPPC. Again, this does not help with the "golden thread", and it further weakens ownership and accountability. It also means that FPPC (and Board) continues to act down, engaging in operational discussions that have not taken place elsewhere. The Board are currently reviewing the overall Board timetable which should help to start remedying this. Given the level of oversight at regional / ICB level, there have been a number of occasions where reporting has had to go externally, prior to internal Board circulation. This was particularly the case with the August forecast which was discussed with the regional CFO prior to Board circulation – noting that this was true for all trusts in Kent and Medway. The same is true of the monthly regional oversight packs. It is important that Board members have site of these documents, at least in parallel to any external discussions.

Assessment on the 15 specific recommendations

Ref	Recommendation, as per report	RSP assessment (Jan 26)
3)	To ensure that the Unitary Board has a clear, shared understanding of the tasks; timescales; risks; and roles, responsibilities and accountabilities for delivery, the interim CFO should be tasked with: • reviewing and updating the financial recovery action plan including progress on the 21 actions/ recommendations made by the former financial improvement director and other reviews; and • proposing updated monthly run-rate projections as key delivery metrics for assurance. This review should be considered formally by the Unitary Board by the end of January 2025, and followed up through the action log.	An external consultancy firm was commissioned to support delivery of the 25/26 financial plan and identify further savings in 26/27. This is helping to strengthen governance over CIP delivery, as well as engaging and upskilling divisions, however, delivery remains low with a forecast outturn of c£12m of recurrent, cash-out, CIP in 2025/26. No decisions have yet been made as to how this work will be taken forward into 2026/27. It is important to note that much of the governance is currently driven by the consultancy firm (for example, they are doing the budget management / oversight of the CIP tracker etc) and the Trust needs to assure itself that the Unitary Board is able to drive accountability and delivery without their presence by the end of March 2026. A comprehensive financial recovery plan is currently in development, alongside a system wide financial recovery plan. It will be essential that ownership sits with the Unitary Board, not the interim CFO. Monthly run-rate projections and forecasting are now incorporated into reporting on a regular basis but this is limited to committee / Board level and they are largely financial. Operational and workforce run-rate projections are still very limited and, again, makes it challenging for committees to triangulate performance and assess the risks.
4)	BAF and corporate risks; gaps in controls and gaps in assurance be reviewed for interface with the delivery of the finance recovery plan; and revised assessments and action plans developed for Committee and Board review; and active follow up of SMART action plans.	The financial risks in the BAF have been strengthened – finance is now considered an extreme risk and the BAF has been further revised to reflect the Trust's stabilisation plan and the key issues / risks it seeks to address. However, this is in the very early stages of being embedded and the follow through into relevant assessments and actions will need continued oversight. To date the BAF has been treated as more of a list than a live, working document, informing decision making / action and committees frequently run out of time to discuss it in any depth.
5)	Check and challenge exchanges at each Board and Committee meetings are captured and included with SMART actions and reporting timelines in action logs for follow up and alignment of expectations and delivery;	Check and challenge exchanges are captured but they are generally written verbatim, rather than being themed and specific actions drawn out. Taking the significant check and challenge over the forecast outturn in the September 2025 FPPC meeting as one example, there were no SMART actions derived from it, albeit the agenda for the following meeting continued the scrutiny in this area.

Assessment on the 15 specific recommendations

Ref	Recommendation, as per report	RSP progress assessment (Jan 26)
6)	The Board and Executive Team consider commissioning as quickly as possible a Board and Team development programme to encourage strong working relations as a Unitary Board;	The level of change at Board (executive) level in the past six months, combined with the uncertainty created by the scoping of a group model, has delayed a development programme being enacted. A first development day was held on 3 November 2025, with a follow-up scheduled for 18 February 2026. This will need to be a key priority as substantive executive recruitment commences.
7)	Financial awareness should be explicitly included in the Board development programme. All Directors should acknowledge that as Unitary Board members they are accountable for the delivery of financial plans and sustainable financial performance.	The interim CFO delivered an initial session held in December 2024 but, as above, financial awareness, will need to be built into the Board Development programme. Whilst much greater reference is given to "Unitary Board" working, and the interim CEO visibly owns the delivery of the financial plan, this is not consistent across all Board members. No "difficult decisions" around delivery (ie performance vs finance) have been taken to Board, in order to properly test "Unitary Board" working. Board conversations tend to be operational rather than strategic in nature and are more focused on NED assurance than collective decision making and accountability.
8)	For assurance, a representative of the ICB be invited to attend meetings of the Finance, Planning and Performance Committee as an observer.	The NHSE Improvement Director (ID) regularly observes at FPPC. The ICB / region receive updates from the ID via the Oversight process. No ICB representative has attended FPPC to date. The Trust and ICB may wish to consider this, particularly when it comes to more challenging "system-wide" issues such as NCTR.
9)	The Trust considers revising through "Patients First" its break-through objectives to encourage focus on monthly run-rate against budget.	The Trust is currently in the process of revising its strategic objectives as part of a governance refresh, led by the Strategic Board Advisor. This will include making a decision around the use of Patient First as the Trust's governance framework. Further work is required to ensure the revised strategic objectives fully align with the 2026/27 and medium term planning submission, such that there is clear accountability and expectations around delivery. Clear and simple communication, and visible leadership, will be essential to ensure all staff understand their contribution to the plan and drive belief.

Assessment on the 15 specific recommendations

Ref	Recommendation, as per report	RSP progress assessment (Jan 26)
10)	The Trust ensures that revised processes are implemented to ensure the Board is fully sighted on budget setting assumptions; and that mitigations to control risks and issues arising are made explicit	Ongoing, unresolved queries around budgets have remained a theme throughout the financial year to date, at times distracting from delivery. This is mainly the result of a significant financial delivery expectation (£46m of CIP) and poor reconciliation between financial, workforce and performance reporting. It will be important that a realistic but challenging plan is set for 26/27 in order to drive ownership and accountability, at the same time as restoring belief (ie in the ability to deliver). This needs to be further supported by accurate reconciliation and triangulation of finance, workforce and performance systems. No zero-based budgeting has been undertaken to date but the Trust may wish to consider whether this is necessary in certain instances; a process for budget sign-off in advance of the new financial year should be agreed as a priority to ascertain any instances of non-alignment early and seek to resolve these.
11)	The Executive Team take time out to reassess its appetite for change and risk to give greater emphasis, pace and urgency through their leadership to the delivery actions needed to achieve financial sustainability	The first executive "away-day" since March took place on 22nd October following a six month period of significant change in the executive team. Further days are now planned with the agenda / development requirements for these being developed. Weekly exec team meetings also take place and there is a greater level of debate and discussion at these meetings than has been the case previously. Collective ownership and risk tolerance still remains an issue, with conversation generally defaulting to "professional silos".
12)	The Chief Executive considers and implements performance management arrangements that will demonstrate increased effectiveness in the delivery of financial control and sustainability. This could require the focussed management of individuals; and or revisions to the Patient First programme to ensure greater assurance of the delivery of financial recovery targets	A new style divisional performance review meeting has been in place since August, however, this is still very much embedded in the Patient First methodology. The meetings included limited divisional finance information, on which divisions are held to account and, as a consequence, there is limited questioning of the divisional financial positions or accountability below this. It should be noted that finance business partners talk to the money during these meeting, not divisional triumvirates (budget holders). There is no divisional forecast discussion and the forecast remains very much "owned" by the finance team; as a consequence deriving explicit operational actions from it remains challenging. Triangulation with workforce and performance data is very limited. The IQPR is being revised to mirror the stabilisation plan and a live dashboard was presented at the October meetings. However, the Patient First "RAG" scoring and watch / driver split is still very much in evidence and, whilst early days limits the ability to triangulate or have wider conversations. Further work is being undertaken to address this. There remains limited triangulation in these meetings with grip and control actions such as rostering, no purchase order, no pay, bank and agency usage, WLIs and post implementation business case review etc.

Assessment on the 15 specific recommendations

Ref	Recommendation, as per report	RSP progress assessment (Jan 26)
13)	The interim CFO acts with pace and urgency to reinvigorate the finance department by setting clear expectations of professional standards; and holding both his team and colleagues to account for delivery of agreed actions	The finance team has undertaken a series of development exercises / team away days in the past nine months, with the support of the South East Regional Academy. There is also a finance department improvement plan (see separate update report). Objectives have been set for the team, establishing clear expectations for professional standards. However, there are ongoing capability and capacity issues in the team that have not yet been addressed.
14)	The Trust should, as a priority, ensure that there is sufficient financial business partner support to divisions to promote improved financial control and business planning to deliver Trust financial sustainability.	A proposal was put forward for business partner development (finance, HR and BI) in the autumn, as part of the Trust's stabilisation plan. This should help to address this action and ensure greater levels of collaboration across corporate teams. Until this is enacted, however, finance business partner capability and capacity remains limited, and has been reliant on RSP funding for over a year. This will not continue into 2026/27. Finance reports are still at the "score-keeping" end (HFMA "Exploring the Role of the Finance Business Partner" 2019) of the business partnering spectrum and cross-corporate team working remains in its infancy. Finance Business Partners speak to the money at performance review meetings and at divisional boards, driving limited financial accountability and ownership. Errors in budgets, reconciliations to rosters and complex reporting further exacerbate this.
15)	The Trust revisits its performance and action plans: • Firstly, to ensure that all action plans outstanding are owned and delivered; and secondly • against best practice outlined in the HFMA and other checklists and agrees improvements. If appropriate the Trust should consider asking auditors KPMG to provide assurance on self-assessments and action plans for improvement as part of the Internal Audit Programme.	The Trust has developed a stabilisation plan to coordinate all actions in one place and ensure that the most pressing challenges are addressed. There remain concerns over the lack of forward-looking and triangulated trajectories to track delivery and drive accountability across all areas. The engagement of PA Consulting, alongside the finance team, is supporting the implementation and oversight of the grip and control checklist (focussing on impactful areas e.g. rostering and workforce controls, procure-to-pay process). It will be important, as part of the Board Development day on 18 February, and enhanced system working, that recovery plans and strategic objectives for 2026/27 are agreed as soon as possible. These should then form the basis for communication and engagement with the wider organisation, to drive delivery.

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Finance Function Progress Update

Medway Foundation NHS Trust

January 2026

Author:
Jabir Alam – Associate Director of Financial Improvement, National Recovery Support Team

Background

Background

- A review of the finance function at Medway was undertaken in March 2025 by the RSP team; commissioned by the Chief Financial Officer (CFO) and supported by the ICB and the region.
- This was following the formalisation of a significant deterioration in the Trust's financial position.

- In summary the review aimed to:
    - Assess the departments capability, capacity and culture.
    - Identify root causes of inefficiencies and errors in financial processes and governance.
    - Recommend improvements to transform into a proactive, customer-focused business partner to the organisation.
    - Encourage inter-departmental collaboration, in particular between finance, HR and BI.
    - Define clear objectives for improvement in the department, underpinned by SMART metrics
    - Support the transition of the finance function into a more outward-facing, customer-focused, and technologically enabled service, capable of delivering insight and contributing to strategic decision-making at all levels.

- The report resulted in a series of actions broken down into the themes listed below. This report provides an update on progress from the RSP perspective:
    - Team and structure
    - Process improvement
    - Month-end process and reporting
    - Business cases and working capital

- RSP RAG scores are based on the RSP's judgement following a review of evidence, visible changes in practice and interviews with action leads.

Summary

This report provides **a progress update as of January 2026** and RAG scores have been updated but also illustrate the assessment in July.
The finance function has made steady progress since the July 2025 assessment, with clearer processes, more consistent reporting and improved engagement across the department. However, structural fragilities and gaps in capability continue to limit the pace and sustainability of change.

The original review found:
Month-end processes were manual, inconsistent and did not give adequate time for the team to perform analysis. The reporting varied across divisions and did not provide sufficient insight to facilitate proactive conversations and decision making with budget holders.
Culture and ways of working were siloed, both within finance and between departments (corporate and clinical). This resulted in miscommunication, reduced understanding and ultimately, as with all siloed working, impacts decision making. The review concluded that the finance team needed to be a more outward facing, proactive and customer orientated department.
Business case governance often bypassed senior finance reviews meaning key decisions were approved without the right level of scrutiny or input from wider corporate teams.
Cash and debt management was found to be a significant risk for the Trust because of low cash levels, poor treasury engagement, and unresolved, long-standing debts.

Updates from latest assessment:

1. Month-end processes

- Good progress has been made with standardising reporting and strengthening the month end processes, with ongoing work to enhance insight. The revised processes now allows any finance team member to work across divisions they do not support, should cover be required. This has not yet translated into a consistently fast and accurate month-end close. It is essential that effectiveness should be prioritised over the speed of closure.
- Standard operating procedures are now in place for month end processes which are now applied more consistently across the department. Processes are more efficient and the SOP's are consistently applied to ensure full adherence to the core requirements of the month-end.
- Revisions to reporting have improved clarity with some further work to be done to highlight key messages and reduce technical detail. Engagement with the reporting improvement has been cautious and the team has not fully connected with the rationale behind it. There is ongoing work to look at a solution for automated dashboards.
- The additional sessions authorisation process continues to be an unresolved issue, remaining entirely manual, with significant work required between workforce and finance to resolve this.

2. **Culture and ways of working**

- Engagement and development across the finance department has been reflected in better collaboration, clearer expectations, and ongoing effort to build capability through training.
- Members of the team won two HFMA awards with the Deputy Finance Business Partner winning a "Guiding star" award for leading on improvements within financial management processes with a commendation for delivering excellent customer service . The Head of Costing won the "Working with Clinicians" award for exceptional engagement with clinical and operational teams to develop service line reporting.
- There remains an engagement weakness with clinical operational teams because of limited on-site presence where the desk allocation solution for finance has not realised. This should be prioritised.
- The finance team structure remains fragile with minimal change since the review and so the concerns raised around resilience, capability and succession planning continue to impact on delivery and customer service.

3. **Business case governance and cash/debt management**

- Reliance on external support for CIP governance and tracking via PA Consulting presents a sustainability risk; internal capability and ownership should be strengthened to reduce dependency into the new year.
- Routine 'Post-Project Assessments' (PPAs) were initiated however not all cases have been followed up on as TIG has been largely stood down.
- Capital oversight has improved via the established capital working group which should be formalised in the new year; further strengthening of governance is required around planning and monitoring.

Recommendations:

1. Increase on site engagement by providing a solution to desk allocations for finance which will then embed closer working with other teams such as HR/BI and operations.
2. Build team resilience and capability by looking at the team structure and making changes that will allow for succession planning and career progression through the levels, and reduce specific business continuity risks.
3. Continue to improve the quality of insights in commentary and agree the approach to finance dashboards on either Integra or via BI.

Update on progress of actions - Team

Objective	Summarised recommendations	MFT Self-Update	RSP RAG Jul'25	RSP RAG Jan'26	RSP Assessment of progress
Customer Service	• **Improve team cohesion** through team building and safe communication spaces to enhance customer service • **Prioritise finance business partner development** with training on customer service and coaching non-finance staff • **Enhance business partnering function** and reduce emphasis on score-keeping by investing in technology, talent development, and strategic planning • **Create dedicated on-site space** for the finance team to foster consistency and collaboration	• Work with South East Regional Academy continues including customer service training. • Desk space action now sits with E&F team and is dependant on space being made available. Due date is now TBC. • Department vision, objectives and actions have been shared and are being incorporated into appraisals			• Away days arranged by the South East Regional Academy plus customer training sessions have been successful although more recently. However, FBP's have queried relevance of some examples as they are having difficulty relating corporate examples from Disney to the NHS. • Desk space allocation is overdue and therefore it is unlikely that progress will be made this financial year. No space has yet been identified for finance team, we would strongly advise this is prioritised.
Learning	• **Create a talent management plan** aligned with exams, training, and future needs; develop future CFOs and senior leaders • **Mandate line management coaching and regular 1:1s**; annual appraisals tied to consistent objectives	• One NHS Finance academy talent management will be reviewed. • Management essentials statman training has been attended.			• This is on track and department objectives have been set.
Other	• **Develop a consistent team vision and objectives** focused on customer service, financial stewardship, improvement, and system working • **Review structure of team** making sure that it is fit for purpose and has succession planning in place	• Team structure, one Deputy FBP is acting-up as an FBP for development following a departure. • Agency FBP has left and substantive FBP has taken on their division.			• There have been minimal changes since the review was done and therefore the concerns we raised in the original review around resilience and capability are still having an impact.

Update on progress of actions – Process Improvement

Objective	Summarised recommendations	MFT Update Summarised	RSP RAG Jul '25	RSP RAG Jan '26	RSP Assessment of progress
Stewardship	• **Journal Review -** Form a working group to eliminate unnecessary journals and use Integra for audit trails. • **Payroll Process -** Establish monthly finance–HR reviews, KPIs for change forms, and clear communication. • **Pay Controls -** Include in internal audit plan. • **Roster Reconciliation -** Align rosters with budgets through joint HR–finance processes. • **SFI Compliance -** Sign off early and embed compliance in divisional reports. • **Management Training -** Include procurement and requisition processes. • **CEO/CFO Letter -** Enforce directives trust-wide from start of financial year	• Payroll correction template in use and code changes can be actioned in ESR. • Payroll process – this has been completed. • Additional session process has been revised and the outcome is that it should sit with Workforce despite capacity constraints, this is now outside of finance team control. • Rostering controls implementation with patchwork is in progress. • SFI's were signed off by Trust Board • Procurement – no Integra access without training has been proposed. • CEO/CFO letter has been shared			• Most journals excluding income (due to the confidential nature of these) are backed up on the Integra software. • The Pay Process mapping exercise has been completed with significant improvements in the process. • The additional sessions process was updated using a template from PA consulting. This did not deliver the intended simplification and was set aside due to over-complicating the process. There is still significant work to integrate finance and workforce data and stop all manual processes. • SFI's were signed off at July's Trust board. This was later than the original deadline of May.
Customer Service	• **Finance–Procurement Collaboration -** Strengthen joint working and integrate procurement into finance team development	• Work with the South East Finance Academy has begun and continues. • Closer working evidenced already through joint meeting attendance, e.g. Treasury meeting.			• The head of procurement has made considerable effort to engage in finance meetings. Further work is needed to improve engagement between the junior teams.
Learning	• **Self-Development -** Encourage staff to explore new tools (AI, Power BI) and engage with external learning platforms, self-development (via regional academy, HFMA, One NHS Finance)	• Team have all been on multiple learning and training sessions e.g. emotional intelligence, management). HFMA conference was attended by some of the team too.			• The team has been engaging in courses and significant enthusiasm for learning. This is a result of the effort that the DCFO and the South East Academy have done to encourage upskilling. • HFMA – Head of Costing won a prize for engaging with clinicians and developing service line reporting. One of the Deputy FBP's also won an HFMA prize for guiding star for showing initiative and leading on areas within financial management for improvement of processes.

Update on progress of actions – Month-end Process/Reporting

Objective	Summarised recommendations	MFT Update Summarised	RSP RAG Jul'25	RSP RAG Jan'26	RSP Assessment of progress
Stewardship	• **Standardised Reporting -** Develop accessible, automated reports for non-finance staff, focusing on insights and next steps • **Develop standardised SOPs for reporting and forecasting**, following continuous improvement methods, Include key metrics: CIP, forecast out-turn, run-rates etc. • Focus reporting commentary on insights and next steps	• Changes have been made to update accrual processes and a new system for prepayments. • Standardised reporting as been developed and revised. This has been automated as reasonably possible. • Prominence of divisional reporting to be enhanced. • SOP's in place for forecasting and month-end.			• Reporting has now been standardised between divisions, but the style remains highly technical (lacking in the "so what?") . Following a review and feedback session chaired by the CFO, the format has been further simplified to emphasise key movements and clearer narrative. This now needs standardising and driven to care group level. However, the quality of commentary still varies, RSP is providing feedback to the FBP's directly on commentary. • Ongoing feedback is being provided to finance in terms of concise and meaningful commentary. • One care group has advised that they prefer the more detailed reporting in the first iteration which indicates that they may need more support from finance in understanding their numbers (which is further hindered by lack of desk space for the finance team) . • If either BI or Integra Dashboards can be produced then that would be a major improvement, however there are several constraints on both methods in terms of access and data sources. Both solutions are being explored in collaboration with various teams internally and externally (Integra Consultant), and through engagement with Dartford to understand what approach they have taken. A decision should be made asap once both options are presented.
Customer Service	• **Ownership Shift -** Divisional triumvirates should lead financial accountability and governance.	• Improvements seen in MEC and CCCS divisions			• Ownership shift will take more time in WC&YP an S&A divisions due to a gaps in divisional leadership and recent changes to business partnering arrangements.
Customer Service	• **Manager Training -** Improve financial literacy among middle managers through integrated training.	• Management essentials training is mandatory for staff above a certain grade. • Budget holder training attendance has had improved engagement and attendance.			• Good progress and engagement from attendees. • PMO programme manager presents efficiency slides in budget holder training which demonstrates more collaboration in training with finance. • Procurement have presented their sections to build awareness of how the PO process works and what budget holder financial limitations are, recipients of the training have been positive, however if the learning has been applied can only be assessed over a longer period. • The next step is ensuring that the principles translate into consistence routine working for budget holders.

Update on progress of actions – Business Cases/Capital

Objective	Summarised recommendations	MFT Update Summarised	RSP RAG Jul'26	RSP RAG Jan'26	RSP Assessment of progress
Stewardship	• **Governance & Funding -** Confirm stakeholder engagement, align with planning, and reserve resources to avoid unfunded approvals. • **Post-Project Assessments -** Conduct PPAs for revenue and capital cases. • **CIP Transparency -** Improve clarity on cash-releasing CIPs to avoid misleading delivery metrics. • **Debt Oversight -** Ensure deputy CFO attends treasury meetings and escalates unresolved debt issues	• Governance – Business case policy updated and new template issued. • PPA's – routine seeking of PPA's to be enacted, continuous monitoring to be embedded. • CIP transparency – discussion in MEC and CCCS • Debt – Deputy CFO attends treasury meetings. Risks considered and escalated to CFO as part of the Aug/Sept RAFOT review.			• The team did an exercise in December to action some PPA's. However, DCFO has advised there has not been much opportunity to follow up on other cases due to lack of TIG meeting. It will be important for example, that a PPA on the virtual ward business case is conducted as soon as possible. • A new capital working group has been established on a fortnightly basis but this will need to be formalised as the Trust moves into the new year. The RSP are supporting the strategy and finance teams to strengthen capital governance. • PA Consulting working with teams on CIP delivery, development and reporting. A fortnightly Sustainability and Delivery Group (SRG) has been established to oversee programme progress and provide a forum for discussion and decision making, with recommendations passing to TLT for approval. It will be important that this is maintained into the new financial year.
Customer Service	• **Business Partner Involvement -** Ensure business partners are engaged in case development and key meetings.	It is now mandatory for FBP's to physically sign off Business Cases before they can go to panel. FBP's have confirmed that their input is now routinely requested.			• Whilst FBP's are involved where they are consulted, there remains a risk that they are not involved from the start of the business case and are only consulted on the financial elements.

Meeting of the Trust Board

Meeting Date: 11 March 2026

NHS Medway NHS Foundation Trust

Title of Report	**Board Assurance Framework**			**Agenda Item**	3.3
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 Board 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.

There have been significant updates to BAF number one and two from the February 2026 version. These include updated actions and milestones. The overall ratings for these issues remain the same.

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The framework has also been split in to risk and issues to ease scrutiny.

There are currently 3 active risk, distributed as follows:

Risk Rating	Score Range	Number of Risks	% of Total
Extreme	15+	2	66%
High	8-12	1	33%
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
13	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.	16	Dir Strategy and Partnership

There remain 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 minimal movement in risk or issue ratings.**			
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 – Issues March 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. • Fortnightly sustainability recovery group. • Vacancy and enhanced non-pay controls. • NHSE Improvement Director support, supplemented by Oversight meetings. • 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. Scrutiny, agreement and implementation of proposals to revised approach of Divisional Performance Review Meetings. 3. Executive-led deep dive and proposals addressing benchmarked efficiency opportunities as set out in CFO paper to the Trust Board. 4. Divisional presentation of 26/27 plans and strategic intent to Executive. 5. Extension of enhanced workforce controls and non-pay review panel. 6. Revised business partner arrangements being implemented and will be fully operational from Apr 26. 7. Full engagement and collaboration with System 'Turnaround' process.	Mar 26 Apr 26 Marr 26 Mar 26 Immediate – review Jul 26 Apr 26 Immediate and ongoing	4	3	12	Treat	31 Mar 2031 (sustainable 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. Establish formal governance with oversight and audit trail. Reported to FPPC. 4. Exploring avenues for external/national funding, including Estates Safety Fund. 5. Update backlog maintenance schedule, risks and mitigations.	Apr 25 Complete Complete Immediate and ongoing May 26	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) and incl. in management essentials training. • 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 and will be fully operational from Apr 25. 2. Business Partner support 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.	Apr 26 Ongoing Ongoing Complete Monthly % complete – 20%	4	3	12	Treat	31 Mar 26	Low	Chief Finance Officer/ 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 completion date now a month delayed (originally Jan 26). 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 the risks identified in the sexual safety assessment, to be aligned with the Genderwise cultural transformation workstream.	Feb 26 Mar 26 Complete Mar 26 % complete – 25%	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 Feb 26 Monthly review Monthly review % complete – 25%	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. Sepsis and pneumonia pathways - EPR order sets those guide and prompt clinicians to deliver wholistic care in these pathways has been implemented. 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

Board Assurance Framework – Risks March 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 ?
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)
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

Domain	Reg	Action Number	Improvement Action	Impact on action delivery	Assurance and Evidence	Action Lead	Directorate Lead	Executive Lead	Expected completion date	Action Tracker	Actual completion date	Date closed	Comments / updates	Evidence received
Responsive	Reg 12	1	**The National Standards for time to assessment, treatment and admission will be met**	Improves patient outcomes and experience through timely care, reduces anxiety, and enhances operational efficiency. It supports workforce wellbeing, lowers costs from prolonged stays, and minimises compliance risks.	% of patients admitted, discharged, or transferred within 4 hours of arrival in ED. 90% of patients receiving initial assessment within 15 minutes of arrival. Average time from ED arrival to ward transfer for admitted patients. 90% of patients reporting satisfaction with waiting times and communication.	General Manager	Div Director of Ops	Chief Operating Officer	Mar-26	On track				
Responsive	Reg 12	2	**Role out the First 72 hours of care project – Implementation of EM5 best practice guidance, improved rapid access in-reach into ED, HCP staff support for community reattendance avoidance**	Improves patient outcomes and experience through timely care, reduces anxiety, and enhances operational efficiency. It supports workforce wellbeing, lowers costs from prolonged stays, and minimises compliance risks.	% of patients admitted, discharged, or transferred within 4 hours of arrival in ED. 90% of patients receiving initial assessment within 15 minutes of arrival. Average time from ED arrival to ward transfer for admitted patients. 90% of patients reporting satisfaction with waiting times and communication.	General Manager	Div Director of Ops	Chief Operating Officer	Mar-26	On track				
Responsive	Reg 12	3	**Senior doctors will attend site meetings over winter and during times of extremis.**	Improves patient outcomes and experience through timely care, reduces anxiety, and enhances operational efficiency. It supports workforce wellbeing, lowers costs from prolonged stays, and minimises compliance risks.	% of patients admitted, discharged, or transferred within 4 hours of arrival in ED. 90% of patients receiving initial assessment within 15 minutes of arrival. Average time from ED arrival to ward transfer for admitted patients. 90% of patients reporting satisfaction with waiting times and communication.	General Manager	Div Director of Ops	Chief Operating Officer	Mar-26	On track				
Responsive	Reg 12	4	**Our executive liaison plan will be in place between 1 December and 31 March.**	Staff supported and clear decisions on improvement accessible	% of patients admitted, discharged, or transferred within 4 hours of arrival in ED. 90% of patients receiving initial assessment within 15 minutes of arrival. Average time from ED arrival to ward transfer for admitted patients. 90% of patients reporting satisfaction with waiting times and communication.	General Manager	Div Director of Ops	Chief Operating Officer	Mar-26	On track				
Responsive	Reg 12	5	**Increase our virtual ward from 80 to 200 beds.**	Avoids patients having to remain in ED and allows ongoing treatment at home, improving patient experience	% of patients admitted, discharged, or transferred within 4 hours of arrival in ED. 90% of patients reporting satisfaction with waiting times and communication.	General Manager	Div Director of Ops	Chief Operating Officer	Mar-26	On track				
Responsive	Reg 12	6	**Increase the number of Specialty In-Reaches into ED and 'front door' presence over winter**	Expedites patient admissions to speciality wards	% of patients admitted, discharged, or transferred within 4 hours of arrival in ED. 90% of patients receiving initial assessment within 15 minutes of arrival. Average time from ED arrival to ward transfer for admitted patients. 90% of patients reporting satisfaction with waiting times and communication.	General Manager	Div Director of Ops	Chief Operating Officer	Mar-26	On track				
Safe	Reg 12	7	**Introduce weekly length-of-stay meetings and twice-daily board rounds**	Drives proactive discharge planning and increases bed availability.	% of patients admitted, discharged, or transferred within 4 hours of arrival in ED. 90% of patients receiving initial assessment within 15 minutes of arrival. Average time from ED arrival to ward transfer for admitted patients. 90% of patients reporting satisfaction with waiting times and communication.	General Manager	Div Director of Ops	Chief Operating Officer	Mar-26	On track				
Safe	Reg 12	8	**Introduce 7-day Matron cover in ED (08:00–22:00) to provide senior leadership and oversight.**	Supports better flow and escalation of patients out of the ED.	% of patients admitted, discharged, or transferred within 4 hours of arrival in ED. 90% of patients receiving initial assessment within 15 minutes of arrival. Average time from ED arrival to ward transfer for admitted patients. 90% of patients reporting satisfaction with waiting times and communication.	General Manager	Div Director of Ops	Chief Operating Officer	Mar-26	On track				
Safe	Reg 12	9	**Introduction of specialist ED FLOW coordinators**	Support faster patient discharges and admissions from ED to an in-patient bed.	% of patients admitted, discharged, or transferred within 4 hours of arrival in ED. 90% of patients receiving initial assessment within 15 minutes of arrival. Average time from ED arrival to ward transfer for admitted patients. 90% of patients reporting satisfaction with waiting times and communication.	General Manager	Div Director of Ops	Chief Operating Officer	Mar-26	On track				
Safe	Reg 12	10	**Strict adherence to the FCP/plus 1 policy ensuring no patient that meets any exclusion criteria for Treatment Escalation Space (TES) is bedded in one of these areas**	Patients will be kept safer as no patient that has exclusion criteria for a Treatment Escalation Space (TES) will be bedded in one of these areas	Audit of patients in TESs meeting inclusion criteria	General Manager	Div Director of Ops	Chief Operating Officer	Mar-26	On track				
Safe	Reg 12	11	**Introduce electronic observation machines into ED, (subject to successful completion of testing and pilot phases).**	Real-time capture of patient observations onto EPR and associated alerts, removing any delays between staff taking observations and manually inputting them into the patient's EPR.	eObs in use Timely observations date improved Incidents linked to obs reduced	General Manager	Div Director of Ops	Chief Operating Officer	Mar-26	On track				

Safe	Reg 12	12	**Undertake a review the suitability of the space used to assess and treat people with mental health needs. Any recommendations that come out of the review will then need to be considered for action.**	The environment for people with mental health needs will be as safe as possible and support the care needs of the patient.	Alterations made to the environment as a result of the review	General Manager	Div Director of Ops	Chief Operating Officer	Mar-26	On track				
Safe	Reg 12	13	**Extend the hours of the adult mental health liaison and specialist support staff.**	People with mental health needs waiting for long periods within the department will receive greater monitoring and a reduced risk of coming to harm.	Improved patient experience Reduced incidents Reduced time spent waiting in the department	General Manager	Div Director of Ops	Chief Operating Officer	Mar-26	On track				
Safe	Reg 12	14	**Recruit more RMNs to work directly within the ED.**	People with mental health needs waiting for long periods within the department will receive greater monitoring and a reduced risk of coming to harm.	Improved patient experience Reduced incidents Reduced time spent waiting in the department	General Manager	Div Director of Ops	Chief Operating Officer	Jun-26	On track				
Safe	Reg 12	15	**Improve our pathways with specialist MH providers of healthcare services.**	By reducing delays in psychiatric liaison review, ongoing management plans will be expedited and any patient awaiting ongoing transfer to a MH hospital will have a reduced wait.	Improved patient experience Reduced incidents Reduced time spent waiting in the department	General Manager	Div Director of Ops	Chief Operating Officer	Mar-26	On track				
Caring	Reg 17	16	**Matrons will complete a daily quality Assurance Checklist on 'Gather' which will be analysed weekly by the HoN for ED for themes and improvement actions.**	Enhanced governance ensures accountability, consistent monitoring, and timely identification of issues. This drives focused improvement actions, improving patient safety, quality of care, and compliance.	By 1 February 2026, the Daily Matrons Assurance checklist will have been transferred to the Gather system whereby data can be analysed and themes for improvement identified.	Head of Nursing	Divisional Director of Nursing	Chief Nursing Officer	Feb-26	On track				
Caring	Reg 10	17	**Hourly comfort checks will be undertaken for all patients in ED, covering pain management, toileting needs, nutrition & hydration, positioning, and provision of information.**	This will ensures patients received proactive care by addressing pain, toileting, hydration, positioning, and information needs. This improves patient comfort, safety, and satisfaction, reduces risk of harm (e.g., falls, pressure ulcers), and supports a consistent, patient-centered approach.	95% of patients receiving documented comfort rounds (pain, toileting, hydration, positioning, information) at required intervals. 90% of patients assessed for pain within 30 minutes of arrival and at regular intervals.	Head of Nursing	Divisional Director of Nursing	Chief Nursing Officer	Feb-26	On track				
Caring	Reg 10	18	**We will achieve compliance with the RCEM guidelines for administering pain medication within 15 minutes of secondary assessment and reviewing pain scores after an hour for patients in the department.**	Improved timely pain management enhances patient comfort, and supports clinical safety standards. This promotes quality care, reduces risk of unmanaged pain, and aligns practice with national best standards.	80% of patients audited will have received pain relief effectively where required with 15 mins and that this is reassessed within 1 hour	Consultant & Clinical Lead for ED/Head of Nursing	Divisional Medical Director	Chief Nursing Officer	Mar-26	On track				
Caring	Reg 10	19	**All staff will wear visible name badges and introduce themselves to patients at every interaction, promoting respect, dignity, and person-centred communication.**	This will promote respect, build trust, and supports person-centred communication. This enhances patient experience, fosters dignity, and strengthens the therapeutic relationship.	To undertake a monthly audit to ensure staff introduce themselves to patients when providing care and treatment. 50% of staff building to 95% compliance by March 2026	Head of Nursing/Clinical lead	Divisional Director of Nursing/Divisional Medical Director	Chief Nursing Officer	Mar-26	On track				
Caring/Safe	Reg 16	20	**Each Temporary Escalation Space (TES) will be equipped with a privacy screen, modesty/comfort items and a call bell.**	This will ensure patient dignity, safety, and comfort. This supports compliance with care standards, reduces risk of harm, and promotes a respectful, patient-centered environment.	80% of patient privacy screens, when required, are observed as being used when appropriate for patients in escalation spaces (Daily Matron Assurance Checklist) Privacy compliance: ≥95% of occupied escalation bays have screens in use during personal care/interventions (weekly spot audit). Dignity pack availability: ≥90% of audited bays have complete packs stocked (weekly stock check). Call bell functionality: 100% working call bells; faults logged and resolved <24 hours (daily checklist; estates report). Call bell - 100% of patients have a functioning call bell in place Noise/alarm adherence: education for staff in regards to setting perimeters for monitors in bays during peak times; soft close bins, soft sole shoes, soft close doors Achieve a 50% within the next 3 months building to 75% increase with alarm rules (monthly observations). Patient experience: ≥80% of surveyed patients recommend ED as a place to receive safe care and treatment (FFT survey). Ward accreditation assessments of ED will take place every 3 months to both check, and provide evidence of sustained improvements in areas such as call bells being within reach, hydration and nutrition options being sufficiently available, patients' pain levels being sufficiently captured and managed, support with toileting and washing being given as often as required and that patients' privacy and dignity needs are being met.	Head of Nursing	Divisional Director of Nursing	Chief Nursing Officer	Mar-26	On track				
Responsive	Reg 10	21	**Any patient waiting in the department for over 12 hours will receive a patient centred check and update discussion on assessment and treatment progress. This personalised check will again be repeated at 18 and 24 hours if still in the ED. This is in additon to action 3.**	Giving patients regular updates on treatment progress and waiting times reduces anxiety, improves experience, and minimizes complaints. This fosters trust, enhances communication, and supports a patient-centered approach to care.	100% of the 5 patients audited as part of the Daily Matrons Assurance checklist have received regular updates and information about their treatment.	Head of Nursing	Divisional Director of Nursing	Chief Nursing Officer	Mar-26	On track				
Caring	Reg 10	22	**Introduce a dignity champion to the emergency department.**	Staff will be supported with providing dignified care for patients and championing an environment that ensures patient privacy and respect at all times.	Incident trends: Month-on-month reduction in privacy-related and poor communication-related complaints and PALS concerns and a downwards trending number of incidents reported for environment-linked issues.	Head of Nursing	Divisional Director of Nursing	Chief Nursing Officer	Apr-26	On track				
Safe / Effective	Reg 12	23	**Every patient in ED will have the necessary risk assessments completed as per best practice guidelines.**	This will support early identification of patient deterioration, timely interventions, and adherence to best practice policies. This reduces harm (e.g., falls, pressure ulcers), enhances patient safety, and promotes consistent, high-quality care across all acute areas.	Achieve ≥85% compliance in monthly audits by March 2026	Head of Nursing	Divisional Director of Nursing	Chief Nursing Officer	Mar-26	On track				
Safe / Effective	Reg 12	24	**Develop an electronic alert function to alert staff to when a particular risk assessment has not yet been completed.**	Greater awareness and oversight for staff to know which risk assessments remain outstanding and patient risks will be known enabling interventions to be undertaken.	Introduction of digital function on EPR	General Manager	Div Director of Ops	Chief Operating Officer	Jun-26	On track				

Safe	Reg 12/Reg 18	25	**Staff training compliance within ED for recognising signs of deterioration via ILS, ALS, ALERT, BEACH will exceed the Trust target (85%).**	This will ensure that staff are equipped to respond promptly to clinical deterioration. This improves patient safety, reduces adverse events, and aligns practice with Trust standards and national best practice.	Training compliance to meet the Trust target of 85% for mandatory training (ILS and ALS)	Head of Nursing	Divisional Director of Nursing	Chief Nursing Officer	Mar-26	On track				
Safe	Reg 9	26	**Patients needing specialist care will be 'pulled' into the specialist wards through the ring fencing of specialist beds, rather than waiting for specialist input into ED e.g. #NOF/NAFF pathway straight to ward.**	Patients requiring specialist care (e.g., #NOF/NAFF pathway) will be transferred promptly to appropriate wards, reducing delays and improving clinical outcomes.	A monthly audit of patients that need specialist care who are 'pulled' in to the specialist wards through ring fencing of specialist beds e.g. #NOF/NAFF pathways	Head of Nursing	Divisional Director of Nursing	Chief Nursing Officer	Mar-26	On track				
Safe	Reg 12	27	**The deteriorating patient dashboard, which gives central oversight of any patient with a raised and deteriorating NEWS2, will be made visible throughout ED so that any staff can respond to signs of deterioration**	This will provide real-time, central oversight of patients with raised and worsening NEWS2 scores. This enables early recognition of deterioration, rapid escalation, and timely interventions, improving patient safety and reducing adverse events. It also supports proactive clinical decision-making and strengthens governance across acute care areas.	Measured through the BI dashboard	Head of Nursing/Clinical lead	Divisional Director of Nursing/Divisional Medical Director	Chief Nursing Officer	Mar-26	On track				
Safe	Reg 12/Reg 18	28	**All ED staff will complete PMVA (prevention and Management of Violence and Aggression) Training to increase their confidence in managing unpredictable situations (linked to people with mental health needs)**	Delivering targeted training for staff on managing unpredictable situations, including mental health crises, enhances confidence and competence. This improves patient safety, reduces escalation risks, and promotes a calm, supportive environment for both patients and staff.	To achieve a compliance rate of >85% by March 2026 in the PMVA (Prevention and Management of Violence and Aggression) and Conflict Resolution Bespoke training to be provided by the Clinical Lead – Mental Health for Children, Young People and Adults in managing advanced needs of mental health patients. >60% of staff will have received this training by March 2026 (managing risk tool)	Clinical Lead – Mental Health for Children	Associate Director of Patient Experience	Chief Nursing Officer	Mar-26	On track				
Safe	Reg 12/Reg 18	29	**All ED staff will be offered managing advanced needs of mental health patients training to support de-escalation of potentially violent situations and prevention of harm using the managing risk tool.**	Delivering targeted training for staff on managing unpredictable situations, including mental health crises, enhances confidence and competence. This improves patient safety, reduces escalation risks, and promotes a calm, supportive environment for both patients and staff.	To achieve a compliance rate of >85% by March 2026 in the PMVA (Prevention and Management of Violence and Aggression) and Conflict Resolution Bespoke training to be provided by the Clinical Lead – Mental Health for Children, Young People and Adults in managing advanced needs of mental health patients. >60% of staff will have received this training by March 2026 (managing risk tool)	Clinical Lead – Mental Health for Children	Associate Director of Patient Experience	Chief Nursing Officer	Mar-26	On track				
Effective	Reg 12/Reg 19	30	**Progress the necessary works to enable the build of the new mental health hub on the hospital site to be started.**	People with mental health needs will have a dedicated, safer and more appropriate space, away from the emergency department, to be assessed and treated.	Build work commencing	General Manager	Div Director of Ops	Chief Operating Officer	Apr-26	On track				
Safe / Effective	Reg 12	31	**Achieve compliance with the RCEM Guidelines for pharmacy staffing levels, through the local Safer Staffing initiative and the business planning process.**	Patients will receive the right medications at the right time, reducing delays and medication errors. This improves clinical outcomes, supports patient safety, and enhances overall quality of care.	Medicines near miss and error reporting numbers	Chief Pharmacist	Site Director of Operations	Chief Medical Officer	Mar-26	On track				
Safe / Effective	Reg 13	32	**Allocate remote bank pharmacist resource ad hoc to screen Decision to Admit (DTA) patients to identify those who are at higher risk based on condition and critical medicines. These patients will then be prioritised for intervention.**	Patients will receive the right medications at the right time, reducing delays and medication errors. This improves clinical outcomes, supports patient safety, and enhances overall quality of care.	Medicines near miss and error reporting numbers	Chief Pharmacist	Site Director of Operations	Chief Medical Officer	Mar-26	On track				
Safe / Effective	Reg 14	33	**Explore a solution with the system provider, at a cost, which once resolved would allow Pharmacy to front-load medicines reconciliation into ED.**	Patients will receive the right medications at the right time, reducing delays and medication errors. This improves clinical outcomes, supports patient safety, and enhances overall quality of care.	Medicines near miss and error reporting numbers	Chief Pharmacist	Site Director of Operations	Chief Medical Officer	Mar-26	On track				
Safe / Effective	Reg 15	34	**Establish and maintain a designated safe space for prescribing and administering medications to minimise distractions and interruptions**	Patients will receive the right medications at the right time, reducing delays and medication errors. This improves clinical outcomes, supports patient safety, and enhances overall quality of care.	Medicines near miss and error reporting numbers	Chief Pharmacist	Site Director of Operations	Chief Medical Officer	Mar-26	On track				
Safe / Effective	Reg 16	35	**Implement daily 5-minute safety huddles in all escalation areas to share immediate learning.**	Patients will receive the right medications at the right time, reducing delays and medication errors. This improves clinical outcomes, supports patient safety, and enhances overall quality of care.	Medicines near miss and error reporting numbers	Chief Pharmacist	Site Director of Operations	Chief Medical Officer	Mar-26	On track				
Safe / Effective	Reg 17	36	**Publish a weekly safety bulletin summarising key themes and actions from reported medication incidents**	Patients will receive the right medications at the right time, reducing delays and medication errors. This improves clinical outcomes, supports patient safety, and enhances overall quality of care.	Medicines near miss and error reporting numbers	Chief Pharmacist	Site Director of Operations	Chief Medical Officer	Mar-26	On track				
Safe / Effective	Reg 18	37	**Role out QR code medicines near miss errors and omissions reporting in ED (as per in-patient wards) and commence a visible incident tracker to monitor trends and progress.**	Patients will receive the right medications at the right time, reducing delays and medication errors. This improves clinical outcomes, supports patient safety, and enhances overall quality of care.	Medicines near miss and error reporting numbers	Chief Pharmacist	Site Director of Operations	Chief Medical Officer	Mar-26	On track				
Safe / Effective	Reg 19	38	**A fast track process for obtaining medications from pharmacy out of hours will be introduced.**	Introducing a fast-track ED-to-Pharmacy prescription process ensures rapid access to essential medications, improving patient safety, reducing delays, and supporting compliance with Trust standards	To educate staff in the utilisation of the in stock locator out of hours and to develop a fast track process for time critical medications to be provided quickly within normal working hours	Chief Pharmacist/Head of Nursing	Site Director of Operations/Divisional Director of Nursing	Chief Nursing Officer	Mar-26	On track				
Safe/Well Led	Reg 13/Reg 15	39	**Ensure all staff that raise a security related incident receive an update on actions taken as a result of the reported incident.**	Security incidents and staff concerns will be promptly addressed and lead to actionable improvements. This promotes a safer environment, builds staff confidence in reporting, and fosters a culture of transparency and accountability.	Theme Safety Huddles sharing the outcomes of incidents including security incidents. PSIT to develop and deliver a monthly face to face Incident Reporting drop in sessions to showcase the incident management process and thematic feedback	Head of Nursing/Head of Patient Safety & Improvement	Divisional Director of Nursing	Chief Nursing Officer	Mar-26	On track				
Responsive / Caring	Reg 9	40	**Any patient requiring reasonable adjustments will be identified and their needs met though our complaince with the Accessible Information Standard (AIS)**	Patients will receive equitable access to care and effective communication. This improves patient experience, reduces risk of misunderstanding, and supports legal and regulatory requirements for inclusion and accessibility.	95% of patients with identified communication or accessibility needs who receive appropriate support (e.g., interpreter, BSL, hearing loop). 100% of patient records accurately documenting communication needs and support provided. 90% of patients with communication needs reporting satisfaction with the support provided (via surveys or feedback). Zero number of reported incidents where lack of communication support impacted care. 100% staff trained on inclusion and accessibility standards and how to access support services.	Head of Nursing	Divisional Director of Nursing	Chief Nursing Officer	Mar-26	On track				
Safe	Reg 9/Reg 12	41	**The percentage of patients triaged within 15 minutes of arrival will exceed 55% (May 2024 – April 2025 data).**	This will improve patient safety, enhance experience, and will streamline ED flow. It will ensure compliance with national guidance and supports efficient, high-quality care.	To achieve a compliance rate of >85% by March 2026	Head of Nursing	Divisional Director of Nursing	Chief Nursing Officer	Mar-26	On track				

Safe/Effective	Reg 12	42	**Consultant cover will meet the Royal College of Emergency Medicine (RCEM) recommendations for senior decision-maker availability between 8am and midnight and then on-call overnight.**	This will ensure timely senior decision-making, improve patient safety and flow, and deliver full compliance with RCEM standards.	100% percentage of scheduled consultant cover provided between 08:00–00:00 and on-call overnight.	Consultant & Clinical Lead for ED	Divisional Medical Director	Chief Nursing Officer	Mar-26	On track				
Safe	Reg 12	43	**Every new member of staff undertaking a shift in ED will receive a local induction setting out their responsibilities and the level of person centred care, privacy, dignity and respect expected**	A local induction process ensures new staff understand their responsibilities from day one, improving safety, compliance, and operational efficiency	100% of all new staff receive a local inducton Zero safety incidents involving new staff within their first month	Head of Nursing	Divisional Director of Nursing	Chief Nursing Officer	Mar-26	On track				
Effective	Reg 9/Reg 10	44	**All local audits within the department will be tracked to completion and the results shared for learning and improvement. Any audit/project not completed must have a clear rationale for non-completion.**	Timely completion of audits and QI projects with actionable findings ensures continuous service improvement, regulatory compliance, and enhanced patient safety	(5% of audits and improvement projects completed on time. 80% show positive impact. 100% of audit findingd to be presented and discussed through the appropriate governance structure and to evidence improvements.	ED Audit Lead	Consultant & Clinical Lead for ED	Divisional Medical Director	Mar-26	On track				
Responsive	Reg 9/Reg 23	45	**Any patient requiring sensory support will be supported by one of our BSL trained staff/hearing loop equipment or will have the assistance of an interpreter**	Providing BSL, hearing loop, or interpreter support for patients with sensory needs ensures safe, equitable care and compliance with accessibility standards	Annual training programme to increase the number of staff trained in the use of British Sign Language. Zero harm incidents reported. Improved FFT response and signpost staff to the AIS policy	Head of Nursing	Divisional Director of Nursing	Chief Nursing Officer	Mar-26	On track				
Well Led	Reg 17	46	**Performance data, audit results, staff feedback, incident themes, risks and patient feedback will be triangulated to support improvement actions.**	Triangulating data, audits, staff and patient feedback, incidents, and risk enables evidence-based improvements that enhance safety, quality, and compliance	Monthly reporting of triangulation of data to be presented and discussed through the appropriate governance structure and to evidence improvements.	General Manager	Divisional Director of Nursing	Chief Nursing Officer	Mar-26	On track				

Meeting of the Trust Board

Meeting Date: 11 March 2026

NHS Medway NHS Foundation Trust

Title of Report	Trust Risk Register and Issues Log Report			**Agenda Item**	3.4
Stabilisation Plan Domain	**Culture**	**Performance**	**Governance and Quality**	**Finance**	**Not Applicable**
			✓		
CQC Reference	**Safe**	**Effective**	**Caring**	**Responsive**	**Well-Led**
	✓	✓			✓
Author and Job Title	Louise Furlong; Head of Quality & Safety				
Lead Executive	Evonne Hunt; Chief Nursing Officer				
Purpose	**Approval**		**Briefing**		**Noting** ✓
Proposal and / or key recommendation:					

Executive Summary

The Trust is operating in an increasingly complex environment shaped by rising demand, workforce pressures, financial constraints, and heightened regulatory scrutiny.

Across operational, clinical, and corporate domains, several consistent themes emerge: capacity strain, variation in quality and performance, challenges in digital maturity, and the need for stronger organisational resilience. These themes are interconnected and, if not addressed, risk undermining the Trust's ability to deliver safe, sustainable, and high-quality care.

Key Themes and Trends

1. Persistent Demand and Capacity Mismatch

- Emergency and elective pathways continue to experience sustained pressure, driven by, acuity, and delayed transfers of care.
- Bed occupancy remains consistently high, limiting flexibility and increasing operational risk.
- Elective recovery trajectories are improving but remain fragile, with performance vulnerable to seasonal surges and workforce gaps.

2. Workforce Fragility and Cultural Variation

- High vacancy rates, reliance on temporary staffing, and uneven leadership capability contribute to inconsistent team performance.
- Staff survey results indicate pockets of strong engagement but also highlight concerns around workload, psychological safety, and retention.
- Variation across services is creating uneven patient experience and operational outcomes.

3. Financial Pressures and Inefficiencies

- Rising agency spend, inflationary pressures, and legacy inefficiencies are constraining the Trust's ability to invest in transformation.
- Productivity varies significantly between departments, suggesting opportunities for standardisation and process redesign.

4. Digital and Data Maturity Gaps

- Limited interoperability, inconsistent data quality, and variable digital adoption impact real-time decision-making.
- Transformation programmes are progressing but require clearer prioritisation and stronger clinical engagement.

5. Regulatory and Quality Challenges

- External reviews highlight recurring issues in governance, documentation, and assurance processes.
- Quality indicators show improvement in some areas but persistent challenges in others, particularly around patient flow, safeguarding, and timely escalation.

The report identifies recommended next steps at both operational and strategic levels to mitigate the extreme risks and to address the broader risk themes identified.

Of the 101 approved risks currently recorded on the risk register, 37% have target scores above the risk appetite threshold for their respective domains. This may indicate a need to review the organisation's existing risk appetite framework or reflect a conscious decision to tolerate higher levels of risk than currently stated.

Issues for the Board / Committee Attention:	The Trust has clear strengths; committed staff, improving performance in key areas, and strong system relationship, but faces significant structural and cultural challenges. Addressing these requires a coordinated, organisation-wide approach that prioritises flow, workforce sustainability, digital maturity, and robust governance. With decisive action and consistent leadership, the Trust can stabilise performance, strengthen resilience, and position itself for long-term improvement.

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	

Medway NHSFT Risk Register & Issues Log Report

February 2026

Report Author:
Louise Furlong; Head of Quality & Safety

Executive Summary

NHS Medway NHS Foundation Trust

MFT is committed to establishing and implementing a positive risk culture by ensuring a comprehensive risk management system.

This report provides an update of the Trusts risk register & issues log, direction of travel, and a comparison summary of all risks/issues, with a particular focus on the extreme risks & significant issues.

The report covers the month of January 2026, and the risk register download was completed on the 2 February 2026. There is a total of 129 risks opened on the Trusts risk register. This is broken down as follows in table 1.

Table 1: Risk Status	Total No.	Since Previous Month
Rejected	16	⬆
Approved (included on the risk register)	**101**	⬆
Awaiting approval at Divisional level	**9**	Unknown
Awaiting approval at Executive level	**3**	Unknown
Awaiting initial review	**16**	Unknown
Closed (in month)	3	⬇
Total	**129**	

Table 2: Of the 101 Approved Risks	Total No.	Since Previous Month
Approved current – Extreme Risks	6	⬇
Approved current – High Risks	72	⬆
Approved current – Moderate Risks	21	⬆
Approved current – Low Risks	2	⬆

Of the Approved Risks, and Risks Awaiting Divisional & Executive Approval	January 2026
New risks added in **January 2026**	25
New risks awaiting divisional & executive approval	0
Risks closed	3
Risks reviewed	No. 84 - 74%
Risks not reviewed in last month	No. 29 - 26%
Risks not reviewed in over a year	0
Risks with incomplete fields for '*existing controls*'	12
Risks with incomplete fields for '*gaps in existing controls*'	14
Risks with incomplete field for *'actions'*	0
Risks with actions overdue by more than 6months	7
Risks Older than 3 years	8

Executive Summary

Whilst the risk register captures potential problems that *might* happen, an issues log records problems that have *already* occurred and need managing

There is a total of 229 issues opened on the Trusts Issues Log. This is broken down as follows in table 1.

Table 1: Issue Status	Total No.	Since Previous Month
Rejected	6	⬆
Approved (included on the issues log)	**210**	⬇
Awaiting approval at Divisional level	**3**	Unknown
Awaiting approval at Executive level	**4**	Unknown
Awaiting initial review	**12**	Unknown
Closed (in month)	10	⬆
Total	**229**	

Table 2: Of the 210 Approved Issues	Total No.	Since Previous Month
Approved current – Significant Issues	4	⬆
Approved current – High Issues	78	⬇
Approved current – Moderate Issues	102	⬇
Approved current – Low Issues	26	⬆
Approved current – Insignificant Issues	0	----

Of the Approved Issues, and Issues Awaiting Divisional & Executive Approval	January 2026
New issues added in **January 2026**	13
New issues awaiting divisional & executive approval	7
Issues closed	10
Issues reviewed	No. 161 & 70%
Issues not reviewed in last month	No. 68 - 30%
Issues not reviewed in over a year	0
Issues with incomplete fields for '*existing controls*'	10
Issues with actions overdue by more than 6months	15
Issues Older than 3 years	29

The report will focus on and break down the Extreme risks and Significant Issues.

Extreme risks are reviewed fortnightly by the risk owner and monthly at divisional governance meetings.

Significant Issues are reviewed monthly at divisional governance meetings

The report will also highlight the number of risks which have a current risk score exceeding that of the Trusts risk appetite.

Conversation Points/Decisions

NHS Medway NHS Foundation Trust

A significant proportion of the extreme risks identified (slides 10–12 and 14–15) have target scores that exceed the Trust's defined risk appetite. Of the 101 approved risks currently recorded on the risk register, 37% have target scores above the risk appetite threshold for their respective domains. This may indicate a need to review the organisation's existing risk appetite framework or reflect a conscious decision to tolerate higher levels of risk than currently stated.

In addition, several extreme risks have shown no reduction in score since their inception (slides 11–15). This suggests that the mitigation actions implemented to date have not achieved the intended impact, and that further, more robust interventions aligned to the severity of these risks are required.

Current Risk Appetite Levels per Risk Category:

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

Across operational, clinical, and corporate areas, several recurring themes are evident, including capacity pressures, variability in quality and performance, limitations in digital maturity, and the need to strengthen organisational resilience. Slide 5 outlines the recommended next steps at both operational and strategic levels to mitigate the extreme risks and to address the broader risk themes identified

Next Steps

NHS Medway NHS Foundation Trust

Recommended Operational Actions

1. **Reassess risk appetite** for domains where targets are consistently unattainable.
2. **Strengthen oversight of overdue actions**, with escalation routes for persistent delays.
3. **Reclassify risks where domains do not reflect actual impact** (e.g., EPR risk to patient safety).
4. **Develop realistic long-term mitigation plans** for systemic risks (mortality, backlog maintenance, fire safety)

Recommended Strategic Actions

1. Build System-Level Capacity and Flow
Expand virtual wards and community-based alternatives to admission.
2. Strengthen Workforce Sustainability
Accelerate recruitment processes, and retention initiatives.
Invest in leadership development, focusing on compassionate leadership behaviours.
Standardise workforce models to reduce variation and reliance on agency staffing.
3. Drive Financial Recovery Through Productivity
Implement service productivity reviews to identify unwarranted variation.
Strengthen financial governance and accountability at divisional and service levels.
4. Accelerate Digital Transformation
Prioritise digital investments that directly support safety, flow, and productivity.
Improve data governance and analytics capability to enable predictive modelling and proactive risk management.
5. Enhance Governance, Assurance, and Quality Improvement
Strengthen risk management processes, ensuring clearer escalation routes and more robust oversight.
Embed continuous improvement methodologies across all services.
Improve triangulation of data (quality, workforce, finance, patient experience) to support informed decision-making.

Rejected Risks/Issues: January 2026

- For the month of January 2026 there were a total of 16 risks and a total of 6 issues identified as rejected.
- The risk rating of the 16 rejected risks is as follows:

Risk Rating	Number
25 (Extreme)	
20 (Extreme)	1
16 (Extreme)	
15 (Extreme)	

Risk Rating	Number
12 (High)	3
10 (High)	
9 (High)	5
8 (High)	1

Risk Rating	Number
6 (Moderate)	4
5 (Moderate)	1
4 (Moderate)	

Risk Rating	Number
3 (Low)	1
2 (Low)	
1 (Low)	
Blank	

- The priority rating of the 6 rejected issues is as follows:

Issue Rating	Number
5 (Significant)	
4 (High)	
3 (Moderate)	1
2 (Low)	
1 (Insignificant)	
Not rated	5

The division and departments the 16 rejected risks and 6 issues belonged to were identified as follows:

- Corporate: 7 Risks, 1 Issue
- MEC: 4 Risks, 4 Issues
- WCYP: 3 Risks, 0 Issues
- CCCS: 1 Risks, 0 Issues
- S&A: 1 Risks, 1 Issue

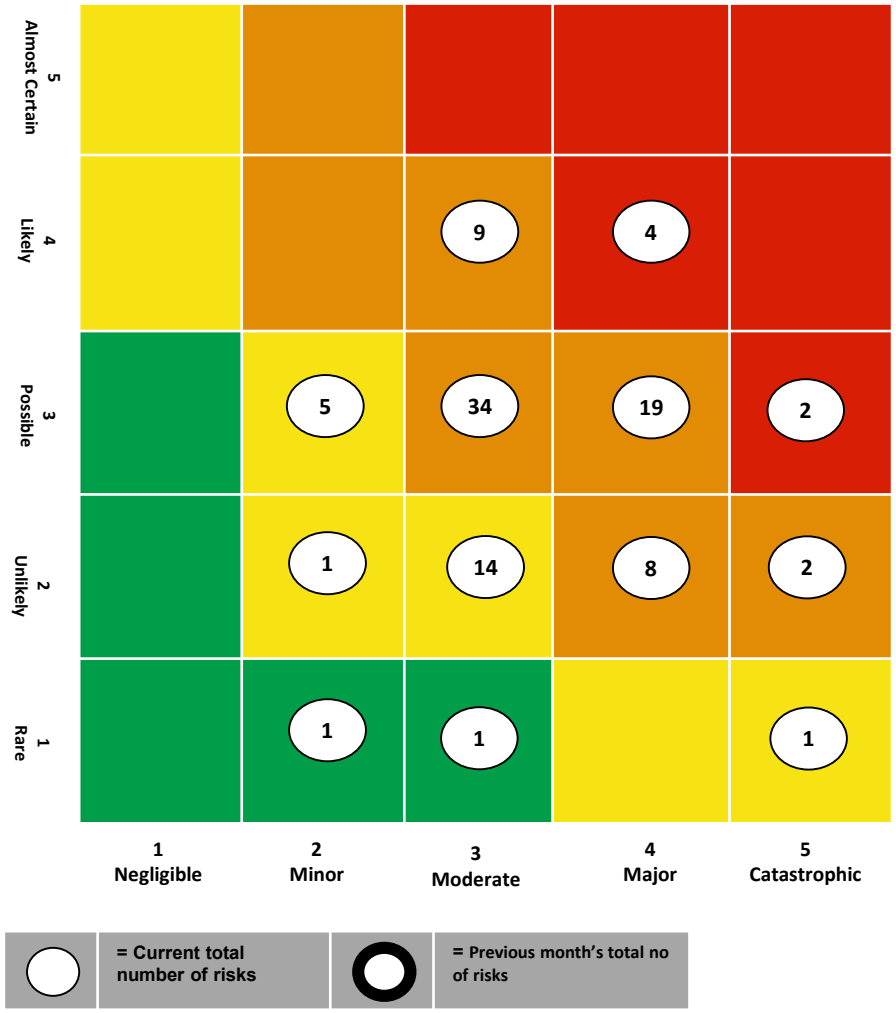
- The reasons for the 16 risks and 6 issues being rejected were categorised as follows: Inappropriate form completed x 20, risk already resolved x 1, duplication x 1

Extreme Risks (Month on Month Profile)

This heat map summarises the total number of risks assigned to each risk rating and compares them to the risk rating of the previous month. ***(December data not available)**

The table below shows the organisation's extreme risks and changes since the previous month.

Medway NHS Foundation Trust



= Current total number of risks

= Previous month's total no of risks

ID	Risk Title	Prev. Month Change	Action Status
1684	Risk of elevated SHMI mortality indicator impact Trust reputation and patient confidence	—	G
1965	Risk of Cyber Attack impacting Trust Information Systems and IT Infrastructure	—	G
2068	Risk of patient safety and care quality impact due to EPR/EPMA system limitations	—	R
2158	Risk of infrastructure failure and compromised clinical safety due to delayed maintenance	—	A
2166	Risk of Fire Safety Breach due to Non-Compliance with HTM 05-01: Managing Healthcare Fire Safety	—	R
2274	Risk of Inadequate Care Provision for 16–17 Year Olds	—	G

Action Status:

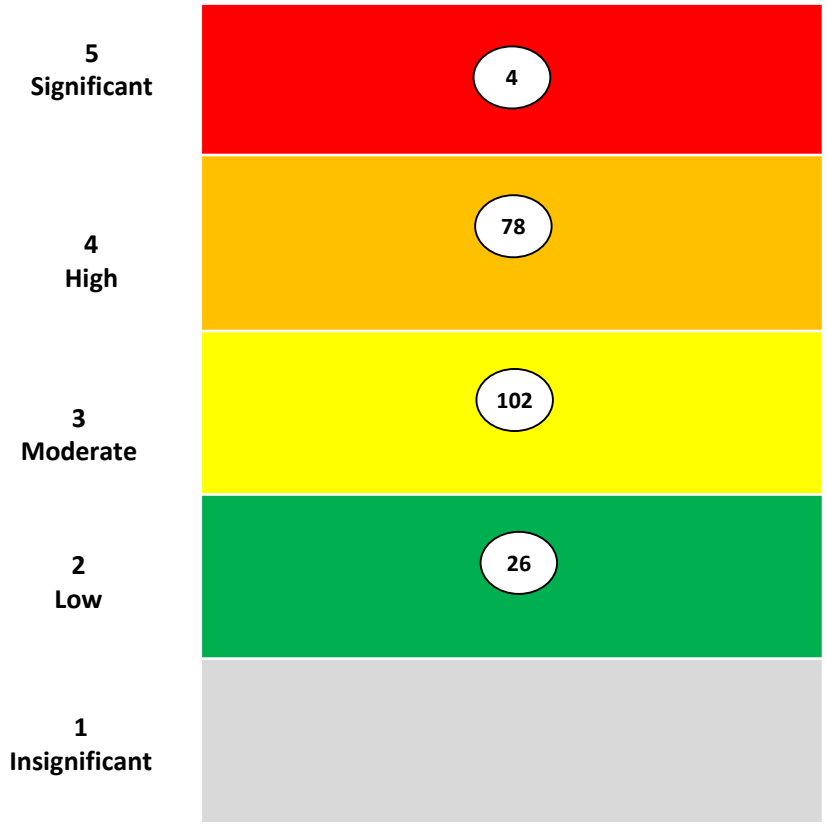
G/Green = All actions within timescale at point of last review	Actions about to become overdue at the point of last review	Actions overdue at the point of the last review

Significant Issues (Month on Month Profile)

This heat map summarises the total number of issues assigned to each priority rating and compares them to the priority rating of the previous month. ***(December data not available)**

The table below shows the organisation's significant issues and changes since the previous month.

Medway NHS Foundation Trust



ID	Issue Title	Prev. Month Change	Action Status
2083	Non-Compliance with Records Management Code: Medical Records Not Properly Culled or Destroyed	—	A
2288	Condemned Ultrasound Machines in Theatres	—	G
2296	Condemned Theatre Trolleys affecting operational delivery	—	G
2685	Cash Flow Pressures Resulting in Extended Trade Creditor Payment Times	—	G

= Current total number of issues

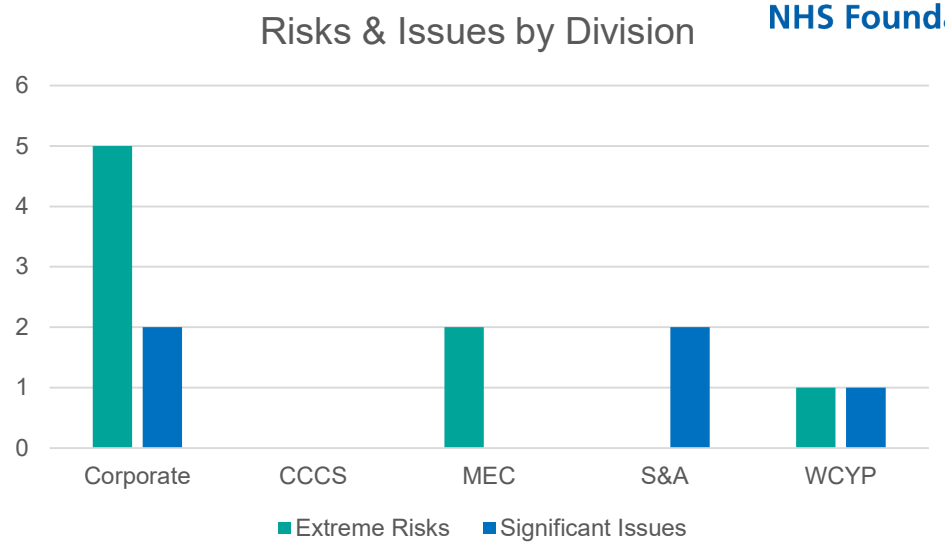
= Previous month's total no of issues

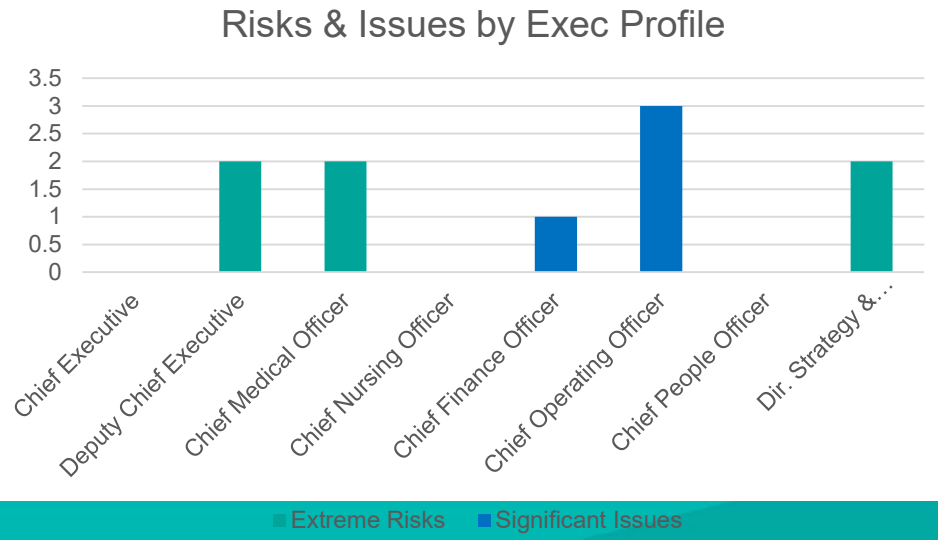
Action Status:

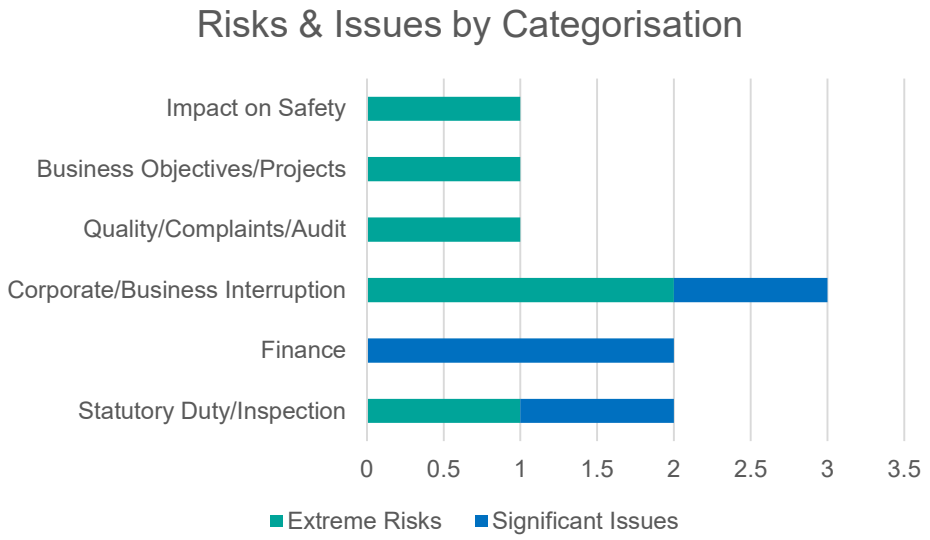
G/Green = All actions within timescale at point of last review	Actions about to become overdue at the point of last review	Actions overdue at the point of the last review

Extreme Risks & Significant Issues (By Executive & Division)

	Extreme Risks	Significant Issues
Chief Executive	---	---
Deputy Chief Executive	2 – 33%	---
Chief Medical Officer	2 – 33%	---
Chief Nursing Officer	---	---
Chief Finance Officer	---	1 – 25%
Chief Operating Officer	---	3 – 75%
Chief People Officer	---	---
Dir. Strategy & Partnerships	2 – 33%	---







Extreme Approved Risks (15 & above)

NHS Medway NHS Foundation Trust

ID	Date Added	Date Approved	Division	Full Description of Risk	Initial Score C x L	Controls	Current Score C x L	Movement	Mitigating Actions	Risk Narrative	Target Score C x L	Target Date	Owner	Exec Lead
1684	31/05/2023	25/07/2023	Corporate	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 adversely affected, LEADING TO reputational damage, reduced stakeholder assurance, and increased scrutiny from regulators and the media, with associated operational and governance consequences for patients, staff, and the wider community.	4 x 2 8	• SJR process is now aligned with RCP guidance, reviewers and both medical and nursing backgrounds and SJR+app used to hold SJR data and reviews. • LFD reports are shared with specialities and included in Quality Care Group and Divisional level reporting • 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. • Business case developed to resource the process. VCP to be approved and target of respiratory related deaths to be implemented.	4 x 4 16	—	1. Review of the Learning from Deaths pathway to ensure concerns raised are adequately addressed and preventable deaths are appropriately escalated and investigated 2. Improvement work to begin on frailty pathways 3. Review of palliative care pathways 4. Improvement work in the form of a Task and Finish Group to begin with nursing and therapies to reduce preventable deconditioning and deterioration 5. Review of all deaths in the last three months to understand issues around preventable admissions and long ED waits, especially for those on the frailty pathway.	The A3 Mortality Refresh is ongoing; therefore, the risk score has remained unchanged from 16. A recent independent review of mortality has identified that the high SHMI is likely to be suggesting an excess of 350-400 deaths in the Trust per year. The likely causes of the high SHMI and key areas of concern including 1. Problems in the hospital and community frailty pathways 2. Problems in palliative care 3. A concerning low preventable morality rate of only 0-0.4% al 4. The most recent SHMI confirms an association with numbers of deaths with palliative care coding and ED performance. 5. Additional concern has been raised around the care of those who die following meeting the No Criteria to Reside (NCTR) status. 5 new actions have been identified to mitigate the risk, with target dates for completion being March 2026. The target risk score (4) is above the Trusts risk appetite range for safety risks (1-3). However, the target score may be unrealistic to attain and the Trust should consider if a higher target score should be considered with a decision to tolerate a level of risk.	4 x 1 4	31/03/2026	Sofia power	Chief Medical Officer

Extreme Approved Risks (15 & above)

Medway NHS Foundation Trust

ID	Date Added	Date Approved	Division	Full Description of Risk	Initial Score C x L	Controls	Current Score C x L	Movement	Mitigating Actions	Risk Narrative	Target Score C x L	Target Date	Owner	Exec Lead
1965	14/02/2024	03/09/2024	Corporate	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 x 3 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 x 3 15	—	1. The Director of IT to engage with a third party provider and the ICS to produce a first draft of a cyber-security strategy for the Trust.	The risk has remained stagnant as an extreme risk since it is was initially raised in February 2024 (48months prior). Since being raised, a single action has been completed (March 2025): *"The Trust has submitted bids to NHS England for investment into Cyber Assurance Dashboard renewal and the implementation of a Ransomware response software and MFA for domain admins and privileged accounts."* The completed action did not result in a reduction in risk score, nor does the single remaining action adequately mitigate the risk. Since the risk was initially raised, the Trust has been targeted by Cyber attack (whether directly or indirectly) the risk score appears to be an adequate reflection of the current position The Trust was directly targeted in September 2025. Prior to that the Trust was indirectly targeted following the MCH attack in November 2024; both specific example cases above and beyond the demonstrable routine attacks that are blocked by antivirus and firewall provisions Additional actions are required to further mitigate the risk The target risk score (10) is above the Trusts risk appetite range for business interruption risks (4-6). However, the target score may be unrealistic to attain and the Trust should consider if a higher target score should be considered with a decision to tolerate a level of risk.	5 x 2 10	27/03/2026	Craig Allen	Director of Strategy & Partnership

Extreme Approved Risks (15 & above)

ID	Date Added	Date Approved	Division	Full Description of Risk	Initial Score C x L	Controls	Current Score C x L	Movement	Mitigating Actions	Risk Narrative	Target Score C x L	Target Date	Owner	Exec Lead
2068	13/05/2024	31/05/2024	Corporate	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, impacting patients, clinical staff, and operational teams.	4 x 4 16	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. Removed the inpatient discharge summary from the ED in light of EPMA order reconciliation manager not transferring between ED and inpatient. POCT - new blood glucose machines to be deployed by end of February. Middleware has also been purchased to allow the integration in to other systems. Blood gas results - currently being tested Workforce gap (ePMA) highlighted at DDat.	4 x 4 16	–	1. POCT 1539; 1488 Integration into EPRR 2. Blood transfusion implementation 3. Dose range limits to be implemented 4. Compare ED location vs patient records 5. Request for ORM enhancements to be made 6. include results acknowledgment 7. QP deployment	The risk has remained stagnant as an extreme risk since it is was initially raised in May 2024. Several actions have been completed including additional workflows being built into the system however; the risk score is yet to be reduced. A number of actions remain significantly overdue which indicate that the risk is not being actively managed in line with the Trust risk management framework. The current risk domain is 'corporate/business interruption', which in risk descriptor terms focuses on loss/interruption to business by timeframe. For example, this risk having a consequence level of 4 suggests that the risk being realised would impact business by approx. 1 week. The risk domain should be reviewed and suggestion that this is aligned to the Domain: *'Impact on the safety of patients, staff or public (physical / psychological harm'* and the risk score reviewed accordingly. The target risk score (10) is above the Trusts risk appetite range for business interruption risks (4-6). However, the target score may be unrealistic to attain and the Trust should consider if a higher target score should be considered with a decision to tolerate a level of risk.	4 x 1 4	31/12/2026	Dilip Pillai	Director of Strategy & Partnership

Extreme Approved Risks (15 & above)

NHS Medway NHS Foundation Trust

ID	Date Added	Date Approved	Division	Full Description of Risk	Initial Score C x L	Controls	Current Score C x L	Movement	Mitigating Actions	Risk Narrative	Target Score C x L	Target Date	Owner	Exec Lead
2158	31/07/2024	27/08/2024	Corporate	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 the required level over five years, THEN infrastructure will progressively deteriorate, LEADING TO unsafe or unsuitable clinical environments and compromising the delivery of essential healthcare services.	4 x 5 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 x 4 16	—	1. Establish backlog prioritisation group 2. Critical asset register update 3. Resurvey 4. Align capital backlog to BCPs	The risk has remained stagnant as an extreme risk since it is was initially raised in July 2024. Several actions have been completed however, the backlog value has likely increased since the risk was initially realised. The outstanding action of resurveying will confirm this; however, this will not mitigate the risk. The risk has been subject to review in collaboration with the CFO as per the monthly risk review meetings for al FPPC risks. An immediate mitigation has been raised: *'Update the list of current backlog maintenance issues with a single line against each, identifying what BCP protocol would be implemented should that infrastructure fail. This could then be held by site and any Estates on-call persons in the event it was needed.'* This has been agreed by the risk owner and head of EPRR to take forwards. The target risk score (4) is within the Trusts risk appetite for Business Objectives/Projects risks (4-6) However the target score may be unachievable given the backlog value. In addition, the risk closure date is estimated to be 2030.	4 x 1 4	31/07/2023	Paul Norman-Brown	Deputy Chief Executive

Extreme Approved Risks (15 & above)

NHS Medway NHS Foundation Trust

ID	Date Added	Date Approved	Division	Full Description of Risk	Initial Score C x L	Controls	Current Score C x L	Movement	Mitigating Actions	Risk Narrative	Target Score C x L	Target Date	Owner	Exec Lead
2166	05/08/2024	27/08/2024	Corporate	Risk of Fire Safety Breach due to Non-Compliance with HTM 05-01: Managing Healthcare Fire Safety IF the Trust does not adhere to fire safety protocols, standards, and guidance across its healthcare buildings— including effective detection, compartmentation, suppression, emergency lighting, staff training, governance oversight, and site housekeeping, THEN the controls designed to prevent, detect, and respond to fire may be insufficient or fail to operate as intended, LEADING TO an increased likelihood and severity of fire-related incidents, resulting in potential loss of life (particularly for complex patients and staff unable to evacuate quickly), injury, property	5 x 3 15	Mandatory fire safety training: 24/7 in house fire response capability Routine fire risk assessments: Fire door inspection and maintenance Fire safety involvement in capital planning -Regular fire alarm testing and engineering presence Systematic installation of a new fire alarm system: Fire damper inspections completed: Post Grenfell cladding replacement: Fire safety walk rounds 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 Smoking reduction group established Completed ward level fire safety works	5 x 3 15	—	1. Fire Plan & Strategy	The risk has remained stagnant as an extreme risk since it is was initially raised in August 2024. Several actions have been completed, with the initial aim to reduce the risk score once fire works were completed on Pembroke Ward. The works on Pembroke have since been concluded with no reduction on risk score realised. The risk has a single action remaining, which is an administrative control, and in principle will not mitigate the risk, therefore additional actions are required to mitigate the risk further, with a trajectory required to show the plan for risk reduction. The target risk score (5) is outside the Trusts risk appetite for Statutory Duty/Inspection risks (1-3) However the target score may be unrealistic given the nature of the organisation.	5 x 1 5	02/10/2028	Neil Adams	Deputy Chief Executive

Extreme Approved Risks (15 & above)

NHS Medway NHS Foundation Trust

ID	Date Added	Date Approved	Division	Full Description of Risk	Initial Score C x L	Controls	Current Score C x L	Movement	Mitigating Actions	Risk Narrative	Target Score C x L	Target Date	Owner	Exec Lead
2274	30/12/2024	07/03/2025	WCYP	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 x 4 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 x 4 16	—	1. Development of a short standard operating procedure (SOP)	The risk is currently scored at 4 (Major) x 4 (Likely) = 16, which indicates a 60–80% probability of inadequate care or an event occurring on a weekly basis, as defined in the risk scoring matrix. There are no linked incidents associated with this risk, and based on the available evidence, the current likelihood rating does not appear to reflect the actual position. Recommendation that this risk is reviewed and considered for downgrade to 4 (Major) x 3 (Possible) = 12. The target risk score (8) is above the Trusts risk appetite range for safety risks (1-3). However, the target score may be unrealistic to attain and the Trust should consider if a higher target score should be considered with a decision to tolerate a level of risk.	4 x 2 8	31/03/2026	Sachin Patil	Chief Medical Officer

Significant Approved Issues (Priority Rating 5)

NHS Medway NHS Foundation Trust

ID	Date Added	Date Approved	Division	Full Description of Issue	Priority Rating	Existing Controls	Mitigating Actions	Issue Narrative	Target Date for Closure	Exec Lead	Owner
2083	20/05/2024	01/07/2024	Corporate	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	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. Review of documents located in regal 2. Business case required	An update is required in relation to the workforce plan for health records cull/destruct, as an update has not been provided since September 2025 when the original PID was rejected at TLT. Both actions identified to address the issue are overdue and once complete the issue would remain, therefore additional actions require identification.	05/11/2026	Chief Operating Officer	Karen Williams

Significant Approved Issues (Priority Rating 5)

Medway NHS Foundation Trust

ID	Date Added	Date Approved	Division	Full Description of Issue	Priority Rating	Existing Controls	Mitigating Actions	Issue Narrative	Target Date for Closure	Exec Lead	Owner
2288	06/01/2025	12/03/2025	SSA	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	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. Monitor and Maintain remaining machines 2. Document all incidents and delays	The issue has remained stagnant at a priority rating of 5 since it was initially raised 12months prior. The issue identifies a significant volume of existing controls and few mitigating actions. The issue is not currently supported by incidental data, however this is being reviewed by the issue owner. No capital funds have been secured to replace the condemned equipment as such the service is having to rely on operational adjustments (such as alternative imaging) where clinically appropriate.	31/03/2026	Chief Operating Officer	Sharon Kaur

Significant Approved Issues (Priority Rating 5)

NHS Medway NHS Foundation Trust

ID	Date Added	Date Approved	Division	Full Description of Issue	Priority Rating	Existing Controls	Mitigating Actions	Issue Narrative	Target Date for Closure	Exec Lead	Owner
2296	13/01/2025	15/01/2025	SSA	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	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. Reallocate trollies efficiently 2. Escalate ongoing operational risks to divisional leadership team	Given the extensive number of current controls and the lack of incidental data linked to this issue, a reduction in priority rating should be considered. The current issue domain is ‘corporate/business interruption’, which in issue descriptor terms focuses on loss/interruption to business by timeframe. For example this issue having a priority rating of 5 suggests that the issue would impact business by 1 week +.	31/03/2026	Chief Operating Officer	Sharon Kaur

Significant Approved Issues (Priority Rating 5)

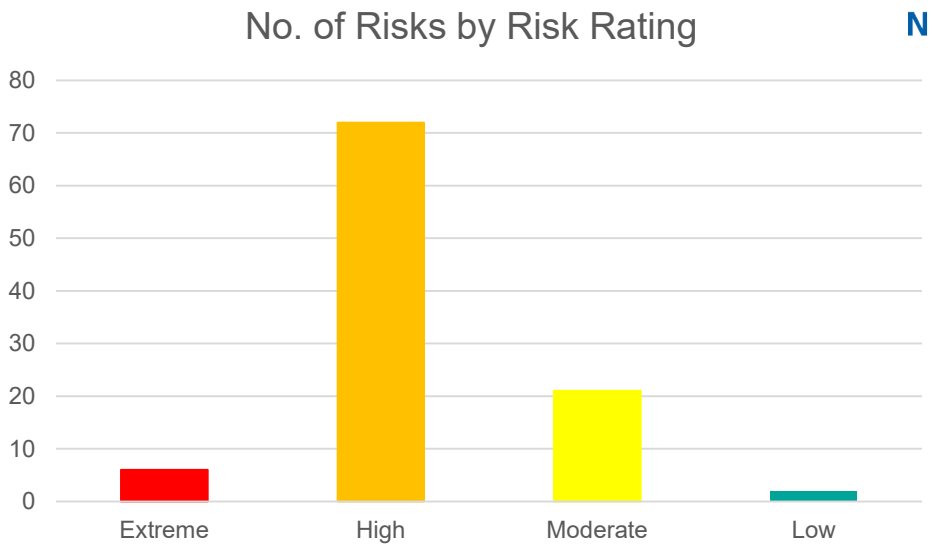
NHS Medway NHS Foundation Trust

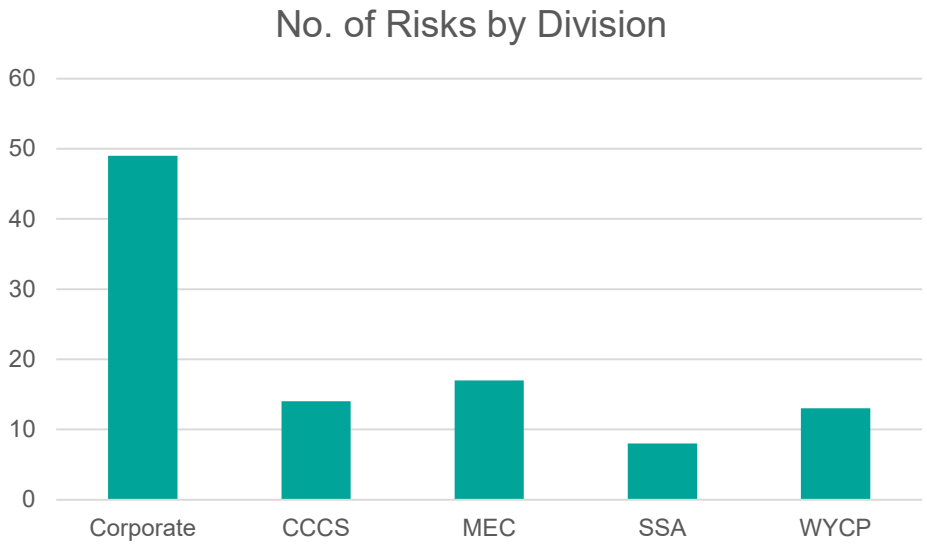
ID	Date Added	Date Approved	Division	Full Description of Issue	Priority Rating	Existing Controls	Mitigating Actions	Issue Narrative	Target Date for Closure	Exec Lead	Owner
2685	30/12/2025	13/01/2026	Corporate	Cash Flow Pressures Resulting in Extended Trade Creditor Payment Times Linked to Issue ID 1861 - Trust Cash Flow. The Trust is experiencing an ongoing cash deficit, with cash outflows exceeding inflows. As a result, the Trust is extending payment of trade payables beyond the standard 30-day terms, either through agreed arrangements with suppliers or by late payment. This position reflects limited short-term options to manage the cash deficit. Cost recovery actions are in progress but are not expected to deliver breakeven in the near term, and applications for deficit support public dividend capital (PDC) are not guaranteed. The continued extension of creditor payment times has the potential to affect supplier relationships and operational sustainability if not actively managed.	5	Regular monitoring of the Trust's cash position through established finance and treasury processes. Fortnightly Trust Treasury Group meetings in place to oversee cash management and prioritise payments. Agreed critical and small supplier list to protect continuity of essential goods and services. Fortnightly System Cash Group meetings to review system-wide cash risks and escalate issues where required. Monthly South East region cash working group calls attended. CFO-approved cash management strategy in place, including a decision to defer payment to NHS bodies (with agreed exceptions) to preserve cash.	1. Submit and progress PDC applications 2. Monthly engagement with system cash group 3. Trust treasury group oversight 4. Apply CFO cash strategy 5. Supplier engagement and payment management 6. I&E plan	The priority rating has increased from 4 to 5 in January 2026 in light of the position for approved non-NHS invoices payments terms not being met. October 2025 payment terms were met, in November payment terms were 5 days late and in December 2025 payment terms were 17days late. This issue is being actively managed in line with the trusts risk framework via FPPC and TLT, with a significant number of actions identified to address the issue.	31/03/2027	Chief Finance officer	Isla Fraser

Risk Status

There are 101 approved risks on the risk register in total (an increase/decrease of 7 from 94 in December 2025.
Of these, there are:

- 9 risks are awaiting approval at the Divisional level
- 3 risks are awaiting approval at the Executive level.



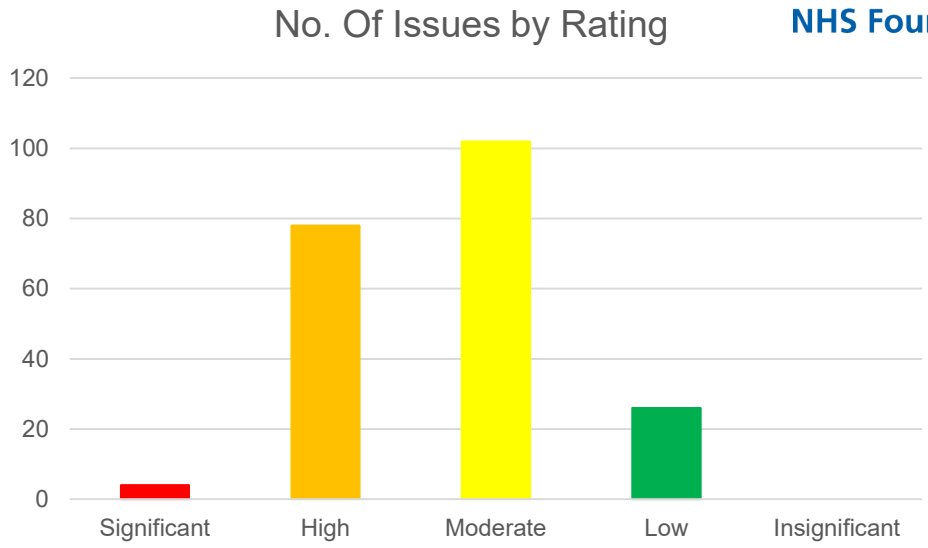


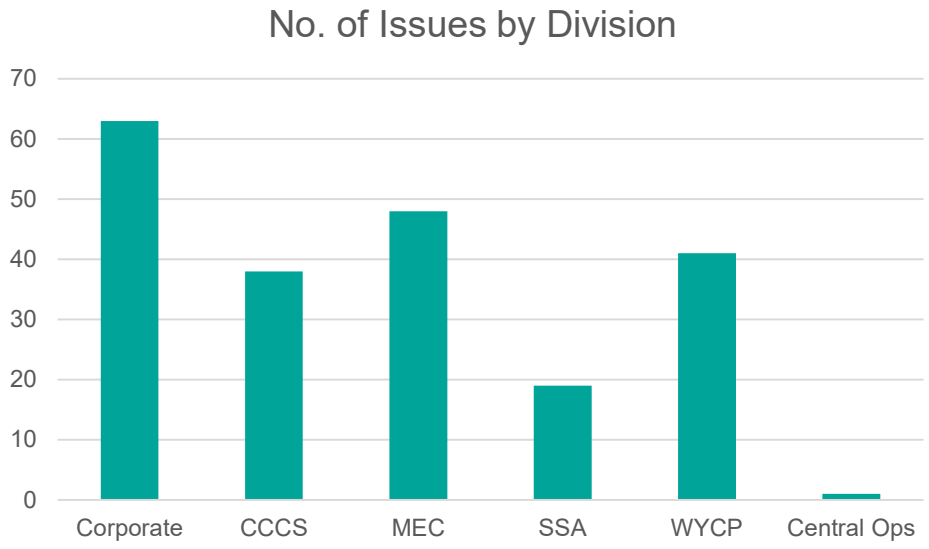
Issue Status

There are 210 approved issues on the issues log in total (a decrease of 11 from 221 in December 2025.

Of these, there are:

- 3 issues are awaiting approval at the Divisional level
- 4 issues are awaiting approval at the Executive level.





Approved Risks Older than 3 Years

There are a total of **8 approved risks** on the risk register that are identified as being **older than 3 years**. The current risk rating of the 8 approved risks on the risk register that are older than 3 years is broken down as follows:

Risk Rating	Number
9 (High)	4
8 (High)	2
6 (Moderate)	1
3 (Low)	1

There are **0 extreme risks** older than 3 years

Approved Issues Older than 3 Years

There are a total of **29 approved issues** on the issues log that are identified as being **older than 3 years**. The current priority rating of the 29 approved issues on the issues log that are older than 3 years is broken down as follows:

Priority Rating	Number
5 (Significant)	0
4 (High)	10
3 (Moderate)	13
2 (Low)	6
1 (Insignificant)	0

There are 0 significant issues older than 3 years.

Closed Risks

A total of **3 risks** were closed in January 2026. Details of the risk closed and rationale for closure are summarised below:

Risk ID	Risk Title	Date Closed	Rationale for Closure
2007	National Patient Safety Alert: Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices	21/01/2026	Approved for closure by Care Group. Target risk score achieved. All internal actions and mitigations for MFT as an acute organisation to reduce the risk of entrapment injuries have been completed.
2438	Prolonged Lack of Repairs Poses Risk to Nursery Environment Condition	08/01/2026	This risk was discussed at the Estates and Facilities Risk Meeting and agreed to be closed and linked to risk 2158 (Risk of infrastructure failure and compromised clinical safety due to delayed maintenance).
2665	Risk of Inadequate Health & Safety Involvement in Estates Projects	22/01/2026	The risk was discussed at the Estates and Facilities Risk Meeting and agreed to be closed as actions have mitigated the risk, including H&S team are scheduled for two Projects meeting each week.

Closed Issues

A total of **10 issues** were closed in January 2026. Details of the risk closed and rationale for closure are summarised below:

Issue ID	Issue Title	Date Closed	Rationale for Closure
1196	Escalation beds opened - no extra pharmacy staff available to cover	21/01/2026	Approved for closure at Divisional Governance Board as underlying theme is of staffing / resource constraint is already captured in 2540
1235	Low Dietetic Capacity Impacting Malnutrition Prevention and Recovery	21/01/2026	Approved for closure at Divisional Governance Board due to improved recruitment and retention and commenced in post of specialist dietitians.
1636	Limited Therapy Provision at Sheppey Frailty Unit	21/01/2026	Approved for closure at Divisional Governance Board due to controls currently sufficient to effectively manage caseload
1972	Staffing Risk – AHP Provision for Neonatal Care	21/01/2026	Approved for closure at Divisional Governance Board. Paeds specialist dietitian has commenced in role
2033	Radiology Reporting Backlog Causing Delays in Patient Care and MDT Review	21/01/2026	Approved for closure at Divisional Governance Board. Medinet extension confirmed
2308	Violence and Aggression Across Cancer & Core Clinical Services	21/01/2026	Approved for closure at Divisional Governance Board. Confirmation of process in event of V&A incident received from all areas. Security staff available at Rochester CDC. Sittingbourne and Sheppey- staff aware to contact 999 in event of incident that requires additional support. Line by line review of staff re: conflict resolution training (current compliance 97%). All appropriate mitigations in place.
2311	No UPS back-up supporting the Interventional Radiology Machine.	21/01/2026	Approved for closure at Divisional Governance Board. Equipment been removed to facilitate replacement so no longer a risk to service.
2367	Lack of Medical Notes for Haematology Procedure	21/01/2026	Approved for closure at Divisional Governance Board. No datixes raised for issue for last 6 months
2447	Imaging Support Worker Job Descriptions Misaligned with National Banding	21/01/2026	Approved for closure at Divisional Governance Board . Uplift has been agreed
2576	Loss of UKAS Accreditation for Antenatal Screening Services at Darent Valley Hospital: Implications for Quality, Safety, and Compliance	21/01/2026	Approved for closure at Divisional Governance Board. DVH have been re-accredited, Issue resolved.

Risk Projection

A total of **0 risks** have had their **current risk score increased** in January 2026
This could indicate that the current control measures are preventing existing risks from becoming uncontrollable, however further action is required to mitigate the risks to within Trust risk appetite.
However it could also indicate that the Trust maturity in relation to risk management requires improvement; effective risk management would result in more frequent fluctuation of risk scores.

Issue Projection

A total of **1 issue** had had their **current priority rating increased** in January 2026, as summarised in **slide 18**
This could indicate that the current control measures are preventing existing issues from becoming uncontrollable, however further action is required to address the issues to within Trust risk appetite.
However it could also indicate that the Trust maturity in relation to risk management requires improvement; effective risk management would result in more frequent fluctuation of issue ratings

Risks are scored using the NPSA Risk Matrix

NHS Medway NHS Foundation Trust

	Consequence					Risk grading key
Likelihood	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Minor**	**5 Catastrophic**	
5. Almost certain	**5**	**10**	**15**	**20**	**25**	**1-3 Low**
4. Likely	**4**	**8**	**12**	**16**	**20**	**4-6 Moderate**
3. Possible	**3**	**6**	**9**	**12**	**15**	**8-12 High**
2. Unlikely	**2**	**4**	**6**	**8**	**10**	**15-25 Extreme**
1. Rare	**1**	**2**	**3**	**4**	**5**	

Meeting of the Trust Board

Date: Wednesday 11th March 2026

Title of Report	Health and Safety Strategy			**Agenda Item**	3.5
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	Lauren Kennett, Senior Strategy Development Officer				
Lead Executive	Evonne Hunt, Chief Nursing Officer				
Purpose	**Approval** X		**Briefing**		**Noting**
Proposal and/or key recommendation:	Approval of the Health and Safety Strategy is recommended to ensure we are compliant with our statutory duties.				
Executive Summary	The Health and Safety Strategy sets out clear ambitions to strengthen the Trust's safety culture, ensuring that health, safety, and wellbeing are fully embedded. It confirms our commitment to integrating recognised frameworks and the NHS Workplace Health & Safety Standards—so that safety continues to become an integral part of how we lead, plan, and deliver care. By aligning with standards, we hope to reinforce a culture that effective health and safety management is not only a requirement but a basis for clinical excellence, and compassionate leadership. The strategy emphasises the development of a mature, safety culture supported by strong leadership, robust governance, and collaboration with staff. By using the DuPont Bradley Curve, we set out a three-year trajectory to move the organisation from compliance-driven behaviours toward an interdependent culture where safety is a shared value. This includes strengthening risk management processes, improving estate resilience, enhancing training and competence, and ensuring staff feel psychologically safe. The strategy also recognises the challenges we face—such as an ageing estate, workforce pressures, and rising population needs—and outlines how collaborative working and digital transformation will help us address them.				

	Clear responsibilities, measurable objectives, and a structured Plan-Do-Check-Act approach underpin the delivery of this strategy. The Health, Safety and Security Group will oversee implementation, supported by colleagues across the Trust. Regular monitoring, and assurance, will ensure that we remain accountable and responsive to emerging risks. Ultimately, this strategy reinforces our commitment to being a safe environment for patients, visitors, and staff, and to fostering a culture where safety, learning, and improvement are embedded.			
Issues for the Board/Committee Attention:	The Trust does not currently have an approved Health and Safety Strategy.			
Committee/ Meetings at which this paper has been discussed/ approved: Date:	• Trust Leadership Team – January 2026 APPROVED • Quality Assurance Committee – February 2026 APPROVED • Trust Board – March 2026			
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	

Health and Safety Strategy

Author:	Health and Safety Manager
Document Owner:	Chief Nursing Officer
Revision Number:	V0.13
Document ID Number:	*TBC*
Approved By:	Trust Board February 2026
Go Live:	February 2026
Date of Next Review:	February 2027

Document Control / History

Revision Number	Reason for change
V0.13	Draft Strategy

Consultation

Health, Safety and Security Group
Quality Assurance Group
Trust Leadership Team
Trust Board
Council of Governors

TO BE READ IN CONJUNCTION WITH ANY POLICIES LISTED IN TRUST ASSOCIATED DOCUMENTS

Table of Contents

1. Foreword

When we come into the hospital to receive care, visit a loved one, or come to work, it's very important that we feel safe. Here at Medway, we are committed to providing a safe environment and positive culture which puts health and safety at the heart of everything we do.

We believe a holistic approach is essential as we cannot do this by working alone. Health and safety is everyone's business as it covers so many aspects of life in a busy hospital; from making sure we comply with local and national regulations to small steps such as making sure we adequately warn you of a wet floor that has just been cleaned to reduce the risk of harm caused by falling.

The Chief Executive holds statutory accountability under Section 2(1) of the Health and Safety at Work Act for ensuring the Trust provides a safe and secure environment for patients, staff, and visitors. Our approach is underpinned by frameworks, including ISO 45001 and HSG65, which provide the foundation for robust governance and continuous improvement in health and safety management. As an acute NHS Trust, we face significant risks that demand ongoing vigilance and proactive mitigation, including violence and aggression, manual handling challenges, fire safety concerns, hazardous substances, water safety, ageing estates, asbestos management, and medical gas hazards. Addressing these risks is essential not only to compliance but to fostering a healthy workplace culture. Central to our strategy is the promotion of psychological safety, staff wellbeing, and a supportive environment where every member of our workforce feels valued, protected, and empowered to deliver the highest standards of care.

In this strategy, we are providing a clear way forward to fully embedding health and safety practices across the wide variety of activities our workforce carries out daily. I would like to thank all colleagues who work extremely hard to drive improvement in all areas across the Trust.

Evonne Hunt, Chief Nursing Officer

2. Introduction

Effective health and safety management supports Medway NHS Foundation Trust by preventing adverse and avoidable incidents from impacting the delivery of its objectives.

This document aims to provide a strategic direction to all Trust departments, to enable a shared vision for the full and effective integration of health & safety management into operational practices and sets out the trust's health and safety objectives, which have been specifically designed to promote the safety culture and continue working towards providing a safer workplace for patients, visitors and staff.

It aims to develop a holistic approach to health and safety that will build on the work already achieved and the improvements in health and safety management being implemented by the Trust to minimise risk and comply with relevant local and national health and safety regulations.

In line with the NHS Workplace Health & Safety Standards (2022), we recognise that effective health and safety management is not only a statutory requirement but also a cornerstone of clinical excellence and organisational resilience. These standards set clear expectations for governance, leadership, and workforce engagement, ensuring that health and safety are embedded across all aspects of our operations.

Our approach is guided by established frameworks that provide both national and international credibility. The Health and Safety Executive's Managing for Health and Safety (HSG65) offers a Plan, Do, Check, Act cycle, enabling us to integrate safety into everyday decision-making. ISO 45001: Occupational Health and Safety Management Systems provides a benchmark for best practice, emphasising leadership accountability and continual improvement. Together, these frameworks underpin a robust approach.

By aligning with these standards, the Trust will build a culture where safety is prioritised, and staff wellbeing is central to our mission. This strategy sets out how we will strengthen our systems, address key hazards, and embed psychological safety across the workforce. We are determined to embed health and safety as a shared responsibility and support compassionate, effective care.

3. Core values

The Health and Safety Management can only be effective in an environment with a positive safety culture. A positive safety culture, as a successful outcome, depends on commonly shared priorities and positive attitudes towards all aspects of the safety culture.

The Trust is committed to providing a positive health and safety culture and a safe environment for our patients, visitors, staff and all users of our services.

Our Health and Safety strategic themes reflect the values of Medway NHS Foundation Trust **(BEST)**.

> **B-** Being **bold** to promote broader ownership of health and safety through safety leadership and governance.

E- Effective risk management, by **everyone**, by managing our risk well to protect patients, visitors and staff from potential risks, including infection, injury, and exposure to harmful substances.

S- Sharing our success by fostering a proactive approach to health and safety where all staff contribute to maintaining a safe environment and being open to review where we can improve.

T- Total commitment **together** as a Trust, to adhering to local and national safety regulations, including Health and Safety Regulations, Care Quality Commission CQC) standards, and other associated standards.

As an acute NHS Trust, we are committed to embedding the principles of compassionate leadership set out in the NHS Leadership Framework to ensure that our leaders model empathy, integrity, and accountability in all aspects of health and safety. We recognise that equity, diversity, and inclusion are integral to safe practice, and we acknowledge that minority staff groups may experience differential risks and safety challenges that must be addressed with fairness and sensitivity. Central to our strategy is increasing psychological safety across the organisation, where staff feel confident to raise concerns, share ideas, and speak up without fear of reprisal. A culture of compassion, inclusivity, and openness is essential to delivering the highest standards of patient care.

This strategy provides a roadmap to enable us to continually improve our services using our improvement ethos and methodology to work towards our objectives.

4. Mission, Vision and Aspirations

Our mission is to ensure that all aspects of health and safety and compliance are fully integrated into the management and culture of our services, enabling efficient and effective delivery through the principles of sensible risk management.

Our vision is to improve the health and safety cultural maturity of the organisation to one of excellence in which:

- Health & Safety becomes integral to business activities
- There is routine and visible senior leadership
- We adopt strong partnership working
- We anticipate safety issues strategically.
- We follow an improvement methodology to investigate the root cause of health and safety concerns and issues.

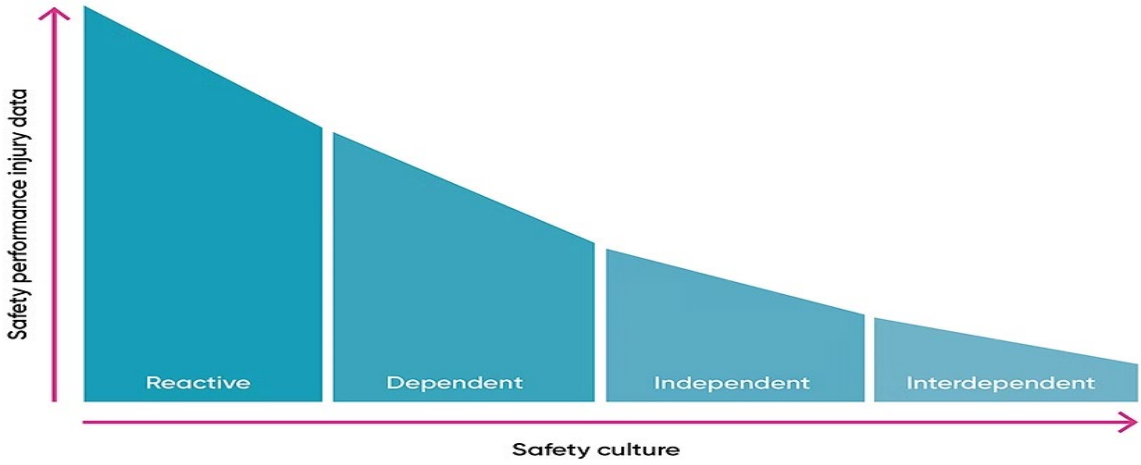
The trust adopts the “Plan – Do – Check – Act” management model (HSG65) as a tool to drive continual improvement.

- Plan – determine the organisation’s plan and policies
- Do – identify risks, report incidents and near misses, organise work for the promotion of a safe and healthy workplace
- Check – measure performance, monitor events, investigate incidents

- Act – Review performance, learn from incidents, and act on lessons learnt

Figure 1: Plan-Do-Check-Act Safety Management Model

We aspire to support the delivery of our duties to prevent harm and demonstrate our commitment to going beyond mere compliance with Health and Safety regulations. Thus, the trust adopts the DuPont Bradley curve to improve the cultural maturity of the organisation, moving it from stages of reactivity to incidents, to a stage where individuals do not just follow rules and procedures, but to a stage where health and safety becomes part of shared value across the organisation.



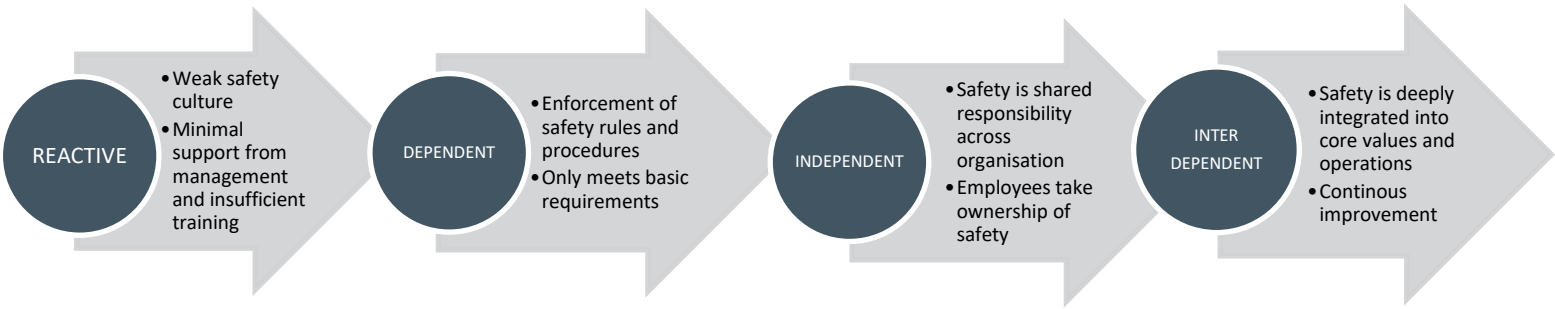


Figure 2: The four stages of cultural maturity of safety (Bradley Du Pont curve)

The improvement of our cultural maturity is essential as accidents/incidents will become rarer, employees' confidence and engagement will increase, creating a safe environment with smoother operations and fewer disruptions.

To support the trusts cultural maturity growth towards interdependence, we have set out a 3-year trajectory goal (2026-2028) in the following areas:

Index/Area	Dependent (Year 1)	Independent (Year 2)	Interdependent (Year 3)
Positive and Visual Leadership Behaviour	• Senior managers and the executives to lead by example, by attending all health and safety courses • Executives and senior managers conducting regular ward tours to discuss health and safety issues (not as a one-off, but routinely). The findings from the tours should be documented and accompanied by a follow-up to act on the findings.	• To embed a proactive approach, by featuring Health and Safety matters in all care group meetings as an agenda item • The Health and Safety agenda is featured on the agenda of all trust board meetings	• Executives and senior leaders maintain a safe and healthy culture throughout the trust through robust measures such as open and authentic two-way communication
Management, Systems and Processes	• Focused on the minimum standard	• Focused on satisfying external experts	• Focused on satisfying including internal and external stakeholders
Human Factors and Behaviour	• Enforcement of strict safety procedures through awareness and education	• Offering safety training that goes beyond the basics, empowering	• Fostering collaboration by building a culture where safety is a

	emphasising importance of compliance to employees	employees to act independently. • Leadership training and safety incentives for employees who take safety into their own hands	team effort, and people feel accountable for each other's well-being. • Peer-to-peer safety reviews and promotion of collaboration
Priority	• Reduction of business risk through cost reduction • The trust meets all regulatory standards and requirements	• To gain Independent assurance across the trust and in the area of health and safety risk	• Safety-first becomes part of the patient-first ethos
Incidents	• Reduce and Respond to incidents	• Prevent Incidents, planned and assured response to incidents	• Eliminate incidents and collective stakeholder incident preparation
Safety	• Safety is a goal	• Safety becomes a personal value	• Safety is embedded as a core value throughout the trust

An independent internal and external assurance will be conducted at year 3 years to assess the Trusts maturity position (employees survey on their perception of safety in the trust; track incident results to identify if the trust is becoming more proactive in addressing risks; and monitor if employees are more involved in safety discussions and initiatives.

The findings of the assurance will be used to set the next 3-year trajectory (2029-2031).

The Trust aspires to improve outcomes in population health and health care. The achievement of the aspiration to create a safe environment in which all users can access services without harm is reliant on all members of staff, as health and safety is everyone's responsibility. Thus, the trust embraces the "one workforce" guidance (effective system-wide co-ordination required in recruitment, planning and development of workforce) as recommended by the NHSE ICS Design Framework and the NHSE ICS people function, to deliver new ways of working that meet population health and wellbeing needs.

The trust has several challenges, risks, and issues which continue to hinder our aspirations:

- aged infrastructure across the estate resulting in an inflexible estate, a large backlog of maintenance and difficulties in retrofitting digital technology and implementing Building Management System (BMS).
- retention and recruitment challenges at every level of our workforce, exacerbated by

the geographical proximity to London without the ability to offer London weighting to agenda for change salaries.

- Ever-increasing population with an increase in the number of those who are dependent (old age, sick, and larger demography) on our provision of healthcare services.

We are continually addressing some of these challenges through proactive property management strategies, optimal utilisation of resources, and maximum support for our workforce by offering career development opportunities.

Furthermore, to best meet the health, care and well-being needs of our population, the trust will continue to draw on the resources of all partner organisations, ensuring we work collaboratively in a system-wide approach

The trust will support prevention initiatives and the wider determinants of health, enabling people to take greater responsibility for their own health and wellbeing; working collaboratively to develop specialist pathways to provide care closer to where people live, reducing the need to travel significant distances to receive the care they need.

Where practicable, we will continue to digitalise our systems and processes to ensure the timely delivery of support that is free from harm to our service users.

5. Responsibilities and Duties

The Trust's Health, Safety, and Security Group (HSSG) will be responsible for overseeing the delivery of the Health and Safety Strategy, for which a detailed implementation plan will be developed, outlining the key activities and success measures to achieve our objectives. This plan will be continually reviewed, responding to new and emerging priorities as well as assuring delivery of the key objectives and actions. The following responsibilities are aligned with the Health and Safety Executive (HSE) and NHS requirements:

- The Trust Executive Directors and senior managers will be responsible for ensuring that health and safety risks are assessed and reduced as low as reasonably practicable in accordance with the Management of Health and Safety at Work regulations 1999.
- The Chief Executive is the accountable officer for Occupational Health and Safety. The Trust Board must receive regular safety reports, Key Performance Indicators (KPIs), assurance audits, and an annual Health and Safety report to monitor progress.
- Our Executive Directors must ensure safety is integrated into business planning, workforce, estates, digital, and finance decisions, including the Serious Incident Requiring Investigation (SIRI) process, our risk register, and Board Assurance Framework.
- Managers at all levels are obliged to provide risk assessments, explore, and implement safe systems of work, performing inspections, training compliance, and accident investigation.

- Our Health & Safety Team are responsible for providing competencies, role expectations, and requirements to maintain Continual Professional Development via the Institute of Occupational Safety and Health (IOSH) and the National Examination Board in Occupational Safety and Health (NEBOSH).

- In terms of contractors and third parties that the Trust deals with, the Construction (Design and Management) Regulations 2015 (CDM 2015) place legal duties on clients, designers, and contractors to manage health, safety, and welfare throughout construction projects.

- All Staff have a duty to report hazards and near misses, complemented by a duty to follow safe systems of work and attend mandatory training. These duties are supported by embedding a 'just culture' that promotes fairness, accountability, and learning from mistakes rather than blaming individuals. It emphasises the importance of creating a supportive atmosphere where staff can report incidents without fear of punishment.

- The Trust have an appointed Health and Safety Team, led by the Health and Safety Manager, to support the Trust in its Health and Safety responsibilities to staff, all users of our services, and compliance with mandatory reporting to other bodies.
- The Health and Safety Manager is responsible for facilitating and promoting a culture that improves health and safety through leading and managing all aspects of the Trust's health and safety procedures in line with current government legislation, regulations, policy guidance and good practice.

6. Strategy Objectives and Actions

The trust has a structured health and safety management approach that is aligned to HSG65, based on the Plan-Do-Check-Act (planning, taking action, checking results and making adjustments based on feedback). This HSG65 guidance helps us to comply with health and safety regulations and maintain a high standard of safety.

The Health and Safety team's ambition is to be certified to the ISO 45001 (Occupational Health and Safety Management System), as this is a more internationally recognised certification. The team is working towards a plan to gain this internationally recognised certification, as well as digitisation of tools in use for managing our safety system.

To achieve our goal of working beyond compliance, our health and safety management system is not just supported by HSG 65 guidance, but by other measures and standards that help us to maintain a high standard of safety. For example, we are also aligned with the NHS Workplace Health and Safety Standards (2022). This standard was developed by the NHS staff council Health Safety and Well-being (HSWG) group to provide practical pointers and signposting for meeting appropriate standards in key areas in workforce health and safety, especially for healthcare services.

The trust conducts an annual self-audit against this NHS Workplace Health and Safety standard to:
- identify current position regarding health and safety legislation,
- determine the effectiveness of the trust's health and safety management system,
- set out issues which need to be addressed
- develop improvement programmes.

Actions are generated from the self-audit for areas that require improvement and are followed through to completion. This self-audit has continued to help us drive continual improvement within our health and safety system.

The following objectives and actions have been created in support of the Trust's Health and Safety Strategy.

Aim	Objective	Measurement of Success	Actions to be taken	Action Owner
Safety Leadership, Culture and Governance	Effective Leadership and Management of Health and Safety across the Trust	The Nominated Committee is chaired by the Chief Nursing Officer, who has delegated responsibility for reviewing safety incidents. Documented evidence of safety discussions during executive meetings.	Chief Nursing Officer to chair the Monthly Health and Safety Security Group meeting	Deputy Chief Nursing Officer
			Inclusion of appropriate health and safety considerations as part of the decision-making process	Executive Directors
			Develop and agree suitable annual health and safety targets and objectives from the NHS Workplace Health and Safety Standard and other relevant standards to drive Health and Safety Performance	Health and Safety (H&S) Manager
Compliance	Effective compliance with all relevant Health and Safety (H&S) legislation and any quality and safety standards, which includes the 5 Care Quality Commission (CQC) Domains	Safe Practice; Full compliance with health and safety legislation and associated requirements, and the 5 CQC Domains	Conduct Regular Health and Safety Audits and provide compliance reports to the Health Safety and Security Group (HSSG) committee	H&S Manager
			Provision of legal updates to HSSG	H&S Manager
			Development of a Register of H&S Legislation	H&S Manager
			Legal Register Reviewed periodically	H&S Manager

Estate and Facilities	Estate and Facilities functionality, maintenance and management	Estate and Facilities compliance to relevant standard Improved condition and functionality of the estate Infrastructure which is flexible, adaptable, and fit for purpose	100% compliance to relevant standard	Finance and Estate Leads
			Reduce critical infrastructure risk (CIR) backlog by 30%	Finance and Estate Leads
			Completion of schedule maintenance works within the allocated timeframe	Finance and Estate Leads
			Removal of Asbestos from buildings and structures	Finance and Estate Leads
			Redesign the computer-aided facilities management module (CAFM) through digitalisation for improved management of trust building and infrastructure. Add functional modules to cater for other elements of facilities, including fire, water, asbestos and medical gases management	Finance and Estate Leads
			Conduct a thorough quarterly inspection of the buildings and infrastructure. Allocated necessary actions from findings and follow-up to address areas that require improvement	Finance and Estate Leads
			Collaborate with various divisional leads and partner organisations to repurpose void, unused or underused spaces within the trust	Finance, Estate Leads, Divisional Leads and partner organisations
Risk Assessment and Control	Comprehensive Risk Assessment and Control	Suitable and Sufficient Risk Assessments;	Collaborate with departments and wards to conduct suitable and sufficient risk assessment for work activities, equipment, area of work, etc., which is monitored through the risk assessment register and reviewed at set intervals	H&S Manager
			Assessment to guide implementation of control or mitigation.	Local Managers

Risk Management	Risk Identification and Risk Register	Effective identification, classification and prioritisation of risks	Education and collaboration to ensure business risks are duly logged by employees	Directorate Lead
			Suitable classification and prioritisation of logged risks on a daily and weekly basis	Risk Management Team
	Risk Action Plan, including a timeframe	Procedure and evidence of an effective action plan suitable for managing risk and completion within the allocated timeframe	Suitable and sufficient action plan allocated to risks and allocation of priorities for action	Risk Management Team
			Risk action owners are designated, and a timeframe for completion is set.	Risk Management Team
	Risk Monitoring and Review	Weekly and Monthly risk monitoring and review	Weekly monitoring to ensure actions allocated to risk are followed up on and completed. Monthly review of risks and actions	Risk Management Team
Involvement and Participation	Increase staff involvement in health and safety management by encouraging them to participate in the process.	Tangible evidence of staff participation and involvement in the Health and Safety Process	Managers are engaging with their staff to conduct risk assessments in their respective work areas	Local Managers
			Provide a mechanism for staff to provide feedback on safety issues	H&S Manager
			Invite Employee Representatives to Health, Safety and Security Group Committee monthly meetings	Committee Administrator
Reporting and Continuous Improvement	Reporting of accidents and incidents	Prompt reporting of all accidents, incidents and near misses; Investigation of accidents and incidents; Sharing and acting on the lesson points of accidents and	All accidents, incidents and near misses to be reported through an online system	All Staff
			Review accidents, incidents and near misses	Health, Safety and Security Group Committee
			Health and safety accidents and incidents are to be initially investigated by the local manager with input from the Health and Safety Team	Local Managers

		incidents; Reduction in the number of accidents and incidents reportable under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)	The H&S team will monitor the actions documented following incidents and support managers in ensuring actions are suitable and sufficient to prevent repeat events	H&S Manager
			The root causes are being identified, and any reasonably practicable changes are being implemented and communicated back to the appropriate staff. Where the lessons learnt are more far-reaching, the H&S Manager will communicate back to the managers and staff in all relevant work areas	H&S Manager
Training and Competence	Provision of appropriate training and guidance to managers and staff that enables them to safely undertake their work activities	100% Compliance with Health and Safety Related Training	All Managers and Staff to complete Trust's Health and Safety related courses (Induction, First Aid, etc.)	All Staff
			Develop Specific training related to specific risk, i.e. Risk assessment; Control of Substances Hazardous to Health (COSHH) assessment, etc.	H&S Manager
			Use data trend analysis to identify other Health and Safety Training needs	H&S Manager
Workplace Safety and Ergonomics	Provision and arrangements to prevent musculoskeletal injuries	Reduction in Ergonomics-related injury during work, i.e. Musculoskeletal Injuries	Provide staff with safe lifting and patient handling techniques	Moving and Handling Lead
			Provide mechanical aids in areas where manual lifting is necessary	Departmental Head
			Conduct regular checks and maintenance of medical and non-mechanical equipment	Director of Estates and Facilities
Emergency Preparedness and	Sufficient arrangement that caters for foreseeable	Suitable and tested Emergency arrangement with all involved	Ensure a detailed emergency response plan is in place for fire, medical emergencies, natural disasters, and	Site Director of Operations

Response	emergencies, i.e. fire, medical, natural disasters, spills, etc.	familiar with their roles and responsibilities	hazardous material spills	
			Ensure weekly check of fire alarms and associate system	Site Director of Operations
			Actions to be taken in a fire emergency are communicated and displayed	Site Director of Operations
			Arrangement and Training for nominated members to support evacuation procedures	Site Director of Operations
Patient Safety and Care	Provision of training and strategies to prevent patient falls	Reduction in patient fall-related incidents	Implement Patient Fall Prevention Strategies	Associate Director of Patient Experience
			Provide training to staff on correct patient handling techniques	Moving and Handling Lead
Monitoring and Review	Effective identification of the area for improvement	Timely and relevant information that allows tracking of progress towards the outcome	Track KPIs such as accident rate, staff compliance, safety arrangement, etc.	Head of Health and Safety
			Review the health and safety strategy to ensure it is effective	Head of Health and Safety

7. Implementation and Monitoring

The Strategy and objectives will be overseen by the Health, Safety and Security Group (HSSG). All staff will be made aware of the Health and Safety Strategy during their induction process and will be able to access the Strategy via the Trust's intranet. There are no specific training requirements associated with this document.

The Health and Safety Team, including health and safety officers, will support the delivery of the strategy, and support the implementation, monitoring and compliance of all associated health and safety requirements.

Progress towards meeting the above objectives and actions will be monitored by the HSSG and reported to the Quality and Assurance Committee (QAC) quarterly.

8. Conclusion

By adhering to this comprehensive Health and Safety Strategy, Medway NHS Foundation Trust is committed to creating a safe, supportive and compliant environment for patients, visitors and staff. Its implementation will ensure the trust can minimise risks, respond effectively to emergencies, continually improve safety standards and foster a strong safety culture that contributes to long term success.

The Trust affirms its commitment to publishing an annual Health and Safety Report, ensuring transparent reporting and a culture of continuous learning across the organisation.

Equality impact considerations will remain central to our strategy. We recognise that different staff groups and service users may experience varying challenges and require us to respond with fairness and sensitivity. Our underpinning implementation plan will enable us to minimise risks, respond effectively to emergencies, continually improve safety standards, and foster a strong safety culture that contributes to long-term success.

Ultimately, the achievement of a safe environment in which all users can access services without harm depends on the collective responsibility of every leader and member of staff, reinforcing that health and safety is everyone's duty and a shared foundation for delivering outstanding care.

9. References

Trust Associated Documents
Clinical Strategy
Infection, Prevention and Control Strategy
Digital, Data and Technology Strategy
Quality Strategy
Research and Innovation Strategy
People Strategy
Freedom to Speak Up Strategy
Estates and Facilities Strategy
Information Governance Strategy
Patient Experience Strategy
The Health and Safety at Work Act 1974
The Management of Health and Safety at Work Regulations 1999
The Health and Safety (Display Screen Equipment) Regulations 1992 (DSE)
The Manual Handling Operations Regulations 1992, as amended in 2002
The Workplace (Health, Safety and Welfare) Regulations 1992
The Personal Protective Equipment at Work Regulations 2022 (PPE)
The Provision and Use of Work Equipment Regulations 1998 (PUWER)
The Lifting Operations and Lifting Equipment Regulations 1998 (LOLER)
The Health and Safety (First Aid) Regulations 1981
The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)
The Confined Spaces Regulations 1997
The Construction (Design and Management) Regulations 2015 (CDM)
The Classification, Labelling and Packaging Regulations 2008 (CLP)

The Control of Asbestos at Work Regulations 2012
The Health and Safety (Safety Signs and Signals) Regulations 1996
The Ionising Radiations Regulations 2017
The Control of Noise at Work Regulations 2005
The NHS Workplace Health and Safety Standards Audit 2022
Health and Safety (Sharps Instruments in Healthcare) Regulations 2013
EH40/205 Workplace Exposure Limits (WEL)
ISO 45001 Occupational Health and Safety Management Systems
HSE HSG65 "Managing for Health and Safety"
NHS Patient Safety Incident Response Framework (PSIRF)
NHS Violence Prevention & Reduction Standard (2021)
NHS Improving Safety Culture Toolkit
NHS Safety Climate Survey guidance
NHS Healthy Workforce Programme (Health & Wellbeing Standards)
Estates and Facilities Alert System compliance requirements

END OF DOCUMENT

Meeting of the Trust Board, 11 March 2026

Patient First Domain (please mark)	Sustainability	People	Patients	Quality	Systems
					X
Title of Report	**Governance Framework update and Scheme of Delegation amendment**			**Agenda Item**	5.1
Author and Job Title	Interim Company Secretary				
Lead Executive	Deputy Chief Executive				
Executive Summary	Approval		**Assurance**	**X**	Noting
	The purpose of this paper is to apprise the Board of progress made in the development of the Governance Framework which forms a key part of the corrective action required to ensure compliance with the License undertakings that are due for completion in quarter one of the 2026/27 period. This report also provides an update on the Standing Financial Instructions, which is one key component of the Framework as it sets out the delegation of duties to the Committees. A more detailed and fuller Standing Financial Instructions update will be provided to the Board in May ahead of their endorsement by Board Committees ahead of final approval by Board on 6 May 2026.				
Proposal and/or key recommendation:	***The Board is asked to:*** 1. Note and approve the approach to carrying out the annual review of effectiveness of the Board and its committees 2. Approve the timeline of the independent review of the Board's effectiveness in quarter three of the 2026/27 period **3.** Approve the incorporation of Performance oversight within the scope of FPPC duties **4. Note and approve the proposed strategic objectives as set out in Appendix A** 5. Approve the incorporation of the Deputy Chief Executive role into the Scheme of Delegation. 6. Approve the proposed limits for the Deputy Chief Executive role to be aligned to the CEO role. These approval levels are: 7. £500K for po and non-PO expenditure 8. £1m capital expenditure 9. £500k for revenue expenditure and contracts 10. £500k for losses, special and write off of debts 11. £500k for contracts				
Governance Route Meeting:	The Board will receive the updated SOD and SFIs following completion of the consultation processes at the May meeting.				

Date submitted:					
Identified Risks, issues and mitigations:	There are existing undertakings on Medway Foundation Trust's Provider licence that specifically relate to the governance structure of the Trust. The content and approach recommended in this paper aims to address that and progress the Trust towards compliance				
Resource implications:	None – this provides an indicator of the Trust's use of financial resource.				
Sustainability and/or Public and patient engagement considerations:	None				
Integrated Impact assessment (please mark):	Yes		No		N/A
					X
Appendices:	N/A				
Freedom of 1.0Information status (please mark):	Disclosable		Exempt		
For further information please contact:					

1.0 Background and Context

In 2025, the Trust committed to completing the actions relating to the undertakings by quarter one in 2026. Work commenced in February to develop a governance framework that is compliant with all these requirements. This paper provides an overview of all the work underway to implement these actions as well as provide assurance on year end arrangements that are in place to ensure compliance to the Corporate Governance Code in relation to an annual, and independent three- yearly review of effectiveness of the Board.

The core elements of this work include:

- Annual review of committee effectiveness and terms of reference
- Annual review of Board effectiveness
- Review of strategic objectives for the 2026/27 period
- Delegations of duties to Committees by the Board, including Standing Financial Instructions
- Annual Review of risk appetite and Board Assurance Framework reset

The Board held a Development Day on 18th February where most of this work was reviewed

Further pieces of work will be undertaken in quarter one, this is set out in more detail in section 6

2.0 Annual review of committee effectiveness and terms of reference

At the February Board development day consideration was given to the Board Committee infrastructure, and specifically:

- Performance oversight within the committee structure
- Roles and Responsibilities of Board and Committee members
- Frequency and alignment of Board and committee meetings

It was determined that the responsibility for performance would remain within the Finance, Planning and Performance Committee, to enable triangulation of operational, activity and financial performance.
As of the February meeting the FPPC has started considering Performance prior to financial performance
Further work is being carried out to align performance assurance feeding into the Board, committee and at Group level, with the output captured in a performance management framework which will also be produced in quarter one of the 2026/27 period.
This work will be incorporated within the Governance Framework

- Delegated authorities for committees, for example FPPC and therefore the Standing Financial instructions and Scheme of Delegation
- Defined roles and responsibilities of the Board and committees in relation to risk management

The annual cycle of the committee's review of effectiveness is currently underway, with the first aspect consisting of an effectiveness survey which commences on 8th March 2026.

This information will be reviewed alongside the terms of reference, which will be submitted to each Board Committee in April ahead of approval by the Board.

3.0 Review of Board's effectiveness

The Code of Governance for NHS Trust places a requirement on the Board to undertake an annual review of its effectiveness, as well as an independent assessment every three years.
For the 2026/27 period, a survey will be carried out in March, which will be reviewed at the April Board Development Day and formally received by the Board in May.
The last independent review of the Board's effectiveness was carried out in the autumn of 2023. It is proposed that the same timeline is applied, in order to align with the three-year timeline, as well as to enable the recruitment of the key roles on the Board, including the post of Chief Executive. Furthermore, this will provide the Board with an independent assessment of progress made in implementing revised corporate governance arrangements.

4.0 Review of Strategic Objectives

At the February Board Development Day, the Board also reviewed its strategic commitments which should be informed by;
*The Care Quality Key Lines of Enquiry
*NHS England Oversight Framework which holds Providers to account on 5 themes -
Quality
Financial
Operational
Strategy
Leadership
*Kent & Medway ICB Strategy
*NHS 10-year Plan
* Existing Trust Strategic Commitments

These also take into account priorities identified in the stabilisation plan, which are incorporated as appendix A within this document
Further work will be undertaken to align the objectives with SMART deliverables

5.0 Standing Financial Instructions and Scheme of Delegation review

The Scheme of Delegation (SOD) is part of the Trust's Standing Financial instructions and subject to regular review, and is due for an update in March 2026.

This document requires amendments to ensure alignment to the corporate governance framework in relation to delegation of duties to groups and committees, for example the delegation of duties to the FPPC.

The FPPC received an initial assessment of the areas of focus that will form part of the work, including recommendations to incorporate the Deputy Chief Executive Role within the Scheme of Delegation.

At the 26th February meeting, the FPPC also endorsed that the DCEO role adopt the same financial delegations as the CEO role.

These approval levels are:

- £500K for po and non-PO expenditure

- £1m capital expenditure
- £500k for revenue expenditure and contracts
- £500k for losses, special and write off of debts
- £500k for contracts

6.0 Next Steps

As part of the development of the Governance Framework and aligned pieces of work the following will be undertaken in quarter one

- Update the governance handbook to include the Trust's Strategic commitments to facilitate the key components of the Trusts Governance Framework
- Ensure alignment of ongoing work to review the clinical governance framework and risk register
- Submit the governance framework to the Board for Approval in May 2026
- Map Board annual cycle of business to strategic commitments and regulatory requirements
- Put in place a Board development programme that is aligned to strategic priorities
- Review Risk Appetite Statement of the Trust at the April Board Development day, and formally thereafter at the May Board
- Revise BAF to align principle risks and strategic objectives
- Define duties of committees and the Board in relation and include in governance framework

Ahead of formal submission of these documents consideration will also be required in relation to
In the next iteration of this report the committee in April will be provided with recommendations in relation to:

- Delegation limits for the Finance, Performance and Planning Committee in relation to business cases and contracts
- Delegation limits for Trust leadership Team in relation to financial approval
- Delegation limits for Executive Directors in relation to revenue and capital business cases
- Delegation limits for Executive Directors in relation to contracts
- Delegation limits for Executive Directors in relation to commitment of expenditure

Other areas of improvement will also be incorporated
The alignment of the Board and the Council of Governors will also be incorporated within the Governance Framework as well as an annual review of effectiveness of the CoG.

7.0 Recommendations

The Board is asked to:

1. Note and approve the approach to carrying out the annual review of effectiveness of the Board and its committees
2. Approve the timeline of the independent review of the Board's effectiveness in quarter three of the 2026/27 period
3. Approve the incorporation of Performance oversight within the scope of FPPC duties

4. Note and approve the proposed strategic objectives as set out in Appendix A
5. 3.Approve the incorporation of the Deputy Chief Executive role into the Scheme of Delegation.
6. Approve the proposed limits for the Deputy Chief Executive role to be aligned to the CEO role.

These approval levels are:

- £500K for po and non-PO expenditure
- £1m capital expenditure
- £500k for revenue expenditure and contracts
- £500k for losses, special and write off of debts
- £500k for contracts

APPENDIX 1

Strategic Commitments

1. Performance

Strategic Commitment:
"We will deliver care to our population in the right place, at the right time, reducing unnecessary waiting and improving outcomes."

Board Objectives & Assurance Items

Board Objective	Description	Assurance Received
1. Deliver the right care in the right environment	Ensure care pathways support timely treatment in appropriate settings (acute, community, primary care).	Routine 'No Criteria to Reside' data Shared PTL data Regular system wide referral management output (once programme operational) Output from system review of service provision
2. Support our population to access care and reduce health inequalities	Improve equity of access through targeted interventions and strengthened partnerships with system partners.	Quarterly health inequalities dashboard presenting access, uptake and outcome metrics by demographic group.
3. Deliver NHS waiting time standards	Meet national RTT, cancer and diagnostic standards.	Monthly performance review showing compliance trajectories and mitigation where off-track.
4. Ensure teams have the skills, capacity and capability to deliver	Workforce planning ensures the right staffing levels and competencies aligned with service needs.	Workforce assurance report including vacancy rates, skill mix, training compliance and forecast modelling.

2. Culture

Strategic Commitment:
"We will develop confident managers who lead with integrity, support our people well and help build a healthy, high-performing organisational culture."

Board Objectives & Assurance Items

Board Objective	Description	Assurance Received
1. Train - Build a future-ready, skilled workforce	Strengthen leadership, management and technical skills across all staff groups.	Quarterly report on leadership development uptake, training completion and competency progression.
2. Retain - Make Medway a great place to work and thrive	Improve staff experience, wellbeing, morale and retention.	Staff survey results, pulse check indicators and retention analysis with key themes and actions.

3. Reform - Transform services to deliver better outcomes and value	Embed continuous improvement approaches and empower teams to redesign services.	Transformation programme dashboard showing benefits realised, efficiency gains and service improvements.

3. Governance, Well-Led & Leadership

Strategic Commitment:
"We will ensure the Board has the capability, capacity and governance structures needed to deliver organisational objectives transparently and sustainably."

Board Objectives & Assurance Items

Board Objective	Description	Assurance Received
1. Strengthen accountability for delivery of the strategic plan	Ensure all Board committees and leaders have clear accountability for their contribution to strategic delivery.	Annual review of Board and committee effectiveness with clear accountability mapping.
2. Deliver robust Board development to enhance skills	Provide continuous development to strengthen leadership, knowledge and decision-making capacity.	Board development plan with attendance, progress reporting and external evaluation.
3. Build capability and resilience through a structured development plan	Develop succession planning, leadership pipelines and resilience measures.	Annual Board and senior leadership succession plan review.

4. Quality

Strategic Commitment:
"We are committed to delivering safe, effective, evidence-based, equitable and compassionate care for every patient, every time."

Board Objectives & Assurance Items

Board Objective	Description	Assurance Received
1. Safe - Deliver a step-change in patient safety	Improve early identification of risk, embed learning and reduce patient harm.	Patient safety outcomes report, including incident themes, harm rates and learning implementation.
2. Effective - Implement national best practice and reduce unwarranted variation	Ensure consistency in clinical outcomes by applying national standards.	Clinical effectiveness dashboard showing compliance with NICE/national standards and variation metrics.

3. Evidence-based -Measure and reduce disparities in health outcomes	Use data and research to improve outcomes across all patient groups.	Quarterly quality and outcomes report segmented by population group.
4. Equitable & Compassionate Care - Deliver respectful, culturally sensitive care	Ensure patient experiences are consistently positive, kind and inclusive.	Patient experience and EDI metrics with compliments, complaints and themes analysis.

5. Finance

Strategic Commitment:
"We will live within our means each financial year and invest for long-term financial sustainability."

Board Objectives & Assurance Items

Board Objective	Description	Assurance Received
1. Deliver run-rate in line with financial plan	Ensure monthly expenditure matches planned financial performance.	Finance report showing run-rate vs plan and variance explanations.
2. Set and deliver an affordable headcount plan	Align workforce spend with affordability and capacity requirements.	Monthly workforce financial monitoring against establishment and temporary staffing usage.
3. Improve productivity	Increase value for money and operational efficiency across services.	Productivity indicators such as GIRFT benchmarks, cost-per-case and efficiency KPIs.
4. Achieve 90% recurrent savings contribution (CIP)	Deliver sustainable cost improvement plans.	SIP tracker showing recurrent vs non-recurrent delivery and risk-rated forecasts.
5. Maintain positive cashflow to avoid external support	Strengthen cash management and avoid additional borrowing.	Cashflow forecasts, liquidity metrics and compliance with cash-management standards.

Meeting of the Board
Meeting Date: 11 March 2026

Title of Report	Gender Pay Gap 2025			**Agenda Item**	5.2
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	Alister McClure, Head of Equality and Inclusion				
Lead Executive	Sheridan Flavin, Chief People Officer				
Purpose	**Approval**	X	**Briefing**		**Noting**
Proposal and / or key recommendation:	• Approval for publication to the Government portal and Trust website				
Executive Summary	This report sets out the gender pay gap calculations for 2025. Publication is due by 31 March 2026. The report is required under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 The Trust's mean gender pay gap is 26.7% (1.1 percentage points lower than the previous year) and the median gender pay gap of 17.2%. (unchanged from the previous year. Both the median and the mean are considerably above the UK average. The gender pay gap relates to gender differentials in the progression to senior roles, in both Agenda for Change and Medical and Dental roles. Since medical and dental pay averages at a higher rate compared to AfC, and the proportion of men in the medical workforce is higher than the AfC workforce, this has a higher impact on the overall gender pay gap. Improving the gender profile of medical and dental roles, therefore, is likely to have the greatest impact on improving the pay gap, and current work through the Genderwise workstream of Cultural Transformation, includes a focus on the medical gender pay gap.				
Issues for the Board / Committee Attention:	The report highlights staff groups that most contribute to the Trust's Gender Pay Gap. Despite continued progress to narrow the gap, it is clear that some gaps will take time to close, owing to long term career development. However, the data makes clear the need for Genderwise workstream of Cultural Transformation, a continued focus on career				

	progression pathways for women in medical careers, and tackling structural and personal forms sex discrimination.			
Committee / Meetings at which this paper has been discussed / approved: Date:	This report is for approval, following conversation with the Equality Steering Group,Trust LeadershipTeam; it has also been presented to the Trust's Genderwise Cultural Transformation workstream.			
Board Assurance Framework / Risk Register:	N/A			
Financial Implications:	Not as a result of this report. However, the Trusts financial position does not diminish its responsibilities to meet adjustment needs, under the Equality Act 2010.			
Equality Impact Assessment and / or patient experience implications	The data and consideration of this report are in themselves, part of the Trust's corporate and mandated equality impact data. Similar reports on disability and ethnicity pay gaps will be produced later in the year subject to national guidance.			
Freedom of Information status:	Disclosable	X	Exempt	

APPENDIX 1

Meeting of the Equality Steering Group 25 February
Draft for the People Committee 26 March 2026

GENDER PAY GAP REPORT FOR 2025

Report Author	Alister McClure, Head of Equality and Inclusion
Lead Director	Sheridan Flavin, Interim Chief People Officer

Executive Summary

This report sets out the gender pay gap calculations for 2025. Publication is due by 31 March 2026 on the Trust external website. The report is required under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017

The Trust's mean gender pay gap is 26.7% (1.1 percentage points lower than the previous year) and the median gender pay gap of 17.2%. (unchanged from the previous year. Both the median and the mean are considerably above the UK average. The gender pay gap relates to gender differentials in the progression to senior roles, in both Agenda for Change and Medical and Dental roles.

Since medical and dental pay averages at a higher rate compared to AfC, and the proportion of men in the medical workforce is higher than the AfC workforce, this has a higher impact on the overall gender pay gap. Improving the gender profile of medical and dental roles, therefore, is likely to have the greatest impact on improving the pay gap, and current work through the Genderwise workstream of Cultural Transformation, includes a focus on the medical gender pay gap.

Additional Appendices:

1a Pay Gap calculations and supporting statement
1b Background and reporting requirements
1c Pay Gap by staff group

APPENDIX 1A - PAY GAP CALCULATIONS AND SUPPORTING STATEMENT

1. GENDER PAY GAP CALCULATIONS

1.1 **Mean and Median Hourly Rates (All staff groups)** – latest figures to the left

1.1.1 As at 31 March each year

Average (mean) Hourly Rate of Pay

Gender			
Year	2025	2024	2023
Male	28.53	26.21	25.75
Female	20.91	18.99	17.90
Difference	9.62	7.31	7.85
Pay Gap %	26.73%	27.9%	30.51%
Direction of travel	Gap Narrowed		

Median Hourly Rate of Pay

Gender			
Year	2025	2024	2023
Male	22.78	20.66	20.34
Female	18.84	17.11	16.10
Difference	3.94	3.55	4.24
Pay Gap %	17.2%	17.2%	20.85%
Direction of travel	Unchanged	Gap Narrowed	

1.2 **Number and Percentage of employees per quartile**

1.2.1 Number of employees per quartile

Quartile	Female	Female	Female	Male	Male	Male
Year	2025	2024	2023	2025	2024	2023
1 (lower)	1109	1056	991.00	270	254	203.00
2 (lower middle)	1111	1053	968.00	263	260	231.00
3 (upper middle)	1152	1076	1005.00	328	201	193.00
4 (upper)	828	818	722.00	554	534	477.00

1.2.1 Percentage of employees per quartile

Quartile	Female %	Female %	Female %	Male %	Male %	Male %
Year	2025	2024	2023	2025	2024	2023
1 (lower)	80.42	80.61	83.00	19.58	19.39	17.00
2 (lower middle)	80.86	80.20	80.73	19.14	19.80	19.27
3 (upper middle)	77.84	84.26	83.89	22.16	15.74	16.11
4 (upper)	59.91	60.50	60.22	40.09	39.50	39.78

1.3 Bonus Payments

1.3.1 Bonus payments comprise chiefly of clinical excellence awards (CEAs). There are a comparatively small number of CEAs, so the impact on the mean and median pay rates is statistically negligible.

Gender	Avg. Pay	Median Pay
Male	8,563.07	6,032.04
Female	6,578.95	6,032.04
Difference	1,984	0
Pay Gap %	23.17	0

Gender	Employees Paid Bonus (CEA)	Total Relevant Employees	%
Female	14	4434	0.32
Male	33	1404	2.35

2. SUPPORTING STATEMENT

2.1 The headline calculations for this Trust are a Mean gender pay gap of 26.7% which, although high, is a significant improvement on previous years. The Median gender pay gap of 17.2%, remains unchanged from the previous year. It is evident that the proportion of men in the workforce increases in the upper quartile, compared to quartiles 1 to 3. The Medical and Dental Pay Gap is 16.84% (compared to 7.9% in the previous year), and disproportionately affects the overall pay gap, owing to the proportion of men in the consultant workforce and the higher average pay rate for medics compared to Agenda for Change. However, the pay gap for Administrative and Clerical roles is also high at 17.62%. The pay gap for healthcare scientists is the highest in any staffing group, at 30.71%; although this is statistically insignificant on the overall pay gap, as this is a very small staff group. Three staff groups (Additional Scientific, Professional and Technical; Allied Health Professionals; and Nursing and Midwifery) have negative pay gaps, where women are proportionately paid more than men. These negative pay gaps offset the overall gender pay gap.

2.2 Amongst medical consultants, men comprise approximately 75% of the workforce. In Agenda for Change (AfC) pay bands, women form over 80% of the workforce. This means that, compared to women, a greater proportion of men are in higher paid roles. Another potential matter to consider is the fact that the Trust has not outsourced some services, such as catering and housekeeping, which have a higher proportion of women in lower pay bands.

2.3 Comparisons with neighbouring trusts and the general situation across England in previous years shows that there is a similar pattern across Acute Trusts, and this will be benchmarked again once all Trusts have published their most recent data. On the one hand, there is reasonable confidence that, owing to Agenda for Change and medical pay reviews, the NHS is providing equal pay (men and women paid equally to carry out the same jobs, similar jobs or work of equal value). However, it is evident that in medical roles there have been, traditionally, significantly more men progressing to the most senior levels, resulting in a gender pay gap.

2.4 Whilst there is also little that the Trust can do in the short term to remove the gender pay gap, because the issue affects professions that have long term career pathways, action can and is being taken to encourage the retention and career progression of women into senior roles, in particular in medicine. The Trust's Patient First Improvement System has been used to identify root causes and potential countermeasures and actions to address them, specifically around the progression of women into senior medical roles, and into consultant roles. This is now embedded into a Cultural Transformation workstream, Genderwise, considering career pathways, mentoring etc for Women into leadership roles, especially in clinical roles, as well as tackling sex discrimination more generally.

2.6 The important issue with gender pay gap analysis is not only to know the data and understand the reasons for the gaps, but to ensure action is taken to address the gap. Noting that the gender pay gap issue is common to many other acute trusts across the NHS, it will be important to continue to explore with partners across the NHS what practical changes can be made. Pay is set nationally so we are limited at a local level to affect pay bands, and it is about our application of nationally agreed terms and conditions that continues to be monitored. This includes:

- Continuing to keep pay structures under proper review, to ensure that equal pay is maintained;
- Improving the professional pathways for women in medical roles to encourage more female medics into consultant and other senior roles;
- Working with Medical Schools/Universities to explore how medical graduates choose the direction of their careers;
- Reviewing how well the Trust manages women's progression after career gaps/maternity;
- Reviewing how well the Trust is managing the progression into senior medical roles for women who work part-time;

- Active promotion of current policies on flexible and family-friendly working, workforce planning and career development opportunities and career pathways for all staff.

2.7 Commitments in the current Equality, Diversity and Inclusion Action Plan are:

Aim	Dependencies	Current Gap	Success Measure for the current action	Timescale	Progress
Deliver actions in the People Strategy that aim to close the AfC Gender Pay Gap	Senior managers, Resourcing and OD teams (links with talent management for lower bands and the Band 7/8a threshold)	AfC GPG is currently <1% (reduced from 3.1% in 2022)	Narrow the gap by at least 0.5 percentage point (i.e. to 1.4% or less) (currently ahead of target)	April 2025	Achieved
Increase the proportion of women moving into senior medical roles, through recruitment and retention	Medical Directorate, Resourcing Teams, Senior Medical Managers (Narrowing the gap in medical pay is a longer-term achievement, owing to the gender balance of medics in different age groups and the length of career paths to senior medical roles)	Medical GPG is 16.84% (also 18.9% in 2022)	Narrow the gap by at least 4 percentage point (i.e. to 15% or less)	Improvements ongoing with regular review	Ongoing
Reduce sex discrimination and gender bias. And promote greater commitment to gender equality.	Cultural Transformation work on workplace safety, and gender justice	Baseline required through review of employee relations data and staff survey* (*currently embargoed)	Improved data on incidents (which may initially show an increase), followed by a 50% reduction target	Ongoing and regularly review	New

2.8. Staff Networks and Staff as Stakeholders

A Women's Network launched in 2023, is a key stakeholder providing insights and assurance on actions to reduce the gender pay gap. A Patient First A3 thinking was used in 2024, involving women in medical careers, to help identify root causes, impacts and countermeasures to address the medical gender pay gap. The Genderwise workstream of the Trust's Cultural Transformation programme is leading engagement with the workforce, including participation of the Women's, Men's and LGBTQIA+ staff networks, a listening events for all staff.

2.9 **Assurance statement.** The gender pay gap for Medway Foundation Trust has been prepared using the NHS Electronic Staff Record (ESR) gender pay gap calculator. The Trust has also used the ACAS guidance to calculate and verify the result.

APPENDIX 1B: BACKGROUND AND REPORTING REQUIREMENTS

1: BACKGROUND

1.1 Following government consultation, it became mandatory on 31 March 2017 for public sector organisations with over 250 employees to report annually on their gender pay gap (GPG). Since the Equality Act 2010 (Specific Duties) Regulations 2011 (SDR) came into force on 10 September 2011, there has been a duty for public bodies with 150 or more employees to publish information on the diversity of their workforce (these are published annually on the Trust website). Although the SDR did not require mandatory GPG reporting, the Government Equalities Office (GEO) and the Equality and Human Rights Commission (EHRC) provided guidance that made it clear that employers should consider including GPG information in the data they already publish. It was evident that not all employers did this, so the government made GPG reporting mandatory by amending the SDR so that all public sector employers with more than 250 employees have to measure and publish their gender pay gaps.

1.2 The requirement to publish GPG reports is set out in the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017. The requirements are summarised in section 4 of this report.

1.3 The difference between the gender pay gap and equal pay

1.3.1 **Equal pay** deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman.

1.3.2 **The gender pay gap** shows the differences in the average pay, across the whole workforce, between men and women. If a workplace has a particularly high gender pay gap, this can indicate there may a number of issues to deal with, and the individual calculations may help to identify what those issues are. In some cases, the gender pay gap may include unlawful inequality in pay but this is not necessarily the case.

1.4 Although each individual NHS Trust is responsible for its own GPG report, the NHS has a nationwide tool to make the relevant calculations.

2: REPORTING REQUIREMENTS

2.1 Employers with 250 employees and over need to publish the following information annually for all employees who are employed under a contract of employment, a contract of apprenticeship or a contract personally to do work. This includes those under Agenda for Change terms and conditions, medical staff and very senior managers. All calculations must be made relating to the pay period in which the snapshot day falls. This will be the pay period ending 31 March 2024. This does not need to be reported on the Government portal until 31 March 2025.

2.2 Employers must:

- calculate the hourly rate of ordinary pay relating to the pay period in which the snapshot day falls;
- calculate the differences between both the median and mean hourly rate of ordinary pay of male and female employees;
- calculate the difference between the median (and mean) bonus pay paid to male and female employees. For the NHS, bonus payments are defined as: clinical excellence awards; long service awards (monetary vouchers); workplace vouchers in addition to salary; recruitment bonuses; and relocation costs in excess of expenses. [The following are not to be considered as either pay or bonuses: salary sacrifice schemes, benefits in kind (e.g. NHS discounts); and the reimbursement of expenses.]

- calculate the proportions of male and female employees who were paid bonus pay;
- calculate the proportions of male and female employees in the lower, lower middle, upper middle and upper quartile pay bands by number of employees rather than rate of pay.

2.3 The Trust is also required to publish a supporting narrative, which must include an assurance statement, agreed by a senior representative of the Trust, and/or the Executive Group and The Trust Board or a Committee of the Board. The calculations must be published on both the Trust website and a Government portal, and supporting statement must be published on the Trust website. Once published, employers are required to implement an action plan to address the gender pay gap.

2.4 The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 identify gender as male and female. There is no consideration in the regulations to people to identify as intersex, or gender non-binary. In terms of gender identity (e.g. Transgender status) the advice provided to employers is to ensure that for the purposes of the GPG report, people's gender is recorded according to their HR/Payroll records.

APPENDIX 1C: PAY GAP BY STAFF GROUP

The Trust must report its pay gap on the Government portal, as set out in Appendix 1 section 1. However, these tables illustrate the pay gap by staff groups.

Individual Staff Groups:

Staff Group	Female £	Male £	Difference £	Pay Gap %
Add Prof Scientific and Technic	21.93	21.27	-0.66	-3.13
Additional Clinical Services	14.66	14.88	0.23	1.52
Administrative and Clerical	17.36	21.08	3.71	17.62
Allied Health Professionals	22.43	21.88	-0.55	-2.52
Estates and Ancillary	14.00	15.29	1.29	8.44
Healthcare Scientists	30.41	43.89	13.48	30.71
Medical and Dental	37.38	44.95	7.57	16.48
Nursing and Midwifery Registered	22.38	22.23	-0.15	-0.68

Colour Key:
Amber is the sex disadvantaged
Red indicates the major contributors to the overall pay gap

Average (Mean) Pay Gap comparing Medical and Dental with Agenda for Change

	2020	2021	2022	2023	2024	2025
Agenda for Change	6%	6.88%	3.1%	1.91%	1%	1.5%
Medical and Dental	19%	21.23%	18.86%	18.87%	17.9%	16.48%

Perinatal Quality Surveillance and Leadership Quarterly Report Q3 25/26

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

MNSCAG –February 2026
Trust Board – March 2026

Executive Summary

- CNST MIS continues the expectation that Trust Boards will receive quarterly reports on Perinatal Quality in line with the minimum data set of the Perinatal Quality Oversight Model (PQOM). (Safety Action 1 and Safety Action 9)
- Monthly updates aligned with the minimum dataset of the PQOM are submitted monthly to QPSCC and QAC along with to every Trust Board.
- This report provides quarterly oversight for Q3 25/26 and includes the following:
  - Incidents
  - Investigations
  - PMRT
  - Complaints
  - Claims Scorecard
  - Staff and Service User Feedback
  - Perinatal Leadership
- For next quarterly report plan to move to SPC charts for dashboard data. BI dashboard set up to support this and working with team to confirm parameters.
- MOSS launched in November 2025 and MFT onboarded and developing local SOP to support reporting processes and governance.
- Compliant with training requirements for CNST Year 7. Working to improve mandatory training compliance rates, particularly for medical staff.

Perinatal Quality:

Incidents

PSIRF/Investigations

PMRT

Complaints

Claims

True North: Quality

Perinatal Surveillance Tool: Quarterly Report - Q3 25/26

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

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

NHS Medway NHS Foundation Trust

Key Messages:

- 465 incidents in Q3, increase from last two quarters. (Q2 – with 413, 448 in Q1)
- 100% of incidents reported are no or low harm with no Moderate or above in Q3.
- 63(↓) (82 in Q2) Incidents related to a Post-partum haemorrhage over 1000mls. Average of 4.15% in Q3, though reduced in December 2025 to 2.95% which is below national average of 3.4%.
- 20 (-) (20 in Q2) related to term babies admitted to the neonatal unit.
- 11 (↑) (8 in Q2) related to 3rd or 4th degree tears.
- 25 (↑) (24 in Q2) medication incidents in Q3, however, 5 and 8 noted in November and December respectively.
- 11 incidents relating to abusive, violent, disruptive behaviour, continue to be reviewed as part of incivility driver. 4 incidents relate to staff behaviour.

Issues, concerns, gaps:

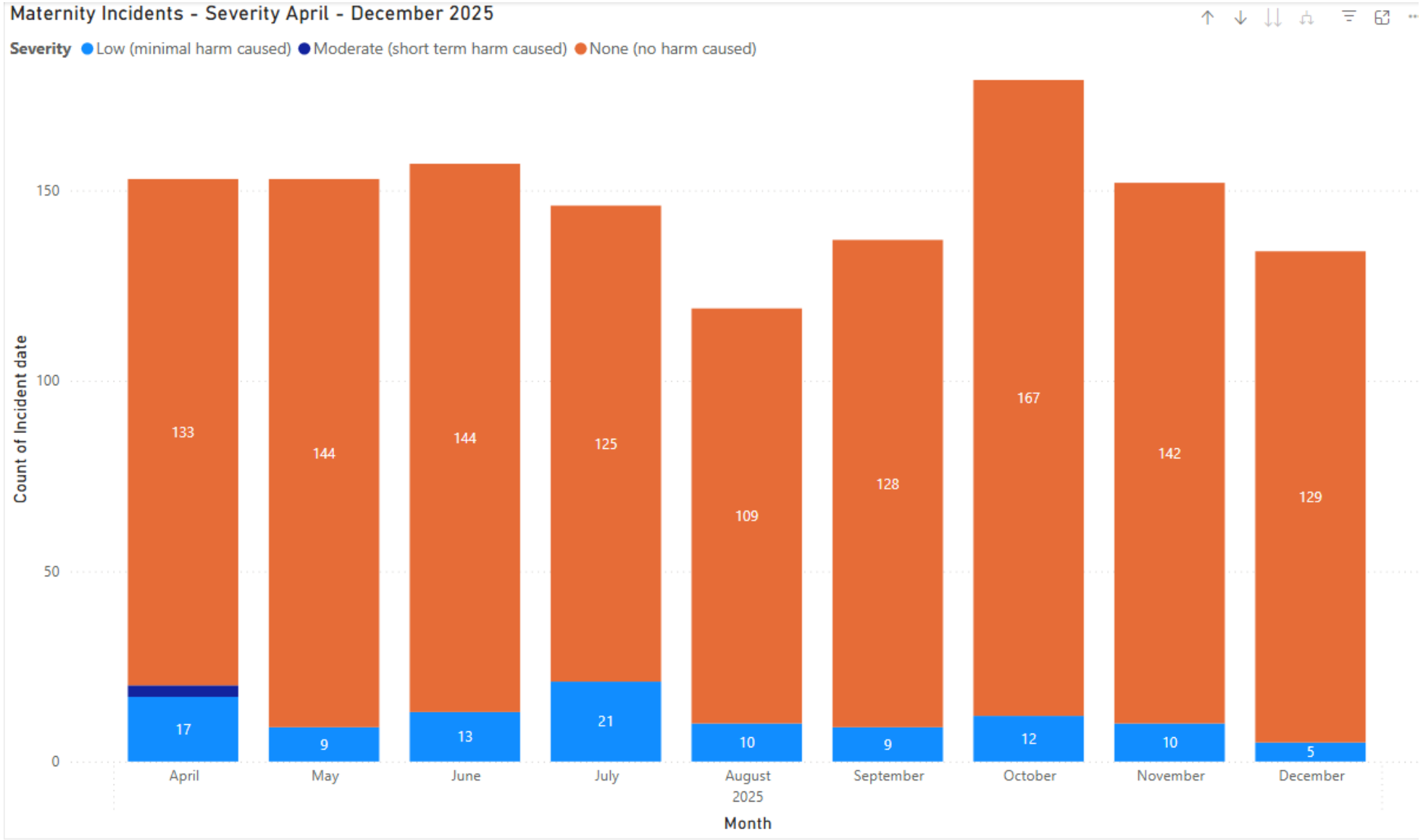
- Q3 % PPH >1500mls 4.15%. Percentage of PPH rates remain above national average 3.4% and is not reflected in the number of datixes reported.
- Slight increase in medication incidents noted in quarter.

Actions & Improvements:

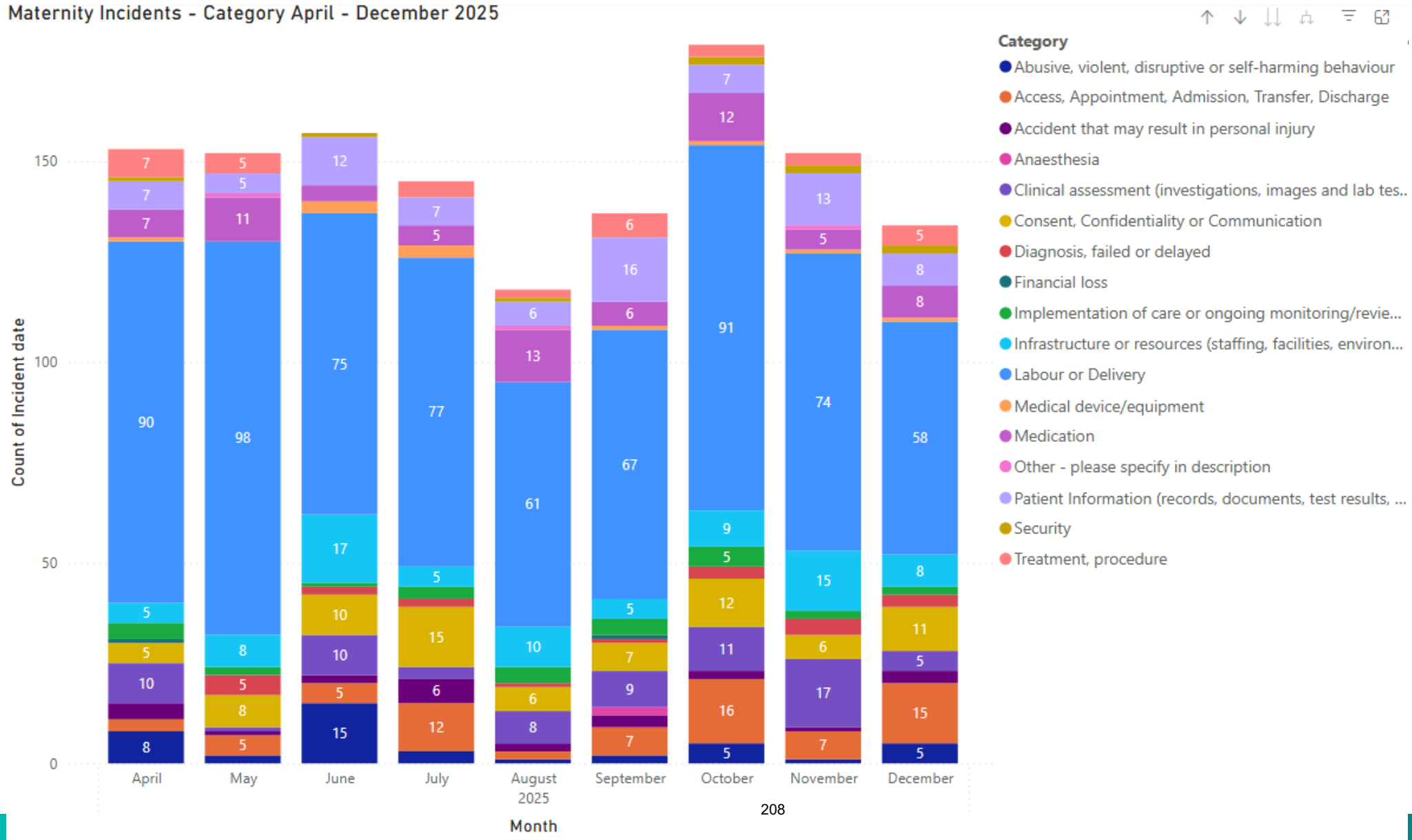
- Sustained reduction in 3rd and 4th degree tears noted, consistently below national target in quarter.
- All incidents of abusive, violent and disruptive behaviour are reviewed by the senior team and as part of the divisional driver to reduce incivility and actions taken as appropriate with individual members of staff.
- Slight increase in medication incidents, though higher numbers noted in October when resident doctors rotation took place. Planned bi-monthly teaching sessions to commence in February at audit meeting to be facilitated by women's and children's pharmacist.
- Communication to all staff via Top 5 and Maternity matters regarding the need to datix all PPHs over 1000mls. Risk midwives conducting retrospective review of PPH data from MIS to ensure no cases that meet CRIG criteria have been missed from review due to lack of datix. Communication regarding need to datix PPH will also be incorporated into PPH QIP which is underway and aligns with the newly published Maternity Care Bundle.

True North: Quality - Perinatal Surveillance Tool: Quarterly Report - Q1-Q3 25/26

Medway NHS Foundation Trust

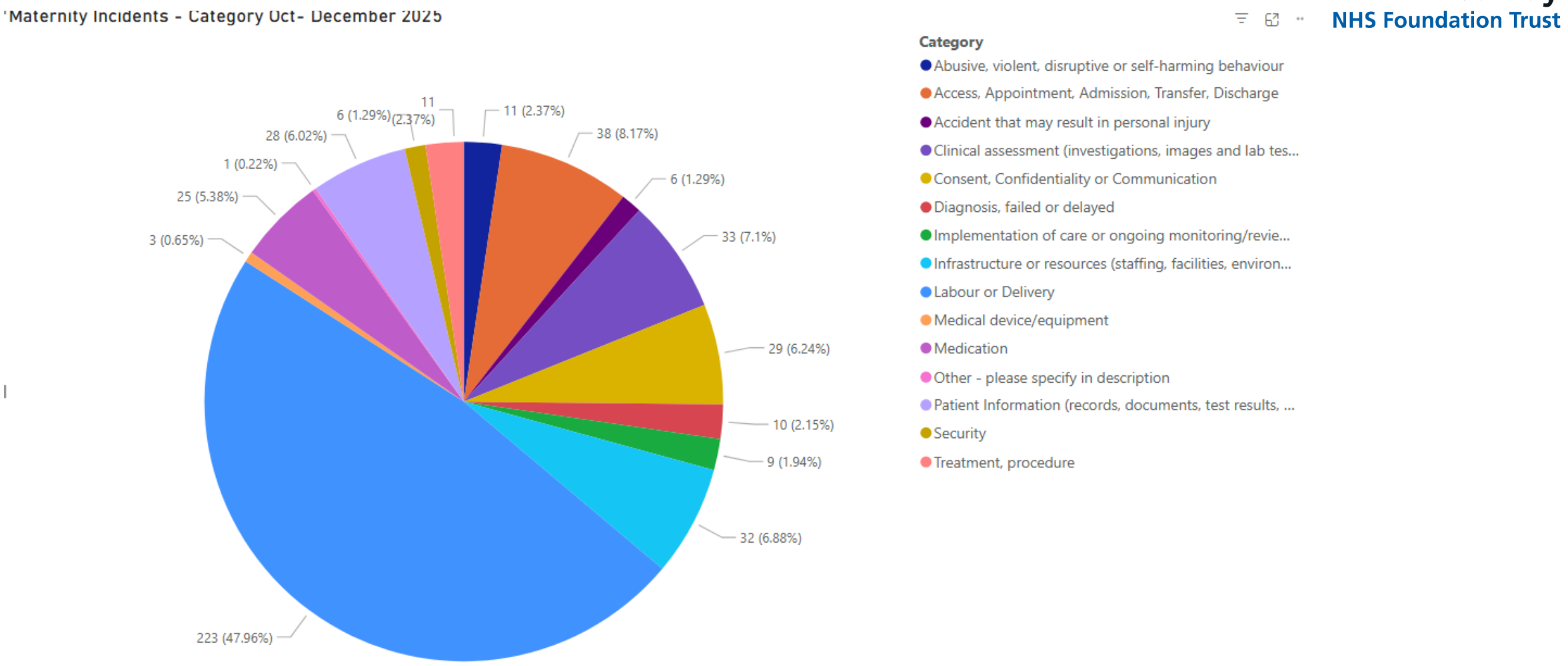


True North: Quality - Perinatal Surveillance Tool: Quarterly Report - Q1-Q325/26



True North: Quality - Perinatal Surveillance Tool: Quarterly Report - Q3 25/26

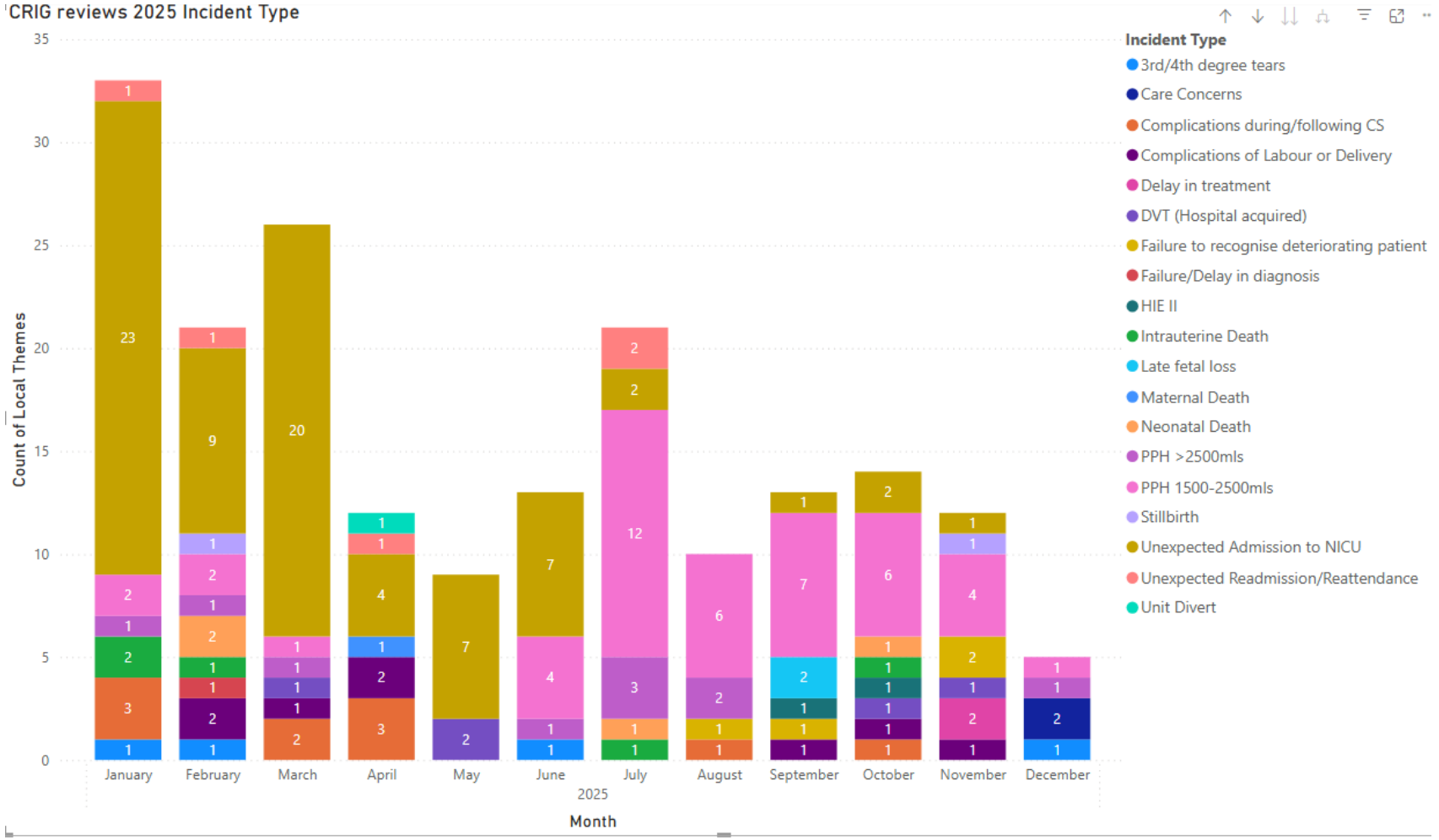
Medway NHS Foundation Trust



True North: Quality – Q3 PSIRF

Key Messages :

- PPH continues to account for the majority of CRIG reviews in Q3
- Process for reviewing ATAIN cases changed in quarter 2, with thematic reviews by dedicated ATAIN midwife being brought to meetings.
- QI project for PPH continues in Q3, with initial scoping meeting held. Key actions include:
    - Deep dive data review completed.
    - Agreement to utilise national proforma in line with the Maternity Care Bundle. Reviewing all listed risk factors and considering additional risks to be added based on local population data.
    - Staff survey to understand current understanding of management and risk factors to be run in January 2026.
    - Targeted education to be developed once proforma live and guideline updated.
    - Deep dive into cases of PPH experienced by black mothers.



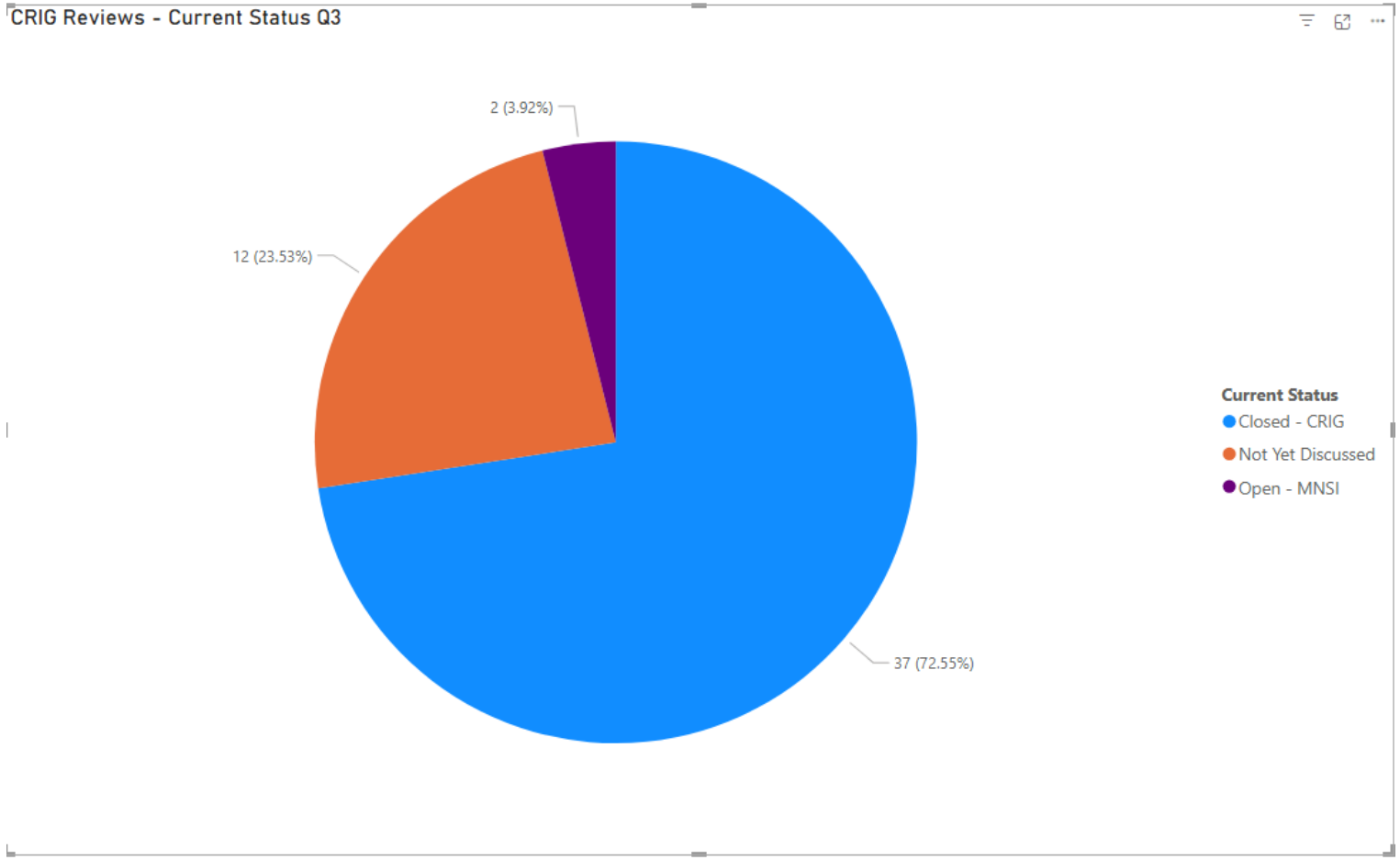
True North: Quality – Q3 PSIRF

Key Messages :

- 0 AARs declared in Q3 25/26
- 2 MNSI referrals,
    - 1 HIE II
    - Intrapartum Stillbirth.
- PMRT reviews not included in chart as reviewed outside of CRIG.
- 1 MNSI report received in quarter (maternal death, VTE)

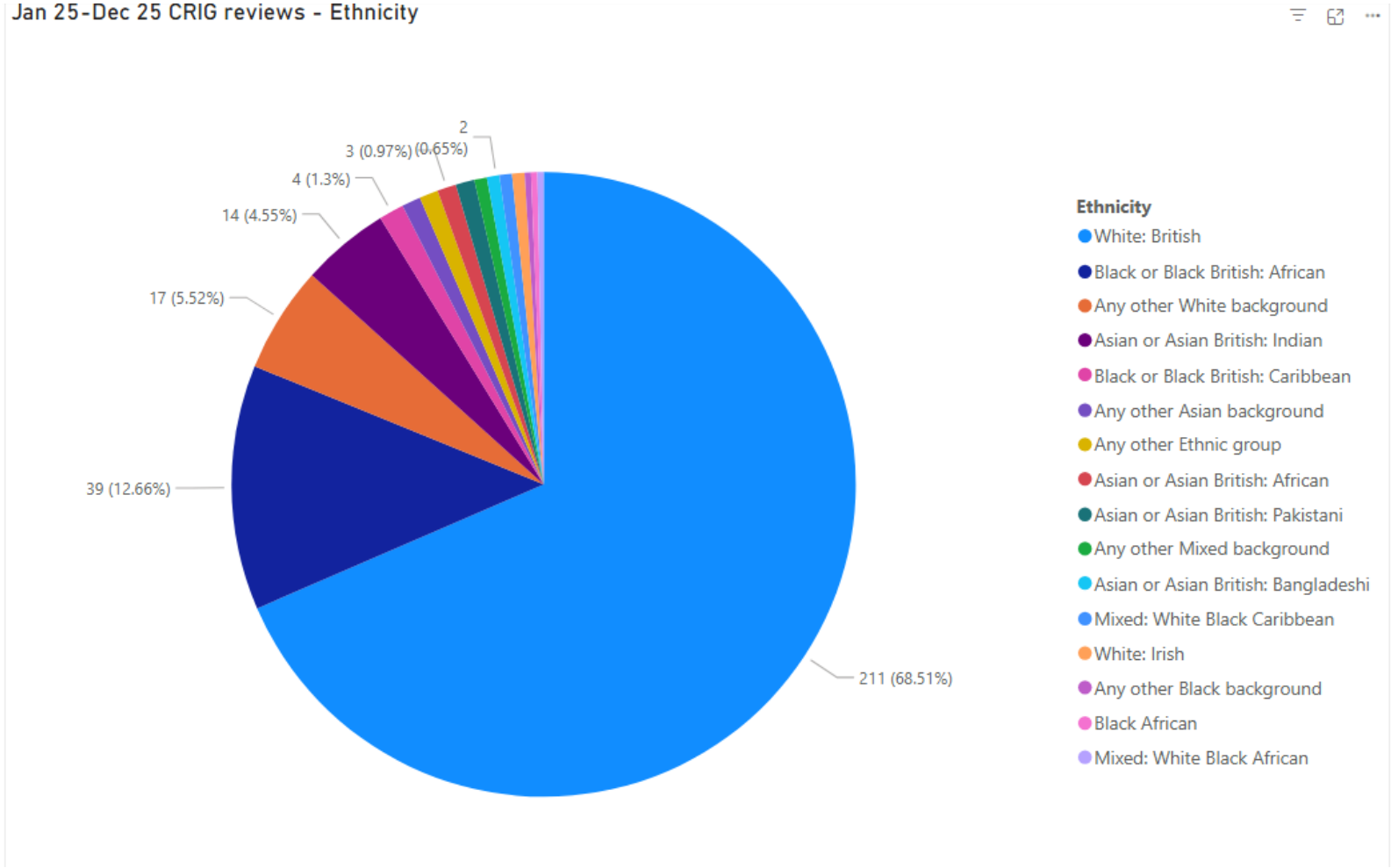
Actions & Improvements :

- QI project for VTE pathway continues in quarter following MNSI report of maternal death.
- Progress against key actions:
    - Mapping of all VTE contact points to identify gaps and concerns.
    - Co-production of Patient information with MNVP, including administration video, padlet and enhanced leaflet underway.
    - Service user feedback survey completed with feedback incorporated into QIP action plans. .
    - Engagement with pharmacy and medical colleagues to review processes.
    - Regular communication on social media for service users to promote the importance of anticoagulants.
    - Guidelines being updated in line with revised processes.
    - Project mapped against Maternity Care bundle.

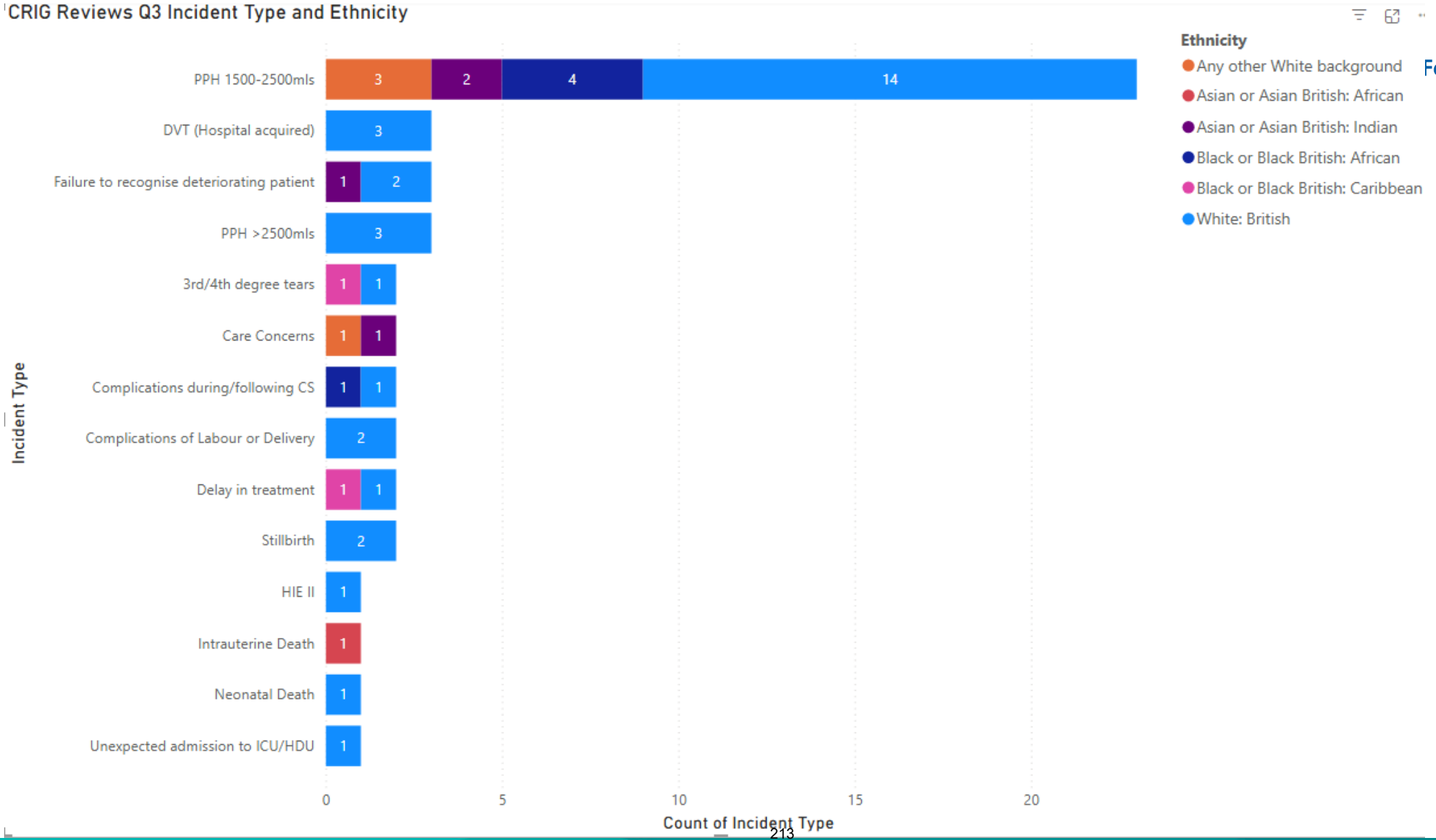


True North: Quality – Q3 PSIRF – Ethnicity Review

- Review of incidents reviewed at CRIG in 2025:
  - 68.5% White British (70% birth-rate)
  - 15% Black or Black British including African, and any other black background (9.93% of birth-rate)
  - 7.14% Asian or Asian British, including Indian, Bangladeshi and any other Asian background (7.23% birth-rate)

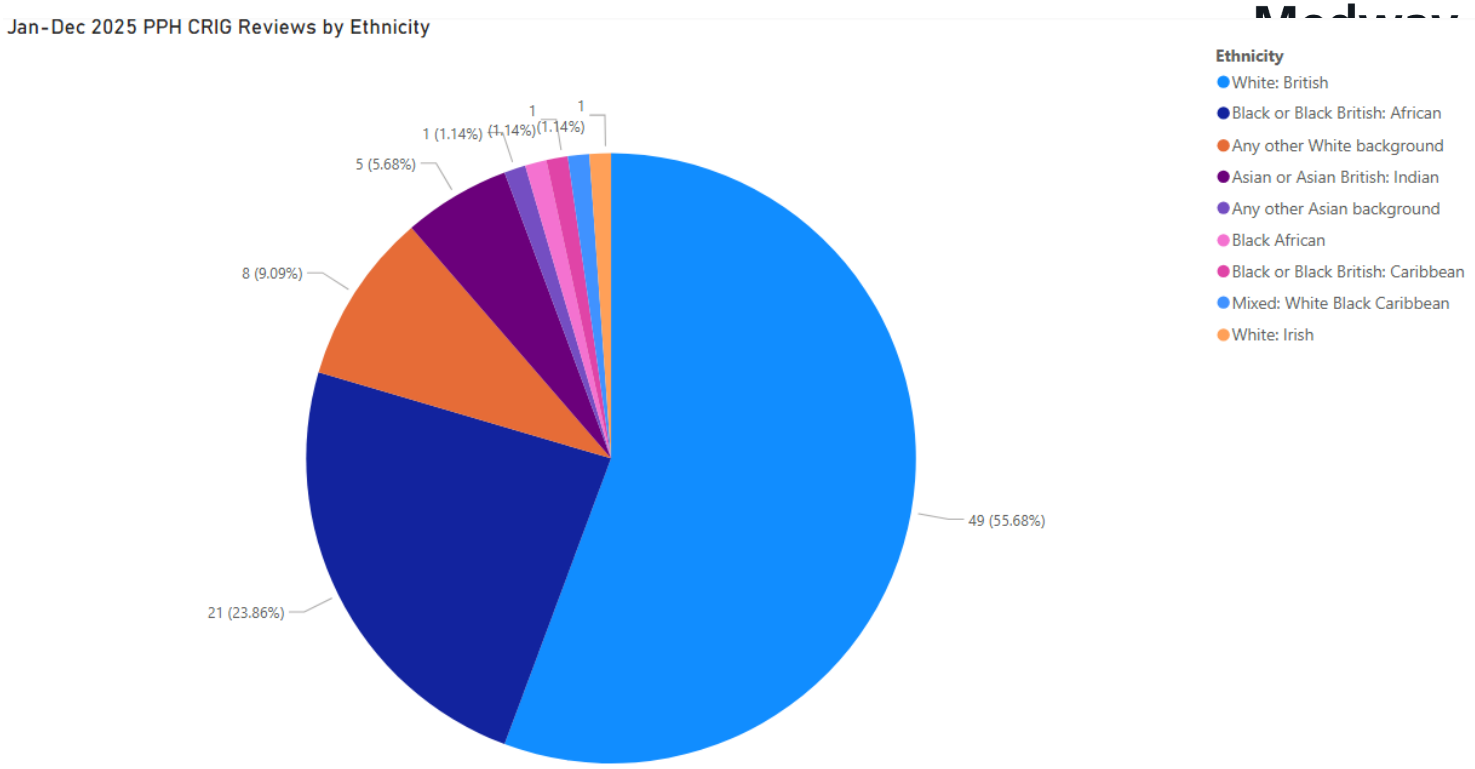


True North: Quality – Q3 PSIRF – Ethnicity Review



True North: Quality – Q3 PSIRF – Ethnicity Review - PPH

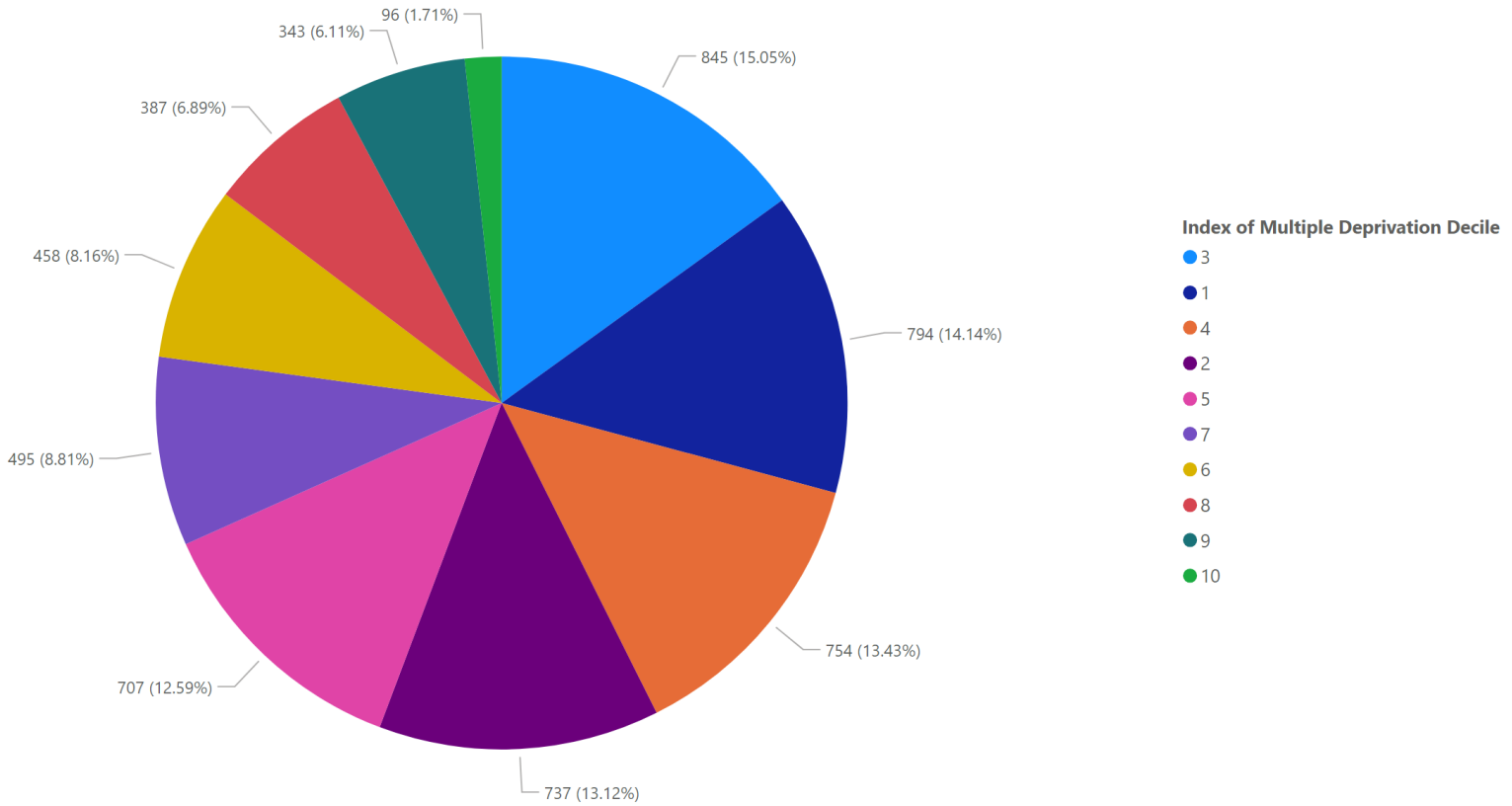
- Review of the PPHs that were reviewed at CRIG >1500mls and >2500mls in 2025 39.46% of PPH reviewed at CRIG were experienced by black mothers
- In Q3 there were 26 PPH >1500mls reviewed at CRIG (decrease from 32 in Q2) . 4 of these were experienced by black mothers. (15%)
- In Q3 there were 3 PPH >2500mls. 0 of these experienced by black mothers.
- This continues to be a disproportion from their 9.93% contribution to the Birth-rate.
- The PPH QIP working group has reviewed the data for the past 18 months and undertaking a deep dive audit into ethnicity, risk factors (eg. Smoking, fibroids, haematological problems) and management (eg. Compliance with guidelines, prophylactic management, escalation to obstetricians) of PPH.
- Data shows that for April 2024 to September 2025 19% of PPHs over 1500mls were experienced by black mothers. This work is being supported closely by the PE & EDI midwife, along with obstetric, education and the senior midwifery team.



True North: Quality – Q3 PSIRF – Deprivation Score

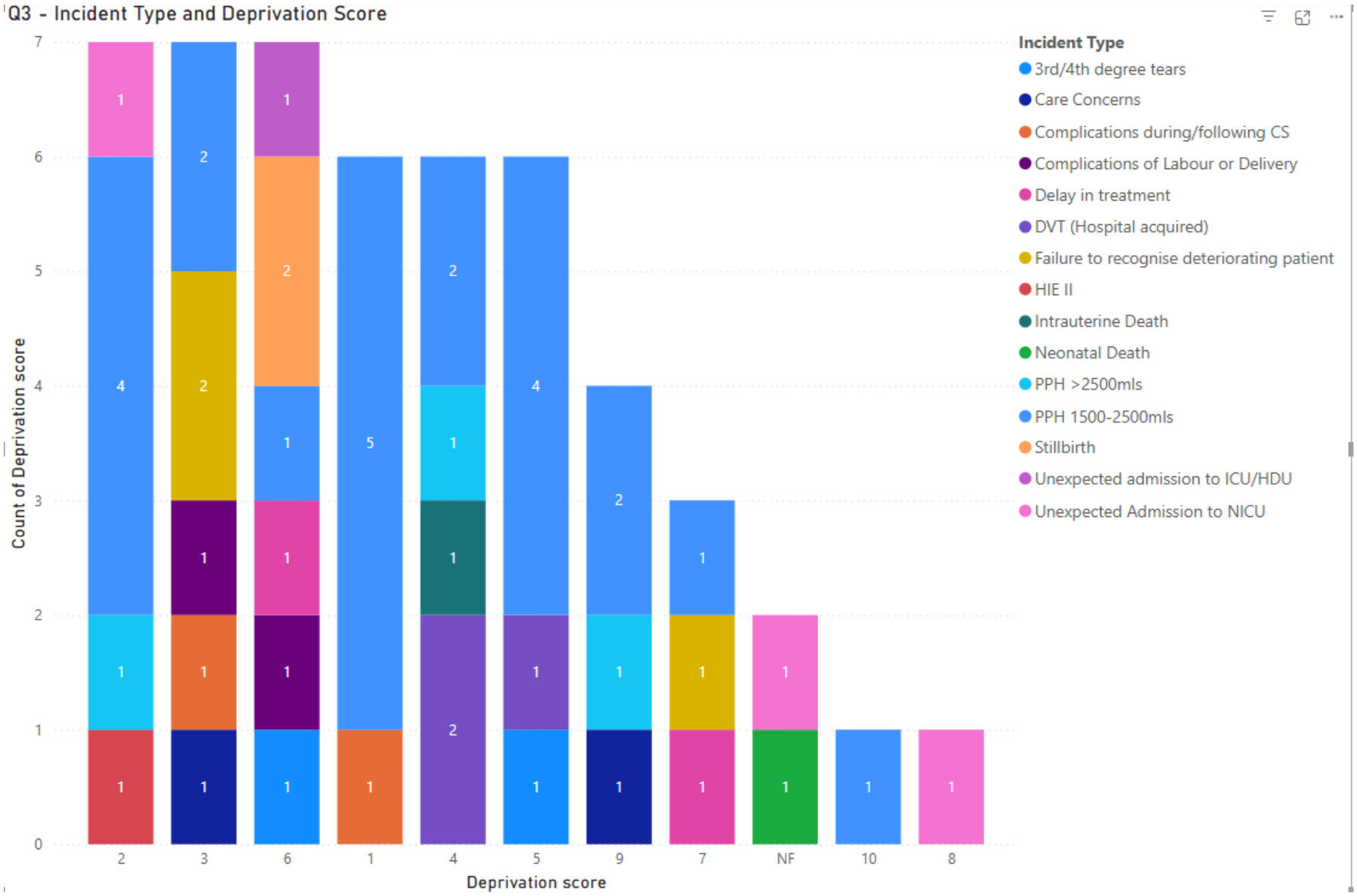
NHS Medway NHS Foundation Trust

MFT Booked Maternity Patients Date of delivery 24/25 Index of Multiple Deprivation Decile



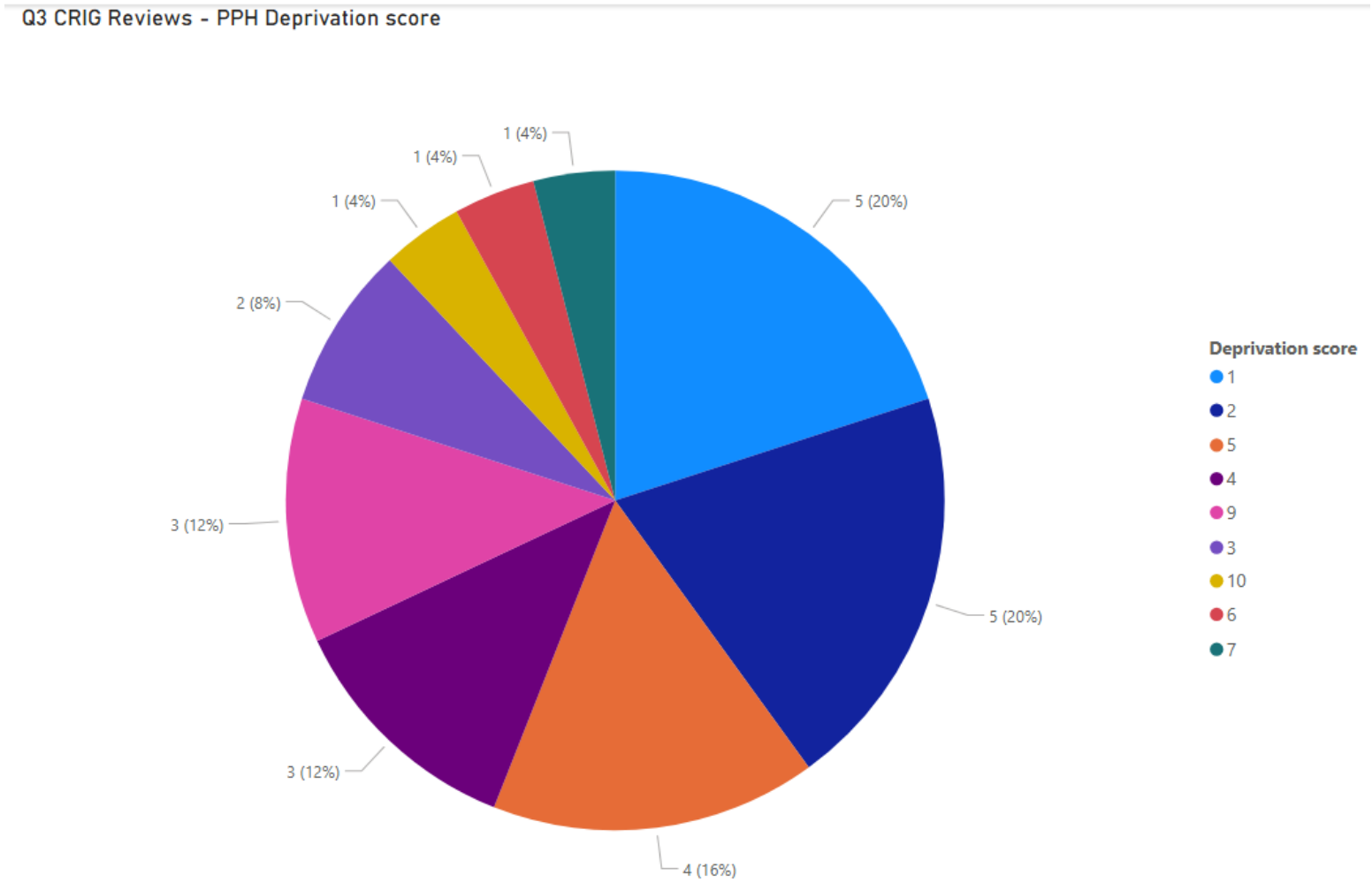
- On review of the booking population with EDD in 2024/2025
- 14% in Multiple Deprivation Decile (MDD) 1
- 13% in MDD 2
- 15% in MDD 3
- 13% in MDD 4
- 13% in MDD 5
- **69% of booking population in lowest 5 centiles.**

True North: Quality – Q3 PSIRF – Deprivation Score



True North: Quality – Q3 PSIRF – Deprivation Score

Medway NHS Foundation Trust



- 76% of PPH >1500mls were from MDD Score 1-5 (compared to 69% of booking population). (Reduction from 83.7% in Q2)
- Part of the PPH QIP project will be looking at demographic details and additional risk factors these groups might have to review management and risk assessment.

Complaints & PALS

Medway NHS Foundation Trust

Key Messages:

- 10 complaints received in Q3 (increase from 6 in Q2)
- 46 PALS contacts. (increase from 21 in Q2)
- Delivery Suite and the Birth Place each received 3 complaints in quarter.

- Complaint themes Jan 25-Dec 26
  - Lack of Nursing Care and attention – 17%
  - Lack of medical care and attention – 11%
  - Complications during labour and delivery - 11%
  - Delays in treatment – 11%

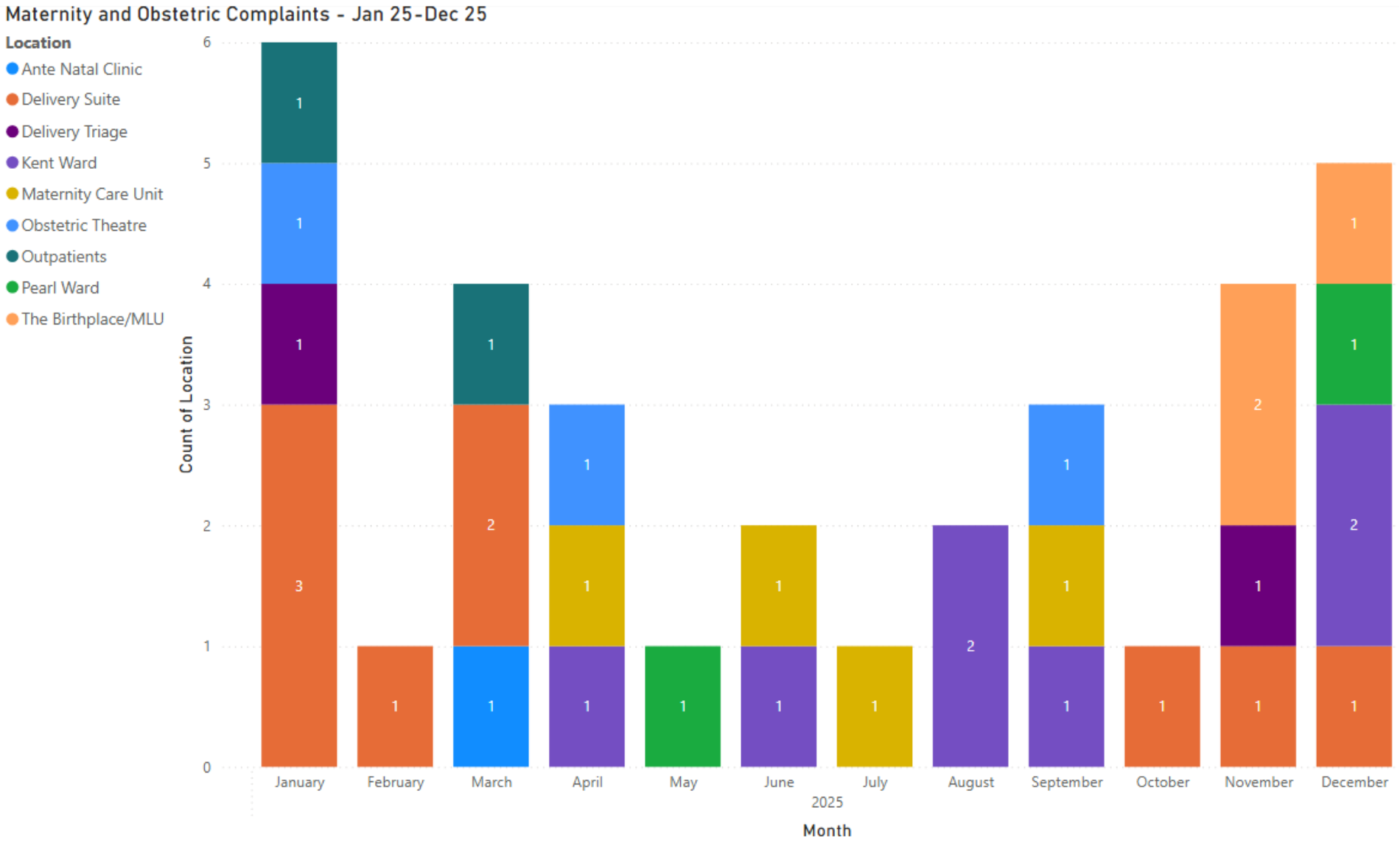
PALS themes Oct Jan-December 2023

- All aspects of clinical treatment 26%
- Communication to Patients – 30%
- Compliments – 15%
- Delays in Treatment 12%

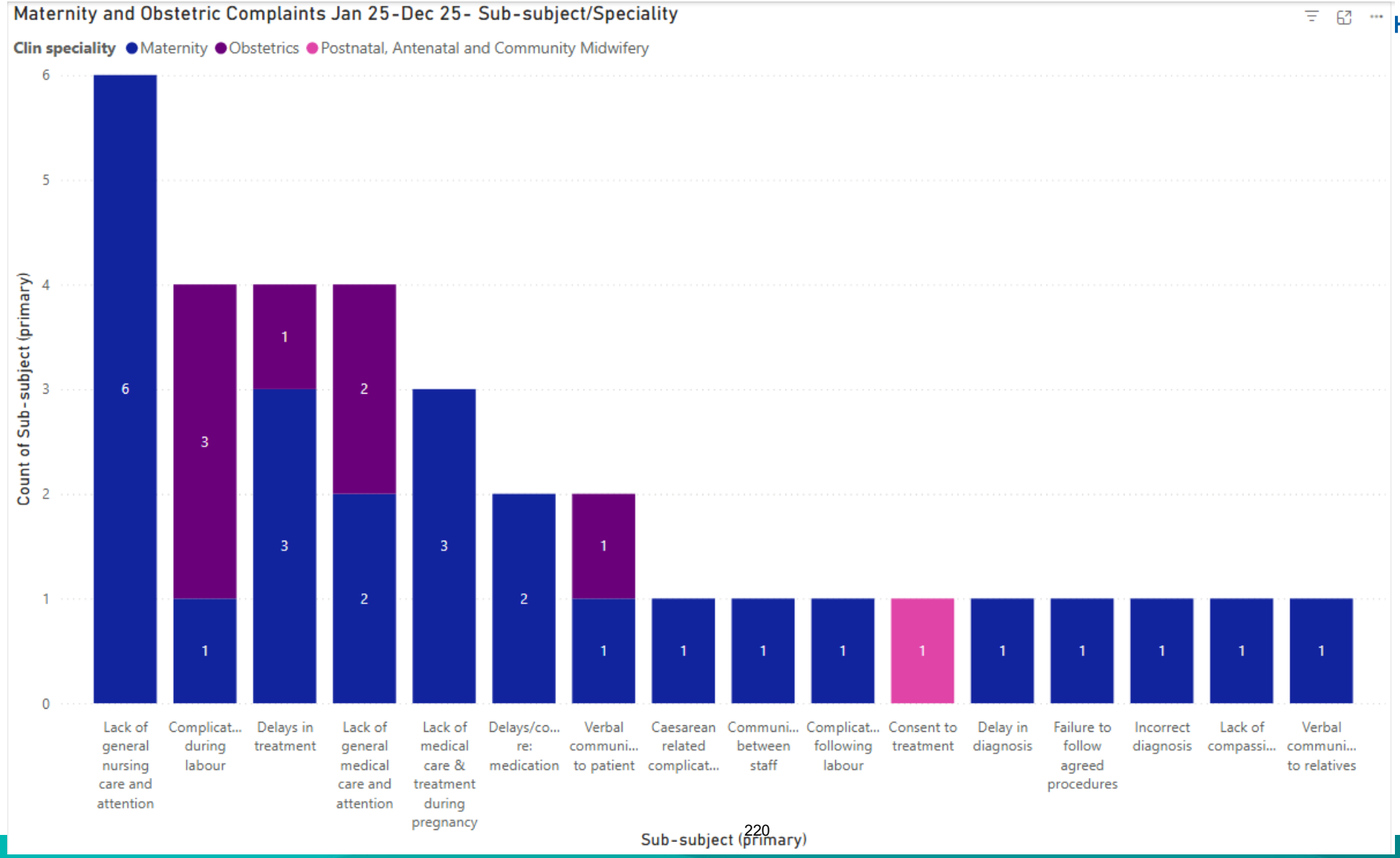
Actions and Improvements :

- Improved senior sister oversight of all complaints to support accountability and direct learning for each area
- Medical and nursing staff to be supported to attend Patient Experience training
- Feedback from complaints continued to be shared with teams and incorporated into Mandatory Training/Simulations with emergency drills for obstetric and neonatal scenarios based on real complaints
- High number of complaints rate to high-risk ie induction, emergency C-section, neonatal resus- share importance of real time debrief at audit / staff meetings etc
- Patient information improvements as part of our QIPs- co-produced with MNVP Clear leaflets, padlets
- Real-time feedback via FFT- QR codes in place
- Trust Customer care training ongoing. Emphasis at this training on empathy and respect in stressful situations.
- Recognition awards in place.
- Celebrate success- all positive feedback shared in team meetings and newsletters and Fri Trust comms

Complaints

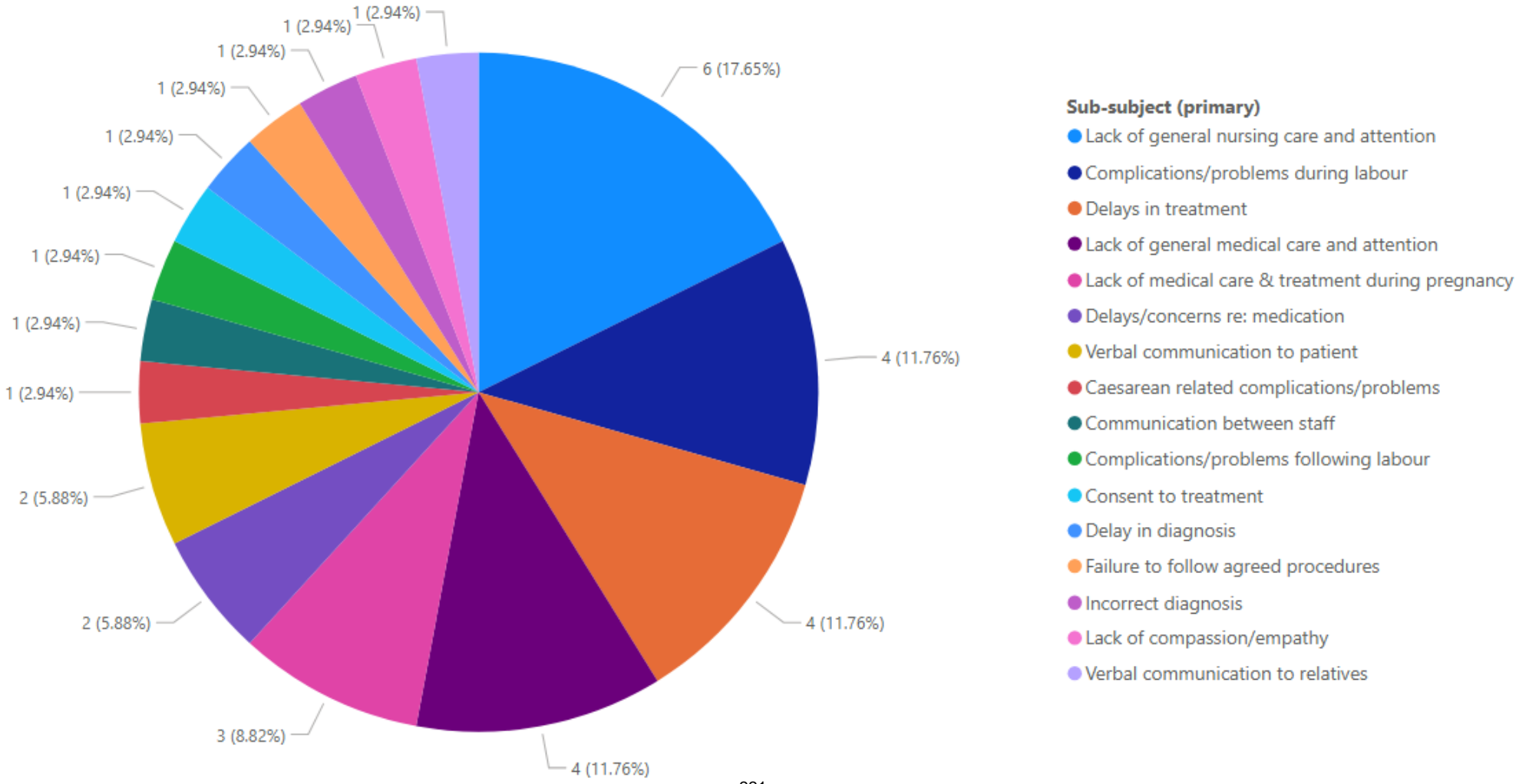

Maternity and Obstetric Complaints - Jan 25-Dec 25
Location
Ante Natal Clinic
Delivery Suite
Delivery Triage
Kent Ward
Maternity Care Unit
Obstetric Theatre
Outpatients
Pearl Ward
The Birthplace/MLU
Count of Location
0
1
2
3
4
5
6
January
February
March
April
May
June
July
August
September
October
November
December
2025
Month

Complaints

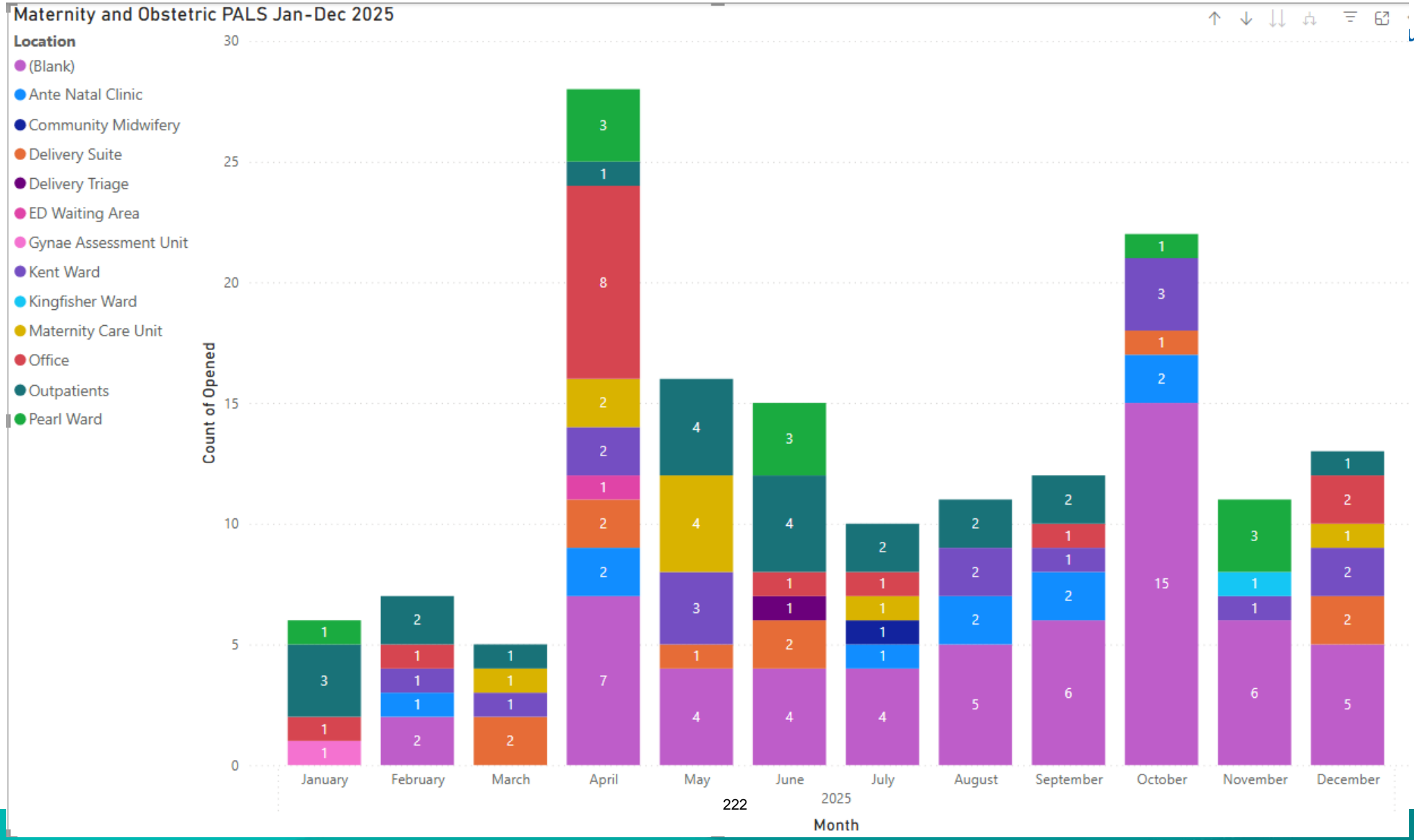

Maternity and Obstetric Complaints Jan 25-Dec 25- Sub-subject/Speciality
Clin speciality Maternity Obstetrics Postnatal, Antenatal and Community Midwifery
Count of Sub-subject (primary)
0
1
2
3
4
5
6
6
1
3
3
1
2
2
3
2
1
1
1
1
1
1
1
1
1
1
1
Lack of general nursing care and attention
Complicat... during labour
Delays in treatment
Lack of general medical care and attention
Lack of medical care & treatment during pregnancy
Delays/co... re: medication
Verbal communi... to patient
Caesarean related complicat...
Communi... between staff
Complicat... following labour
Consent to treatment
Delay in diagnosis
Failure to follow agreed procedures
Incorrect diagnosis
Lack of compassi...
Verbal communi... to relatives
Sub-subject (primary)

Complaints

Maternity and Obstetric Complaints Jan 25-Dec 25 Sub-subject

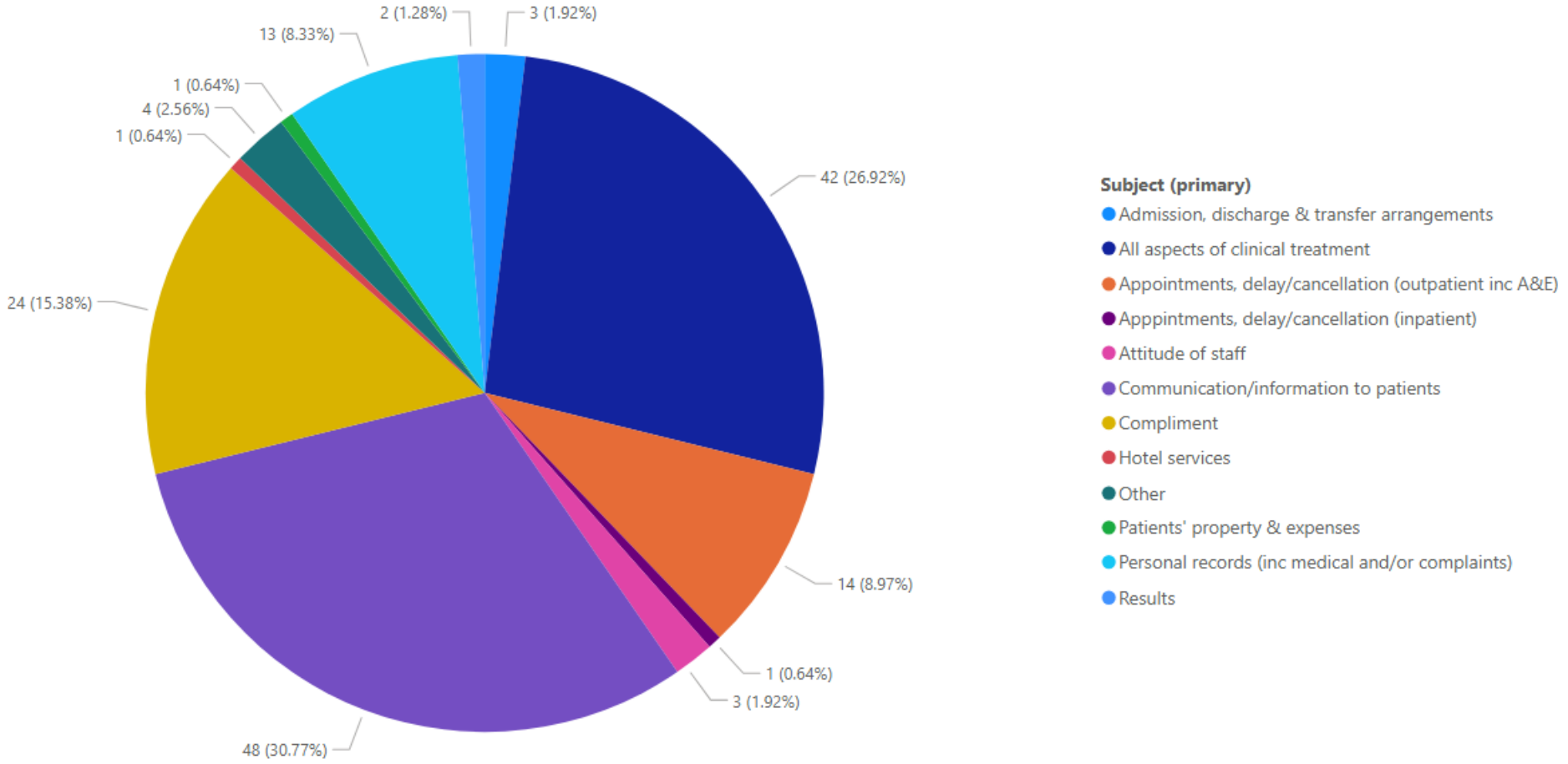


PALS


Maternity and Obstetric PALS Jan-Dec 2025
Location
(Blank)
Ante Natal Clinic
Community Midwifery
Delivery Suite
Delivery Triage
ED Waiting Area
Gynae Assessment Unit
Kent Ward
Kingfisher Ward
Maternity Care Unit
Office
Outpatients
Pearl Ward
Count of Opened
0
5
10
15
20
25
30
January
February
March
April
May
June
July
August
September
October
November
December
2025
Month

PALS

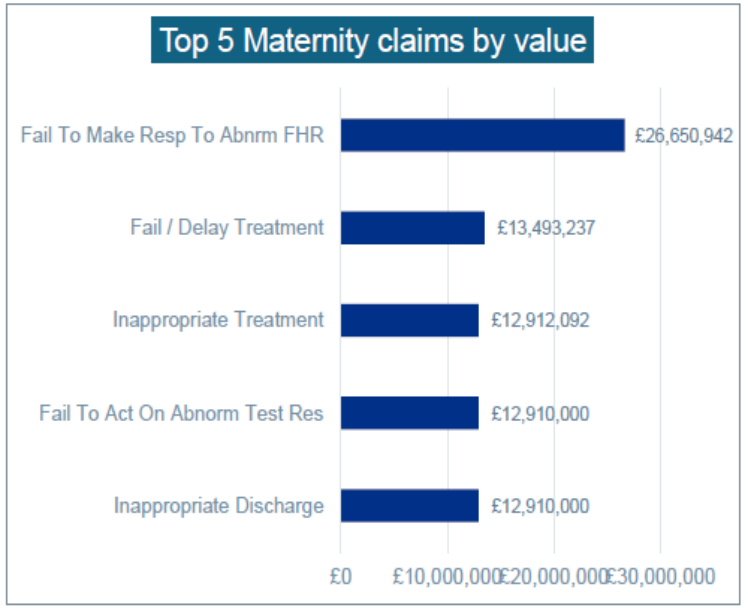
Maternity PALS - Jan 25-Dec 25 - Subject



True North: Quality – Claims

Key Messages:

- New scorecard was published in September 2025.
- Full detail of scorecard has not been made available to maternity team so detailed analysis on all claims cannot be undertaken.
- 54% of claims on the NHS Resolution Scorecard were closed without damages and 48% were settled with damages paid.
- There are 25 open claims on the current scorecard and 37 closed.
- NHSR coding suggests the highest volume of claims (16) were due to alleged fail/delay in treatment. All other codes had less than 5 claims.
- The highest value claims were relating to failure to respond to abnormal fetal heart.
- The highest injury code by volume was unnecessary pain (10), followed by stillborn (7)
- The highest injury codes by value were brain damage, followed by cerebral palsy.



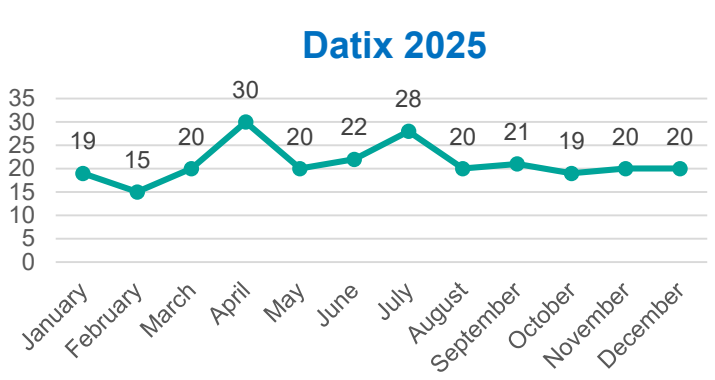
Issues, concerns, gaps:

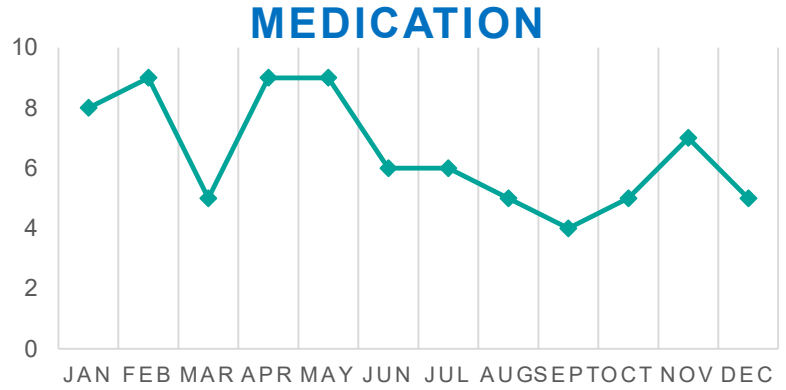
- The scorecards are affected by a significant data quality issue, whereby the speciality is incorrectly coded in a proportion of claims, and the cause ("fail/delay diagnosis", "fail/delay treatment" etc.) is also not always accurate. This is a national issue, that in large part perpetuates due to absence 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.

Actions & Improvements:

- Continue to work with legal and NHSR to get access to full scorecard data to enable data cleansing of incorrect coding and identify themes and trends from all claims, not just closed.
- Continue to ensure robust governance processes in place with CRIG and PMRT reviews and escalation to the appropriate committee of all cases that warrant further investigation.
- Continue to train and support staff to embed the PSIRF model, identifying areas for quality improvement to support patient safety.
- Continue to update training courses such as fetal monitoring and PROMPT with learning from incidents and service user feedback to ensure learning from cases are shared with all staff to improve outcomes across the service.

Quality: Success and Challenges in NICU





NHS Medway NHS Foundation Trust

Key Messages:

- 20 reported incidents (Datix) for November
- 20 reported incidents (Datix) for December

Common theme:

- Medication Incidents – slight increase in November (7) but then a reduction in December (5).
- Implementation of care/Treatment Incidents
- Neonatal Transport – Infrastructure and Medical Device.

Levels of Harm:

- 6 cases reported with "Low Harm" in November
- 2 cases reported with ''Low Harm'' in December

Safety Alerts/National Reminders/Other issues:

- BAPM: LISA

Formal Reviews/Investigations:

- AO inquest scheduled on 10/4/2026

Unit activity - 2 closures in November

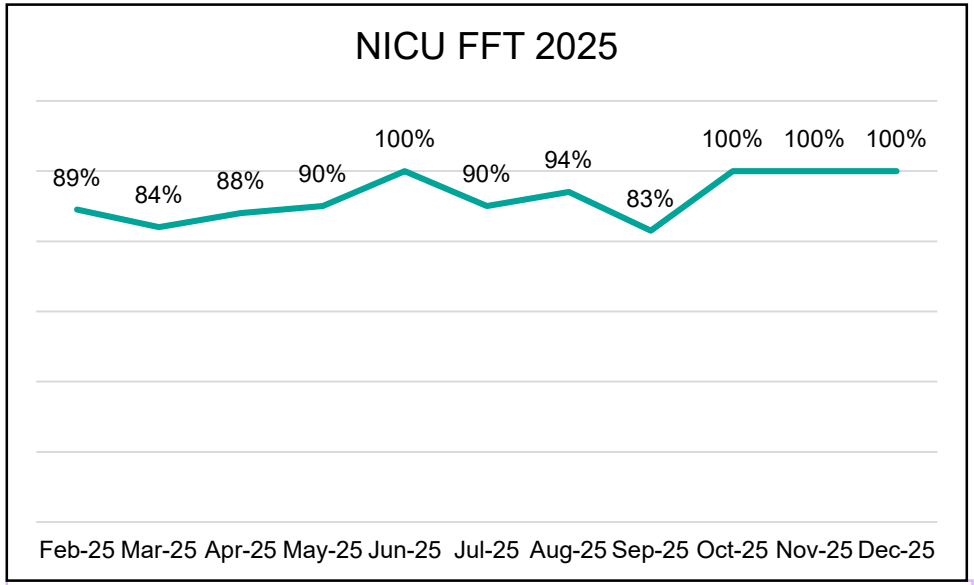
Issues/Concerns/Gaps:

- **Medication Datix**:
  - Administration (5); Prescription (6)
    - Rates swapped for TPN
    - Expired Bespoke TPN (not changed)
    - Overdose of Teicoplanin (6.8mg vs 68mg)
    - No fluid prescription for a baby transferred from another unit, using transport prescription.
    - Error in prescription from old to new drug charts (weight & route).
- **Implementation of care**
  - Nasal skin breakdown of baby with nasal CPAP
  - Long line leak and dislodgement
- **Neonatal transport**:
  - Broken ambulance delaying time critical transfer
- **Completed local investigation of EST** – rejected case by MNSI. We have identified areas of improvement, but overall the baby did not needed cooling during the time of assessment.

Actions/Improvements/ Next Steps:

- **Medication incidents**
  - Continued bi-weekly review of medication incident
  - Updating of drug and fluid charts to prevent prescribing errors – with possible use of checking stickers for nurses to confirm prescriptions are correct
  - Encourage use of "Change every 24hours sticker" for Bespoke PN – Plan to make large so more viable.
- **Implementation of Care/Treatment**
  - Liaised with Trust TVN for skin breakdown. Exploring options for use of barriers – cannulaide
  - Medical education team to create a guide on how to properly secure lines and how to use Vygon Fr 2.0 with small needle (correct positioning of hub to prevent accidental puncture of line)
- **Neonatal Transport**
  - New Ambulances on order.
- **Other**:
  - Review possibility of improving badgernet scoring for HIE to automatically assign level based on the inputted assessment.
  - Explore use of automated screening tool in grading HIE level (used by Imperial College research)
  - Badgernet integration with blood gas machine – awaiting update.

NICU- FFT and Complaints



Key Messages:

- 2 Complaint received for December 2025
- FFT 100% , 25 responses (November) and 23 responses (December)
  - Continued improvement from previous months
  - Lots of positive feedback from parents
    - Kind, Compassionate, supportive staff
    - Warm and welcoming
    - Environment was clean and tidy
    - Good communication, updated with plans
    - Help with feeding support

Issues/Concerns/Gaps:

- FFT:
  - "Would have liked more regular updates"
  - "Better communication between departments would have been helpful"
  - "A lot of information to take in"
  - Would have been nice if accommodation included husbands

Actions/Improvements/ Next Steps:

- Regular badgernet entries are sent to families- at least once a shift- encourage staff to be more proactive with sending updates, as well as managing expectations of parents with regard to updated schedule; making a plan with them.
- Continue to work on communication across NICU and maternity, building relationships, facilitating joint simulations to improve processes
- Have regular check in with families in our care ensuring they have all the information in digestible chunks, admission packs given to every family, including all the info they can read in their own time.

True North: Quality

Key Messages:

- **Maternity Outcomes Signal System (MOSS)** launched in November 2025.
- MOSS flags potential safety issues, prompting a locally led critical safety check to determine if there are real safety issues.
- The MOSS charts produces “signals” of potential safety issues in maternity care arising during labour and birth using stillbirths and term neonatal deaths up to 28 days.
- From 2026 this will also include HIE II and III.
- Trends are plotted based on the accumulation of events compared to a national reference rate.
- A rise indicates the rate of events is increasing compared to reference rate.
- Signals are generated when there is a doubling in the rate of events compared to the reference rate. The colour of signals simply refers to the statistical confidence – amber means MOSS is 95% confidence the rate has doubled (level 1) and red means MOSS are 99% confident .
- The plotted dots on the blue line do not directly refer to the number of incidents in a month, but are a cumulative calculation based on all available data against the reference range. i.e. there were no incidents meeting MOSS criteria in December, however the plotted point is not at “0”.
- Dots above the threshold lines would be amber and red alerts respectively and would require the Trust to complete a “critical safety check”.
- This check would review key metrics such as staffing and acuity for the past 3 months which with the goal of determining if there was any underlying factors creating safety issues.
- Reviews would need to be carried out within 8 working days and signed off by the Trust and ICB.
- The MOSS SOP has been shared with the Trust Patient Safety team and a local SOP is being developed to support the governance processes and signoff within the Trust and the region.

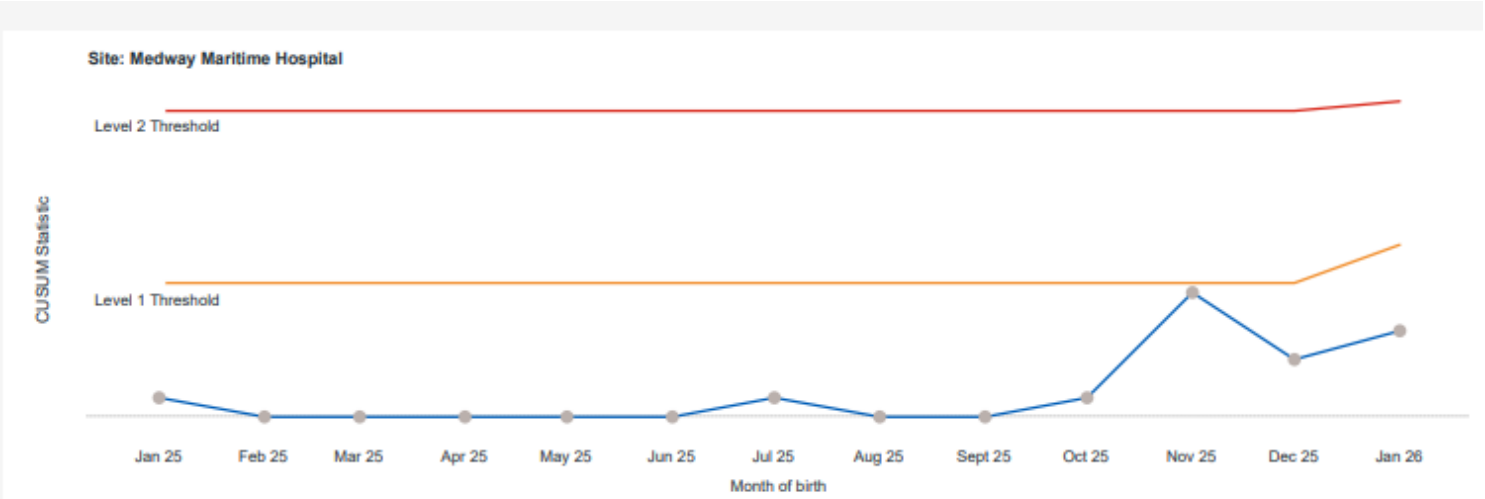


Table of Events - Trust: Medway NHS Foundation Trust

Date of term birth	Events (term only)	Site name
14 Jan 26	1 Term Stillbirth(s)	Medway Maritime Hospital
19 Nov 25	1 Term Neonatal Death(s)	Medway Maritime Hospital
09 Nov 25	1 Term Stillbirth(s)	Medway Maritime Hospital
17 Oct 25	1 Term Stillbirth(s)	Medway Maritime Hospital
09 Jul 25	1 Term Neonatal Death(s)	Medway Maritime Hospital
23 Jan 25	1 Term Stillbirth(s)	Medway Maritime Hospital

Of note:

- Term Neonatal Death November 2025 – known congenital abnormality
- Term Still Birth November 2025 – Placental Abruption
- Term Still Birth October 2025 – Placental Abruption

Perinatal Surveillance Tool Q3 25/26 Perinatal Mortality Review Tool

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

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

Medway NHS Foundation Trust

Key Messages :

- 9 (↓) MBRRACE reportable cases in Q3
- 7 Neonatal deaths – all extreme prematurity or expected due to diagnosed congenital abnormalities.
- 5 PMRTs completed in Q3, no care gradings of C or D noted.
- 43 PMRT actions have been identified in 2025, with a thematic breakdown showing 13 relate to communication with families and 16 relating to guidelines, policies and procedures.

Issues, Concerns & Gaps:

- Recommendations and actions discussed at PMRT meetings are not always converted into SMART actions with key stakeholder involvement.
- Care gradings of C or D (may have made a difference to outcome for mother or baby or would have made a difference to the outcome for mother or baby) are not routinely escalated through Trust PSIRF process.

Actions & Improvements :

- Review process with key PMRT stakeholders across maternity and neonatal to consider taking the recommendations and actions from PMRT to an MDT group with operational/service level responsibility to ensure actions are SMART and are held centrally to ensure effective monitoring and oversight.
- Update Trust Incident management policy to reflect need to send C or D graded PMRT reviews to PSIRG.

PMRT Actions 2025 – Theme/Contributory Factor	
Communication - Communication Management	3
Communication - Communication Management - Ineffective communication flow to staff up, down and across	1
Communication - Communication Management - Ineffective interface for communicating with other agencies (partnership working)	1
Communication - Communication Management - Lack of effective communication to patients/relatives/carers of risks	1
Communication - Verbal communication - Inappropriate tone of voice and style of delivery for situation	3
Communication - Written communication	2
Communication - Written communication - Lack of information to patients	1
Communication - Written communication - Records incomplete or not contemporaneous (e.g. unavailability of patient management plans, patient risk assessments, etc)	1
Education and Training - Appropriateness	1
Education and Training - Competence - Lack of knowledge	1
Equipment - Usability	1
Organisational - Organisational structure	1
Patient Factors - Clinical Conditions	1
Patient Factors - Clinical Conditions - Complexity of condition	2
Patient Factors - Physical Factors	2
Patient Factors - Social Factors	3
Staff Factors - Cognitive Factors	1
Task Factors - Guidelines, Policies and Procedures	11
Task Factors - Guidelines, Policies and Procedures - Not adhered to / not followed	1
Task Factors - Procedural or Task Design	4
Team Factors - Leadership	1
Grand Total	43

Perinatal Surveillance Tool Q3 25/26 Perinatal Mortality Review Tool

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Medway NHS Foundation Trust

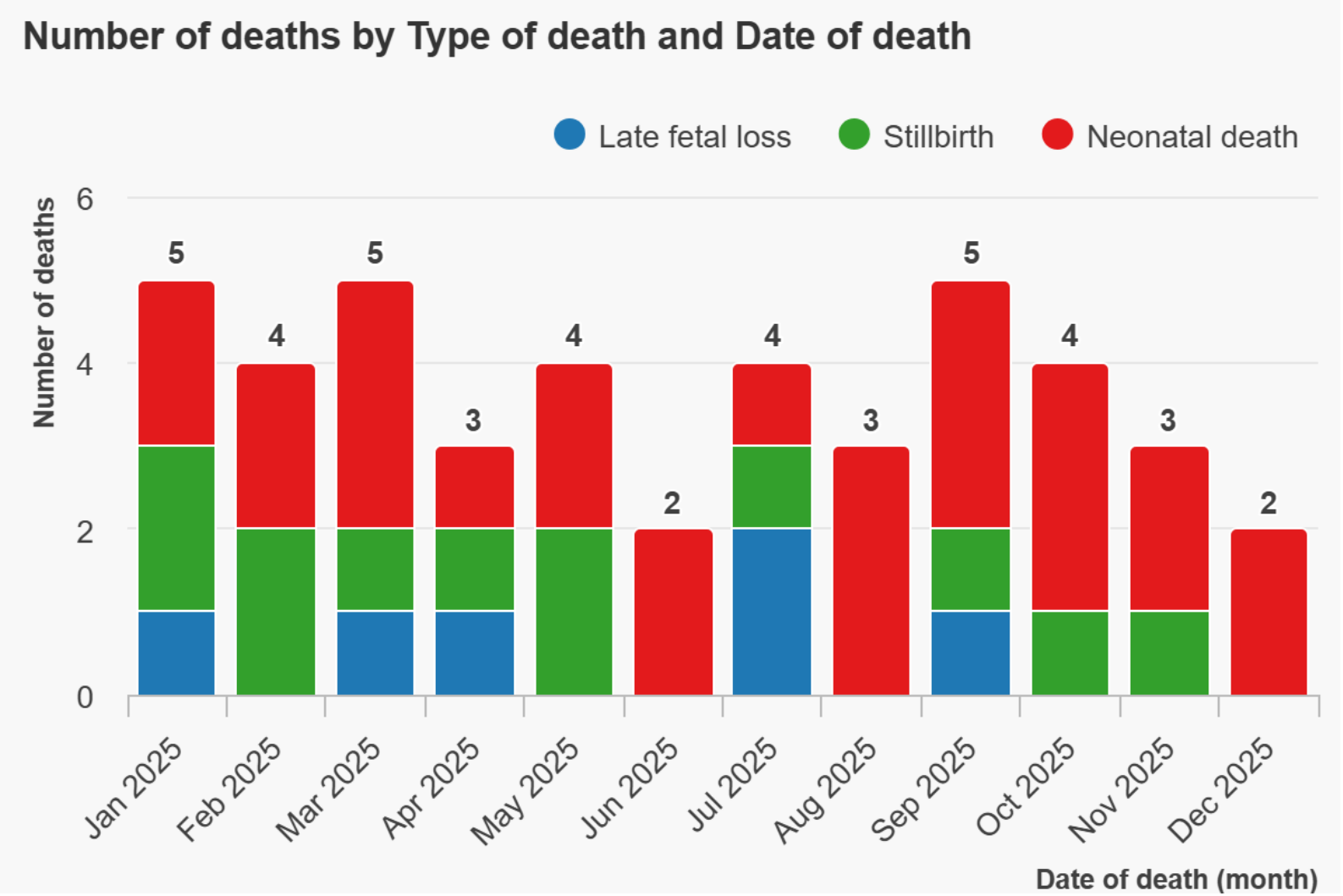
Perinatal Case ID	Grading of care of the mother and baby up to the point that the baby was confirmed as having died	Grading of care of the mother following confirmation of the death of her baby	Grading of care of the mother and baby up to the point of birth of the baby	Grading of care of the baby from birth up to the death of the baby	Grading of care of the mother following the death of her baby
99331/1	A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	-		
99362/1	A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	-	-	-
99439/1	A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	-	-	-
99772/1	-	-	A - The review group concluded that there were no issues with care identified up the point that the baby was born	B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	A - The review group concluded that there were no issues with care identified for the mother following the death of her baby
99912/1	-	-	B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	A - The review group concluded that there were no issues with care identified for the mother following the death of her baby

Perinatal Surveillance Tool Q3 25/26– Perinatal Mortality Review Tool

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

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

Medway NHS Foundation Trust



Perinatal Surveillance Tool Q3 25/26– Perinatal Mortality Review Tool

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

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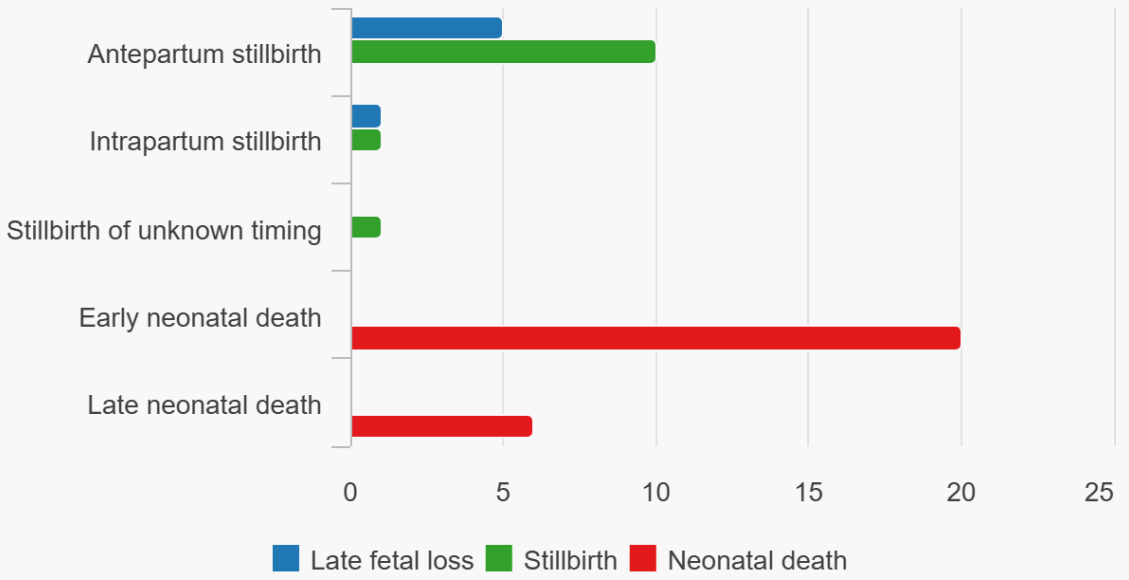
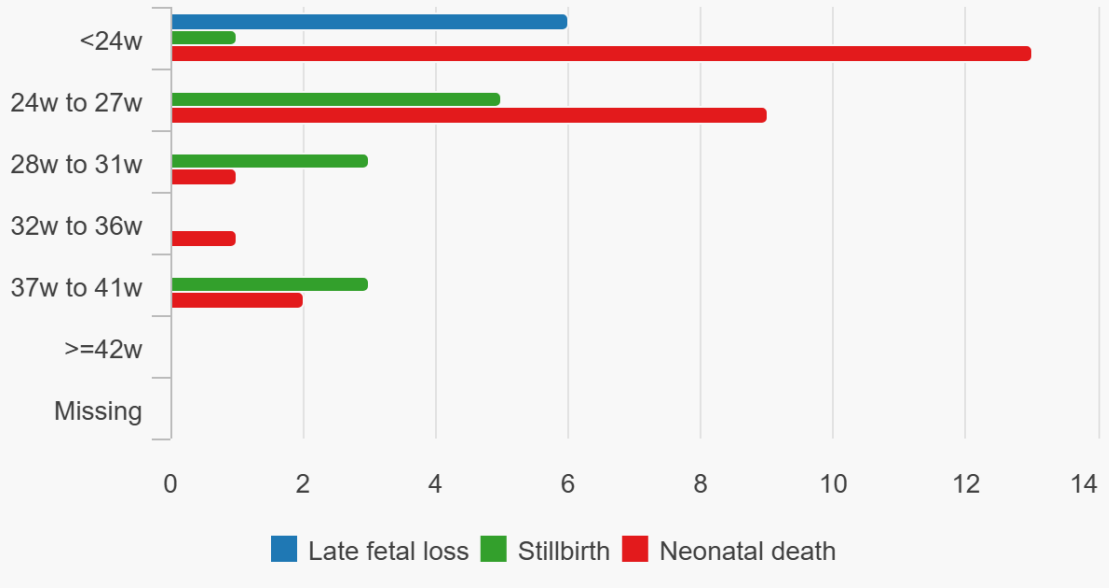
Medway NHS Foundation Trust

Number of deaths by Timing of death and Type of death



Number of deaths by Gestational age and Type of death



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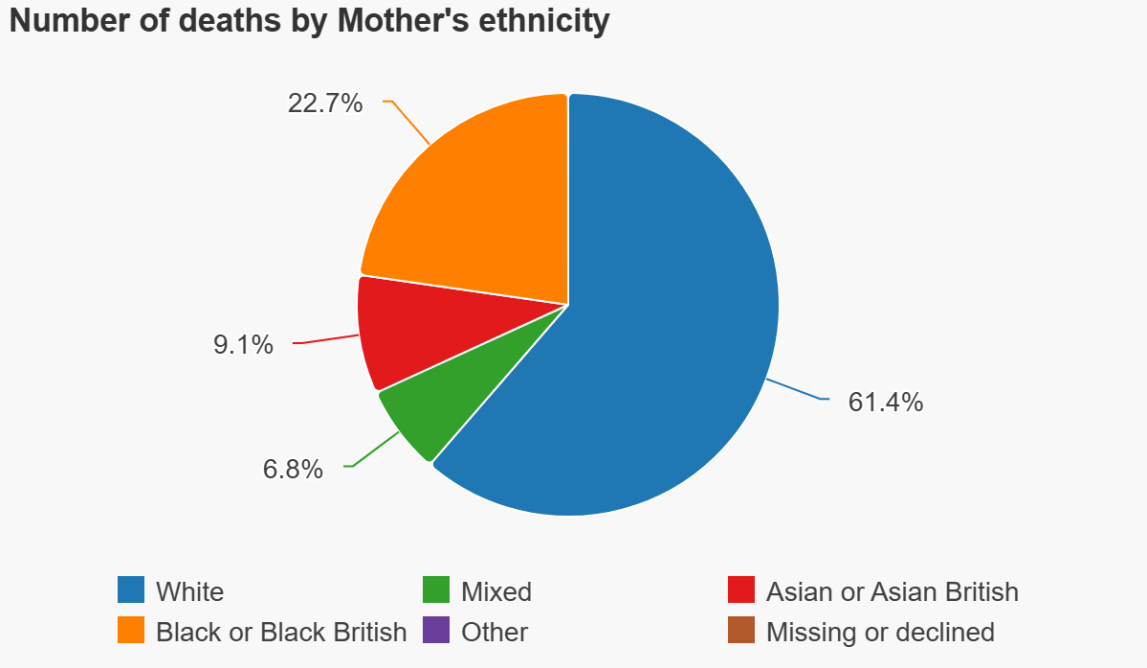
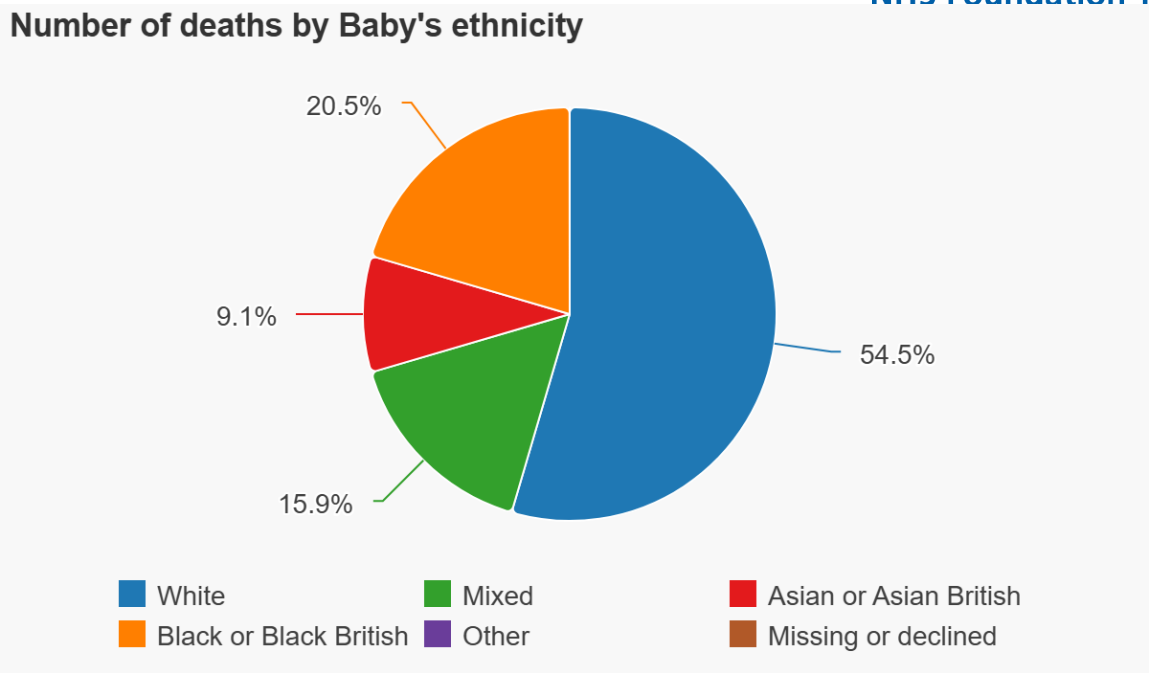
Medway NHS Foundation Trust





Issues, Concerns & Gaps:

- The proportion of non-white babies reported to MBRRACE for perinatal loss in 2025 as 30.6%. This is an increase from local rate of 22.7% in 2023 compared to national rate of 28%. National data is not available to benchmark our current position, and we await the MBRRACE 2024 report to understand our position against the 2024 data.
- However the increasing percentage of poor outcomes for BAME families requires review and analysis of the details of these cases will be undertaken to determine any themes or trends and to support the development of any QIP work required to improve outcomes.

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

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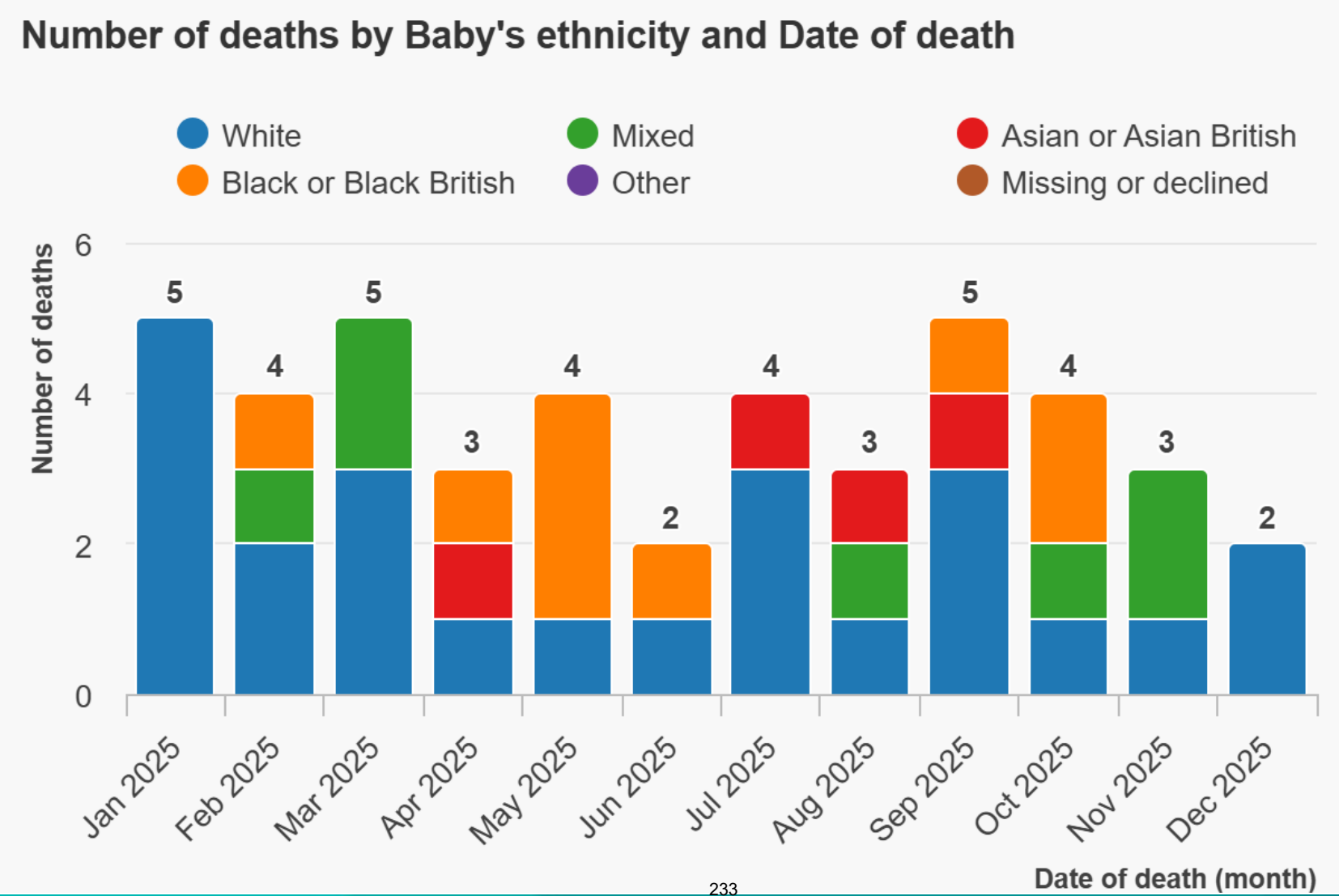
Medway NHS Foundation Trust



Service User, MNVP and Staff Feedback Perinatal Leadership

Perinatal Surveillance Tool Data Q3 25/26– Service User Feedback

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

NHS Medway NHS Foundation Trust

Key Messages:

- 15 Steps planned for January 2026.
- Co-production of CQC Picker Survey Action plan arranged for December.
- Working with chief pharmacist at ICB to review halal options for non-halal medications eg. Fragmin.
- Positive FFT comments including feedback regarding:
- Care Planning
- Communication
- Respect for choices

Issues, concerns, gaps:

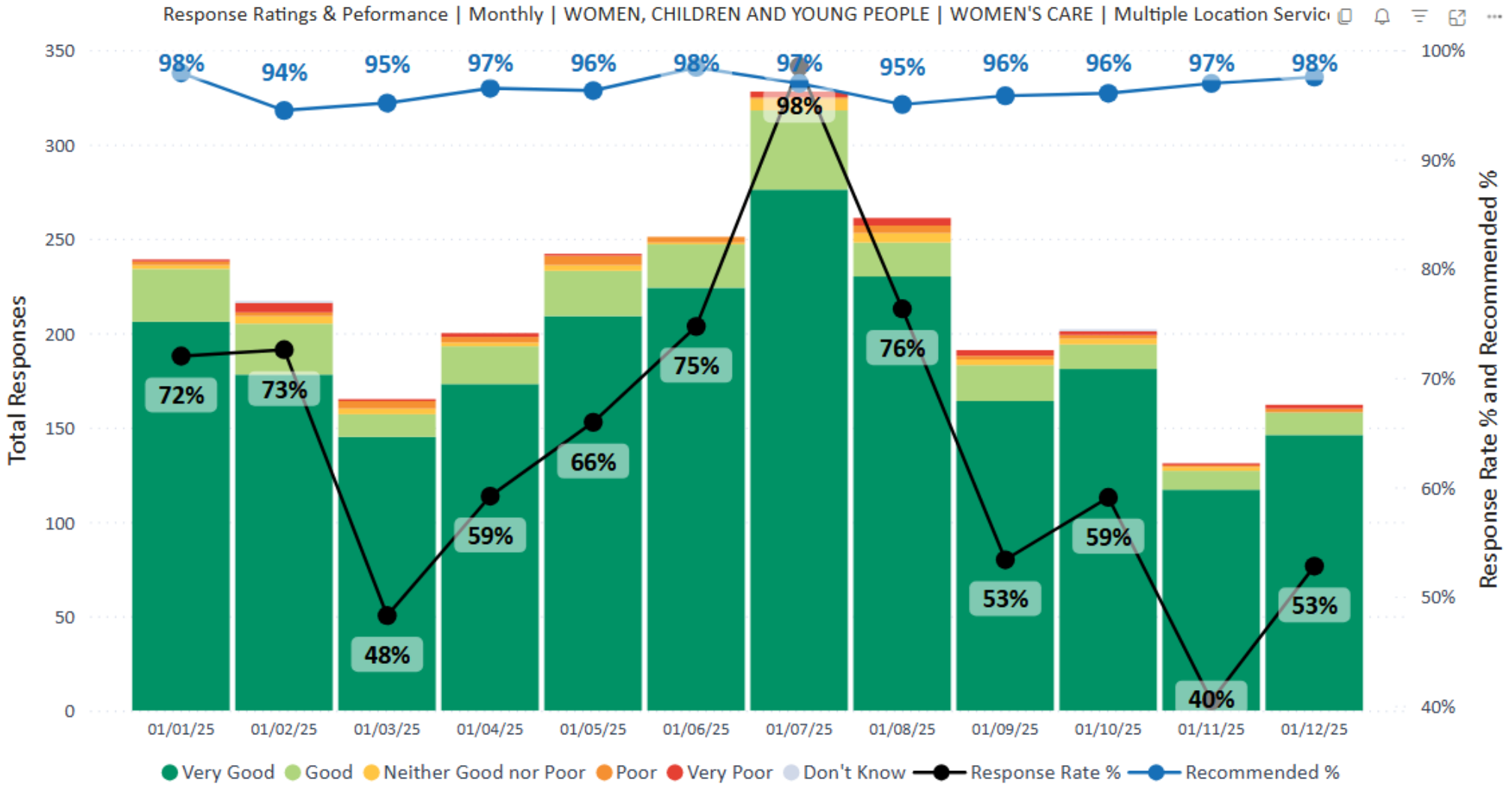
- Service users missing scan appointments due to queuing to access carpark.
- Poor communication around discharge, medication and plans of care.
- Concerns raised regarding cleanliness, particularly of bathrooms.
- Delays in IOL pathway/Poor Communication
- Delays in doctors reviews for NICU
- Concerns regarding food available
- Bathrooms and facilities

Actions and improvements

- Development of cultural experience survey for service users to be rolled out in coming months.
- MNVP part of working group for PPH QIP and to support coproduction of service user information and videos for VTE pathway
- Picker Survey 2025 results received into organisation. Action plan coproduced.
- Additional funding or MNVP provision approved by ICB
- Targeted actions in individual areas to address concerns.
- Estates and facilities works underway to improve environment.

Perinatal Surveillance Tool Data Q3 2023/24– Service User Feedback – Maternity FFT

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



Perinatal Surveillance Tool Data Q3
25/26– Staff Feedback & Perinatal Leadership

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

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

NHS Medway NHS Foundation Trust

Key Messages:

- Student forums continue monthly with majority of feedback being positive, with reports they are enjoying their placements and maximising learning opportunities.
- 7 Midwifery Degree apprenticeships ongoing.
- 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.

Issues, concerns, gaps:

- Community Connectivity. - Purchase order for community connectivity approved and process to install commenced

Actions and improvements

- **Divisional Driver of Incivility**
  - Fortnightly review of all incivility datix, FFT, etc by Director level and actions and accountability
  - Feeds into Trust Driver Meeting.
  - Plan agreed to undertake peer-culture survey across WCYP with 4 targeted culture questions to get a sense check of current cultural climate and develop targeted actions in response to this.

- **Perinatal Culture and Leadership Programme:**
  - All Band 7 and above manager's including ADOM have completed culture coach training
  - All manager's undertaking Management Essential Training provided by the Trust
  - Quad engaged in PCLP improvement work with regular attendance at leadership sessions.
  - Awaiting roll out of national Equality/Culture training following national investigation into maternity services.
  - MOMENTS Cultural Training has been booked for senior team in January and February 2026
  - Work with Trust OD team to implement 360' feedback process for leaders
  - Utilise staff surveys and anonymous feedback mechanisms to support improvement, including seek feedback on communication preferences and leadership.
  - Continue to engage with FTSUG and welcome opportunities for staff engagement sessions.
  - Continue to support staff wellbeing in line with the Trust's vision.
  - Continue to work alongside Trust leadership to implement the Trust's cultural vision as supported by the work of Absolute Diversity.

Perinatal Surveillance Tool Data Q3 25/26– Training Compliance

Medway NHS Foundation Trust

Key Messages:

- Achieved compliance with all elements of training required for CNST year 7 in November 2025.
- Staff to be trained under new starter clause are completing their training in January and February 2026 and anticipate achieving full compliance for these members of staff to be fully compliant with Safety Action 8.
- Allocations for 2026 training are being finalised with training being allocated as early as possible to minimise pressure on October and November training sessions.
- 2026 midwifery essential skills commenced, with additional sessions on Equality, Diversity and Patient Experience now incorporated along with personalisation and choice.
- Disparities, including ethnicity and social deprivation now incorporated into training across maternity, including CTG and PROMPT.
- Mandatory Training:
  - Midwifery – 87.5%
  - MSWS 87.33%
  - Medical – 77%
  - Admin and Clerical – 85%

Issues, concerns, gaps:

- Newly added Trust-wide mandatory training requirements do not currently have capacity for colleagues to book sessions (eg. Oliver McGowan level 2).
- Mandatory training rates for medical team below Trust Target – CD addressing with individual staff and maximising bespoke training opportunities eg. Utilising audit to improve compliance.

Fetal Monitoring Training and Assessment	Obstetric Consultants	Obstetric Residents	Midwives
Nov 2025 Compliance	93.33%	100.00%	94.95%
CNST Trajectory	93.33%	100.00%	94.95%

PROMPT – Staff Group	Nov 2025 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%

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%

Conclusions and Next Steps

- This quarter has demonstrated continued progress in our commitment to delivering safe, high-quality perinatal care.
- 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.
- Review of perinatal losses with a focus on ethnicity to be undertaken.
- Service user and staff feedback continue to drive service improvement and development.
- 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 requirements.

NHS Medway NHS Foundation Trust

Meeting of the Trust Board in Public

Date: Wednesday 11th March 2026

Title of Report	Perinatal Quality, Leadership and Claims Q3 Report				**Agenda Item**	5.3c
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**	X	**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 MIS continues the expectation that Trust Boards will receive quarterly reports on Perinatal Quality in line with the minimum data set of the Perinatal Quality Oversight Model (PQOM). (Safety Action 1 and Safety Action 9)
	• Monthly updates aligned with the minimum dataset of the PQOM are submitted monthly to QPSCC and QAC along with to every Trust Board.
	• This report provides quarterly oversight for Q3 25/26 and includes the following:
	  • Incidents
	  • Investigations
	  • PMRT
	  • Complaints
	  • Claims Scorecard
	  • Staff and Service User Feedback
	  • Perinatal Leadership
	• For next quarterly report there is a plan to move to SPC charts for dashboard data. BI dashboard set up to support this and working with team to confirm parameters.
	• MOSS launched in November 2025 and MFT onboarded and developing local SOP to support reporting processes and governance.
	• Compliant with training requirements for CNST Year 7. Working to improve mandatory training compliance rates, particularly for medical staff.					

	• This quarter has demonstrated continued progress in our commitment to delivering safe, high-quality perinatal care. • 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. • Review of perinatal losses with a focus on ethnicity to be undertaken. • Service user and staff feedback continue to drive service improvement and development. • 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 requirements
Issues for the Board/Committee Attention:	**Issues:** **PPH** • Percentage of PPH rates remain above national average for the quarter (4.15% locally vs 3.4% nationally for PPH >1500mls) – 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** • New scorecard was published in September 2025. • Full detail of scorecard has not been made available to maternity team so detailed analysis on all claims cannot be undertaken. • 54% of claims on the NHS Resolution Scorecard were closed without damages and 48% were settled with damages paid. **Maternity Outcomes Signal System (MOSS)** • Launched in November 2025, MOSS flags potential safety issues, prompting a locally led critical safety check to determine if there are real safety issues. • The MOSS charts produces “signals” of potential safety issues in maternity care arising during labour and birth using stillbirths and term neonatal deaths up to 28 days. • Signals are generated when there is a doubling in the rate of events compared to the reference rate. The colour of signals simply refers to the statistical confidence – amber means

	MOSS is 95% confidence the rate has doubled (level 1) and red means MOSS are 99% confident. • Dots above the threshold lines would be amber and red alerts respectively and would require the Trust to complete a "critical safety check". • This check would review key metrics such as staffing and acuity for the past 3 months which with the goal of determining if there was any underlying factors creating safety issues. • Reviews would need to be carried out within 8 working days and signed off by the Trust and ICB. • The MOSS SOP has been shared with the Trust Patient Safety team and a local SOP is being developed to support the governance processes and signoff within the Trust and the region			
Committee/ Meetings at which this paper has been discussed/ approved: Date:	Maternity and Neonatal Safety Champion Assurance Group, 6 February 2026			
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	

Meeting of the Trust Board

Date: 11 March 2026

Title of Report	**Urgent Review into Homebirth Services – Prevention of Future Deaths Response**			**Agenda Item**	5.3d
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**	X	**Noting** X
Proposal and/or key recommendation:	• The Board is requested to review and discuss the content of the report.				

Executive Summary	• On 26 November 2025 the Chief Midwifery Officer for England and the Regional Chief Midwifery of the South East wrote to Trusts providing maternity care regarding the provision of homebirth services.
	• This was in response to a Prevention of Future Deaths (PFD) Report that was issued following the tragic deaths of Jennifer Cahill and her child Agnes Cahill following a homebirth under the care of Manchester Foundation Trust. The PFD report was sent to the following:
	  • The Secretary for State for Health and Social Care
	  • The Chief Executive of the Royal College of Midwives
	  • The Chief Executive of the Nursing and Midwifery Council
	  • The Chief Executive of the Royal College of Obstetrics
	  • The Chief Executive of National Institute for Clinical Excellence
	  • The Chief Executive of NHS England.
	  • In response to this the Chief Midwifery Officer and Regional Chief Midwife asked that all Trusts review their homebirth provision and consider the following:
	  • **The operational running of the home birth service**
	  • **Care planning and risk assessment**
	  • **Governance and Oversight.**
	  • In response to this letter, along with a request from the IBC to provide an assurance response, a through review of the full coronial report was undertaken. The				

	maternity service have identified 17 actions and with 2 of those now complete, to provide assurance against the points raised in response to the PFD. • The report assures the Board that the maternity service has a robust process in place to manage homebirths, provide in depth and personalised care planning and risk assessment and that there is suitable governance and oversight. • The report also provides oversight to the Board of the number of service users requesting Personalised Care and Support Plans (PSCP) which may result in them requesting care outside of guidance, including homebirths. • The actions identified seek to strengthen the service across these three aspects, including outcome focused audits, formal processes for consultant review, risk stratification of pregnancy and birth, and plans to incorporate homebirth outcomes into Perinatal Quality Oversight Model reporting to Trust Board.			
Issues for the Board/Committee Attention:	N/A			
Committee/ Meetings at which this paper has been discussed/ approved: Date:	Maternity and Neonatal Safety Champion Assurance Group (MNSCAG) 1 December 2025 Quality Assurance Committee, January 2026			
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	

Urgent Review into Homebirth Services – Prevention of Future Deaths Response

MNSCAG December 2025
QAC January 2026
Trust Board March 2026

Executive Summary

- On 26 November 2025 the Chief Midwifery Officer for England and the Regional Chief Midwifery of the South East wrote to Trusts providing maternity care regarding the provision of homebirth services.
- This was in response to a Prevention of Future Deaths (PFD) Report that was issued following the tragic deaths of Jennifer Cahill and her child Agnes Cahill following a homebirth under the care of Manchester Foundation Trust. The PFD report was sent to the following:

    - The Secretary for State for Health and Social Care
    - The Chief Executive of the Royal College of Midwives
    - The Chief Executive of the Nursing and Midwifery Council
    - The Chief Executive of the Royal College of Obstetrics
    - The Chief Executive of National Institute for Clinical Excellence
    - The Chief Executive of NHS England.

- In response to this the Chief Midwifery Officer and Regional Chief Midwife asked that all Trusts review their homebirth provision and consider the following:
    - **The operational running of the home birth service**
    - **Care planning and risk assessment**
    - **Governance and Oversight.**

- In response to this letter, along with a request from the IBC to provide an assurance response, a through review of the full coronial report was undertaken. The maternity service have identified 17 actions and with 2 of those now complete, to provide assurance against the points raised in response to the PFD.
- The report assures the Board that the maternity service has a robust process in place to manage homebirths, provide in depth and personalised care planning and risk assessment and that there is suitable governance and oversight.
- The report also provides oversight to the Board of the number of service users requesting Personalised Care and Support Plans (PSCP) which may result in them requesting care outside of guidance, including homebirths.
- The actions identified seek to strengthen the service across these three aspects, including outcome focused audits, formal processes for consultant review, risk stratification of pregnancy and birth, and plans to incorporate homebirth outcomes into Perinatal Quality Oversight Model reporting to Trust Board.

BRAG

	Urgent Review into Homebirth Services.
Completed	2
Overdue	0
Off Track with actions to deliver	0
On Track	15
Total Number of actions	17
Percentage of actions completed/on track	100%

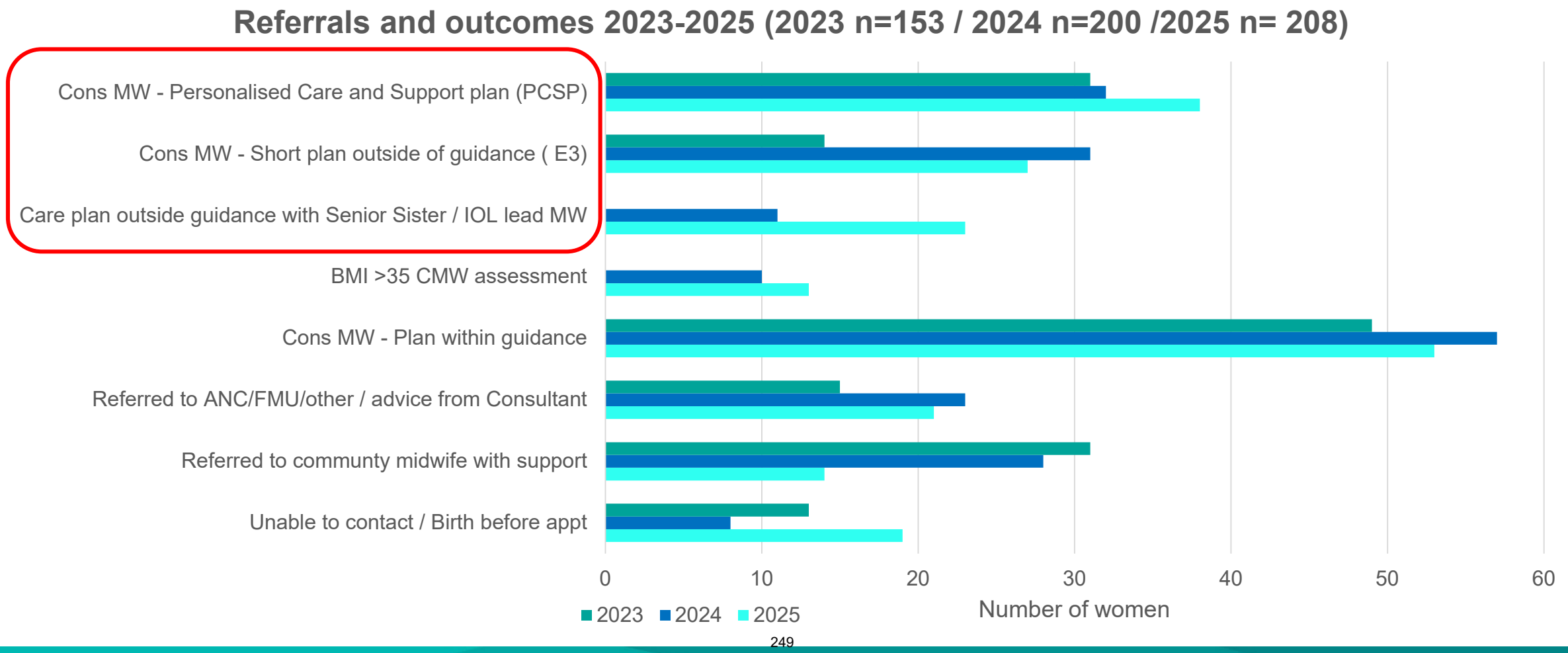
Theme	Number of Actions	% Complete or on track
The operational running of the home birth service	5	100%
Care planning and risk assessment	6	100%
Governance and Oversight.	6	100%

Personalised Care and Support

Medway NHS Foundation Trust

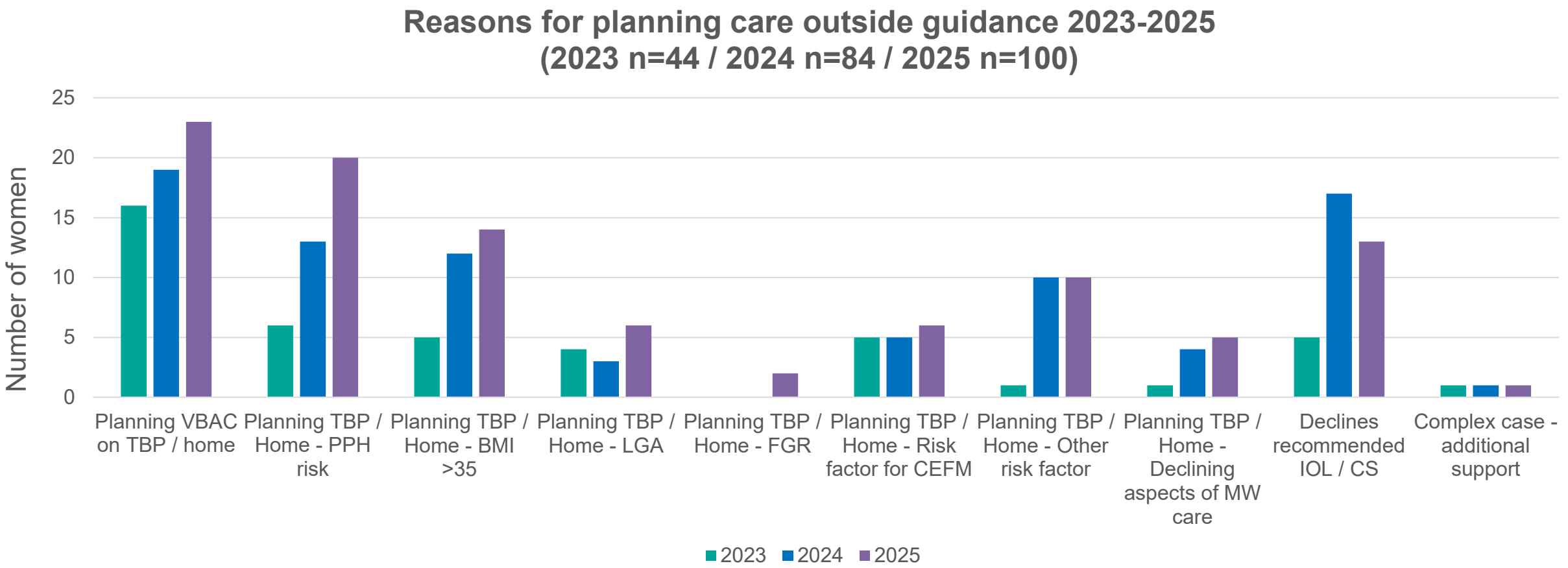
- An increasing number of women and birthing people are requesting personalised care and support plans(PSCP) that may result in them receiving care outside of guidance.
- The Consultant Midwives manage these requests, receiving 153 referrals in 2023, 200 in 2024 and 208 in 2025.
- The consultant midwives work closely with the women and birthing people, along with the Consultant Obstetrician to develop a PSCP. After consultation, a large number of women accept care within guidance.
- In 2025, 98 chose care outside of guidance, with 92% planning for birth at home or on the Birth Place (Midwifery led unit). 38 of these had a detailed PSCP, 21 had a senior sister plan (utilising consultant midwife/consultant obstetrician developed proforma) and 13 utilised the BMI proforma (High BMI not strictly outside guidance but requires review)
- Many of requesting care outside of guidance and PSCP have multiple risk factors.
- 73% (72) were multiparous women, often with previous traumatic birth, seeking a different experience, with the majority of this group (74%) having had a previous vaginal birth.
- The consultant midwives audit the outcomes of these cases and share their findings at audit.
- 42% (38/78) of those with a PSCP (excluding those with a PSCP for BMI only) had labour care in their planned place of birth. 58% did not have care in their planned place of birth, with many women accepting care that is not within their agreed plan when faced with an ‘actual problem’, rather than choosing care based on the ‘chance of a problem’ occurring.
- The need for formal obstetric job planning to meet the needs of PSCPs and care outside of guidance has been identified and this is currently being reviewed by the Clinical Director and Director of Midwifery.

Consultant Midwife Personalised care and support planning

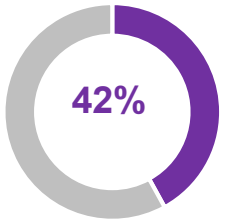


Personalised care and support plans

Planned care outside of guidance



PCSP – outcomes



42% of women who planned OOG care on TBP/HOME 2025 had **labour care in their planned place of birth** (33 / 78)

73% Gave birth in planned place of birth (24/33)
27% transfer rate to Delivery Suite

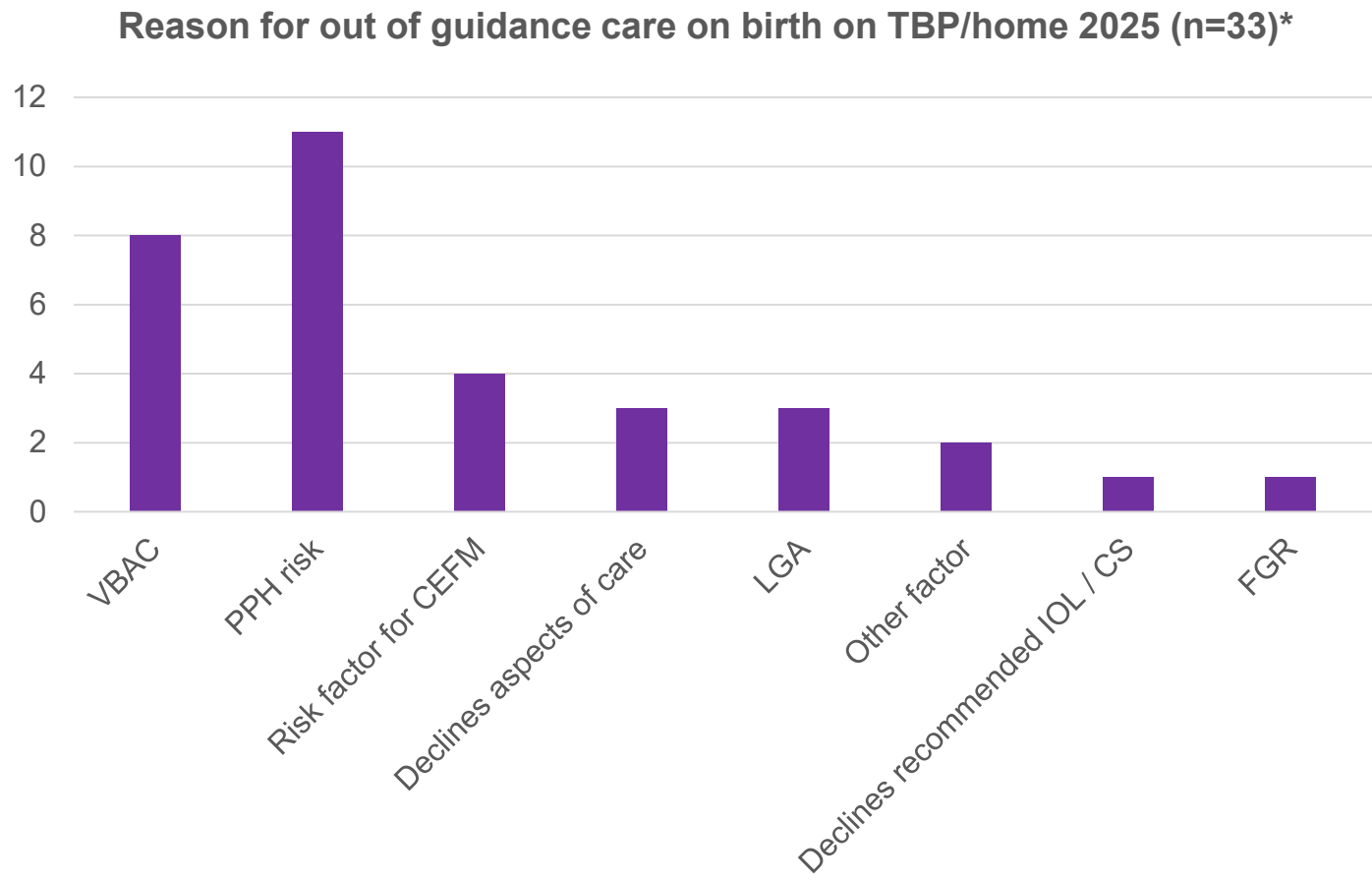
97% (32/33) had a vaginal birth

42% - Care on Delivery Suite for clinical reasons
e.g. PROM, mec, RFM, IOL

12% - Changed mind
e.g. chose Delivery Suite or ELCS

3% HB team not available
1 of these women then freebirthed

1% Choose freebirth



*Number of women with PSCP who laboured on TBP or at home.
Excludes women with PSCP for BMI only.

Action Plan

No	Key lines of enquiry	Evidence Available	Gaps in Evidence/Assurance	Mitigating Actions /Comments	Action Due Date	Implementation Lead	BRAG
Urgent Review of Homebirth Services following Prevention of Future Deaths Report - NHSE							
Operational Running of Service							
1	How do you ensure prompt midwifery care is available 24 hours a day?	Day time: Community Senior Sisters provide homebirth coordinator oversight 0800-1600 Monday to Friday. Out of hours: Labour Ward Coordinator provides homebirth coordination/oversight.	Current homebirth audit is annual and does not include full details of all maternal and neonatal outcomes.	Increase audit to 6 monthly and include maternal and neonatal outcomes.	Jul-26	Community Matron	
2	How do you ensure that staff are properly equipped, trained, prepared and skilled for providing birth and neonatal care in a home setting?	Baby lifeline homebirth kit utilised. This is checked weekly and restocked and checked for completeness after use. Community Emergency Training undertaken annually All community midwives participate in mandatory essential skills training and Hospital Obstetric Emergency Training (PROMPT), Neonatal and Adult Resuscitation Training . Consultant midwives brief community teams on any planned out of guidance homebirths to ensure teams are aware of care plans, maternal expectations and risk factors.	Current Community Emergency Training is annual.	Reviewing current Community Emergency Training to enhance programme in line with MFT caseload and out of guidance requests to support midwives with clinical management and risk assessment. The plan will then to roll out more regular bespoke training sessions to ensure community teams maintain skill set for managing emergencies in the home.	Jul-26	Community Matron	
3	How do you ensure that staff have senior multidisciplinary support available to them at all times?	Community midwives attending homebirths escalate any concerns or seek advice from the Labour Ward Coordinator who can advise and or liaise with the Registrar or Consultant on Call as required.		Audit compliance with 2 hourly LWC review and review guidelines to include clear escalation flow charts.	Jun-26	Community Matron	

Action Plan

No	Key lines of enquiry	Evidence Available	Gaps in Evidence/Assurance	Mitigating Actions /Comments	Action Due Date	Implementation Lead	BRAG
Urgent Review of Homebirth Services following Prevention of Future Deaths Report - NHSE							
Operational Running of Service							
4	How do you ensure that staff have sufficient rest periods?	All community staff contribute to the homebirth service, in addition to their contracted hours 08:00-17:00 7 days, they also contribute to the on call rota which is 17:00-20:00 and 20:00-08:00. When staff are required to attend a homebirth on their on call they are released from duty the following day. When staff are working during day and have an overnight on call shift, they are given a period of 3 hours rest between shift ending and on-call beginning. 2 midwives are in attendance at all homebirths to allow for breaks to be taken during the shift. Community midwives are no longer first on-call to support the delivery suite, with 2 hospital on call midwives being rostered for every night shift. Community midwives may only be called in to support the hospital after escalation to the manager on call.		No mitigations to increase rest periods currently within the gift of current establishment/budget/workforce model. However, service will remain responsive to any changes in national guidance to maintain safety for staff and service users.			
5	How do you ensure potential transfer and extraction processes are clear and planned for each birth?	Homebirth assessments are completed by community midwives at 36 weeks within the home to allow the midwife to assess access requirements and risks. This risk assessment is shared with all community midwives and is part of the patient's electronic record so that the midwife responding to the homebirth is able to access the full information. Any access risks and births outside of guidance are shared with the ambulance service. As part of personalised care planning, transfer recommendations and thresholds are discussed and agreed with the patient. Homebirth policy clearly outlines the need for midwives to undertake continual risk assessment and make arrangements to transfer patients to the obstetric led unit should any complications with mother or baby arise. For unplanned homebirth, or Born Before Arrival, when Delivery Suite has been contacted it is standard operating procedure for an ambulance to be sent alongside two midwives. If community midwives cannot attend within 15 minutes, ambulance will transfer patient directly to Delivery Suite.		Review all guidelines relating to homebirth including Homebirth Guideline, Choice of Place of Birth, and Maternal-Neoantal Transfer Guideline to ensure streamlining of information and clear and consistent information regarding transfer and handover.	Jun-26	Community Matron/Consultant Midwives	

Action Plan

No	Key lines of enquiry	Evidence Available	Gaps in Evidence/Assurance	Mitigating Actions /Comments	Action Due Date	Implementation Lead	BRAG
Care Planning and Risk Assessment							
6	How do you ensure systematic assessment of complexity and risk?	All patients are stratified according to risk in pregnancy. Obstetric Led birth choices clinics Consultant Midwife/Senior Midwife risk assessment and personalised care planning completed and coproduced with the patient for any patient requesting care outside of guidance. Risk assessment at every antenatal contact and personalised care and support plan updated if any new risks emerge, including place of birth and management of 3rd stage. Risk assessment tool within labour and wholistic review/fresh eyes review undertaken during labour and compliance with this is routinely audited. Intermittent auscultation (IA) during labour - every 15 minutes in fist stage, every 5 minutes during second stage to monitor fetal heart. Maternal and Neonatal Early Warning Observation systems in place and utilised within the homebirth setting.	Current risk stratification does not include risk profile for labour and birth.	Consultant midwives to review and update risk stratification letters and process to include two risk categories, one for pregnancy and one for labour and birth.	Mar-26	Consultant Midwives	
7	How do you ensure the Multidisciplinary team (MDT) ensures a personalised approach to women planning care in light of any identified issues (particularly when a homebirth is not recommended).	As for action 6 Monthly meeting with consultant midwives and community teams to discuss upcoming complex/out of guidance planned homebirths to ensure oversight of risks, management and mitigation.	Currently no formal requirement for patients requesting homebirth outside of guidnace to have a consultant review.	Review pathway and update guidance (Homebirth, Care outside of guidance, and choice of place of birth) to include requirement for Consultant review for all service users requesting homebirth outside of guidance.	Mar-26	Consultant Midwives	
8				Keep case and attendnace log for monthly consultant Midwife Meeting	Mar-26	Consultant Midwives	
9			No formal process for Consultant review of Care outside of guidance written plans.	Review obstetric consultant job plans with Clinical Director to allocate sessions for consultant review of high-risk out of guidance cases.	Mar-26	ADOM	

Action Plan

No	Key lines of enquiry	Evidence Available	Gaps in Evidence/Assurance	Mitigating Actions /Comments	Action Due Date	Implementation Lead	BRAG
Care Planning and Risk Assessment							
10	How do you ensure the MDT continues to maintain good communication at all stages of care with women and between all teams including ambulance services?	Risk assessment is completed at every antenatal contact. Documented personalised care plan is revisited when new risks occur and at the onset of labour. Any newly identified risks or changes to plan are escalated to the MDT/Ambulance service as required. Personalised Care plans, including those for patients who choose care outside of guidance, is a live document and is available to all staff via the maternity electronic record system as well as the service user.		Reivew all guidelines relating to homebirth including Homebirth Guideline, Choice of Place of Birth, and Maternal-Neoantal Transfer Guideline to ensure streamlining of information and clear and consistent information regarding transfer and handover.	June 2026	Consultant Midwives/Matrons	
11	How do you ensure dynamic risk assessment is managed and responded to throughout pregnancy, birth and the postnatal period?	As for action 6					

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
Governance and Oversight							
12	How do you ensure governance is structured to ensure robust oversight of homebirth services by the whole organisation, so the executive board has appropriate oversight.	Dashboard containing details of homebirths are currently shared via Maternity and Neonatal Safety Champion Assurance Board monthly and also shared with Quality Assurance Committee. Both meetings include the Chief Nursing Officer and Board Level Safety Champion (Non-Exec Director)	Currently full details of the homebirth service, including outcomes are not shared with the Turst Board.	Include regular updates to Trust Board via Perinatal Quality Oversight Model Reporting via IQPR slides and Perinatal Quality Reports.	Jul-26	ADOM	
13	How do you ensure that there is an audit programme that covers and clinical and operational guidance and leads to continual improvement?	Annual audit plan in place and closely moniroted and updated as guidance and clinical needs change.	Current homebirth audit is annual and does not include full details of all maternal and neonatal outcomes.	Homebirth audit schedule to be increased to 6 monthly to provide additional assurance. Audit to include outcomes and audit agaisnt guidance including risk assesmsnet, escalation and transfer.	Jul-26	Community Matron	
14		Transfers from homebirth now added to CRIG review list.	Transfers from homebirth are not routinely reviewed by MDT.	All transfers from homebrith (maternal or neonatal) to be reviewed at CRIG meeting to ensure timely review and identification of any concerns.	Jan-26	Community Matron/Intrapartum Matron	
15	How do you ensure there is comprehensive homebirth guidance including standard operating procedures for all stages and aspects of care?	Robust homebirth guidance in place, reviewed every 2 years or as clinical guidance changes.		As for action 12			
16				Coproduce Patient facing padlet for choice of place of birth, including detailed homebirth section, to support service users with informed consent and informed discussions.	Jul-26	Community Matron	
17				Coproduce Service User Feedback survey to gain better understanding of the experience of homebirth service users and use this to drive improvement.	Jul-26	Community Matron	

Conclusions and Next Steps

- Share findings regional as per ICB request.
- Heads of Midwifery across region to present findings at regional HOM day with plan to escalate concerns and requests nationally including:
  - Standardisation of on-calls and rest periods
  - Provision of vehicles
  - Standardisation of equipment
  - Standardisation of community skills updates
  - Standardisation of renumeration for on calls
  - Standardisation of length-of-time post qualification before working in community homebirth setting.
  - Standardisation of transfer and extraction.
  - Standardisation of communication with acute site
- Include homebirth service updates routinely to QAC and Trust Board
- Add action plan to Quality Improvement Plan for monitoring and oversight.

Meeting of the Trust Board
Wednesday, 11 March 2026

Patient First Domain (please mark)	Sustainability	People	Patients	Quality	Systems
	X	X	X	X	X
Title of Report	**Maternity Enhanced Support and Oversight Programme**			**Agenda Item**	5.3e
Author and Job Title	Alison Herron, Director of Midwifery				
Lead Executive	Evonne Hunt, Chief Nursing Officer				
Executive Summary	Approval	X	Briefing		Noting

Background

- As part of the regional programme of Insight Visits, NHS England, led by the Regional Chief Midwife and supported by the ICB Maternity and Neonatal Team conducted a visit to Maternity and Neonatal Services on 3 September 2025.
- The purpose of the visit was to review maternity and neonatal services and their progress against the Three Year Delivery Plan, and identify if there were any areas where the regional team could offer support.
- The maternity and neonatal teams provided a comprehensive evidence bundle along with a detailed presentation, sharing our successes, improvement work along with areas of risk and challenge within the service.
- The visiting team also conducted staff stakeholder events with numerous staff groups, from band 5 and student midwives, resident doctors, senior midwives and consultants. They also met with the Chief Nurse, NED, and the Maternity and Neonatal Leadership team.
- In response to the risks and challenges raised by the Maternity and Neonatal Teams, along with feedback received during the stakeholder sessions, the Regional team decided to offer MFT some additional support under the “Enhanced Support and Oversight Framework” (ESOF).
- The aim of ESOF is to support Trusts before there is a significant safety or quality concern. It does not affect the CQC rating of the service and is not a regulatory programme. It is also distinct from the Maternity Improvement Programme, which MFT are not part of.
- All Trusts within the Kent and Medway ICB are currently being supported by ESOF.

Current Position

- NHSE provided MFT with informal feedback following the visit and the full report was received in December 2025, and this was aligned to the 4 themes of the Three Year Delivery Plan.
- An onboarding meeting to ESOF was held in January 2026, with a plan for regular touchpoint meetings with the regional team and a further insight visit planned for 25 March 2026.
- The Maternity Service have identified 47 improvement actions. (54 in total, with 7 actions that are repeats so have not been included in the final action count)
- 83% of these are on track or have been completed since the visit.

	• 8 Actions have been identified as off-track with actions to deliver:
	  • Succession planning for Bereavement Service/7 Day service
	  • Trust Executive Leadership Structure
	  • Cultural challenges within maternity including leadership, culture training, support for BAME colleagues

Proposal and/or key recommendation:	• Note position and progress • Approve for onward reporting to Trust Board
Governance Route Meeting: Date submitted:	• Maternity and Neonatal Safety Champion Assurance Board, 6 February 2026

Identified Risks, issues and mitigations:	• Of the 47 actions, 8 Actions have been identified as off-track with actions to deliver:
	  • Succession planning for Bereavement Service/7 Day service
	  • Trust Executive Leadership Structure
	  • Cultural challenges within maternity including leadership, culture training, support for BAME colleagues
	• The maternity team acknowledge the need for cultural and leadership improvement and have already implemented changes in this area including
	  • Culture coach training for all band 7 manager's and above
	  • Management essentials training for all managers
	  • Work with Absolute Diversity to undertake training and culture work across the service.
	  • PE&EDI Midwife incorporating more culture content into annual training programme.

Resource implications:	N/A
Sustainability and/or Public and patient engagement considerations:	N/A

Integrated Impact assessment (please mark):	Yes	No	N/A
			X

Appendices:				
Freedom of Information status (please mark):	Disclosable	X	Exempt	
For further information please contact:	Alison Herron, Alison.herron2@nhs.net			

Maternity Enhanced Support and Oversight Programme

Ali Herron, Director of Midwifery
Kate Harris, Associate Director of Midwifery
Hany Habeeb, Clinical Director, Women's

MNSCAG February 2026
TLT Quality February 2026
Trust Board March 2026

Executive Summary

Background

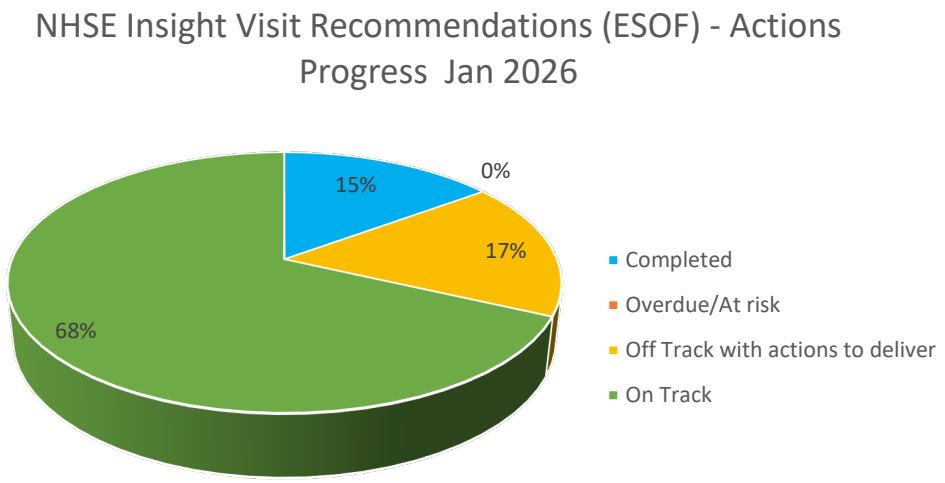
- As part of the regional programme of Insight Visits, NHS England, led by the Regional Chief Midwife and supported by the ICB Maternity and Neonatal Team conducted an visit to Maternity and Neonatal Services on 3 September 2025.
- The purpose of the visit was to review maternity and neonatal services an their progress against the Three Year Delivery Plan, and identify if there were any areas where the regional team could offer support.
- The maternity and neonatal teams provided a comprehensive evidence bundle along with a detailed presentation, sharing our successes, improvement work along with areas of risk and challenge within the service.
- The visiting team also conducted staff stakeholder events with numerous staff groups, from band 5 and student midwives, resident doctors, senior midwives and consultants. They also met with the Chief Nurse, NED, and the Maternity and Neonatal Leadership team.
- In response to the risks and challenges raised by the Maternity and Neonatal Teams, along with feedback received during the stakeholder sessions, the Regional team decided to offer MFT some additional support under the “Enhanced Support and Oversight Framework” (ESOF).
- The aim of ESOF is to support Trusts before there is a significant safety or quality concern. It does not affect the CQC rating of the service and is not a regulatory programme. It is also distinct from the Maternity Improvement Programme, which MFT are not part of.
- All Trusts within the Kent and Medway ICB are currently being supported by ESOF.

Current Position

- NHSE provided MFT with informal feedback following the visit and the full report was received in December 2025, and this was aligned to the 4 themes of the Three Year Delivery Plan.
- An onboarding meeting to ESOF was held in January 2026, with a plan for regular touchpoint meetings with the regional team and a further insight visit planned for 25 March 2026.
- The Maternity Service have identified 47 improvement actions. (54 in total, with 7 actions that are repeats so have not been included in the final action count)
- 83% of these are on track or have been completed since the visit.
- 8 Actions have been identified as off-track with actions to deliver:
    - Succession planning for Bereavement Service/7 Day service
    - Trust Executive Leadership Structure
    - Cultural challenges within maternity including leadership, culture training, support for BAME colleagues

Actions and Improvements

	NHSE Insight Visit Recommendations (ESOF)
Completed	**7**
Overdue/At risk	**0**
Off Track with actions to deliver	**8**
On Track	**32**
Total Number of actions	47
Percentage of actions completed/on track	83%



NHSE Insight Visit Recommendations ESOF - Aligned to Three Year Delivery Plan	
Theme 1: Listening to Women and Families with Compassion	**8**
Objective 1: Care that is personalised	1
Objective 2: Improve equity for mothers and babies	5
Objective 3: Work with service users to improve care	2
Theme 2: Growing, retaining and supporting our workforce	**14**
Objective 4; Grow our workforce (ICB/NHSE)	2
Objective 5: Value and Retain our workforce	4
Objective 6: Invest in skills	8
Theme 3: Developing and Sustaining a culture of safety, learning and support.	**9**
Objective 7: Develop a positive safety culture	4
Objective 8: Learn & Improve	5
Objective 9: Support and Oversight	0
Theme 4: Standards and structures that underpin safer, more personalised and more equitable care.	**16**
Objective 10: Standards to ensure best practice	7
Objective 11: Data to inform learning	3
Objective 12: Make better use of digital technology in maternity and neonatal services	6
Total	**47**

Actions and Improvements

Key Messages

- Following the Insight Visit in September 2025 and the subsequent report received in December 2025, the Maternity Service have identified 47 improvement actions. (54 in total, with 7 actions that are repeats so have not been included in the final action count)
- 83% of these are on track or have been completed since the visit.
- These have been aligned to the 3 Year Delivery Plan as per the visit report, with a breakdown of the numbers of actions and their current status in the adjacent table.
- A significant number of actions had been identified prior to the visit and are being managed via ongoing Quality Improvement projects (e.g. PPH, IOL, MCU/Triage), Culture and leadership work and the risk register, with regular monitoring via internal governance processes.

- Of the 47 actions, 8 Actions have been identified as off-track with actions to deliver:
  - Succession planning for Bereavement Service/7 Day service
  - Trust Executive Leadership Structure
  - Cultural challenges within maternity including leadership, culture training, support for BAME colleagues

- The maternity team acknowledge the need for cultural and leadership improvement and have already implemented changes in this area including
  - Culture coach training for all band 7 manager's and above
  - Management essentials training for all managers
  - Work with Absolute Diversity to undertake training and culture work across the service.
  - PE&EDI Midwife incorporating more culture content into annual training programme.

- As part of ESOF the regional team have offered to link MFT with other Trusts in the region to learn from improvement work they have undertaken and this opportunity has been welcomed.

- The maternity and neonatal teams are also being supported by the Patient Safety Team to review and align their actions and quality improvement projects.

NHSE Insight Visit Recommendations ESOF - Aligned to Three Year Delivery Plan/Current Status	
Theme 1: Listening to Women and Families with Compassion	**8**
Completed	1
Overdue/At risk	0
Off Track with actions to deliver	1
On Track	6
Theme 2: Growing, retaining and supporting our workforce	**14**
Completed	4
Overdue/At risk	0
Off Track with actions to deliver	1
On Track	9
Theme 3: Developing and Sustaining a culture of safety, learning and support.	**9**
Completed	0
Overdue/At risk	0
Off Track with actions to deliver	6
On Track	3
Theme 4: Standards and structures that underpin safer, more personalised and more equitable care.	**16**
Completed	2
Overdue/At risk	0
Off Track with actions to deliver	0
On Track	14
Total	**47**

Next Steps

Medway NHS Foundation Trust

Key Messages

- Following the onboarding meeting and initial touch point meeting the following next steps have been identified:
  - MFT to review action plan and ensure it is streamlined to cover key priority areas.
  - Communicate key priority areas with staff and seek staff input to coproduce actions and improvement work.

  - Further insight visit planned for 25 March 2026 and requested to provide an update on:
    - MCU/Triage Work
    - IOL pathway
    - Postnatal Flow
    - Obstetric workforce/Job Planning
    - Maternity Workforce/Culture/Equality and Diversity
    - Progress against action plan

- Establish regular reporting schedule to MNSCAG, TLT (Quality) and every Trust Board.