

Agenda

Trust Board Meeting in Public

Wednesday, 1 July 2026 at 10:00 – 13:30 - Trust Board Room, Gundulph Offices and via MS

Teams

Item	Subject	Presenter	Page	Time	Action
1. Preliminary Matters					
1.1	Chair’s introduction and apologies	Chair		10:00	Note
1.2	Quorum				Note
1.3	Declarations of interest				Note
1.4a 1.4b	Minutes of 6 May 2026 and Action Log		3 13	Decision	
2. Opening Matters					
2.1	Chairman’s report System Governance and Joint Committee Alignment	Chairman	Verbal 14	10:05	Assurance
2.2	Chief Executive Officer report	Chief Executive	24	10:20	Assurance
2.3	Lead Governor’s report	Lead Governor	Verbal	10:25	Note
3. Quality and Performance					
3.1	Integrated Improvement Plan	Chief Executive	28	10:30	Assurance
3.2	Integrated Quality Performance Report	Chief Operating Officer	62	10:40	Assurance
3.3	Mortality report, Learning from Deaths (May)	Chief Medical Officer	105	10:50	Assurance
3.4	Month 2 Finance Report	Chief Finance Officer	131	11:00	Assurance
3.5	2026/27 Cost improvement Plan	Turnaround Director	145	11:10	Assurance
3.6	Capital Report	Chief Finance Officer	154	11:20	Assurance
3.7	Band 5 job evaluation delivery plan	Deputy Chief Nursing Officer	160	11:30	Decision
4. Board Assurance					
4.1	Reports of the Committee Chairs a) Quality (May) b) People (May) c) Finance, Planning & Performance d) Audit and Risk (June)	Chairs of Committees	171 174 Verbal 176	11:40	Assurance /Decision
5. Regulatory and Corporate Governance					

Agenda

Item	Subject	Presenter	Page	Time	Action
5.1	Annual Freedom to Speak Up Report	Freedom to Speak Up Guardian	181	12:00	Assurance
5.2	Risk Register	Head of Quality and Safety	196	12:10	Assurance
6. Board Effectiveness					
6.1	Annual review of Committee terms of reference: - Audit Committee - Remuneration Committee - Finance, Performance and Planning Committee - People Committee - Cash Committee	Interim Company Secretary	220	12:20	Decision
6.2	Governance Framework and Undertakings update report	Interim Company Secretary	283		Approval
6.3	Annual Review of register of interests		291		Note
6.4	Annual review of Constitution		294		Decision
6.5	Board Designations report	Chairman	356	12:30	Note
6.6	Patient Safety Incident Backlog Assurance Report	Chief Nursing Officer	361	12:40	Note
6.7	Backlog Maintenance Report	Director of Estates	370	12:50	Assurance
6.8	Q4 Perinatal Oversight Report	Director of Midwifery	385	12:55	Assurance
6.9	10 Point Plan for Resident Doctors	Chief Medical Officer	496	13:15	Assurance
6.10	Committee in Common Terms of Reference	Chair and Strategic Board Advisor	504	13:20	Decision
7. Closing Matters					
7.1	Questions from the Council of Governors and Public	Chair	Verbal	13:25	Assurance
7.2	Matters to report to the Council of Governors				
7.3	Any Other Business and Reflections				
	Date and time of next meeting: 2 September 2026				

Minutes of the Trust Board Meeting in Public
Wednesday, 06 May 2026 at 10:00 – 12:30
Medway Maritime Hospital, Windmill Road, Gillingham, Kent, ME7 5NY
And via MS Teams

PRESENT		
	Name:	Job Title:
Members:	John Goulston	Trust Chair
	Alison Davis	Chief Medical Officer
	Gary Lupton	Non-Executive Director
	Helen Wiseman	Non-Executive Director
	Mojgan Sani	Non-Executive Director
	Paulette Lewis	Non-Executive Director
	Simon Wombwell	Chief Finance Officer (Interim)
	Steph Gorman	Chief Nursing Officer (Interim)
	Frances Woodroffe	Deputy Chief Executive (Interim)
	Jenny Chong	Non-Executive Director
	Siobhan Callanan	Chief Executive (Interim)
	Sheridan Flavin	Chief People Officer (Interim)
Attendees:	Martina Rowe	Lead Governor
	Karen Fegan	Governor
	Fiona Wise	NHSE Board Advisor
	Anan Shetty	Governor
	Natasha Turner	Governor
	Stephen Corbett	Governor
	Paul Green	Governor
	Jane Perry	Academic Non-Executive Director
	Susan Plummer	Deputy Lead Governor
	Matt Taiano	Governor
	Chris Barton	Governor
	Michael Turnham	NPIP
	Steve Lennox	NPIP

Apologies:	Darren Palmer	Chief Operating Officer (Interim)

1.0 PRELIMINARY MATTERS

1.1 Chair's Introduction and Apologies

The Chair opened the public session by welcoming all present. Apologies were noted as recorded, with acknowledgement of those members unable to join.

1.2 Quorum

The meeting was confirmed as quorate. The Chair verified that the required number of Board members were present in accordance with the Trust's constitution and governance framework.

1.3 Declarations of Interest

John Goulston advised his position as Chair at Kent Community Health NHS Foundation Trust has been extended for 3 months until 01 July 2026.
No other new Declarations were presented.

1.4a Minutes of the Last meeting

The minutes of the Trust Board meeting held on 11 March 2026, were reviewed and approved as a true and accurate record subject to minor amendments made.

1.4b Action Log

The Action Log was reviewed and updated, available under a separate cover.

1.4c Frances provided an update on the Trust being asked by the ICB to take over the Urgent Treatment Centre contract for 12 months. The CEO will support efforts to clarify the service specification, funding, and headcount requirements before a Board decision is made.

ACTION: Fire Safety Audit Update to come to the July Board (Estates)

2.0 OPENING MATTERS

2.1 Chairman's Report

John Goulston outlined the ongoing leadership transition, including the recruitment process for a new Chief Executive, upcoming stakeholder events, and the recruitment of other Executive posts, with final interviews and approval scheduled in coming weeks.

2.1.1 John advised the CEO interview process involves regional and ICB colleagues, with recommendations proceeding to the Trust Remuneration Committee and Council of Governors.

2.1.2 Recruitment for additional Executive posts is underway, with interviews expected towards the end of June 2026, aiming to strengthen the Board's leadership team John thanked Alison Davis and Frances Woodroffe, who will be leaving in June, for their service.

2.1.3 John highlighted the need for the Trust to improve operational services, as Kent and Medway were the only system in the South East forecasting a planned deficit position

2.2 Chief Executive Officer Report

The Chief Executive highlighted the following to the Board:

- 2.2.1 An expression of gratitude to colleagues for their continued professionalism, resilience and dedication during a challenging time.
- 2.2.2 Sincere thanks to Alison Davis, Chief Medical Officer, and Frances Woodroffe, Interim Chief Operating Officer, who will be leaving the Trust at the end of June.
- 2.2.3 The Trust is in the process of recruiting to the post of 'Turn around Director', updates will be shared once this individual is in post.
- 2.2.4 A warm welcome National Provider Improvement Programme (NPIP) colleagues, who are currently working with the Trust.
- 2.2.5 A new collaborative approach is being developed across the system, with provider alliances, stronger system leadership and clearer governance to support delivery of the NHS Ten Year Health Plan and improve outcomes for local people, and gain traction in developing a frailty model.
- 2.2.6 Recognition of the expanding Virtual Hospital Service in the inaugural national NHS Excellence Awards.
- 2.2.7 A strong response to this year's Medway Annual Star Awards, with 189 nominations received from staff across nine categories, up 12 per cent on last year.
- 2.2.8 Long service awards, with thanks to all staff involved, with over two thousand years of service between them.
- 2.2.9 Mojgan enquired into the forward plan for the virtual hospital; and if improvements are being seen with ED waits. Frances confirmed next steps include the expansion aligned to the community focusing on elderly patients. Month on month, the programme continues to improve 12 hour waits in ED.

3.0 IMPROVEMENT PLAN AND STRATEGY, INCLUDING IQPR

3.1a Culture

- 3.1.1 Siobhan and Sheridan detailed progress on the cultural transformation programme, including significant reduction in HR case backlog through the adoption of informal resolution approaches, and enhanced support for divisional leaders, with ongoing efforts to embed learning and improve staff engagement.
- 3.1.2 Siobhan emphasised the need for good representation and staff engagement, with listening sessions reviewing out of hours and night time visits. There is also a need to ensure engagement for those who do not have access to IT. Executive continue to sponsor listening events, extending the 'you said, we did'.
- 3.1.3 Sheridan confirmed HR backlog cases have reduced from 51 to 3, all of which are due for completion in May 2026. The new approach emphasises informal resolution and mediation, supported by updated policies and a robust employee relations tracker.

3.1.4 Paulette enquired about the cultural learning and how this will be embedded. Sheridan advised the employee relations team now prioritises informal conversations and mediation before formal processes, aiming to resolve issues early and prevent escalation, supported by management essentials training for leaders.

3.1.5 Paulette enquired about support from senior leaders. Sheridan confirmed each division has a named people business partner and ER advisor, with monthly performance review meetings attended by people and finance partners to support divisional management and case handling.

3.1b Performance

Frances provided an update on operational performance, including elective and cancer targets, challenges in urgent and emergency care, the impact of a meningitis outbreak, and ongoing quality improvement initiatives such as the virtual hospital and frailty pathways.

3.1.6 Frances advised the Trust met referral to treatment and cancer targets for 52 and 31/62 days, with fewer long-waiting patients, and improved treatment numbers noting the need to address ongoing challenges in specialties like rheumatology and neurology.

ACTION: Bring a recovery plan for rheumatology and neurology services to FPPC to address RTT performance and 52-week wait risks (Frances)

3.1.7 A meningitis outbreak led to increased ED attendance and required reconfiguration of care pathways, resulting in four-hour performances below plan and increased 12 hour waits.

3.1.8 The virtual hospital has expanded to support up to 150 patients, with demonstrable impact on hospital flow, reduced corridor care, and improved length of stay, particularly for older patients, with plans to further integrate with community partners.

3.1.9 Frances advised work is ongoing to develop frailty models to improve palliative care pathways, including reopening short stay and Same Day Emergency Care (SDEC) units, and collaborating with community partners to reduce unnecessary hospital admissions.

3.1.10 John emphasised zero tolerance of corridor care, as an important piece of work. Frances confirmed a lot of focus was being put on addressing corridor care,. Corridor care is a symptom of poor flow; therefore it was importance to address the root cause of the challenge. John suggested it would be good to know the areas the organization could address, and the impact of organising pathways. Siobhan confirmed support is being received from the ICB, reviewing best practice.

3.1.11 Paulette enquired how the organisation works with partner and community GP's, and if they understood the challenges with patients coming into ED because of the lack of GP appointments; therein response to Paulette's question on collaborative working. Siobhan confirmed the Trust is actively participating in provider and neighborhood alliances, aiming to integrate primary care, voluntary sector, mental health, and community services to manage outpatients and reduce acute admissions. Alison advised of regular meetings with GP committees and system medical directors are underway to address high need patient cohorts, improve data sharing, and develop joint approaches to care delivery.

- 3.1.12 Mojgan highlighted the need to also include the pharmacy community. Siobhan confirmed efforts are being made to better engage the voluntary sector and community pharmacy in supporting patient care, with discussions on providing space within the hospital and increasing referrals to community services.

ACTION: Bring an update back to the Board on the provider alliance, specifically regarding neighborhood scheme and engagement with the voluntary sector. (Siobhan)

- 3.1.13 Sheridan advised the Trust is considering strategies to address language and demographic barriers in the community, aiming to improve understanding of alternative care options and reduce unnecessary ED attendances.

3.1c Quality

Alison Davis and Evonne Hunt updated the Board on the Quality Improvement Plan.

- 3.1.14 Alison advised the Board on SHIMI and the focus at the Frailty summit with community and system partners. A Pneumonia and Sepsis pathway is now in place. Learning from Deaths has been strengthened through the PSIRF process.

- 3.1.14 Evonne confirmed a new clinical quality governance framework is being developed, with early warning dashboards and revised complaints handling using red-amber-green approach to ensure timely and appropriate responses.

- 3.1.15 Paulette Lewis enquired to concerns regarding emergency and QR coding for falls on certain wards.

ACTION: Investigate and address issues of emergency alarms for falls on certain wards, and ensure appropriate escalation and risk assessment (Evonne)

3.2 Finance – including Month 12 Report

Simon presented highlighted the following:

- 3.2.1 Simon stated the Trust ended the financial year with a £54.9m deficit, £50m adverse to plan, primarily due to the loss of deficit support funding and ambitious savings targets that were not met. The Trust had to borrow an additional £40m, incurring ongoing interest costs.
- 3.2.2 Simon noted of the £45m savings target, £18m was expected from system collaboration, which was not delivered. The Trust faces a new savings target of £38.8m for the coming year, with a stretch target of £50m, and will continue to receive deficit support funding.
- 3.2.3 The Finance, Planning and Performance Committee (FPPC) is closely monitoring the development and delivery of cost improvement plans, with 100% of the original £38m programme identified and a focus on deep dives into key areas such as job planning.
- 3.2.4 The Trust is tightening financial governance, approval processes, and use of standing financial instructions, with a focus on discretionary spend, agency and back costs, and structural changes to achieve financial targets.
- 3.2.5 External consultants, including PA Consulting and the System Improvement Director, have provided capacity, frameworks, and recommendations, particularly around ward closures,

corporate and clinical models, and urgent emergency care, with action plans being developed and monitored.

- 3.2.6 John emphasises the need to understand the triangulation between workforce, headcount and services, where is the organisation in terms of activity and staff figures.
- 3.2.7 Gary commented, in regards to risk appetite, the Board need to have sight of difficult decisions for challenge and a collective decision. The run rate needs to fall consistently to deliver confidence.
The Chair agreed and requested a specific report on Cost Improvement Plan for Board review alongside the application of risk appetite

Action: Chief Finance Officer

3.3 Risk Management Strategy

Molly introduced the first draft of the risk management strategy which aims to proactively identify and mitigate risk before they crystalise, enhance risk maturity, and empower senior managers through training and development, with an implementation plan to be monitored by the Audit Committee.

- 3.3.1 Helen enquired which committee will hold responsibility For oversight of risk management Molly confirmed the Quality Assurance Committee (QAC) is proposed s the Board's risk committee, with governance, risk, and compliance subcommittee jointly chaired by the CNO, CMO and CFO to manage interdependencies and triangulate risk across finance, quality and performance.
- 3.3.2 Molly confirmed the Terms of Reference (ToR's) for key committees, standing financial instructions, and the Scheme of Delegation were updated to reflect new responsibilities, with plans for clear communication and annual training for budget holders and managers.
- 3.3.4 Jenny requested a 'roadmap' for milestones to achieve the move from 'risk aware' by 2028. Molly confirmed a roadmap is being developed to enable the Trust to move from risk aware to risk defined and risk enabled over the next several years, with annual internal audit reviews and milestones to ensure sustainable progress and measure risk maturity A risk management action plan would be submitted to the Audit Committee and monitored there alongside QAC to aid scrutiny

ACTION: Updates to include Clinical Risk, and include addition to the five strategic objectives. To be reviewed at the Audit and Risk Committee.

The Board **APPROVED** the Risk Strategy subject to these changes

3.4 Trust Risk and Issues Report

The report was taken as read.

Evonne confirmed the report will reflect the Risk Management Strategy once approved. Controls will be monitored through subcommittees with leads attending to ensure triangulation and consistency of reporting.

3.5 External Capital Bids Update

Frances updated the Board on successful and pending capital bids, including significant funding for urgent care and diagnostics.

- 3.5.1 Frances confirmed the Trust has secured or is close to securing substantial capital funding, including £22.7m for urgent care, £26m for front door redesign, and £25m for estates safety, with projects to be delivered over multiple years.

- 3.5.2 Gary congratulated all colleagues who have been involved in the bids.

4.0 BOARD ASSURANCE

4.1 Reports of the Committee Chairs

4.1a Quality Assurance Committee

Mojgan Sani updated the Board in line with the paper submitted.

- 4.1.1 The Quality Committee focused on preventable deaths and a recent never event, requesting further information on actions and learning, and emphasising, the need for operational commitments to provide assurance.
- 4.1.2 The effectiveness survey highlighted areas for improvement with support from the Company Secretary. A strong subcommittee will provide assurance into QAC.
- 4.1.3 Siobhan emphasised the need for divisional reports to be updated and presented to QAC for triangulation of reporting.
- 4.1.4 Mojgan highlighted the Alert, Assure, Advise (AAA) template for assurance reporting for committees, with recommendations for training for report authors to improve the quality and focus of assurance papers. It was agreed that this template would be used for future Chair Assurance reports to the Board and QAC for a period of six months

ACTIONS: Provision of training to report authors and and disseminate chair reports to committee and group chairs

4.1b People Committee

Jenny Chong presented the report in line with the paper submitted.

- 4.1.5 Jenny highlighted risks around neurology consultant workforce and non-compliance with statutory training, with escalations to the system and plans for improved governance and education and training.
- 4.1.6 Jenny commented on the MSK deep dive presented to the Committee, with a request for an update to be delivered in September 2026. The impact on Trust accounts for 15% of sickness, costing £2m per year. Sheridan commented on plans for targeted prevention and improved risk assessments.
- 4.1.7 The staff survey response rate has declined by 7% with notable drops in advocacy, diversity and raising concerns. Divisions are working on action plans which will be presented to the next People Committee. Despite the decline in uptake BAME staff engagement has improved.

4.1.8 Sheridan advised that divisional absence management guidance has been developed, with a target to reduce sickness absence from 5.1% to 4.1%, supported by people business partners and regular performance review meetings.

4.1.9 Sheridan confirmed a new people insights report is being developed to connect data on vacancies, sickness, and cost improvement plan delivery, aiming to provide actionable insights for workforce planning and risk management.

4.1c Finance, Performance and Planning Committee

Helen Wiseman updated the Board in line with the paper submitted.

4.1.8 The FPPC is monitoring cost improvement plans, job planning, and implementing recommendations from the System Improvement Director, with ongoing scrutiny of financial performance.

5.0 REGULATORY AND CORPORATE GOVERNANCE

5.1 Annual Review of Committee Terms of Reference

5.1a Remuneration Committee

APPROVED subject to minor amendments

5.1b Finance, Planning and Performance Committee

APPROVED subject to minor amendments to be reviewed at FPPC.

5.1c Quality Assurance Committee

APPROVED subject to minor amendments to be reviewed at QAC.

5.2 Annual Review of Standing Financial Instructions and Scheme of Delegation

Molly Marcu presented the report in line with paper submitted which now includes roles for delegation.

The report was **APPROVED** subject to minor amendments

ACTION: A one-page summary to be disseminated via Comms

ACTION: To be added to the forward planner for annual review.

5.3 Annual Review of Standing Orders

Molly Marcu presented the report in line with paper submitted. The standing orders form part of the constitution which is due for review at the July Board.

5.4 Board Members Designations

Molly Marcu presented the document for noting.

5.4.1 John commented on the Trust Chair, currently, as a member of FPPC, this is due to a vacancy within the Non-Executive Directors. To be updated once a new NED is in post.

The Board **NOTED** the update.

5.5 Estates Strategy

Neil McElduff presented the strategy to the Board. The strategy has been developed in collaboration with clinical teams, outlining a 30-year investment plan to modernize the hospital, improve working conditions, and align with clinical, digital, and financial strategies.

- 5.1.1 Neil confirmed that business cases will be developed for each project and require Board approval, with oversight by FPPC and integration with the Trust's annual work plan.
- 5.1.2 Gary encouraged colleagues to report estate related incidents, through Datix, to support future capital bids.
- 5.1.3 Frances confirmed plans to incorporate research on the impact of estates conditions on patient safety into operational processes.

ACTION: Neil to provide a summary report to CoG in May.

5.6 Lead Governors Report

Tina Rowe gave the Board a verbal update on recent Governor engagement and upcoming activities, including the appointment of a new Partner Governor Marion Cogger, coffee and chat sessions, ward accreditations and preparations for the Medway Star Awards.

6.0 Closing Matters

6.1 Questions from the Council of Governors and Public

- 6.1.1 Susan Plummer asked if NPIP colleagues will be attending the Council of Governors meeting. Steve Lennox confirmed they will be attending.
- 6.1.2 Tina Rowe asked if PA consultancy have recommended immediate actions. Simon confirmed PA have been involved in extra capacity for additional reporting, helping on ward closures, corporate target functions, and clinical models. They have identified seven priorities.
- 6.1.3 Tina Rowe enquired if capital spending should happen early in the financial year. Simon responded that the idea is to spend capital as soon as possible, there were delays due to cash challenges. There is a business case and procurement process for capital spending.
- 6.1.4 Tina Rowe asked, in regards to MSK, colleagues with back pain is this due to sitting at desks too long. Jenny confirmed this will be reviewed by risk assessments, the Trust now has a colleague for rigorous review.

6.2 Escalations to the Council of Governors

- Committee Chairs Assurance Reports.
- Summary of Risk Management Strategy
- Designations of the Board
- Summary of the Estates Strategy.

6.3 Any Other Business and Reflections

No other business for this meeting.

6.4 Date and time of next meeting

Wednesday, 01 July 2026

The meeting closed at 12:20

These minutes are agreed to be a correct record of the Board Meeting in PUBLIC of Medway
NHS Foundation Trust held on Wednesday, 06 May 2026

Goulston

Signed by Chair Date:

DRAFT

Public Trust Board

Action Log

Actions are RAG Rated as follows:

Off trajectory -
The action is
behind
schedule

Due date passed
and action not
complete

Action complete/
propose for
closure

Action not yet
due

Meeting Date	Minute Ref / Action No	Action	Action Due Date	Owner	Current position	Status
14.01.26	TB/2026/004	Fire Safety Audit update to be presented to the March Board meeting	02.09.26 ~~05.03.26~~	Estates and Facilities	Rescheduled to the September meeting	Amber
06.05.26	TB/2026/005	Recovery plan for rheumatology and neurology services to FPPC to address RTT performance and 52-week wait risks	01.07.26	Chief Operating Officer	ACTIONED	Green
06.05.26	TB/2026/006	Update back to the Board on the provider alliance, specifically regarding neighborhood scheme and engagement with the voluntary sector	01.07.26	Chief Executive		White
06.05.26	TB/2026/007	Investigate and address issues of emergency alarms for falls on certain wards, and ensure appropriate escalation and risk assessment	01.07.26	Chief Nursing Officer		
06.05.26	TB/2026/008	Monthly Finance Report - Cost Improvement Plan for board review alongside the application of risk appetite	01.07.26	Chief Fiance Officer		
06.05.26	TB/2026/009	Risk Mangement Strategy - Updates to include Clinical Risk, and include addition to the five strategic objectives. To be reviewed at the Audit and Risk Committee	22.05.26	Chief Fiance Officer	ACTIONED	Green
06.05.26	TB/2026/010	QAC Assurance Report - Provision of training to report authors and disseminate chair reports to committee and group chairs	01.07.26			
06.05.26	TB/2026/011	Committee Terms of Reference - A one-page summary to be disseminated via Comms. To be added to the forward planner for annual review	01.07.26	Company Secretary	Added to forward planner. One page summary to Comms once all Committee ToRs approved.	Amber
06.05.26	TB/2026/012	Estates Strategy - NM to provide a summary report to CoG in May	13.05.26	Directors of Estates and Facilities	ACTIONED - summary presented at the May CoG	Green

Report to	NHS System Leadership Group
Meeting date	26 June 2026
Report Title	System Governance and Joint Committee Alignment: Joint Committee Board Report
Key question	Is the System Leadership Group content with the proposed approach to issuing a consistent Joint Committee update to all Boards, including the phasing and supporting arrangements?
Executive Lead	Adam Doyle, Chief Executive Officer, NHS Kent and Medway
Author	Adam Doyle, Chief Executive Officer, NHS Kent and Medway

Which of the organisation's strategic objectives does the report support:	
☐ Commission the right services each year	☐ To ensure financial sustainability over three years
☒ Lead strategy and ensure commissioning levers deliver impact	☐ Develop into a high-performing Commissioning Organisation
☐ Renew our culture for long-term sustainability	

Recommendation (outcome / action requested):
Meeting action required: ☒ Seek assurance ☐ Decision/approval required ☐ For noting/information Recommendation(s) to the Meeting: The Meeting is asked to: NOTE the contents of this report SUPPORT the approach to co-ordinated circulation across partner organisations NOTE the proposed phasing, with the ICB Company Secretary working with partner organisation Company Secretaries and Director of Communications to support messaging and consistency of communications

Executive summary:
This paper presents the draft Board report summarising the outcome of the Joint Committee discussion on system transformation, care models and commissioning architecture, for onward consideration by the ICB Board and partner provider Boards.

The intention is to provide a single, consistent system narrative following Joint Committee, ensuring alignment across organisations on the agreed direction of travel and expectations for delivery.

The ICB Company Secretary is working with Company Secretaries across partner organisations to agree the phasing of Board discussions, ensuring coordinated timing and alignment of governance processes. The Director of Communications will support the approach to ensure clarity and consistency of messaging.

The System Leadership Group is invited to note the proposed approach and provide assurance that it is appropriate.

Proposed next steps:

- Finalise the Board report following SLG feedback
- Agree phasing and timing of Board presentations with partner Company Secretaries
- Support coordinated communication and messaging across organisations
- Issue report to all Boards in line with agreed approach

Governance pathway to date:

Meeting name:	Date:	Outcome:
N/A		

Contact for further information

Adam Doyle, adam.doyle5@nhs.net

COMPLIANCE NOTES:

Equality, health inequalities, and quality impact assessment

If this report is presented for decision/approval, please complete:

Has an assessment been undertaken?

- ☐ Yes (please attach the action plan as an appendix to this paper)
- ☒ No/Not applicable (please indicate why an assessment was not required)

An Equality and Health Inequalities and Quality Impact Assessment has not been undertaken as this paper is a strategic update on agreed system direction and proposed Board reporting, and does not introduce any direct changes to services, access or delivery.

Conflicts of Interest

COMPLIANCE NOTES:

Are there any conflicts associated with authors or reporting officers?

☐ Yes ☒ No

If yes, please confirm how the conflict has been managed.

FOI Status

Is this report disclosable under FOI?

☒ Yes ☐ No

If no, please specify why:

Financial Implications

Are there financial implications associated with this report?

☐ Yes ☒ No

If yes, please describe:

Legal Implications

Are there legal implications associated with this report?

☐ Yes ☒ No

If yes, please describe:

Quality and Safety Implications

Are there quality or safety implications associated with this report?

☐ Yes ☒ No

If yes, please describe:

Patient and Public Engagement

Are there patient and public engagement implications associated with this report?

☐ Yes ☒ No

If yes, please describe. If no, please specify why:

There are no patient and public engagement implications as this paper communicates an agreed system position and approach to Board reporting; any future service changes arising from this work will be subject to appropriate engagement.

SYSTEM GOVERNANCE AND JOINT COMMITTEE ALIGNMENT: JOINT COMMITTEE BOARD REPORT

1. INTRODUCTION

This paper presents the draft Board report summarising the outcome of the Joint Committee discussion on system transformation, care models and commissioning architecture. It is intended for onward consideration by the ICB Board and partner provider Boards, providing a single, consistent system narrative and ensuring alignment on the agreed direction of travel and expectations for delivery.

2. STRATEGIC ALIGNMENT

This report supports delivery of the agreed system transformation programme, including the move to a more integrated, population-based model of care, strengthened provider alliances and the transition to strategic commissioning. It enables a consistent understanding across Boards, supporting collective leadership, coordinated decision-making and alignment to system priorities, including improved outcomes, reduced inequalities and financial sustainability.

3. JOINT COMMITTEE BOARD REPORT

The attached report reflects the outcome of the Joint Committee discussion, confirming areas of agreement and setting out clear expectations for the next phase of delivery. It is designed to be issued to all Boards as a consistent account of system direction, supported by coordinated phasing of discussions across organisations. The ICB Company Secretary is working with Company Secretaries across partner organisations to agree the timing and sequencing of Board consideration, with support from the Director of Communications to ensure clarity and consistency of messaging.

4. KEY RISKS, MITIGATIONS, AND CONTROLS

There is a risk that, without a coordinated approach, differing timing or interpretation of the Joint Committee outcomes across organisations could lead to inconsistency in understanding, messaging or organisational response. This is being mitigated through a structured, system-wide approach led by the ICB Company Secretary in collaboration with partner Company Secretaries to align Board cycles and phasing. In addition, communications support will ensure consistent messaging and narrative across organisations, reducing the risk of misalignment and supporting collective ownership of the agreed direction.

5. OTHER CONSIDERATIONS

There are no other considerations relevant to this report.

6. REQUIRED OUTCOMES AND NEXT STEPS

The Meeting is asked to:

- **NOTE** the proposed Board report content following Joint Committee
- **SUPPORT** the approach to coordinated circulation across partner organisations
- **NOTE** the proposed phasing, with the ICB Company Secretary working with partner organisation Company Secretaries and Director of Communications to support messaging and consistency of communications

7. SUPPORTING DOCUMENTATION

There are no supporting documents relevant to this report.

Appendices:

Appendix 1: Joint Committee Board Report

NHS Kent and Medway Joint Committee
System Transformation, Care Models and Commissioning Architecture
Report for Noting – Following Joint Committee Discussion

1. Purpose

- 1.1. This paper brings together the previously circulated system architecture and care model proposals and provides an update following discussion at the Joint Committee.
- 1.2. The purpose of this report is to confirm the areas of agreement reached, clarify the expectations arising from that discussion, and provide a consistent system narrative for consideration by the ICB Board and partner provider Boards.
- 1.3. The Joint Committee confirmed that there is now a shared understanding of both the direction of travel and the scale of change required across Kent and Medway.

2. Context and Rationale for Change

- 2.1. The context set out in the original paper remains unchanged. The system continues to operate under sustained financial, operational and workforce pressure, with variation in access and outcomes and a delivery model that remains overly reliant on hospital-based care.
- 2.2. The Joint Committee explicitly confirmed that:
 - The current model has reached its limits and is no longer sustainable
 - Incremental change will not deliver the scale of improvement required
 - A more fundamental shift in how care is organised and delivered is necessary
- 2.3. There was a clear and consistent articulation from provider organisations that their current models are both clinically and financially unsustainable in their present form. This was recognised collectively as a critical driver for change across the system.

3. The System Model: Four Layers of Care

- 3.1. The Joint Committee confirmed agreement with the four-layer model of care as the organising framework for the system:
 - Primary care
 - Neighbourhood care
 - Intermediate care at scale
 - Acute care
- 3.2. There was strong support for this structure as the right foundation for future delivery. However, the discussion emphasised that the models within these

layers must remain deliberately fluid and adaptive, rather than fixed end-states.

3.3. The Committee recognised that:

- The overall framework is now clear and widely understood
- Clinical models within each layer are at varying stages of development
- Further clinically led work is required to define how care will be delivered in practice

3.4. Importantly, the discussion highlighted that stronger clinical leadership across the health and care economy is now essential to progress this work. The scale of change required cannot be delivered solely through organisational or managerial leadership. It will require:

- Visible and credible clinical leadership at system level
- Greater alignment of clinical leaders across organisations and care settings
- Clinically led design and ownership of future service models

3.5. It was therefore agreed that strengthening clinical leadership capacity and coherence across Kent and Medway is a critical enabler of the next phase, alongside the continued development of detailed clinical models, particularly within acute care.

4. Implications for System Architecture

4.1. The system architecture described in the original paper, with neighbourhoods as the core unit of delivery supported by alliance-based working, was supported by the Joint Committee.

4.2. The discussion reinforced the expectation that:

- Organisations will operate within a clearly defined system framework
- Decision-making will be taken at the appropriate level with shared accountability
- Behaviour will shift from organisational optimisation to system-wide outcomes

4.3. There was a clear acknowledgement that this represents not only a structural change but a significant shift in leadership behaviour across the system.

5. Provider Alliances and Delivery Expectations

5.1. The Joint Committee confirmed the central role of provider alliances in leading delivery and transformation across the system.

5.2. There was a clear and consistent view that acute providers will need to work significantly more closely together, particularly in relation to:

- Clinical service lines
 - Workforce utilisation
 - Cost management
 - Productivity and efficiency
- 5.3. This shift will require strong and aligned clinical leadership across acute providers, ensuring that decisions on service configuration and delivery are clinically led, evidence-based and collectively owned.
- 5.4. The Committee agreed that the Neighbourhood Health Alliance must now accelerate its development and delivery role at pace.
- 5.5. In particular, it will need to move quickly to a position where it is:
- Clinically led, with clear models of care
 - Operationally effective at scale
 - Financially accountable for delivery
- 5.6. This again reinforces the requirement for consistent clinical leadership within and across neighbourhoods, bringing together primary, community and specialist expertise.

6. Strategic Commissioning and Commissioning Intentions

- 6.1. The Joint Committee reaffirmed support for the transition to strategic commissioning, with commissioning intentions as the primary mechanism for translating strategy into delivery.
- 6.2. The discussion also clarified more explicitly how the ICB's role will evolve in practice.
- 6.3. There was a clear expectation that the commissioning function will be increasingly focused on securing the best possible value from contracts and ensuring that every pound spent delivers demonstrable benefit for population outcomes. This represents a shift towards a more rigorous and outcomes-focused approach to commissioning, with greater scrutiny of value, productivity and impact.
- 6.4. It was recognised within the discussion that this approach may create individual organisational pressures for providers, particularly where existing contracts, cost bases or service configurations are not aligned to the emerging model.
- 6.5. However, there was a clear and shared view that these challenges must not be addressed in isolation. Instead, they will need to be worked through collectively across the system, with the provider alliances acting as the primary mechanism for resolving these issues.
- 6.6. This reinforces the expectation that:

- Financial and contractual challenges will be overtly addressed at a provider and system level
 - Providers will work together through alliance arrangements to redesign services and manage consequences
 - Commissioning and provider collaboration will be essential to ensure a coherent transition to the new model
- 6.7. The Committee also emphasised that this transition must be managed in a way that maintains delivery grip during 2026/27.

7. Financial Context and System Imperative

- 7.1. A central theme of the discussion was the scale of the system's financial challenge.
- 7.2. The Joint Committee agreed that the system financial position is now paramount in shaping decisions and priorities. This reinforces the need for:
- Rapid progress on productivity and efficiency
 - Alignment between financial plans and clinical models
 - Collective ownership of financial sustainability across organisations
- 7.3. The clinical and quality outcomes and financial context was recognised as a major driver of urgency in implementing the new model.

8. Governance and System Leadership

- 8.1. The Joint Committee confirmed agreement with the proposed governance arrangements, including the role of the Joint Committee as the primary forum for system-level decision making and accountability. There was explicit agreement that:
- A formal report will be produced following each Joint Committee meeting
 - This report will be shared with all partner Boards in public
 - This will provide a single, consistent narrative of system decisions and progress
- 8.2. This paper constitutes part of that agreed reporting approach.

9. Organisational Development and Leadership

- 9.1. The discussion reinforced that delivery of the model will require a step change in leadership capability, relationships and behaviours across the system.
- 9.2. The Joint Committee supported the proposed organisational development approach, recognising that:

- Building trust and collective leadership is essential to success
- Leadership behaviour must align with system expectations
- Clinical leadership must be strengthened alongside managerial leadership, with a clearer and more consistent voice for clinicians in system decision-making and service design
- This programme is a core enabler of transformation rather than a supporting activity

10. Key Risks and Focus for the Next Phase

10.1. The risks outlined in the original paper were endorsed, with particular emphasis on:

- The pace of clinical model development
- Clarity of accountability for delivery
- The ability of organisations to operate collectively

10.2. The Joint Committee was clear that progress over the next six months will depend on maintaining clarity of direction, strengthening system leadership and ensuring that delivery is not compromised during the transition.

11. Conclusion

11.1. The Joint Committee discussion confirmed that Kent and Medway has reached a clear point of alignment on its future model. There is now:

- Agreement on the overall structure and direction of travel
- A shared recognition that the current model is unsustainable
- Clear expectations for greater collaboration, particularly within acute services
- A requirement to accelerate neighbourhood delivery
- A clear need to strengthen clinical leadership across the system
- A collective understanding that financial sustainability is central to all decisions

11.2. The focus now moves from agreement to delivery, with pace, discipline and collective leadership critical to success.

12. Recommendation

12.1. The ICB Board and partner provider Boards are asked to:

- Note the outcome of the Joint Committee discussion
- Confirm their continued support for the agreed direction of travel
- Consider the implications for their organisations, particularly in relation to collaboration, clinical model development, leadership capacity and financial sustainability

Chief Executive's report: 1 July 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.

Chief Executive appointment

Mark Orchard has been appointed as the Trust's new Chief Executive, starting this autumn. He has held Board-level executive roles in complex NHS organisations for over 17 years, spanning hospital and community services, physical and mental health commissioning, and system oversight.

Currently Group Deputy Chief Executive for Portsmouth Hospitals University NHS Trust and Isle of Wight NHS Trust, he has also held several national roles, including serving as President of the Healthcare Financial Management Association.

Mark's leadership will be key to setting shared priorities with local NHS and council partners, and deepening collaboration with Dartford and Gravesham NHS Trust, to build on what we each do well, drive innovation to improve patient care, and strengthen future services. Recruitment to four substantive Executive Director positions is under way.

Industrial action

I would like to thank colleagues for their significant effort in preparing for last month's planned industrial action by Resident Doctors, putting detailed plans in place to ensure rosters were covered and protecting planned activity, alongside emergency care. Following the decision to stand down the action, colleagues responded quickly to stand down cover arrangements and reinstate as much planned activity as possible.

Archbishop of Canterbury visit

We were delighted to welcome the Archbishop of Canterbury, Dame Sarah Mullally, to the hospital in June as part of a wider pastoral visit within the Diocese of Rochester. During her visit, Archbishop Sarah shared her deep gratitude for the work of Trust staff and for the comfort and support the chaplains offer to staff and to patients and their families, and spent time on a ward. The visit was particularly poignant for Matron Sharon Molloy who worked with Archbishop Sarah, a former Chief Nursing Officer for England, 37 years ago at the former Westminster Hospital.

Eliminating corridor care

We are embarking on a significant system-wide programme to eliminate corridor care, which will support the delivery of our Improvement Plan priorities – treating patients sooner, improving outcomes, transforming our culture, strengthening our finances and improving our governance.

The work aligns with NHS England's guidance on corridor care, issued in March, and the NHS's commitment to eliminate practices that impact patient experience, safety and staff morale. We know from elsewhere in the NHS that eliminating corridor care is achievable, and we will build on learning both locally and nationally.

Recognising that this is a whole-system challenge, a series of workstreams is being established to focus on clinical standards, improving flow, reducing long stays, frailty and mental health. This work will be overseen by a new fortnightly system oversight forum, jointly chaired by NHS Kent and Medway and NHS England South East, bringing partners together to drive delivery, remove barriers and maintain collective accountability.

Maternity and neonatal services

Donna Ockenden's review into maternity and neonatal services at Nottingham University Hospitals NHS Trust sets out serious and distressing failings, and although focused on one organisation, the findings have clear implications for the wider NHS.

In response, we will undertake a comprehensive self-assessment of our maternity and neonatal services against the findings and recommendations of the Ockenden review. This will provide assurance regarding the quality and safety of our services, our culture, governance arrangements and our approach to addressing health inequalities, while identifying any areas requiring improvement.

We will also assess our position against the findings of the National Maternity and Neonatal Investigation led by Baroness Amos, which examines services across 12 trusts. Where gaps are identified, a clear improvement plan will be developed.

Acting on culture review findings

Last month's *Be the Change* events strengthened staff awareness of the actions we are taking in response to last year's culture review and encouraged colleagues to play an active role in creating a safer, fairer and more inclusive workplace.

Some of the themes from our own review echo those in Lord Mann's recent report on racism and antisemitism in the NHS, which calls for stronger leadership, clearer standards and better support for staff who experience discrimination.

In his letter to Chief Executives, Sir Jim Mackey, Chief Executive, NHS England, set out required actions for all NHS organisations, including adopting the Seven Anti-Racism Principles, strengthening equality and anti-racism training, and ensuring Boards address staff survey findings on experiences of racism.

This national direction aligns closely with our own cultural transformation programme, and we will incorporate new requirements into our existing cultural transformation workstreams. An update will be provided to the September Board.

National Oversight Framework

I am pleased to report continued improvement in our position within the National Oversight Framework (NOF) quarterly league table, moving from 133/134 in quarter one last year to 114/134 in quarter four. This reflects the significant progress made in improving access to cancer and elective care over the latter half of last year.

NHS England published the NHS Oversight Framework for 2026/27 last month, setting out a refined approach to oversight that strengthens the link between performance, capability and the level of support required, and clarifies the role of regional teams in driving improvement.

We welcome the support of the National Provider Improvement Programme (NPiP) team, who are working with us to support improvements in governance, culture, Board effectiveness and improvement capability.

Investing in new equipment to improve care

In May we opened our upgraded Interventional Radiology suite following a £3m investment in a new machine that delivers enhanced image quality, lower radiation doses and expanded clinical capability.

Our Interventional Radiology team undertakes around 1,500 procedures each year, many of them time critical. The new equipment enables procedures we could not previously offer and improves the patient experience through upgraded facilities in both the suite and recovery areas.

Increased recovery capacity also means we can complete more outpatient and biopsy procedures in each session, helping to reduce waiting times, particularly for patients on cancer pathways.

National recognition

I am delighted that two Trust teams have achieved national recognition in recent weeks.

Our Virtual Hospital won the Delivering Value Award at Wednesday's inaugural NHS Excellence Awards, highlighting its impact in safely shifting care from hospital to home. Colleagues from our Surgical Medical Acute Recovery Team (SMART) received the award at NHS ConfedExpo in Manchester.

Our Knowledge and Library Team has been shortlisted for a Health Service Journal (HSJ) Patient Safety Award for creating a single, trusted source of clinical guidance on the British Medical Association (BMJ) Best Practice app, driving an almost 200 per cent increase in guideline use, improving consistency of care. Winners will be announced in September.

Annual Star Awards

Finally, I would like to recognise all colleagues nominated for this year's Medway Annual Star Awards, which will take place at the hospital on Thursday 16 July. This is a very special opportunity to celebrate colleagues who have shown great compassion and commitment over the last year.

Nine of the twelve awards were nominated by colleagues, with the Team of the Year and Employee of the Year picked by a judging panel from our monthly award winners. Our public-voted category is the Hospital Hero Award, and I would like to particularly acknowledge this year's finalists:

- Annie Huxtable, a much-loved play specialist known to families as "Aunty Annie";
- Alpha Abawag ("Pinky"), a Senior Clinical Support Worker in Same Day Emergency Care (SDEC) recognised for her calm, compassionate support to patients;
- Dr Surendra Singham, whose swift clinical judgement ensured timely specialist care for a young patient with a complex condition; and
- Marina Crockett, a Pembroke Ward hostess whose warmth and kindness provided comfort to patients and families at some of their most difficult moments.

Together, they represent the very best of Medway — colleagues who go above and beyond to deliver outstanding care and support to our patients and community.

Cultural Transformation Programme Programme Board

11.06.2026



Agenda – Cultural Transformation Board



Objectives	✓ Review progress for Milestones and deliverables across the programme ✓ Understanding high level position for each CT workstreams ✓ Monitor and manage programme risks and issues ✓ Share celebration's for work going on in the programme. ✓ Escalate any issues and concerns to the Stakeholders	#	Agenda Item	Lead	Start time	Time (60 mins)
		1.	Welcome and Apologies	Chair	10:15	5 mins
		2.	Review Actions from Previous meeting	Chair		
		3.	High Level Programme Update 1. Review Key Milestones and Programme Timeline 2. Interdependences, Risk and Issues review 3. Review KPIs	Programme Manager	10:20	15 mins
		4.	Workstream Highlight report updates Workstream 1- Rebuilding Trust – Workstream Update	Rodney Harford-Rothwell & Jennifer Teke	10:35	25 mins (5 mins per workstream)
			Workstream 2- HR Processes – Workstream Update	Sylvia Stevenson & Stephen McGowan		
			Workstream 3 – Safe to work, Safe to Care – Workstream Update	Stemby Pindeni & Amanda Russell		
			Workstream 4 – Leadership Accountability and Fixing the middle – Workstream Update	Lisa Webb		
			Workstream 5 – GenderWise – Workstream Update	Ghada Ramadan		
		5.	Communication and Engagement Highlight report activity – Workstream Update	Abby King	11:00	5 Mins
		6.	Summary of Decisions and Actions	Chair	11:05	5 mins
		7.	AOB	All Stakeholders		
		8.	Date and time of next meeting: Thursday 9th July 10:15			

Action Log – Outstanding/Due actions

Meeting Date	Workstream	Action	Action Due Date	Owner	Current Position	Status
13/04/2026	Programme Board	Develop Model for managing listening advocates	15/05/2026	Workstream 1	To be discussed in WS1 meeting 15/04/2026	Overdue
14/05/2026	Workstream 1 - Rebuilding Trust	Confirm ownership model for Listening Advocate; develop approach for non-9–5 staff engagement (WS1)	11/06/2026	Rodney Hardford - Rothwell/ Jenny Teke	This action can be done, once below action relating to Sylvia and SROs is complete	In progress - On track
14/05/2026	Workstream 1 - Rebuilding Trust	Liaise with Workstream leads regarding how to manage Listening Advocates moving forward	11/06/2026	Sylvia Stevenson	Preliminary discussion to take place to agree approach with key stakeholders from the workstream before taking approach to the workstream	In progress - At risk
14/05/2026	Workstream 1 - Rebuilding Trust	Bring revised Listening event SOP back to Programme Board	11/06/2026	Rodney Hardford - Rothwell/ Jenny Teke	Collating feedback from Listening advocates that have used current SOP to inform amendments to the SOP. SOP will be updated and reviewed in line with agreed revision date	In progress - At risk
14/05/2026	Programme Board	Provide clearer update, timelines and purpose of Genderwise dashboard	11/06/2026	Ghada Ramadan		Not Started

High Level Programme Update

Adam Walton – Programme Manager



Cultural Transformation	
Exec Lead	Sheridan Flavin/Siobhan Callanan
Programme Manager	Adam Walton
Date	June 2026
Programme RAG Status	Amber
RAG Justification	x4 Workstreams AMBER, x1 Workstream GREEN - Capacity and resource constraints continue to impact delivery, particularly around securing consistent operational and clinical engagement across some workstreams and subgroups. This is affecting the pace at which activities can be progressed and embedded. SROs, and delivery of key engagement activities such as Listening Advocate training and stakeholder events. - Engagement and participation across workstreams remains variable. Whilst some workstreams have established memberships and regular attendance, others are still building membership and are not consistently achieving the level of engagement required to drive activity forward. This presents a programme-level risk to maintaining momentum and delivering planned outcomes.. - The programme has significantly increased listening and engagement activity; however, the processes for analysing feedback, identifying themes and consistently demonstrating outcomes are still under development. The "You Said, We Did" approach is yet to be agreed, limiting the programme's ability to evidence impact and demonstrate how staff feedback is driving change across the organisation.

Progress Update	
- Communications and engagement activity continues to increase across the programme, with successful Marketplace events, listening sessions, surveys, Clock Tower content and leadership-led engagement helping to raise awareness and encourage staff participation. - Significant progress has been made in developing the organisation's listening approach, including the growth of the Listening Advocate network with the use of MS teams, establishment of communities of practice and improved mechanisms for gathering staff feedback across multiple channels. - Leadership, management and inclusion initiatives continue to progress, including the development of new learning offers, expansion of Lunch and Learn programmes, targeted listening activity and work to better understand the impact of leadership development across the organisation. - Whilst momentum across the programme remains positive, challenges remain around capacity, engagement and workstream maturity. Further work is required to fully embed the "You Said, We Did" approach, improve analysis of listening feedback and ensure all workstreams have the membership and support needed to deliver sustainable change.	



Celebrations:

- 51 Listening Advocates have now been trained, with a further 24 booked, bringing the total to 75 colleagues engaged in the programme
- Listening Advocate Teams Channel launched, creating a growing community of practice and peer support network.
- Successful delivery of the first Cultural Transformation Marketplace event with strong staff engagement.
- Genderwise survey launched, receiving over 100 responses on its first day and generating strong engagement.
- "Leading with Confidence: Addressing Racism in the Workplace" training module agreed and ready for delivery.



Programme Workstreams

- Workstream 1: Rebuilding Trust
- Workstream 2: HR Case Review/ Processes
- Workstream 3: Work Safety
- Workstream 4: Leadership Accountability and fixing the middle
- Workstream 5: GenderWise



Escalations and Decisions:

No escalations or decisions for programme board



Key Milestones Achievements this Period:

- Launch of the Listening Advocate page on The Clock Tower and community of teams.
- 51 Listening Advocates trained, with additional cohorts booked.
- "Leading with Confidence: Addressing Racism in the Workplace" training module agreed and ready for delivery.
- Psychological Safety listening questions agreed and subgroup governance arrangements confirmed.

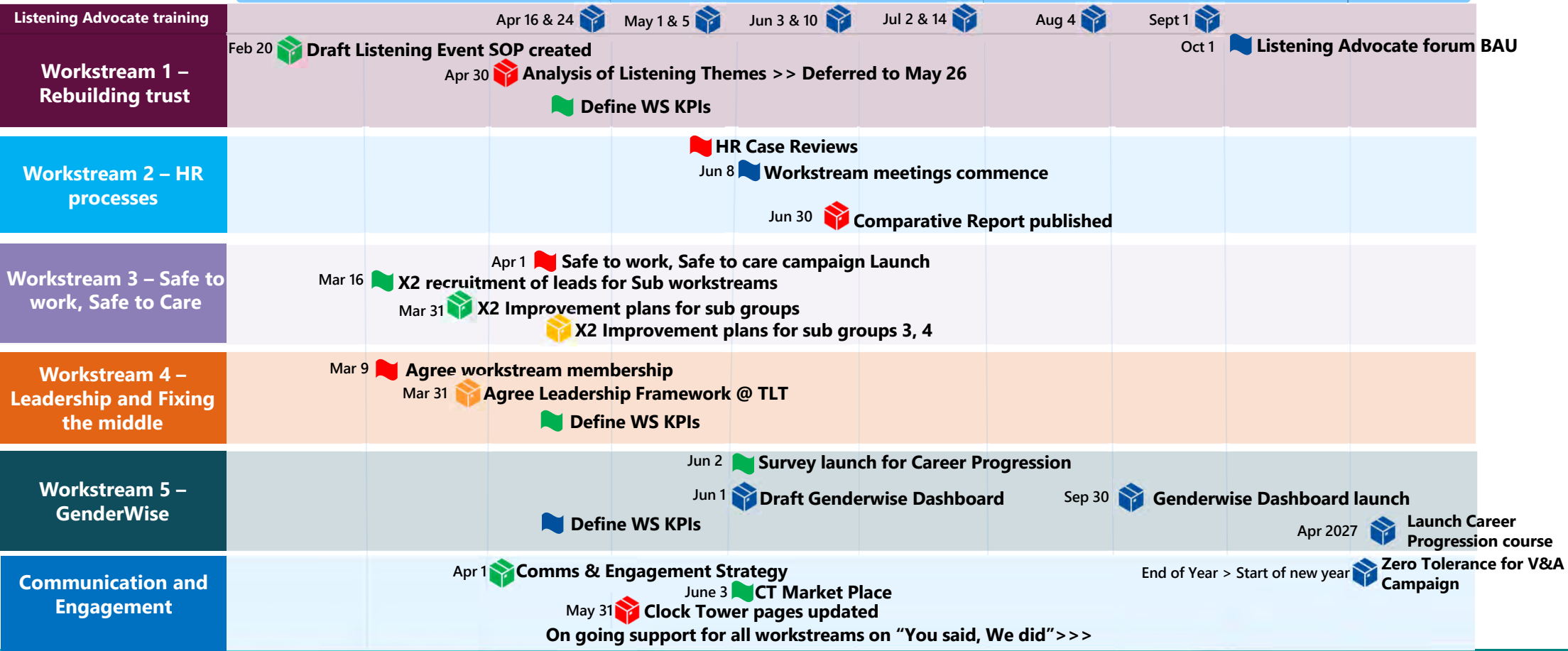


Key Milestones Planned:

- Establish a consistent "You Said, We Did" communication process across the organisation.
- Complete final comparator case review and publish findings and recommendations.
- Deliver Psychological Safety local listening events and thematic analysis.
- Expand and communicate the Lunch & Learn programme.

Icon	What it is
	Milestone
	Deliverable

Cultural Transformation Timeline



MFT CT Structure



Medway

NHS Foundation Trust

Executive Sponsors
John Goulston [Chair] and Siobhan Callanan [Interim CEO]

People Team Committee
Sheridan Flavin [Interim CPO] and Jenny Chong [NED]

Frances Woodroffe
Deputy CEO

Sheridan Flavin
Interim CPO

Evonne Hunt
CNO

Simon Wombwell
Interim CFO

Darren Palmer
Acting COO

Alison Davis
CMO

Jane Perry
NED

Mojgan Sani
NED

Gary Lupton
NED

Helen Wiseman
NED

Paulette Lewis
NED

Jenny Chong
NED

WS1: Rebuilding Trust
F. Woodroffe – Exec. Sponsor
J. Perry – NED Partner
Public Governors x 2

WS2: HR Case Review
S. Flavin – Exec. Sponsor
M. Sani – NED Partner

WS3: Work Safety
Evonne Hunt – Exec. Sponsor
G. Lupton – NED Partner
Staff Governor - TBC

WS4: L/ship Account & Fixing the middle
D. Palmer – Exec. Sponsor
S. Flavin – Exec. Sponsor
H. Wiseman – NED Partner
P. Lewis – NED Partner

WS5: Genderwise
A. Davis – Exec. Sponsor
J. Chong – NED Partner
Staff Governor – K Feegan

Communicating, Engaging and Connecting with Our People

Learning, Growing and Improving Together

Owning, Acting and Staying Accountable

MFT CT Workstreams

WS1: Rebuilding Trust

F. Woodroffe – Exec. Sponsor
J. Perry – NED Partner
Public Governors x 2

WS2: HR Case Review

S. Flavin – Exec. Sponsor
M. Sani – NED Partner

WS3: Work Safety

Evonne Hunt – Exec. Sponsor
G. Lupton – NED Partner
Staff Governor – Matthew Taino

WS4: L/ship Account & Fixing the middle

D. Palmer – Exec. Sponsor
S. Flavin – Exec. Sponsor
H. Wiseman – NED Partner
P. Lewis – NED Partner

WS5: Genderwise

A. Davis – Exec. Sponsor
J. Chong – NED Partner
Staff Governor – K Feegan

Name	Title
Jennifer Teke	Head of Research & Innovation
Rodney Hartford - Rothwell	Head of Infection Control and Prevention
Nikki Singh	Head of Staff well-being and Experience
Sophie Cawsey	Communication and Engagement lead
Phoebe Eluwande	Practice Development Nurse
Lisa Webb	Associate Director of Organisational Development
Laura Potter	Director of Nursing & AHP
Jocelyn Hargan	Divisional Director of Nursing – S&A
Adebayo Da - Costa	Divisional Medical Director - MEC
Neil McElduff	Director Of Estates and Facilities
Victor Anota	Clinical Director - AEM
Natasha Barrett-Salvador	Freedom to speak up Guardian

Name	Title
Stephen McGowen	Deputy Chief People Officer
Sylvia Stevenson	Director – Absolute Diversity
Emma Wilson	Head of Employee Relations
Jo Nicholls	Resolution Business Partner
Jackie Wyse	ER Manager
Abby King	Deputy Director of Comms and Engagement

Name	Title
Amanda Russell	Director Of Nursing WYCP
Stemby Pinden	Head of Occupational Health
Jessica Harman	Simulation & Clinical Skills Manager
Andrew Sibthroe	Business Change Analyst
Louise Farrow	Macmillan Lead Cancer Nurse/Head of Nursing - C&A
Natasha Mersh	Lead Nurse Manager - ED
Hayley Pierre	Communication and Engagement lead

Name	Title
Lisa Webb	Associate Director of Organisational Development
Jacqui Berry	Head of Clinical Education
Jackie Nolan	Organisational Development Manager
Idowu Olowe	Leadership and Management Tutor/Coach
Stella Jones	Head of Communications and Engagement
Graeme Hallows	Matron - Surgery
Deanne Opeodu	Nurse - KingFisher Ward

Name	Title
Ghada Ramadan	Divisional Medical Director - WCYP
Vanessa page	Staff Health and Wellbeing Manager
Richard Pemberton	Library & Knowledge Services Manager
Nancy Paulding	Workforce Intelligence Lead
Cathryn Cassidy	Administration General Surgery
Caroline Mpita	Head of Clinical Workforce
Simon Bailey	Director of Business Intelligence, Planning and Performance
Amanda Crawford	Communication and Engagement lead

All/ Most workstreams supported by:

1. Programme Management
2. Listening Advocates
3. Absolute Diversity
4. Head of EDI

Current Programme & Project KPIs



Programme KPIs	Workstream	Plan/Target	Trend	Justification for Variance	Feb 26 Actual	Mar 26 Actual	April Actual	May Actual
80% of middle managers completing the TLT development programme (Advanced Management Essentials for B8a and above / Management Essentials for B7)	Workstream 4 – Leadership accountability and fixing the middle	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	72.5% (AME) 55.3% (ME)	73.63% (AME) 61.21% (ME)	75.12% (AME) 68.61% (ME)	78.79% (AME) 72.39% (ME)
100% of backlog cases in Employee Relation (ER) have been reviewed and outcomed (Lead: CPO)	Workstream 2- HR Processes	100% cases outcomed	▲		13 Cases remaining	11 Cases Remaining	2 Cases Remaining (To be closed by may 2026)	0 Cases Remaining

KPI Name	Workstream	Target	Description of metric
Listening Advocates Trained	Workstream 1	100	To recruit and train a minimum of 100 Listening Advocates within the organisation - to look at a ratio of 1:40 staff members
Trustwide Listening Event	Workstream 1	1 a month	Monthly Trustwide listening schedule tracked by Rebuilding Trust Working Group
Listening Event Feedback Timeliness	Workstream 1	100% of feedback submitted within 48 Hours	Submission of Listening Themes from events using the listening tool. Submission by Listening advocates as per SOP
Thematic Analysis	Workstream 1	100% analysed	Reports reviewed by Head of Wellbeing & Staff Experience and Head of EDI each cycle triangulated with NSS, People Pulse, WRES, WDES and FTSU
Appraisal Compliance	Workstream 4	90%	Number of staff that have an up to date appraisal
Appraisal Training Compliance	Workstream 4	85%	Number of staff that are compliant with their appraisal training
Violence and Aggression incidents	Workstream 3	TBC	Number of V&A incidents reported
Leadership pipeline	Workstream 5	TBC	Gender participation & completion of key leadership programmes (AML, ILM, Passport to Clinical Leadership, CPD funding)
Incivility trends	Workstream 5	TBC	Gender related incivility incidents (DATIX / incivility reports – exploratory)
Gender pay gap	Workstream 5	TBC	Gender pay gap by staff group (admin & clerical, AHP, medical)

Interdependencies & Risks

Interdependencies

Staff engagement activity (listening events and networks) will inform several workstreams.
BI and data capability is a shared dependency across multiple workstreams to support monitoring, reporting and impact measurement.
 Engagement with **staff networks and listening mechanisms** will provide insight that informs multiple workstreams across the programme.
 Leadership and Management offers in any workstream are dependant on what is currently on offer or being progressed through workstream 4

Date	Workstream	Risk Name	Description	Risk Owner	Mitigations
22-Mar-26	Workstream 3/ Programme	Allocation of time for Staff to support the Cultural Programme	Currently all staff are unable to be allocated time to support this work and drive change to support the completion of this programme with the pressures on performance and financial drivers within the organisation	Stemby Pinden / Amanda Russell	Line managers to support staff and allow for "Protected time". Agree what protected time looks like for nurses and Clinicians in Programme Board and Communicate that effectively.
11-Feb-26	Workstream 4 - Leadership accountability and fixing the middle	Delayed to obtaining an Operational/ Clinical Staff supporting the workstream	Delayed to obtaining an Operational/ Clinical Staff supporting the workstream	Frances Woodcroft	Support the recruitment of Operational/clinical staff to the workstream to support Leadership accountability
22-Mar-26	Programme	Leadership gaps	A high number of senior interim/vacant roles may affect continuity of sponsorship and decision-making. Cultural change programmes require visible and consistent leadership over time to role model and embed	Siobhan Callanan	Recruit to senior leadership roles, ensure strong buy in with deputies - Ongoing
31-Mar-26	Programme	Ineffective reach and inclusivity of programme communications and engagement	There is a risk that communications and engagement activity within the cultural transformation programme does not consistently reach all staff groups, particularly those with limited access to digital channels (e.g. non-PC-based roles). This may result in variable awareness, understanding, and involvement in the programme across the organisation.	All Programme Stakeholders	- Develop and implement a multi-channel communications approach, including non-digital methods (e.g. face-to-face briefings, team huddles, posters, screensavers, payslip messaging where possible) – Comms and Engagement Strategy - Introduce regular, visible engagement opportunities (e.g. listening events, walkarounds, drop-ins) aligned to programme themes - Establish a network of Listening Advocates across different staff groups and settings - Tailor communications to be clear, concise, and relevant to different staff audiences (clinical, operational, corporate) - Monitor reach and engagement through pulse feedback, event attendance, and informal insight to continuously adapt approach - Align closely with internal communications teams to ensure consistency and amplification, while maintaining shared ownership

Elective Recovery & Productivity Programme – TLT Highlight Report

Workstream	
Programme Manager	Jodie Taggart
SRO	Toni Sheeran
Date	28.05.26
Project RAG Status	
RAG Justification	The ER&P programme plans to deliver £4.1m against a £4m target. £3.778m of this is fully developed, with 400k plans in progress.

Progress Update

The programme continues to work with Operational, Clinical and Corporate colleagues to progress plans against the £400k scheme identified but awaiting further confirmation. We are also scoping additional schemes but awaiting further information.

Project	Achievements this Period	RAG Status	Milestones to be Completed Next Period
Theatres and Pre-Assessment	Weekend theatre list removal confirmed; costings finalised. Loan Kit numbers received from Procurement. MRSA Swab SOP sent for Review. Process mapping to identify productivity opportunities in pre-assessment. Graphnet business case live – pending ICB decision.		Agree Graphnet funding position with ICB. Implement productivity gains within pre-assessment and identify F2F reduction opportunities. ePR development review (link to Digital). Plan “Perfect Month” with Peri-Op and Critical Care colleagues.
Digital and Patient Experience	Big Hand (DMO) Audit complete – working closely with Digital and Training teams to switch off. Franking machine audit complete and delivered for Month 1.		Complete PKB Engagement Plan with Sophie Cawsey. Identify letter view lead and begin improvements. Confirm ePR roadmap for Outpatients. Dictation switch off to single system planned from end of July.
Outpatients / Waiting List / PTL/ Training	Areas of focus identified – Room utilisation scoping commenced and room booking audit undertaken. Virtual appointments scoping underway (identify suitable services and criteria for increasing). Access policy compliance benchmarking initiated. SPoA pathway currently being reviewed. Advice and Guidance being progressed in 10 specialties.		Agree KPIs. Complete virtual appointment criteria per specialty. Complete room utilisation room review and implement new room rota from 31 May. Agree access policy compliance standards – DNA/Cancellation/Booking timeframes. Commence roll out of A&G from June.
Diagnostics	Straight to test pathways reviewed. Digital check-in services scoped. DM01 delivery maintained at 97.3%.		Reschedule planning session and DM01 delivery risk from Endoscopy estates works required in 26/27. Confirm CDC watch metrics.

Milestones & KPIs



Milestones	Completion Target Date	RAG	Status
Identify savings against the initial £3m target	01.04.26	Green	Complete
Finalise scope and initiate workstreams for 26/27 programme	20.04.26	Green	Complete
Identify £0.5m to bridge the gap to £4m stretch target	05.05.26	Green	Complete
Agree governance structure for reporting	01.05.26	Yellow	Awaiting update from Execs
Update risks and interdependencies report	08.05.26	Yellow	In progress
Confirm and write up PIDs/IAs required under each workstream	29.05.26	Yellow	3 PIDs outstanding.

RTT Performance - Latest

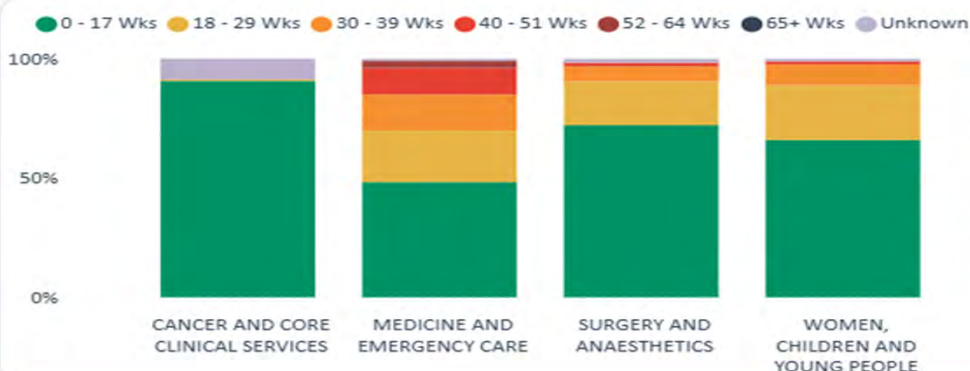
Latest

Trend

Comparison

View Incomplete performance trends, live or latest monthly/weekly, with breakdown by division, care group, or specialty using filters.

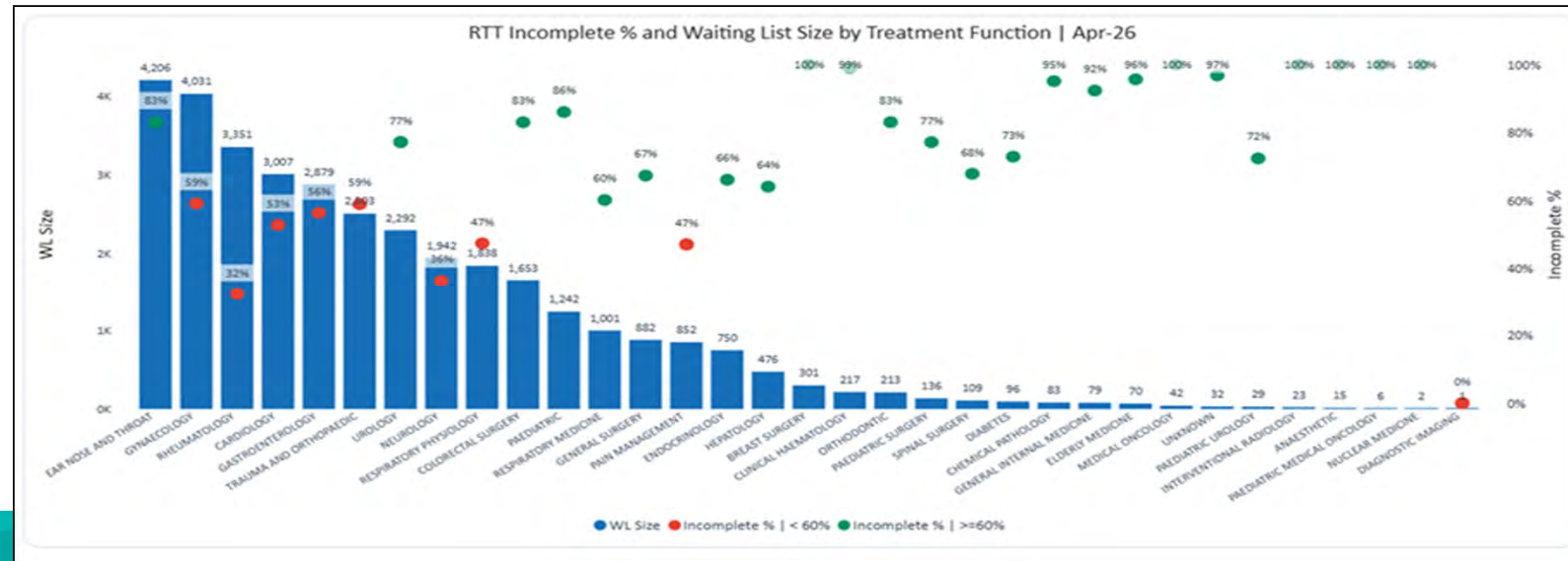
	0 - 17 Wks	18 - 29 Wks	30 - 39 Wks	40 - 51 Wks	52 - 64 Wks	65+ Wks	Total	%	Unknown	Total Inc Unk
CANCER AND CORE CLINICAL SERVICES	429	3	0	0	0	0	432	99.31%	41	473
MEDICINE AND EMERGENCY CARE	7,480	3,423	2,346	1,728	461	0	15,438	48.45%	136	15,574
SURGERY AND ANAESTHETICS	9,996	2,526	879	210	2	0	13,613	73.43%	226	13,839
WOMEN, CHILDREN AND YOUNG PEOPLE	3,643	1,288	489	73	0	0	5,493	66.32%	58	5,551
Total	21,548	7,240	3,714	2,011	463	0	34,976	61.61%	461	35,437



	0 - 17 Wks	18 - 29 Wks	30 - 39 Wks	40 - 51 Wks	52 - 64 Wks	65+ Wks	Total
AWAITING DECISION TO TREAT	2,259	591	257	133	7	0	3,247
AWAITING OP APPT - NEW	10,697	3,415	1,851	1,248	314	0	17,525
AWAITING OP APPT - FUP	644	230	114	70	3	0	1,061
AWAITING TCI DATE - DIAGNOSTIC	205	24	39	6	0	0	274
AWAITING TCI DATE - TREATMENT	2,180	1,429	598	87	1	0	4,295
OP APPT BOOKED - NEW	4,092	1,057	495	257	132	0	6,033
OP APPT BOOKED - FUP	782	315	125	68	4	0	1,294
TCI BOOKED - DIAGNOSTIC	311	26	9	10	0	0	356
TCI BOOKED - TREATMENT	378	153	226	132	2	0	891
Total	21,548	7,240	3,714	2,011	463	0	34,976

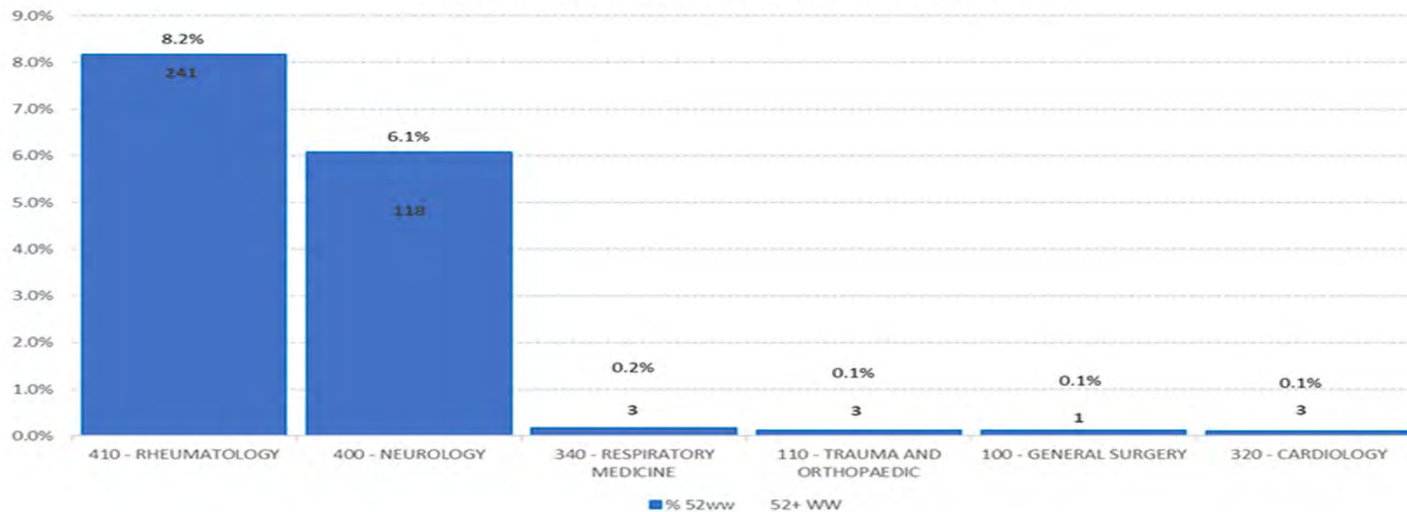
KPIs Continued ...

KPI Name	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Patients Waiting For 1st Appointment < 18 Weeks %												
Trajectory	60.00%	60.00%	60.50%	61.00%	61.00%	60.50%	60.00%	61.00%	61.00%	62.00%	62.00%	63.00%
Actual	62.10%	63.24%										
Variance	2.10%	3.24%										
RTT 52 Week Waiting List %												
Trajectory	1.00%	0.94%	0.89%	0.75%	0.75%	0.60%	0.59%	0.45%	0.30%	0.15%	0.08%	0.00%
Actual	1.07%	1.19%										
Variance	0.07%	0.25%										
RTT 52+ Week Waiters												
Trajectory	347	320	300	250	250	200	200	150	100	50	25	0
Actual	369	413										
Variance	22	93										
RTT Incomplete Performance %												
Trajectory	60.00%	61.40%	62.10%	62.80%	63.50%	63.50%	62.50%	64.30%	64.50%	65.60%	66.30%	67.00%
Actual	61.49%	62.21%										
Variance	1.49%	0.81%										
RTT Waiting List Size												
Trajectory	34,653	34,011	33,774	33,543	33,316	33,459	34,140	33,326	33,363	32,942	32,732	32,526
Actual	34,359	34,761										
Variance	-294	750										



KPIs Continued...

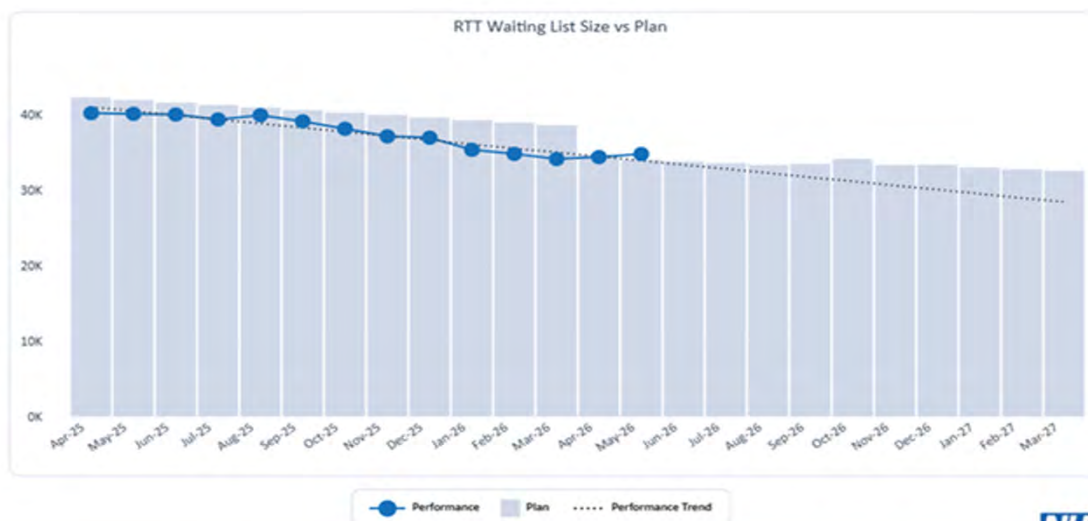
RTT: 52+ Week Waiting List %, by Specialty | April-26



Contract Year
 All

Key Performance Indicator
 RTT Waiting List Size

Month	Actual	Plan	Variance
Aug-25	39,907	40,916	-1,009
Sep-25	39,089	40,583	-1,494
Oct-25	38,102	40,250	-2,148
Nov-25	37,104	39,917	-2,813
Dec-25	36,921	39,584	-2,663
Jan-26	35,321	39,251	-3,930
Feb-26	34,777	38,918	-4,141
Mar-26	34,098	38,585	-4,487
Apr-26	34,359	34,653	-294
May-26	34,761	34,011	750
Jun-26		33,774	
Jul-26		33,543	



Apr-26

31.30K

TOTAL ATTENDANCES

1.88K

TOTAL DNA

5.68%

DNA %

9.94%

Patient Cancellation %

15.83%

Hospital Cancellation %

3.12%

PIFU %

12 Month Average

1,106

PIFU Attendances

3.46%

PIFU %

Finances

Target – Elective Reform and Productivity	£4,000,000
Schemes identified to achieve estimated target above (PYE)	£4,178,459

FYE	£4,178,459	PYE	

Scheme Name	Pipeline	Opportunity	Plans in Progress	Fully Developed	Implemented	PID Status	IIA Status
Reduction in insourced services - Gastro/Endoscopy					£686,600	Approved	Approved
Reduction in insourced services - Endoscopy (modular unit)					£446,400	Approved	Approved
Reduce insourced services - Orthopaedics + Pain					£862,475	Approved	Approved at IIA Panel
Reduce insourced services - ENT					£1,134,000	Approved	Approved at IIA Panel
Franking Reduction					£8,000	Approved	Approved
Removal of relocatable MRI scanner (6 months)					£350,984	Approved	Approved at IIA Panel
ENT and Theatres Non-Pay					£290,000	Approved	Approved at IIA Panel
MRSA Swabbing						With Division for Updates	With Division for Updates
Graphnet	£0					In Development	In Development
Increase in endoscopy activity				£400,000		With Division for Updates	With Division for Updates
				£400,000	£3,778,459		

Risks & Issues

Key Risks	Mitigating actions	RAG after mitigation	Owner
£400k still awaiting full PID/IIA workup to support financial profile.	Prioritise completion		SRO
If interdependencies across multiple programmes such as digital, clinical review, demand and capacity, fragile services and medical productivity aren't understood there is a risk that work would be duplicated and potential double counting.	Identify interdependencies and track, ensuring communication with colleagues to ensure oversight and tracking of activity is understood.		SRO
Issue	Action Taken	RAG	Owner
Lack of detailed demand and capacity planning has been completed so we do not have an accurate overview.	Linking in with PA and BI to understand the D&C models that are being put in place in terms of job planning and business planning. First drafts underway for Elective work in Theatres and Outpatients		SRO
Delivery of the programme relies on strong engagement from clinical and operational teams.	Engaging clinical leaders early and aligning improvement with clinical priorities and patient outcomes. Providing clear communication and feedback on programme benefits.		SRO
ePR incompatibility in Theatres – data not feeding correctly – active patient safety risk escalated.	Vendor engagement underway and theatre templates in development.		Sharon K / Adrian B / SRO
Escalations and Decisions		Owner	
Celebrations			
Plans to over-achieve stretch target of £4m			
Scoping and audit work 90% complete across workstreams – which are established and key stakeholders are engaged			
Performance remains on track to deliver (and in some areas exceed) Elective Reform Target			

Post-72 Back Door UEC Programme – TLT Highlight Report

Programme	
Project Manager	Jacqui Leslie
SRO	Tracy Stocker
Date	12 th June 2026
Project RAG Status	
RAG Justification	Red: There remains a gap to the £3.5M programme target of approx. £700K which has still not been bridged since the previous month's report. The NCTR workstream CIP commitment of £800K links to the 50% reduction in NCTR patients (and resulting G&A bed occupancy). This commitment will be realised through internal and system-driven improvements detailed in the PID and IIA refreshed on the 12/06/26 which now re-configures the MEC bed base (specifically within Frailty) to rationalise the medical and nursing staffing model and create therapy-led capacity to managed co-located NCTR patients. The Virtual Hospital workstream CIP scheme value of £2M, phased from M2 – M12 is now delivering, thus significantly reducing the risk of programme CIP target

Progress Update			
The programme continues to prioritise delivery of enabling activity within the NCTR workstream to support improvements in the area of NCTR bed occupancy. The occupancy for NCTR continues to improve since last report and ended the month but is at risk of plateauing. There is a programme of further internal Board Round optimisation underway across the MEC bed base which will be accompanied by a joint acceleration of the TOC process to further reduce patients remaining in acute once they have deemed to have NCTR. Two further clinical areas will become the focus from the 22/06/26 for an intensive four-week period. The NCTR PD and IIA redrafts were completed and sent to the MEC Divisional SMT on 12/06/26 for review prior to forwarding to the Turnaround Director in the w/c 15/06/26. The risk linked to the maturity of remaining workstreams within the current programme scope was discussed with the SRO on 12/06/26 and a programme scope review is due to be advised on 16/06/26, following a review with the Interim COO. The previously escalated issue linked to the establishment of the Joint Steering Group, (proposed to cover UEC, Flow and Elective Recovery and Productivity) will be subject to the same review as the aforementioned programme scope.			
Project	Achievements this Period	RAG Status	Milestones to be Completed Next Period
NCTR	Board Round / Flow optimisation activities to roll onto the next two inpatient areas. TOC SOP drafted		Programme scope review pending. Expansion of Flow / Board Round optimisation plans to include joint action on TOC optimisation are due to commence in a further two MEC wards in w/c 22/06/26, (due to IA in the w/c 15/06/26). TOC SOP implementation phased in across the two inpatient areas selected for the next phase of Flow optimisation. The existing governance gaps remains. This will be further escalated in the next reporting period with the outstanding risk linked to the establishment of a weekly senior system escalation structure and a status position of OBC2.
Virtual Hospital / Care	£2M CIP contribution now in delivery		Monthly CIP target in delivery from M2.
Comm / Post 72hr Frailty	None		Determine inclusion as part of programme scope decisions

Milestones & KPIs

Milestones	Completion Target Date	RAG	Status
TOC optimisation pilot jointly with SAFER Board Round mobilisation plan	17/07/26	Green	Green - on track. Engagement plan with next phase wards due for completion 16/06/26.
Re-define programme scope and project / workstreams and revisit stakeholder mapping	19/06/26	Amber	Amber – delayed scope discussions with Interim COO due to capacity to meet and other predecessor decisions yet to be taken.
Senior System weekly NCTR review	12/06/26	Amber	COO / SRO System Meeting has lapsed. Refresh planned with linked to TOC Operational Plans and Joint Programme Steering Group mobilisation (pending above milestone)
Review of Trust CLD Policy and Discharge Policy	30/04/26	Red	Programme resource identified. Engagement with SRO is constrained due to operational pressures. Profile for completion within June to set up for new proposals in revised NCTR PID
Revised PID / IIA for NCTR signed off by Division and Trust Turnaround Director	24/06/26	Green	Green – PID & IIA redrafted and sent for Divisional SMT review 12/06/26.

Programme KPI	Target	Latest	Plan	RAG	Justification for Variance	May 26 Planned	May 26 Actual	June 26 Planned	Commentary
NCTR Beds occupied – average	68 patients (representing 50% reduction)	104*	68	Amber	Moved from red to amber given sustained improvement since RIE / TOC mobilisation	126	109	68	* Reported as at w/e 07/06/26
Average inpatient NCTR LoS	3 (days)	6*	6	Red	LLOS discharges have impacted Average IP NCTR stay in May	6	8.84	5	* Reported as at w/e 07/06/26
Financial KPI linked to CIP	£3.5M	£2.80M (annual)	£3.5M (annual)	Red	Gap to target remains as £700K	£291,666.67	£333,333	£291,666.67	Gap to target remains £700K

Finances

Target - UEC & Flow Programme (overall)	£7,000,000
Target - UEC & Flow Programme (Post 72-hour / Ward Admission)	£3,500,000
Schemes identified to achieve estimated target above (PYE)	£2,800,000

FYE	£3.7M TBC	PYE	£2,800,000 TBC

Workstream Name	Pipeline	Opportunity	Plans in Progress	Fully Developed
NCTR – reduction of 50% by 30/06/26 with concurrent bed base reduction from October 2026	Yes	Yes	Yes	No
Virtual Hospital / Virtual Care – Financial yield confirmed and in delivery	Yes	Yes	Yes	Yes (£2M)
Community Frailty and post-72hours of care - yet to be determined	TBC	No	No	No
Total	£800K			

Gap to Target - £700K

Risks & Issues

Key Risks	Mitigating actions	RAG after mitigation	Owner
Status position of system-led OBC2 for capacity increases to support transfers of care and NCTR reductions not understood	Escalate to TLT COO re: progression of the Business Cases within the UEC Programme Board Membership. Engage with ICB stakeholders working within post-72 hours Programme for status position		Tracy Stocker (SRO)
Issue	Action Taken	RAG	Owner
UEC & Flow Joint Steering Group yet to be established to oversee UEC and Elective Recovery Programmes	Re-escalated to Interim COO. Draft TOR's developed and circulated to Programme Managers across UEC, Flow & Elective Reform. Requested meeting for 04/06/26 to confirm next steps		Jacqui Leslie (Programme Manager)
Gap to CIP target for post-72 hour Programme of £660K remains	PA Consulting identifying further opportunities for cost improvements within the current programme scope		Tracy Stocker (SRO)
Escalations and Decisions			Owner
Decision – System-level UEC Board review / refresh / reinstatement			Darren Palmer
Decision – Divisional level approval for revised PID and IIA linked to NCTR			Tracy Stocker / Jacqui Leslie
Celebrations			
Wards selected for phase two Flow / Board Round optimisation (Tennyson and Keats wards) commencing 22/06/26, jointly with TOC Optimisation workstream			
PID and IIA redrafted for Divisional review with proposal to configure Therapy-Led NCTR Reablement capacity within an equivalent 60-bedded area			

Stabilisation Plan: Quality Programme

Quality Assurance Committee

15th June 2026



Quality	
Exec Lead	Alison Davis
Programme Manager	Chris Parokkaran
Date	15/06/2026 (QAC)
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 patients 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 2222 calls, Sepsis pathways, pneumonia and avoidable deconditioning and deterioration particularly in ED and inpatients who are NCTR. Clinical pathway outlier groups in the trust SHMI dataset currently is Pneumonia, COPD and UTI.



Programme Workstreams:

1. Frailty Pathways
 - a. Hospital Frailty Pathway
 - b. Hospital Frailty SPOA
 - c. Community Frailty pathways.
2. Palliative Care Pathways.
3. Nursing and therapies to prevent deconditioning.
4. Deteriorating patients and Avoidable 2222 Project.
5. Learning from Death Process and Governance.
6. Clinical Pathways – Pneumonia QIP & Sepsis QIP

Milestones Achievements in last 30 days (May 2026)

1. Engagement with neighbourhood team initiated to understand the model of digitizing neighbour hood health for Patient Needs Group 10/11. Frailty Summit held on 14th of May with good engagement from community system region and other experts.
2. Progressing LFD pathway and SHMI dashboard with KPIs, strengthening governance through MMSG approvals, embedding SJR processes on GATHR, and enhancing learning, oversight, and training through SOPs and structured feedback.
3. Working on End of Life (EOL) dashboard. Still awaiting EPR team to work on elements that would help to complete dashboard launch work.
4. Finalising therapy outcome measures and KPIs, embedding baseline mobility tracking, progressing audit insights, addressing definition clarity for deconditioning, and engaging ED to improve patient outcomes.
5. Establishing the Deteriorating Patient workstream structure, aligning with Fundamentals of Care, engaging stakeholders through TOR and A3 development, and progressing towards a coordinated and structured first workstream meeting.
6. Expansion of the adult sepsis bundle to include bespoke pathways for paediatric, maternity, and neutropenic sepsis. Establishment of a robust, trust-wide sepsis audit. Timelines to be confirmed. The paediatric sepsis bundle will be made mandatory.
7. Pneumonia group to start work stream meeting. Actions discussed to improve antibiotic prescribing within first 4 hours of admission. Education with staff for CURB score recording. Meeting with EPR.

Milestones Planned for next 30 days (June 2026)

1. Further scoping of the pre-72-hour pathway and further development of OBC1 and interdependencies to be scoped by divisional directors. Expected re-launch of Frailty assessment unit scheduled for 15th June. Discussions planned for the launch of Medway and Swale Frailty network.
2. Aligning yearly priorities with timelines, progressing LFD governance and sign-offs, strengthening M&M learning, and expanding SJR training and reviewer capacity through a Trust-wide SOP rollout and regular training
3. EOL team to finalise avoidable admission criteria with ED team. Establish combined workstream meeting with Frailty workstream and continue collaboration with EPR to digitise EOL forms.
4. Establishing deconditioning definition and governance, progressing ED-focused subgroup and Gemba insights, embedding audits and EPR integration, and driving improvements in mobility, environment, and outcome measurement through structured workstream actions.
5. Launching the Deteriorating Patient workstream, engaging stakeholders through A3 development, and defining key aims, maturity assessment and KPIs to drive improvement.
6. Progressing the Paediatric Sepsis project through mandatory e-learning, securing funding for licences, and improving Sepsis 6 compliance via targeted education and enhanced lactate and fluid monitoring.
7. Pneumonia work stream monthly meeting to continue and focus on making the whole Pneumonia Bundle electronic.
8. Audit with COPD deep dive underway and UTI deep dive to be established.

Progress Update



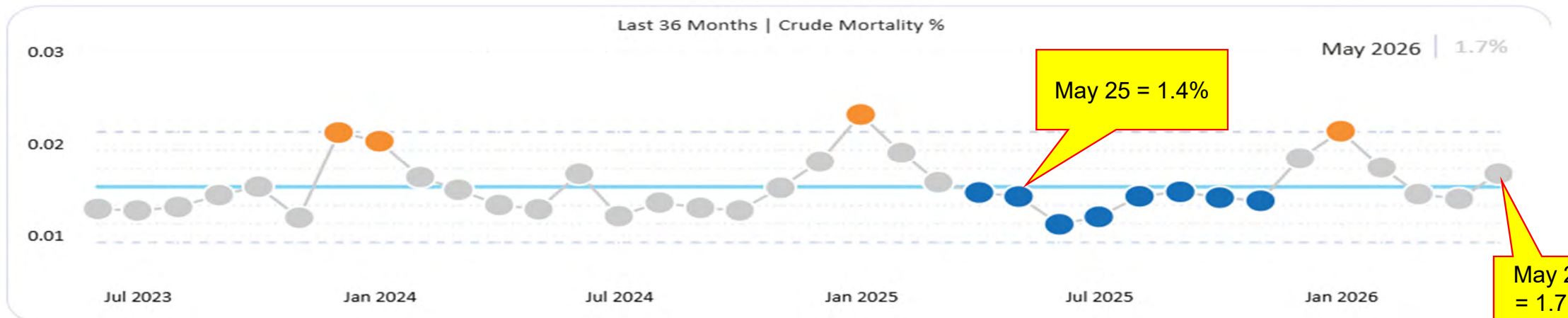
NHS Foundation Trust

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. All other workstreams have now established to support with reduction of SHMI.

Workstream Update	Milestones	Target Date	RAG	Status
Frailty Pathways including Hospital Frailty Pathway, Hospital Frailty SPOA Community Frailty pathway	Further scoping of the pre-72-hour pathway and further development of OBC1 and interdependencies to be scoped by divisional directors.	April 26		On track . Relaunch of Frailty SDEC.
Palliative care pathways	Advancing PEOLC through pathway development, EPR integration, and data-driven insights, while strengthening frailty-focused care, communication training, and targeted frontline interventions to reduce avoidable admissions and improve end-of-life outcomes.	March 26		Off track. Awaiting EPR to create certain mandatory fields so then data can be available to build dashboard.
Learning from Deaths Pathway	Aligning yearly priorities with timelines, progressing LFD governance and sign-offs, strengthening M&M learning, and expanding SJR training and reviewer capacity through a Trust-wide SOP rollout and regular training	July 26		On track.
Clinical Pathways (Sepsis QIP and Pneumonia QIP)	Progressing the Paediatric Sepsis project through mandatory e-learning, securing funding for licences, and improving Sepsis 6 compliance via targeted education and enhanced lactate and fluid monitoring. Pneumonia work stream monthly meeting to continue and focus on making the whole Pneumonia Bundle electronic. Audit with COPD deep dive underway and UTI deep dive to be established. KPI data is static overall and needs further improvement and shift so that the trend moves to positive outcomes.	September 26		On track. Working groups for both QIP established . Pneumonia project overall has an improvement in recording of CURB scores and correct antibiotics prescriptions.
Deteriorating / Avoidable 2222 project and Deconditioning patient project.	Launching the Deteriorating Patient workstream, engaging stakeholders through A3 development, and defining key aims and KPIs to drive improvement. Establishing deconditioning definition and governance, progressing ED-focused subgroup and Gemba insights, embedding audits and EPR integration, and driving improvements in mobility, environment, and outcome measurement through structured workstream actions.	June 26		Ontrack for deconditioning and deteriorating patients as both workstreams established.

Programme KPIs

KPI	Latest (May -26)	Trend	Justification for Variance	Apr 26 Actual	Apr 26 Planned	May 26 Actual	May 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 March 26 in mid-September 2026)	1.30(Jan 25-Dec 25)	▲	There has been a noted increase in SHMI crude rate and a drop in expected causing SHMI to increase.	1.29 (Nov 24–Oct 25)	1.15	1.30(Jan 25- Dec 25)	1.15
Crude Mortality Rate (%) in the month to be less than the same time period 12 months previously	1.7%	▲		1.5%	1.1%	1.7%	1.1%
90% Compliance in NICE guidelines SEPSIS 6 Bundle care using monthly audit data (Data set based on 40 patients)	Data not available for May due to delay in Audit	▲	Compliance with high risk Sepsis patients for IV antibiotic therapy treatment within 1 hour is 93% in both ED and in- patients and Sepsis 6 full bundle compliance is failing with on going monitoring of fluid balance and repeat lactate primarily within ED.	55%	90%	Data not available yet.	90%



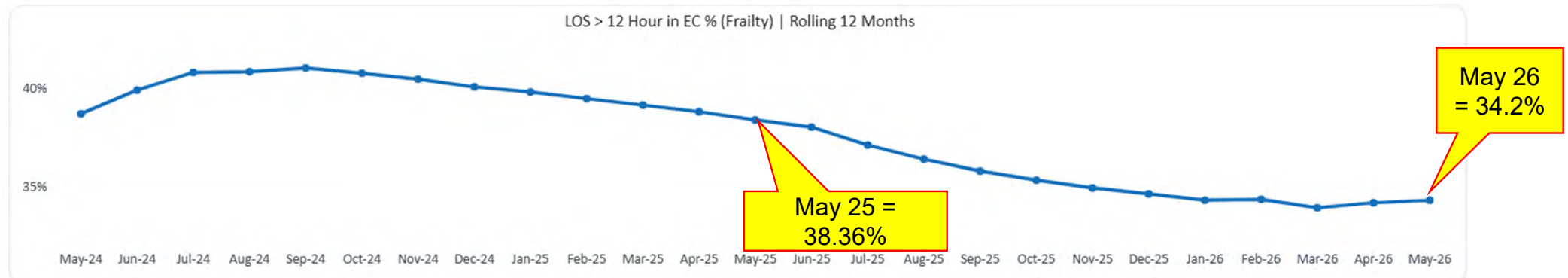
Workstream (Project) KPIs



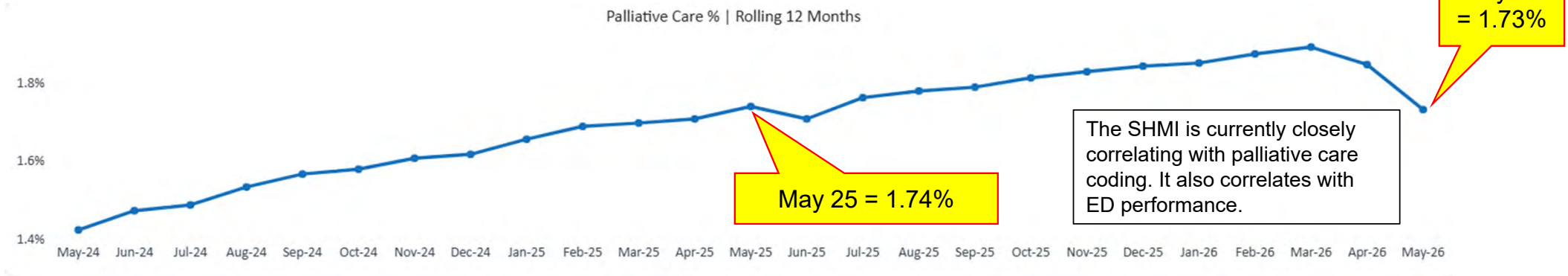
Project	KPI	Baseline Oct 25	Trend	April 26	May 26	May 26 Planned/ Trend
Learning from Deaths Project	Over 75 & CFS score >5 with >12 hours LOS in ED	33.6%	▲	34.1%	34.2%	Upward Trend
Learning from Deaths Project	Preventable deaths based upon number of deaths declared as PSII as reported on STEIS over the last 12 months.	1 (0.9%) Year 25-26 total-16 (1.2%)	▲	19 (1.4%) Mar 25- Apr 26	19(1.4%) June 25- May 26	Stagnant
Leaning from Deaths Project	Percentage of SJRs completed (Target 12.5%)	13.9%	▲	11.4%	9.1%	Downward Trend
Palliative care pathways Project	Downward trend for no of patient percentage under palliative care	1.81%	▲	1.72%	1.73%	Upward Trend
Sepsis QIP	90% compliance to the NICE guidelines. Currently ED data not included to check compliance. Understanding data availability with BI.	85%	▲	34%	35%	90%
Pneumonia QIP	Antibiotics within guidelines given within 4 hours for 90% of Pneumonia patients in MFT	Data was not available	▲	78% (54% within the guideline)	75% (60% within the guidelines)	85%
Deconditioning Patients Project (Nursing and AHP)	MUST Score completion rate Outcome measure to be finalised for measurement of deconditioning among patients. To upload this outcome measure on EPR so data can be generated and KPI established	73.3%	▲	47.5%	60.2%	Upward Trend

Workstream (Project) KPIs

Learning from deaths project KPI - Over 75 & CFS score >5 with >12 hours LOS in ED(May 24 - May 26)



Palliative care project KPI -Palliative care percentage referrals (May 24 - May 26)



Project Risks

Project	Risk	Mitigation	RAG	Owner
Medway Hospital Frailty pathway Project(UEC flow front door & back door)	Projects dependent on ICB Business case which are expected to include community frailty, single point of access and palliative care.	Risk escalated to Francis and Francis has escalated to ICB. Palliative care nurses attending ED board round to identify patients that can be managed in the community.		Francis Woodroffe
Frailty Pathway	If ED is under pressure, the frailty assessment unit will be bedded; this will make the unit non functional and adversely affect the staff morale.	Alternate escalation space within Trust to be identified that will not impact areas that support flow. Set COO/Deputy COO approval requirement to bed the assessment unit. If unit is to be bedded, Frailty team to identify suitable patients.		Koruth Varghese Jo Saunders
Palliative Care Pathway	There is a risk that EPR not able to update the system for the dashboard to go live. Waiting for EPR and BI to update for the dashboard to live.	EPR to prioritise go live date for updated EOL decision form. Then BI to upload this data into live dashboard.		Marie Spicer
LFD Project	Reduction is the number of SJR reviewers	Alison to issue comms at 10x10. Divisional nursing leads to identify SJR volunteers and email names to Sofia Power.		Sofia Power/ Alison Davis
Sepsis Project	Sepsis e- learning licence for mandatory training will expire on 26 th of June due to lack of funding (4K). Therefore, funding to be secured to continue this training from the CPD budget.	Escalation done to Steph Gorman and agreement done that CPD funding can be used one the CPD budget available.		Stephanie Gorman

Project Risks

Project	Risk	Mitigation	RAG	Owner
Deteriorating Patient Project	Medical Engagement, Divisional Engagement and Patient safety engagement	Sara Sharp raised concern with Execs regarding engagement		Alison Davis
Deteriorating Patient Project	Limited Staff resource e.g. Deteriorating Patient nurse/ Learning from deaths nurse	Raised with Execs and confirmation of recruitment to be discussed		Evonne Hunt
Deconditioning Patients Project (Nursing and AHP)	Operational pressures have increased across all staff due to Trust Improvement Plan delivery, making it difficult to prioritise competing meetings and tasks. This is further complicated by conflicting priorities and the need to focus on work with financial impact	Raise with Exec Alison and Evonne in Quality BO huddle and Patient Safety meeting		Laura Potter
Pneumonia Project	Lack of communication between several electronic systems that makes it difficult to have appropriate documentation in each system.	Escalate to EPR team to see if systems can be integrated		Alison Davies / Francis Woodroffe
Pneumonia Project	Co-morbidity data does not pull through automatically unto initial assessment on EPR	Escalate to EPR team and the Executive team		Alison Davies / Francis Woodroffe

Project Celebrations



Celebrations:

1. Palliative care workstream: Change to PEOLC system going live now. This will allow BI to pull data.
2. Pneumonia Workstream :Good compliance for oxygen prescriptions at 98% for last month
3. Sepsis Workstream: Both ED and Inpatients scored > 90 % for administration of antibiotics to the high risk patients
4. Deconditioning Patient Workstream: Harvey, Kingfisher, Ocelot, Phoenix and Victory ward all scored 100% MUST SCORE
5. Deteriorating Patient: 1st Workstream meeting in diaries for 4th June after a lot of initial hard work to set up the workstream amongst all pressure
6. Frailty Pathway Workstream: Date set for relaunch of frailty assessment unit - 15/06/2026
7. Learning from Deaths workstream: SJRs completed on GATHR for the first months of March and April with no reported issues (issue was highlighted on risk register but regularly monitored with support in place to mitigate any disruption).
8. Successful Frailty Summit with good engagement from community partners.



Pre-72 Front Door UEC Programme – TLT Highlight Report

Programme	
Project Manager	Sriaswini Manjunathan
SRO	Gemma Brignall
Date	10th June 2026
Project RAG Status	
RAG Justification	Amber with a Red risk — [REDACTED] - Dependent on external decisions: Progress on key front door projects — including the UTC takeover, Mental Health safe haven, and OBC1 — remains contingent on decisions from the ICB and NHS England. Until these are confirmed, the programme cannot fully close the delivery plan or lock associated CIP trajectories - KPI delivery to plan

Progress Update
- Project working groups established for individual workstreams to oversee delivery and mitigate risks at project level. - Cost Improvement Programme (CIP) savings identification undertaken with horizon scanning for Front Door / UEC Flow, including explicit clarity on which savings are attributed to the UEC programme to prevent double counting with other MEC or corporate projects. - MEC Divisional Board designated as the steering group, providing oversight and assurance across the programme. - External engagement with the ICB undertaken to agree next steps for the UTC, ensuring alignment with system-wide priorities. - Community partners (Neighbourhood) have been contacted and met with Care Group Leads to discuss their upcoming plans and support offers.

Project	Achievements This Period	RAG	Milestones Next Period
UTC Takeover	Formal notification received for 12-month urgent award to MFT. Project group established to map pathways and define requirements for continuity of UTC provision.	Amber	Secure formal decision / mandate from ICB and NHS England; finalise delivery plan
Mental Health Safe Haven	Planning phase commenced; Business case underway for NHSE funding for capital build	Amber	Complete feasibility assessment; submit for ICB / NHSE decision on commissioning and funding
OBC1	Frailty Assessment Unit: Project governance in place with project group setup and stakeholders identified Frailty Walkabout completed with MEC DDO Frailty Assessment Unit go-live took place Monday 08/06 SFU: PID and IIA completed and awaiting approval	Amber	Frailty Assessment Unit: Options to be agreed and programme plan to be developed. Frailty Assessment Unit SOP to be completed end of June and training/education plan to be put in place by consultants
Non-Pay Savings	CIP savings identification undertaken with horizon scanning across UEC / Front Door; double-counting with other MEC or corporate schemes excluded	Green	To understand CIP trajectories for Pharmacy IV Antibiotics and Paracetamol/Ibuprofen prescriptions

Milestones & KPIs

Milestones	Completion Target Date	RAG	Status
Confirm Programme scope and deliverables	01/04/2026		Completed individual project scopes and created project working groups for each
Programme governance setup and initial steering group	01/05/2026		MEC divisional board agreed as the oversight/steering group meeting.
ICB and NHSE decisions for funding and UTC takeover	01/05/2026		Awaiting final decisions
Design phase – Design pathways /escalations / SOPs for UTC, MH Safe Haven, Frailty SDEC and SFU	01/07/2026		Project groups looking to complete initial As-is process mapping
Mobilise phase – Confirm pathways, Estates readiness for each of the projects where applicable	(Dependent on project delivery / go-live dates)		
Data and dashboards – Confirm KPIs for individual projects with SRO and develop dashboard	(Dependent on project delivery / go-live dates)		
Delivery phase	(Dependent on project delivery / go-live dates)		
Go-Live	Frailty Assessment Unit – 08/06		

Programme KPI	Target	Latest (May26)	Plan	RAG	Justification for Variance	Apr 26 Planned	Apr 26 Actual	May 26 Planned	Commentary
Total Avg. time to initial assessment	15	25.20	15			15	25.80	15	
4- hour standard: Percentage of patients seen with 4 hours	95%	77.1%	80%			80%	75.2%	80%	
Average referral to DTA	60	106	60			60	231	60	
Patients waiting over 12 hours in ED	<4%	7.7%	5.9%			<9.4%	7.7%	5.9%	

Milestone plan

Data Gathering & Analysis to Support
Scoping and KPIs



Governance		KPIs
Executive Lead:	Chief Operating Officer	4hr performance 12hr LOS performance - Triage within 15mins - Number of referrals and DTAs - Number of TES in use - Reduction in growth in attendances - Reduction in bank overnight staff - Reduction in day 2 clinical staff for TES in ED - Frailty Assessment Area Attendances via ED
SRO:	Director of Winter / Divisional Director MEC	
Delivery forum:	UEC & Flow – Pre 72 hours Steering Group Workstream Meetings (weekly)	
Delivery Assurance:	TLT, FPPC and Weekly Meetings with Turnaround Director	
Escalation:	TLT and Trust board meetings	

Finances

Target – Pre-72 UEC/Flow Programme	£3,500,000
Schemes identified to achieve estimated target above (PYE)	£800,000

FYE	1,752,866	PYE	800,000

Scheme Name	Pipeline	Opportunity	Plans in Progress	Fully Developed
De-escalation of temporary spaces (SDEC Overnight) – Now covered in the Corporate Nursing CIP			£200,000	
De-escalation of temporary spaces (Emerald Short Stay) - Now covered in the Corporate Nursing CIP			£353,800	
De-escalation of temporary spaces (ED) - Now covered in the Corporate Nursing CIP			£0	
SFU Sub contract arrangement			£175,2866 (FYE) (£800,000 in-year effect)	
Total			£800,000	

Rationale:

As the de-escalation of temporary spaces (ED, ESS, SDEC Overnight) is now captured in the Corporate Nursing CIP, it is included here for delivery only—not for cost improvement savings—to prevent double counting.

Risks & Issues

Key Risks	Mitigating actions	RAG after mitigation	Owner
MH Safe Haven project delays – Risk of quotation validity expiring before works are awarded, potentially necessitating a re-tender process if current quotes lapse. This would result in schedule slippage against the 42-week project completion timeline, further compounding an already delayed delivery schedule.	1. Expedite the decision-making process for awarding the funding 2. Accept a calculated risk and proceed with purchasing the Stage 4 design now		Programme Director / COO
Risk of proceeding with the Meddoc takeover by 1 September without finalised financials, with a potential cost deficit at delivery	Expedite the funding decision		Programme Director / COO
Further ward closures increasing pressure on flow at the Front door	Escalated spaces as a temporary measure		MEC DDO and Programme Director

Issue	Action Taken	RAG	Owner

Escalations and Decisions	Owner
Timeline delivery for UTC and Mental Health Safe Haven have been escalated	Gemma Brignall
To purchase the Stage 4 design for Mental Health new build before quote lapses	Gemma Brignall

Celebrations
MFT has received formal notification of UTC/ Meddoc takeover from 1st September 2026 as an Emergency contract award
Frailty Assessment Unit has gone live as of Monday 8 th June

Integrated Quality & Performance Report

May - 2026



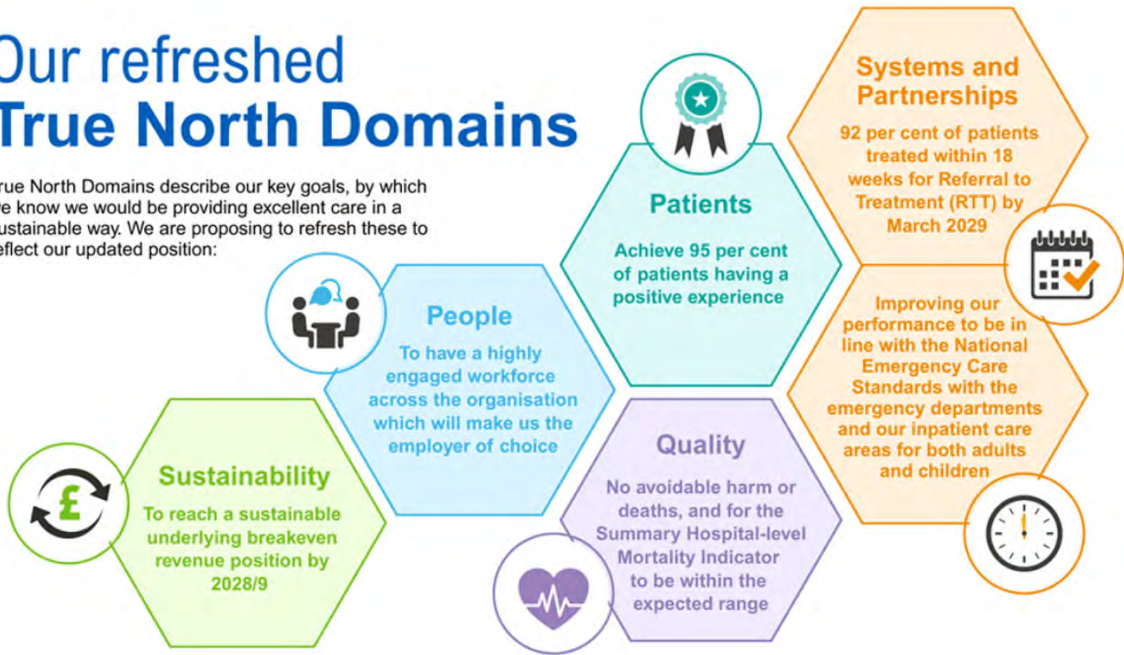
Executive Summary



Siobhan Callanan
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

People
Systems & Partnerships
Quality
Patients
Sustainability

Common			
Improve			
Concern			
People	9	7	3
Systems & Partnerships	17	14	8
Quality	30	6	9
Patients	12	1	2
Sustainability	5	3	1

Assurance

Common			
Improve			
Concern			
People	9	4	5
Systems & Partnerships	10	3	17
Quality	9	2	3
Patients	5	0	4
Sustainability	5	0	2

Variation icons:
Orange indicates concerning **special cause variation**, requiring action. **Blue** indicates where improvement appears to lie. **Grey** indicates no significant change (**common cause variation**).

Assurance icons:
Blue indicates that you would consistently expect to achieve a target. **Orange** indicates that you would consistently expect to miss the target. **Grey** tells you that sometimes the target will be met and sometimes missed due to random variation – in a RAG report this indicator would flip between red and green.

Executive Summary



Assurance

True North & Driver KPIs
All Domains

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

National Staff Engagement Score
RTT 65+ Week Waiters
RTT Incompletes Performance %

Variation

No Significant Change

Low or No Harm Incidents %

Crude Mortality Rate %
Emergency Care FFT Recommend %
Total Pay Spend (£) vs Budget
WTE Actual vs Plan

Incivility Cases (Combined)
Outpatient FFT Recommend %
Total EC 4 Hour Performance %
Total FFT Recommend %
Type 1 LOS > 12 Hours in EC %

Deceased Patient – Clinical Coding Validation...

Concerning Variation

Variance to CIP Target (£)

Executive Summary

True North Strategy and Supporting Breakthrough Objectives



Ambition:

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

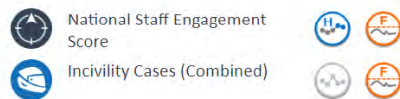
Vision:

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:



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:



Ambition:

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

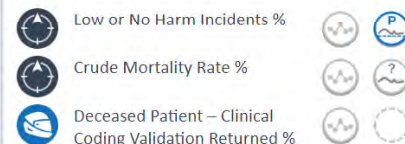
Vision:

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:



Ambition:

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

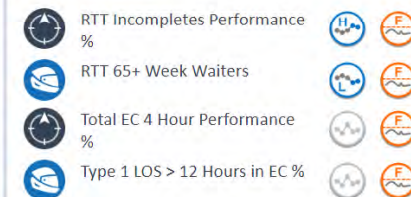
Vision:

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:



Ambition:

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

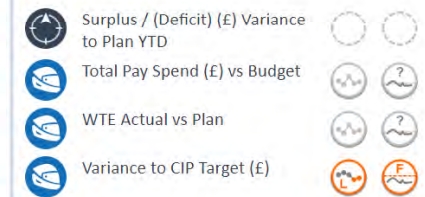
Vision:

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:



Executive Summary

Trust Improvement Plan



Culture

Siobhan Callanan, CEO

Key Messages

The programme continues to make steady progress, with stronger governance, clearer workstream structures and improved collaboration across teams. There has been a significant increase in communications and engagement activity across the programme, including a 'Be the Change' Month long market event to promote the programme. Positive momentum continues in Listening Advocate training with more staff signing up along with positive a number of responses for surveys around Women progression and Psychological safety

Issues, Concerns & Gaps

The programme remains AMBER due to ongoing capacity and resource pressures affecting pace of delivery. Some workstreams still lack operational and clinical representation, while competing organisational priorities continue to delay key milestones. The "You said, We Did" approach is still yet to be agreed limiting the ability to evidence impact and demonstrate how staff feedback is driving change across the organisation

Actions & Improvements

Workstreams now have governance structures and processes in place. Listening activity is being developed into a more structured process linked to actions and communications through a "You Said, We Did" approach. Further engagement sessions, Listening Advocate training and development of thematic reporting and dashboards are underway to improve insight, visibility and measurable impact across the programme. More frontline area engagement is planned for the next month to bring the Cultural programme to the areas of work.



Governance & Quality

Alison Davis, CMO

Evonne Hunt, CNO

Key Messages

- SHMI remains elevated
- Significant incident backlog
- Significant complaints backlog with complaints volume increasing

Issues, Concerns & Gaps

- Complaint response breaches at 77%
- Significant incident backlog (428)
- Inconsistent PSIRF application
- Persistent SHMI outliers and variable Mortality & Morbidity processes at speciality level

Actions & Improvements

- Recovery plan in place for both the incident and complaints backlog
- Work underway to standardise the application of PSIRF and the associated governance arrangements
- Targeted deep dives underway for SHMI drivers (COPD & UTI)



Performance

Darren Palmer, COO

Key Messages

- Elective recovery delivering improvement - RTT overperforming against plan (April), driven by focused recovery actions.
- Cancer pathways showing mixed performance: strong 62-day delivery but 28-day standard below plan with inconsistency across tumour sites.
- UEC performance remains under significant pressure, particularly 12-hour ED waits, reflecting ongoing flow and capacity constraints.
- System operating under sustained demand with reduced bed base, placing increased reliance on effective patient flow and discharge processes.

Issues, Concerns & Gaps

- Variation in elective performance across specialties, particularly Rheumatology and Neurology, with long waits continuing to rise.
- Cancer 28-day performance impacted by diagnostic and histology delays, with limited improvement in turnaround times.
- Persistent high levels of 12-hour breaches and corridor care indicating insufficient flow through ED and downstream capacity constraints.
- Increased demand (mental health attendances and ambulance conveyances) further exacerbating ED pressures.
- Reduced bed base creating structural capacity gap, requiring tighter grip on NCTR, discharge performance and escalation processes.

Actions & Improvements

- Delivery of targeted recovery plans for Rheumatology and Neurology, with clear focus on reducing long waits and restoring sustainable capacity.
- Strengthened cancer pathway management, including escalation on histopathology turnaround times and focused improvement actions in key tumour groups.
- UEC improvement programme progressing, including frailty pathway implementation and review of acute workforce model to increase senior decision-making capacity.
- Enhanced executive-led oversight of patient flow, including daily performance grip on 12-hour breaches, NCTR and corridor care.
- Continued focus on improving discharge processes and system coordination to maximise flow across the reduced bed base.



Financial Recovery Plan

Simon Wombwell, CFO

Key Messages

- Phase 3 of the system work – Medium Term Financial Planning (MTFP) – underway and reported via TLT. First briefing to Finance, Planning and Performance Committee due at is June 2026 meeting.
- Dovetailing into the above, the Trust's local FRP – as initialised by PA Consulting in Q1 of 2026 – will resume

Issues, Concerns & Gaps

- MTFP requires mature strategies and savings planning for all financial years; this will also need to include those medium-to-long-term 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.

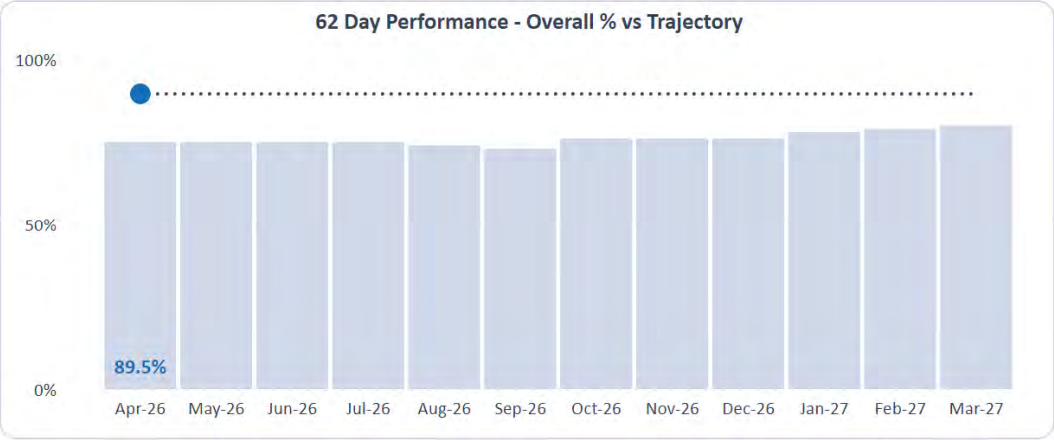
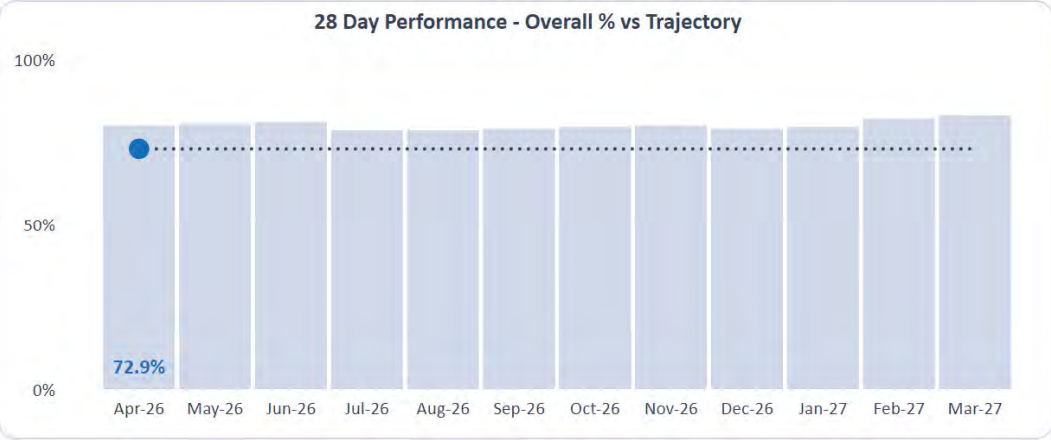
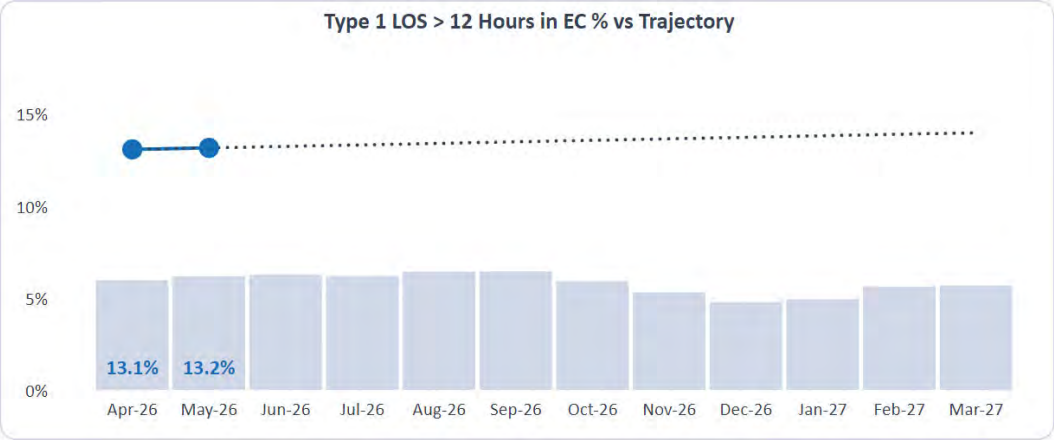
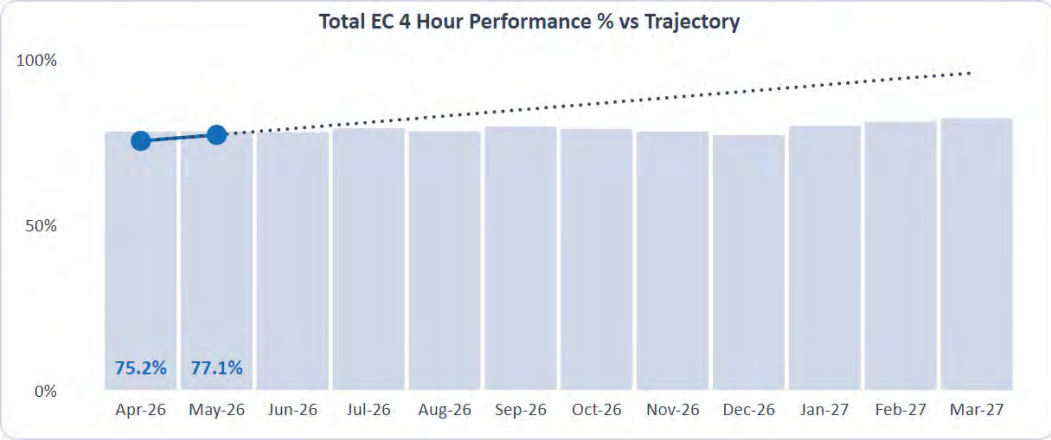
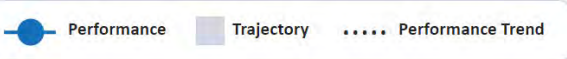
Actions & Improvements

- Substantive appointments to Trust Board.
- Full identification and implementation of efficiencies for 2026/27.
- Strengthen ownership and accountability of Divisions.
- Integrate finance recovery with workforce and performance programmes.
- Full engagement and commitment to Phase 3 System work (MTFP).

Executive Summary

Trust Improvement Plan - Performance vs Trajectory

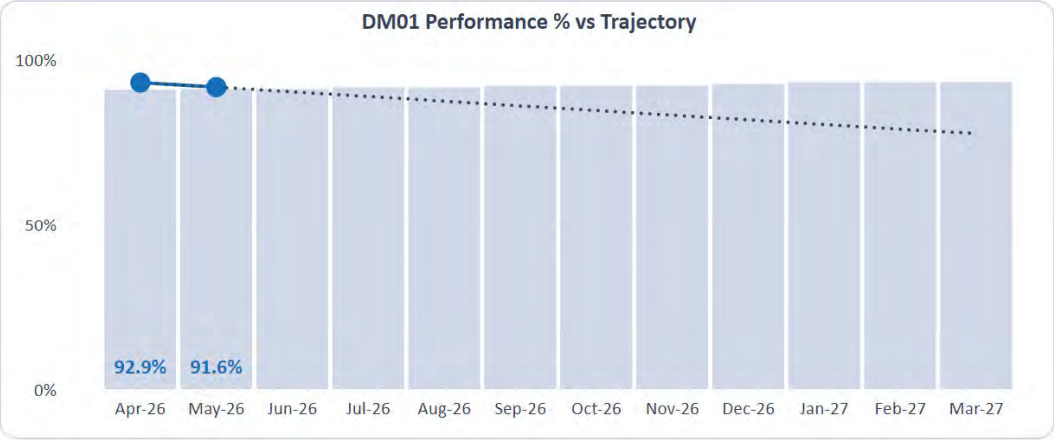
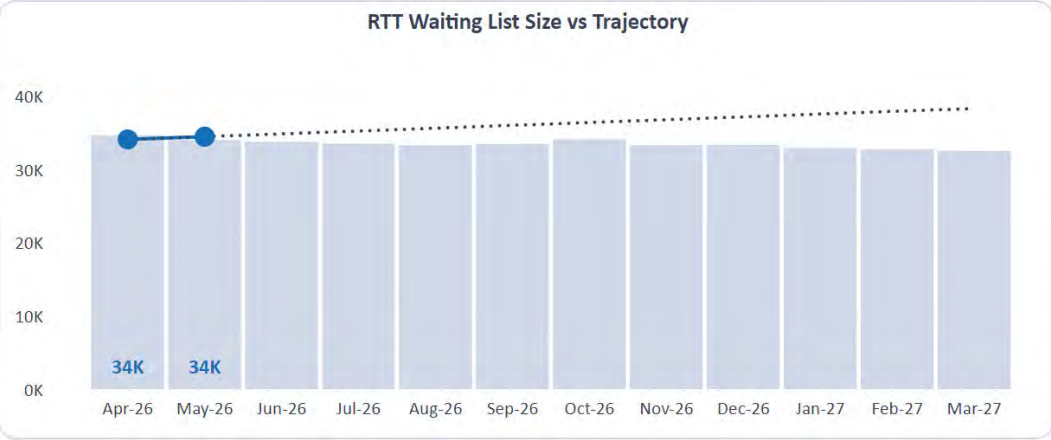
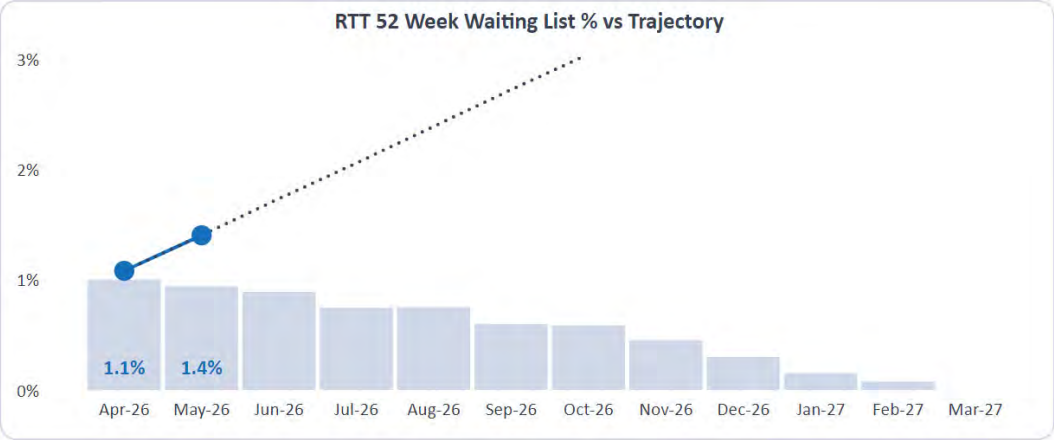
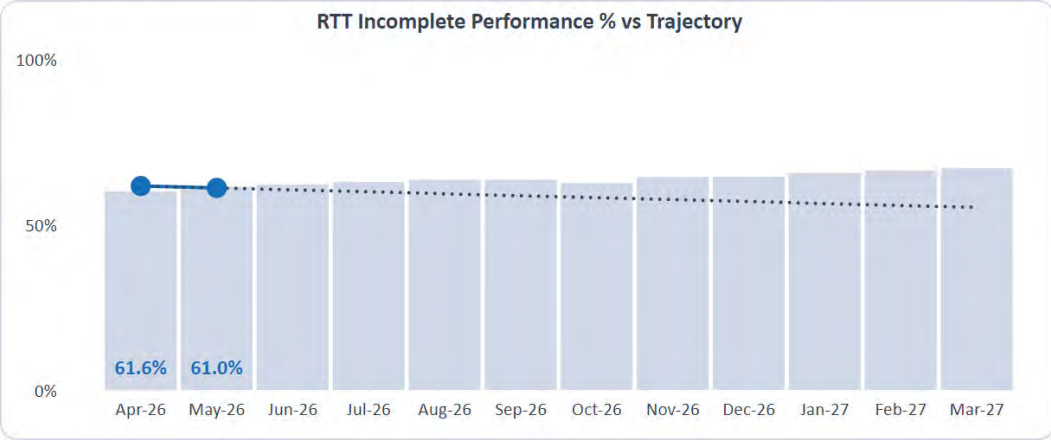
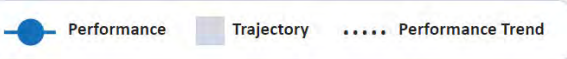
Emergency Care and Cancer KPIs



Executive Summary

Trust Improvement Plan - Performance vs Trajectory

RTT and Diagnostics KPIs





Patients

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



Evonne Hunt
Chief Nursing Officer



Sub Domain

Variation



Complaints	4	0	2
FFT	3	0	0
PALS	2	0	0
Patient Experience	2	1	0
PHSO	1	0	0

Assurance



1	0	2
1	0	2
0	0	0
3	0	0
0	0	0

Operational Leads:

Steph Gorman - *Deputy Chief Nurse (IPC, clinical workforce, safeguarding, professional standards)*

Karen Kessack - *Deputy Chief Nurse (Quality, patient safety, clinical effectiveness, patient experience)*

Committees:

Quality Assurance Committee (QAC)



Patients Summary



Assurance

Watch KPIs Only
Patients Domain

	 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
Variation	  Improving Variation	Mixed Sex Accommodation Breaches		
	 No Significant Change	Complaints Breached % - Red Critical Care Admission Delays > 4Hrs Critical Care Discharge Delays > 4Hrs		Complaints Complaints Breached % - Green Complaints Re-Opened PALS Closed % Parliamentary and Health Service Ombudsm... Patient Advice and Liaison Service (PALS) Co...
	  Concerning Variation		Complaints Breached % - Amber Complaints Breached % - Total	



Patients

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



FFT

Total FFT Recommend %

Type	Threshold	V	A	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
	95.0%			91.5%	91.5%	91.0%	90.7%	90.5%	90.9%	90.1%	90.7%	90.3%	90.7%	90.4%	89.9%

True North Domain: **Patients**

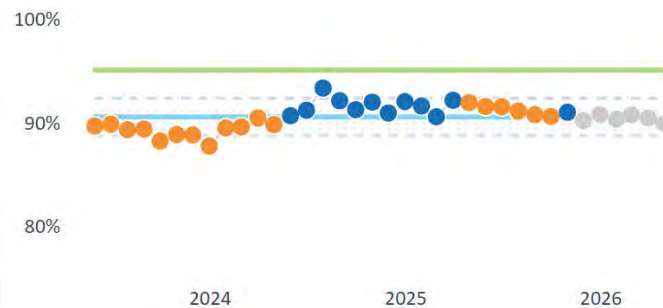
KPI Threshold: 95.0%

Sub Domain KPIs: 3

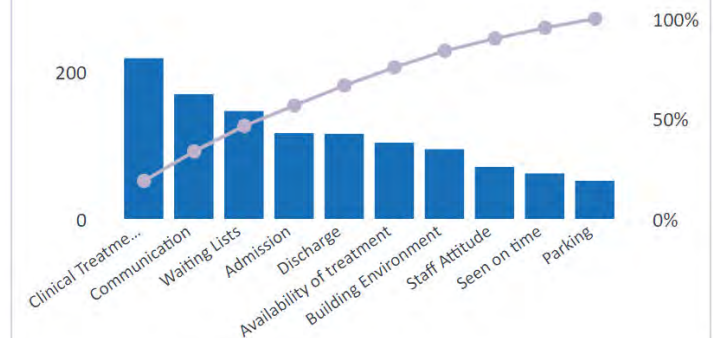
Variation Summary:



Total FFT Recommend % | Last 36 Months



Latest Month | Negative Responses by Theme (Top 10)



Key Messages

FFT scores remain consistently below the **95% target**, averaging around **90–91%**, with a slight recent decline to **89.9%**. Performance is stable but not improving. Patient feedback highlights clinical care, communication, and waiting times as the main areas of dissatisfaction.

Issues, Concerns & Gaps

- Lack of standardised feedback collection across some areas.
- Ongoing missed opportunities to capture patient feedback.
- Inconsistent ownership and accountability.
- Continued patient concerns regarding care, communication, and waiting times.

Actions & Improvements

- Focus on what matters most to patients
- Improve communication and patient involvement
- Use real-time feedback to drive improvement
- Strengthen leadership and accountability
- Share learning from high-performing areas



Key Messages

- There were 14 MSA unjustified breaches in critical care (14 in previous month)
- 100% new complaints acknowledged.
- 36 new complaints registered, this is the same number of complaints received for the month before. Themes include; delays in treatment and diagnosis, dissatisfied with medical care provided during pregnancy, complications following labour, concerns regarding nursing care & delays in medication and pressure sores, corridor care.
- PALS themes include; appointment delays & queries, written & verbal communication to patients and relatives, delays in care and treatment, delays in receiving results, concerns around discharge, corridor care.
- 24 complaints due for response. 21 (87.5%) of these breached.
- 2 New PHSO cases – 2 being assessed for potential investigations (SM) 1 PHSO cases closed with no investigation necessary.

Issues, Concerns & Gaps

- There is no update to when the automated MSA reporting will go live on Teletracking.
- 87.5% (21) breach rate for responding to complaints KPI – causes include:
- 10 (47.6%) of complaints breached awaiting comments from staff across all divisions.
- 3 (14.2%) breached during Divisional/Care Group review/approval process.
- 8 (38%) breached during DCNO review and approval process.
- Delays in receiving comments from staff to enable investigations to close on time.
- 161 open complaints at month end - Since October 2025, with the exception of one month, more complaints have been opened each month than closed.
- A risk has been raised due to the number of complaint investigations open and breached
- An increase of enquiries received by the PALS team across all areas and also an increase in inpatient enquiries being received across the Trust.

Actions & Improvements

- MSA data continues to be collected manually and is scrutinised prior to submission
- Improvement actions are linked to ongoing QIP work wherever possible and contribute to the QIP work if new issues are identified.
- The Complaint Handling Policy; including timeframes and KPI's has been updated and commenced in May. BI dashboard reflects the changes.
- A new weekly complaints & PALS Flash report is now circulated to divisional triumvirate colleagues.
- Ongoing open communication with CG and Divisional leads to progress complaint investigations.
- All DDoNs and HoNs have been requested to attend any PALS enquiry received regarding a current inpatient to support to resolve concerns proactively.



Patients

KPI Scorecard



Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
Patients	FFT			Total FFT Recommend %	95.0%			91.5%	91.5%	91.0%	90.7%	90.5%	90.9%	90.1%	90.7%	90.3%	90.7%	90.4%	89.9%
				Emergency Care FFT Recommend %	80.0%			76.5%	76.7%	78.2%	77.2%	76.8%	76.7%	75.1%	76.2%	74.8%	74.0%	74.6%	77.9%
				Outpatient FFT Recommend %	95.0%			92.3%	92.6%	92.9%	93.0%	91.9%	92.4%	91.3%	92.3%	91.9%	92.8%	93.0%	92.8%
	Patient Experience			Mixed Sex Accommodation Breaches	0			30	25	24	29	19	5	18	10	18	9	14	14
				Critical Care Admission Delays > 4Hrs	5.0%			4.3%	8.1%	4.1%	8.4%	8.1%	3.7%	8.4%	9.3%	7.2%	5.3%	7.5%	7.4%
				Critical Care Discharge Delays > 4Hrs	35.0%			45.8%	51.0%	52.4%	64.4%	37.2%	40.4%	38.7%	39.8%	46.8%	45.5%	51.9%	45.1%
	Complaints			Complaints	-			38	21	27	44	30	25	31	24	27	29	36	36
				Complaints Re-Opened	-			2	2	3	1	6	2	1	1	2	1	2	3
				Complaints Breached % - Total	5.0%			8.3%	16.1%	13.3%	16.7%	17.6%	40.0%	72.7%	76.9%	76.5%	95.5%	73.3%	87.0%
	PALS			Complaints Breached % - Red	5.0%			0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	25.0%	75.0%	66.7%		80.0%	50.0%
				Complaints Breached % - Amber	5.0%			8.7%	16.7%	10.3%	17.4%	18.2%	42.9%	79.3%	77.3%	78.6%	95.5%	72.0%	90.5%
				Complaints Breached % - Green	5.0%			-	-	-	-	-	-	-	-	-	-	-	-
				Patient Advice and Liaison Service (PALS) Concerns	-			475	533	302	510	617	506	506	357	419	461	585	466
				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%



Patients

KPI Scorecard



Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
Patients	PHSO			Parliamentary and Health Service Ombudsman (PHSO) Cases	-			2	1	1	0	1	0	2	4	0	3	1	2



Quality

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



Evonne Hunt
Chief Nursing Officer



Alison Davis
Chief Medical Officer



Sub Domain

	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
Incident Management	6	1	4	2	1	2
IPC	2	1	0	1	1	0
Falls	1	0	0	0	0	0
Health & Safety	1	1	0	0	0	0
Legal & IG	0	1	0	0	0	0
Maternity	8	0	0	0	0	0
Mortality	9	1	5	4	0	1
Pressure Ulcer	3	0	0	1	0	0
VTE	0	1	0	1	0	0

Operational Leads:

Karen Kessack - *Deputy Chief Nurse (Quality, patient safety, clinical effectiveness, patient experience)*

James Alegbeleye - *Medical Director for Quality & Safety*

Committees:

Quality Assurance Committee (QAC)



Quality Summary



Assurance

Watch KPIs Only
Quality Domain



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



No
Significant
Change



Concerning
Variation

Variation

HSMR (12m)
VTE Risk Assessment Completed %

EDNs Completed Within 24hrs %

Mental Capacity Act Training Compliance %
Regulation 28 Reports

Fractured NOF Within 36 Hours
MRSA Cases - Hospital Acquired
Never Events
Pressure Ulcers - Total (Reportable)
SIRs Completed %

After Action Review (AAR) Declared
Assaults - Patient on Staff
Duty of Candour Compliance Stage 2 %
E.coli Cases - Hospital Acquired
Falls per 1,000 Bed days
HSMR Expected Death Rate (Month)
Maternity and Newborn Safety Investigation...
Neonatal Deaths +14

Violence & Aggression Incidents

Clinical Incidents with Harm (Moderate and ...
SHMI (12m)

After Action Review (AAR) Open - Month End
Deceased Patient - Clinical Coding Validation...
Duty of Candour Compliance Stage 1 %
HSMR Expected Death Rate (12m)
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	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
	95.0%			99.5%	98.9%	98.6%	98.8%	98.8%	99.2%	98.2%	97.6%	98.0%	98.4%	98.9%	98.2%

True North Domain: | **Quality**

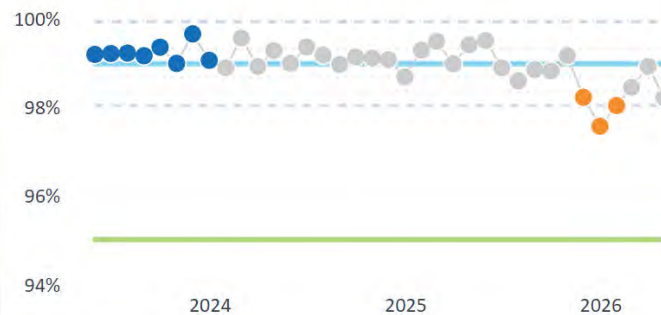
KPI Threshold: 95.0%

Sub Domain KPIs: 11

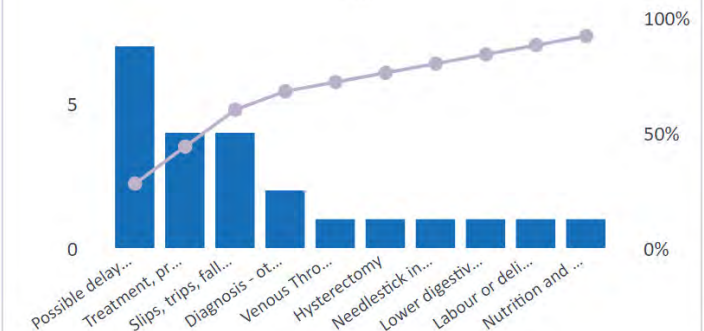
Variation Summary:



Low or No Harm Incidents % | Last 36 Months



Latest Month | Incidents (excl Low or No harm) by Incident Reason (Top 10)



Key Messages

- Overall harm low, but high incident volume concentrated in ED and frailty pathways.
- ED overcrowding and staffing gaps driving safety risks and KPI deterioration.
- Recurrent absconding and behavioural incidents increasing organisational risk.
- Medication safety and documentation errors persist despite controls.
- Effective escalation and immediate responses limiting harm in most incidents.

Issues, Concerns & Gaps

- ED crowding compromising fire safety, monitoring, and timely treatment delivery.
- Repeated staffing shortfalls across ED and neonatal areas impacting care quality.
- High frequency of absconding patients, including vulnerable and mental health cohorts.
- Medication processes unreliable: missed doses, incorrect routes, supply/access failures.
- Data quality concerns: incomplete investigations, missing documentation, inconsistent classification.

Actions & Improvements

- Implement whole-system flow actions to reduce ED overcrowding and corridor care.
- Strengthen staffing escalation and workforce planning in high-risk services.
- Introduce targeted absconding prevention bundle for high-risk patient groups.
- Standardise medication safety checks, stock visibility, and competency reinforcement.
- Improve Datix completion, investigation timeliness, and executive oversight of learning.



Quality

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



Mortality

Crude Mortality Rate %

Type	Threshold	V	A	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
	1.30%			1.12%	1.20%	1.42%	1.47%	1.41%	1.37%	1.84%	2.13%	1.74%	1.45%	1.39%	1.47%

True North Domain: | **Quality**

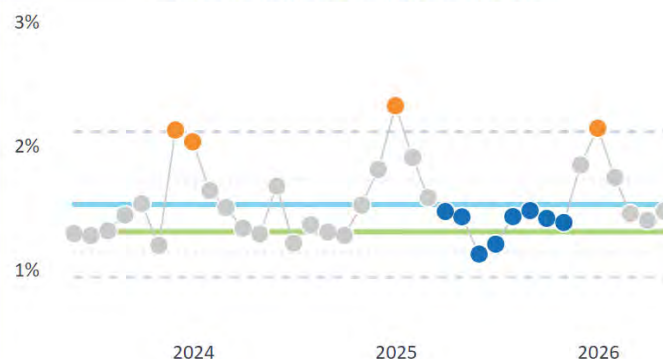
KPI Threshold: 1.30%

Sub Domain KPIs: 15

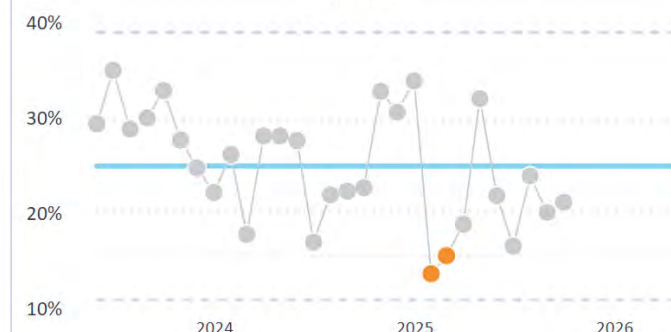
Variation Summary:



Crude Mortality Rate % | Last 36 Months



Deceased Patient – Clinical Coding Validation Returned % | Last 36 Months



Key Messages

- HSMR+ for the period of Feb 25- Jan 26 reports as 90.9 and 'lower than expected'. This is an improvement.
- SHMI for the period of Dec 25- Jan 26 reports as 1.30 and 'higher than expected'
- Pneumonia and UTI remain outlying diagnosis alerts for SHMI
- ED performance deteriorated in Jan 26 at Medway, compared to Dec 25. There were increasing waiting times, increasing delays to admissions and an increase in frail patients attending ED.
- 8.9% of deaths underwent a stage 1 SJR review with no deaths reported as preventable (over 50/50) through the SJR process

Issues, Concerns & Gaps

- SHMI remains above expected levels at 1.30, with a slight increase in underlying data compared to the previous month though the overall value has remained unchanged.
- UTI and pneumonia continue to be outliers and are among the top diagnostic groups impacting SHMI.
- Escalation and Ceilings of Care decisions for frail patients

Actions & Improvements

- Best practice guidance for M&M meetings approved and now being used , to support divisions in strengthening governance and reporting structures for M&M meetings
- Pneumonia pathway now embedding. UTI deep dive in progress with piloting of a more clinically focussed methodology
- Ongoing work with system partners following frailty summit. Specific focus on frail patients in the eliminating corridor care programme
- Work with Medical Examiners maturing to align with the Learning from Deaths Process
- Excellent feedback following training of new SJR reviewers



Maternity



Key Messages

Perinatal Quality – Incidents: 157 datix (↑) reported for maternity, 16 (↑) incident in maternity rated low harm, 2 (↑) Incidents rated Moderate (MNSI Referral, postnatal PE following incorrect anticoagulant dose - PSII), 0 incident rated above moderate harm, 1 HIE (Higher Eschaemic Encephalopathy) - term baby – MNSI referral, 1 MNSI referral in May – baby born in poor condition, HIE II, cooled. MRI normal, 0 maternal deaths, 0 Adverse homebirth incidents, 0 Term stillbirths. 1 still birth 33 weeks – reported to MBRRACE; PPH (dashboard) – Total over >1000mls 40(↑) >1500mls 15 (↑), > 2500mls 2 (↑), Total Caesarean Section (CS) 46.4% (↓), 28 Datix (↓) relating to PPH >1000mls, 2 (↑) datix relating to 3rd/4th degree tears, 5 (↑) recorded via Maternity Dashboard. 26 (↓) Incidents in NICU, (5 ↓) relating to medication. 3 incidents low harm; Staffing - 4.82 WTE Band 5/6 vacancy available to advertise, All new starters now in post, 1 leaver in next 3 months Perinatal Quality – PMRT – Perinatal Losses: 1 x stillbirth 33 weeks, 3 Neonatal deaths, 28+3 (at 18 days of life), 27+3, 23+5 (born at neighbouring Trust), Perinatal Losses Not MBRRACE reportable): Miscarriage: 2 (19+0, 20+0), TOP:4 (11+5, 12+4, 13+3, 15+2) Fetal anomaly, PMRT Meetings held in May 2026: 3 Maternity Led PMRT – all cases A,A,A No care concerns identified, 0 Neonatal Led PMRT, MOSS ALERTS: 0 Maternity Outcomes Signal System (MOSS) Level 1 or Level 2 Alerts; Listening to Women and Families – Service Users and MNVP – (From FFT) 96.8% recommend rate for May 2026, 50% positive comments, 1 x poor and 3 x very poor, Very poor – Poor experience with antenatal and postnatal care planning, waiting times in Triage, missing urine samples, Poor – standard of care on postnatal ward; Staff Feedback - Positive feedback from staff reported by Board Level Safety Champion following walk about, Low morale across the unit due to reduced bank rates, Concerns raised regarding the team aurelia pathway (elective section), Loss of remuneration for Professional Midwifery Advocate hours (PMA), Positive feedback regarding Blood Awareness well communications; External – NHSE Enhanced Support and Oversight progress meeting held March 2026 – Report received - largely positive feedback (Progress is evident across governance, culture, and QIP,)

Issues, Concerns & Gaps

Perinatal Quality – Incidents: 3rd and 4th degree tears consistent number since December. Datix not completed for all instances, Datix not completed for all PPH >1000mls (28 datixes, 57 incidences. PPH (postpartum haemorrhage) 3.7% (national 3.4%) – QIP in place, Incorrect dosage of anticoagulant prescribed postnatally for a high-risk patient – PSII declared. Staffing - 15.74 WTE maternity leave with a further 8.29 WTE due to go off on maternity leave in coming months, Awaiting Exec/Trust decision to enable recruitment into fixed term contracts to cover maternity leave, Ward Clerk shortages – issue and risk to service support. To be reviewed at next issue/risk meeting, Requirement for approval to commission birth rate plus staffing review in 2026 – due 3 yearly and for compliance to CNST year 8; Risk - CNST Year 8 requiring 2 training compliance submissions -July and November. July date at risk due to industrial action. Close monitoring of compliance continues; Perinatal Quality - PMRT - Maternity: No care concerns identified in PMRTs reviewed in month; Listening to Women and Families – Service Users and MNVP - Samples delivered to Trust to send to pathology, not being processed by laboratory; Staff + Service User Feedback – Board level safety champion raised concerns regarding time for detailed discussions with staff on walkabout when they are working clinically, Inconsistent taking of breaks across the unit; External – NHSE Enhanced Support and Oversight progress identified Maternity triage remaining the most significant risk – advised immediate executive action to ensure safe and sustainable service delivery, Implementation tool for Maternity Care Bundle in order to fully complete Gap Analysis only published in June 2026 (was due beginning May 2026)

Actions & Improvements

Perinatal Quality – Incidents - Blood sample collection awareness week held in May with teaching video for all staff based on real cases. OASI (Obstetric Anal Sphincter Injury) 1.4% (national 3.29%) are at improved rates and below national target for April 2026; Staffing - Sustained improvement in retention for both midwives and MSWs over last 5 year, Line by line budget review underway to ensure establishment vs WTE is aligned, Working with Trust leads to progress fixed term contracts to cover significant maternity leave gaps; Training - Close monitoring of compliance for PROMPT, CTG and NBLS in order to meet submission compliance for CNST Year 8 Safety Action A, Plan to request change of mid-point date to 30 September via QAC due to industrial action. Approach approved by NHR/NHSE.; Perinatal Quality – PMRT - Weekly meetings to review and ensure all PMRTs are held in allocated time to ensure compliance with CNST Safety Action C, Changes to CNST do not require strict adherence to timescales for compliance. Plan to maintain compliance timescales as per CNST year 7 requirements as best practice; Listening to Women and Families – Service Users and MNVP - Training commenced for BSOTS (Birmingham obstetric triage assessment tool) – launch date planned June 2026 – to increase efficiency in triaging patients and therefore reduce wait times, Matron working with pathology service manager to explore any gaps in the transportation/testing pathway; Staff Feedback – Positive response to Senior Sisters trialling 12 hour MOC shifts to free up more availability on shop floor for increased visibility, Changes to NIPE, Virtual walkabout and bespoke listening sessions arranged with Board Level Safety Champion, Targeted work on ensuring taking of breaks, with shared ownership by Labour Ward Coordinator and Midwife in charge of each ward area, Senior team reviewing team aurelia pathway, Monitoring bank fill rates through weekly meetings with CNO; External – MNVP involvement in BSOTS launch, MNVP including ‘you said’ ‘we did’ action tracker in safety champions meeting, Poor attendance from other Regional DOM’s at meeting regarding SOP Care for Women Outside of Geographical area. SOP approval being sought virtually and ICB will pick up approval in their June PPAM meetings at the other 3 Trusts, Meeting held with MNVP re Listening Event – planned for early July



Quality



Key Messages

Falls- The Trust maintained the 2025/26 QIP target of <5.5 OBD. 71 falls were recorded in May demonstrating a 6% reduction from April 2026 (76). 2 incidents resulted in severe harm however any identified learning already aligns with the Falls QIP.

VTE- The Trust continues to achieve VTE risk assessment above the National Target.

Pressure ulcers- 24 reportable incidents of hospital acquired pressure ulcers. There were no Cat 4 pressure ulcers in May. Celebrations -Victory Ward are 409 days pressure ulcer free, CCU, 406 days and Bronte 115 days

Issues, Concerns & Gaps

Falls- Risk 2733 remains active however, Emergency Sounds for falls alarms only relates to 3 wards now.

VTE- Due to CNS VTE absence, the Trust HAT has not been calculated and validated at the time of report. Key themes from HAT investigations include incorrect dose of thromboprophylaxis according to weight, delay in prescribing, review of risk assessment in 7 days.

Pressure ulcers- Repositioning continues to remain top contributory theme. EPR project initiated to improve pressure ulcer care plan and repositioning document. Intensive support is provided to areas of concern. Increased length of stay in the Emergency department, patients on chairs, trolleys. Collaboration continues with the End of Life care Team to include pressure ulcer patient information updated to include end of life care. There is no Trust wide pressure ulcer dashboard on BI limiting visibility, thematic analysis and timely assurance

Actions & Improvements

Falls: AZT devices have been requested and are awaiting approval to alter the Courtney Thorne call bell system from the emergency buzzer sound to a falls alarm sound.. The Courtney Thorne call bell system can now be used to monitor response times to falls alarms and number of activations where a fall was prevented. The falls Team is providing intensive support to areas of concern

VTE-Weekly VTE walkarounds continue to support real time clinical advice, improve documentation quality and support early identification of VTE related safety risks. Collaborate with EPR team to introduce re assessment prompts and have clear area for weight to be recorded

Pressure ulcers- Trust wide learning groups have transformed learning from being ward specific to Trust wide with shared ownership for reducing pressure ulcers and improving patient outcomes. ASSKING audit reduced from monthly to quarterly to allow Tissue Viability team to support wards in improvement focus. Tissue Viability Padlet will be launched June 2026 to improve access to learning



Quality

KPI Scorecard



Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
Quality	Incident Management			Low or No Harm Incidents %	95.0%			99.5%	98.9%	98.6%	98.8%	98.8%	99.2%	98.2%	97.6%	98.0%	98.4%	98.9%	98.2%
				Clinical Incidents with Harm (Moderate and above)	0			6	13	14	12	15	11	20	23	23	20	14	22
				Patient Safety Incident Investigations (PSII) Declared	-				2		1	1		3	7	8	4	9	3
				After Action Review (AAR) Declared	-			4	5	5	2	4	3	3	2	1	4	9	2
				After Action Review (AAR) Open - Month End	-			14	15	18	19	19	21	21	23	23	27	36	37
				Never Events	0			0	0	0	0	0	0	1	0	0	1	0	0
				Duty of Candour Compliance Stage 1 %	-			100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	88.9%	81.8%	66.7%	83.3%	62.5%
				Duty of Candour Compliance Stage 2 %	-			100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		66.7%	100.0%	100.0%
				EDNs Completed Within 24hrs %	90.0%			86.2%	87.3%	84.3%	87.1%	85.8%	85.4%	84.8%	85.0%	84.5%	83.0%	84.4%	83.3%
				Violence & Aggression Incidents	126			237	221	265	214	267	230	184	241	199	218	208	244
				Assaults - Patient on Staff	-			65	72	120	54	82	79	56	63	62	69	81	65
	Falls			Falls per 1,000 Bed days	-			4.46	4.71	4.63	4.72	4.73	4.13	3.64	4.85	5.22	3.78	4.89	4.46
	Pressure Ulcer			Pressure Ulcers - Total (Reportable)	24			28	21	23	23	40	38	32	43	27	31	30	24



Quality

KPI Scorecard



Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
Quality	Pressure Ulcer			Pressure Ulcers - Grade 4	-			2	1	2	0	0	2	1	1	0	0	0	0
				Pressure Ulcers per 1,000 Bed Days (Reportable)	-			1.76	1.27	1.38	1.43	2.43	2.42	1.97	2.57	1.78	1.92	1.96	1.51
	IPC			C-Diff Cases - Hospital Acquired YTD (Cumulative)	53			13	19	23	25	26	29	31	34	36	39	3	5
				MRSA Cases - Hospital Acquired	0			0	1	0	1	0	0	0	3	0	0	0	0
				E.coli Cases - Hospital Acquired	-			3	4	7	5	5	0	5	8	6	1	2	7
	Mortality			Crude Mortality Rate %	1.30%			1.12%	1.20%	1.42%	1.47%	1.41%	1.37%	1.84%	2.13%	1.74%	1.45%	1.39%	1.47%
				Deceased Patient – Clinical Coding Validation Returned %	-			21.7%	16.5%	23.8%	20.0%	21.1%	-	-	-	-	-	-	-
				Deceased Patient – Clinical Coding Validation Sent %	-			93.2%	94.0%	92.3%	91.3%	18.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
				HSMR (12m)	100			97.04	95.80	95.53	94.76	94.26	93.44	93.49	90.90	90.51			
				HSMR Expected Death Rate (12m)	-			5.7%	5.7%	5.8%	5.9%	6.0%	6.0%	6.1%	6.3%	6.2%			
				HSMR Expected Death Rate (Month)	-			5.4%	5.8%	6.2%	6.0%	6.0%	5.7%	7.8%	8.1%	4.9%			
				SHMI (12m)	1			1.25	1.26	1.26	1.27	1.29	1.30	1.30	1.30				
				SHMI Expected Death Rate (12m)	-			3.5%	3.5%	3.6%	3.6%	3.6%	3.5%	3.5%	3.5%				



Quality

KPI Scorecard



Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
Quality	Mortality			SHMI Crude Death Rate (12m)	-			4.4%	4.4%	4.5%	4.5%	4.6%	4.6%	4.6%	4.6%				
				Fractured NOF Within 36 Hours	92.0%			78.8%	66.7%	31.6%	58.8%	88.9%	60.0%	78.6%	56.0%	65.2%	54.8%	66.7%	
				Number of Deaths Reviewed via SJR	-			12	19	17	16	16	11	9	14	15	12	13	10
				SJRs Completed %	12.5%			14.1%	19.6%	16.8%	14.3%	13.7%	10.2%	6.7%	8.2%	11.8%	10.3%	12.4%	8.9%
				Total Number of Deaths Due to Failings in Care	-			0		0	1	0	1	0	0	1		0	0
				Number of LD Deaths Reviewed via SJR	-			1	0	1	1	1	1	1	1	0	0	0	0
				Total Number of LD Deaths Due to Failings in Care	-			0					0	0	0				
	VTE			VTE Risk Assessment Completed %	95.0%			96.1%	97.8%	95.6%	98.3%	99.3%	99.2%	98.4%	98.8%	98.7%	98.9%	98.9%	98.6%
	Maternity			Total Caesarean Birth (% of Total Women Birthed)	-			49.0%	50.0%	52.3%	44.5%	50.8%	52.1%	58.1%	52.1%	47.4%	53.2%	54.6%	46.4%
				Planned Caesarean Births (Elective) (% of Total Women Birthed)	-			20.6%	23.9%	19.3%	21.0%	21.9%	19.2%	25.1%	20.4%	19.6%	22.0%	22.8%	18.8%
				Unplanned Caesarean Births (Emergency) (% of Total Women Birthed)	-			28.4%	26.1%	33.1%	23.5%	28.9%	33.2%	33.0%	31.7%	27.8%	31.2%	31.8%	27.6%
				PPH >=1500ml	-			14	17	16	15	21	14	10	12	12	22	12	15
				Total Still Births (>=24+0 weeks)	-			0	1	0	1	2	1	0	1	0	0	1	1



Quality

KPI Scorecard



Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
Quality	Maternity			Neonatal Deaths	-			2	1	3	3	3	2	2	1	1	2	3	3
				Maternity and Newborn Safety Investigations (MNSI) Declared	-			0	0	0	0	0	1	1	0	0	0	0	0
				Number of cases of Hypoxic Encephalopathy (HIE) grades 2 & 3	-			0	0	0	1	1	0	0	0	0	1	0	1
	Health & Safety			Resuscitation Training Compliance %	-			83.5%	84.0%	84.1%	83.0%	82.9%	83.3%	84.4%	83.3%	83.2%	82.6%	82.7%	82.0%
				Mental Capacity Act Training Compliance %	-			86.8%	86.4%	86.5%	86.6%	86.6%	85.7%	85.9%	86.2%	86.4%	86.7%	87.0%	87.1%
	Legal & IG			Regulation 28 Reports	-			0	0	0	0	0	0	0	0	0	0	0	0



Systems & Partnerships

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



Darren Palmer
Chief Operating Officer



Sub Domain

Emergency Care
Access

Variation

Common	8	3	4
	9	11	4

Assurance

Common	3	2	6
	7	1	11

Operational Leads:

Stewart Nisbet - *Director, Surgery and Anaesthetics*
 Claire Payne - *Director, Medicine and Emergency Care*
 Sam Chapman - *Director, Cancer and Core Clinical Services*
 Sam Chapman - *Director, Women, Children and Young People*

Committees:

Finance & Performance Committee



Systems & Partnerships



Assurance

Watch KPIs Only
Systems & Partnerships



KPI consistently passing the threshold



KPI Inconsistently hitting, passing and falling short of the threshold



KPI consistently falling short of the threshold



No threshold Set for KPI



Improving Variation

30 Day Readmission Rate

62 Day Performance - Overall %
Cancer USC Performance %

28 Day Performance - Overall %
62 Day PTL Backlog
DM01 Performance %
PIFU %
RTT 52 Week Breaches
RTT 52 Week Waiting List %
RTT Waiting List Size

14 Day Readmission Rate
IP Discharged Before Noon % (Inc transfers t...



No Significant Change

Bed Occupancy - NCTR % (G&A)

31 Day Performance - Overall %
Average Elective Length of Stay (days)
Operations Cancelled by Hospital on Day
Patients Waiting For 1st Appointment < 18 ...
Total EC 4 Hour Performance - Non-Admitted...
Type 1 EC 4 Hour Performance %
Urgent Operations Cancelled for 2nd Time

OP Average Time to First Appointment (days)
Outpatient DNA Rate %
Total EC 12 Hour DTAs

104 Day Cancer Waits
Ambulance Handover Delays (> 30 mins)
Day Case Rate %
Number of ED Arrivals by Ambulance



Concerning Variation

Average Non-Elective Length of Stay (days)

Ambulance Handover Delays (> 60 mins)

Average Time in EC Department - Excl. Type ...
ED Corridor 45 Minute Breaches
ED Corridor 45 Minute Breaches %

Average Length of Stay - Adult Patients
Average Length of Stay - Older Adult Patients
OP First to Follow Up Ratio

Variation



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	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
	67.0%			54.6%	53.7%	52.8%	53.5%	54.6%	55.8%	57.1%	57.9%	59.6%	62.0%	61.6%	61.0%

True North Domain: **Systems & Partnerships**

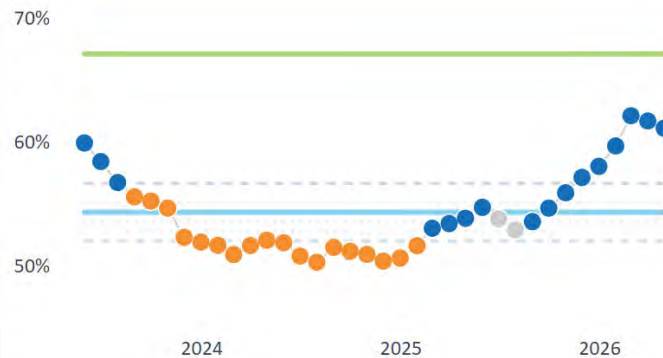
KPI Threshold: 67.0%

Sub Domain KPIs: 24

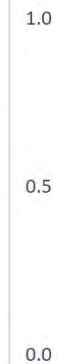
Variation Summary:



RTT Incompletes Performance % | Last 36 Months



Year to Date | by (Top 10)



Key Messages

Incomplete performance is 61.1% against plan of 61.4%. Validation is ongoing however there is a possibility we may not achieve plan this month.

Patients waiting > 52 weeks is 1.4%, 483 against a plan of 320

Overall waiting list size is 34,527 against a plan of 34,011

Issues, Concerns & Gaps

All but 7 specialties are delivering RTT performance > 60%.

Rheumatology (31%) and Neurology (35%) are the lowest performing specialties.

There are three specialties where patients are waiting >52 weeks – Rheumatology 280, Neurology 194, Cardiology 8

Actions & Improvements

A paper has been developed to explore options to support improving the Rheumatology position. This was initially submitted through TLT; however, further information has been requested and the paper will be resubmitted



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	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
	82.0%			77.6%	76.3%	73.3%	75.7%	74.7%	73.9%	69.9%	70.1%	73.1%	76.4%	75.2%	77.1%

True North Domain: | **Systems & Partnerships**

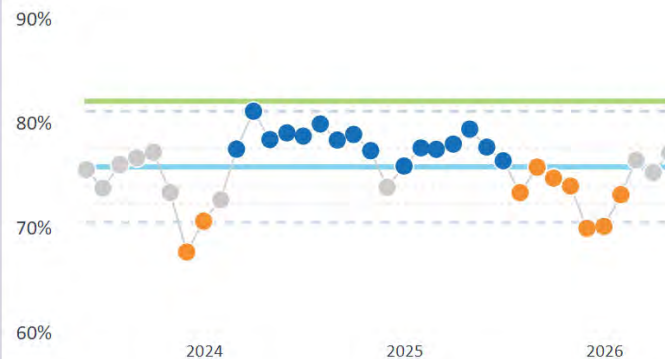
KPI Threshold: 82.0%

Sub Domain KPIs: 15

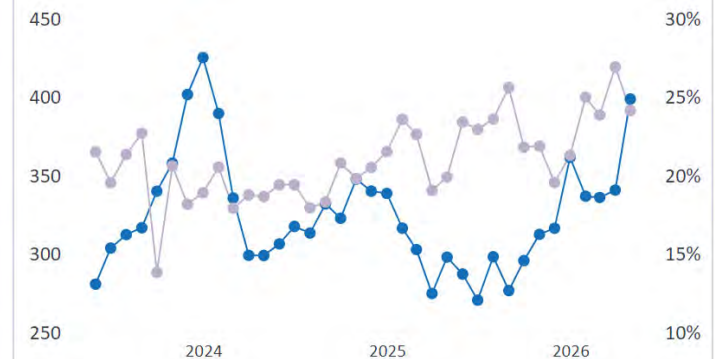
Variation Summary:



Total EC 4 Hour Performance % | Last 36 Months



Average Time in ED vs Bed Occupancy - NCTR % (G&A)



Key Messages

ED 4 hour performance improved in May to 77.1%, an increase of 1.9% from April. However, 12-hour breaches increased to 1,315, a 5.7% increase on April. Contributing factors were a 6.8% increase in mental health attendances and a 5.1% increase in ambulance conveyances.

Issues, Concerns & Gaps

As a result of ongoing flow and capacity issues, escalation areas and corridor care remained open in May. Increase in mental health patients awaiting assessment and transfer out of the department, contributed to capacity and resource pressures.

Actions & Improvements

Focus on reducing 12-Hour breaches through daily review of all breaches and weekly deep dives into non-admitted delays.
Soft launch of the Frailty assessment Unit on 8th June to support flow of frailty patients out of ED.
Ongoing review of Acute Medical workforce model to allocate additional senior clinical decision makers to support with the Acute patient flow.



Access



Key Messages

RTT - 7 specialties where performance is < 60 %

DM01 – Performance 91.6%, against plan of 91%, validation is ongoing. Imaging 97.2%, Endoscopy 89.5%, Physiological Measurements 82.6%

CDC activity overall has delivered above plan for May 8089 vs 7997plan. Swale CDC was slightly off plan by 11 diagnostics with Medway over delivering by 103 diagnostics.

Cancer April (published data)

- 28D performance was 72.9% against 80% plan
- 31D performance was 99.1%, consistently above target of 98%.
- 62D performance was 89.5% against a 75% plan, this was the highest ever recorded performance
- 62D backlog position increased from 6.8% to 8%

Issues, Concerns & Gaps

RTT

Further capacity issues within Rheumatology due to sickness within the department.

The number of patients waiting > 52 wks continues to increase month on month. This is primarily in Rheumatology and Neurology.

DM01

Audiology, sleep and cystoscopy performance lower compared with previous months. Admin capacity within sleep service is causing an issue with patients bookings.

Cancer April

- 28D - Total of 449 breaches in April with 116 of these in Lower GI, 69 in Head & Neck / Thyroid, and 53 in Breast.
- Top contributing reasons for breaches within these tumour groups were histology delays [101], Imaging delays at MFT & DGT [29], Share point review delays [38]
- Histopathology – Turnaround times remain challenged at MTW in April. Formal escalation has made to Kent and Medway Cancer Alliance. Recovery plan has been requested from the Alliance.

Actions & Improvements

Access

Options being explored for additional support within Rheumatology and Neurology.

DM01

Capacity and booking processes being reviewed within cardiology diagnostics

Sleep service out to internal advert for admin support.

Cancer April

- Lower GI – Improvement plan in place
- Head & Neck pathway – challenges with timely diagnostics, working with Imaging at MFT and DGT
- Histopathology – turnaround times remain challenged, we have not seen an improvement in April as initially communicated. May remains a challenge.
- Still awaiting outcome of SDF funding requests from KMCA to support cancer pathway sessions.



Emergency Care



Key Messages

- ED 4-hour performance improved to **77.1%**, an increase of **1.9%** from April **75.2%**, with the department achieving the national standard on 7 days during the month.
- 12-hour breaches increased to **1,315**, a **5.7%** increase on April (1244) and is the highest level recorded since January.
- Length of stay performance improved marginally by **0.1%** at **4.6%** compared with April **4.7%**, although performance remains close to peak winter pressure levels.
- Initial Assessment performance improved to **55.8%**, a further **increase of 3.2%**, from April's **52.6%** bringing the department in line with the current national average.
- There were **3,341** ambulance conveyances in May, a **5.1%** increase on April. 15-minute handover compliance dropped to **65% from 67% in April**. ED continues to work collaboratively with SECAMB under sustained pressure to minimise handover delays.
- There were **423** Mental Health attendances in May, a **6.8%** increase on April (396) and is the second-highest monthly total in the last 12 months (March 2026: 431), with ongoing delays in assessment, inpatient beds and external placements impacting departmental flow and capacity

Issues, Concerns & Gaps

Ongoing **flow and capacity** challenges across the wider Trust continue to impact ED performance, resulting in prolonged waits, corridor care and increased operational risk; work continues to strengthen flow processes, **expedite discharges** and improve whole-system **escalation and coordination**.

- Sustained use of **corridor care** (**963 ED corridor** 45 minute breaches in May compared to **929 in April**) and escalation areas continues to affect patient privacy, dignity, experience and staff wellbeing.
- **Mental health patients** awaiting assessment, admission or specialist placement continue to contribute to prolonged lengths of stay and reduced departmental capacity.
- **Workforce pressures** continue across nursing, medical and operational teams. The recruitment process has created delays in progressing vacancies. Currently there is an inability to progress workforce plans at the pace required to meet service demand. This has increased reliance on temporary staffing solutions while limiting opportunities to build sustainable workforce resilience across the service. Mitigating actions have included maximising workforce flexibility through role swaps, cross-cover arrangements, staff upskilling, and skill mix reviews, with roles and duties adapted where appropriate to maintain service resilience and patient safety.

Actions & Improvements

- Continued focus on **reducing 12-Hour breaches** through **weekly deep dives** into non-admitted delays, **daily review** of all breaches to identify learning opportunities, direct feedback to teams, and analysis of recurring themes and trends to support targeted improvement actions.
- Continued delivery of the ED Improvement Programme through targeted **performance reviews**, operational deep dives, pathway redesign and implementation of **learning identified** through performance and quality governance processes.
- **Recruitment activity** continues across nursing, medical and operational workforces to reduce vacancies and reliance on temporary staffing.
- Strengthening collaboration with specialty teams, Psych Liaison and Trust-wide flow initiatives to support timely **patient assessment, treatment and discharge**.
- EM5 continued to support patient flow and departmental performance, managing **441 attendances** during the month despite periods of reduced capacity and temporary pauses due to operational pressures.
- Frailty SDEC/Assessment Unit soft launch in June that will eventually support flow of frailty patients from ED.



Systems & Partnerships

KPI Scorecard



Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
Systems & Partnerships	Access			RTT Incompletes Performance %	67.0%			54.6%	53.7%	52.8%	53.5%	54.6%	55.8%	57.1%	57.9%	59.6%	62.0%	61.6%	61.0%
				RTT 65+ Week Waiters	0			101	75	384	555	496	136	30	9	3	0	0	0
				RTT Waiting List Size	32,526			39,993	39,335	39,907	39,089	38,102	37,104	36,921	35,321	34,777	34,098	34,091	34,468
				RTT 52 Week Breaches	0			1,735	1,756	2,053	2,116	1,953	914	533	327	224	285	368	483
				RTT 52 Week Waiting List %	0.0%			4.3%	4.5%	5.1%	5.4%	5.1%	2.5%	1.4%	0.9%	0.6%	0.8%	1.1%	1.4%
				Patients Waiting For 1st Appointment < 18 Weeks %	63.0%									58.9%	60.9%	61.7%	64.1%	62.3%	61.8%
				OP Average Time to First Appointment (days)	60			119.39	122.82	180.48	154.20	130.64	154.24	122.72	126.98	116.89	112	103.88	106.28
				Outpatient DNA Rate %	5.0%			6.3%	5.8%	6.4%	6.3%	6.3%	6.4%	6.6%	6.4%	6.1%	6.2%	5.6%	5.8%
				OP First to Follow Up Ratio	-			1.73	1.79	1.76	1.81	1.79	1.68	1.83	1.79	1.69	1.69	2.02	1.98
				PIFU %	5.0%			2.4%	2.8%	2.9%	3.8%	3.6%	3.9%	4.1%	4.3%	3.9%	3.9%	3.1%	3.2%
				Operations Cancelled by Hospital on Day	13			13	10	8	21	30	18	4	15	6	5	3	7
				Urgent Operations Cancelled for 2nd Time	0			0	1	2	1	0	0	2	0	2	0	0	1
				Day Case Rate %	-			87.9%	87.8%	86.8%	87.5%	87.0%	87.8%	88.5%	87.2%	87.7%	88.2%	87.3%	85.8%



Systems & Partnerships

KPI Scorecard



Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
Systems & Partnerships	Access			Average Elective Length of Stay (days)	3			2.97	3.18	3.65	2.60	2.70	3.43	3.45	2.10	2.54	3.32	2.56	2.85
				Average Non-Elective Length of Stay (days)	10			6.01	6.50	6.22	6.26	6.87	6.34	6.63	6.75	6.69	6.80	6.55	6.92
				Average Length of Stay - Adult Patients	-			3.32	3.49	3.49	3.32	3.71	3.40	3.63	3.47	3.48	3.40	3.47	3.87
				Average Length of Stay - Older Adult Patients	-			5.18	5.42	5.50	5.09	5.63	5.16	5.50	5.46	5.66	5.02	5.38	6.10
				104 Day Cancer Waits	-			20	19	11	18	13	15	13	7	9	12	1	
				Cancer USC Performance %	93.0%			87.5%	89.1%	90.8%	95.3%	97.0%	95.2%	97.4%	95.6%	97.2%	95.9%	94.3%	
				28 Day Performance - Overall %	83.0%			65.3%	71.9%	75.4%	76.6%	76.3%	78.9%	75.8%	71.6%	83.2%	76.9%	72.9%	
				31 Day Performance - Overall %	98.0%			96.3%	98.0%	98.6%	98.0%	100.0%	99.1%	96.2%	96.6%	98.2%	98.5%	97.6%	
				62 Day Performance - Overall %	80.0%			60.9%	64.9%	71.6%	68.4%	76.0%	82.1%	73.8%	81.0%	73.7%	80.5%	89.5%	
				62 Day PTL Backlog	6.0%			11.9%	10.9%	11.3%	10.7%	9.9%	8.0%	10.8%	11.2%	8.6%	6.8%	8.0%	9.4%
				DM01 Performance %	93.1%			86.8%	86.0%	80.0%	82.4%	85.5%	90.8%	87.7%	91.9%	97.3%	94.6%	92.9%	91.6%
Emergency Care				Total EC 4 Hour Performance %	82.0%			77.6%	76.3%	73.3%	75.7%	74.7%	73.9%	69.9%	70.1%	73.1%	76.4%	75.2%	77.1%
				Type 1 LOS > 12 Hours in EC %	6.0%			10.0%	11.5%	12.6%	11.5%	11.9%	11.7%	13.0%	14.4%	13.5%	11.2%	13.1%	13.2%

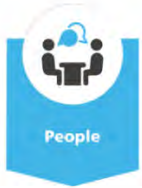


Systems & Partnerships

KPI Scorecard



Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
Systems & Partnerships	Emergency Care			Total EC 4 Hour Performance - Non-Admitted %	85.0%			82.7%	81.6%	78.6%	81.4%	79.7%	79.4%	75.3%	75.0%	78.2%	81.4%	80.1%	82.4%
				IP Discharged Before Noon % (Inc transfers to ADL)	-			19.1%	21.0%	19.6%	19.3%	19.3%	18.7%	17.2%	19.7%	19.8%	19.0%	20.3%	22.4%
				Type 1 EC 4 Hour Performance %	71.4%			67.1%	65.7%	61.6%	66.6%	66.0%	64.6%	59.9%	57.6%	63.6%	69.5%	65.9%	68.1%
				Total EC 12 Hour DTAs	0			454	614	696	632	728	593	680	876	816	671	806	846
				Average Time in EC Department - Excl. Type 5 (mins)	240			286.62	270.06	297.66	276.12	295.21	311.94	315.84	361.04	336.25	335.45	340.17	398.20
				ED Corridor 45 Minute Breaches	0			427	676	700	677	804	705	785	1,029	898	813	929	963
				ED Corridor 45 Minute Breaches %	0.0%			4.2%	6.6%	7.3%	6.7%	7.8%	7.2%	7.9%	10.4%	10.2%	8.0%	9.8%	9.7%
				Number of ED Arrivals by Ambulance	-			2,947	3,120	3,063	3,058	3,215	3,193	3,463	3,381	2,927	3,243	3,108	3,281
				Ambulance Handover Delays (> 30 mins)	-			28	47	69	53	82	61	116	180	96	97	129	141
				Ambulance Handover Delays (> 60 mins)	0			0	2	2	2	1	2	4	20	5	7	1	20
				Bed Occupancy - NCTR % (G&A)	96.0%			23.4%	22.9%	23.5%	25.6%	21.8%	21.8%	19.5%	21.2%	24.9%	23.8%	26.9%	24.1%
				30 Day Readmission Rate	13.0%			8.3%	8.2%	7.5%	7.4%	7.7%	7.0%	7.7%	7.5%	7.0%	6.8%	7.2%	7.0%
				14 Day Readmission Rate	-			5.8%	5.5%	5.4%	5.1%	5.1%	4.6%	5.5%	5.4%	5.0%	4.9%	5.0%	5.0%



People

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



Sheridan Flavin
Chief People Officer



Sub Domain

Variation



StatMan	2	1	0
Workforce	5	6	2
Safe Staffing	2	0	1

Assurance



1	2	0
6	2	5
2	0	0

Operational Leads:

Steve McGowan - *Deputy Chief People Officer*

Committees:

People Committee



People



Assurance

Watch KPIs Only
People Domain

P KPI consistently passing the threshold

? KPI Inconsistently hitting, passing and falling short of the threshold

F KPI consistently falling short of the threshold

○ No threshold Set for KPI



Improving
Variation

Agency Spend %
StatMan Training Compliance %
Vacancy Rate %

Bank Spend %
Time to Hire - AfC

Voluntary Turnover %



No
Significant
Change

StatMan: Patient Safety L1 Compliance %

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 - Total %

Staff Fill Rate % (Total) - Registered Nurse

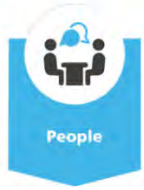


Concerning
Variation

Care Hours per Patient Day (CHPPD)
Staff Appraisal Rate %

Sickness Absence Rate - Long Term %

Variation



People

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



Workforce

Incivility Cases (Combined)

Type	Threshold	V	A	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
	20			68	80	72	72	69	78	58	78	63	81	56	61

True North Domain: **People**

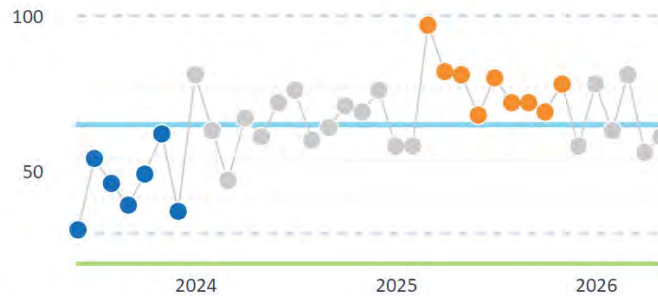
KPI Threshold: 20

Sub Domain KPIs: 13

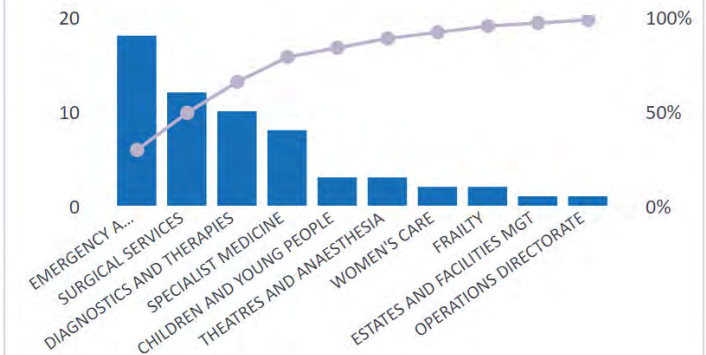
Variation Summary:



Incivility Cases (Combined) | Last 36 Months



Latest Month | Incivilities by Care Group (Top 10)



Key Messages

- Incivility reporting sustained; Equality Steering Group (ESG) oversight in place.
- Staff survey actions progressing via CT workstreams.
- Appraisal compliance below target
- Sickness absence above target; stress remains primary driver.

Issues, Concerns & Gaps

- Appraisal compliance not improving at required pace.
- Continued high stress-related absence.
- Variation in incivility across care groups.

Actions & Improvements

- ESG oversight strengthened for incivility themes.
- Divisional action plans aligned to CT priorities.
- Increased focus on appraisal completion and manager accountability.
- Enhanced ER/OH support for sickness management.
- CT marketplace planned (June) to drive engagement.

Key Messages

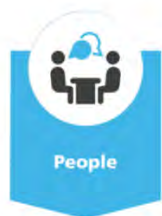
- Culture and behaviours remain a priority and incivility continues to be actively managed.
- Appraisal compliance below target.
- Sickness absence remains above plan; stress-related absence predominant.
- Engagement activity informing CT delivery.

Issues, Concerns & Gaps

- Limited improvement in appraisal completion rates.
- Persistent stress-related absence levels.
- Ongoing cultural/behavioural challenges.

Actions & Improvements

- Reinforced leadership accountability for appraisals and appraisal training compliance levels shared regularly to drive the mandatory training requirement
- Proactive sickness case management is in place; absence management guidance developed for managers, people business partners and Occupational Health working closely together to assist managers with staff who have met the sickness absence triggers
- Continued staff engagement (listening events, development sessions).
- CT workstreams progressing workforce improvements
- CT marketplace to increase visibility and engagement and take the work of culture transformation to staff in their workplace.

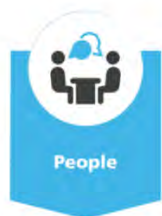


People

KPI Scorecard



Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
People	Workforce			Incivility Cases (Combined)	20			68	80	72	72	69	78	58	78	63	81	56	61
				Voluntary Turnover % - First 2 Years Employment	1.00%			0.9%	1.1%	1.1%	0.7%	1.1%	0.9%	1.7%	1.8%	0.4%	0.2%	1.0%	1.2%
				Staff Appraisal Rate %	90.0%			90.0%	89.1%	89.1%	88.9%	88.2%	87.6%	87.2%	87.2%	86.6%	86.7%	86.4%	85.5%
				Vacancy Rate %	9.0%			4.2%	4.1%	4.2%	4.7%	5.1%	5.2%	5.0%	5.3%	5.3%	5.0%	4.3%	4.8%
				Voluntary Turnover %	8.0%			8.1%	7.9%	7.8%	7.6%	7.3%	7.1%	7.2%	7.2%	7.0%	6.8%	6.8%	6.8%
				Sickness Absence Rate - Total %	4.0%			4.7%	4.9%	4.8%	5.1%	5.5%	5.3%	5.5%	5.4%	5.3%	5.0%	4.7%	5.0%
				Sickness Absence Rate - Short Term %	2.0%			2.0%	2.1%	2.1%	2.4%	2.7%	2.5%	2.9%	2.7%	2.6%	2.3%	2.0%	2.4%
				Sickness Absence Rate - Long Term %	2.0%			2.7%	2.8%	2.7%	2.8%	2.9%	2.8%	2.7%	2.6%	2.6%	2.7%	2.7%	2.6%
				Time to Hire - AfC	42			56.50	49.10	35.70	50.60	44.40	52.90	40.40	39.60	46.90	39.20	44.80	51.20
				Time to Hire - Medical	70			76.70	85.40	80.10	68.10	57.50	81.90	72.60	61	85.80	81.10	114.90	104.60
				Agency Spend %	3.7%			0.9%	0.8%	0.9%	0.9%	0.9%	1.1%	0.7%	0.6%	0.3%	0.5%	0.7%	0.4%
				Bank Spend %	10.0%			9.1%	9.8%	9.7%	9.7%	8.8%	10.1%	9.7%	8.8%	10.7%	6.5%	9.0%	6.8%
	Safe Staffing			Staff Fill Rate - Total %	85.0%			87.6%	87.5%	87.8%	87.2%	89.7%	91.9%	90.4%	91.1%	89.8%	89.3%	87.1%	89.7%



People

KPI Scorecard



Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
People	Safe Staffing			Staff Fill Rate % (Total) - Registered Nurse	-			88.9%	88.4%	87.6%	89.4%	92.6%	92.9%	91.6%	93.3%	91.6%	90.0%	87.0%	88.9%
				Care Hours per Patient Day (CHPPD)	9.50			9.35	9.29	9.23	9.20	9.08	9.07	9.01	8.84	8.82	8.98	8.99	8.79
	StatMan			StatMan Training Compliance %	85.0%			89.5%	89.8%	89.4%	89.2%	89.4%	89.3%	89.3%	88.9%	88.9%	89.6%	89.5%	89.9%
				StatMan: Patient Safety L1 Compliance %	85.0%			94.5%	94.0%	94.3%	94.8%	94.8%	95.0%	95.1%	94.7%	94.2%	93.1%	93.2%	93.0%
				StatMan: Patient Safety L2 Compliance %	85.0%			-	-	-	-	-	-	-	-	-	-	-	-



Sustainability

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



Simon Wombwell
Chief Finance Officer



Sub Domain

Financial Position

Variation



Assurance



Operational Leads:

Paul Kimber - *Deputy Chief Finance Officer*

Committees:

Finance & Performance Committee
Audit & Risk Committee

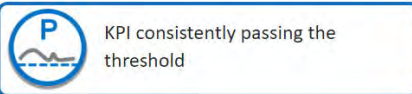


Sustainability

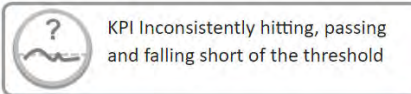


Assurance

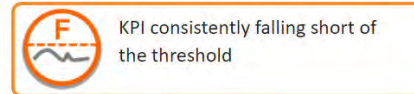
Watch KPIs Only
Sustainability Domain



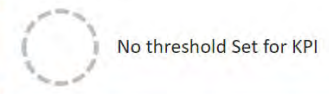
KPI consistently passing the threshold



KPI Inconsistently hitting, passing and falling short of the threshold



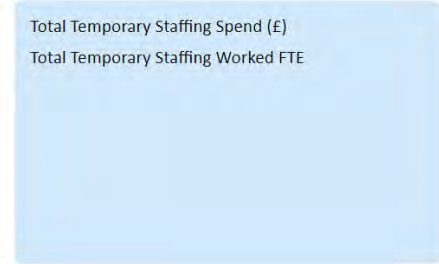
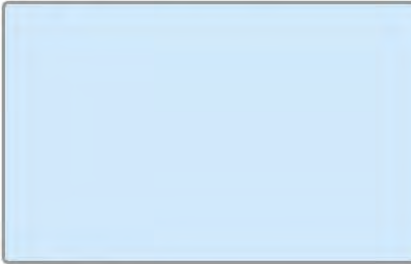
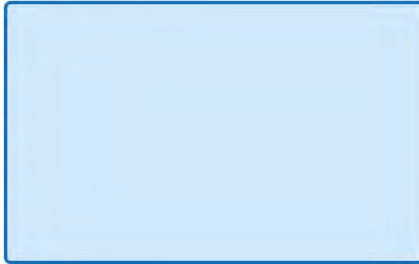
KPI consistently falling short of the threshold



No threshold Set for KPI



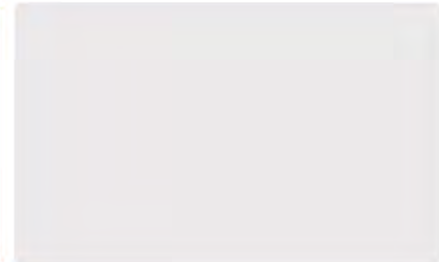
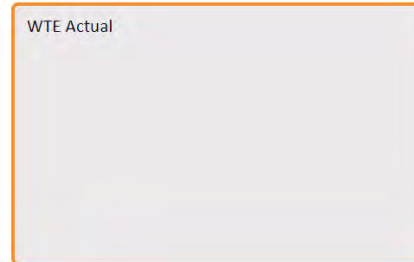
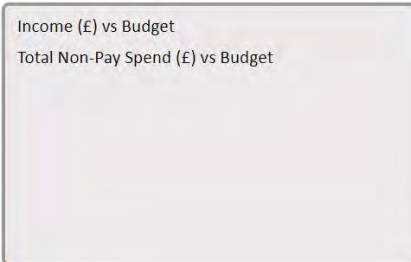
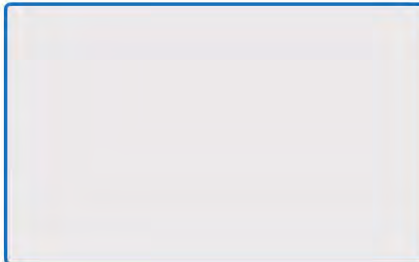
Improving
Variation



Total Temporary Staffing Spend (£)
Total Temporary Staffing Worked FTE



No
Significant
Change

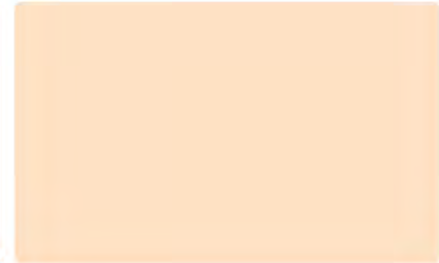


Income (£) vs Budget
Total Non-Pay Spend (£) vs Budget

WTE Actual



Concerning
Variation



Variation



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	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
	£0.00m			-0.19m	-2.11m	-4.87m	-8.20m	-17.92m	-25.42m	-34.18m	-38.21m	-45.41m	-50.62m	0.00m	-0.19m

True North Domain: | Sustainability

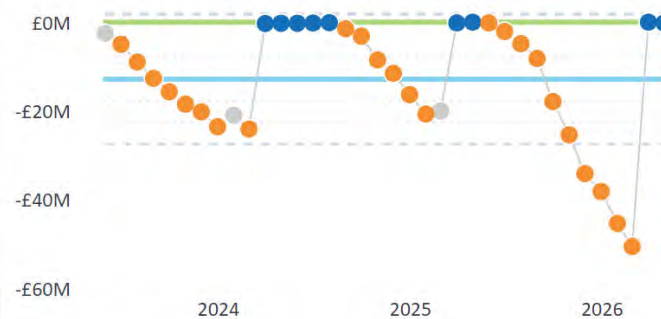
KPI Threshold: £0.00m

Sub Domain KPIs: 9

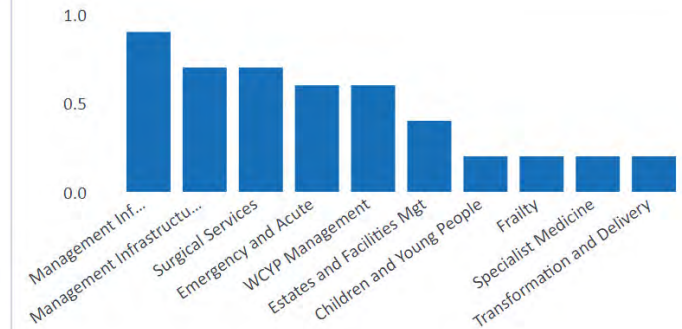
Variation Summary:



Surplus / (Deficit) (£) Variance to Plan YTD | Last 36 Months



YTD Variance to Budget (£m) by Key Variances (Top 10)



Key Messages

The Trust is 'on Plan' for Month 2 / May, delivering a breakeven (£3.0m deficit excluding Deficit Support Funding ("DSF")). The YTD position is also 'on plan' and recognises £5.9m of DSF. Q1 DSF has been agreed by NHSE. Whilst Month 2 saw an increase in the efficiencies reported (up from £1.2m to £2.2m) this still falls short of the £6.6m YTD planning requirement and the larger stretch target.

To close the gap and meet the May Plan we have had to engage technical adjustments; the shortfall will need to be addressed urgently through further cost / capacity reduction to maintain target delivery.

Issues, Concerns & Gaps

The Trust's expenditure run-rate is higher than plan and poses a high risk to delivery of the control total in 2026/27.

The efficiency target is £3.3m per month – whilst we report an increase in delivery for Month 2 this still falls short of requirements.

The maturity, implementation and delivery of the efficiency programme is therefore of significant concern.

Should the Trust not meet its plan during the year, it risks the withdrawal of DSF; this is cash-backed income.

Actions & Improvements

An affordable establishments review is launching to ensure teams have the right roles, numbers and skill mix to deliver services efficiently.

A robust assessment of efficiencies, their forecast and phasing – including how the technical mitigations will be covered – is urgent.

Emerging cost pressures from Divisions require clear identification and articulation.

The Trust must submit its forecast to the System Financial Improvement Director each month using the 'Provider Assurance Model'; Divisions will be required to complete and sign-off their local forecast using this template as part of a timely closedown of the month end.



Sustainability



Key Messages

The Trust is 'on Plan' for Month 2 / May, delivering a breakeven (£3.0m deficit excluding Deficit Support Funding ("DSF")). The YTD position is also 'on plan' and recognises £5.9m of DSF. Q1 DSF has been agreed by NHSE. Whilst Month 2 saw an increase in the efficiencies reported (up from £1.2m to £2.2m) this still falls short of the £6.6m YTD planning requirement and the larger stretch target. To close the gap and meet the May Plan we have had to engage technical adjustments; the shortfall will need to be addressed urgently through further cost / capacity reduction to maintain target delivery.

Issues, Concerns & Gaps

The Trust's expenditure run-rate is higher than plan and poses a high risk to delivery of the control total in 2026/27. The efficiency target is £3.3m per month – whilst we report an increase in delivery for Month 2 this still falls short of requirements. The maturity, implementation and delivery of the efficiency programme is therefore of significant concern. Should the Trust not meet its plan during the year, it risks the withdrawal of DSF; this is cash-backed income.

Actions & Improvements

An affordable establishments review is launching to ensure teams have the right roles, numbers and skill mix to deliver services efficiently. A robust assessment of efficiencies, their forecast and phasing – including how the technical mitigations will be covered – is urgent. Emerging cost pressures from Divisions require clear identification and articulation. The Trust must submit its forecast to the System Financial Improvement Director each month using the 'Provider Assurance Model'; Divisions will be required to complete and sign-off their local forecast using this template as part of a timely closedown of the month end.



Sustainability

KPI Scorecard



Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
Sustainability	Financial Position			Surplus / (Deficit) (£) Variance to Plan YTD	£0.00m			-0.19m	-2.11m	-4.87m	-8.20m	-17.92m	-25.42m	-34.18m	-38.21m	-45.41m	-50.62m	0.00m	-0.19m
				Total Pay Spend (£) vs Budget	£0.00m			0.88m	1.01m	2.40m	3.20m	3.51m	3.85m	4.23m	2.86m	3.34m	23.59m	0.99m	1.21m
				WTE Actual vs Plan	0			171.36	216.61	170.44	172.94	114.43	124.82	103.33	-1.85	175.88	214.28	84.12	-42.83
				Variance to CIP Target (£)	£0.00m			-1.24m	-2.36m	-3.53m	-3.84m	-4.08m	-2.67m	-3.91m	-3.67m	-4.14m	-4.23m		
				WTE Actual	5,155			5,616.48	5,697.79	5,658.10	5,678.19	5,634.10	5,642.45	5,624.51	5,518.56	5,696.44	5,734.14	5,560.88	5,438.44
				Total Temporary Staffing Worked FTE	-			589.93	622.10	601.07	634.38	574.09	594.66	584.11	503.71	656.51	682.29	510.41	406.02
				Total Temporary Staffing Spend (£)	-			2.89m	3.20m	3.08m	3.16m	2.87m	3.37m	3.12m	2.72m	3.21m	3.49m	2.85m	2.15m
				Total Non-Pay Spend (£) vs Budget	£0.00m			-0.56m	0.31m	0.17m	1.05m	1.57m	1.23m	0.92m	0.64m	0.89m	1.18m	-0.24m	-0.76m
				Income (£) vs Budget	£0.00m			0.44m	-0.65m	-0.10m	1.03m	-4.71m	-3.24m	-2.88m	-0.61m	-2.09m	19.42m	0.48m	0.06m

Meeting of the Public Trust Board

Meeting Date: 01 July 2026

Title of Report	Learning from Death Report			Agenda Item	3.3
Stabilisation Plan Domain	Culture	Performance	Governance and Quality	Finance	Not Applicable
			x		
CQC Reference	Safe	Effective	Caring	Responsive	Well-Led
	x	x			
Author and Job Title	Sofia Power, Learning from Deaths Manager Caris Grimes, Clinical Mortality Lead				
Lead Executive	Jeremy Davis Chief Medical Officer				
Purpose	Approval		Briefing		Noting x
Proposal and / or key recommendation:	The Trust is asked to note the report, which was discussed at the Quality Assurance Subcommittee on the 15 th of June 2026, and provides Learning from Deaths data, outcomes, and ongoing improvement work.				
Executive Summary	The report summarises Learning from Deaths activity, findings, and improvement actions for April 2026. 12 Structured Judgement Reviews completed (11.4% of deaths), with 7 escalated for further review. - Most deaths were not preventable; 2 cases with slight preventability remain under review, including 1 PSII. - Three deaths were declared Patient Safety Incident Investigations (PSIIs), all investigations are ongoing. - Care quality varied, with all poor ratings escalated for deeper review and shared for specialty learning. Key themes include: - System pressures, particularly Emergency Department flow delays - Variation in end-of-life care and delayed recognition of dying phase - Communication and documentation gaps (including DNAR and family engagement) - Delays in escalation and missed deterioration Mortality position: - SHMI remains elevated at 1.30 - ED delays and clinical outliers (e.g. pneumonia, UTI) contributing factors				

	Next steps include: • Refocusing reviews and strengthening Patient Safety escalation • Monthly reporting of fatal PSIs • Targeted deep dives and strengthened governance arrangements • Ongoing palliative care and frailty improvement programmes		
Issues for the Group/Committee/Board Attention:	• Risk 1684: Elevated SHMI impacting reputation and confidence; linked to ED delays, frailty, palliative care and pathway performance. • Risk 2865: Insufficient SJR reviewer capacity, limiting ability to meet targets and maintain review quality. • Governance: Need for strengthened and consistent implementation of M&M best practice across divisions. • Escalation: Requirement for increased medical input into end-of-life care improvement programmes.		
Meetings at which this paper has been discussed / approved: Date:	• Mortality and Morbidity Surveillance Group (MMSG) – 21 May 2026 • Quality assurance Subcommittee (QAC) – 15th June 2026		
Board Assurance Framework / Risk Register:	• Risk 1684 – Elevated SHMI mortality indicator • Risk 2865 – SJR reviewer capacity and retention • Issue 2714 – SJR platform disruption (proposed for closure)		
Financial Implications:	No direct financial implications identified in the report.		
Integrated Impact Assessment (IIA) implications	None of significance to report.		
Freedom of Information status:	Disclosable X		Exempt

Learning from Deaths- Structured Judgement Review Report

Reporting period: 01 April 26- 30 April 26



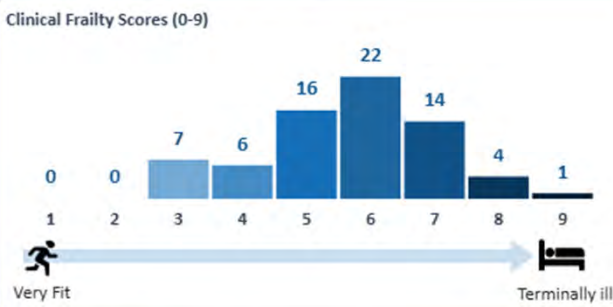
Mortality Summary Report

April 2026

 **110** **Total Deaths**

 **92** **IP Deaths**

 **18** **EC Deaths**

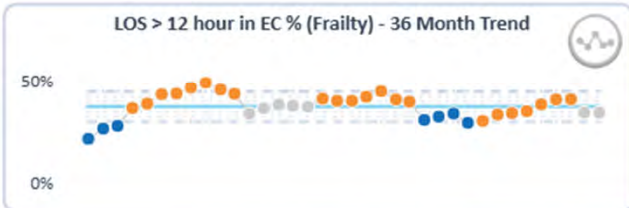


 **6** **NCTR Deaths**

12 **SJR Completed (Stage 1)**

11.4% **Stage 1 Completed %**

7 **SJR Completed (Stage 2)**



PSII

3 **Preventable Deaths (Fatal PSII)**

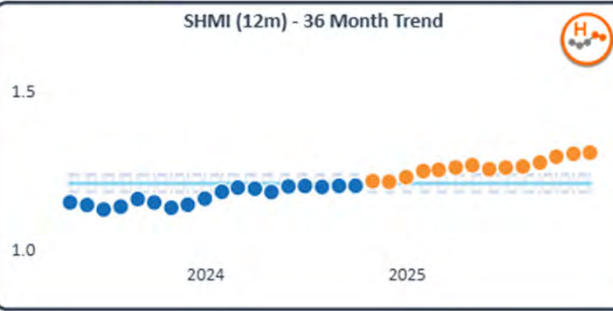
2.9% **Preventable Deaths (Fatal PSII) %**

SHMI Dec-25

1.30 **SHMI**

1,823 **Observed**

1,399 **Expected**



Observed Deaths by Charlson Index Score

Charlson Index Score	Observed Deaths
1 - No Charlson Comorbidities	140
2 - Charlson Comorbidity Value 1-5	100
3 - Charlson Comorbidity Value > 5	1,583

Excess Deaths by SHMI Diagnosis Group (Top 5)

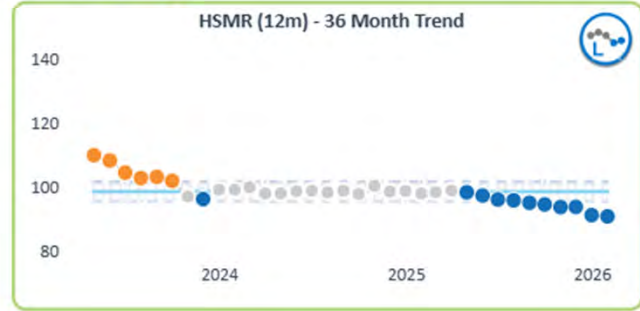
Diagnosis Group	Excess Deaths
Pneumonia (excluding TB/STD)	46
COPD & bronchiectasis	37
Other connective tissue disease	22
Urinary tract infections	17
Short gestation and slow fetal growth	14

HSMR+ Feb-26

90.51 **HSMR**

906 **Observed**

1,001 **Expected**



Excess Deaths by HSMR Diagnosis Group (Top 10)

Diagnosis Group	Excess Deaths
Other connective tissue disease	11
Chronic obstructive pulmonary disease and bronchiectasis	10
Pulmonary heart disease	6
Skin and subcutaneous tissue infections	6
Viral infection	6
Acute cerebrovascular disease	5
Intestinal infection	4
Acute bronchitis	4
Other liver diseases	4
Cardiac arrest and ventricular fibrillation	3

1. Summary of activity

During April 2026, 12 Structured Judgement Reviews (SJRs) were completed, all at Stage 1. Of these, 7 cases were escalated to Stage 2 review, indicating areas of concern requiring further review.

- 83% of deaths were expected (10/12)
- 83% were deemed not preventable (10/12), with 2 cases showing slight evidence of preventability
- No deaths were identified as preventable (over 5050) from the SJR process in April.
- Three deaths reported as Fatal and confirmed Patient Safety Incidents through the Patient Safety Process

Overall care was rated:

- Good or Excellent: 5 cases
- Adequate: 2 cases
- Poor: 4 cases (all 4 cases escalated to the stage 2 panel)

Key areas of positive practice included:

- Timely initial clinical assessment and escalation
- Good multidisciplinary working
- Compassionate end-of-life care in several cases

However, recurring system and care quality concerns were identified:

- Prolonged Emergency Department (ED) stays impacting care quality
- Inconsistencies in end-of-life care delivery
- Documentation and consent issues
- Delays in treatment and escalation
- Communication challenges with families

3. Medical Examiner (ME) referrals – key highlights for April 26

Overview

- Cases referred by the Medical Examiner represented 42% of all SJRs completed (5/12)
- Referrals primarily driven by concerns regarding quality of care, decision-making, and patient experience

Key Reasons for Referral

1. Delays in Care and Patient Flow

- Prolonged waits for transfer between wards/sites
- Extended ED stays impacting care delivery
- Concerns regarding system flow affecting patient condition

2. End-of-Life Care and Planning

- Potential late recognition of end-of-life phase
- Missed opportunities for earlier palliative care involvement
- Concerns that patients may not have died in their preferred place of care

3. Communication with Patients and Families

- Families reporting: Lack of clarity around prognosis and treatment plans
- Insufficient involvement in decision-making
- Concerns about consistency of communication between teams

4. Clinical Decision-Making and Escalation

- Questions around:
 - Appropriateness of treatment decisions
 - Timeliness of escalation
 - Whether alternative management (e.g. earlier palliation) should have been considered

Specific Case Concerns Raised by ME:

- Delay in transfer leading to patient exhaustion and deterioration
- Patient not positioned appropriately despite clinical need
- Concerns that palliative care could have been initiated earlier, enabling better end-of-life experience.

Key Message: ME referrals highlight quality and experience issues rather than preventability of death. Strong overlap with wider themes: Patient flow pressures (ED and transfers), variation in end-of-life care , Communication and decision-making

5. Key learning identified

NHS Founda

Learning identified		
ED pressures and patient flow	• Prolonged stays impacting basic care, timely treatment and dignity for patients • Staffing pressures impacting care delivery	
Documentation and communications	• Variable quality of discussions with families with some reporting to feel excluded or unclear about treatment plans • Gaps in consent, DNACPR completion and clinical decision making	
End of life care variation	• Inconsistent symptom control management, communication and timely recognition of the dying phase	
Recognition and escalation of deterioration	• Delays in review and missed opportunities to act on clinical deterioration	
Delays in treatment	• Delays in surgery. Medications and specialist input	
Areas of good practice identified		
• Timely ED assessment and early escalation • Strong multidisciplinary working (therapy, frailty and specialist teams) • Patient centred care and respectful of patients wishes		
Stage 2 panel actions		
Stage 2 issues identified	Actions	Owner
• Limited medical review and poor documentation were evident throughout the admission, including prior to the patient's deterioration. • Repeated escalation by nursing staff (hypotension and refusal of medication) did not result in a medical review, despite similar concerns the previous day. • A possible link between low haemoglobin (Hb 89) and a cardiac event was considered, although transfusion was not indicated. • The Stage 2 panel raised concerns regarding potential missed opportunities to act on declining haemoglobin levels in this and previous admissions, requiring further review • Slight evidence of preventability- requires Divisional review	Issue escalated to Patient Safety for Divisional Review. Divisional review completed on 13/04/2026 PSII confirmed – case under open investigation- no further updates as of 17/05.	MEC Divisional Governance Lead for MEC HoN for AEM
• Consultant confidence in TEP and DNAR completion. Some cultural issues identified leading to a reluctance in starting patients on EOL pathways	Grand Round presentation in progress to present the legal framework on DANR completion and how this works in practice Treatment escalation and complex conversations course	Trust Solicitor Consultant in Palliative medicine Consultant in Anaesthesia and Critical Care
• Possible delay in surgery and pain management for patient	Sent to Orth M&M – completed. M&M team confirmed patient was unfit for surgery, if this was carried out, patient would have been unlikely to survive. No preventable harm, no further investigation needed	Patient Safety lead- T&O

8. Conclusion

April's SJR reviews demonstrate that while many patients received good, compassionate care, there are clear systemic pressures and variability in care quality—particularly relating to ED flow, end-of-life care, and documentation.

The learning identified provides clear opportunities for improvement, particularly in:

- Delivering consistent, dignified end-of-life care
- Strengthening communication and documentation
- Mitigating the impact of ED pressures on patient safety

9. Forward plans

The Learning from Deaths pathway has outlined clear guidance on how deaths are selected to be reviewed through the SJR process and those that are referred to patient safety.

To maintain oversight of deaths where concerns or failings have contributed to the death of the patient and are escalated through the Patient Safety route, Patient Safety will report on progress updates in relation to deaths rated a fatal as level of harm and reported as Patient Safety Incident Investigations (PSII) to outline immediate actions taken and learning and action identified through the PSII investigation.

It is anticipated that this process will begin at the next reporting period for MMSG in June.

Mortality update

Chris Barton, Dr Foster

Summary

- SHMI remains above expected (1.30) with a slight month on month increase
- Expected deaths plateauing; crude mortality rate improved slightly
- Coding improvement not contributing to SHMI change

Key issues:

- Increase in % of deaths occurring post 30-days discharge. The national relationship between SHMI performance and in-hospital deaths infers that a further increase in deaths out of hospital may be important in improving SHMI
- Outliers: UTI and Pneumonia.
- ED delays remains significantly above average and likely contributing to mortality outcomes
- Palliative care analysis finds Medway have a higher rate than national peers, longer LOS for palliative patients but shorter LOS for palliative deaths. Medway have a higher palliative rate across all main disease groups.
- Increasing trend in #NOF mortality (within expected at present, continue to monitor)

Cerebrovascular Accident deep dive

Dr James Adam

CVA deep dive into Saturday admissions- as alerted by Dr Foster

- 4/5 deaths directly linked to head injury
- All were not survivable on admission
- Timely assessment and intervention in all cases
- Specialist advice sought in all cases
- Early recognition of deterioration and EOLC planning
- Frailty and NOK involved in decision making
- All deaths expected
- One sudden and unexpected death not related to head injury – outcome precipitated by conflicting treatment priorities

Actions:

- Mortality to link in with Deputy Chief Nurse and T&O with regards to Flowtron and TED stocking use.
- Progression of Silver Trauma Audit to be updated at MMSG

COPD deep dive progress update

Dr Chengappa

Cohort design in progress: Deaths, survivors and 'near miss' (peri arrest)

Data to be collected:

- COPD diagnosis accuracy – coding review to check accuracy of primary diagnosis and unsure this is appropriately coded
- COPD severity
- Comorbidity/frailty markers
- Exacerbations in the last 12 months
- Discharge metrics

Review of preventable deaths- key areas to examine:

- Delays in NIV/over oxygen
- Delays in escalation to critical care/ inappropriate TEP
- Bed pressure and delays in moving to appropriate areas
- Failure to recognise end stage disease and organise appropriate ACP/palliative care support

MDT involvement

- Respiratory Teams
- ED and Acute Medicine
- Geriatricians
- Community Respiratory Teams
- Existing MDT

Project Scale and Delivery

- Minimum of 50 cases
- Shared dataset e.g. Excel
- Involvement of registrars and CNS's
- Potential need for BI support

Next Steps

- Finalise data collection fields, cohort definitions and project timelines
- Confirm roles and responsibilities for data gathering
- BI support requirements

Palliative care support update

Marie Spicer

- Criteria for potentially avoidable admissions is currently being developed and will go to Palliative End of Life Care Group in June for agreement and then escalated.
- All nurses will have access to KMCR to allow for GP summaries to be viewed including the John Hopkins scoring.
- Focus will be on groups 10 and 11 using the traffic light system as the patients should have ACP's, anticipatory medications and conversations in the community. This will enable patients to be discharged from ED and SDEC back into the community.
- A traffic light icon has been requested for EPR and a discharge pathway is in draft form, going out for comment next week,
- Palliative care and frailty work streams will merge focussing on frailty initially.
- Trolley dashes to develop communication training will start on Tuesday and will focus on trending themes.
- A new A3 is underway to show what a gold service should look like.
- The updated referral system will go live on Monday which allows BI to pull the data and update the EOL decision form on EPR.

Risks and Escalations

Escalations

- A need for greater medical input into palliative and end of life care support across the trust.
- A best practice guide for Mortality & Morbidity (M&M) has now been developed, including standardised templates for minutes, action logs, and reporting. The guide and associated templates will be rolled out across specialties to strengthen the consistency and quality of M&M meetings, and to support more robust reporting to the Mortality and Morbidity Surveillance Group. Successful implementation will require active engagement from specialties and will benefit from senior leadership support to ensure adoption, compliance, and sustained oversight.

Risks

- No new risks identified

Mortality & Morbidity Surveillance Group

Risk Register and Issues Log

May 2026



Risk Register

Risk ID	Added Date	Risk Description	Domain	Initial Score C x L	Key Existing Controls	Gaps in Controls	Current Score C x L	Actions to Reduce Risk	Action Due Date	Target Score C x L	Owner	Exec Lead	Target Date
1684	31/05/2023	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.	Quality, Complaints, Audits	4 x 2 (8)	Frailty: Frailty Summit scheduled; frailty SDEC reopening and pre-72h community model being planned. Palliative & End-of-Life Care: Monthly meetings with community palliative care to reduce avoidable admissions. EOL dashboard development underway; awaiting EPR fields. PEOLC system update going live. Learning from Deaths: LfD pathway refreshed and pending MMSG sign-off. SJR training programme in development; reviewer recruitment ongoing. M&M audit data presented to divisions for learning. Sepsis & Pneumonia: Sepsis 6 bundle training underway; paediatric sepsis e-learning becoming mandatory. Pneumonia nurse in post; monthly audits commenced. CURB-65 education and 4-hour antibiotic compliance monitored. Deteriorating Patients & Deconditioning: Deteriorating Patient and Avoidable 2222 workstreams established; A3 in development. Deconditioning Group established; harms recorded on Datix.	Frailty: Community frailty pathway cannot progress until PMO support and ICB business case are in place. Frailty SDEC reopening delayed due to ward closures. Palliative & End-of-Life Care: EPR has not yet created mandatory fields required for the EOL dashboard; BI cannot build dashboard until fields exist. Learning from Deaths: Insufficient SJR reviewer capacity to meet KPI. LfD pathway, TOR and M&M SOP still awaiting final approval. Sepsis & Pneumonia: ED sepsis data unavailable for audit; BI escalation unresolved. Sepsis audit methodology change has reduced compliance and requires stabilisation. Deteriorating Patients & Deconditioning: Resource not yet secured to start the deteriorating patient workstream. Deconditioning outcome measure not yet uploaded to EPR, preventing KPI development.	4 x 5 (20)	- Monthly meeting with community palliative care to discuss themes to improve delayed discharges and understand avoidable admissions. Work on End of Life (EOL) dashboard. Analysing data availability. EPR team to work on elements that would help to complete dashboard launch work. Establish KPI once data is available. - Confirmation date for Frailty SDEC re-opening. Community stakeholder meeting to be organised and scoping of Pre-72 hours planned. - Stakeholders for the Deteriorating Patient and Avoidable 2222 workstreams are to be agreed. An A3 will then be developed to define and support the annual work plan. The Deconditioning Patient Group will need to ensure that all deconditioning-related harm is recorded on Datix as an incident and to consider introducing this as a KPI once sufficient data is available. A meeting will also be arranged with ED leads to identify opportunities to improve outcomes for deconditioning patients within the ED. - Map this years key priorities along with the time frame. First draft for LFD pathway to be completed and signed off by MMSG. New TOR and new annual work plan for MMSG. Present M&M audit data to division for considering actions for learning. Finalise SJR training programme to increase the number of SJR reviewers. M&M best practice guide/SOP to be drafted. - Expansion of the adult sepsis bundle to include bespoke pathways for paediatric, maternity, and neutropenic sepsis. Establishment of a robust, trust-wide sepsis audit. Paediatric sepsis bundle to be made mandatory. Pneumonia Group to improve correct antibiotic prescribing within first 4 hours of admission. Education with staff for CURB score recording. Pneumonia nurse and monthly audit of Pneumonia treatment to commence. - A3 Mortality Refresh. - Review of the Learning from Deaths Pathway.	31/03/2026 30/04/2026 30/04/2026 30/06/2026 30/09/2026 Complete Complete	4 x 1 (4)	Sofia Power, Learning from Deaths Manager	Chief Medical Officer	30/09/2026

Risk Register

Risk ID	Added Date	Risk Description	Domain	Initial Score C x L	Key Existing Controls	Gaps in Controls	Current Score C x L	Actions to Reduce Risk	Action Due Date	Target Score C x L	Owner	Exec Lead	Target Date
2865	15/04/2026	Insufficient SJR Reviewer Capacity and Retention If there is an insufficient number of Structured Judgement Review (SJR) reviewers and ongoing challenges in recruiting and retaining trained reviewers, then reviewer capacity and capability will be reduced, limiting the ability to undertake timely and sufficient mortality reviews, leading to failure to achieve the 12.5% review target, delays in completing reviews of care concerns, backlog accumulation, increased pressure on existing reviewers, potential decline in review quality, and missed opportunities for organisational learning and improvement.	Statutory Duty / Inspections	3 x 3 (9)	Mortality Group oversight of SJR performance and backlog. Monthly reporting of SJR completion rates. Existing cohort of trained reviewers undertaking reviews where capacity allows. Prioritisation of cases based on clinical significance and learning potential.	Insufficient number of trained reviewers to meet demand. No formalised recruitment and retention plan for SJR reviewers. Limited protected time for reviewers to undertake SJR activity. Inconsistent reviewer availability.	3 x 3 (9)	1. Develop and implement a recruitment and retention plan for SJR reviewers. 2. Establish protected time for reviewers within job plans. 3. Provide refresher training and support for existing reviewers. 4. Strengthen monitoring of SJR timeliness and backlog trajectory.	31/12/2026 31/12/2026 31/12/2026 31/12/2026	3 x 1 (3)	Sofia Power, Learning from Deaths Manager	Chief Medical Officer	31/12/2026

Issues Log

Issue ID	Added Date	Risk Description	Domain	Priority Rating	Key Existing Controls	Actions to Reduce Risk	Action Due Date	Owner	Exec Lead	Target Date for Closure
2714	26/01/2026	Disruption to the Structured Judgement Review (SJR) platform due to vendor administration The current SJR platform used by the Trust is going into administration in March 2026, leaving the organisation without a dedicated reporting database. Alternative solutions being explored, such as MS Teams or Gather however there is a lack critical functionality, including the ability to "save and continue," which forces SJR reviewers to complete reviews in a single session. This increases the time burden on reviewers, who must balance clinical priorities with SJR completion, and no protected time is currently allocated for this activity. This may lead to delayed reviews, reduced compliance with SJR processes, increased staff workload, and potential impact on patient safety and quality assurance.	Quality, Complaints, Audits	3 Moderate	- MS Teams, Gather, and other interim solutions are being explored. - Digital/IG teams are already engaged to assess feasibility and compliance. This reduces the likelihood of a total service gap. - SJR reviewers can still complete reviews using manual SJR Word templates if the platform becomes unavailable. This ensures the process does not halt entirely. - A cohort of staff is already trained in the national SJR methodology. - SJR completion rates and backlogs are monitored through established frameworks (e.g., Mortality & Morbidity Surveillance Group, Quality/Patient Safety governance meetings).	- Put in place alternative platforms (e.g., MS Teams, Gather) and define how they will be used if the primary system fails, including quick guidance and testing to ensure service continuity. - Ensure manual SJR Word templates are accessible, supported by a clear process for completion, tracking, and later upload to maintain review activity during system downtime. - Sustain reviewer capability through trained staff, monitoring completion rates and backlogs via existing governance forums to maintain safety and quality oversight.	31/03/2026 31/03/2026 31/03/2026	Sofia Power, Learning from Deaths Manager	Chief Medical Officer	31/03/2026

Issue awaiting closure: No issues reported with Gather platform, all reviewers have adapted well to the new platform and have been trained with no reported issues. Issue currently merges with a risk of SJR reviewer capacity but this is already covered in Risk 2865

Stabilisation Plan: Quality Programme

Trust Board

1st July 2026



Quality	
Exec Lead	Alison Davis
Programme Manager	Chris Parokkaran
Date	01/07/26 Board
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 patients 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 2222 calls, Sepsis pathways, pneumonia and avoidable deconditioning and deterioration particularly in ED and inpatients who are NCTR. Clinical pathway outlier groups in the trust SHMI dataset currently is Pneumonia, COPD and UTI.



Programme Workstreams:

1. Frailty Pathways
 - a. Hospital Frailty Pathway
 - b. Hospital Frailty SPOA
 - c. Community Frailty pathways.
2. Palliative Care Pathways.
3. Nursing and therapies to prevent deconditioning.
4. Deteriorating patients and Avoidable 2222 Project.
5. Learning from Death Process and Governance.
6. Clinical Pathways – Pneumonia QIP & Sepsis QIP

Milestones Achievements in last 30 days (May 2026)

1. Engagement with neighbourhood team initiated to understand the model of digitizing neighbour hood health for Patient Needs Group 10/11. Frailty Summit held on 14th of May with good engagement from community system region and other experts.
2. Progressing LFD pathway and SHMI dashboard with KPIs, strengthening governance through MMSG approvals, embedding SJR processes on GATHR, and enhancing learning, oversight, and training through SOPs and structured feedback.
3. Working on End of Life (EOL) dashboard. Still awaiting EPR team to work on elements that would help to complete dashboard launch work.
4. Finalising therapy outcome measures and KPIs, embedding baseline mobility tracking, progressing audit insights, addressing definition clarity for deconditioning, and engaging ED to improve patient outcomes.
5. Establishing the Deteriorating Patient workstream structure, aligning with Fundamentals of Care, engaging stakeholders through TOR and A3 development, and progressing towards a coordinated and structured first workstream meeting.
6. Expansion of the adult sepsis bundle to include bespoke pathways for paediatric, maternity, and neutropenic sepsis. Establishment of a robust, trust-wide sepsis audit. Timelines to be confirmed. The paediatric sepsis bundle will be made mandatory.
7. Pneumonia group to start work stream meeting. Actions discussed to improve antibiotic prescribing within first 4 hours of admission. Education with staff for CURB score recording. Meeting with EPR.

Milestones Planned for next 30 days (June 2026)

1. Further scoping of the pre-72-hour pathway and further development of OBC1 and interdependencies to be scoped by divisional directors. Expected re-launch of Frailty assessment unit scheduled for 15th June. Discussions planned for the launch of Medway and Swale Frailty network.
2. Aligning yearly priorities with timelines, progressing LFD governance and sign-offs, strengthening M&M learning, and expanding SJR training and reviewer capacity through a Trust-wide SOP rollout and regular training
3. EOL team to finalise avoidable admission criteria with ED team. Establish combined workstream meeting with Frailty workstream and continue collaboration with EPR to digitise EOL forms.
4. Establishing deconditioning definition and governance, progressing ED-focused subgroup and Gemba insights, embedding audits and EPR integration, and driving improvements in mobility, environment, and outcome measurement through structured workstream actions.
5. Launching the Deteriorating Patient workstream, engaging stakeholders through A3 development, and defining key aims, maturity assessment and KPIs to drive improvement.
6. Progressing the Paediatric Sepsis project through mandatory e-learning, securing funding for licences, and improving Sepsis 6 compliance via targeted education and enhanced lactate and fluid monitoring.
7. Pneumonia work stream monthly meeting to continue and focus on making the whole Pneumonia Bundle electronic.
8. Audit with COPD deep dive underway and UTI deep dive to be established.

Progress Update



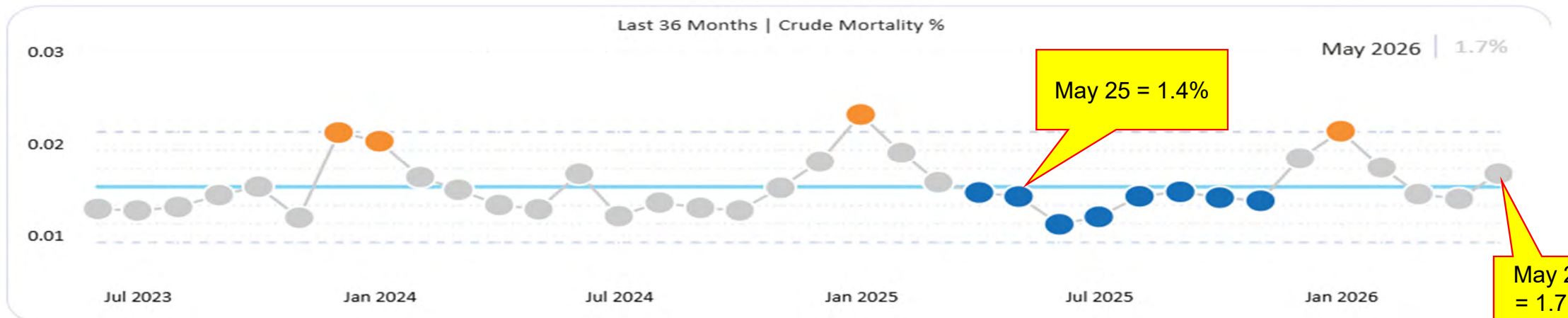
NHS Foundation Trust

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. All other workstreams have now established to support with reduction of SHMI.

Workstream Update	Milestones	Target Date	RAG	Status
Frailty Pathways including Hospital Frailty Pathway, Hospital Frailty SPOA Community Frailty pathway	Further scoping of the pre-72-hour pathway and further development of OBC1 and interdependencies to be scoped by divisional directors.	April 26		On track . Relaunch of Frailty SDEC.
Palliative care pathways	Advancing PEOLC through pathway development, EPR integration, and data-driven insights, while strengthening frailty-focused care, communication training, and targeted frontline interventions to reduce avoidable admissions and improve end-of-life outcomes.	March 26		Off track. Awaiting EPR to create certain mandatory fields so then data can be available to build dashboard.
Learning from Deaths Pathway	Aligning yearly priorities with timelines, progressing LFD governance and sign-offs, strengthening M&M learning, and expanding SJR training and reviewer capacity through a Trust-wide SOP rollout and regular training	July 26		On track.
Clinical Pathways (Sepsis QIP and Pneumonia QIP)	Progressing the Paediatric Sepsis project through mandatory e-learning, securing funding for licences, and improving Sepsis 6 compliance via targeted education and enhanced lactate and fluid monitoring. Pneumonia work stream monthly meeting to continue and focus on making the whole Pneumonia Bundle electronic. Audit with COPD deep dive underway and UTI deep dive to be established. KPI data is static overall and needs further improvement and shift so that the trend moves to positive outcomes.	September 26		On track. Working groups for both QIP established . Pneumonia project overall has an improvement in recording of CURB scores and correct antibiotics prescriptions.
Deteriorating / Avoidable 2222 project and Deconditioning patient project.	Launching the Deteriorating Patient workstream, engaging stakeholders through A3 development, and defining key aims and KPIs to drive improvement. Establishing deconditioning definition and governance, progressing ED-focused subgroup and Gemba insights, embedding audits and EPR integration, and driving improvements in mobility, environment, and outcome measurement through structured workstream actions.	June 26		Ontrack for deconditioning and deteriorating patients as both workstreams established.

Programme KPIs

KPI	Latest (May -26)	Trend	Justification for Variance	Apr 26 Actual	Apr 26 Planned	May 26 Actual	May 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 March 26 in mid-September 2026)	1.30(Jan 25-Dec 25)	▲	There has been a noted increase in SHMI crude rate and a drop in expected causing SHMI to increase.	1.29 (Nov 24–Oct 25)	1.15	1.30(Jan 25- Dec 25)	1.15
Crude Mortality Rate (%) in the month to be less than the same time period 12 months previously	1.7%	▲		1.5%	1.1%	1.7%	1.1%
90% Compliance in NICE guidelines SEPSIS 6 Bundle care using monthly audit data (Data set based on 40 patients)	Data not available for May due to delay in Audit	▲	Compliance with high risk Sepsis patients for IV antibiotic therapy treatment within 1 hour is 93% in both ED and in- patients and Sepsis 6 full bundle compliance is failing with on going monitoring of fluid balance and repeat lactate primarily within ED.	55%	90%	Data not available yet.	90%



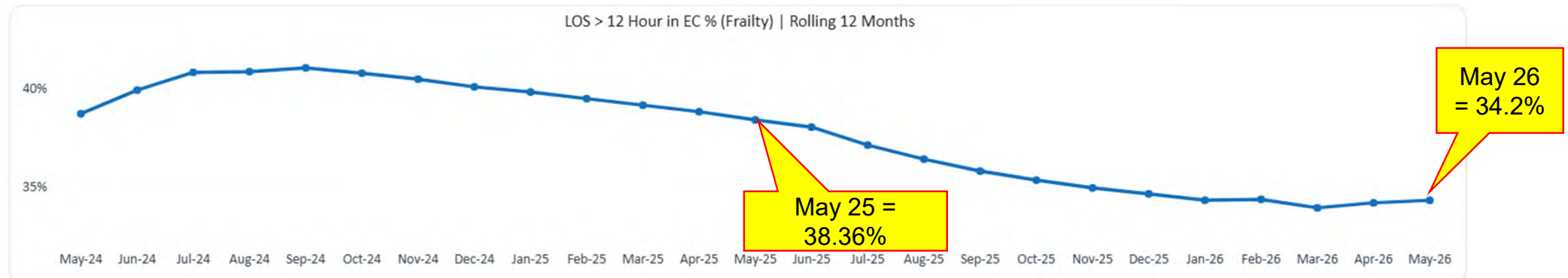
Workstream (Project) KPIs



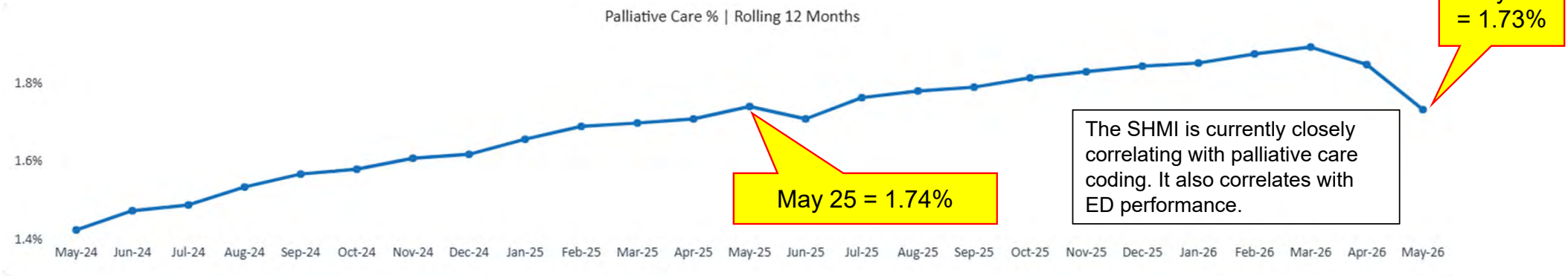
Project	KPI	Baseline Oct 25	Trend	April 26	May 26	May 26 Planned/ Trend
Learning from Deaths Project	Over 75 & CFS score >5 with >12 hours LOS in ED	33.6%	▲	34.1%	34.2%	Downward Trend
Learning from Deaths Project	Preventable deaths based upon number of deaths declared as PSII as reported on STEIS over the last 12 months.	1 (0.9%) Year 25-26 total-16 (1.2%)	▲	19 (1.4%) Mar 25- Apr 26	19(1.4%) June 25- May 26	Upward Trend
Leaning from Deaths Project	Percentage of SJRs completed (Target 12.5%)	13.9%	▲	11.4%	9.1%	Downward Trend
Palliative care pathways Project	Downward trend for no of patient percentage under palliative care	1.81%	▲	1.72%	1.73%	Downward Trend
Sepsis QIP	90% compliance to the NICE guidelines. Currently ED data not included to check compliance. Understanding data availability with BI.	85%	▲	34%	Data not available yet	90%
Pneumonia QIP	Antibiotics within guidelines given within 4 hours for 90% of Pneumonia patients in MFT	Data was not available	▲	78% (54% within the guideline)	75% (60% within the guidelines)	85%
Deconditioning Patients Project (Nursing and AHP)	MUST Score completion rate Outcome measure to be finalised for measurement of deconditioning among patients. To upload this outcome measure on EPR so data can be generated and KPI established	73.3%	▲	47.5%	60.2%	Upward Trend

Workstream (Project) KPIs

Learning from deaths project KPI - Over 75 & CFS score >5 with >12 hours LOS in ED(May 24 - May 26)



Palliative care project KPI -Palliative care percentage referrals (May 24 - May 26)



Project Risks

Project	Risk	Mitigation	RAG	Owner
Medway Hospital Frailty pathway Project(UEC flow front door & back door)	Projects dependent on ICB Business case which are expected to include community frailty, single point of access and palliative care.	Risk escalated to Francis and Francis has escalated to ICB. Palliative care nurses attending ED board round to identify patients that can be managed in the community.		Francis Woodroffe
Frailty Pathway	If ED is under pressure, the frailty assessment unit will be bedded; this will make the unit non functional and adversely affect the staff morale.	Alternate escalation space within Trust to be identified that will not impact areas that support flow. Set COO/Deputy COO approval requirement to bed the assessment unit. If unit is to be bedded, Frailty team to identify suitable patients.		Koruth Varghese Jo Saunders
Palliative Care Pathway	There is a risk that EPR not able to update the system for the dashboard to go live. Waiting for EPR and BI to update for the dashboard to live.	EPR to prioritise go live date for updated EOL decision form. Then BI to upload this data into live dashboard.		Marie Spicer
LFD Project	Reduction is the number of SJR reviewers	Alison to issue comms at 10x10. Divisional nursing leads to identify SJR volunteers and email names to Sofia Power.		Sofia Power/ Alison Davis
Sepsis Project	Sepsis e- learning licence for mandatory training will expire on 26 th of June due to lack of funding (4K). Therefore, funding to be secured to continue this training from the CPD budget.	Escalation done to Steph Gorman and agreement done that CPD funding can be used one the CPD budget available.		Stephanie Gorman

Project Risks

Project	Risk	Mitigation	RAG	Owner
Deteriorating Patient Project	Medical Engagement, Divisional Engagement and Patient safety engagement	Sara Sharp raised concern with Execs regarding engagement		Alison Davis
Deteriorating Patient Project	Limited Staff resource e.g. Deteriorating Patient nurse/ Learning from deaths nurse	Raised with Execs and confirmation of recruitment to be discussed		Evonne Hunt
Deconditioning Patients Project (Nursing and AHP)	Operational pressures have increased across all staff due to Trust Improvement Plan delivery, making it difficult to prioritise competing meetings and tasks. This is further complicated by conflicting priorities and the need to focus on work with financial impact	Raise with Exec Alison and Evonne in Quality BO huddle and Patient Safety meeting		Laura Potter
Pneumonia Project	Lack of communication between several electronic systems that makes it difficult to have appropriate documentation in each system.	Escalate to EPR team to see if systems can be integrated		Alison Davies / Francis Woodroffe
Pneumonia Project	Co-morbidity data does not pull through automatically unto initial assessment on EPR	Escalate to EPR team and the Executive team		Alison Davies / Francis Woodroffe

Project Celebrations

Celebrations:

1. Palliative care workstream: Change to PEOLC system going live now. This will allow BI to pull data.
2. Pneumonia Workstream :Good compliance for oxygen prescriptions at 98% for last month
3. Sepsis Workstream: Both ED and Inpatients scored > 90 % for administration of antibiotics to the high risk patients
4. Deconditioning Patient Workstream: Harvey, Kingfisher, Ocelot, Phoenix and Victory ward all scored 100% MUST SCORE
5. Deteriorating Patient: 1st Workstream meeting in diaries for 4th June after a lot of initial hard work to set up the workstream amongst all pressure
6. Frailty Pathway Workstream: Date set for relaunch of frailty assessment unit - 15/06/2026
7. Learning from Deaths workstream: SJRs completed on GATHR for the first months of March and April with no reported issues (issue was highlighted on risk register but regularly monitored with support in place to mitigate any disruption).
8. Successful Frailty Summit with good engagement from community partners.

Meeting of the Trust Board

Date: 1st July 2026

Title of Report	Finance Report Month 2 / June 2026				Agenda Item	3.4			
Stabilisation Plan Domain	Culture	Performance	Governance and Quality	Finance	Not Applicable				
				X					
CQC Reference	Safe	Effective	Caring	Responsive	Well-Led				
					X				
Author and Job Title	Matt Chapman, Head of Financial Management Cleo Chella, Associate Director Income and Contracts 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:	It is recommended the Committee confirm it has sufficient assurance on: • The actual and forecast performance of the Trust against its plan. • The sufficiency of actions in hand to deliver the plan. • Any further actions required for consideration.								
Executive Summary	The Trust is reporting to plan against its control total for month 2 and YTD, being a breakeven (in-month) and deficit of £1.2m (YTD; £7.1m deficit excluding Deficit Support Funding ["DSF"]). DSF of £3.0m has been recognised in month / £5.9m YTD in line with plan. Non-recurrent management estimates of ~£2.0m have been transacted in month (higher than in month 1) to deliver the plan. The Trust has recognised the full cost of the pay award (both the accepted AfC award and the proposed medical pay award) even though the medical award has not yet been paid; it has also recognised additional funding to meet those costs which are at rates over and above national planning assumptions. The Trust assumed a net cost of £0.3m of industrial action in month 1; following actual payroll deductions made in month 2 this net cost is actually closer to £0.5m and the balance therefore recognised in-month. Activity data is not yet fully available and thus clinical income has been reported to plan, with two deviations: i) as noted above, additional funding for the pay awards above planning assumptions has been accrued; ii) the phasing of the planned activity/income was low for the YTD and thus the Trust has recognised an additional £0.8m above plan to better reflect receipt of contractual income from the commissioner in twelfths. (£0.5m of this was recognised in month 1, with a further £0.3m in month 2.)								

On a **normalised basis** the Trust's expenditure run-rate remains relatively flat between months 1 and 2. Non-pay expenditure has shown a reduction so far year-on-year, whilst pay has increased by less than the value of the pay award (inflation). This is reflected by the reduction in worked WTEs in the same period, from a 2025/26 average of 5,632 WTEs to 5,495 WTEs YTD average in 2026/27.

Normalised	25/26 avg.	M1 Act.	M2 Plan	M2 Act.
Income (£m)	40.1	41.2	42.0	41.8
Pay (£m)	(29.4)	30.0	28.3	29.7
Non-pay (£m)	(14.4)	(13.9)	(14.0)	(13.9)
WTE	5,633	5,557	5,478	5,435
CIP (£m)	0.9	1.2	3.3	2.2

CIP delivery for the YTD is £3.4m (£1.2m reported in M1, £2.2m in month 2) against a plan requirement of £6.6m.

Focus continues to identify and meet the £38.8m savings target (stretch target of £50m to allow for project delays, cost pressures and risk) but YTD results show we have only delivered ~50% of the £6.6m target (the CIP target is phased equally across 2026/27 at ~£3.3m per month). The shortfall will need to be addressed urgently through further cost / capacity reduction to maintain target delivery.

The Trust's cash position is above plan at the end of the month, with £27.1m held. This is an expected timing matter only and payments are expected to flow in due course.

Issues for the Group/Committee/Board Attention:

Unless rapid and sustainable reductions in expenditure are made the Trust will face a **high risk** of not delivering its financial plan this year.

The Committee/Trust Board needs a **formal recommendation** from the Trust Turnaround Director and System Delivery Director of the forecast CIP delivery in June and July (as a minimum) and a list of 'Difficult Decisions' at least equal to the gap for decision at its Board meeting on 1st July.

The **non-recurrent measures utilised may begin to unwind** from month 3. Those measures deployed may only result in the deferral of risk / bringing forward of benefit (e.g. £0.8m income recognition) and thus these short-term measures need to be addressed through the action above.

Emerging cost pressures could result in an increased level of expenditure; in particular, the proposed increase in histopathology charges (recharges are specifically being reviewed at a system level by the System Delivery Director) as well as potential risk over the community provider debt.

Further **risk is the withdrawal of Deficit Support Funding (DSF)** for future adverse to plan performance (actual or forecast). This would lead to a need for cash support, as happened last year.

The sufficiency of approach to achieve the financial plan in terms of capacity, capability and project delivery, with recommendations in the Deep Dive Paper prepared by the System Financial Improvement Director. The expected position was reinforced in the April NHSE SE Financial Accountability Meeting (24/4 letter from Karen Geoghagan, NHSE SE CFO).

Meetings at which this paper has been discussed / approved: Date:	• Planning papers to FPPC, Trust Board and Board Development session. • Month end Flash Report circulated to Trust Board. • Financial performance discussed at Trust Leadership Team. • Finance, Planning and Performance Committee has received this report. • Financial Recovery Group (FRG) meets weekly to review and drive the CIP programme.			
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 also recognise the potential for increased regulatory intervention and reinforcement of the need for financial sustainability.			
Integrated Impact Assessment (IIA) 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 (risk: adverse impact on performance targets). • 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 prices for supplies and services.			
Freedom of Information status:	Disclosable	X	Exempt	

Finance Report

For the period ending 31st May 2026 (M2)

Contents

1. Executive Summary
2. Income and Expenditure vs Plan
3. Income and Expenditure Run-rate
4. Forecast Outturn Risks and Mitigations
5. Statement of Financial Position
6. Cash
7. Conclusions

1. Executive Summary

The financial results for May 2026 (Month 2) are summarised below. Performance is measured against the plan submitted to NHSE in March, which sets a year-end deficit target of £35.4m to 31 March 2027. This excludes Deficit Support Funding (DSF), which is payable subject to delivery of the planned deficit.

£m	Plan	Actual	Var.	Commentary
Income and Expenditure (I&E) Surplus / (Deficit)				
In-month vs control total <u>inc. DSF</u>	0.0	0.0	0.0	The Trust is reporting a financial position in line with the planned deficit agreed with NHSE. The in-month reported position includes £0.3m of clinical income above plan (£0.8m YTD) as a result of recognition in twelfths in line with commissioner receipts, together with the further release of £0.25m from the annual leave accrual (totalling £0.8m year to date). During May, approximately £2.0m of the reported performance is non-recurrent (~£3.1m YTD), including those items above; further focus is required to reduce underlying expenditure and strengthen delivery of the savings programme in support of achieving the planned break even at year end.
In-month vs control total <u>excl. DSF</u>	(3.0)	(3.0)	0.0	
Year to date vs control total <u>excl. DSF</u>	(7.1)	(7.1)	0.0	
Annual Plan inc. DSF	0.0	0.0	0.0	
Annual Plan excl. DSF	(35.4)	(35.4)	0.0	
Efficiencies Programme				
In-month / April	3.3	2.2	(1.1)	The Trust continues to work closely with the Turnaround Director, supported by PA Consulting and the PMO team, to identify, develop and deliver efficiencies. Good progress continues to be made in the development of schemes, with a strong focus on accelerating delivery to achieve the requirements of the financial plan.
Year to Date	6.6	3.4	(3.2)	
Cash				
Month end	7.2	27.1	19.9	The Trust plans assumed payment of outstanding balances early in 2026/27, including capital creditors at the year end. This is expected to be a timing matter only.
Capital				
YTD	2.6	0.1	(2.5)	2026/27 capital funding is currently £17.3m internal capital and £4.8m Salix grant. £10m of internal capital was approved for continuing projects; a further £9m is in capital reserves awaiting final approval of the allocation. The Trust is awaiting the outcomes of a number of external bids made for 2026/27 which would secure additional fund and a larger programme for the year.
Forecast	22.1	22.1	-	

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

£m	In-month			Year-to-date		
	Plan	Actual	Var.	Plan	Actual	Var.
Clinical income	39.6	39.6	0.0	78.5	79.2	0.8
High cost drugs	2.2	2.3	0.1	4.3	4.5	0.2
Donated asset adj.	0.4	0.0	(0.4)	0.8	0.0	(0.8)
Other income	3.2	3.2	(0.0)	6.3	5.9	(0.4)
Total income	45.4	45.1	(0.3)	89.9	89.6	(0.2)
Nursing	(12.6)	(12.0)	0.5	(25.6)	(24.1)	1.4
Medical	(8.8)	(9.4)	(0.6)	(17.8)	(19.5)	(1.7)
Other	(8.5)	(8.1)	0.4	(16.9)	(15.5)	1.4
Efficiency target	1.6	0.0	(1.6)	3.3	0.0	(3.3)
Total pay	(28.3)	(29.5)	(1.2)	(57.0)	(59.2)	(2.2)
Clinical supplies	(5.2)	(5.1)	0.2	(10.6)	(10.3)	0.2
Drugs	(1.3)	(1.4)	(0.1)	(2.5)	(2.5)	(0.0)
High cost drugs	(2.4)	(2.1)	0.3	(4.8)	(4.0)	0.8
Other	(6.0)	(4.7)	1.3	(12.0)	(10.0)	2.0
Efficiency target	0.9	0.0	(0.9)	2.0	0.0	(2.0)
Total non-pay	(14.0)	(13.2)	0.8	(27.8)	(26.8)	1.0
EBITDA	3.2	2.4	(0.8)	5.1	3.6	(1.4)
Non-operating exp.	(2.9)	(2.4)	0.5	(5.8)	(4.9)	0.9
Surplus/(deficit)	0.3	(0.0)	(0.3)	(0.7)	(1.2)	(0.5)
Technical adj.	(0.2)	0.1	0.3	(0.5)	0.1	0.5
Control total	0.0	0.0	0.0	(1.2)	(1.2)	0.0
DSF	(3.0)	(3.0)	0.0	(5.9)	(5.9)	0.0
Perf. excl. DSF	(3.0)	(3.0)	0.0	(7.1)	(7.1)	0.0
Bank cap	8.2%	6.8%	1.4%	8.3%	7.9%	0.4%
Agency cap	1.0%	0.4%	0.6%	1.2%	0.5%	0.7%

Commentary

The YTD favourable variance in clinical income reflects £0.8m of additional contractual income recognised to align with a monthly profile in twelfths (as opposed to working days). Donated asset income relates to the Decarbonisation Grant supporting (capital related spend), excluded from control total performance.

Overall pay is adverse by £2.2m, mainly due to the under-delivery of the efficiency programme, which is phased evenly across the year. The favourable Nursing pay variance reflects the Maternity Pay reserve (£0.3m), Trust reserves (£0.2m) and the SMART Team budget (£0.7m). Other Pay includes the benefit from the release of the annual leave accrual (£0.9m) and centrally held reserves not issued to the position. Medical pay includes c.£0.5m net industrial action costs (£0.6m gross costs offset by £0.1m of pay deductions).

Overall non-pay shows a favourable variance to plan, this is mainly due to cost control measures supporting the position, lower energy and utility costs, and a rates rebate. This variance is also supported by some underspending, and we will need to monitor this for evidence of sustainable change. The favourable variance in High Cost Drugs reflects certain drugs that have moved back into tariff and hence are now reported in the 'Drugs' line item.

Depreciation underspend due to the delayed completion of capital projects.

Timing of the Salix grant (decarbonisation project – donated asset income)

The full-year forecast is breakeven, supported by deficit funding. Excluding this funding, the forecast deficit is £35.4m.

In-month and YTD bank staff expenditure are below cap, this includes £0.3m of gross additional costs associated with medical industrial action in April. Overall agency costs remain below the spend cap, continuing the position reported last year.

3. Income and Expenditure Run-rate

The table shows a 13-month rolling view of nominal income and expenditure up to and including month 2 (May 2026). The vertical dashed red line delineates the new financial year, at which point pay inflation and similar changes (such as CNST cost growth) take effect.

£m	Actual												
	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
Clinical income	38.6	38.1	38.6	37.7	39.2	36.6	34.7	33.8	37.0	34.9	37.7	39.6	39.6
High cost drugs	2.1	2.3	2.7	2.2	2.2	2.4	2.3	2.4	2.4	2.3	2.2	2.2	2.3
Other operating income	2.8	2.9	2.9	2.7	2.6	(0.1)	3.1	2.9	3.2	3.2	22.1	2.7	3.2
Total patient care and other operating income	43.6	43.3	44.2	42.6	44.0	38.8	40.1	39.1	42.6	40.4	62.0	44.5	45.1
Donated asset income	0.4	0.1	0.3	0.3	1.9	0.1	0.0	0.3	0.6	0.8	16.9	0.0	0.0
Total Income	44.0	43.4	44.5	42.9	45.9	38.9	40.2	39.4	43.2	41.2	78.9	44.5	45.1
Nursing	(11.5)	(11.8)	(11.8)	(13.4)	(12.4)	(12.4)	(12.1)	(12.4)	(12.1)	(12.0)	(12.5)	(12.1)	(12.0)
Medical	(8.9)	(8.9)	(9.5)	(10.9)	(9.3)	(9.3)	(10.2)	(9.9)	(9.2)	(9.4)	(9.4)	(10.1)	(9.4)
Other	(8.5)	(8.3)	(8.8)	(4.7)	(8.0)	(7.9)	(7.8)	(7.8)	(7.8)	(7.8)	(27.8)	(7.4)	(8.1)
Efficiency target	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Pay	(28.9)	(29.0)	(30.1)	(29.0)	(29.7)	(29.6)	(30.1)	(30.1)	(29.1)	(29.2)	(49.8)	(29.6)	(29.5)
Clinical supplies	(5.1)	(5.9)	(7.3)	(5.5)	(5.5)	(5.6)	(5.9)	(6.3)	(6.1)	(5.6)	(6.3)	(5.3)	(5.1)
Drugs	(1.2)	(1.6)	(1.6)	(1.0)	(1.2)	(1.4)	(1.1)	(1.3)	(1.1)	(1.2)	(1.1)	(1.2)	(1.4)
High cost drugs	(2.3)	(2.1)	(2.4)	(2.2)	(2.4)	(3.0)	(2.2)	(2.4)	(2.4)	(2.2)	(2.4)	(1.9)	(2.1)
Other	(5.8)	(4.2)	(3.7)	(5.4)	(5.4)	(5.9)	(6.4)	(5.2)	(5.7)	(5.5)	(5.1)	(5.3)	(4.7)
Efficiency target	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Non-Pay	(14.3)	(13.8)	(15.0)	(14.1)	(14.5)	(15.9)	(15.6)	(15.2)	(15.3)	(14.6)	(14.9)	(13.6)	(13.2)
Contribution	0.7	0.6	(0.6)	(0.2)	1.8	(6.6)	(5.5)	(5.9)	(1.2)	(2.6)	14.2	1.3	2.4
Non-operating exp.	(2.5)	(2.5)	(2.3)	(2.5)	(2.6)	(2.5)	(1.6)	(3.3)	(2.4)	(3.4)	(2.5)	(2.5)	(2.4)
Reported surplus/(deficit)	(1.7)	(1.9)	(3.0)	(2.7)	(0.8)	(9.1)	(7.1)	(9.2)	(3.6)	(6.0)	11.7	(1.2)	(0.0)
Adjustment to control total	(0.4)	(0.0)	(0.3)	(0.3)	(1.9)	(0.0)	(0.0)	0.2	(0.5)	(0.8)	(16.9)	0.0	0.1
Control total surplus/(deficit)	(2.1)	(1.9)	(3.2)	(3.0)	(2.6)	(9.1)	(7.1)	(9.0)	(4.2)	(6.8)	(5.2)	(1.2)	0.0
Deficit Support Funding ("DSF")	(4.0)	(4.0)	(3.4)	(3.4)	(3.4)	-	-	-	-	-	-	(3.0)	(3.0)
Control total surplus/(deficit) adjusted for DSF	(6.1)	(5.9)	(6.7)	(6.4)	(6.1)	(9.1)	(7.1)	(9.0)	(4.2)	(6.8)	(5.2)	(4.1)	(2.9)
Worked WTEs	5,532	5,615	5,696	5,655	5,677	5,632	5,642	5,623	5,517	5,694	5,733	5,557	5,435

Includes £3m per month DSF (nil receivable Oct 25 to Mar 26).

£19m centrally funded pension income / cost.
Restated: £3.1m & £8.8m respectively

£0.3m net industrial action cost.

A number of HCD have transferred into tariff and hence reported within the 'drugs' line in 26/27.

Significant reduction in temporary staff WTE, primarily attributable to lower nursing bank utilisation.

4. Forecast Outturn Risks and Mitigations

The Trust is expected to deliver the Planned Break Even (deficit of £35.4m after adjusting out DSF). While there are significant risks and uncertainties associated with the delivery of the 2026/27 financial plan at this early stage of the year, these are being actively managed. A high-level summary of the key risks and mitigations is provided in the table opposite.

1. This reflects the efficiencies tracker **risk adjusted values** and forecast shortfall at the time of writing.
2. Given reductions in additional sessions, outsourcing and capacity in general we flag a potential risk in shortfall against RTT targets and hence risk clawback by the commissioner.
3. Work is underway with Divisions to understand **existing and emerging cost pressures**, including the ward(s) which remains open despite implementation of Virtual Hospital.
4. Recovery of the long **outstanding debt** with our community provider could be at risk.
5. Historically we have experienced growth of ~10% year-on-year with **NKPS charges**.
6. **Histopathology services** could be withdrawn unless these higher rates are agreed. Work is underway via the System Delivery Director to address.
7. Claims have been made to recognise previous nursing experience outside of the NHS for our **international nurses**. The estimated cost of doing so is reflected.
8. Further potential risks to the forecast that cannot be reliably quantified at this time include:
 - **Industrial Action** – further action is planned for w/c 15th June; this, plus any action thereafter, will give rise to additional cost pressures of ~£0.1m per day. In prior years organisations have been instructed not to include any assumption of further action in forecasts; we continue to apply this assumption.
 - Similar to assessments in previous years (for other staff bands) claims have been made for Band 5 **nursing job evaluation**. No quantification or assessment of this is available at this time.
 - **Medical pay award** – this remains unresolved at national level; whilst tariffs are adjusted, the Trust typically realises a cost pressure due to its medical staffing levels and skill mix.
 - **Utilities** – ongoing global conflict could push prices higher.
 - A&E and **winter** – should significant A&E growth continue and/or winter be harsher than predicted, the Trust may incur additional unbudgeted costs without an income source to fund these.

Further efficiency opportunities are being identified and developed, and the duration of the remaining financial year provides both time and flexibility to address emerging risks and cost pressures. Accordingly, the Trust continues to forecast delivery of the approved plan.

£m	Best	Likely	Worst
Plan (excl. DSF)	(35.4)	(35.4)	(35.4)

Risks (in order of Trust control – most to least)				
1	Shortfall against efficiencies target	(4.1)	(12.5)	(21.3)
2	Elective income delivery	-	(2.0)	(5.0)
3	Emerging Divisional cost pressures	TBC	TBC	TBC
4	Community services debt loss	-	(0.6)	(1.8)
5	NKPS growth	-	(1.0)	(1.5)
6	Histopathology services	-	(2.0)	(2.5)
7	Recognition of non-NHS experience for international nurses	-	(1.0)	(1.0)
8	See further risks in bullets opposite.	TBC	TBC	TBC
Sub-total		(4.1)+	(19.1)+	(33.1)+

Mitigations				
9	Relentless focus on efficiency delivery	4.1	12.5	-
10	System maturity over recharges	-	1.5	-
11	Elective overperformance on other commissioner contracts	-	1.5	-
12	Divisional management of cost pressures	TBC	TBC	TBC
13	Technical flexibility	-	2.0	3.0
14	Other mitigations to be identified	-	1.6	-
Sub-total		4.1	19.1	3.0

Net change	-	-	(30.1)

Forecast	(35.4)	(35.4)	(65.5)

15 DSF	35.4	35.4	8.9

Position after DSF	-	-	(56.6)

The assessment is that delivery of the 2026/27 plan is **high risk**.
The largest risk to the Plan is the delivery of the savings target.

5. Statement of Financial Position

31 March 2026 (draft)	£m	Month end Actual	Movement vs Prior Year
320.9	Non-current assets	317.5	(3.4)
6.3	Inventory	6.4	0.1
40.1	Trade and other receivables	32.7	(7.4)
22.5	Cash	27.1	4.6
68.9	Current assets	66.2	(2.7)
(0.7)	Borrowings	(0.8)	(0.1)
(74.7)	Trade and other payables	(65.1)	9.6
(1.3)	Provisions and other liabs.	(6.0)	(4.7)
(76.7)	Current liabilities	(71.9)	4.8
(7.8)	Net current liabilities	(5.7)	2.1
(5.3)	Borrowings	(5.2)	0.1
(2.1)	Provisions and other liabs.	(2.2)	(0.1)
(7.4)	Non-current liabilities	(7.4)	-
305.7	Net assets employed	304.4	(1.3)
565.8	Public dividend capital	565.8	-
(325.9)	Retained earnings	(327.2)	(1.3)
65.8	Revaluation reserve	65.8	-
305.7	Total taxpayers' equity	304.4	(1.3)

Key messages:

Non-current assets reflect the net impact of investment expenditure, and depreciation.

Net current liabilities (*current assets less current liabilities*) at the end of May are £5.7m.

- **Trade and other receivables** have reduced in month by ~£2.0m to £32.7m (~81% of one-month's normalised income).
- **Cash** is currently favourable to plan due to a number of payables disputes planned for payment in March that remained unsettled in May; all approved invoices have been brought up to date and we continue to work with service teams on outstanding and overdue approvals. Cash has been held to enable this to happen.
- **Trade and other payables** have decreased in monthly due to settlement of capital payables as capital grant cash has been received.
- **Borrowings** – both current and non-current include a 25-year DHSC capital loan taken out in 2013 and capitalised lease asset ranging from 3-10 years.
- **Other liabilities** relate to deferred income, materially being education income received quarterly in advance.

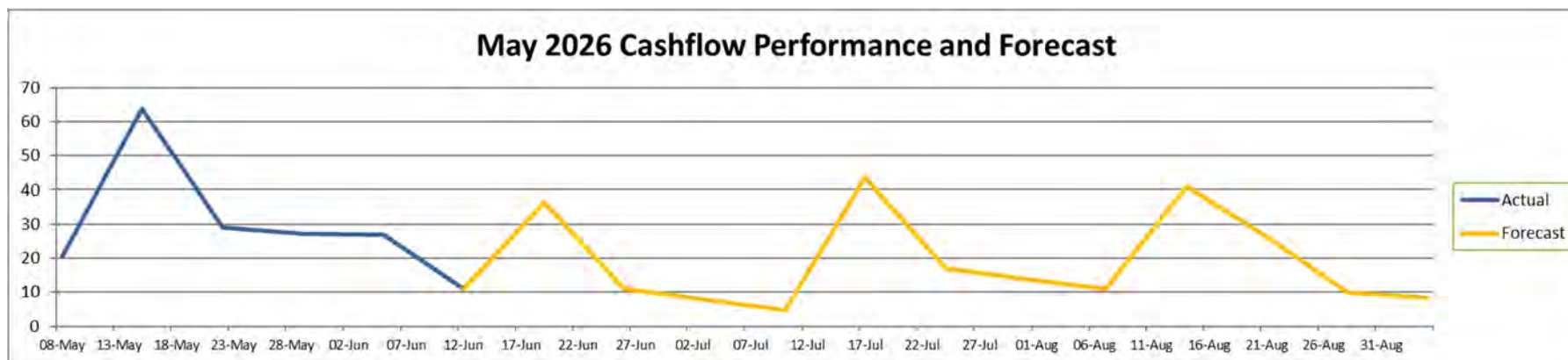
No new **Public Dividend Capital** has been received or repaid since the year end.

The **revaluation reserve** remains at £65.8m and is not expected to change until the annual revaluation in March 2026.

6. Cash

6.1 13-week cashflow

	w/e																	
	Actual					Forecast												
£m	08/05/26	15/05/26	22/05/26	29/05/26	05/06/26	12/06/26	19/06/26	26/06/26	03/07/26	10/07/26	17/07/26	24/07/26	31/07/26	07/08/26	14/08/26	21/08/26	28/08/26	04/09/26
BANK BALANCE B/FWD	24.3	20.4	63.8	28.9	27.1	27.0	11.1	36.4	11.0	7.9	4.8	43.5	17.1	13.9	10.9	40.9	26.5	9.9
Receipts																		
NHS Contract Income	0.1	46.9	0.1	0.1	0.1	0.1	38.7	0.1	0.1	0.1	52.0	0.1	0.1	0.1	38.7	0.1	0.1	0.1
Other	0.3	0.5	0.2	0.1	0.8	0.3	0.2	1.1	0.2	0.3	0.3	0.5	0.2	0.3	0.3	0.2	0.5	0.2
Total receipts	0.4	47.4	0.3	0.2	0.9	0.3	38.9	1.2	0.3	0.3	52.3	0.6	0.3	0.3	39.0	0.3	0.6	0.3
Payments																		
Pay Expenditure (excl. Agency)	(0.4)	(0.3)	(28.7)	(0.3)	(0.3)	(0.4)	(5.1)	(24.1)	(0.4)	(0.4)	(5.1)	(24.1)	(0.4)	(0.4)	(0.4)	(13.3)	(15.9)	(0.4)
Non Pay Expenditure	(2.2)	(3.6)	(5.5)	(4.4)	(0.7)	(4.9)	(8.2)	(2.7)	(2.7)	(2.7)	(8.2)	(2.7)	(2.7)	(2.7)	(8.2)	(1.1)	(1.1)	(1.1)
Capital Expenditure	(1.7)	(0.0)	(0.9)	(0.3)	(0.0)	(10.9)	(0.3)	(0.7)	(0.3)	(0.3)	(0.3)	(0.3)	(0.7)	(0.3)	(0.3)	(0.3)	(0.7)	(0.3)
Total payments	(4.3)	(3.9)	(35.1)	(5.0)	(1.0)	(16.2)	(13.6)	(27.5)	(3.4)	(3.4)	(13.6)	(27.1)	(3.8)	(3.4)	(8.9)	(14.7)	(17.7)	(1.8)
Net Receipts/ (Payments)	(3.9)	43.4	(34.8)	(4.8)	(0.1)	(15.9)	25.3	(26.3)	(3.1)	(3.1)	38.7	(26.5)	(3.6)	(3.1)	30.0	(14.4)	(17.1)	(1.5)
Funding Flows																		
DH Revenue Support	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Working Capital Support	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PDC Capital	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Grant Capital	0.0	0.0	0.0	2.9	0.0	0.0	0.0	0.9	0.0	0.0	0.0	0.0	0.4	0.0	0.0	0.0	0.4	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	(0.1)	2.9	0.0	0.0	0.0	0.9	0.0	0.0	0.0	0.0	0.4	0.0	0.0	0.0	0.4	0.0
BANK BALANCE C/FWD	20.4	63.8	28.9	27.1	27.0	11.1	36.4	11.0	7.9	4.8	43.5	17.1	13.9	10.9	40.9	26.5	9.9	8.3



6.2 12-month rolling operating cash flow

Scenario 1: Based on the 2025/26 cash trend and 2026/27 Plan the year end cash shortfall would be ~£34m.

Mitigation: Working capital management, including review of creditor payment terms.

	Current Year 2026/27													Next Year 2027/28
	ACTUALS		FORECAST											
£m	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27	Apr-26	May-26
OPENING CASH (REVENUE)	(3.5)	0.4	1.5	(6.9)	(3.4)	(8.8)	(13.4)	(6.5)	(13.7)	(15.4)	(6.0)	(9.9)	(17.0)	(15.6)
OPENING CASH (CAPITAL)	26.0	24.3	25.6	16.6	17.3	18.1	19.0	19.7	20.5	20.9	21.8	22.2	22.6	30.7
OPENING TOTAL CASH	22.5	24.7	27.1	9.6	13.9	9.2	5.6	13.3	6.8	5.5	15.8	12.3	5.6	15.1
Receipts														
NHS Contract Income (Revenue)	42.0	45.4	36.9	50.3	36.9	36.9	50.3	36.9	36.9	50.3	36.9	36.9	41.4	45.8
NHS Contract Income (Capital)	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0
Other	2.8	1.2	2.5	1.4	1.3	1.3	1.3	1.3	1.3	1.3	1.2	1.4	1.2	1.3
Total receipts	46.8	48.6	41.4	53.7	40.2	40.3	53.6	40.3	40.3	53.6	40.2	40.3	44.6	49.1
Payments														
Pay Expenditure (excl. Agency)	(30.4)	(29.7)	(30.0)	(30.5)	(30.1)	(30.1)	(30.5)	(30.1)	(30.5)	(30.1)	(30.1)	(30.1)	(30.7)	(30.1)
Non Pay expenditure prior year CR	0.0	0.0	(0.8)	(0.8)	(0.8)	(0.8)	(0.8)	(0.8)	0.0	0.0	0.0	0.0	0.0	0.0
Non Pay Expenditure	(10.6)	(15.7)	(17.1)	(16.8)	(16.8)	(13.6)	(16.8)	(16.8)	(16.8)	(15.5)	(15.5)	(17.8)	(13.9)	(16.8)
Efficiencies delivered	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
Cost pressures (winter pressures)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	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	0.0	0.0	0.0	0.0
Creditor Stretch	0.0	0.0	0.0	0.0	4.0	6.6	3.4	2.3	7.4	3.4	3.6	7.4	3.4	0.0
Capital Expenditure	(11.4)	(3.7)	(12.0)	(1.7)	(1.7)	(1.6)	(1.7)	(1.7)	(2.1)	(1.6)	(2.1)	(2.1)	(1.6)	(1.8)
Total payments	(52.4)	(49.1)	(59.8)	(49.8)	(45.4)	(39.5)	(46.4)	(47.1)	(42.0)	(43.7)	(44.1)	(42.6)	(42.8)	(48.7)
Net Receipts/ (Payments)	(5.6)	(0.5)	(18.4)	3.9	(5.1)	0.8	7.2	(6.8)	(1.8)	9.8	(3.9)	(2.3)	1.8	0.4
Funding Flows														
DH Revenue Support	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
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
PDC Capital CDC	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PDC Capital	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Grants - Capital	7.8	2.9	0.9	0.4	0.4	0.5	0.4	0.4	0.4	0.4	0.4	0.5	7.8	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)
Dividend payable	0.0	0.0	0.0	0.0	0.0	(4.9)	0.0	0.0	0.0	0.0	0.0	(4.9)	0.0	0.0
Total Funding	7.8	2.9	0.9	0.4	0.4	(4.4)	0.4	0.4	0.4	0.4	0.4	(4.4)	7.8	(0.1)
NET INFLOW / (OUTFLOW) REVENUE	3.8	1.1	(8.4)	3.6	(5.5)	(4.5)	6.9	(7.2)	(1.7)	9.4	(3.9)	(7.1)	1.4	0.1
NET INFLOW / (OUTFLOW) CAPITAL	(1.6)	1.3	(9.1)	0.8	0.8	0.9	0.8	0.8	0.4	0.9	0.4	0.4	8.2	0.3
TOTAL NET INFLOW / (OUTFLOW)	2.2	2.4	(17.5)	4.3	(4.7)	(3.6)	7.7	(6.5)	(1.3)	10.3	(3.5)	(6.7)	9.6	0.4
OPENING CASH (REVENUE)	0.4	1.5	(6.9)	(3.4)	(8.8)	(13.4)	(6.5)	(13.7)	(15.4)	(6.0)	(9.9)	(17.0)	(15.6)	(15.5)
OPENING CASH (CAPITAL)	24.3	25.6	16.6	17.3	18.1	19.0	19.7	20.5	20.9	21.8	22.2	22.6	30.7	31.0
CLOSING TOTAL CASH	24.7	27.1	9.6	13.9	9.2	5.6	13.3	6.8	5.5	15.8	12.3	5.6	15.1	15.5
£m	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27	Apr-26	May-26
CLOSING TOTAL CASH	24.7	27.1	9.6	13.9	9.2	5.6	13.3	6.8	5.5	15.8	12.3	5.6	15.1	15.5
Creditor Stretch	0.0	0.0	0.0	0.0	4.0	6.6	3.4	2.3	7.4	3.4	3.6	7.4	3.4	0.0
FORECAST CLOSING IF CREDITORS NOT SLIPPE	23.1	25.5	9.6	12.3	3.6	(6.5)	(2.3)	(11.0)	(19.7)	(12.9)	(19.9)	(34.0)	(27.9)	(27.5)
Cash flow forecast in NHSE plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Variance	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Days to slip	0	0	0	0	8	13	7	5	15	7	7	15	7	0
cumulative creditors slip	0	0	0	0	8	21	28	33	47	54	61	76	83	83
Total credit terms	30	30	30	30	38	51	58	63	77	84	91	106	113	113

Risks/Issues

- The above forecast includes £4.5m to settle prior year disputed invoices (£4m NHSPS, £0.5m other). Total purchase ledger invoices older than 2025/26 total £17m (95% intra NHS). If/when disputes are resolved to release payments this would increase cash pressure by ~ £13m. This includes £7m Dartford NHST, £3.3m Maidstone and Tunbridge Wells NHST, £1.2m Kent Community NHSFT.
- Also not included is £7.8m of payments for sales ledger invoices older than 2025/26, payment of which would partially offset the expected payment pressure.
- Settlement of the remaining 2025/26 purchase/sales ledger balances are assumed as part of the day to day cycle.
- Assumes full payment of 2026/27 DSF

6.3 12-month rolling operating cash flow plus efficiencies

Scenario 2: 100% efficiencies (£30.6m) as per plan from June would give a year end cash shortfall of £3.4m.

Scenario 3: 50% of efficiencies (£15.3m) as per plan from June would give a year end cash shortfall of £18.7m.

	£m	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27	Apr-26	May-26	Jun-26
SCENARIO 2: CIP Delivered as per plan from Q2	CLOSING TOTAL CASH excluding CR slip	23.1	25.5	9.6	12.3	3.6	(6.5)	(2.3)	(11.0)	(19.7)	(12.9)	(19.9)	(34.0)	(27.9)	(27.5)	(34.0)
	PAY			1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9
	NON PAY			1.2	1.2	1.2	1.2	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1
	INCOME			0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
	TOTAL CIP	0.0	0.0	3.1	3.1	3.1	3.1	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0
	FORECAST CLOSING	23.1	25.5	12.7	18.6	13.0	6.0	13.3	7.5	1.8	11.7	7.7	(3.4)	5.8	9.1	5.7
	Cash flow forecast in NHSE plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Variance	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	£m	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27	Apr-26	May-26	Jun-26
SCENARIO 3: 50% of CIP delivered as per plan	CLOSING TOTAL CASH	23.1	25.5	9.6	12.3	3.6	(6.5)	(2.3)	(11.0)	(19.7)	(12.9)	(19.9)	(34.0)	(27.9)	(27.5)	(34.0)
				1.6	1.6	1.6	1.6	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5
	FORECAST CLOSING	23.1	25.5	11.2	15.5	8.3	(0.3)	5.5	(1.7)	(9.0)	(0.6)	(6.1)	(18.7)	(11.1)	(9.2)	(14.1)
	Cash flow forecast in NHSE plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Variance	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Both scenarios forecast a cash shortfall without including any assumptions on prior year balance settlements, some mitigations will therefore still need to be applied.

7. Conclusions

The Trust reports delivery to Plan for the YTD as at month 2; this is despite having to absorb the net cost of industrial action taken during April and shortfalls against savings targets. In contrast, there has been some progress in driving down variable pay and non-pay spend. To achieve Plan we have applied temporary, one-off measures of ~£2.0m in-month (~£3.1m YTD). This creates a **high risk** that finances will deteriorate later in the year unless spending is reduced through greater savings delivery. Adverse performance to plan and/or lack of confidence in delivering the full year plan will result in loss of DSF and the need for further cash borrowing.

Key actions to be taken include the following.

#	Action	Lead	Due
1	Delivery of ward closures / review of Virtual Hospital impact.	MEC and COO	June 2026
2	Line-by-line expenditure check and challenge with Divisional and Corporate Directors.	System Delivery Director / TD	Ongoing
3	Scrutiny of contracts (income and expenditure) to ensure value for money and completeness of recognition.	System Delivery Director	June 2026
4	Continued application of existing enhanced control processes, including recruitment freeze, reduction/removal of insourcing and outsourcing, weekly divisional and programme meetings with the System Delivery Director.	Various	Ongoing
5	Greater scrutiny, challenge and assurance over the efficiencies programme, with clear milestones for identification, implementation and delivery. This must culminate in a robust efficiencies forecast that reduces run-rate and meets the 'four tests'.	Trust Turnaround Director	June 2026
6	The Committee/Trust Board needs a formal recommendation from the Trust Turnaround Director and System Delivery Director of the forecast CIP delivery in June and July (as a minimum) and a list of 'Difficult Decisions' at least equal to the gap for decision at its Board meeting on 1st July.	Trust Turnaround Director and System Delivery Director	End of June 2026
7	Develop, communicate and crystallise a singular message from Board-to-Ward in respect of the challenges faced by the Trust.	Trust Turnaround Director	July 2026
8	Phase Three work with System Financial Improvement Director launched, including in-year improvement work and medium-term financial planning.	Chief Finance Officer	Launched – final outputs due August 2026

7. Conclusions (continued)

The Trust is not presently in a cash-constrained position. However, this will be kept under review in light of the capital programme and working capital position overall. Should an adverse position within income and expenditure arise, there is a risk that cash support would be required. Cash flow forecasting and scenario planning will be addressed in more depth by the Cash Committee (part of FPPC).

It is recommended the Committee confirm it has sufficient assurance on:

- The actual and forecast performance of the Trust against its plan.
- The sufficiency of actions in hand to deliver the plan.
- Any further actions required for consideration.

Simon Wombwell

Chief Finance Officer

June 2026

Meeting of the Board

Meeting Date: 01 July 2026

Title of Report	2026/27 Cost Improvement Plan			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
Author and Job Title	Ian O'Connor, Turnaround Director				
Lead Executive	Siobhan Callanan, Chief Executive (interim)				
Purpose	Approval		Briefing		Noting
Proposal and / or key recommendation:	This report updates the Board on progress being made by the Trust against its financial turnaround objective, by way of reviewing the report and discussion at the most recent Finance, Planning and Performance Committee The Board is asked to note the report and consider any further enhancement to the processes in place				
Executive Summary	Good progress with the schemes identified to date. £48 million of schemes identified that are risk adjusted to £33.2 million Work is underway to estimate the full extent of the improvement needed within the £38.8 to £50.3 million range reported to the Board when setting the financial plan for the year.				
Issues for the Group/Committee/Board Attention:	Cost Improvement plan is profiled in equal 12ths as has been identified. Overall financial performance to be reported at Q1 expects a nil variance to plan. Work continues to assess the likely position in Q2 to secure deficit support funding.				
Meetings at which this paper has been discussed / approved: Date:	Finance Planning and Performance Committee with the Finance Recovery Group reviewing detailed schemes				
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:	Awaiting detailed assessment of existing and additional pressure to allow this evaluation				

Integrated Impact Assessment (IIA) implications	IIA assessments are undertaken for all schemes with no significant issues to report on the schemes making up the plan			
Freedom of Information status:	Report available in public papers			

Introduction

This report seeks to

- Provide excerpts from the information at the Finance, Planning and Performance Committee (FPPC)
- Update the Board on changes to the top level number since the FPPC paper was written
- record the actions being taken to address the continuing shortfall in the risk adjusted that are both in train and reflect any further actions identified through the governance process to Board

Progress

Good progress is being made in identifying opportunities for change. The report to FPPC shows £48 million of identified schemes with a risk adjusted £33.2 million of delivery. By way of triangulation, work with the Divisions, their Finance Business Partners and the Programme Management Office suggests a forecast against the plan at £34.8 million so in a similar range.

As at 18th June schemes totalling £48.4m have been identified with £35.2 million identified as the forecast. This excludes mitigation currently at £3.0 million.

Alongside the System Delivery Director, the delivery programme is

- asking/requiring Executives and their identified leads to move the existing programme along the gateway continuum more quickly improving the risk adjusted value and Divisional forecast
- continuing to identify additional initiatives for consideration though check and challenge, curiosity and qualitative improvements

- Developing a governance approach that ties in with the financial governance paper currently in development

Clarification of required CIP

- at present the identified requirement is between £38.8 million and £50.3 million. The Executive are at present seeking to refine the requirement for CIP delivery for 2026/27 and 2027/28 though:
- identifying known pressures not in the plan
- considering those items identified as risks to delivering the financial requirement of break even (after deficit support funding) and seeking mitigation
- establishing the impact of the full year financial impact of the schemes in development on the medium term financial model

FPPC issues

- to further increase pace and certainty around the cost improvement programme
- to provide more detail on values and reasons on rejected schemes and those potentially requiring a difficult decision and where these decisions are being made

Recommendations

The Board is asked to note the report and clarify any further steps it would like to see enacted

Excerpts from FPPC Report

Headlines

Progress

Some good progress over the first months of 2027/28 in both identifying new schemes and securing progression through the Gateways. Predominantly led by the Director of System Delivery these schemes now total £47.7 million and have a risk adjusted delivery total at slightly below £29.0 million.

To date the Trust is reporting delivery of £1.2million in April rising to £2.2 million in May, £3.4 million year to date

The programme focus has shifted to:

- Identifying real opportunity that breaches the £50.4 million stretch target identified by the Board
 - Establishing clarity of the cost pressures not included in the baseline plan and incorporating any additional (local) schemes into the programme
 - Considering and budgetary control changes that need to be addressed
 - moving all schemes on the CIP tracker into “fully developed” at pace (i.e. IIA and PID completed and signed off – with a start date and financial delivery projection)
 - bringing the delivery of schemes forward into Q1/Q2
 - ensuring grip and control processes are being followed
 - clarifying any difficult decisions required to bridge the remaining gap and considering the appropriate forum for decision making
- All divisions and high-priority area programme teams have been challenged with identifying their “difficult decisions” for review at FRG
 - Reviewing internal governance arrangements that do not stifle progress and ensure clear line of sight from the detailed operational position to the Executive and onwards to provide assurance to the Finance, Planning and Performance Committee and onwards to the Board

As is seen in the evolving maturity of the reported programme, the weekly meetings with the operational teams and System Delivery Director continue to bear fruit and these will continue.

Evolving and enhancing these operational schemes alongside the Divisions developing ideas and opportunities for enacting the opportunity continue through the normal operational process managed by the Chief Operating Officer as well as through regular dialogue between other executive senior responsible officers and the turnaround team. These include:

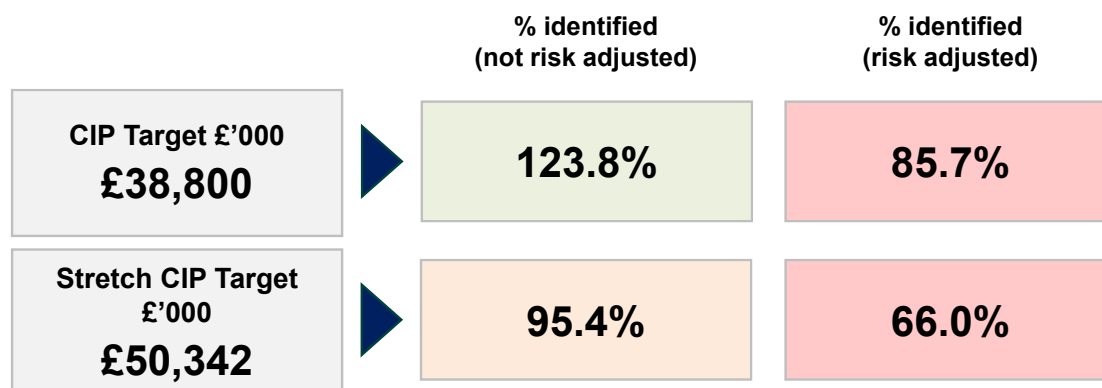
- Reviewing and removing out-patients capacity while maintaining and improving referral to treatment times
- Development of a therapy led unit allowing non-acute patients to be treated in a more specific environment ahead of their discharge
- Reviewing and quantifying the impact of the virtual ward business case and understanding the root causes for the Trust thus far being unable to remove the expected in-patient capacity

The Committee is aware that the cost improvement programme is, as required by regulators, split into a programme of equal 12ths. This is contrary to the original plan, however it does focus the Trust on accelerating its delivery over the early part of the year.

At present around £3.1 million of the gap between the Trusts declared planned position and reporting balance against that plan is supported by “mitigation” including accounting devices. This includes a pressure for strike action now quantified at £0.5 million.

This document describes the understood position as at 11/06/26

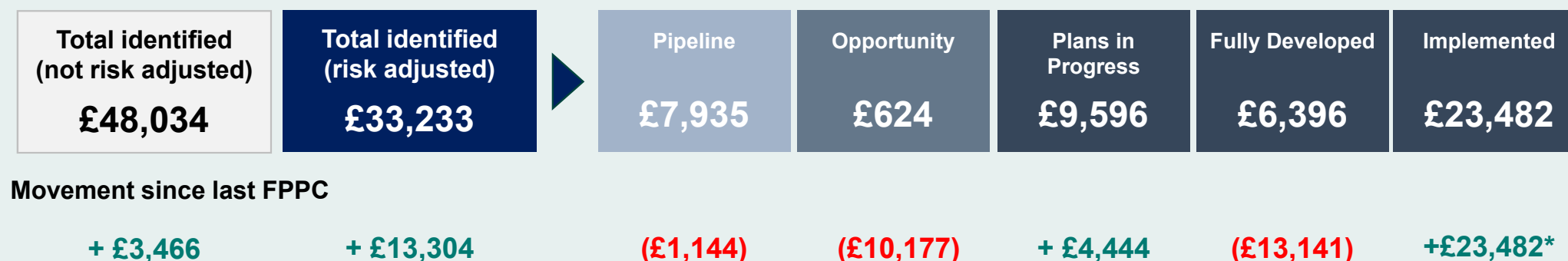
26/27 programme



Progress

- The % of the original £38.8 target continues to rise as does the ratio against the stretch position
- Good progress in the position reported through the weekly check and challenge meetings in moving schemes through the gateways between Pipeline and Implemented
- Significant change in the risk adjusted identification
- Opportunity still in moving schemes out of pipeline and plans in progress to the latter stages of the programme and onwards to delivery

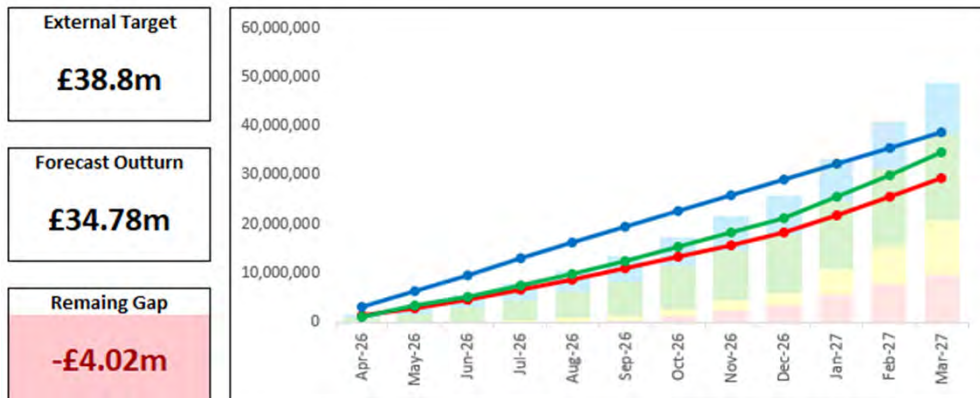
Current status of 26/27 programme (in-year impact – identified (£'000))



* Reported in error at nil in month 1

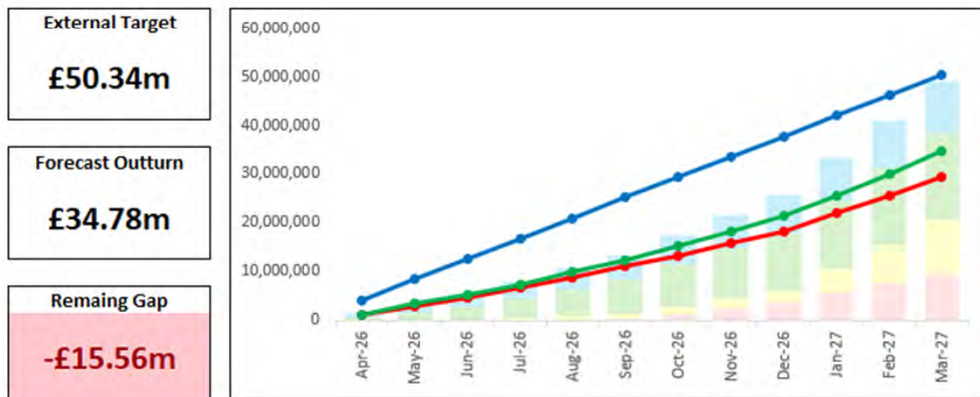
26/27 programme: actual and forecast delivery overview

Trust Delivery Overview



Identified	
(not adjusted)	(adjusted)
£48.93m	£29.52m
Change since last FPPC	
-£0.91m	£1.05m

Gap	
(not adjusted)	(adjusted)
£10.13m	-£9.28m

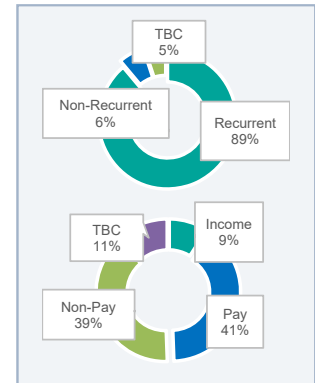


Revised monthly target to meet £38.8m (accounting for delivery to date)

£3.6m (+£0.4m)

Revised monthly target to meet £50.3m (accounting for delivery to date)

£4.3m (+£0.7m)



- To date £3.4 million has been validated as delivered through the programme
- The stretch target is designed to pick up known and anticipated cost pressures as well as the impact of any under performance against the plans
- The risk adjusted value described follows a prescribed methodology with Kent dependant on the gateway status. Reviews by Divisions supported by the finance team suggests a forecast of existing schemes totalling £34.8 million, It is possible that there is a degree of optimism bias in this forecast.
- The majority of the scheme identified are recurrent with currently an equal balance of pay and non pay schemes in train
- Mitigations are recorded outside of these values (£3.1 million YTD)

26/27: top risks and issues

Description	RAG	Mitigations
A failure to deliver of the required run rate reduction leading to removal of deficit support funding		- Developing earlier and improved forecasting between the finance and operational divisions so as to get early sight of areas of concern allowing earlier intervention - Developing an understanding recognised and opaque cost pressure - Continuing weekly meetings with divisions, corporate leads and high-priority area leads to review, assess and drive progress to delivery
Delays in agreeing, implementing and monitoring the necessary controls reducing the likelihood of delivering the overall Cost Improvement Programme leading to financial and reputational issues		- FRG implemented weekly (with executive and divisional / corporate leads) to review overarching position and to sign-off decisions required on controls - Weekly KPI tracking implemented (or being implemented / developed where not already in place) to monitor delivery against plan
Schemes are delayed as a result of the IIA process delaying the delivery of cost improvement and increasing the delivery required for future months.		- IIA panel being increased from weekly to twice weekly (where required) - IIA tracking process implemented for oversight of scheme-level IIA progress - Review of the IIA paperwork required being undertaken
There remains a gap between the value of CIP identified and the stretch target of £50.3m which may mean under-delivery if existing schemes are either rejected or don't deliver to plan. Pareto processes may come into play		- Weekly meetings with divisions, corporate leads and high-priority area leads to review, assess and drive progress to delivery - Encouraging the identification of difficult decisions – using the weekly FRG to rapidly review, assess and make approval decisions
There is a disconnect between the role, responsibility and accountability of high-priority areas and divisions which may mean that new schemes are not identified quickly or implemented at the pace required		- Divisional leads attending weekly high-priority meetings - Executive Senior Responsible Officer framework being established - Clear alignment of high-priority area schemes into divisional targets – to ensure that the divisions / corporate leads can see the expected impact of these initiatives on their CIP delivery

Conclusions and Recommendations

Conclusions

- Some good progress in the first quarter in identifying additional schemes and securing divisional engagement in implementation
- Adopting a positive stance and taking into account some of the mitigations currently deployed the Trust is close to achieving the target included in the original plan
- There are some areas where governance can be modified and ownership and assurance from ward to board and back again can be improved while ensuring that progress and innovation is not stifled
- The difficult decision process is still to be refined, and indeed some of the schemes are only difficult if the Trust is unable to find alternative ways of working
- Mitigations for identified risks and issues are in place and either being monitored regularly during or are being developed.

Next Steps

- Development of further schemes to achieve the £50.3 million target
- Focus on delivery of identified plans and in particular those high value schemes identified in this report
- Quantify and agree the level of pressure on break even from existing and emerging cost pressures
- Enhance budgetary control processes and reinforce grip and control measures

Recommendations

Continue with the identification and development of schemes using existing and enhanced processes identified in this report (Turnaround Director and System Delivery Director)

Review and document the governance process to be followed (Turnaround Director)

Review compliance with grip and control processes already in place (Chief Finance Officer)

Executive SROs to use their existing governance processes to assure delivery (Executives)

The Finance, Planning and Performance committee is asked to note this report and consider any further enhancements or focus it considers might be necessary

Meeting of the Trust Board

Meeting Date: 01 July 2026

Title of Report	2026/27 Capital Plan			Agenda Item	3.6
Stabilisation Plan Domain	Culture	Performance	Governance and Quality	Finance	Not Applicable
				X	
CQC Reference	Safe	Effective	Caring	Responsive	Well-Led
	X			X	X
Author and Job Title	Paul Kimber, Deputy Chief Financial Officer				
Lead Executive	Simon Wombwell, Chief Finance Officer				
Purpose	Approval		Briefing		Noting X
Proposal and / or key recommendation:	The Trust Board is asked to note the process for development of the capital programme for 2026/27 and the next steps for this to be finalised.				
Executive Summary	The Trust has been allocated a 2026/27 CDEL of £17.25m, with an additional £4.9m anticipated for decarbonisation schemes via national grant funding. A structured business planning and prioritisation process has been undertaken, with full engagement from the Trust Leadership Team (TLT) and clinical and corporate divisions. Committed expenditure and rollover schemes from 2025/26 have been identified and incorporated, providing a clear baseline position. The initial programme has been constructed to slightly over-programme against CDEL, reflecting a deliberate and well-established approach to managing delivery risk and scheme slippage. While year-to-date (month 2) capital spend is currently lower than a straight-line profile, this reflects phasing of scheme delivery rather than underlying delivery risk, and full utilisation of the CDEL remains forecast. Additional prioritisation work is underway through specialist groups (Estates, IT, Medical Devices) to ensure that the final programme fully reflects strategic risk, operational resilience, and patient safety considerations. The capital programme remains subject to governance through TLT and the Trust Investment Group (TIG), providing assurance on prioritisation, affordability, and in-year control.				
Issues for the Group/Committee/Board Attention:	As above.				

Meetings at which this paper has been discussed / approved: Date:	Trust Investment Group – 22 nd June 2026			
Board Assurance Framework / Risk Register:	BAF #2: limited capital monies.			
Financial Implications:	This paper sets out how the finite capital resource will be allocated.			
Integrated Impact Assessment (IIA) implications	N/A All individual projects are required to produce a business case including an IIA.			
Freedom of Information status:	Disclosable	X	Exempt	

1. Purpose

- 1.1 This paper provides the Trust Board with an update on the development of the 2026/27 capital programme, including the outcomes of the business planning process, current commitments against the Trust's Capital Departmental Expenditure Limit (CDEL), and the governance arrangements in place to ensure delivery within that limit.
- 1.2 The paper also sets out the approach being taken to prioritisation and provides assurance regarding the robustness of the capital planning and control framework.

2. Background and Business Planning Process

- 2.1. The Trust has undertaken a comprehensive capital planning exercise to support the development of a **five-year capital plan**, aligned to organisational strategy, operational priorities, and risk mitigation requirements.
- 2.2. The draft plan was circulated to the **Trust Leadership Team (TLT)** on late 2025 with a request for:
 - Validation and updating of existing schemes (including removal of superseded items and revision of cost estimates where updated quotations are available); and
 - Submission of new capital requirements.
- 2.3. All submissions were assessed using the Trust's **standardised prioritisation matrix**, incorporating:
 - Alignment to Trust strategy
 - Patient and staff safety implications
 - Legal or regulatory compliance requirements
 - Relationship to the corporate risk register
 - Contribution to efficiency and productivity
- 2.4. Returns from across the organisation have been consolidated into a single programme, ensuring visibility of both current commitments and emerging pressures.

3. 2025/26 Outturn and Impact on 2026/27

- 3.1. The Trust closed its 2025/26 capital programme, allowing:
 - Final confirmation of year-end expenditure; and
 - Identification of ongoing **schemes requiring rollover into 2026/27** to enable completion.
- 3.2. These rollover commitments form a **first call on the 2026/27 CDEL** and have been explicitly reflected in the current programme position

4. 2026/27 Capital Allocation and Funding

- 4.1. The Trust's **CDEL allocation for 2026/27 is £17.25m**, representing the internally funded capital envelope.
- 4.2. In addition:
 - The Trust is planning for **£4.9m of externally funded capital investment**, principally relating to decarbonisation schemes.
 - A number of **Public Dividend Capital (PDC) bids** have been submitted to NHS England, including bids through the Estates Safety Fund. These are progressing through the national assurance and pre-approval process.

- 4.3. This blended funding approach supports delivery of both **core infrastructure requirements and strategic transformation priorities**.

5. Current Commitments

- 5.1. The programme has first incorporated:
- **Rollover schemes from 2025/26;**
 - **Committed expenditure**, including project staffing and previously agreed funding streams (e.g. decarbonisation initiatives); and
 - **Pre-approved priority schemes**, including areas such as cyber security and key system upgrades (e.g. Metavision).
- 5.2. These commitments, totalling £9.87m from internally funded CDEL, are shown below.

£'000	Final 26/27 commitments	Funded by (vs net):			
		Internal	PDC	Grant	Charity
Existing commitments					
Project staff costs	550	550	0	0	0
Decarbonisation	7,832	2,949	0	4,883	0
EPR	2,299	2,299	0	0	0
Bowel screening	752	752	0	0	0
Property Services Leases	594	594	0	0	0
Existing commitments	12,027	7,144	0	4,883	0
2025/26 rollover commitments/priorities					
Windows servers	500	500	0	0	0
Maternity system	160	160	0	0	0
Edge network	200	200	0	0	0
Cyber Security	200	200	0	0	0
PAS upgrade	275	275	0	0	0
Clinical Observation workflow	595	595	0	0	0
General Xray	590	590	0	0	0
Metavision upgrade	82	82	0	0	0
Paperless patient food menu system	124	124	0	0	0
Additional commitments	2,726	2,726	0	0	0
Total PRE-APPROVED	14,753	9,870	0	4,883	0

6. Development of the 2026/27 Programme

- 6.1. Following identification of baseline commitments, remaining capacity within the CDEL was provisionally allocated based on the **prioritisation scores derived from the planning process**.
- 6.2. In developing the draft programme:
- Schemes were ranked according to their prioritisation scores;
 - Available funding was then applied down the prioritised list; and
 - A **managed level of over-programming** was introduced.
- 6.3. This approach is deliberate and reflects:
- Historical experience of **in-year scheme slippage and re-profiling**;
 - The need to ensure **full utilisation of available CDEL**; and
 - The importance of maintaining **flexibility to respond to emerging in-year priorities**.

- 6.4. The proposed programme was reviewed by TLT, with agreement to proceed with rollover and committed schemes as a minimum baseline.

7. Further Prioritisation and Risk Considerations

- 7.1. While the initial prioritisation process provided a structured ranking, it has been recognised that:
- Some schemes not currently within the affordability threshold may represent **emerging or latent operational risks**; and
 - There is a risk that deferral of such schemes could result in **future cost escalation or operational impact**.
- 7.2. To address this, further work has been commissioned through the following capital sub-groups:
- Estates
 - IT
 - Medical Devices
- 7.3. These groups are working with divisions to:
- Reassess priorities using the Trust matrix; and
 - Apply **informed management judgement where appropriate** to reflect operational realities.
- 7.4. The outputs will be presented to the **Trust Investment Group (TIG) on 22 June 2026**, with recommendations to be escalated to TLT for final approval of the discretionary programme.

8. Delivery, Monitoring and CDEL Assurance

- 8.1. Although **year-to-date capital expenditure is currently below a straight-line trajectory** (the plan is phased equally across the year), this is the lived experience from prior years, and major schemes will typically accelerate later in the financial year. Actual spend to the end of May is shown below.

£'000	Actual
Backlog Maintenance	62
Fire	(7)
Medical and Surgical Equipment Programme	9
IT	44
Cyber Security	(77)
EPR	(62)
CDC	(1)
Decarbonisation	81
Donations	9
Estates Safety Fund	(212)
Total Capital Expenditure (exc contingencies)	(154)
Slippage schemes	233
Total Capital Contingencies	233
Total Capital	79

- 8.2. Based on:
- The level of committed expenditure;
 - The scale of the prioritised programme; and

- The deliberate over-programming approach, the Trust **remains confident of full utilisation of its £17.25m CDEL in 2026/27.**

8.3. Robust controls are in place to manage delivery, including:

- A clearly defined **approval framework through TLT and TIG;**
- Regular **capital monitoring and forecasting**, including review of slippage and re-phasing;
- Active **programme management of major schemes;** and
- The ability to **prioritise and mobilise additional schemes in-year** where delivery risk emerges.

9. Conclusion and Recommendation

9.1. The Trust has established a **structured, risk-based, and well-governed capital planning process**, underpinned by clear prioritisation criteria and strong organisational engagement.

9.2. Despite a slower start to in-year expenditure, the programme is:

- Affordably constructed,
- Appropriately prioritised, and
- Supported by robust governance and monitoring arrangements.

9.3. The Board is therefore asked to:

- a) **Note** the current position on the 2026/27 capital programme;
- b) **Take assurance** from the controls in place to ensure delivery within CDEL; and
- c) **Note** the further prioritisation work being undertaken, with final recommendations to be considered through TLT following review by TIG.

Meeting of the Board

Wednesday, 01 July 2026

Title of Report	Nursing Band 5 Job evaluation Programme	Agenda Item	3.7
Author and Job Title	Caroline Mpita, Head of Clinical Workforce		
Lead Executive	Evonne Hunt, Chief Nursing Officer		
Executive Summary	Approval	Briefing	Noting X
	Following publication of revised national Nursing and Midwifery Profiles and subsequent national direction from NHS England and the Secretary of State for Health and Social Care, all NHS organisations are required to review Band 5 nursing roles. This is a nationally mandated programmes with potential workforce and financial implications The review aims to ensure: • Equal pay for work of equal value • Consistency of job matching • Alignment between role content and Agenda for Change banding • Fair and transparent application of Job Evaluation principles NHSE has issued a formal implementation template and delivery requirements. Submission of delivery plan to the region is due 31st July 2026 with completion of programmes scheduled for October 2028 Key risks include • Workforce instability • Industrial relations challenge • Equal pay claims • Insufficient job matching capacity • Financial pressure • Failure to meet NHSE deadlines • Inconsistent matching outcomes • Reputational impact • Variation between professions		
Proposal and/or key recommendation:	Board to note delivery timeline Phase 1- Mobilisation- July – December 2026 Phase 2 Role review January -December 2027 Phase 3 2027-2028 Appeals Phase 4 Closure October 2028 Throughout the timeline there will be quarterly reporting to the Board which will include Progress, Risks and Mitigations and any escalation triggers		
<u>Governance Route Meeting:</u> Date submitted:	TLT – 23/06/2026		
Identified Risks, issues and mitigations:	Risks • Inconsistent job matching and job descriptions • Variations across the divisions and across the professions • Back pay expectations		

	• Employment tribunal claims Mitigations • Partnership working • Joint communication- early engagement with staff • Staff-side representation • Transparent appeals process						
Resource implications:	Insufficient numbers of trained job matchers Financial implication to train sufficient matchers						
Sustainability and/or Public and patient engagement considerations:	N/A						
Integrated Impact assessment (please mark):	<table border="1"> <tr> <td>Yes</td><td>No</td><td>N/A</td></tr> <tr> <td></td><td></td><td>X</td></tr> </table>	Yes	No	N/A			X
Yes	No	N/A					
		X					
Appendices:							
Freedom of Information status (please mark):	<table border="1"> <tr> <td>Disclosable</td><td></td><td>Exempt</td><td>X</td></tr> </table>	Disclosable		Exempt	X		
Disclosable		Exempt	X				
For further information please contact:	Caroline Mpita Carolinempita@nhs.net						

Nursing Band 5 Job Evaluation Programme

Trust Board Assurance Report

June 2026



Executive Summary

Purpose

- To assure the Board of the national Nursing Band 5 Job Evaluation Review Programme and to seek endorsement for the proposed implementation approach.

Why does this matter?

- Following publication of revised national Nursing and Midwifery Profiles and subsequent national direction from NHS England and the Secretary of State for Health and Social Care, all NHS organisations are required to review Band 5 nursing roles.
- The review aims to ensure:
 - Equal pay for work of equal value
 - Consistency of job matching
 - Alignment between role content and Agenda for Change banding
 - Fair and transparent application of Job Evaluation principles

Key Messages

- Nationally mandated programme
- Potential workforce and financial implications
- Significant industrial relations interest
- Delivery required by October 2028
- Funding support available nationally

Board Assurance Rating

Domain	Assurance
Governance	Amber
Compliance	Amber
Workforce Impact	Amber
Financial Impact	Amber
Delivery Risk	Amber

National Context



This is not a local Medway initiative. It is a nationally mandated programme.

Programme is to be complete by October 2028

What has changed: Changes to Nursing Practice

The nursing role has evolved significantly. Examples include



Today's Band 5 nurses deliver more complex, advanced & accountable care than ever before

Workforce Impact Assessment



Medway

NHS Foundation Trust



SCOPE OF REVIEW:

The programme affects **all** Band 5 registered nursing roles.

WORKFORCE GROUPS		WORKFORCE CONSIDERATIONS	
Workforce Area	Review Required	Potential implications for:	
 Adult Nursing	✓ Yes	 Recruitment	
 Emergency Care	✓ Yes	 Retention	
 Critical Care	✓ Yes	 Career pathways	
 Theatre Services	✓ Yes	 Succession planning	
 Children's Services	✓ Yes	 Staff morale	
 Community Services	✓ Yes	 Professional identity	
 Specialist Nursing Roles	✓ Yes		

NHS Job Evaluation Principles

The review will be undertaken in accordance with the NHS Job Evaluation Handbook.

PRINCIPLES		
 Equal pay for work of equal value Ensuring fair and equitable reward for comparable roles.	 Objective assessment Assessment based on role requirements, not opinion.	 Evidence-based matching Decisions supported by documented evidence.
 Consistency checking Cross-organisational moderation and quality assurance.	 Staff-side involvement Partnership working with Trade Unions and staff representatives.	 Transparent appeals process Clear route for review and challenge where appropriate.

IMPORTANT CLARIFICATION	
The review assesses:  THE ROLE The duties, responsibilities, knowledge, skills, autonomy and accountability required by the role.	The review does NOT assess:  THE INDIVIDUAL It does not assess the performance, competence, experience or other personal attributes of the individual.

Speciality	Number of staff potentially affected
Adult Nurses (incl Critical care and Community)	723
Specialist Nurses	5
ED Nurses- Adult	50
Theatre nurses	93
Children's nurses	61
Children's ED	12
Total	944

MFT Current Position

PROGRESS TO DATE: COMPLETED

	Review of national guidance	
	Attendance of NHS webinars	
	Initial workforce mapping	
	Job descriptions drafted	
	Initial job matching undertaken	
	Preliminary financial assessment completed	
	Initial benchmarking discussions commenced	



IN PROGRESS

	Governance framework development
	HR process review
	Trade union engagement
	Job evaluation capacity review



Funding: NHS England has confirmed tariff support arrangements to recognise this cost pressure.

Financial Modelling

Ward	Actual Band 5 Nurse WTE	Actual Band 6 Nurse WTE	No.of shifts per month covered by Band 5	WTE uplift to Band 6
Arethusa	29.6	5	7	0.56
Harvey	21	5.1	13	1.04
Kingfisher	17.5	5.2	5	0.4
Ocelot	6.9	4	10	0.8
McCulloch	20.9	5	13	1.04
Phoenix	20.9	5.1	1	0.08
Victory	14	4	11	0.88
Pembroke	22.5	5.3	5	0.4
Bronte	15.8	4	10	0.8
Wakeley	16	4.9	21	1.68
Emerald SS	12.9	4.9	7	0.56
Milton	18.4	5.1	10	0.8
Sheppey	14	4.1	12	0.96
Tennyson	16.9	4.8	22	1.76
Byron	16.4	6.5	3	0.26
Will Adams	15.4	5	5	0.4
Keats	18.1	5	3	0.26
Total	297.2	83	158	12.68



Areas Identified Through Desktop Review



Initial desktop review of general medical/ surgical wards identified areas where Band 5 nurses were working in the capacity of a Band 6.



In the remaining areas, Band 5 nurses tend to work within the scope of practice identified in the national profiles.



The graph identifies the areas where Band 5 staff are undertaking Band 6 responsibilities.



The graph identifies the potential WTE uplift required for these staff to continue to work in a Band 6 capacity.



Findings will help inform workforce planning and ensure alignment between role responsibilities and grading.



Key Outcomes



Clear understanding of where Band 5 nurses are working in a Band 6 capacity.



Confirmation that Band 5 nurses are working within scope of practice in other areas.



Identification of specific areas requiring Band 6 level responsibilities.



Estimation of potential WTE uplift needed to sustain Band 6 capacity.



Evidence base to support workforce planning and role alignment.

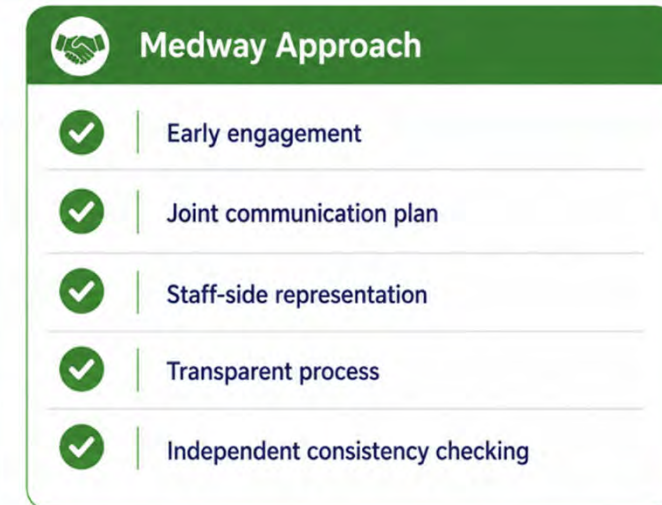
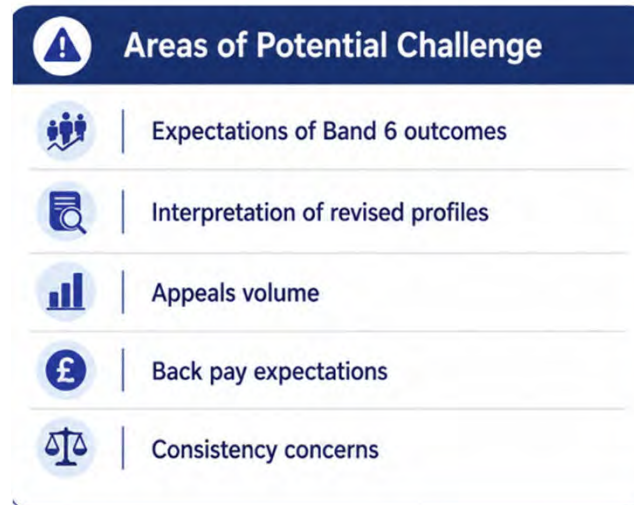
Risks, Benefits & Industrial Position

Strategic Risk Assessment

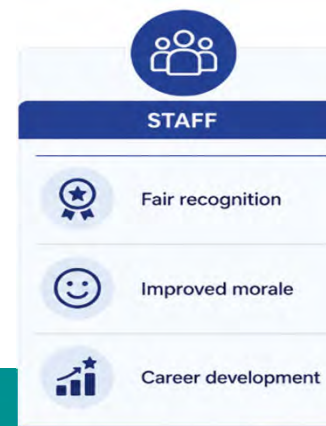


A fair, consistent & transparent approach is essential to reduce equal pay risk & maintain workforce confidence

Trade Union Engagement: Significant national interest exists regarding this programme



Expected Benefit: What the Trust gains



Delivery Plan & Board Assurance

DELIVERY TIMELINE



PHASE 1 – MOBILISATION

July – December 2026

- ✓ Governance established
- ✓ Training completed
- ✓ Communications launched



PHASE 2 – ROLE REVIEW

January – December 2027

- ✓ JD validation
- ✓ Matching reviews
- ✓ Consistency checking



PHASE 3 – APPEALS

2027–2028

- ✓ Formal appeals process
- ✓ Outcome review



PHASE 4 – CLOSURE

By October 2028

- ✓ Completion
- ✓ NHSE submission
- ✓ Benefits review

HOW THE BOARD WILL BE ASSURED



QUARTERLY
REPORTING



TRUST
BOARD

REPORTS TO INCLUDE



- Progress against trajectory
- Financial impact
- Risks and mitigations
- Staff-side feedback
- Matching outcomes
- Appeals activity
- Workforce impact

ESCALATION TRIGGERS



- Significant financial pressure
- Industrial dispute
- Equal pay challenge
- Failure to achieve milestones

Decisions Required

The Board is asked to:

- **Note:** the national requirement to undertake a Nursing Band 5 Job Evaluation Review
- **Endorse:** the proposed governance arrangements
- **Support:** investment in sufficient Job Evaluation capacity
- **Approve:** the implementation approach and delivery plan
- **Receive:** quarterly assurance reports until programme completion

Report to:	Trust Board	Meeting date:	18 th May 2026
Report title:	QAC	Agenda number:	
Board Committee meeting date:	01 July 2026	Author:	Paulette Lewis Chair QAC

Agenda

The Committee received a comprehensive set of strategic, quality, and assurance reports and held detailed discussions to triangulate evidence and assess assurance levels.

Key areas of focus included:

- Integrated Quality Performance Report (IQPR)
- Patient safety incident backlog and Duty of Candour
- Complaints backlog and discharge delays
- Mortality, SHMI, and harm review findings
- Infection prevention (hand hygiene and mask compliance)
- Subcommittee assurance reports

The Committee noted improved transparency in reporting but identified significant areas where further assurance is required

Alerts and actions requested from the Board

☐ Patient Safety Incident Backlog (Critical Escalation)

- 839 incidents identified, with 428 still open and 113 requiring high-level investigation.
- Evidence that some incidents were closed without proper investigation.
- 59 Duty of Candour breaches.
- Regulators have been informed and external support engaged.

Board is asked to seek ongoing assurance on recovery trajectory, governance, and learning embedment.

☐ Duty of Candour Non-Compliance

- 59 outstanding breaches represent a serious governance concern.

Board to require a deep dive and formal progress report.

☐ Complaints Backlog and Governance

- 39 complaints breaching national timelines.
- Concerns around process inefficiencies rather than capacity.

Board to seek assurance on redesigned processes and impact on patient experience.

❑ Never Event – Incorrect Implant and System Gaps

- Risk linked to absence of effective safeguards including digital scanning.
Board to ensure mitigating controls are implemented pending system resolution.

❑ Digital Scanning Solution Risk

- Ongoing system limitation impacting safety controls.
Interim operational controls required until full solution implemented.

Assurance

The Committee's position is **mixed assurance**, with several areas of concern:

- **Not assured** on the **patient safety incident backlog**, governance processes, and Duty of Candour compliance.
- **Limited assurance** regarding **SHMI (1.30)** and underlying drivers (frailty, care delays).
- **Concern** regarding declining **hand hygiene compliance** (11 of 33 areas below standard) and mask-fit compliance challenges.
- **Assured** on subcommittee reporting overall, though with risks noted across effectiveness and safety domains.

The Committee emphasised the need for demonstrable improvement.

Advise

The Committee advises the Board to:

- Ensure **robust oversight of discharge improvement plans**, particularly addressing flow delays and system pressures.
- Strengthen **complaints handling processes**, including thematic learning and early intervention models.
- Reinforce **basic standards of care**, including nutrition, hydration, infection control, and patient observation.
- Improve **data triangulation across complaints, incidents, and mortality** to drive learning.
- Ensure **visibility and ownership of action logs**, with clear accountability and timely updates.

Risks

High-Priority Risks

- Patient safety incident backlog and governance failures
- Duty of Candour non-compliance
- Complaints backlog and performance breaches
- SHMI and mortality concerns
- Harm associated with prolonged ED waits

- Corridor care and operational pressures

Operational and Clinical Risks

- Rheumatology delays and deteriorating 52-week waits
- Cancer pathway delays due to histopathology turnaround
- Digital system limitations (e.g., EPR/EPMA, scanning)
- Never event risk (incorrect implant controls)

Additional Risks / Issues

- Ward alarm sound issues impacting patient safety
- System-wide financial pressures affecting capacity and flow

Decisions

- Agreement to **escalate patient safety backlog to the Board with regular updates required.**
- Recognition of the need for **cultural change alongside operational recovery.**
- Endorsement of **strengthened governance processes**, including improved escalation and oversight.
- Continued support for **quality governance review and system-wide improvements.**

Overall Committee Position

The Committee recognised **improved transparency and engagement**, but highlighted that:

- There are **significant governance and safety concerns requiring urgent attention**
- The organisation must move from **identification of issues to demonstrable improvement**
- Sustained assurance will depend on **delivery, cultural change, and strengthened systems**

Report to:	Trust Board	Meeting date:	1 July 2026
Report title:	People Committee Assurance Report	Agenda number:	
Board Committee meeting date:	20 May 2026	Author:	Jenny Chong

Agenda

The Committee discussed the following items:

- Wellbeing Audit
- Stabilisation/Improvement Plan
- Statutory Mandatory Training Assurance Report (on workplan)
- Apprenticeship Reforms and Impact strategy
- Terms of Reference Review
- Committee Effectiveness Survey results
- People Insight Report
- Staff Survey Action Plan
- Health and Wellbeing Guardian Report
- 10 Point Plan Update for Improving work lives of Resident Doctors
- Rapid Case Review including BAME and non BAME staff
- IQPR (People Section)
- Risk and Issues Register

Alerts and actions requested from the Board

The Committee wishes to alert the Board to the following:

1. Financial Pressures impact on the following areas

- Lack of funding to make Wellbeing areas adequate and consistent in standard. Charitable Funds committee to be approached for bid funding
- Apprenticeships: Strict recruitment controls on staff capacity are limiting apprenticeship recruitment; inability to backfill staff is reducing participation in nursing apprenticeships and placements, which impact career progression
- Staff survey comments show staff concern around financial impact on understaffing; patient to staff ratios; morale and wellbeing

2. People Insight

- Increased in sickness levels with “anxiety and stress” the top reason.
- Voluntary turnover for staff with less than 2 years of service is significantly higher than those with more than 2 years of service
- Appraisal rates have continued to decline

Assurance

The Committee wishes to provide assurance to the Board that:

1. **StatMand:** Overall training compliance is 89.6%, exceeding target of 85%. Declining compliance in specific areas of Resuscitation, Fire Safety, and Moving and Handling to be monitored. National changes increasing the frequency of Manual Handling training for Doctors has impacted our Compliance figures. Workforce capacity challenges have increased Did-Not-Attend training rates.
2. **Apprenticeships Reforms and Impact strategy:** Levy spending achieved a record 61% and service is GOLD-rated. 2026/27 strategy to focus on strengthening early career pathways; maximise use of apprenticeship units and reduce levy expiry risk; protect clinical workforce pipelines; and align apprenticeship activity to future workforce planning and demand.
3. **Resident Doctor 10-point Action Plan:** Latest Resident Doctor survey result improved by 13% to 76%. Actions delivered on access to rest facilities, food provision, psychological support, payroll improvement, statutory and mandatory training recognition, and strengthened leadership and governance arrangements. Ongoing improvement work on annual leave equity, designated on-call parking, protected breaks, and cultural interventions (NHS Safe Learning Environment Charter to be adopted).

Advise

The Committee wishes to advise the Board of:

1. **Wellbeing Audit:** An audit of 33% of Staff Wellbeing areas identified a disparity and inconsistency in quality and adequacy of the Wellbeing rooms. Financial pressures have limited the works to improve and upgrade the facilities. The Charitable Funds committee will be approached to explore a bid and approval process for staff welfare items.
2. **Stabilisation and Improvement Plan:** Cultural Transformation workstreams have established KPI themes to measure progress and impact. The Emergency Department have launched body-worn cameras to tackle violence and aggression and improve staff safety.
3. **Annual Committee Effectiveness Survey results:** The Committee noted the findings and recognise improvement is required in timeliness of sub-committee reporting and action tracking; quality of assurance in papers; sub-committee structure
4. **Staff Survey Action Plan:** Each division has created their local action plan with at least 3 improvements and 1 specific EDI action.
5. **Employee Relations:** Backlog is down to 2 outstanding cases. Improved Employee Relations process in mediation is proving effective and reducing formal grievance cases. No disciplinary case is taking longer than 3 months.

Risks

The Committee discussed the following risks as part of regular review of BAF risks:

- Deterioration of Staff Survey results
- Neurology consultant workforce capacity and recruitment challenge

Decisions

The Committee made the following decisions under its delegated authority from the Board:

None. The Terms of Reference was not approved as it is still in draft format and various points are still being discussed.

Meeting of the Trust Board in Public

Meeting Date: 01 July 2026

Title of Report	Audit and Risk Committee Update to Trust Board.			Agenda Item	4.1d
Stabilisation Plan Domain	Culture	Performance	Governance and Quality	Finance	Not Applicable
			X	X	
CQC Reference	Safe	Effective	Caring	Responsive	Well-Led
					X
Author and Job Title	Mojgan Sani Non Executive Director / Interim Chair of ARC				
Lead Executive	Simon Wombwell Chief Finance Officer				
Purpose	Approval		Briefing	X	Noting
Proposal and / or key recommendation:	The Board is asked to note, for assurance the update from the Audit and Risk Committee held on 22 June 2026.				
Executive Summary	The Audit and Risk Committee met on 22 nd June 2026 to receive the Audit Findings and Value for Money (VFM) Report from our External Auditors, Grant Thornton. We also received the Annual Report and Conclusion from our Internal Auditors. The Audit Committee reviewed the 2025/26 Annual Accounts, Annual Governance Statement and Annual Reports.				
Issues for the Group/Committee/Board Attention:	○ Audit and Risk Committee recommends Board adoption of the 2025/26 Annual Report, Accounts and Annual Governance Statement, supported by an unmodified external audit opinion. ○ Significant VFM weaknesses remain across financial sustainability, governance and efficiency; key risks include savings delivery, BPPC performance, disputed balances and capital/intangible controls. ○ Board should oversee a single financial governance improvement plan, tighter savings and working-capital management, and robust completion of internal audit and core financial control actions during 2026/27.				
Meetings at which this paper has been discussed / approved: Date:	N/A				
Board Assurance Framework / Risk Register:	N/A				
Financial Implications:	None				
Integrated Impact Assessment (IIA) implications	N/A				
Freedom of Information status:	Disclosable		Exempt		X

Recommendation to the Board on adoption of the 2025/26 Annual Report, Annual Accounts and Annual Governance Statement

1. The Audit and Risk Committee has reviewed the 2025/26 Annual Report, Annual Accounts and Annual Governance Statement, together with the reports of the external and internal auditors, **and recommends that the Board adopt these documents**. The Committee's advice is that the documents are suitable for approval, while recognising that the Board must do so in full awareness of the significant weaknesses identified by the external auditors in value for money arrangements and the control issues that remain open for management action.
2. In reaching this recommendation, the Committee considered the external auditor's Audit Findings Report, the Auditor's Annual Report, the proposed audit opinion, the internal audit annual report, and the supporting management explanations presented to the Committee. The Committee also considered whether the Annual Report and Accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for stakeholders to assess the Trust's position and performance.
3. Grant Thornton (External Auditors) report that the quality of the draft financial statements and supporting working papers was good, and they expect to issue an unmodified audit opinion once their final completion procedures are concluded, including the Engagement Lead quality review, the signed management representation letter, and final review of the updated Annual Report and financial statements. They also state that they have not identified any outstanding matters requiring modification of the financial statements opinion.
4. The Committee nevertheless draws the Board's attention to the fact that the auditors identified several important matters requiring Board focus in the year ahead. These do not prevent adoption of the Annual Report, Accounts and Annual Governance Statement, but they do require continued Board oversight, timely executive action and clear monitoring through committee structures.

Key issues for Board attention

5. First, the external auditors identified significant weaknesses in the Trust's arrangements for securing value for money (VFM) across all three criteria of financial sustainability, governance, and improving economy, efficiency and effectiveness. In particular, they identified weaknesses in the delivery of efficiencies (citing poor track record in this respect), the Trust's limited response to NHSE undertakings, the absence of a single consolidated financial governance improvement plan, and the continuing operational challenges reflected in NHS Oversight Framework segmentation and participation in the National Provider Improvement Programme (NPIP).
6. The Committee therefore asks the Board to note the auditors' three key recommendations. These are:
 - KR1 - to strengthen arrangements to deliver savings targets through a clear organisation-wide framework for accountability, oversight and forward planning;
 - KR2 - to strengthen and embed leadership and governance arrangements to support delivery of the Stabilisation Plan and address NHSE undertakings; and
 - KR3 - to establish a single consolidated financial governance improvement plan to address revised finance-related undertakings and prior review recommendations.
7. Secondly, the auditors identified one unadjusted audit difference above their reporting threshold but below overall materiality. This relates to a disputed receivable of £1.7m connected to historical triage services to Medway Community Healthcare (MCH), where the auditors were not able to obtain sufficient evidence over existence and recoverability in line with IFRS 9 expectations, although, as discussed at FPPC, management has continued to pursue recovery.
8. The Committee considered this matter carefully. The issue does not alter the recommendation to adopt the Accounts, but the Board should require management to maintain a clear resolution timetable and return with a further recommendation around a debt provision should recovery remain uncertain during 2026/27.
9. Thirdly, the auditors reported the management's decision to correct a prior period classification error in relation to the Electronic Patient Record (EPR) system, which had historically been included in our accounts (within Property, Plant and Equipment); this has now been restated as Intangible Assets under IAS 38. This restatement reduced Property, Plant and Equipment by £14.445 million at 31 March 2025 and increased Intangible Assets by the same amount, with no impact on net assets or the reported deficit.
10. The Committee accepts management's explanation and the corrected treatment in the Accounts. However, the Board should note the associated control recommendation from the auditors that the Trust strengthen technical accounting review and documentation for complex capital and digital projects, so that future classifications and associated disclosures are robust at the point of initial recognition.
11. Fourthly, the auditors reported materially weak Better Payment Practice Code performance, with only 78.9% of non-NHS invoices by volume and 71.9% by value. Further, only 53.0% of NHS invoices by volume paid within target during the year. They attributed this deterioration to the Trust's deficit position, tightened cash management arrangements and the working capital management plan.

12. The Committee recognises that this issue sits within the wider financial sustainability challenge facing the Trust. The Board should therefore continue to monitor the interaction between deficit recovery, liquidity, supplier relationships and payment performance, and link into cash management oversight (recognising the ongoing risk of losing deficit support funding in 2026/27).
13. Fifthly, the Committee notes the governance and internal control issues reflected in both external and internal audit reporting, triangulating with external reports on governance and our Undertakings.
14. The external auditors reported delays in receiving certain elements of the Annual Report, Annual Governance Statement, Remuneration Report and payroll-related information, and recommended stronger cross-departmental coordination in support of the audit timetable.
15. An improvement recommendation that ARC should receive regular formal reports on progress in implementing internal audit (IA) actions. At year end 21 management actions remain due, six of which are high rated. The Committee heard this would be improved through the TLT and new Governance, Risk and Compliance Committee (GRC) by giving IA greater visibility and access to the management teams. This also led to some discussion around who holds responsibility for 'compliance', which is covered by the portfolios of CMO, CNO, CFO and Trust Secretary – the Board could helpfully build this topic into future discussions on risk and compliance.
16. The Annual Governance Statement appropriately reflects that the Trust can provide reasonable, and not absolute, assurance on governance, risk management and internal control. In the Committee's view, the Annual Governance Statement is materially consistent with the assurance available, provided that the Board remains sighted on the significant control issues and ensures disciplined follow-through during 2026/27.

Recommendation on adoption

15. Having considered the evidence above, the Committee recommends that the Board adopt the 2025/26 Annual Report, Annual Accounts and Annual Governance Statement. This recommendation is made on the basis that the Board also endorses a clear programme of follow-up action against the auditor findings and keeps these matters under active review through the Board, ARC and FPPC, led by the CEO through the wider Executive Team.

External auditor opinion

16. The external auditors have issued an unmodified opinion on the 2025/26 financial statements, confirming that the **Accounts give a true and fair view and have been properly prepared in accordance with the relevant Department of Health and Social Care Group Accounting Manual and NHS Foundation Trust Annual Reporting Manual requirements**. They also report that the audited parts of the Remuneration and Staff Report have been properly prepared and that the other information in the Annual Report is materially consistent with the financial statements.
17. The auditors have not exercised any additional statutory powers and have nothing to report by exception in relation to public interest reporting or unlawful expenditure.

Chair's recommendations to the Board

18. The Chair of the Audit and Risk Committee recommends that the Board, over the year ahead, focus on the following five priorities:
19. First, require delivery of a single consolidated financial governance improvement plan, with named owners, milestones and formal Board reporting, in response to KR3.
20. Secondly, strengthen oversight of savings delivery and recurrent efficiency schemes, including clear accountability, credible phasing and early escalation where delivery risk emerges, in response to KR1.
21. Thirdly, ensure leadership, governance and risk management arrangements are embedded consistently in support of the Stabilisation Plan and NHSE undertakings, in response to KR2.
22. Fourthly, require tighter management of judgemental balances and working capital pressures, including disputed receivables, disputed payables, provisioning decisions and Better Payment Practice Code performance.
23. Fifthly, require regular ARC reporting on completion of internal audit recommendations and on the strengthening of core financial controls, particularly for capital accounting, impairment review and cross-organisational year-end reporting processes.

Acknowledgments

24. On behalf of the Audit and Risk Committee I would like to acknowledge the efforts of all teams in another challenging year. The workload this year has been unrelenting and consolidating to form of the annual report, annual governance statement and accounts given colleague changes, significant regulatory and external reviews should be recognised by the Board. Whilst this has been a team effort, I would like to highlight two colleagues specifically: Isla Fraser, Financial Controller who has led production of the accounts successfully for another year, working well with our auditors and Molly Marcu, Interim Company Secretary who has picked up the Annual Report and AGS after joining us late in the financial year.

Meeting of the Trust Board in Public

Meeting Date: 01 July 2026

Title of Report	Freedom to Speak Up			Agenda Item	5.1
Stabilisation Plan Domain	Culture	Performance	Governance and Quality	Finance	Not Applicable
	x				
CQC Reference	Safe	Effective	Caring	Responsive	Well-Led
Author and Job Title	Natasha Barrett- Salvador- Freedom to speak up.				
Lead Executive	Sheridan Flavin – Interim Chief People Officer				
Purpose	Approval	x	Briefing		Noting
Proposal and / or key recommendation:	There are for recommendations for consideration based on the assessment of cases for this period. Placing these into an action plan to compliment the high-level actions from the FTSU Board Reflection and Planning tool is recommended. 1. Given the high number of patient safety concerns raised in Emergency and Acute Medicine, further consideration is welcomed regarding how pressures in this directorate are reviewed and addressed. Consideration is also welcomed regarding how staff in this area are supported during periods of increased service pressure. 1. When looking at the theme of Worker Safety/Wellbeing we see this predominantly relates to impact from perceived incivility in the workplace. Consideration is welcomed on how awareness around personal impact and incivility in the workplace can be emphasised with staff via either training or internal communications. 1. Although Discrimination and Inequality is not a leading theme, we do see over 50% of these cases coming from within one directorate. Further exploration of this at a local level in collaboration with the guardian could be beneficial. It could be inciteful to understand staff experience in this area and whether team or leadership culture is impacting this data. 1. Consideration to review awareness of objectivity and fairness within internal recruitment processes. Staff also would benefit from being able to ensure meaningful feedback is available to unsuccessful candidates if requested.				
Executive Summary	This report covers a 12-month reporting period beginning on 1st April 2025 and ending on 31st March 2026. During this period 124 concerns were raised via The Guardian Service (GSL).				

	Of these 124 concerns, 23 were rated red, 73 amber and 26 green. There were 2 white cases – these require no further case management and have no risk profile. The most prominent job group to raise concerns via the FTSU Guardian is Medical and Dental (31). The top three themes reported during this period include Patient Safety/Quality of Care (26), Bullying/Harassment (21) and Worker Safety/Wellbeing (19). These are also the top three multi-theme occurrences. Emergency & Acute have seen the highest number of concerns overall (32) within a directorate. This area is also leading on themes relating to Patient Safety/Quality of Care (14) and Worker Safety/Wellbeing (7). Estates & Facilities Management see the second highest number of concerns raised with 9 of these relating to Discrimination and Inequality. 44% of staff using The Guardian Service have reported doing so due to a perception that they have raised their concerns before but not felt listened to. 86% of cases have been escalated in some capacity to the trust with only 14% requesting to remain confidential within the remit of the service. No cases of detriment have been reported during this period. Four recommendations have been made at the end of the report based on the assessment of cases from this period.			
Issues for the Group/Committee/Board Attention:	Please refer to recommendations			
Meetings at which this paper has been discussed / approved: Date:	Monthly meetings undertaken with FTSU and Medway Executive lead			
Board Assurance Framework / Risk Register:	Please see FTSU report for further attention.			
Financial Implications:	Not applicable for the FTSU			
Integrated Impact Assessment (IIA) implications	Not applicable for the FTSU			
Freedom of Information status:	Disclosable	x	Exempt	

Meeting of the Trust Board in Public

Meeting Date: 01 July 2026

Title of Report	Freedom to Speak Up			Agenda Item	5.1
Stabilisation Plan Domain	Culture	Performance	Governance and Quality	Finance	Not Applicable
	x				
CQC Reference	Safe	Effective	Caring	Responsive	Well-Led
Author and Job Title	Natasha Barrett- Salvador- Freedom to speak up.				
Lead Executive	Sheridan Flavin – Interim Chief People Officer				
Purpose	Approval	x	Briefing		Noting
Proposal and / or key recommendation:	There are for recommendations for consideration based on the assessment of cases for this period. Placing these into an action plan to compliment the high-level actions from the FTSU Board Reflection and Planning tool is recommended. 1. Given the high number of patient safety concerns raised in Emergency and Acute Medicine, further consideration is welcomed regarding how pressures in this directorate are reviewed and addressed. Consideration is also welcomed regarding how staff in this area are supported during periods of increased service pressure. 1. When looking at the theme of Worker Safety/Wellbeing we see this predominantly relates to impact from perceived incivility in the workplace. Consideration is welcomed on how awareness around personal impact and incivility in the workplace can be emphasised with staff via either training or internal communications. 1. Although Discrimination and Inequality is not a leading theme, we do see over 50% of these cases coming from within one directorate. Further exploration of this at a local level in collaboration with the guardian could be beneficial. It could be inciteful to understand staff experience in this area and whether team or leadership culture is impacting this data. 1. Consideration to review awareness of objectivity and fairness within internal recruitment processes. Staff also would benefit from being able to ensure meaningful feedback is available to unsuccessful candidates if requested.				
Executive Summary	This report covers a 12-month reporting period beginning on 1st April 2025 and ending on 31st March 2026. During this period 124 concerns were raised via The Guardian Service (GSL).				

	Of these 124 concerns, 23 were rated red, 73 amber and 26 green. There were 2 white cases – these require no further case management and have no risk profile. The most prominent job group to raise concerns via the FTSU Guardian is Medical and Dental (31). The top three themes reported during this period include Patient Safety/Quality of Care (26), Bullying/Harassment (21) and Worker Safety/Wellbeing (19). These are also the top three multi-theme occurrences. Emergency & Acute have seen the highest number of concerns overall (32) within a directorate. This area is also leading on themes relating to Patient Safety/Quality of Care (14) and Worker Safety/Wellbeing (7). Estates & Facilities Management see the second highest number of concerns raised with 9 of these relating to Discrimination and Inequality. 44% of staff using The Guardian Service have reported doing so due to a perception that they have raised their concerns before but not felt listened to. 86% of cases have been escalated in some capacity to the trust with only 14% requesting to remain confidential within the remit of the service. No cases of detriment have been reported during this period. Four recommendations have been made at the end of the report based on the assessment of cases from this period.			
Issues for the Group/Committee/Board Attention:	Please refer to recommendations			
Meetings at which this paper has been discussed / approved: Date:	Monthly meetings undertaken with FTSU and Medway Executive lead			
Board Assurance Framework / Risk Register:	Please see FTSU report for further attention.			
Financial Implications:	Not applicable for the FTSU			
Integrated Impact Assessment (IIA) implications	Not applicable for the FTSU			
Freedom of Information status:	Disclosable	x	Exempt	



Annual Report
1 April 2025 to 31 March 2026



Circulation:

Public Board

Main point of contact:

Sheridan Flavain
Chief People Officer

Prepared by:

Natasha Barratt Salvador
FTSU Guardian

Rebecca Crosbie
Operations Manager

The Guardian Service Ltd.

Date:

May 2026

Contents

1. Executive summary.....	3
2. Purpose of the paper	3
3. Background to Freedom to Speak Up	3
4. The Guardian Service	3
5. Access and Independence	4
6. Categorisation of Calls and Agreed Escalation Timescales.....	4
7. Number of concerns raised	5
8. Confidentiality	5
9. Themes	6
10. Trends in Cases.....	6
11. Assessment of Cases	6
12. Statistical Graphs	7
13. Why do staff use The Guardian Service?	11
14. Detriment.....	11
15. Action taken to improve the Freedom to Speak Up Culture.....	11
16. Learning and Improvements	11
17. Comments & Recommendations	12
18. Staff Feedback.....	12

1. Executive summary

This report covers a 12-month reporting period beginning on 1st April 2025 and ending on 31st March 2026. During this period 124 concerns were raised via The Guardian Service (GSL).

Of these 124 concerns, 23 were rated red, 73 amber and 26 green. There were 2 white cases – these require no further case management and have no risk profile.

The most prominent job group to raise concerns via the FTSU Guardian is Medical and Dental (31).

The top three themes reported during this period include Patient Safety/Quality of Care (26), Bullying/Harassment (21) and Worker Safety/Wellbeing (19). These are also the top three multi-theme occurrences.

Emergency & Acute have seen the highest number of concerns overall (32) within a directorate. This area is also leading on themes relating to Patient Safety/Quality of Care (14) and Worker Safety/Wellbeing (7).

Estates & Facilities Management see the second highest number of concerns raised with 9 of these relating to Discrimination and Inequality.

44% of staff using The Guardian Service have reported doing so due to a perception that they have raised their concerns before but not felt listened to.

86% of cases have been escalated in some capacity to the trust with only 14% requesting to remain confidential within the remit of the service.

No cases of detriment have been reported during this period.

Four recommendations have been made at the end of the report based on the assessment of cases from this period.

2. Purpose of the paper

The purpose of this paper is to give an overview of the cases raised at Medway Foundation Trust (MFT) to the Freedom to Speak Up Guardian employed by The Guardian Service Limited (GSL) during the full reporting year of 2025/26. This reporting period begins on 1st April 2025 and ends on 31st March 2026.

This paper does not include any data relating to cases raised internally and only those raised with the Guardian. This paper will not contain any identifiable information to ensure that confidentiality of those raising concerns is respected in line with national guidelines.

3. Background to Freedom to Speak Up

Following the Francis Inquiry¹ 2013 and 2015, the NHS launched 'Freedom to Speak Up' (FTSU). The aim of this initiative was to foster an open and responsive environment and culture throughout the NHS enabling staff to feel confident to speak up when things go or may go wrong; a key element to ensure a safe and effective working environment.

4. The Guardian Service

The Guardian Service Limited (GSL) is an independent and confidential staff liaison service. It was established in 2013 by the National NHS Patient Champion in response to The Francis Report. The Guardian Service provides staff with an independent, confidential 24/7 service to raise concerns, worries or risks in their workplace. It covers patient care and safety, whistleblowing, bullying, harassment, and work

¹ <https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry>

grievances. We work closely with the National Guardian Office (NGO) and attend the FTSU workshops, regional network meetings and FTSU conferences. The Guardian Service is advertised throughout the Trust as an independent organisation. This encourages staff to speak up freely and without fear of reprisal. Freedom to Speak Up is part of the well led agenda of the CQC inspection regime. The Guardian Service supports the Trust's Board to promote and comply with the NGO national reporting requirements.

The Guardian Service Ltd (GSL) was implemented in Medway Foundation Trust on 23rd September 2024.

Communication and marketing have been achieved by meeting with senior staff members, joining team meetings, site visits, the Intranet and the distribution of flyers and posters across the organisation. All new staff will become aware of the Guardian Service when undertaking the organisational induction programme.

5. Access and Independence

Being available and responsive to staff are key factors in the operation of the service. Many staff members, when speaking to a Guardian, have emphasised that a deciding factor in their decision to speak up and contacting GSL was that the Guardians are not NHS employees and are external to the Trust.

6. Categorisation of Calls and Agreed Escalation Timescales

The following timescales have been agreed and form part of the Service Level Agreement.

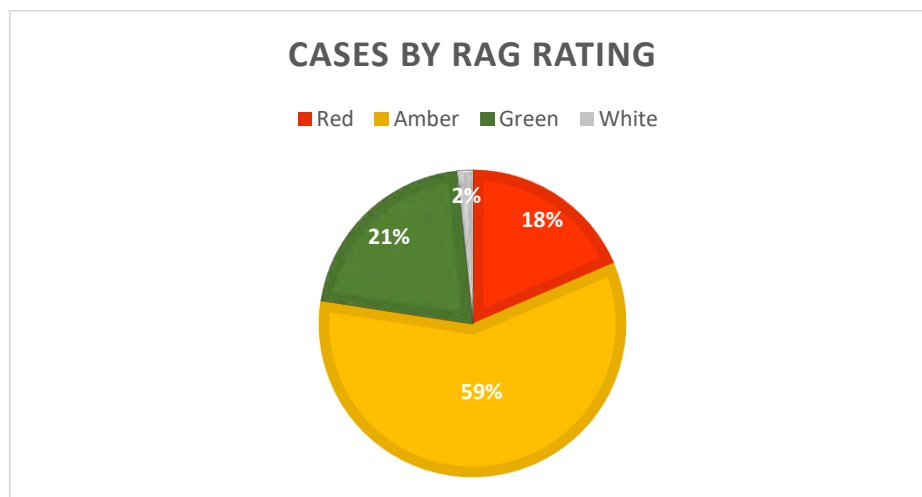
Call Type	Description	Agreed Escalation Timescales
Red	Includes patient and staff safety, safeguarding, danger to an individual including self-harm.	Response required within 12 hours
Amber	Includes bullying, harassment, and staff safety.	Response required within 48 hours
Green	General grievances e.g. a change in work conditions.	Response required within 72 hours
White	No discernible risk to organisation.	No organisational response required

Open cases are continually monitored and regular contact is maintained by the Guardian with members of staff who have raised a concern to establish where ongoing support continues to be required. This can be via follow up phone calls and/or face to face meetings with staff who are in a situation where they feel they cannot escalate an issue for fear of reprisal. Guardians will also maintain contact until the situation is resolved or the staff member is satisfied that no further action is required. Where there is a particular complex case, setbacks or avoidable delays in the progress of cases that have been escalated, these would be raised with the organisational lead for the Guardian Service at regular monthly meetings.

Escalated cases are cases which are referred to an appropriate manager, at the request of the employee, to ensure that appropriate action can be taken. As not all employees want their manager to know they have contacted the GSL, they either progress the matter themselves or take no further action. There are circumstances where cases are escalated at a later date by the Guardian. A staff member may take time to consider options and decide a course of action that is right for them. A Guardian will keep a case open and continue to support staff in such cases. In a few situations contact with the Guardian is not maintained by the staff member.

7. Number of concerns raised

For the 2025/26 reporting period **124** cases were raised with the FTSU Guardian. The chart below shows the percentage of cases by RAG rating.



8. Confidentiality

Confidentiality	No. of concerns	Percentage
Keep it confidential within Guardian Service remit	17	13.71
Permission to escalate with names	50	40.32
Permission to escalate anonymously	39	31.45
Permission to escalate without name	18	14.52
Total	124	

Keep it confidential within Guardian Service remit relates to cases where a staff member is either using the service for impartial support without escalating or using the service to build confidence to escalate their concerns internally themselves following a conversation with the guardian.

Permission to escalate with names relates to cases where escalation has been agreed with full disclosure.

Permission to escalate anonymously relates to cases where neither the guardian nor the trust knows the identity of the staff member.

Permission to escalate without name relates to cases where the guardian knows the identity of the staff member, but the staff member does not wish for the trust to know their identity.

9. Themes

Concerns raised are broken down into the following categories;

Theme	Total
Patient and Service User Safety / Quality	26
Management Issue	8
System Process	18
Bullying and Harassment	21
Discrimination / Inequality	16
Behavioural / Relationship	15
Other (Describe)	0
Worker Safety	19
Sexual Misconduct	1
Grand Total	124

10. Trends in Cases

For the purposes of reporting a time period, half year period 2024/25 refers to the period from September 2024 (when the service was implemented into the Trust) to 31st March 2025 a full year period 2025/26 refers to 1st April 2025 to 31st March 2026.

As the service only went live midway through the 2024/25 reporting period there isn't any year-on-year comparable data yet.

We can, however, see an increase in cases relating to the theme of Worker Safety/Wellbeing and a decrease in cases from within the Medical Directorate. For the half year period of 2024/25 there was one case with a primary theme of Worker/Safety Wellbeing, this increased to 19 for the full 2025/26 period. For half year period of 2024/25 11 cases were raised within the Medical Directorate and for the full 2025/26 period this decreased to 8 for double the time frame.

In addition to this we can also see an increase in staff from the Medical and Dental job group using the service. For the half year period 2024/25 11 cases were raised from this job group and for the full 2025/26 period it increased to 31.

11. Assessment of Cases

Here we will explore the most prevalent themes.

Patient Safety is the top theme for the 2025/26 reporting period (26). 14 of these 26 cases were from within emergency and acute medicine.

Cases within this theme relate to impact on care due to:

- Winter service pressures
- Communication failures
- Transition from emergency departs to ward environments
- Normalisation of corridor care
- Staff shortages
- Increased service pressures

Staff report they lack confidence in escalation and action relating to their concerns when raised internally. Staff report needing further assurance, consistent feedback and shared learning.

Bullying and harassment continues to present as a recurring theme within cases. 21 cases have been logged with this as a primary theme and 27 within multi theme occurrences.

This reflects ongoing challenges around workplace culture, communication, and psychological safety. The cases appear to be influenced by a combination of factors, including:

- Increasing workforce pressures
- Hierarchical structures
- Inconsistencies in management capability and confidence when addressing conflict or performance issues.

Staff feedback indicates that some concerns arise from behaviours perceived as dismissive or intimidating, particularly in high-pressure clinical environments where communication styles can be misinterpreted or where operational stress impacts interpersonal interactions.

Worker Safety/Wellbeing cases have increased during the 2025/26 reporting period. Of these 21 cases we predominantly see staff reporting impact on their wellbeing due workplace pressures or perceived incivility. Behaviours and workplace experiences impacting staff wellbeing include:

- Perceptions of micromanagement
- Incivility including persistent raised voices and unprofessional behaviour
- Workplace pressures heightening stress

Staff report increased experiences of work-related stress which can lead or extended periods of sickness absence. Staff report a lack of trust in dealing with these issues at a local level. There is feedback from staff that reports impact from resident doctors' strikes causing increased pressures on wider teams.

Discrimination and Inequality is not a leading theme, we do see the majority of these cases coming from within one directorate. Further exploration of this in collaboration with the guardian at a local level could be beneficial to understand what factors are impacting these cases.

Systems/Processes has continued to increase as a case theme. The areas worth noting within this theme are:

- Internal recruitment - fears that this can lack fairness, objectivity and transparency. With perceptions that feedback if unsuccessful is difficult to attain. It is also perceived that internal relationships often impact decision making.
- Training opportunities perceived as lacking

Some recommendations have been made at the end of the report in response to the assessment of case themes.

12. Statistical Graphs

Concerns raised by Directorate

The Guardian Service reports by the following Directorates as requested by the Trust:

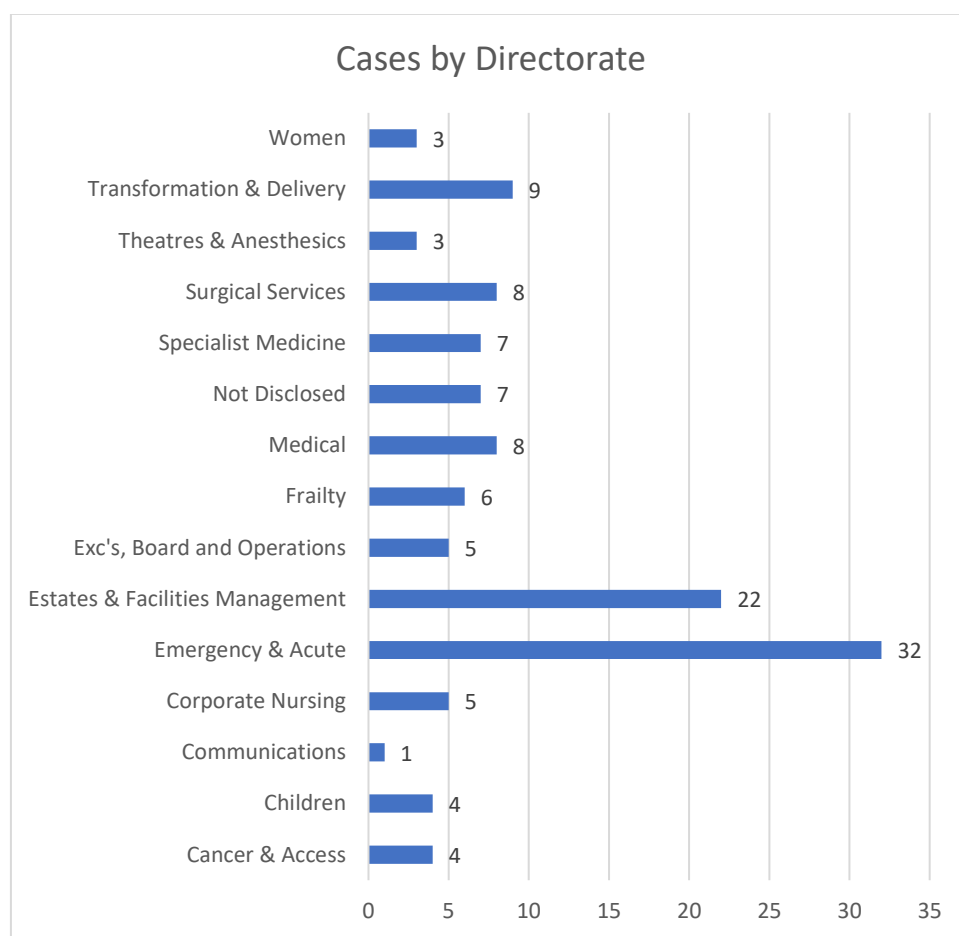
• Cancer & Access	• Frailty
• Children	• Medical
• Communications	• Specialist Medicine
• Corporate Nursing	• Surgical Services
• Emergency & Acute	• Theatres & Anaesthesia
• Estates and Facilities Management	• Transformation & Delivery
• Exc's, Board and Operations	• Women

The chart below shows us that Emergency and Acute (32) and Estates and Facilities Management (22) are the directorates where the highest number of concerns have been raised during this period. The subsequent charts show the breakdown in themes for these two directorates.

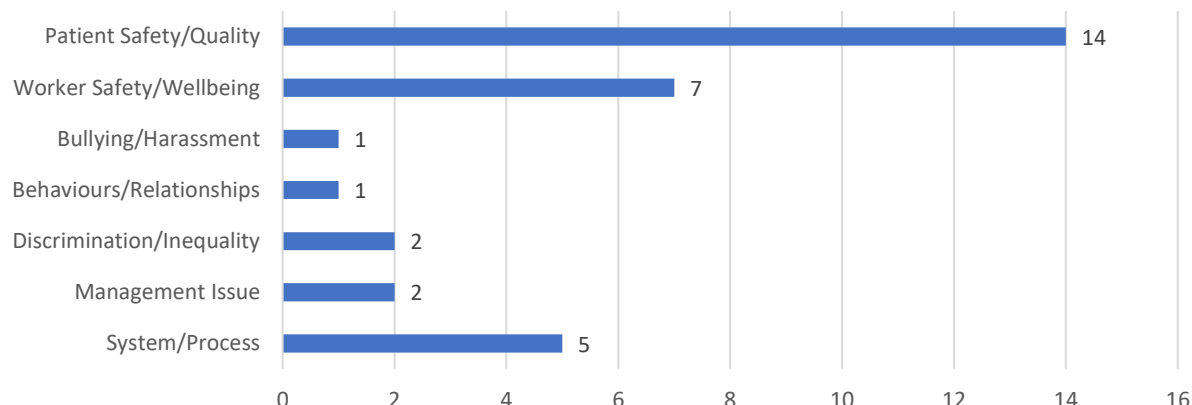
14 of the 32 cases within Emergency and Acute relate to the theme of Patient Safety/Quality of Care.

Within Estates and Facilities Management, we see 9 cases relating to the theme of Discrimination/Inequality.

Although the service went live midway through the previous reporting period we can see there has been a decrease in cases from within the medical directorate which was a leading area previously.

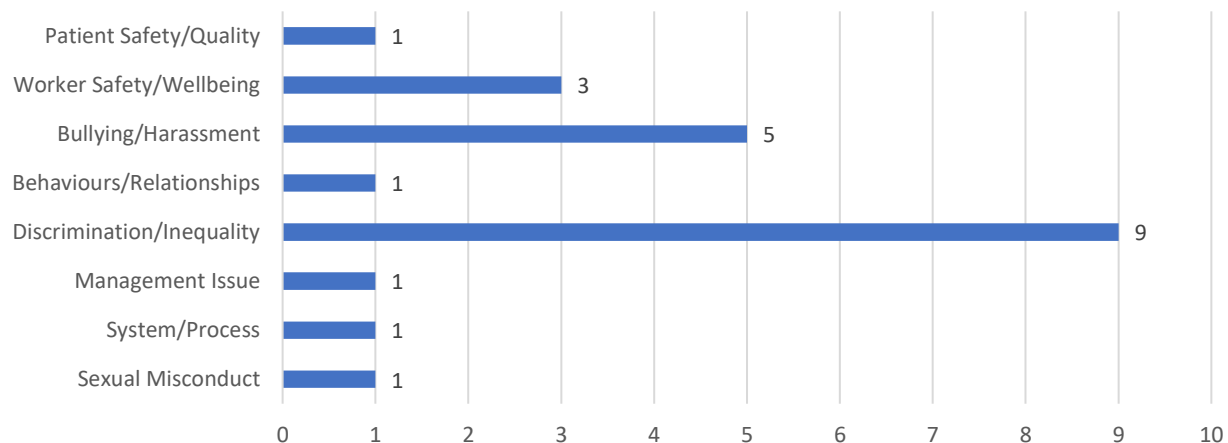


Emergency and Acute Directorate Cases by Theme



	System/Processes	Management Issue	Discrimination/Inequality	Behaviours/Relationships	Bullying/Harassment	Worker Safety/Wellbeing	Patient Safety/Quality
Series1	5	2	2	1	1	7	14

Estates and Facilities Management Directorate Cases by Theme



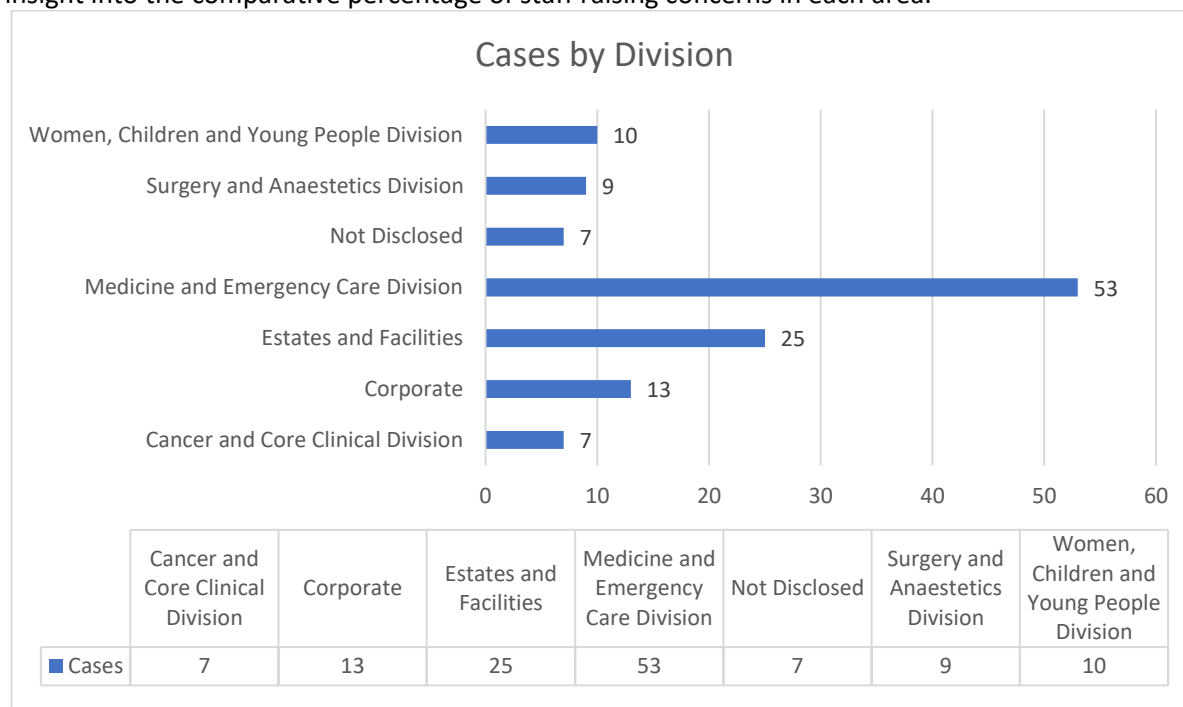
	Sexual Misconduct	System/Process	Management Issue	Discrimination/Inequality	Behaviours/Relationships	Bullying/Harassment	Worker Safety/Wellbeing	Patient Safety/Quality
Series1	1	1	1	9	1	5	3	1

Concerns raised by Location

The Guardian Service reports under the following locations at the request of the Trust:

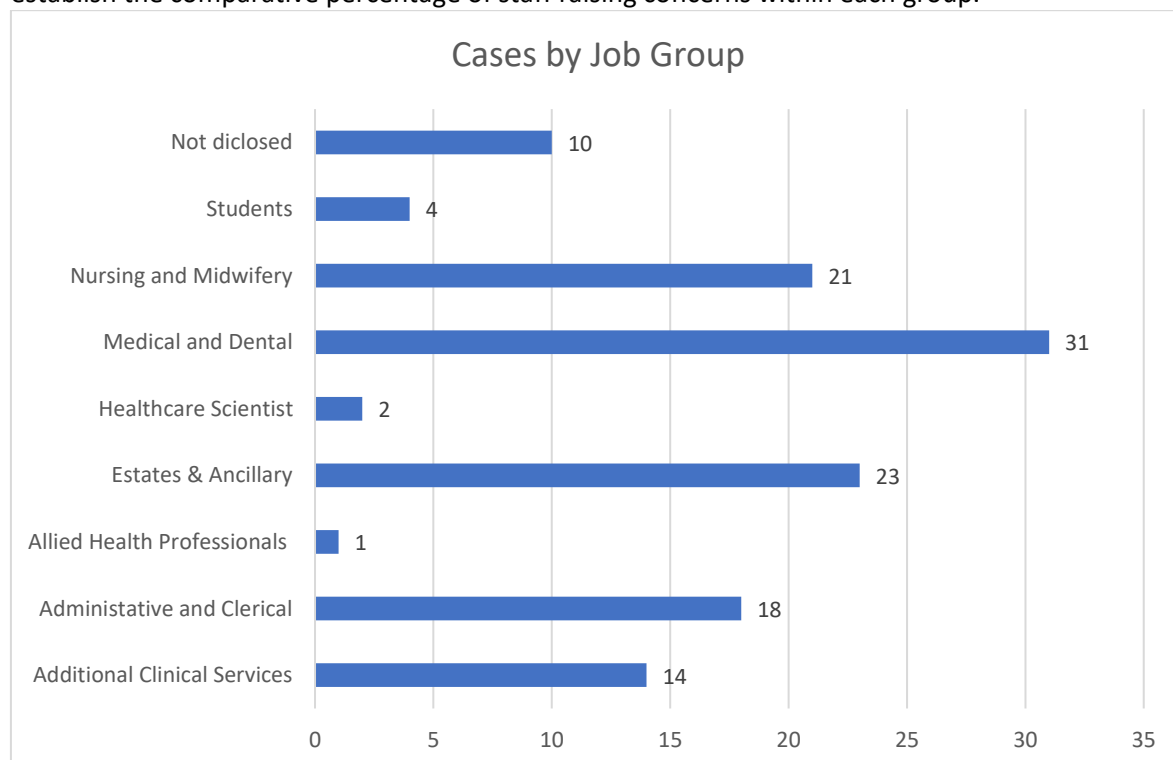
- Cancer and Core Clinical Division
- Corporate
- Estates and Facilities
- Medicine and Emergency Care Division
- Surgery and Anaesthetics Division
- Women, Children and Young People Division
- Not Disclosed

If we look at cases raised by Division we can see that 53 of the 124 cases have been raised within the Medicine and Emergency Care Division. It can be useful to consider headcount in each division to gain insight into the comparative percentage of staff raising concerns in each area.

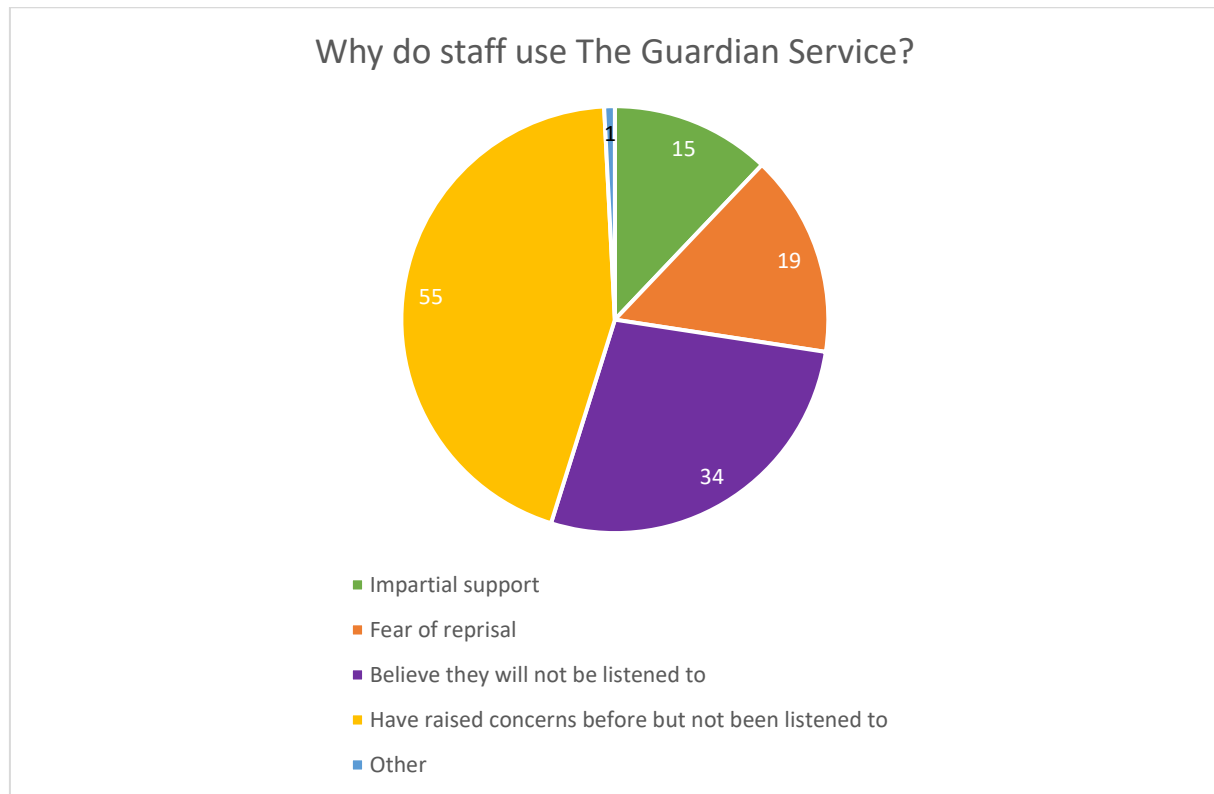


Concerns raised by Job Group

The chart below shows us cases raised by Job Group. We can see that the most prevalent group for raising concerns in Medical and Dental. It is worth considering the headcount for each job group to establish the comparative percentage of staff raising concerns within each group.



13. Why do staff use The Guardian Service?



14. Detriment

There have been no cases of detriment reported via the FTSU Guardian during this period.

15. Action taken to improve the Freedom to Speak Up Culture

The trust has worked with the Guardian to ensure they have good visibility and ongoing engagement across the trust including attendance at staff network meetings and other relevant forums. In addition, FTSU insights are shared and reviewed within People Committee, Trust Board and monthly/quarterly meetings with the Executive Lead and Non-Executive Director for FTSU.

The trust has commissioned an external consultant who is supporting the Cultural Transformation Programme and whilst progress is being made, the impact of this will take some time to embed within the organisation.

16. Learning and Improvements

In the first half of the 2025/26 reporting period the guardian often found escalation response times to be lacking. In some cases, breaching the expected timeframes. This can have a negative impact on staff experience and increase a sense of futility when speaking up.

The guardian has noticed an improvement to response times during the latter part of this reporting year. Managers responsiveness to red concerns has seen notable improvement. Continued work is still needed to ensure ongoing responsiveness and consistency when responding to concerns. In addition, it is important to consider closing the loop on cases effectively following initial responses to escalation.

17. Comments & Recommendations

There are four recommendations for consideration based on the assessment of cases for this period. Placing these into an action plan to compliment the high-level actions from the FTSU Board Reflection and Planning tool is recommended. The board reflection and planning tool should be completed every two years by the board as a reflection exercise. This can be done as part of a board seminar. This will need to be periodically reviewed across the two years to monitor progress on any actions.

1. Given the high number of patient safety concerns raised in Emergency and Acute Medicine, further consideration is welcomed regarding how pressures in this directorate are reviewed and addressed. Consideration is also welcomed regarding how staff in this area are supported during periods of increased service pressure.
2. When looking at the theme of Worker Safety/Wellbeing we see this predominantly relates to impact from perceived incivility in the workplace. Consideration is welcomed on how awareness around personal impact and incivility in the workplace can be emphasised with staff via either training or internal communications.
3. Discrimination and Inequality is not a leading theme, we do however see over 50% of these cases coming from within one directorate. Further exploration of this at a local level in collaboration with the guardian could be beneficial. It could be inciteful to understand staff experience in this area and whether team or leadership culture is impacting this data. There is currently incivility work taking place in each directorate and this insight could strengthen that.
4. Consideration to review awareness of objectivity and fairness within internal recruitment processes. Staff also would benefit from being able to ensure meaningful feedback is available to unsuccessful candidates if requested.

18. Staff Feedback

Please note this feedback is written by staff and has not been edited or changed.

Would you recommend the Guardian Service to a colleague?

- The Guardian Service is a lifeline. I really hope this independent continues to stay at Medway for the duration of my career here.
- The Guardian is a great addition to Medway Hospital. Having that support available and onsite makes all the difference.
- The level of service provided by the Guardian is on another level. When we feel failed , the Guardian has helped us keep the faith.
- Tasha Barrett has been extremely supportive and is a credit to herself and the Guardian service. she is always going above and beyond to assist were possible
- The Guardian Service delivered by the Guardian is excellent and highly valued.
- The Guardian has been fantastic, I cannot fault her communication, her approachability and would be happy to go to her with anything I think needs escalating!!
- The Guardian is very helpful and now we have a outside company to speak up to, this is in the best interests of everyone who needs to this be it for any reason.
- No Thank you
- Very helpful and I felt heard. Was very polite and nice and also said if I ever need anything else then just to contact her straight away.

- The Guardian actively listens and helps you feel heard, this helps validate your own emotions and helps to process them.
- The guardian service helps you find your own voice so you can be heard.
- The Guardian has yet again stood up for not only myself, but my colleagues as well. The Guardian validated our feelings and helped us to safely vent frustrations and anxiety
- I don't have faith the trust to follow policy. its evidently one rule for staff another for senior management!
- I am pleased to have the opportunity to speak up and believe it is vital that we do when things are not right.
- There were no repercussions on me, which is always the fear when speaking out. The Guardian was amazing and made me feel safe, listened to & explained the outcome.
- no one should have to take bullying at work
- Very quick to respond and I felt as if she really cared about my concern. Kept my updated within a very suitable time frame.

Meeting of the Trust Board

Meeting Date: 1st July 2026

Title of Report	Trust Risk Register and Issues Log Report			Agenda Item	5.2
Stabilisation Plan Domain	Culture	Performance	Governance and Quality	Finance	Not Applicable
			✓		
CQC Reference	Safe	Effective	Caring	Responsive	Well-Led
	✓	✓		✓	✓
Author and Job Title	Claire Cowell, Integrated Governance Lead				
Lead Executive	Evonne Hunt, Chief Nursing Officer				
Purpose	Approval		Briefing		Noting ✓
Proposal and / or key recommendation:	The Trust Board is asked to note the current position of the Trust Risk Register and Issues Log , including extreme risks, significant issues and overdue actions.				
Executive Summary	This report summarises the status of the Trust’s risks and issues as at 1 June 2026. There are 180 open risks and 223 open issues. Key changes include: • Increase in approved risks • Rise in overdue actions • Stable number of extreme risks and significant issues • Completion of the ISO 31000:2018 Gap Analysis • Inclusion of new analyses: average duration of open risks and distribution of risks across Divisions				
Issues for the Board / Committee Attention:	• 14 risks have actions overdue >6 months • 35 risks not reviewed within timeframe • 7 extreme risks remain active • 2 significant issues remain open • Several risks >3 years old require strengthened closure trajectories • ISO 31000 Gap Analysis identifies three partially compliant areas requiring action				
Committee / Meetings at which this paper has been discussed / approved: Date:	Quality Assurance Committee 15 th June 2026.				

Board Assurance Framework / Risk Register:	BAF presented separately.			
Financial Implications:	None directly; several risks relate to estates and digital investment requirements.			
Equality Impact Assessment and / or patient experience implications	Effective risk management supports improved patient safety and experience. No adverse equality impacts identified.			
Freedom of Information status:	Disclosable	✓	Exempt	

Trust Board

Risk Register & Issues Log Report

Report Author:
Claire Cowell, Integrated Governance Lead



Executive Risk Summary

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 **Trust Risk Register and Issues Log**, direction of travel, and a comparison summary of all risks/issues, with a particular focus on the extreme risks and significant issues.

The report covers the month of **May 2026** and the data download was completed on the 1st June 2026. There are a total of **180** risks opened on the risk register. This is broken down as follows in Table 1.

Table 1: Risk Status	Mar-26	Apr-26	May-26	Trend
New Risks Added	44	13	34	↑
Risks Awaiting Initial Review	41	39	35	↓
Risks Awaiting Approval at Divisional Level	21	29	23	↓
Risks Awaiting Approval at Executive Level	0	1	0	↓
Approved Risks	103	111	122	↑
Approved Risks with Actions Overdue by more than 6 months	14	9	14	↑
Approved Risks Reviewed within Timeframe	70	99	87	↓
Approved Risks <u>Not</u> Reviewed in Timeframe	33	12	35	↑
Approved Risks Not Reviewed for more than 12 months	0	0	0	→
Approved Risks Older than 3 Years	7	6	7	↑
Rejected Risks	17	34	26	↓
Closed Risks	3	10	4	↓

Table 2: Of the 122 Approved Risks	Total	Since Previous Month
Extreme Risks (rated 15 ≥)	7	→
High Risks (rated 8 - 12)	87	↑
Moderate Risks (rated 4 – 6)	25	↑
Low Risks (rated 1 – 3)	3	→

Executive Issue Summary

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

There are a total of **223** issues opened on the Issues Log. This is broken down as follows in Table 1.

Table 1: Issue Status	Mar-26	Apr-26	May-26	Trend
New Issues Added	6	7	11	↑
Issues Awaiting Initial Review	16	18	12	↓
Issues Awaiting Approval at Divisional Level	0	6	9	↑
Issues Awaiting Approval at Executive Level	0	0	0	→
Approved Issues	212	203	202	↓
Approved Issues with Actions Overdue by more than 6 months	21	33	26	↓
Approved Issues Reviewed within Timeframe	130	163	121	↓
Approved Issues <u>Not</u> Reviewed within Timeframe	82	40	81	↑
Approved Issues Not Reviewed for more than 12 months	0	0	1	↑
Approved Issues Older than 3 Years	33	35	38	↑
Rejected Issues	8	14	10	↓
Closed Issues	1	18	4	↓

Table 2: Of the 202 Approved Issues	Total	Since Previous Month
5 – Significant	2	→
4 – High	70	↓
3 – Moderate	102	↑
2 – Low	28	↓
1 – Insignificant	0	↓

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

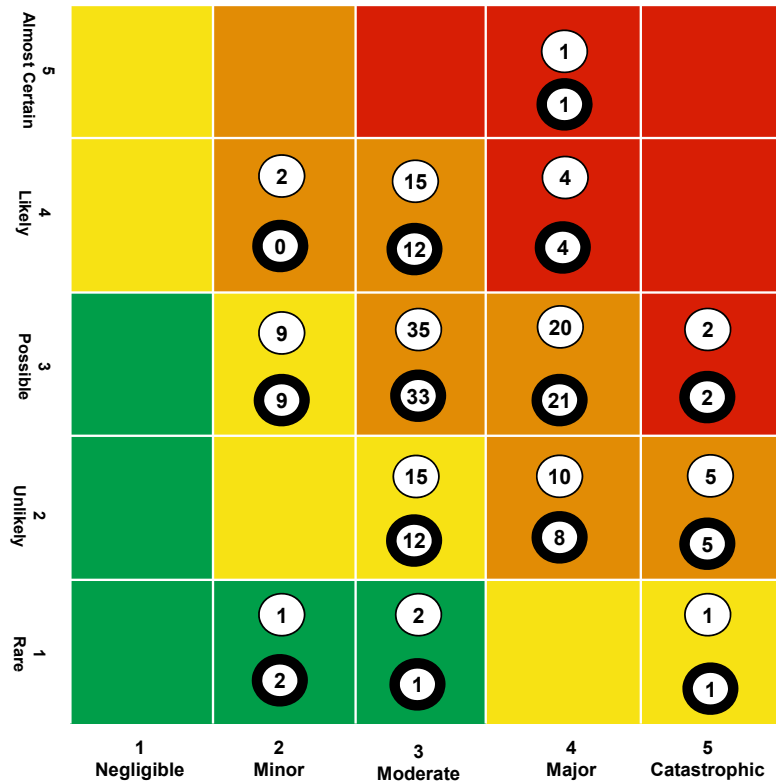
Extreme risks are reviewed fortnightly by the risk owner and monthly at Divisional governance meetings.

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.

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.



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

Risk ID	Division	Risk Title	Exec Owner	Direction of Score	Action Status
1684	Corporate	Risk of elevated SHMI mortality indicator impact Trust reputation and patient confidence	CMO	—	R
2068	Corporate	Risk of patient safety and care quality impact due to EPR/EPMA system limitations	COO	—	G
2158	Corporate	Risk of infrastructure failure and compromised clinical safety due to delayed maintenance	CEO	—	A
2672	Medicine & Emergency Care	Risk of patient harm due to demand exceeding organisational capacity (provision of care in corridors)	COO	—	R
2673	Medicine & Emergency Care	Risk of patient harm due to extended ED waiting times (>12 Hours)	COO	—	R
1965	Corporate	Risk of Cyber Attack impacting Trust Information Systems and IT Infrastructure	COO	—	G
2166	Corporate	Risk of Fire Safety Breach due to Non-Compliance with HTM 05-01: Managing Healthcare Fire Safety	CEO	—	G

Action Status Key:

G - All actions within timescale at point of last review

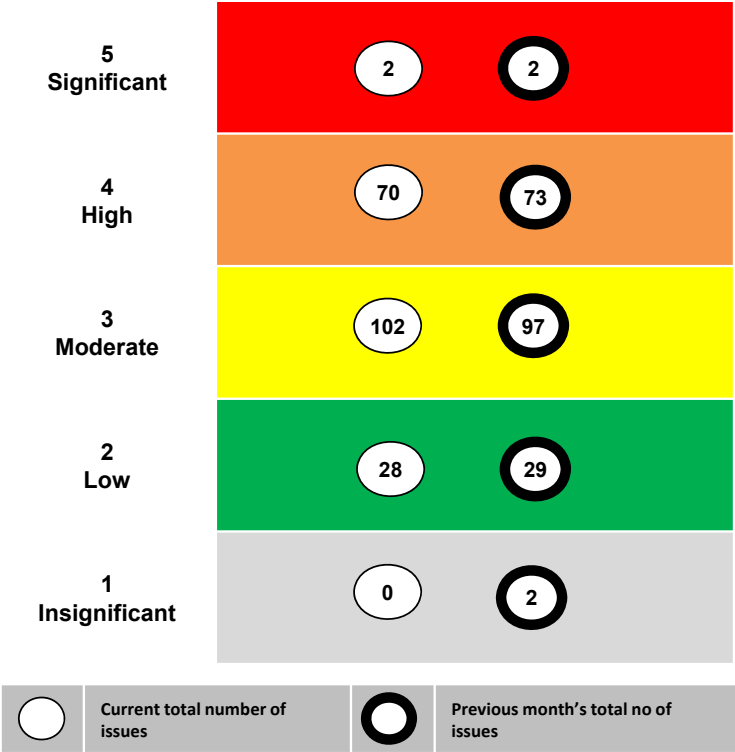
A - Actions about to become overdue at the point of last review

R - 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.



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

Issue ID	Division	Issue Title	Exec Owner	Direction of Rating	Action Status
2083	Corporate	Non-Compliance with Records Management Code: Medical Records Not Properly Culled or Destroyed	COO	—	R
2666	Medicine and Emergency Care	Critical Depletion of Neurology Consultant Workforce Impacting Service Capacity and Patient Care	CMO	—	G

Action Status Key:

G - All actions within timescale at point of last review	A - Actions about to become overdue at the point of last review	R - Actions overdue at the point of the last review

Approved Extreme Risks (15 and above)

Slides 7 to 13 set out the organisation's approved extreme risks. The Committee is asked to note the points highlighted.

Risk 1684: Risk of elevated SHMI mortality indicator impact Trust reputation and patient confidence	Slide 7
Risk 2068: Risk of patient safety and care quality impact due to EPR/EPMA system limitations	Slide 8
Risk 2158: Risk of infrastructure failure and compromised clinical safety due to delayed maintenance	Slide 9
Risk 2672: Risk of patient harm due to demand exceeding organisational capacity (provision of care in corridors)	Slide 10
Risk 2673: Risk of patient harm due to extended ED waiting times (>12 Hours)	Slide 11
Risk 1965: Risk of Cyber Attack impacting Trust Information Systems and IT Infrastructure	Slide 12
Risk 2166: Risk of Fire Safety Breach due to Non-Compliance with HTM 05-01: Managing Healthcare Fire Safety	Slide 13

ID	Date Added	Date Approved	Description	Domain	Initial Score C x L	Current Score C x L	Target Score C x L	Trust Risk Appetite	Existing Controls	Actions	Action Due Date	Exec Lead	Proposed Date for Closure	Confidence in Achieving Closure
1684	31/05/2023	25/07/2023	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. <i>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 patients stay 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 2222 calls, Sepsis pathways, pneumonia and avoidable deconditioning and deterioration particularly in ED and inpatients who are NCTR. Clinical pathway outlier groups in the trust SHMI dataset currently is Pneumonia, COPD and UTI.</i>	Quality / Complaints / Audits	4 x 2 (8)	4 x 5 (20)	4 x 1 (4)	Low 1-3	Palliative & End-of-Life Care: Monthly meetings with community palliative care to reduce avoidable admissions. EOL dashboard development underway; awaiting EPR fields. PEOLC system update going live. Frailty: Frailty Summit scheduled; frailty SDEC reopening and pre-72h community model being planned. Deteriorating Patients & Deconditioning: Deteriorating Patient and Avoidable 2222 workstreams established; A3 in development. Deconditioning Group established; harms recorded on Datix. Learning from Deaths: LfD pathway refreshed and pending MMSG sign-off. SJR training programme in development; reviewer recruitment ongoing. M&M audit data presented to divisions for learning. Sepsis & Pneumonia: Sepsis 6 bundle training underway; paediatric sepsis e-learning becoming mandatory. Pneumonia nurse in post; monthly audits commenced. CURB-65 education and 4-hour antibiotic compliance monitored.	1. Palliative & End-of-Life Care - Monthly meeting with community palliative care to review causes of avoidable admission. End of Life (EOL) dashboard. 2. Frailty Pathways - Confirmation date for Frailty SDEC re- opening. Community stake holder meeting to be organised and scoping of Pre- 72 hours planned. 3. Deteriorating Patients & Deconditioning - Stakeholders to be agreed for the Deteriorating Patient and Avoidable 2222 workstreams. 4. Learning from Deaths - Map this years key priorities. LfD pathway to be completed. New TOR and annual work plan for MMSG. Present M&M audit data to divisions. Finalise SJR training programme. M&M best practice guide/SOP to be drafted. 5. Clinical Pathways (Sepsis QIP and Pneumonia QIP) - Expansion of the adult sepsis bundle. Establishment of a robust, trust-wide sepsis audit. Paediatric sepsis bundle to be made mandatory. Pneumonia Group to improve correct antibiotic prescribing. Education with staff for CURB score recording. Pneumonia nurse and monthly audit of Pneumonia treatment to commence.	31/03/2026 30/04/2026 30/04/2026 30/06/2026 30/09/2026	Chief Medical Officer	30/09/2026	Low

The target closure date is currently September 2026. Given that a number of identified actions are already overdue, the target date is unlikely to be achieved, this is reflected in the low confidence level given. The risk was originally raised 3 years ago, with an initial risk score of 6, this increased to a score of 16 in June 2025 and again to 20 in February 2026, which indicates that the actions taken to-date have not had an impact on risk mitigation. The target date for closure needs review, in line with a full review of the actions and their respective completion dates. The risk owner should identify a trajectory for risk reduction, to establish a clear correlation between identified mitigating actions and risk score reduction.

ID	Date Added	Date Approved	Description	Domain	Initial Score C x L	Current Score C x L	Target Score C x L	Trust Risk Appetite	Existing Controls	Actions	Action Due Date	Exec Lead	Proposed Date for Closure	Confidence in Achieving Closure
2068	13/05/2024	31/05/2024	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.	Corporate / Business Interruption	4 x 4 (16)	4 x 4 (16)	4 x 1 (4)	Moderate 4-6	EPMA / Medicines Safety - Clinical decision support alerts active for allergies, interactions and maximum dose limits for key drugs. - Interim EPMA pharmacy resource in post and progressing EPMA-related items. - Prescriber education in place to mitigate known EPMA limitations. Blood Transfusion - Blood transfusion prescribing remains on paper with mandatory training and QPulse pathway available when charts are unavailable. - Blood transfusion workflow currently in testing ahead of deployment. Point of Care Testing (POCT) - POCT blood gas connectivity launched successfully (29/04/26). - New blood glucose machines and middleware procured; integration work underway. - POCT database continues to record results correctly while EPR ranges are reviewed. EPR Functionality & Workflow Controls - ED discharge summary removed to prevent reconciliation errors. - Vendor engagement ongoing for dose-range limits, ORM enhancements and ED location issues. - Known EPR limitations mitigated through local workarounds and staff training.	- Blood Transfusion implementation - OP Deployment - Dose Range Limits - ORM Proposal - Results Acknowledgement - Solution for ED EPR Bed Allocation - Review Lack of Dose Range Limits when Prescribing on EPMA - Verify ED Bed Allocation - POCT 1539, 1488 integration into EPR - ED Location against patient records	30/06/2026 31/07/2026 18/08/2026 31/12/2026 31/12/2026 Complete Complete Complete Complete Complete Complete	Chief Operating Officer	31/12/2026	Medium

The target closure date is currently December 2026, with a medium confidence level of reaching this. A number of actions have been closed, with the remaining actions on-track to close within the identified timeframes. The current risk score of 16 indicates that there is a 60-80% probability of harm being caused to patients as a result of the EPMA and EPR system limitations. The risk owner should review whether the likelihood/probability score is appropriate given the number of mitigations in place.

ID	Date Added	Date Approved	Description	Domain	Initial Score C x L	Current Score C x L	Target Score C x L	Trust Risk Appetite	Existing Controls	Actions	Action Due Date	Exec Lead	Proposed Date for Closure	Confidence in Achieving Closure
2158	31/07/2024	27/08/2024	Risk of infrastructure failure and compromised clinical safety due to delayed maintenance IF the Trust's backlog maintenance liability (now assessed at £163m following the 2025 six-facet survey update) continues to exceed available capital funding, THEN critical infrastructure will further deteriorate, LEADING TO increased risk of infrastructure failure, compromised clinical safety, regulatory non-compliance, and disruption to essential healthcare services. This reflects the updated backlog position and critical risk profile, which identifies £65m of critical infrastructure risk requiring immediate intervention.	Business Objectives / Projects	4 x 5 (20)	4 x 4 (16)	4 x 1 (4)	Moderate 4-6	- Six-facet survey updated December 2025, confirming deterioration and increased backlog. - Estates Strategy and Strategic Asset Management Plan approved, establishing a structured ISO 55000-aligned framework. £22m Estates Safety Fund secured (theatre ducts, fire safety, demolition). - Capital programme for 2026–27 in development with NHSE engagement. - Condition-based asset register and maintenance team in place. - Ongoing replacement programmes (theatre lights, heating pumps, flooring, drainage). - Development of critical asset register underway.	- 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. - Establish Backlog Prioritisation Group: Convene a multi-disciplinary group (Estates, Finance, Clinical Safety, Governance) to agree prioritisation criteria for backlog spend. - Develop and publish a trajectory for risk score reduction, as requested by FPPC (23/04/2026). - Critical Asset Register Update to address the gap of obsolete systems (POD, nurse call, theatre lights, distribution boards, heating pumps, roof leaks, flooring, drainage). - Identify backlog items. - Establish Capital Pipeline for 2024/25. - NHSE Funding Bid Submission to address funding shortfall; reliance on capital allocations. - Create Model for Maintenance Priorities and Capital Pipeline Tracking. - Completion of resurvey to address lack of updated condition data; gaps in assurance.	31/03/2026 30/06/2026 31/07/2026 26/02/2027 Complete Complete Complete Complete Complete	Chief Executive	31/07/2030	Medium

This risk has been on the risk register since 2024, in which time the backlog maintenance position has worsened from £120 to £163million, which is reflected in the risk score of 16. The target date for closure is 2030 which reflects the volume of work and scale of investment required to mitigate the risk, however only short-term actions have been identified. The risk owner should identify the longer term actions and also indicate a trajectory for risk reduction and ultimately closure.

ID	Date Added	Date Approved	Description	Domain	Initial Score C x L	Current Score C x L	Target Score C x L	Trust Risk Appetite	Existing Controls	Actions	Action Due Date	Exec Lead	Proposed Date for Closure	Confidence in Achieving Closure
2672	12/12/2025	10/03/2026	Risk of patient harm due to demand exceeding organisational capacity (provision of care in corridors) IF patient demand exceeds available organisational capacity, THEN care may be delivered in corridors and other non-designated areas LEADING TO significant challenges to maintaining patient safety, dignity, and staff wellbeing, compromised quality of care, increased pressure on clinical teams, and reduced compliance with national performance and safety standards, particularly during periods of heightened demand such as winter.	Impact on the safety of Patients, Staff or Public	4 x 4 (16)	4 x 4 (16)	4 x 2 (8)	Low 1-3	- Daily bed management meetings: Site-wide coordination of patient flow, escalation of bottlenecks, and prioritisation of discharges. - Real-time capacity dashboards: Electronic monitoring of bed occupancy, ED attendances, and flow indicators. - Escalation protocols: Clear triggers for opening surge areas, redeploying staff, and activating winter plans. - Winter resilience plans: Pre-agreed actions including additional beds, discharge lounges, and community step-down capacity. - Clinical safety oversight: Matron and senior nurse rounds in corridor areas to monitor patient safety and dignity. - Infection prevention controls: Enhanced cleaning schedules, PPE compliance, and monitoring of corridor care environments. - System partner coordination: Daily calls with community, social care, and ambulance services to unblock flow. - Executive oversight: Weekly review of capacity pressures and corridor care incidents at Trust Executive level. - Governance reporting: Risk register entry, board assurance framework linkage, and escalation to committees.	- AMU Capacity: Beds on Lister ward need to be converted back to standard AMU model to support with facilitating transfers of patients requiring 24/48 hours of clinical input. - Trust requires system support with discharging NCTR patients from acute hospital. - Improve FLOW and Discharge: Linked to UEC and 26/27 Plans, improve Flow and discharge of patients. - Increase of Virtual Ward Capacity	31/05/2026 01/06/2026 31/08/2026 Complete	Chief Operating Officer	31/03/2026	Low

The risk has only been on the Trust risk register for 6 months, despite this being a known risk for a significant period of time, therefore it is not possible to review how the risk score has changed over time in correlation to patient activity/demand etc. The target date for risk closure has since passed (March 2026). In addition the risk has not been reviewed and/or updated since April 2026 despite 'extreme' risks requiring review and update every 2weeks. This risk urgently requires review and update.

ID	Date Added	Date Approved	Description	Domain	Initial Score C x L	Current Score C x L	Target Score C x L	Trust Risk Appetite	Existing Controls	Actions	Action Due Date	Exec Lead	Proposed Date for Closure	Confidence in Achieving Closure
2673	12/12/2025	10/03/2026	Risk of patient harm due to extended ED waiting times (>12 Hours) IF patients wait more than 12 hours in the Emergency Department (ED), THEN this may result in delays to assessment, treatment, and admission, LEADING TO clinical deterioration, increased pressure on staff, compromised patient safety and dignity, heightened operational strain, reputational damage to the Trust, and increased regulatory scrutiny, as well as reduced compliance with national patient safety and performance standards.	Impact on the safety of Patients, Staff or Public	4 x 4 (16)	4 x 4 (16)	4 x 2 (8)	Low 1-3	- Emergency Department escalation protocols: Clear triggers for senior clinical review, site escalation, and activation of surge capacity when breaches approach. - Monitoring of ED attendances, breaches, and bed availability to support proactive decision-making. - Daily site operations meetings: Coordinated oversight of patient flow, discharge planning, and escalation of bottlenecks. - Clinical safety oversight: Senior nurse/matron rounds in ED to monitor patients waiting >12 hours, ensuring safety checks and escalation. - Discharge improvement programmes. - System partner coordination: Daily calls with community, social care, and ambulance services to unblock flow and reduce ED congestion. - Workforce deployment. - Executive oversight: Weekly review of ED performance and 12-hour breaches. - Governance reporting: Risk register entry, escalation to Quality Assurance Committee, and linkage to Board Assurance Framework.	- Increase of Virtual Ward Capacity - AMU Capacity: Beds on Lister ward need to be converted back to standard AMU model to support with facilitating transfers of patients requiring 24/48 hours of clinical input. - Trust requires system support with discharging NCTR patients from acute hospital.	Complete 31/05/2026 01/06/2026	Chief Operating Officer	31/03/2026	Medium

The risk has only been on the Trust risk register for 6months, despite this being a known risk for a significant period of time, therefore it is not possible to review how the risk score has changed over time in correlation to patient activity/demand etc. The target date for risk closure has since passed (March 2026) and the confidence level 'Medium'. Given the target date for closure has passed the confidence level should be 'Low'. In addition the risk has not been reviewed and/or updated since April 2026 despite 'extreme' risks requiring review and update every 2weeks. This risk urgently requires review and update.

ID	Date Added	Date Approved	Description	Domain	Initial Score C x L	Current Score C x L	Target Score C x L	Trust Risk Appetite	Existing Controls	Actions	Action Due Date	Exec Lead	Proposed Date for Closure	Confidence in Achieving Closure
1965	14/02/2024	03/09/2024	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.	Corporate / Business Interruption	5 x 3 (15)	5 x 3 (15)	5 x 2 (10)	Moderate 4-6	- 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.	- Cyber Security Strategy - NHSE Cyber Funding	Complete Complete	Chief Operating Officer	30/06/2026	High

This risk has been on the risk register for circa 2 years, with last review taking place in May 2026. The latest risk review has not taken into account the recent cyber attack on the organisation (Malicious Email Event). The target date for closure is June 2026 with an associated 'High' confidence level. This however is contradicted by the number of gaps in controls currently identified. In addition, all actions are marked as 'complete'. This risk requires review to take into account the latest cyber security event, and to identify mitigating actions against each of the gaps in control. This will likely result in an extended target date for closure which should also be reflected.

ID	Date Added	Date Approved	Description	Domain	Initial Score C x L	Current Score C x L	Target Score C x L	Trust Risk Appetite	Existing Controls	Actions	Action Due Date	Exec Lead	Proposed Date for Closure	Confidence in Achieving Closure
2166	05/08/2024	27/08/2024	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 damage, disruption to patient care, regulatory non-compliance, reputational harm, and financial impact arising from recovery costs, legal claims, fines, or insurance consequences.	Statutory Duty / Inspections	5 x 3 (15)	5 x 3 (15)	5 x 1 (5)	Low 1-3	- Mandatory fire safety training: Annual fire safety training for all staff, with optional fire warden training available Trust wide. 24/7 in house fire response capability: Dedicated team attending all detector and call point activations around the clock. - Routine fire risk assessments: Departmental fire risk assessments undertaken to identify and manage local hazards. - Fire door inspection and maintenance programme: Annual inspections, with repair or replacement carried out as required. - Fire safety involvement in capital planning: Fire safety team embedded in the design and planning stages of all capital projects. - Regular fire alarm testing and engineering presence: Weekly alarm tests and a five day on site presence from fire alarm engineers. - Systematic installation of a new fire alarm system: Ongoing upgrade programme to replace outdated panels and improve reliability. - Fire damper inspections completed: Inspections undertaken to ensure compliance and functionality. - Post Grenfell cladding replacement: All cladding on site replaced to meet updated fire safety standards. - Fire safety walkarounds: Regular checks by the fire safety team to verify controls and identify issues. - Capital investment in fire safety infrastructure: Funding allocated for compartmentation, fire doors, fire alarm replacement, and emergency lighting. - HBN compliant ED build with misting system request noted: Ensures compliance despite changes during construction. - Smoking reduction group established: Reduces ignition risks associated with smoking behaviours. - Completed ward level fire safety works: Pembroke works complete; Nelson Ward fire alarm fully operational.	- Capital program to continue fire works in the Trust, and in particular to address Panel 5, Red Zone. - Fire Paper and Strategy. - Compartmentation works to Pembroke Ward - Compartmentation Site Wide	01/12/2026 21/06/2030 Complete Complete	Chief Executive	02/10/2028	Medium

The target date for closure is 2028, however the actions identified to mitigate the risk do not reflect how this risk will be proportionally reduced over time. I.e. there is a single action for 2026 and another for 2030 (which exceeds the risk closure date). The risk progress notes capture detail regarding a regular compartmentation action plan, but this is not reflected in the associated actions. Given the duration over which this risk is intended to be reduced, the risk owner should identify a trajectory for risk reduction and ultimately closure, which correlates to the respective actions.

Approved Significant Issues

ID	Date Added	Date Approved	Division	Issue Description	Domain	Priority Rating	Existing Controls	Actions	Action Due Date	Exec Owner	Proposed Date for Closure	Confidence in Achieving Closure Date
2083	20/05/2024	01/07/2024	Health Records	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.	Statutory Duty / Inspections	5 - Significant	There is now a Health Records Handbook in place that reflects the requirements of the NHS Records Management Code of Practice. Destruction Pilot ongoing.	- Progress VCP request to ensure minimum staffing health records is maintained. - Business Case - Tighter process to be implemented around files being destroyed - Review of documents located at off site storage (Regal)	29/05/2026 Complete Complete	Deputy Chief Executive	05/11/2026	Medium
2666	05/12/2025	05/02/2026	Medicine and Emergency Care	Critical Depletion of Neurology Consultant Workforce Impacting Service Capacity and Patient Care The Neurology service is facing a critical depletion of consultant workforce. Of the four budgeted consultant posts, one consultant is on maternity leave until July 2026, and two consultants are confirmed to leave in December 2025 and January 2026. This will leave the service with only one consultant between January to March 2026, significantly reducing capacity for outpatient clinics and in-reach cover. Although two substantive posts have been offered, one new consultant will not start until early March 2026 and the second has an unconfirmed start date. Recruitment attempts for a fixed-term maternity cover have been unsuccessful, meaning the service will remain one consultant down until July 2026.	Human Resources / Staffing / OD / Competence	5 - Significant	One consultant remains in post to provide continuity of service during the depletion period. Two consultants have been successfully appointed, with one due to start beginning of March 2026 and another with a start date pending. The maternity absence is known and scheduled, allowing workforce planning and governance oversight. Recruitment attempts made for fixed-term cover. Request for an agency locum consultant for three months approved at divisional VCP on 27/11/2025. Awaiting outcome of Exec VCP.	- Recruitment Attempts for Fixed-Term Cover. - Workforce planning around maternity leave. - Agency Locum Request - Onboard substantive recruits. - Maintain continuity of service.	12/06/2026 26/06/2026 Complete Complete	Chief Medical Officer	31/07/2026	Medium

Average Duration of Open Risks

The average length of time risks remain open varies across risk levels:

- **Extreme risks** have been open for an average of **14 months**, reflecting the complexity and multi-factorial nature of these risks.
- **High risks** have been open for an average of **13 months**, consistent with operational and clinical risk profiles.
- **Moderate risks** remain the longest-standing category at **17 months**, influenced by several corporate risks that have been open for more than three years.
- **Low risks** have been open for an average of **12 months**, reflecting a small and stable cohort.

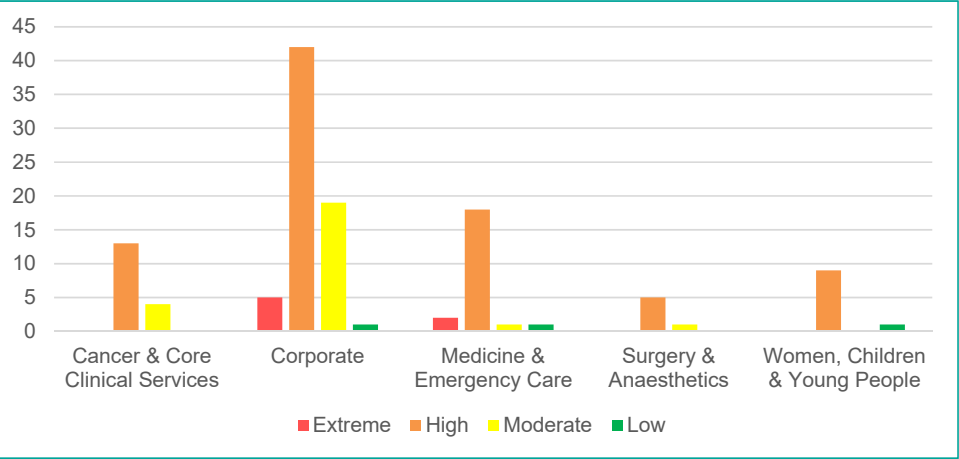
Key message: Moderate risks represent the most prolonged area of exposure. A strengthened closure trajectory and targeted review of long-standing corporate risks will support improved risk maturity and alignment with the Trust's revised risk appetite.

Risk Level	Number of Open Risks	Average Duration Open	Commentary
Extreme	7	14 months	Driven by long-standing risks including SHMI and infrastructure.
High	87	13 months	Majority are operational/clinical risks with steady review cycles.
Moderate	25	17 months	Longest standing group due to several risks >3 years old.
Low	3	12 months	Small cohort, durations influenced by stable, low impact risks,

Distribution of Risks Across Division's

The distribution of approved risks varies across Divisions, reflecting differences in service complexity, operational scale, and governance maturity. Corporate and Medicine & Emergency Care hold the largest proportion of risks, with other Divisions maintaining smaller but important thematic risk profiles.

- **Corporate Division** holds the highest number of risks, including long-standing strategic, estates, digital, and statutory-compliance risks. Finance, HR/OD, Business Intelligence hold thematic risks relating to data quality, workforce, contract management, and organisational culture.
- **Medicine & Emergency Care** has a significant volume of operational and patient-safety risks, reflecting sustained pressure on flow, capacity, and emergency pathways.
- **Surgery & Anaesthetics** holds a smaller number of risks, primarily relating to theatres, peri-operative processes, equipment reliability, and workforce capacity.
- **Cancer & Core Clinical Services** maintains a focused risk profile linked to diagnostics, imaging, and equipment dependencies.
- **Women, Children & Young People** holds a defined set of risks associated with specialist equipment, screening pathways, and service continuity.



Key message: The distribution of risks aligns with organisational complexity. Corporate and Medicine & Emergency Care account for the majority of open risks, while Surgery & Anaesthetics and other specialist Divisions hold smaller but clinically significant risk portfolios requiring continued oversight.

Approved Risks & Issues Older than 3 Years

There are a total of 7 approved risks on the risk register that are identified as being older than 3 years as follows:

ID	Date Added	Risk Title	Current Rating	Exec Lead	Proposed Date for Closure	Confidence in achieving closure date
1376	28/11/2019	Risk of Falls from Height in Multi-Level Car Park	8	CEO	31/03/2026	Medium
1256	18/06/2020	Risk of Compromised Patient Safety and Care Due to Non-Compliance with Fundamentals of Nursing Care	6	CNO	01/04/2027	Medium
1333	10/03/2022	Increased Nosocomial Transmission Risk Due to Inadequate Mechanical Ventilation	9	CNO	28/12/2026	Low
1452	13/10/2022	Risk of non-compliance with Ionising Radiation Regulations 2017 within Nuclear Medicine	9	COO	30/06/2026	Low
1486	29/11/2022	Risk of delayed Diagnostic Imaging due to Lack of Neurologist Countersignature	9	COO	31/08/2026	Medium
1545	23/01/2023	Consent to Blood Transfusion Risk	8	CMO	26/06/2026	Medium
1684	31/05/2023	Risk of elevated SHMI mortality indicator impact Trust reputation and patient confidence	20	CMO	30/09/2026	Low

There are a total of 38 approved issues on the log that are identified as being older than 3 years. Of these, 7 are rated Low, 21 are Moderate, 10 are High and none are rated Significant. The issues rated as High are summarised below:

ID	Date Added	Issue Title	Priority Rating	Exec Lead	Proposed Date for Closure	Confidence in achieving closure date
1300	15/11/2021	Inability to Access Patient Records at Community Antenatal Clinics	4 – High	CNO	31/07/2026	Medium
1364	27/06/2022	Interventional Radiology Staffing Gaps Causing Service Disruption	4 - High	CMO	01/09/2026	Medium
1372	30/06/2022	Poor compliance with Trust Wide Resuscitation Training	4 - High	CMO	31/07/2026	Low
1433	05/07/2022	Delayed Recording of Observations on Electronic Patient Record (EPR)	4 - High	CMO	31/07/2026	High
1408	14/07/2022	Unreliability and Repeated Failures of the Emergency Pager/Bleep System	4 - High	COO	31/03/2026	Medium
1497	09/12/2022	PoCT Inability to Safely Report Rapid Molecular Test Results	4 - High	COO	31/03/2026	Medium
1556	31/01/2023	Shortage of Falls Equipment Across the Trust	4 - High	CNO	22/05/2025	High
1584	09/02/2023	Incorrect Patient Data Due to Inappropriate Use of Copy and Paste in Sunrise EPR	4 - High	COO	26/06/2026	Medium
1645	17/04/2023	Unsupported Server Operating Systems	4 - High	COO	29/05/2026	Medium
1657	04/05/2023	Missed Medication Administration on Sunrise	4 - High	COO	31/07/2026	Medium

Closed Risks & Issues

A total of **4 risks** were closed in May 2026 as follows:

ID	Date Added	Risk Title	Reason for Closure
2619	13/10/2025	Failure to Achieve CNST Compliance Due to Failure to meet Safety Action 1 Targets and Safety Action 8 Training Shortfalls	CNST year 7 closed on 31st March 2206. Risks relating to year 7 are no longer relevant as year 7 has closed. CNST year 8 will commence in May 2026. Declared non compliant on safety action 1 and complaint with safety action 8. Once year 8 received Trust position will be reviewed and consideration if a new risk needs to be developed for year 8 CNST targets. Current risk score of 12 tolerated as safety action 1 was not met.
2621	13/10/2025	Risk of compromised Maternity Care due to Inexperienced Midwifery Workforce Skill Mix	Divisional Board approved for closure as there have been no issues or incidents reported relating to staff competency over the last 6 months.
2628	22/10/2025	Fire Safety Risk: Obstruction of Fire Exit by Sleep Clinic Storage Cages	Confirmed closure of a fire safety risk related to obstruction of an exit in the sleep clinic, which has now been resolved.
1979	01/03/2024	Risk of Patient Harm: Metavision System Failure due to unsupported IT Systems	Metavision upgrade has been completed.

A total of **4 issues** were closed in May 2026 as follows:

ID	Date Added	Issue Title	Reason for Closure
2608	08/10/2025	Inadequate Security of Kitchen Door Magpies OPD	Key safe lock has been installed which has mitigated the risk.
2623	17/10/2025	Recurrent Network Connectivity Failures Affecting Follow Me Printers in the Fetal Medicine Department	Follow me printer issues have been resolved.
2384	18/03/2025	Lack of Airconditioning in Fetal Medicine and Maternity Care Unit	Air conditioning works completed.
2644	13/11/2025	Immediate Disruption to SMART Service Due to Unlicensed Citrate Buffered NaCl 0.9% Supply	The Pharmacy team has confirmed that updated stability evidence from the manufacturer demonstrates that flucloxacillin and piperacillin/tazobactam are stable for more than 24 hours in normal saline, meaning citrate buffer is no longer required for these agents. Reserved stock remains available for benzylpenicillin. All prescriptions continue to be reviewed by Pharmacy, ensuring safe and controlled practice. The SMART service is now fully operational with no remaining constraints, and the associated action has been completed.

Risk & Issue Projection

No risk or issue ratings increased in May.

ISO 31000:2018 Gap Analysis

A full gap analysis against **ISO 31000:2018 Risk Management** has been completed. The review assessed Trust compliance across all sections of the standard, including principles, framework, and process requirements.

Key Findings:

- The Trust is **largely compliant** with ISO 31000, supported by an in-date and published **Risk Management Framework (CORP-GRL-HAND-1)** and established governance structures.
- **Strong compliance** was demonstrated in: – Leadership and commitment – Roles, responsibilities and accountability – Risk assessment processes – Integration of risk into governance and decision-making – Monitoring, evaluation and continual improvement
- **Partial compliance** was identified in three areas: – Integration of external and internal context – Articulation of risk management commitment – Communication and consultation
- **Improvement actions** have been defined, including: – Adding explicit sections on external and internal context – Developing a Risk Management Resourcing Plan – Creating a structured Communication & Consultation Plan

Status:

The gap analysis is **complete**, and actions have been incorporated into the Risk Management Framework update programme for 2026.

ISO 31000:2018 Gap Analysis

ISO 31000 Section	Compliance Status	Summary of Position
Scope	Compliant	Standard definitions and scope fully met.
Normative References	Compliant	No normative references required.
Terms & Definitions	Compliant	All definitions adopted and reflected in Trust documentation.
Principles	Compliant	Principles embedded within the Risk Management Framework.
Framework – General	Compliant	Framework in place, published, and aligned to governance structures.
Leadership & Commitment	Compliant	Clear executive accountability; QAC designated as risk committee.
Integration	Partially Compliant	External and internal context not explicitly described; requires enhancement.
Design – Understanding Context	Compliant	Internal and external context defined; annual review in place.
Design – Risk Management Commitment	Partially Compliant	Commitment articulated but lacks explicit resourcing detail (budget, training, system capacity).
Design – Roles & Responsibilities	Compliant	Clear roles defined in Framework and ToRs.
Design – Resource Allocation	Compliant	Dedicated risk management function and systems in place.
Design – Communication & Consultation	Partially Compliant	Reporting described but no structured communication plan.
Implementation	Compliant	Framework implemented and embedded across governance.
Evaluation	Compliant	Annual review and monthly reporting in place.
Improvement	Compliant	Framework reviewed regularly; continual improvement evidenced.
Process – General	Compliant	Risk process embedded and aligned to governance.
Process – Communication & Consultation	Partially Compliant	Communication occurs but lacks a formal plan.
Process – Scope, Context & Criteria	Compliant	Scope and criteria clearly defined in Framework.
Process – Risk Identification	Compliant	Risk descriptors and identification processes defined.
Process – Risk Analysis	Compliant	Analysis aligned to DATIX and Framework guidance.

Risks are scored using the NPSA Risk Matrix

	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 in Public
Wednesday, 01 July 2026

Title of Report	Annual review of Board Committee Terms of Reference	Agenda Item	6.1
Author and Job Title	Interim Company Secretary		
Lead Executive	Chief Executive		
Executive Summary	Approval	X	Assurance
			Noting
	The terms of reference of the committees of the Board have been reviewed as part of an annual process to aid the refresh of the governance framework of the Trust This process considers work required to aid compliance with the Provider License undertakings imposed on the Trust, which require completion by the end of Quarter one in the 2026/27 period. To date, the Board has agreed the terms of reference for the Quality Assurance Committee and is now asked to consider the approval of the terms of reference for: • Audit Committee • Remuneration Committee • Finance, Performance and Planning Committee • People Committee • Cash Committee		
Proposal and/or key recommendation:	<i>The Board is asked to</i> 1. Note the amendments to the Committee terms of reference as summarised in section 2 of this report. 2 Note and approve the terms of reference of: • Audit Committee – Appendix A • Remuneration Committee– Appendix B • Finance, Performance and Planning Committee – Appendix C • People Committee – Appendix D • Cash Committee – Appendix E		
Governance Route Meeting: Date submitted:	These terms of reference have been reviewed and endorsed by the committees prior to submission to Board		
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		

Sustainability and/or Public and patient engagement considerations:	None		
Integrated Impact assessment (please mark):	Yes	No	N/A
			X
Appendices:			
Freedom of Information status (please mark):	Disclosable	x	

1.0 Context

The terms of reference of the Board Committees have been reviewed as part of the annual process that enables the identification of mechanisms to enhance effectiveness of performance.

Section two of this report outlines the changes to the terms of reference in light of this review

2.0 Summary of changes to terms of reference

2.1 Audit Committee

The main change to the Audit Committee's duties is in relation to a more arm's length role in relation to its independent scrutiny of risk management, in line with best practice

In May, the Board approved the Quality Committee would become the Risk Committee of the Board, and as a consequence of that agreement the Audit Committee terms of reference have been updated to reflect this role.

This is in line with best practice as most risks in an NHS setting are aligned to quality

Furthermore, this approach enables the Audit Committee to independently assess the effectiveness of the system of internal control, in line with the Corporate Governance Code

The terms of reference are attached as **Appendix A** to this document.

2.2 Remuneration Committee

The Committee's duties have been updated to reflect the separation of the its role from the Nominations Committee.

In addition, the terms of reference were updated to incorporate the role of the Committee in relation Fit and Proper Persons Regulations and the associated policy, which the Committee approved at the April meeting

Other changes include specific duties in relation to performance appraisal, remuneration and succession planning

Lastly, there is a specific regulatory duty pertaining to the approval of the 2026/27 remuneration report, which the Committee approved before it was added to the annual report.

The terms of reference are attached as **Appendix B** to this document.

2.3 Finance, Performance and Planning Committee

The duties of the Committee remain broadly the same, however the narrative has been updated to specify the role of the Finance, Performance and Planning Committee as an assurance rather than an operational committee.

Finance, Performance and Planning Committee remains the committee with oversight for operational performance.

In addition, in section 4.39, the terms of reference of the committee now specifically includes cybersecurity, as part of a digital oversight role that was previously in place

Lastly, there are also standard duties incorporated in relation to commercial contract monitoring

The terms of reference are attached as **Appendix C** to this document.

2.4 Cash Committee

The Cash Committee terms of reference were endorsed by the Finance, Performance and Planning Committee on 18th June and are attached as **Appendix D** to this document

2.3 Finance, Planning and Performance Committee

The duties remain broadly the same, however the narrative has been updated to specify the role of the FPPC as an assurance committee

FPPC remains the committee with oversight for operational performance.

In addition, in section 4.39, the terms of reference of the committee now specifically includes cybersecurity, as part of a digital oversight role that was previously in place

Lastly, there are also standard duties incorporated in relation to commercial contract monitoring

The terms of reference are attached as **Appendix C** to this document.

3.0 Recommendations

The Board is asked to:

1. Note the amendments to the Committee terms of reference as summarised in section 2 of this report.
2. Note and approve the terms of reference of:
 - Audit Committee – Appendix A
 - Remuneration Committee– Appendix B
 - Finance, Performance and Planning Committee – Appendix C
 - People Committee – Appendix D
 - Cash Committee – Appendix E

Title of Document	Audit Committee Terms of Reference
Name of originator/author:	Interim Company Secretary
Name of the responsible committee	Audit Committee
Name of executive lead:	Chief Executive
Ratified by:	Trust Board
Date ratified	
Date issued:	
Review date:	
Version	Version 3.4

Version Control			
Version No	Amendment (include summary detail of changes)	Amended by	Date
V1.	Revised format and content based on HFMA model Terms of Reference.	V1. Re-drafted version	Revised format and content based on HFMA model Terms of Reference.
V2.	Updated to the 2025 standard (pg 4 of 7)	V2. Internal Audit standards	Updated to the 2025 standard (pg 4 of 7)
V3	Annual Review	Company Secretary	May 2026

Audit Committee Terms of Reference

1. Constitution

- 1.1 The Audit Committee (the Committee) is established as a standing Committee in accordance with the Medway NHS Foundation Trust (the Trust) Constitution, Standing Orders and Scheme of Delegation. These Terms of Reference set out the remit, responsibilities, delegated authority, membership and reporting arrangements of the Committee
- 1.2 The Committee is accountable to the Trust Board (the Board) and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the Trust
- 1.3 The Committee is authorised by the Board to act within its Terms of Reference. All employees and individuals appointed by the Trust are directed to co-operate with any request made by the Committee
- 1.4 The Committee will liaise with and function as a resource for other Trust committees and forums, where specific matters are most appropriately considered by the Committee in line with its responsibilities
- 1.5 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and can request the attendance of individuals and authorities outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions
- 1.6 Where the Board scrutiny or decision is required for related matters, the Committee will consider these in advance and act as the sponsor for any recommended action/decision required by the Board
- 1.7 The remit of the Committee is outlined below. The nature of how these are delivered will be determined by the Committee Chair in discussion with the relevant lead executive officer of the Trust.

2. Purpose

- 2.1 The Board is responsible for ensuring there is a system of effective internal control including:
 - i. Management of the Trust's activities in accordance with statute and regulations.
 - ii. The establishment and maintenance of a system of internal control to give reasonable assurance that assets are safeguarded, waste or inefficiency avoided, and reliable financial information produced, and that value for money is continuously sought.

- 2.2 The Committee shall provide the Board with a means of independent and objective review of the Trust's financial, corporate governance, risk management and internal control arrangements. In addition, the Committee shall:
- i. Seek assurance of the independence of external and internal audit through annual assessment.
 - ii. Seek assurance on the Trust's Corporate Governance compliance. This role will be discharged by reviewing assurance reports on key areas.
 - iii. Convene a special meeting of the Audit Committee whereby all members of the Trust Board are invited to attend to approve and sign off the Annual Report & Accounts (full delegation from the Trust Board). This recognises that all Directors are equally and individually responsible for the contents of the Annual Report & Accounts.
 - iv. Report & Accounts (full delegation from the Trust Board). This recognises that all Directors are equally and individually responsible for the contents of the Annual Report & Accounts.
- 2.3 The Committee performs an independent review of the internal control processes across all of the activities of the Trust, and the Charitable Fund and reports findings to the Board.

3. Duties

The duties of the Committee can be categorised as follows:

3.1. Governance, Risk Management and Internal Control

- 3.1.1. The Committee shall independently scrutinise the implementation and ongoing effectiveness of the system of risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.
- 3.1.2. Risk Management: The Committee has responsibility for scrutinising the adequacy of the control framework and the extent to which it enables the Trust to operate within its risk appetite.
- 3.1.3. The Committee's work plan incorporates a review of the organisation's risk management processes, from service to corporate level on a cyclical basis, to gain assurance that systems in place are effective. Internal audit will conduct cyclical independent audits of compliance with the risk management framework and the Audit Committee will receive the results of these reviews and assurance that any recommendations are implemented.
- 3.1.4. In particular the Committee will:
- i. Review the BAF
 - ii. Assure itself of the adequacy and effectiveness of the implementation of the Risk Management
 - iii. Strategy and the Corporate Risk Register (which is overseen by the Quality Committee)

- 3.1.5. Annual Report: The Committee will review:

- i. The adequacy of the Annual Governance Statement together with any accompanying Head of Internal Audit Opinion statement, external audit opinion or other appropriate independent assurances;
- ii. The statements to be included in the Annual Report concerning internal controls and risk management, especially whether the assessment of the Foundation Trust's principal risks is robust; and
- iii. The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- iv. Before the specially convened meeting of the Audit Committee whereby all members of the Trust Board are invited to approve and sign off the Annual Report

3.1.6. Policies: The Committee shall assure itself that there are policies for ensuring compliance with procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority and for the Standards of Business Conduct (which includes bribery and fraud as a component). In addition, significant policies relating to internal control will be included such as the Trust's Expenses Policy.

3.2. Whistleblowing and Fraud

3.2.1. Internal: The Committee shall:

- i. Review the Trust's procedures for detecting fraud.
- ii. Review the Trust's systems and controls for the prevention of bribery and receive reports on non-compliance.
- iii. Review arrangements for the Trust's employees to raise concerns in confidence about possible wrong doing in financial reporting or any other matters

3.2.2. Counter Fraud: The Committee shall:

- i. Review and monitor the organisation's counter-fraud arrangements, through the Local Counter Fraud Specialist's Annual Work Plan, updates and annual report.
- ii. Monitor the policies and procedures relating to counter fraud and anti-corruption activities as set out in the Secretary of State Directions and performed by the Counter Fraud Specialist.

3.3. Assurance

3.3.1. The Committee shall review the findings of other significant assurance functions, both internal and external, and make recommendations to the Board on matters affecting the governance of the NHS Foundation Trust. These could include:

- i. Clinical audit
- ii. Any review undertaken by regulators (e.g. NHSE and Care Quality

- Commission)
- iii. NHS Resolution
- iv. Professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges and accreditation bodies).
- v. The Greener NHS programme via a report from the Sustainability Group

3.4. Internal Audit

3.4.1. The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides independent assurance. Specifically, the Committee will:

- i. Monitor and review the quality and effectiveness of the internal audit function.
- ii. Consider and approve the remit of the internal audit function and ensure it has adequate resources and appropriate access to information to enable it to perform its function effectively and in accordance with the relevant professional standards. The Committee shall also ensure the function has adequate standing and is free from management and other restrictions.
- iii. Consider the appointment of the Internal Auditor, and any questions of resignation and dismissal.
- iv. Review the internal audit strategic and annual plans, consider the major findings of internal audit investigations (and management's response), and ensure co-ordination between the internal and external auditors.
- v. Discuss with the Internal Auditor any matters arising from audit work as appropriate.
- vi. Review and monitor management's responsiveness to the findings and recommendations of the Internal Auditor.
- vii. Meet the Internal Auditor at least once a year, without management being present, to discuss their remit and any issues arising from the internal audits carried out.

3.4.2. The Internal Auditor shall be given the right of direct access to the Chair of the Trust and to the Chair of the Committee.

3.5. External Audit

3.5.1. The Committee will oversee the Trust's relationship with the External Auditor and receive independent assurance reports.

3.5.2. The Committee will assess the Trust's External Auditor's work and fees on an annual basis to ensure the work is of a sufficiently high standard and reasonable, as per section 23(6) of Schedule 7 of the NHS Act 2006.

3.5.3. The Committee will consider and make recommendations to the Council of Governors in relation to the appointment, re-appointment and removal of the appointment of the External Auditor, after following the criteria for such matters agreed with the governors.

3.5.4. The Committee shall, on instruction from the Council of Governors, oversee the selection process for new auditors. If an External Auditor resigns, the Committee shall investigate issues leading to this and recommend to the Council of Governors whether any action is required. It is for the Chair of the Board to inform NHS Improvement of the reasons for ceasing an External Auditor's appointment.

3.5.5. The Committee will oversee the relationship with the External Auditor including (but not limited to):

- i. Ensuring the External Auditor complies with the Code of Audit Practice issued by the National Audit Office.
- ii. Approving their remuneration, whether fees for audit or non-audit services, and ensuring that the level of fees is appropriate to enable an adequate audit to be conducted, in line with what is agreed between the Committee and Council of Governors.
- iii. Agreeing and implementing a policy regarding the supply of non-audit services by the External Auditor and monitoring that service, in accordance with the agreement of the Council of Governors.
- iv. Approving their terms of engagement, including any engagement letter issued at the start of each audit and the scope of the audit, as agreed between the Council of Governors and the Committee.
- v. Discussing with the External Auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy.
- vi. Reviewing and approving the annual External Audit plan and ensuring that it is consistent with the scope of the audit engagement.
- vii. Reviewing the findings of the audit with the External Auditor. This shall include, but not be limited to the following:
 - a. A discussion of any major issues, including their local evaluation of audit risks, which arose during the audit
 - b. Any accounting and audit judgements.
 - c. Level of errors identified during the audit.
- viii. Review any representation letter(s) requested by the External Auditor before they are signed by management.
- ix. Consider the management letter and management's response to the External Auditor's findings and recommendations.
- x. Review External Audit reports, including value for money reports and annual audit letters, together with the management response.
- xi. Undertake an annual review of the effectiveness of the External Auditor.
- xii. Meet the External Auditor at least once a year, without management being present, to discuss their remit and any issues arising from the audits carried out.

3.6. Financial Reporting

3.6.1. The Committee shall monitor the integrity of the published financial statements of the Trust and any other formal announcement relating to its financial performance, reviewing significant financial reporting issues and

judgements which they contain. The Committee shall also review summary financial statements, significant financial returns to regulators and any financial information contained in other official documents, including the Annual Governance Statement.

3.6.2. To aid this process, the Committee shall review and challenge where necessary:

- i. The consistency of, and any changes to, accounting policies both on a year on year basis and across the Foundation Trust. In addition, the Committee shall approve accounting policies of the Trust.
- ii. The methods used to account for significant or unusual transactions where different approaches are possible.
- iii. Whether the Foundation Trust has followed appropriate accounting standards and made appropriate estimates and judgements, taking into account the views of the External Auditor.
- iv. The clarity and completeness of disclosure in the Foundation Trust's financial reports and the context in which statements are made.
- v. Key issues raised by the External Auditor within the ISA 260 report (Communication of Audit Matters to Those Charged with Governance)
- vi. The meaning and significance of the figures, notes and significant changes.
- vii. Explanation of estimates or provisions having material effect.
- viii. The schedule of losses and special payments.
- ix. Any reservations and disagreements between the External Auditors and management not satisfactorily resolved.

3.6.3. Where the Committee is not satisfied with any aspect of the proposed financial reporting by the Foundation Trust, it shall report its views to the Board

3.7. Standing Orders and Standing Financial Instructions

3.7.1. The Committee shall undertake a regular assessment of the application of the Trust Standing Orders and Standing Financial Instructions and associated documentation on behalf of the Board. Specifically, this will include:

- i. To review on behalf of the Trust Board the operation of, and proposed changes to, the Standing Orders and Standing Financial Instructions and Standards of Business Conduct.
- ii. To monitor the effective maintenance of the register of interests and hospitality register.
- iii. To examine the appropriateness of circumstances where there is significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or suspension of Standing Orders.

4. Membership and Attendees

4.1. The Committee members shall be appointed by the Board in accordance with the Trust Constitution and shall consist of three Independent Non-Executive

Members, including at least one with recent financial experience.

- 4.2. The Chair of the Audit Committee will be appointed by the Board. In accordance with the constitution, the Committee will be chaired by a Non-Executive Director who has been appointed on account of their specific knowledge skills and experience making them suitable to Chair the Committee.
- 4.3. In the absence of the Committee Chair and /or appointed deputy, one of the remaining members present shall elect themselves to chair the meeting.
- 4.4. The Chair of the Trust and the Chief Executive shall not be a member of the Committee.
- 4.5. Only members of the Committee have the right to attend meetings of the Committee however, when appropriate:
 - i. The Chief Executive should be invited to attend, at least annually, to discuss with the Audit committee the process for assurance that supports the Annual Governance Statement.
 - ii. The Chair will on occasions where it is deemed appropriate, invite other independent Non- Executive Directors to attend meetings.
 - iii. Internal Auditors and the Local Counter Fraud Specialist shall attend every meeting of the Committee, in order to facilitate the Internal Auditor's Opinion, and to allow the Committee to monitor progress of internal audit plan.
 - iv. The External Auditor will be invited to attend meetings of the Committee on a regular basis, especially when matters concerning corporate governance, internal control risk management and value for money are being discussed.
 - v. The Committee should meet privately with the External and Internal Auditors at least once a year, not in the presence of management.
 - vi. The Chief Finance Officer shall normally attend meetings.
 - vii. Other Executive Directors should be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director.
- 4.6. The Company Secretary will provide guidance to ensure the Committee is properly constituted and advised, enabling it to fulfil its collective responsibility.

5. Quorum

- 5.1. The Quorum necessary for the transaction of business shall be a minimum of two Non- Executive Directors present in person or by phone or other electronic means. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.
- 5.2. The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

6. Meeting, quoracy and voting

- 6.1. The Committee will meet in private.
- 6.2. The Committee will normally be held at least quarterly and arrangements and notice for calling meetings are set out in the Standing Orders.
- 6.3. Additional meetings may be held on an exceptional basis at the request of the Chair or any three members of the Audit Committee
- 6.4. When the Chair of the Audit Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as they shall specify.
- 6.5. The Board, Chair or Chief Executive of the Trust may ask the Audit Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.
- 6.6. In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

7. Quorum

- 7.1. For a meeting to be deemed quorate the following members should present **a minimum of two independent Non-executive members of Committee.**
- 7.2. If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.
- 7.3. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken. If it is deemed that a decision cannot be taken because matters relating to conflict of interest result in the Committee not being able to be quorate at any time, the matter will be referred to The Board.

8. Decision making and voting

- 8.1. Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.
- 8.2. Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.
- 8.3. Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.
- 8.4. If a decision is needed which cannot wait for the next scheduled meeting, the

Chair may conduct business on a 'virtual' basis using telephone, email or other electronic communication.

9. Accountability and reporting

- 9.1. The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.
- 9.2. The minutes of the meetings or a summary of the minutes shall be formally recorded by the secretary and submitted together with recommendation where appropriate, to the Board, in accordance with the Standing Orders.
- 9.3. The submission to the Board shall include details of any matters in respect of which actions or improvements are needed.
- 9.4. The Committee will submit an assurance report to The Board following each of its meetings,
- 9.5. Public reports will be made as appropriate to satisfy any requirements in relation to disclosure of public sector executive pay.
- 9.6. The Committee will provide the Board with an Annual Quality Report. The report will summarise its conclusions from the work it has done during the year.

10. Notice of meetings

- 10.1. Notice of any Committee meeting must indicate:
 - i. Its proposed date and time, which must be at least five (5) working days after the date of the notice, except where a meeting to discuss an urgent issue is required (in which case as much notice as reasonably practicable in the circumstances should be given).
 - ii. Where it is to take place.
 - iii. An agenda of the items to be discussed at the meeting and any supporting papers.
 - iv. If it is anticipated that members of the Committee participating in the meeting will not be in the same place, how it is proposed that they should communicate with each other during the meeting.

11. Policy and best practice

- 11.1. The Committee will be conducted in accordance with the Trust policy on Standards of Business Conduct, specifically:
 - i. There must be transparency and clear accountability of the Committee.
 - ii. The Committee will hold a members Declaration of Interests register which will be noted at each meeting of the Committee and presented when updated
 - iii. Members must declare any interests and /or conflicts of interest at the start of the meeting. Where matters on conflicts of interest arise, the Chair will determine what action to take. This may include requesting that individuals withdraw from any discussion/voting until the matter(s)

is concluded.

- 11.2. Members of the Committee should aim to attend all scheduled meetings each financial year.
- 11.3. Committee members and participants must maintain the highest standards of personal conduct and in this regard must comply with:
 - i. The laws of England and Wales
 - ii. The spirit and requirements of the NHS Constitution
 - iii. The Nolan Principles
 - iv. Any additional regulations or codes of practice relevant to the Committee

12. Secretariat

- 12.1. The Company Secretary or their nominated deputy shall be the secretary to the Committee and will provide administrative support and advice.
- 12.2. The duties of the secretariat include but are not limited to:
 - i. Agreement of the agenda with the Chair of the Committee and attendees together with the collation of connected papers;
 - ii. Taking the minutes and keeping a record of matters arising and issues to be carried forward;
 - iii. Advising the Committee as appropriate
 - iv. Reviewing every decision to suspend the standing orders.
- 12.3. Before each Committee meeting an agenda and papers will be sent to every Committee member no less than five (5) business days in advance of the meeting, unless the meeting has been convened at short notice, in which case papers will be sent at the earliest opportunity.
- 12.4. If a Committee member wishes to include an item on the agenda, they must notify the Chair no later than ten (10) business days prior to the meeting. In exceptional circumstances for urgent items this will be reduced to five (5) business days prior to the meeting. The decision as to whether to include the agenda item is at the discretion of the Chair.

13. Groups of the Committee or task and finish groups

- 13.1. The Audit Committee may appoint groups or task-and-finish groups to advise it and assist in fulfilling its duties. However, the Audit Committee cannot delegate any of its decision-making authority to any group or task and finish group.
- 13.2. The Audit Committee shall approve the membership and terms of reference for these groups and receive reports as appropriate.

14. Review

- 14.1. The Terms of Reference of the Audit Committee shall be reviewed by members of the Committee and the Board annually, or as required in line with any developments or changes to the Trust constitution, national guidance, or

feedback from auditors, with recommendations made to the Board for approval.

- 14.2. As part of the Board's annual performance review process, the Committee shall review its collective performance and put measures in place to implement any identified areas of improvement.

DRAFT

Title of Document	REMUNERATION COMMITTEE Terms of Reference
Name of originator/author:	Interim Company Secretary
Name of the responsible committee	Remuneration Committee
Name of executive lead:	Chief Executive
Ratified by:	Trust Board
Date ratified	
Date issued:	
Review date:	
Version	Version 3.0

Version Control			
Version No	Amendment (include summary detail of changes)	Amended by	Date
1.0	Original Draft	Company Secretary	
2.0	Annual Review	Deputy Company Secretary	February 2025
3.0	Annual Review	Company Secretary	March 2026
3.1			
3.2			
3.3			

Remuneration Committee Terms of Reference

1. Constitution

1.1 The Remuneration Committee (the Committee) is established as a standing Committee in accordance with the Medway NHS Foundation Trust (the Trust) Constitution, Standing Orders and Scheme of Delegation. These Terms of Reference set out the remit, responsibilities, delegated authority, membership and reporting arrangements of the Committee

1.2 The Committee is accountable to the Trust Board (the Board) and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the Trust

1.3 The Committee is authorised by the Board to act within its Terms of Reference. All employees and individuals appointed by the Trust are directed to co-operate with any request made by the Committee

1.4 The Committee will liaise with and function as a resource for other Trust committees and forums, where specific matters are most appropriately considered by the Committee in line with its responsibilities

1.5 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and can request the attendance of individuals and authorities outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions

1.6 Where the Board scrutiny or decision is required for related matters, the Committee will consider these in advance and act as the sponsor for any recommended action/decision required by the Board

1.7 The remit of the Committee is outlined below. The nature of how these are delivered will be determined by the Committee Chair in discussion with the relevant lead executive officer of the Trust

2. Purpose and responsibilities

2.1 The Committee is formed to:

- a) Confirm the appointment of the Chief Executive, subject to the approval of the Council of Governors, under paragraph 17(3), Schedule 7, National Health Service Act 2006.
- b) Ratify the appointment and termination of Executive Directors, under paragraph 13(4), Schedule 7, National Health Service Act 2006, following Chief Executive recommendation.

- c) Ratify the appointment of other voting and non-voting Executive Director members of the Board (who are not statutory Directors within the Act) following Chief Executive recommendation.
- d) Review the outcomes of the appraisals for the Chief Executive and other Executive Directors.
- e) In consultation with the Council of Governors, consider the size, structure and composition of the Board; and succession plans in that regard.
- f) Consider and agree the remuneration for the Chief Executive and the other Executive Directors, taking into account remuneration decisions affecting other staff within the Trust.

3. Authority

3.1 The Committee is authorised by the Board to:

- a) Investigate any activity within its Terms of Reference
- b) Seek any information it requires within its remit, from any employee or member of the Trust (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these Terms of Reference.
- c) Commission any reports it deems necessary to help fulfil its obligations.
- d) Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the Trust for obtaining legal or professional advice.
- e) Create task and finish sub-groups to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and Terms of Reference of any such task and finish sub-groups in accordance with the Trust's constitution, standing orders and SORD, but may or may not delegate any decisions to such groups.

3.2 Benchmarking and guidance

- a) The Committee will take proper account of national agreements and appropriate benchmarking, for example Agenda for Change and guidance issued by the Government, the Department of Health and Social Care, NHS England and the wider NHS in reaching their determinations.

4. Membership and Attendance

Membership

4.1 The Committee is formed of all Non-Executive Directors and associate Non-Executive Directors where applicable.

4.4 The following are expected to regularly attend meetings of the Committee:

- a) Chief Executive or their nominated deputy.
- b) Chief People Officer or their nominated deputy.
- c) Company Secretary or their nominated deputy.

4.5 When determining the membership of the Committee, active consideration will be made to diversity and equality.

Chair of the Committee

4.6 In accordance with the constitution, the Committee will be chaired by the Senior Independent Non-Executive Member Board Chairman of the Board appointed on account of their specific knowledge skills and experience making them suitable to Chair the Committee.

4.7 The Chair of the Committee will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference.

Attendees

4.8 Only members of the Committee have the right to attend Committee meetings, but the Chair of the Committee may invite relevant staff to the meeting as necessary in accordance with the business of the Committee.

4.9 The Chair of the Committee may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

4.10 No individual should be present during any discussion relating to:

- a) Any aspect of their own pay.
- b) Any aspect of the pay of others when it has an impact on them.

5. Reporting

5.1 The committee Chair shall report to the Trust Board of Directors on all proceedings undertaken within its duties and responsibilities.

5.2 The committee shall make whatever recommendations to the Trust Board of Directors it deems appropriate on any area within its remit where action or improvement is needed.

5.3 The Committee Chair (on behalf of the Remuneration Committee) shall make a statement in the annual report about its activities and the process used to decide remuneration.

5.4 The Committee shall make information available regarding the attendance of all members at Committee meetings.

5.5 The Committee will take reasonable steps to proactively ensure risks that fall within its remit are identified and mitigated where-ever practically possible

6. Duties

6.1 Performance Appraisal

The Chief Executive and Executive Directors are assessed against the Trust's Performance Framework.

6.2 The Chair will review the team objectives agreed with the Chief Executive and the other Executive Directors and confirm to the Committee that the objectives are appropriate, SMART and reference performance standards that will allow each executive to be assessed against each objective as 'not met, met, or exceeded expectations.

6.3 The Committee will receive reports on the performance of the Chief Executive and the other Executive Directors against the performance assessment frameworks for individual executive directors and the executive team.

6.4 The NHSE Framework is used for the assessment of the Chair and the Non-Executive Directors.

6.5 The Committee will receive confirmation from the Chair in respect of the Chief Executive and from the Chief Executive in respect of the other Executive Directors on completion of their annual appraisals and of any issues which have been identified.

6.6 The Committee will review the agreed Directors' objectives intra-year to ensure their continuing relevance, and the overall format of the update reports to the Board to ensure they clearly indicate if the objective is being achieved or not

7. Remuneration

7.1 In accordance with Section E, provision 2.7 of the Code of Governance for NHS Provider Trusts, the Remuneration Committee has delegated responsibility from the Board of Directors for setting remuneration for all Executive Directors including pension rights and any compensation payments.

7.2 The Remuneration Committee should also recommend and monitor the level and structure of remuneration for senior management that are on a VSM salary.

7.3 Establish and keep under review a remuneration policy in respect of Executive Board Directors.

7.4 Annually scrutinise, challenge and approve the remuneration report prior to its inclusion within the Annual report

7.5 Consult the Chief Executive about proposals relating to the remuneration of the other Executive Directors.

7.6 In accordance with all relevant laws, regulations and trust policies, decide and keep under review the terms and conditions of office of the trust's Executive Directors, including:

- Salary, including any performance-related pay or bonus;
- Provisions for other benefits, including pensions and cars;
- Allowances;
- Payable expenses;
- Compensation payments

7.7 Use national guidance and market benchmarking analysis in the annual determination of remuneration of Executive Directors, while ensuring that increases are not made where trust or individual performance do not justify them.

7.8 In adhering to all relevant laws, regulations and trust policies establish levels of remuneration which are sufficient to attract, retain and motivate Executive Directors of the quality and with the skills and experience required to lead the trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the Trust;

7.9 Use national guidance and market benchmarking analysis in the annual determination of remuneration of Executive Directors, while ensuring that increases are not made where trust or individual performance do not justify

them;

7.10 Be sensitive to pay and employment conditions elsewhere in the Trust.

7.11 Monitor and assess the output of the evaluation of the performance of individual Executive Directors, and consider this output when reviewing changes to remuneration levels

7.12 Advise upon and oversee contractual arrangements for executive directors, including but not limited to termination payments to avoid rewarding poor performance

7.13 The Committee must seek external advice and appropriate benchmarking data every three years on the remuneration packages of the Chief Executive and other Executive Directors)

7.14 The Committee will consider any proposed significant changes in the terms of employment of Trust employees, as requested by the Board of Directors.

7.15 Should the situation arise; the Committee will consider and make recommendations to the Trust Board on what termination payments might reasonably be paid to an Executive Director whose contract of employment is terminated.

8. Succession Planning

8.1 The Committee will;

- monitor the succession planning arrangements for the Board of Directors and senior managers annual

9. Fit and Proper Persons Compliance

9.1 The Committee will seek assurance on compliance with the application of the policy in relation to:

- Recruitment and appointments process
- Approach to undertaking Fit and Proper Person investigations
- Annual attestations

10. Appointments

10.1 The Committee will:

10.1.1 Regularly review the structure, size and composition (including the

skills, knowledge, experience and diversity) of the Board, making use of the output of the board evaluation process as appropriate, and make recommendations to the Board, and Nomination Committee of the Council of Governors, as applicable, with regard to any changes.

10.1.2 Give full consideration to and make plans for succession planning for the Chief Executive and other Executive Directors taking into account the challenges and opportunities facing the trust and the skills and expertise needed on the Board in the future.

10.1.3 Keep the leadership needs of the Trust under review at executive level to ensure the continued ability of the trust to operate effectively in the health economy.

10.1.4 Be responsible for identifying and appointing candidates to fill posts within its remit as and when they arise.

10.1.5 When a vacancy is identified, evaluate the balance of skills, knowledge and experience on the Board, and its diversity, and in the light of this evaluation, consider and comment on a description of the role and capabilities required for the particular appointment prepared by the Chief Executive.

10.1.6 In identifying suitable candidates, the Committee shall use open advertising or the services of external advisers to facilitate the search; consider candidates from a wide range of backgrounds; and consider candidates on merit against objective criteria.

10.1.7 Ensure that a proposed Executive Director's other significant commitments (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the Board as they arise.

10.1.8 Ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported.

10.1.9 Consider any matter relating to the continuation in office of any Board Executive Director including the suspension or termination of service of an individual as an employee of the trust, subject to the provisions of the law and their service contract

10.1.10 Ensure that guidance from HM Treasury is considered where any off-payroll appointments are proposed.

11. Meetings, Quorum and Voting

11.1 The Committee will meet in private.

11.2 The Committee will meet at least twice a year, with one of the meetings

scheduled for the approval of the remuneration report.

11.3 Arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

11.3 When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as they shall specify.

11.4 The Board, Trust Chair or Chief Executive may ask the Committee to convene further meetings to discuss issues on which they want the Committee's advice.

11.5 In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

12. Quorum

12.1 For a meeting to be quorate a minimum of three Non-executive Members of the Board are required, including the Chair of the Committee.

12.2 If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

12.3 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken. If it is deemed that a decision cannot be taken because matters relating to conflict of interest result in the Committee not being able to be quorate at any time, the chair will determine whether to convene virtual proceedings and secure a decision virtually, or defer the matter to the Board if appropriate.

13. Decision making and voting

13.1 Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair of the Committee may call a vote.

13.2 Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

13.3 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

13.4 If a decision is needed which cannot wait for the next scheduled meeting, the Chair of the Committee may conduct business on a 'virtual' basis using telephone, email or other electronic communication.

14. Accountability and Reporting

14.1 The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

14.2 The Committee will submit a regular report to the Board summarising its meetings and decisions made, as required by the Board.

14.3 The Committee will provide the Board with an Annual Report. The report will summarise its conclusions from the work it has done during the year.

15. Notice of Meetings

15.1 Notice of any Committee meeting must indicate:

- a) Its proposed date and time, which must be at least five (5) working days after the date of the notice, except where a meeting to discuss an urgent issue is required (in which case as much notice as reasonably practicable in the circumstances should be given).
- b) Where it is to take place.
- c) An agenda of the items to be discussed at the meeting and any supporting papers.
- d) If it is anticipated that members of the Committee participating in the meeting will not be in the same place, how it is proposed that they should communicate with each other during the meeting.

16. Policy and Best Practice

16.1 The Committee will be conducted in accordance with the Trust policy on Standards of Business Conduct, specifically:

- a) There must be transparency and clear accountability of the Committee
- a) The Committee will hold a members Declaration of Interests register which will be noted at each meeting of the Committee and presented when updated
- b) Members must declare any interests and /or conflicts of interest at the start of the meeting. Where matters on conflicts of interest arise, the Chair will determine what action to take. This may include requesting that individuals withdraw from any discussion/voting until the matter(s) is concluded

16.2 Members of the Committee should aim to attend all scheduled meetings each financial year

16.3 Committee members and participants must maintain the highest standards of personal conduct and in this regard must comply with:

- a) The laws of England and Wales
- b) The spirit and requirements of the NHS Constitution
- c) The Nolan Principles
- d) Any additional regulations or codes of practice relevant to the Committee

17. Secretariat

17.1 The Company Secretary shall be the secretary to the Committee and will provide administrative support and advice. The duties of the secretariat include but are not limited to:

- a) Agreement of the agenda with the Chair of the Committee and Executive Lead
- b) Collation of connected papers and circulation of the pack five (5) working days prior to the meeting
- c) Taking the minutes, action log and keeping a record of matters arising and issues to be carried forward
- d) Advising the Committee as appropriate

17.2 Before each Committee meeting an agenda and papers will be sent to every Committee member no less than five (5) working days in advance of the meeting, unless the meeting has been convened at short notice, in which case papers will be sent at the earliest opportunity

17.3 If a Committee member wishes to include an item on the agenda, they must notify the Company Secretary/Executive Lead and Chair no later than ten (10) business days prior to the meeting. In exceptional circumstances for urgent items this will be reduced to five (5) business days prior to the meeting. The decision as to whether to include the agenda item is at the discretion of the Chair.

18. Confidentiality

18.1 Members of the Committee shall respect the confidentiality requirements set out in the Trust's Standing Orders, relevant corporate policies and these Terms of Reference unless separate confidentiality requirements are set out for the Committee in which event these shall be observed.

18.2 Decisions of the Committee will be published by the Committee except where matters under consideration or when decisions made are of a confidential nature, in which case they will be excluded from any public record and shall not be publishable.

19. Review

19.1 The Terms of Reference of the Committee shall be reviewed by members of the Committee annually, or as required in line with any developments or changes to the Trust constitution, national guidance or feedback from auditors, with recommendations made to the Board for approval.

DRAFT

Title of Document	Finance, Planning and Performance Committee Terms of Reference
Name of originator/author:	Interim Company Secretary
Name of the responsible committee	Finance, Planning and Performance Committee
Name of executive lead:	Chief Finance Officer
Ratified by:	Trust Board
Date ratified	
Date issued:	
Review date:	
Version	2.6

Version Control			
Version No	Amendment (include summary detail of changes)	Amended by	Date
1.0	Original Draft	Company Secretary	Nov 2022
2.0	Draft Approved by FPPC	Company Secretary	Dec 2022
2.1	Draft ratified by Trust Board	Company Secretary	Jan 2023
2.2	Draft ratified by Trust Board	Company Secretary	May 2023
2.3	Update	Company Secretary	Jan 2024
2.4	Review	Company Secretary	Jan 2025
2.5	Annual review	Company Secretary	April 2026

Finance, Planning and Performance Committee

Terms of Reference

1. Constitution

1.1. The Finance, Performance and Planning Committee (“the Committee”) is established as a standing Committee in accordance with the Medway NHS Foundation Trust (“MFT”) Constitution, Standing Orders and Scheme of Reservation and Delegation (“SORD”). These Terms of Reference set out the remit, responsibilities, delegated authority, membership and reporting arrangements of the Committee.

1.2. The Finance, Planning and Performance Committee is accountable to the MFT Trust Board (“the Trust Board”) and its members, including those who are not members of the Trust Board, are bound by the Standing Orders and other policies of MFT.

1.3. The Finance, Planning and Performance Committee is authorised by the Trust Board to act within its Terms of Reference. All employees and individuals appointed by MFT are directed to co-operate with any request made by the Committee.

1.4. The Finance, Planning and Performance Committee will liaise with and function as a resource for other MFT committees and forums, where specific matters are most appropriately considered by the Committee in line with its responsibilities.

1.5. The Finance, Planning and Performance Committee is authorised by the Trust Board to obtain outside legal or other independent professional advice and can request the attendance of individuals and authorities outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

2. Authority

2.1. The Finance, Planning and Performance Committee is authorised by the Trust Board to:

- Investigate any activity within its terms of reference
- Seek any information it requires within its remit, from any employee or member of MFT (who are directed to co-operate with any request made by the Finance, Planning and Performance Committee) within its remit as outlined in these terms of reference
- Commission any reports it deems necessary to help fulfil its obligations
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Finance, Planning and Performance Committee must follow any procedures put in place by MFT for obtaining legal or professional advice

3. Purpose

3.1 The purpose of the Committee is to provide assurance to the Board of the Trust's financial management and organisational performance, business planning, estate and facilities management, sustainability and digital infrastructure.

The Committee shall also make decisions on behalf of the Board per the Scheme of Delegation and /or specific delegated authority made by the Board.

3.2 The Committee shall seek assurance, on behalf of the Board:

- a. That the Trust is operating within current statutory and regulatory frameworks and external reporting standards and requirements, including the NHS Oversight Framework and Treasury policies and procedures, and that any corrective action has been initiated and managed as appropriate.
- b. That the strategic financial principles, priorities, risk and performance parameters are aligned and support the Trust's strategic objectives and its long-term sustainability that the Trust's degree of exposure to financial risk, and any potential to compromise the achievement of the strategic objectives is being effectively managed.
- c. That reporting on the financial performance of the Trust is being triangulated against agreed plans, progress and performance measures, reporting on progress to the Board.
- d. That the Trust's resources and assets are being used effectively and efficiently.
- e. That the robustness, credibility and quality of financial management and planning information is reviewed and triangulated by the Committee.
- f. That the development, effective management, and delivery of the Trust's capital programme is being carried out, and that this is fit for purpose.
- g. That the Trust meets the operational constitution standards as included in the Trust's annual plan. Where trajectories are not being met, to ensure that clear plans are in place to recover the position.

3.3 Maintain oversight on behalf of the Board of pertinent financial and performance issues, risks and achievements and shall approve relevant investments within its delegated authorities as set out in the Scheme of Delegation. •

4. Duties

4.1 Financial Management

The Finance, Planning and Performance Committee's duties can be categorised as to:

- a. Review the trust's annual financial plan and targets, and performance against them before submission to the Board of Directors
- b. Oversee the robust and effective delivery of financial targets by ensuring a comprehensive financial management control framework is in place
- c. Receive monthly reports on the trust's financial and performance management

position and review the robustness of the risk assessments underpinning forecasts and, where appropriate, any plans for corrective action

- d. Review on a regular basis updates in relation to Service Line Reporting to triangulate with service performance data
- e. Monitor the detailed monthly income and expenditure position
- f. Oversee progress of CIP delivery to provide assurance to the Board of Directors that this is being driven throughout the organisation
- g. Oversee proactive and forward-looking actions in forecasting both financial and non-financial performance
- h. Scrutinise and assess financial business cases submitted to the committee according to the Scheme of Reservation & Delegation.

4.2 Performance

- a. Ensure delivery of performance targets by ensuring a comprehensive performance management control framework is in place
- b. Receive monthly reports on detailed service performance and provide assurance that appropriate measures are in place to address under and over-performance and, where appropriate any plans for corrective action
- c. Monitor commercial performance including SLAs and sub-contracting arrangements
- d. Receive assurance on the management of contract queries to commissioners
- e. To undertake high-level, exception-based monitoring of the delivery of operational and financial performance to ensure that the Trust is operating in line with its annual business plan, to deliver the agreed strategy and agree detailed capital and revenue objectives and, where not, satisfy itself that appropriate action is being taken by Executive Directors.
- f. To review forecast performance against operational targets and improvement trajectories, escalating issues of non-delivery to the Trust Board, and monitoring against achievement of any national funding
- g. To monitor identification of schemes within the Efficiency Programme and overall forecast delivery, receiving advice regarding remedial action being taken as necessary by the Executive Team and ensure regular reports are provided to the Trust Board.
- h. To review operational performance in relation to information technology, information governance, data quality and estates and facilities strategy.

4.3. Strategy

To provide an objective view of the financial and operational performance, and financial strategy of the Trust, together with an understanding of the risks and assumptions within the Trust. Including to routinely review and consider the following key update in detail on:

- Finance and Performance
- Contract monitoring
- Treasury management
- Savings/transformation
- Procurement

- Estates
- Digital transformation
- Capital programme

4.6 To oversee the development and proposal for approval by the Board of the Trust's financial strategy, budgets and Efficiency Programmes (Cost Improvement Plans).

4.7 To approve and monitor the implementation of supporting strategies (e.g. Estates Strategy, Procurement Strategy, IM&T Strategy, Business Intelligence Strategy and Commercial Development Strategy)

Income and Contracts management

4.7. To review the Trust contracting approach with key commissioners

4.8. To monitor in-year income against contract and levels of risk, including commissioner challenges, accrued income, fines and penalties, and income disputes.

4.9. To review arrangements for non-activity related income streams, particularly CQUIN, to understand alignment with Trust clinical priorities and levels of income risk.

4.10 To consider material opportunities to grow new commercial income streams and market share of existing services.

Annual Trust planning cycle

4.16. To consider the Trust's medium and long-term financial strategy, in relation to both revenue and capital.

4.17 To oversee the Trust's business planning process and agree principles and approach for internal budget setting and the development of directorate business plans, including workforce plans and activity, linked to the Trust's Corporate Objectives.

4.18. To review the annual efficiency improvement programme and transformation plan to provide assurance that delivery risk is minimised and productivity and efficiency maximised, in particular that contingency, phasing and risk mitigation plans are appropriate and that savings programmes are realistic and deliverable.

4.19 To receive benchmarking and other information (for example from GIRFT and Model Hospital) to assess Trust productivity and ensure targeting or efficiency programmes.

4.20 To review the Trust procurement strategy, systems and arrangements for obtaining best value.

4.21 To monitor progress against the NHS standards of Procurement within the Trust.

4.22 To consider the implications of wider changes in NHS policy and governance within the Committee's remit including (but not limited to) the development of Integrated Care Boards (ICB), NHSE regulatory oversight and developments of provider collaborative.

Capital management

4.25. To review the strategic five-year capital programme and the annual capital budgets and recommend as appropriate to the Trust Board;

4.26. To consider the financial proposals for investment in the estate and technology to ensure alignment with Trust strategy.

4.27 To review and approve capital business cases identified within the annual capital budget to ensure that each business case is within the resources approved by the Trust Board and that the business case comply with the business case standards set by the Trust and outside regulators.

4.28. To approve capital business cases in accordance with the Trust's Scheme of Reservation and Delegation (SORD).

4.29 To provide assurance to the Trust Board on the functioning of the capital programme and associated business cases

Treasury management

4.30. To manage and review investment decisions in accordance with the Trust's Standing Financial Instructions and Scheme of Delegation, and ensure safe harbouring of "cash", following the agreed controls and ensuring all investment is risk averse

4.31 To review Trust finance applications including loan applications.

4.33. To provide assurance to the Trust Board on all Treasury Management issues

Investment appraisal

4.34. To review the benefits realisation of business cases and post implementation reviews of business cases it approves to ensure that the standard of business case

preparation is consistently high

4.36 To review and monitor the Trust's Business and Financial Performance by receiving high level monthly reports from the outputs

4.37 To provide assurance to the Trust Board on all investment appraisal activity, approve specific investment and disinvestment proposals including any in respect of property assets

Digital strategy

4.38. To review, approve and monitor the implementation of the Digital strategy

4.39. To review and provide assurance regarding the implementation of the digital transformation programmes to deliver the digital strategy, including cyber security

4.43 To seek assurance that the underpinning systems and processes for data collection and management are robust and provide relevant, timely and accurate information to support operational management of the Trust.

4.44 To monitor the effectiveness of the Trust's financial and operational performance reporting systems, ensuring that the Trust Board is assured of continued compliance through its annual reporting, reporting by exception where required.

4.45 To review in detail via a deep dive any major performance variation, to obtain assurance on behalf of the Trust Board as to the effectiveness of corrective actions and associated governance arrangements.

4.46 To consider changes to the Trust reporting requirements under any new regulatory arrangements.

Risk management

4.47 The Committee will monitor at each meeting the risks and associated actions of risks within its scope of the Board Assurance Framework. In undertaking this role, the Committee will seek assurance from the Executive Directors on oversight of risk.

4.48 The Committee will seek assurance on steps taken by the Trust to stay within risk appetite parameters agreed by the Board, and recommend mitigations to the Board where this is deviated from as part of the Chair's assurance reports

4.49 The Committee will seek assurance that the Trust's risk management process is effective by assessing, reviewing and monitoring:

- The systems, policies and practices in place to ensure robust risk management processes within the scope of its role including the application of best practice such as the HM Treasury 'Three Lines of Defence' model.
- The completeness and accuracy of identified risks within the remit of the Committee on the corporate risk register.
- The implementation of the Trust's risk management strategy and policy
- The effectiveness of processes that are in place to ensure the escalation of risks from local and divisions risk registers to the corporate risk register

5 Membership and Attendance

5.1 The Committee members shall be appointed by the Board in accordance with the Trust Constitution and shall consist of three Independent Non-Executive Members with sufficient skills to discharge its responsibilities.

5.2 The Committee will be chaired by a Non-executive Member of the Board appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee

5.3 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference.

5.5 The Board Chair may be a member of the Committee but may not be appointed as the Chair

5.6 For the avoidance of doubt, Associate Non-Executive Directors may be appointed to the Committee as members

5.7 For the avoidance of doubt, Trust employees who serve as members of the Committee do not do so to represent or advocate for their respective department, division or service area but to act in the interests of the Trust as a whole and as part of the Trust-wide governance structure.

5.8 Membership of the committee will include:

- a) Three Non-Executive Directors/Associate Non-Executive Directors –
- b) Chief Finance Officer
- c) Deputy Chief Finance Officer
- d) Chief Operating Officer
- e) Deputy Chief Operating Officer

5.9 Where a Member of the Committee is unable to attend a meeting, a suitable alternative may be agreed with the Chair, however attendees that are not

members will not count towards the quorum

5 Attendees

- 6.1 Only members of the Finance, Planning and Performance Committee have the right to attend Committee meetings, but the Chair may invite relevant attendees to the meeting as necessary in accordance with the business of the Committee.
- 6.2 Meetings of the Committee may also be attended by the following individuals who are not members of the Committee for all or part of a meeting as and when appropriate.
- Chief Medical Officer or Chief Nursing Officer
 - Company Secretary
 - Chief People Officer
 - Director of Planning and Operational Performance
 - Chief Executive
 - Deputy Chief Executive
- 6.3 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.
- 6.4 Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions or to present papers as per the annual work plan.
- 6.5 Trust Directors and/or staff and Executives shall be invited to attend those meetings in which the Finance, Planning and Performance Committee will consider areas of risk or operation that are their responsibility.

6 Meeting, quoracy and decisions

- 7.1 Members of the Finance, Planning and Performance Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.
- 7.2 Meetings of the Finance, Planning and Performance Committee will not be open to the public. Papers and minutes of Committees meetings will be subject to the Freedom of Information Act and disclosable to the public, unless the Chair determines that disclosure would be prejudicial to the public interest or the interests of MFT by reason of the confidential nature of the business transacted or for other special reasons. These should be stated in the documents and minutes of the meeting.

7.3 In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

7.4 The Finance, Planning and Performance Committee shall be quorate with at least 50% of members being in attendance, including the Committee Chair and either the Chief Finance officer or Deputy Chief Officer.

7.5 The aim of the Finance, Planning and Performance Committee will be to achieve consensus decision-making wherever possible with the show of hands. Where a vote is required, each member of the Committee shall have one vote. The Committee shall approve a recommendation subject always to the meeting being quorate and the majority of Members present approving the proposal. Where the vote is tied, the Chair shall have a casting vote.

7 Decision making and voting

8.1 Decisions will be taken in accordance with the Standing Orders. The Finance, Planning and Performance Committee will ordinarily reach conclusions by consensus. If this is not possible the Chair may call a vote.

8.2 Only members of the Finance, Planning and Performance Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

8.3 Where there is a split vote, with no clear majority, the Chair of the Finance, Planning and Performance Committee will hold the casting vote.

8.4 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis using telephone, email or other electronic communication.

8 Accountability and reporting

9.1 The Chair will provide assurance reports to the Trust Board following each meeting and draw to the attention of the Trust Board any issues that require disclosure.

9 Notice of meetings

9.1 Notice of any Finance, Planning and Performance Committee meeting must indicate:

- Its proposed date and time, which must be at least five (5) working days after the date of the notice, except where a meeting to discuss an urgent issue is required (in which case as much notice as reasonably

- practicable in the circumstances should be given);
- Where it is to take place;
- An agenda of the items to be discussed at the meeting and any supporting papers;
- If it is anticipated that members of the Finance, Planning and Performance Committee participating in the meeting will not be in the same place, how it is proposed that they should communicate with each other during the meeting.

10 Policy and best practice

10.1 The Finance, Planning and Performance Committee will be conducted in accordance with the MFT policy on Standards of Business Conduct, specifically:

- There must be transparency and clear accountability of the Finance, Planning and Performance Committee.
- The Finance, Planning and Performance Committee will hold a members Register of Interests which will be presented to each meeting of the Committee.
- Members must declare any interests and /or conflicts of interest at the start of the meeting. Where matters on conflicts of interest arise, the Chair will determine what action to take. This may include requesting that individuals withdraw from any discussion/voting until the matter(s) is concluded

10.2 Members of the Finance, Planning and Performance Committee should aim to attend all scheduled meetings each financial year.

10.3 Finance, Planning and Performance Committee members and participants must maintain the highest standards of personal conduct and in this regard must comply with:

- The laws of England and Wales
- The spirit and requirements of the NHS Constitution
- The Nolan Principles
- Any additional regulations or codes of practice relevant to the Finance, Planning and Performance Committee

11 Secretariat

11.1 The Company Secretary or their nominated deputy shall be the secretary to the Finance, Planning and Performance Committee and will provide administrative support and advice. The duties of the secretariat include but are not limited to:

- Agreement of the agenda with the Chair of the Finance, Planning and Performance Committee and attendees together with the collation of connected papers;
- Taking the minutes and keeping a record of matters arising and issues

- to be carried forward;
- Advising the Finance, Planning and Performance Committee as appropriate.
- Reviewing every decision to suspend the standing orders.

11.2 Before each Finance, Planning and Performance Committee meeting an agenda and papers will be sent to every Committee member no less than five (5) business days in advance of the meeting, unless the meeting has been convened at short notice, in which case papers will be sent at the earliest opportunity.

11.3 If a Finance, Planning and Performance Committee member wishes to include an item on the agenda, they must notify the Chair no later than ten (10) business days prior to the meeting. In exceptional circumstances for urgent items this will be reduced to five (5) business days prior to the meeting. The decision as to whether to include the agenda item is at the discretion of the Chair.

12 Confidentiality

12.1 Members of the Finance, Planning and Performance Committee shall respect the confidentiality requirements set out in the MFT's Standing Orders, relevant corporate policies, and these Terms of Finance, Performance and Planning Assurance Committee in which event these shall be observed.

12.2 Decisions of the Finance, Planning and Performance Committee will be published by the Committee except where matters under consideration or when decisions made are of a confidential nature, in which case they will be excluded from any public record and shall not be publishable.

13 Groups of the Committee or task and finish groups

13.1 The Finance, Planning and Performance Committee may appoint groups or task-and-finish groups to advise it and assist in fulfilling its duties. However, the Committee cannot delegate any of its decision-making authority to any group or task and finish group.

13.2 The Committee shall approve the membership and terms of reference for these groups and receive reports as appropriate.

13.3 The groups of the Committee are:

- a. Digital Data and Technology Group
- b. Financial Recovery Group
- c. Green Sustainability Group
- d. Estates and Facilities Group
- e. Trust Investment Group
- f. Performance Assurance Group

14 Review

14.1 The Terms of Reference of the Committee shall be reviewed by members of the Committee and the Board annually, or as required in line with any developments or changes to the Trust constitution, national guidance, or feedback from auditors, with recommendations made to the Board for approval.

14.2 As part of the Board's annual performance review process, the Committee shall review its collective performance and put measures in place to implement any identified areas of improvement.

DRAFT

Title of Document	People Committee Terms of Reference
Name of originator/author:	Interim Company Secretary
Name of the responsible committee	People Committee
Name of executive lead:	Chief Executive
Ratified by:	Trust Board
Date ratified	
Date issued:	
Review date:	
Version	Version 3.4

Version Control			
Version No	Amendment (include summary detail of changes)	Amended by	Date
1.0	Original Draft	Company Secretary	
2.0	Attendees – added – representation from Integrated Care Board		June 2024
3.0	Annual Review	Deputy Company Secretary	February 2025
3.1	Annual Review	Company Secretary	May 2026

People Committee Terms of Reference

1. Constitution

1.1 The People Committee (the Committee) is established as a standing Committee in accordance with the Medway NHS Foundation Trust (the Trust) Constitution, Standing Orders and Scheme of Reservation and Delegation (Scheme of Delegation). These Terms of Reference set out the remit, responsibilities, delegated authority, membership and reporting arrangements of the Committee

1.2 The Committee is accountable to the Trust Board (the Board) and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the Trust

1.3 The Committee is authorised by the Board to act within its Terms of Reference. All employees and individuals appointed by the Trust are directed to co-operate with any request made by the Committee

1.4 The Committee will liaise with and function as a resource for other Trust committees and forums, where specific matters are most appropriately considered by the Committee in line with its responsibilities

1.5 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and can request the attendance of individuals and authorities outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions

1.6 Where the Board scrutiny or decision is required for related matters, the Committee will consider these in advance and act as the sponsor for any recommended action/decision required by the Board

1.7 The remit of the Committee is outlined below. The nature of how these are delivered will be determined by the Committee Chair in discussion with the relevant lead executive officer of the Trust.

2. Purpose

2.1 The Committee is formed to:

1. To seek assurance to the Trust Board on all aspects of workforce governance, culture and organisational development (OD) supporting the provision of safe, high quality, patient-centred care, and in delivery of the

strategic workforce objective.

- b. To oversee the progression of the strategic priorities and Trust ambitions in relation to workforce and OD are delivered in an affordable manner and any corporate risks identified are managed.
- c. To oversee the implementation of the Equality, Diversity and Inclusion agenda to create opportunities and reduce barriers for everyone – across the Trust.
- d. To gain assurance, on behalf of the Trust Board that the Trust is making sufficient progress towards a Fair, Safe and Just Culture, with a focus on health and wellbeing and a more consistent and positive experience for all staff.

3. Authority

3.1 The People Committee is authorised by the Board to:

- a) Investigate any activity within its terms of reference
- b) Seek any information it requires within its remit, from any employee or member of the Trust (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference
- c) Commission any reports it deems necessary to help fulfil its obligations
- d) Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the Trust for obtaining legal or professional advice
- e) Create task and finish sub-groups to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the Trust's constitution, standing orders and Scheme of Delegation but may/may not delegate any decisions to such groups

3.2 For the avoidance of doubt, the Committee will comply with the Trust Standing Orders, Standing Financial Instructions and the Scheme of Delegation, other than where there has been an explicit agreement made by the Board.

3.3 The Committee has authority to ratify Trust strategies, policies, procedures and guidelines which are applicable to the Committee's role or recommend these for approval by the Trust Board as required

4. Membership and Attendance

- 4.1 The Committee members shall be appointed by the Board in accordance with the Trust Constitution and shall consist of three Independent Non-Executive Members with sufficient skills to discharge its responsibilities.
- 4.2 The Chair of the People Committee will be appointed by the Board. In accordance with the constitution, the Committee will be chaired by a Non-Executive Director who has been appointed on account of their specific knowledge skills and experience making them suitable to Chair the Committee.
- 4.3 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.
- 4.4 For the avoidance of doubt, Trust employees who serve as members of the Committee do not do so to represent or advocate for their respective department, division or service area but to act in the interests of the Trust as a whole and as part of the Trust-wide governance structure.
- 4.5 Membership of the committee will include:
 - a) Two Non-Executive Directors– (one of whom will be the Committee Chair)
 - b) Associate Non-Executive Director
 - b) Chief People Officer
 - c) Deputy Chief People Officer
 - d) Chief Medical Officer
 - e) Chief Nursing Officer
- 4.6 The Chief Executive has a standing invite to attend the committee
- 4.7 Where a Member of the Committee is unable to attend a meeting, a suitable alternative may be agreed with the Chair
- 4.8 When determining the membership of the Committee, active consideration will be made to diversity and equality.
- 4.9 Only members of the Committee have the right to attend Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Committee.

5. Duties

The People Committee's duties can be categorised as follows.

Strategy

- 5.1 To receive assurance that the People Strategy is being delivered and monitor its effectiveness in supporting the Trust's Strategic Objectives.
- 5.2 To shape, approve and drive the Trust's People and Organisational Development Strategy and assure its implementation to seek assurance appropriate impact
- 5.3 To receive assurance that the Equality, Diversity and Inclusion Strategy is being delivered.

Statutory and Regulatory Compliance

- 5.4 To receive assurance reports on compliance with the Workforce NHS Constitution pledges.
- 5.5 To receive external assurance reports from Care Quality Commission (CQC) and other regulatory/statutory bodies in relation to the workforce agenda and seek assurance that management responses/action plans are robust.
- 5.6 To receive an annual statement, for approval, regarding the Modern Slavery Act policy and monitoring.
- 5.7 To scrutinise action plans relating to People and Culture arising from Care Quality Commission (CQC) inspections and receive assurance that effective improvement measures are taking place
- 5.8 To review and drive key workforce performance indicator improvement against key elements of the People Strategy including:
 - Sickness absence, bank/agency usage and expenditure, education and development, appraisal and staff turnover and seek assurance agreed targets are being met;
 - Equality, Diversity and Inclusion Reports and Action Plans – e.g. Gender Pay, WRES, WDES etc.,
 - NHS Staff Survey Results;
 - Freedom to Speak Up Reports for all staff
 - Resident doctor's surveys
 - Guardian of Safe Working and GMC/HEE Surveys.

- Feedback from staff in training
- Employee relations

Risk management

5.9 The Committee will monitor at each meeting the risks and associated actions in the Board Assurance Framework. In undertaking this role, the Committee will seek assurance from the Executive Directors on oversight of risk.

The Committee will seek assurance that the Trust's risk management process is effective by assessing, reviewing and monitoring:

- The systems, policies and practices in place to ensure robust risk management processes including the application of best practice such as the HM Treasury 'Three Lines of Defence' model.
- The completeness and accuracy of identified risks on the corporate risk register.
- The implementation of the Trust's risk management strategy and policy
- The effectiveness of processes that are in place to ensure the escalation of risks from local and divisions risk registers to the corporate risk register

Culture

- 5.10 To maintain oversight of the implementation of the cultural transformation plan
- 5.11 To seek assurance the Trust's activities are systematically and effectively promoting health and wellbeing, and psychological safety.
- 5.12 To seek assurance that the Trust has a comprehensive Leadership Development programme in place to support all leaders and which is designed to reinforce the culture the Trust is seeking to achieve and will evaluate the effectiveness of the programme to inform further improvements.
- 5.13 To seek assurance the Trust has a systematic approach to assessing culture, relationships and behaviours within teams and that where issues are identified, each team has a suitable action plan to address any findings.
- 5.14 To review and monitor performance against people-related policies and procedures to seek assurance they will positively enhance the Trust's culture and receive assurance on their implementation timeliness, fairness, integrity and consistency.

- 5.15 To maintain oversight of improvements arising from the triangulation of feedback from staff surveys, investigations, employment tribunals exit interviews, Freedom to Speak Up Guardians and other sources.
- 5.16 To seek assurance on the development of the Trust's staff engagement and communications strategies and related programmes of work;
- 5.17 To seek assurance engagement and consultation processes with staff, stakeholders and communities reflect the ambition and values of the Trust and also meet statutory requirements;
Policy and
- 5.18 To seek assurance the Trust's values and appropriate standards of behaviour in accordance with the Standards of Business Conduct/Conflicts of Interest Policy and Professional Leaderships Behaviours, are being practiced throughout the organisation;
- 5.19 To review and monitor implementation of the Trust's annual workforce plans.
- 5.20 To receive assurance that staff engagement and satisfaction levels are being managed through delivery of initiatives such as the Staff Survey and recognition and reward initiatives
- 5.21 To receive reports and action plans on the requirements of new and emerging guidance from regulators and external agencies that relate to workforce.
- 5.22 To receive assurance that all staff are receiving an effective annual appraisal and that robust succession plans and talent management processes are in place.
- 5.23 To receive assurance as to whether statutory and mandatory training requirements are being complied with.
- 5.24 To receive the results and monitor progress against action plans in relation to the NHS Staff Survey, Staff Friends and Family Test and other workforce satisfaction measures as agreed.
- 5.25 To receive reports relating to the creation and delivery of workforce plans aligned to Trust and Integrated Care System strategies to provide assurance that the Trust has adequate staff with the necessary skills and competencies to meet the future needs of patients and service users;
- 5.26 To consider the control and mitigation of workforce related risks and provide

assurance to the Board that such risks are being effectively controlled and managed

- 5.27 To receive assurance that the Trust is meeting the quality assurance requirements of education and professional development in relation to nursing, medicines and allied health professionals
- 5.28 To oversee the regular review and development of the Trust's Health and Wellbeing services, and make recommendations to the Trust Board for approval
- 5.29 To oversee the regular review and development of the Trust's recruitment and retention strategies and plans, and where appropriate makes recommendations to the Trust Board for approval
- 5.30 To oversee the regular review and development of the Trust's training and development strategies and plans, and where appropriate makes recommendations to the Board of Directors for approval
- 5.31 To gain assurance that the attraction recruitment and retention strategies, plans and implementation are effective and where appropriate test the data and alternative approaches.
- 5.32 To oversee the regular review and development of new roles and career pathways, and where appropriate makes recommendations to the Trust Board for approval.
- 5.33 To oversee the innovation, research and development in place to develop a dynamic new workforce to meet the future needs of the population, and where appropriate makes recommendations to the Trust Board for approval.
- 5.34 To oversee the development and ongoing monitoring of strategic partnerships; including, but not limited to, education, schools and the university sector.

6. Meeting, quoracy and voting

- 6.1 The Committee will meet in private.
- 6.2 The Committee will normally be held on a bi-monthly basis in accordance with the arrangements for calling meetings as set out in the Standing Orders.

- 6.3 Additional meetings may be held on an exceptional basis at the request of the Chair or members of the Committee.
- 6.4 When the Chair of the People Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as they shall specify.
- 6.5 The Board, Chair or Chief Executive of the Trust may ask the People Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.
- 6.6 In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

7. Quorum

- 7.1 For a meeting to be deemed quorate the following members should be present:
 - a) **A minimum of two Non-executive members (which may include an associate NED) of the Board, and either the Chief People Officer and Chief Nursing Officer or Chief Medical Officer.**
- 7.2 If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.
- 7.3 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
- 7.4 If it is deemed that a decision cannot be taken because matters relating to conflict of interest result in the Committee not being able to be quorate at any time, the matter will be referred to The Board.

8 Decision making and voting

- 8.1 Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.
- 8.2 Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.
- 8.3 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

- 8.4 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis using telephone, email or other electronic communication.

9 Accountability and reporting

- 9.1 The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.
- 9.2 The minutes of the meetings or a summary of the minutes shall be formally recorded by the secretary and submitted together with recommendation where appropriate, to the Board, in accordance with the Standing Orders.
- 9.3 The submission to the Board shall include details of any matters in respect of which actions or improvements are needed.
- 9.4 The Committee will submit an assurance report to The Board following each of its meetings,
- 9.5 Public reports will be made as appropriate to satisfy any requirements in relation to disclosure of public sector executive pay.
- 9.6 The Committee will provide the Board with an Annual Report. The report will summarise its conclusions from the work it has done during the year.

10 Notice of meetings

- 10.1 Notice of any Committee meeting must indicate:
- a) Its proposed date and time, which must be at least five (5) working days after the date of the notice, except where a meeting to discuss an urgent issue is required (in which case as much notice as reasonably practicable in the circumstances should be given).
 - b) Where it is to take place.
 - c) An agenda of the items to be discussed at the meeting and any supporting papers.
 - d) If it is anticipated that members of the Committee participating in the meeting will not be in the same place, how it is proposed that they should communicate with each other during the meeting.

11 Policy and best practice

- 11.1 The Committee will be conducted in accordance with the Trust policy on Standards of Business Conduct, specifically:
- a) There must be transparency and clear accountability of the Committee.
 - a) The Committee will hold a members Declaration of Interests register which will be noted at each meeting of the Committee and presented when updated
 - b) Members must declare any interests and /or conflicts of interest at the start of the meeting. Where matters on conflicts of interest arise, the Chair will determine what action to take. This may include requesting

that individuals withdraw from any discussion/voting until the matter(s) is concluded

- 11.2 Members of the Committee should aim to attend all scheduled meetings each financial year.
- 11.3 Committee members and participants must maintain the highest standards of personal conduct and in this regard must comply with:
 - a) The laws of England and Wales
 - b) The spirit and requirements of the NHS Constitution
 - c) The Nolan Principles
 - d) Any additional regulations or codes of practice relevant to the Committee

12 Secretariat

- 12.1 The Company Secretary or their nominated deputy shall be the secretary to the Committee and will provide administrative support and advice. The duties of the secretariat include but are not limited to:
 - a) Agreement of the agenda with the Chair of the Committee and attendees together with the collation of connected papers;
 - b) Taking the minutes and keeping a record of matters arising and issues to be carried forward;
 - c) Advising the Committee as appropriate
 - d) Reviewing every decision to suspend the standing orders.
- 12.2 Before each Committee meeting an agenda and papers will be sent to every Committee member no less than five (5) business days in advance of the meeting, unless the meeting has been convened at short notice, in which case papers will be sent at the earliest opportunity.
- 12.3 If a Committee member wishes to include an item on the agenda, they must notify the Chair no later than ten (10) business days prior to the meeting. In exceptional circumstances for urgent items this will be reduced to five (5) business days prior to the meeting. The decision as to whether to include the agenda item is at the discretion of the Chair.

13 Use of groups or task and finish groups

- 13.1 The People Committee may appoint groups or task-and-finish groups to advise it and assist in fulfilling its duties. However, the People Committee cannot delegate any of its decision-making authority to any group or task and finish group.
- 13.2 The People Committee shall approve the membership and terms of

reference for these groups and receive reports as appropriate.

The groups of the Committee are:

- Equality Steering Group
Local Academic and Medical Education Board
- Nursing, Midwifery and Allied Health Professionals, Recruitment, Retention, Education and Development Group
- Mandatory Learning Oversight Group
- Joint Local Negotiating Committee for medical and dental staff
- Joint Staff Committee for Afc staff

14 Confidentiality

14.1 Members of the Committee shall respect the confidentiality requirements set out in MFT's Standing Orders, relevant corporate policies and these Terms of Reference unless separate confidentiality requirements are set out for the Committee in which event these shall be observed.

14.2 Decisions of the Committee will be published by the Committee except where matters under consideration or when decisions made are of a confidential nature, in which case they will be excluded from any public record and shall not be publishable.

15 Review

15.1 The Terms of Reference of the People Committee will be reviewed by members of the Committee and the Board annually, or as required in line with any developments or changes to the Trust constitution, national guidance, or feedback from auditors, with recommendations made to the Board for approval.

15.2 As part of the Board's annual performance review process, the Committee shall review its collective performance and put measures in place to implement any identified areas of improvement

MEDWAY NHS FOUNDATION TRUST
CASH COMMITTEE
TERMS OF REFERENCE

Approved:

Version Control:

<i>Version No</i>	<i>Amendment</i>	<i>Amendment Owner</i>	<i>Date of Amendment</i>
1.0	Original Draft		
1.1	Amendments following initial feedback	Deputy CFO	20 May 2026

Medway NHS Foundation Trust

Cash Committee

Terms of Reference

1. Introduction

- 1.1. The Cash Committee (the Committee) is established as a standing Committee in accordance with the Medway NHS Foundation Trust (the Trust) Constitution, Standing Orders and Scheme of Reservation and Delegation (SORD). These Terms of Reference set out the remit, responsibilities, delegated authority, membership and reporting arrangements of the Committee
- 1.2. The Committee is accountable to the Trust Board (the Board) and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the Trust
- 1.3. The Committee is authorised by the Board to act within its Terms of Reference. All employees and individuals appointed by the Trust are directed to co-operate with any request made by the Committee
- 1.4. The Committee will liaise with and function as a resource for other Trust committees and forums, where specific matters are most appropriately considered by the Committee in line with its responsibilities
- 1.5. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and can request the attendance of individuals and authorities outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions
- 1.6. Where the Board scrutiny or decision is required for related matters, the Committee will consider these in advance and act as the sponsor for any recommended action/decision required by the Board
- 1.7. The remit of the Committee is outlined below. The nature of how these are delivered will be determined by the Committee Chair in discussion with the relevant lead executive officer of the Trust

2. Purpose

- 2.1. To provide assurance to the Board in consultation with the other Board committees that adequate and appropriate governance structures, processes and controls are in place throughout the Trust in respect of treasury management. In particular:
 - a) To scrutinise, understand and challenge the rolling 13-week and 12-month cash flow forecasts, including variance analysis as appropriate. This will include an

overview of:

- cash flows relating to all aspects of clinical and non-clinical income and other contractual arrangements;
 - capital receipts and expenditure;
 - all payroll related cash outflows e.g. salaries, Tax & NI, non-contractual pay and all non-pay expenditure.
- b) Ensure sufficient liquidity to meet obligations and minimise financing costs.
 - c) Consider and probe receivable and payable management performance, including Better Payment Practice Code compliance.
 - d) Identify and escalate risks to cash flow and liquidity, including making recommendations to the Trust Board in respect of cash support/loan applications.
 - e) To continually review and assess the appropriateness of arrangements in place within the Trust in respect of cash management and reporting of cash position/forecasts.

3. Authority

3.1. The Committee is authorised by the Board to:

- a) Investigate any activity within its terms of reference
- b) Seek any information it requires within its remit, from any employee or member of the Trust (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference
- c) Commission any reports it deems necessary to help fulfil its obligations
- d) Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the Trust for obtaining legal or professional advice
- e) Create task and finish sub-groups to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the Trust's constitution, standing orders and SORD but may/may not delegate any decisions to such groups

4. Membership and Attendance

Membership

4.1 The Committee members shall be appointed by the Board in accordance with the

Trust Constitution

- 4.2 The Board will appoint a minimum of two Non-Executive Members (one of whom is the Chair) of The Board to the Committee. In addition, the Committee will include the following participants who are required to attend all meetings of the Committee:
- a) Chief Finance Officer
 - b) Deputy Chief Finance Officer
 - c) Financial Controller
- 4.3 Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair.
- 4.4 Other members of the Committee need not be members of the Board or employees of the Trust, but they may be
- 4.5 When determining the membership of the Committee, active consideration will be made to diversity and equality
- 4.6 The Chair of the Board may be a member of the Committee but may not be appointed as the committee Chair.

Chair

- 4.7 The Committee will be chaired by a Non-Executive Member of the Board appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee
- 4.8 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference

Attendees

- 4.9 Only members of the Committee have the right to attend Committee meetings, but the Chair may invite relevant attendees to the meeting as necessary in accordance with the business of the Committee
- 4.10 Meetings of the Committee may also be attended by the following individuals who are not members of the Committee for all or part of a meeting as and when appropriate. Such attendees will not be eligible to vote:
- a) Chief Executive Officer
 - b) Associate Director of Procurement
 - c) Turnaround / Recovery Director
- 4.11 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

- 4.12 Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions or to present papers as per the annual work plan.
- 4.13 Trust Directors and/or staff and Executives shall be invited to attend those meetings in which the Committee will consider areas of risk or operation that are their responsibility

5. Meetings, Quorum and Voting

- 5.1 Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavor to reach a collective view.
- 5.2 Meetings of the Committee will not be open to the public. Papers and minutes of Committees meetings will be subject to the Freedom of Information Act 2000 and disclosable to the public, unless the Chair determines that disclosure would be prejudicial to the public interest or the interests of the Trust by reason of the confidential nature of the business transacted or for other special reasons. These should be stated in the documents and minutes of the meeting.
- 5.3 In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.
- 5.4 The Committee shall be quorate with at least 50% of members being in attendance, including the Committee Chair.
- 5.5 The aim of the Committee will be to achieve consensus decision-making wherever possible with the show of hands. Where a vote is required, each member of the Committee shall have one vote. The Committee shall approve a recommendation subject always to the meeting being quorate and the majority of Members present approving the proposal. Where the vote is tied, the Chair shall have a casting vote.

Decision making and voting

- 5.6 Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. If this is not possible the Chair may call a vote
- 5.7 Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter

- 5.8 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote
- 5.9 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis using telephone, email or other electronic communication

6. Accountability and reporting

- 6.1 The Chair will provide assurance reports to the Board at each meeting as deemed necessary and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

7 Notice of Meetings

- 7.1 Notice of any Committee meeting must indicate:
- a) Its proposed date and time, which must be at least five working days after the date of the notice, except where a meeting to discuss an urgent issue is required (in which case as much notice as reasonably practicable in the circumstances should be given).
 - b) Where it is to take place.
 - c) An agenda of the items to be discussed at the meeting and any supporting papers.
 - d) If it is anticipated that members of the Committee participating in the meeting will not be in the same place, how it is proposed that they should communicate with each other during the meeting.

8 Policy and best practice

- 8.1 The Committee will be conducted in accordance with the Trust policy on Standards of Business Conduct, specifically:
- a) There must be transparency and clear accountability of the Committee.
 - b) Members must declare any interests and /or conflicts of interest at the start of the meeting. Where matters on conflicts of interest arise, the Chair will determine what action to take. This may include requesting that individuals withdraw from any discussion/voting until the matter(s) is concluded.
- 8.2 Members of the Committee should aim to attend all scheduled meetings each financial year.
- 8.3 Committee members and participants must maintain the highest standards of personal conduct and in this regard must comply with:

- a) The laws of England and Wales
- b) The spirit and requirements of the NHS Constitution
- c) The Nolan Principles
- d) Any additional regulations or codes of practice relevant to the Committee

Equality diversity and inclusion

- 8.4 Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

9 Secretariat

- 9.1 The Company Secretary, supported as required by the Deputy Chief Financial Officer, shall be the secretary to the Committee and will provide administrative support and advice. The duties of the secretariat include but are not limited to:
- a) Agreement of the agenda with the Chair of the Committee and Executive Lead
 - b) Collation of connected papers and circulation of the pack five (5) working days prior to the meeting
 - c) Taking the minutes, action log and keeping a record of matters arising and issues to be carried forward
 - d) Advising the Committee as appropriate
 - e) Reviewing every decision to suspend the standing orders
- 9.2 Before each Committee meeting an agenda and papers will be sent to every Committee member no less than five (5) working days in advance of the meeting, unless the meeting has been convened at short notice, in which case papers will be sent at the earliest opportunity.
- 9.3 If a Committee member wishes to include an item on the agenda, they must notify the Company Secretary/Executive Lead and Chair no later than ten (10) business days prior to the meeting. In exceptional circumstances for urgent items this will be reduced to five (5) business days prior to the meeting. The decision as to whether to include the agenda item is at the discretion of the Chair.

10 Confidentiality

- 10.1 Members of the Committee shall respect the confidentiality requirements set out in the Trust's Standing Orders, relevant corporate policies, and these terms of the Committee in which event these shall be observed
- 10.2 Decisions of the Committee will be published by the Committee except where

matters under consideration or when decisions made are of a confidential nature, in which case they will be excluded from any public record and shall not be publishable

11 Review

- 11.1 The Terms of Reference of the Committee shall be reviewed by members of the Committee and the Board at least annually, or as required in line with any developments or changes to the Trust's constitution, national guidance, or feedback from auditors, with recommendations made to the Board for approval.
- 11.2 As part of the Board's annual performance review process, the Committee shall review its collective performance and that of its individual members.

Appendix 1

This guidance aims to promote fiscal responsibility that do not compromise effective, efficient and economic delivery of services.

1. Treasury management

The key responsibilities of Treasury Management roles within the Trust are detailed below:

Trust Board of Directors

- Approve external funding arrangements and overall treasury policy.
- Delegation of responsibility for approval of the Trust's treasury procedures, controls and detailed policies to the Cash Committee.

Cash Committee

- Approve the Trust's borrowing strategy and policies.
- Ensure that the Trust's borrowing strategy is applied with a view to mitigating risk.
- Approve the Trust's interest rate risk management strategy and policies
- Review and monitor borrowing policy and performance against the relevant benchmarks in respect of all Trust funds (revenue, capital and charitable)
- Monitor compliance with treasury policies and procedures on borrowing in respect of limits, approved counterparties and types of investments
- Ensure bank mandates are in place for all accounts and that such mandates are updated for changes in signatories and authority levels
- Approve external funding arrangements within delegated authority
- Delegate responsibility for treasury management operations to the Chief Finance Officer
- Promote good financial practice throughout the Trust
- To make recommendations for the application and draw down of cash support applications.

Chief Finance Officer

- Approve cash budgets and cash management systems
- Define the Trust's treasury management approach for approval by the Cash Committee
- Ensure treasury activities are reported on a timely and accurate basis to the Cash Committee
- Manage key banking relationships
- Manage treasury activities within agreed policies and procedures
- The Chief Finance Officer will hold regular meetings with the Treasury Management team to discuss issues and consider any points that should be brought to the attention of the Cash Committee

Deputy Director of Finance (in conjunction with the Financial Controller)

- Ensure treasury activities are reported on a timely and accurate basis to the Chief Finance Officer
- Manage key banking relationships

- Manage treasury activities within agreed policies and procedures
- Ensure accurate and timely recording and reconciliation of the accounting records of all treasury transactions

The overall objectives of the Cash Committee in relation to operating treasury management are to:

- Manage the financial risk associated with operational activities such as interest rate risk, and
- Ensure availability of competitively priced funding for working capital with an acceptable risk profile.

2. Treasury management

The principal role of treasury management is to maintain liquidity, to mitigate and manage risk and to ensure a competitive return within an acceptable risk profile. The objectives of treasury management are to undertake the following key objectives:

1. To ensure the availability of flexible competitively priced funding from alternative sources to meet the Trust's current and future requirements.
2. Identifying and managing the financial risks arising from operational activities.
3. Develop and maintain strong, long-term relationships with a core group of quality banks that can meet current and future funding requirements.

3. Funding

From a funding perspective the key objective is to ensure the availability of flexible and competitively priced funding from alternative sources to meet the Trust's current and future requirements.

The Trust will continue to maintain a risk-averse approach to funding, recognising the on-going requirements to have committed funds in place to cover existing business cash flows and to provide flexibility for seasonal cash-flows and capital expenditure programmes. As a consequence:

- Approval is required from the Board of Directors prior to obtaining any proposed funding facilities;
- Forbids entering trading positions or purely speculative trading, and;
- Forbids pre-financing in anticipation of potential projects.

4. Identifying and managing operational risk

The regular reporting of treasury activities is crucial in allowing all relevant parties to be aware of transactions undertaken and to appreciate the Trust's financial position.

The treasury controls proposed are designed to ensure the Trust's treasury activities are undertaken in a controlled and a properly reported manner. The key components will include:

- Clearly defined roles and responsibilities in treasury activities for the Board, the Cash Committee and the Chief Finance Officer;
- Regular reporting of treasury activities;
- Controls on who can operate bank accounts and authorisation limits, and;

- Segregation of duties between those who deal, those who initiate payment and those who account for treasury activities;

The Trust's treasury procedures will be subject to periodic review by both internal and external audit and any significant deviations from agreed policies and procedures will be reported, where appropriate, to the Cash Committee.

5. Treasury management controls

The overall objective of the Committee is to ensure Treasury activities are undertaken in a controlled manner, thereby ensuring that the Trust is not exposed to undue operational risks. This will be achieved by ensuring:

- Segregation of duties is specified between those who deal, those who initiate payments and those that account for transactions;
- Confirmation of transactions will be requested from all counterparties and subsequently reviewed;
- All transactions are recorded within the General Ledger system and supported by appropriate instruction/confirmation;
- All payment instructions/confirmations will require two authorised signatories in accordance with the approved bank mandates; and
- Bank mandates are regularly reviewed and sent to all counter-parties.

All bank mandates are maintained within the finance department with each mandate being approved by the Cash Committee as to signatories and appropriate limits.

Meeting of the Trust Board, 1 July 2026

Title of Report	Governance Framework update	Agenda Item	6.2			
Author and Job Title	Interim Company Secretary					
Lead Executive	Chief Executive					
Executive Summary	Approval	x	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 overview of work that is required to progress the remaining elements of the governance framework.					
Proposal and/or key recommendation:	The Board is asked to: 1. Note the update on the governance framework 2. Note and approve the proposed Board Development Plan as set out in Appendix A 3. Note and approve the proposed Annual workplan as set out in Appendix B 4. Note and approve the next steps in relation to the priorities for the progression of the undertakings.					
Governance Route Meeting: Date submitted:	The Board will receive an update on the undertakings at the September Board meeting					
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:				

GOVERNANCE FRAMEWORK AND UNDERTAKINGS UPDATE

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 Board and Committee effectiveness and terms of reference

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 was carried out in April and formally received by the Board in May and will feed into the overall board development priorities for the 2026/27 period, which are incorporated within this report as **Appendix A**

The Board formally received its annual effectiveness review in May and accepted the adoption of the recommendations below

Recommendation 1

A board level cultural transformation development programme should be considered

June progress update:

A cultural transformation program is in place, this includes Non-Executive and Executive Director input

Recommendation 2:

Further work is required to ensure that:

- a. A review is undertaken to ascertain which strategies are required, and therefore still extant, and if necessary duplication addressed
- b. Delivery of the strategic objectives are aligned with board and committee business to ensure they have effective oversight.
- c. Consideration should be given to introducing a set of Key Performance Indicators (KPIs) for the Board and committees to monitor implementation of the strategic objectives

June Progress update

This work will be incorporated through the implementation of actions relating to strategy which are set out below in section 4 of this report.

Recommendation 3

The Board development plan should incorporate a review of the priority strategies of the Trust

June Progress update:

This work will be incorporated within the refresh of the Board Development plan in quarter two

3.0 Review of Committee effectiveness and terms of reference

An annual review of terms of reference have been carried out taking into account findings from the annual review of effectiveness of the committees.

The updated terms of reference are incorporated separately on the agenda

Key findings from the effectiveness review have indicated a requirement for timely and robust reporting as well as the need to refresh workplans to reflect the priorities of the Committees so that updates are received prospectively rather than reactively, either through the regular compliance report or as specific updates.

At the February Board development day consideration was given to the Board Committee infrastructure, whether any changes were required to enhance assurance.

There was a specific focus on

- 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.

This was then factored into the terms of reference of the Finance, Planning and Performance Committee which are incorporated on the agenda under item 6.1

Terms of reference of the Quality Assurance Committee were agreed by the Board on 6th of May 2026.

The remaining terms of reference are incorporated under item 6.1 and these are for the People, Audit and Cash Committee

In undertaking this work consideration was given to the delegated authorities of the committees which are in the refreshed Standing Financial Instructions.

The Committees reviewed their effectiveness between April and June and where relevant updates are incorporated within terms of reference.

4.0 Update on 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

Work is still ongoing to align the objectives with SMART deliverables, which will feed into the Board Assurance Framework. The Board Assurance Framework will be considered at the September Board following the completion of this work.

The annual workplan of the Board will also be updated to incorporate the strategic outcomes, and in the meantime, it has been refreshed to incorporate best practice reports, which are incorporated as **Appendix B**.

5.0 Standing Financial Instructions and Scheme of Delegation

The Board approved the Standing Financial Instructions and Scheme of Delegation in May, which enabled delegated limits for the Board Committees and the tighter grip and control in relation to financial approvals.

6.Next Steps

As part of the development of the Governance Framework and compliance with the undertakings the following will be undertaken in quarter two:

- Identification of Strategic Objective deliverables
- Refresh of the Board Assurance Framework to reflect the strategic objective deliverables
- Completion of the Financial Recovery Plan
- Progression of actions required to achieve compliance with CQC regulations 10 (privacy and dignity) and 12 (safety)
- Commissioning of a well led review in quarter three
- Appointment and onboarding of new executive team
- Implementation of Board Development Programme

7.0 Recommendations

The Board is asked to:

1. Note the update on the governance framework
2. Note and approve the proposed Board Development Plan as set out in **Appendix A**
3. Note and approve the proposed Annual workplan as set out in **Appendix B**
4. Note and approve the next steps in relation to the priorities for the progression of the undertakings

Trust Board Work Plan Annual Work Plan 2026 -27

		2026				2027	
Item	Lead	May	Jul	Sept	Nov	Jan	Mar
Preliminary Standing Items							
Welcome and Apologies	Chair	X	X	X	X	X	X
Quorum	Chair	X	X	X	X	X	X
Declarations of Interest	Chair	X	X	X	X	X	X
Chairs Report	Chair	X	X	X	X	X	X
Chief Executive Report	Chief Executive	X	X	X	X	X	X
Minutes of previous Meeting	Chair	X	X	X	X	X	X
Matters Arising and Action Log	Chair	X	X	X	X	X	X
Standing Items							
Board Assurance Framework	Company Secretary			X	X	X	X
Risk and Issues Register	Chief Nursing Officer	X	X	X	X	X	X
Annual review of risk appetite statement							
Integrated Quality Performance Report	Chief Operating Office	X	X	X	X	X	X
Patient /Staff story	Chief Nursing Officer/Chief People Officer			X	X	X	X
Committee Chair's Report	Committee Chair	X	X	X	X	X	X
Kent and Medway Joint Committee update	Chair and Chief Executive		X		X		X
Lead Governors Report	Lead Governor	X	X	X	X	X	X
Financial Recovery Plan Report	Chief Finance Officer		X		x		X
Cost Improvement Plans	Chief Finance Officer		X	X	X	X	X
Capital update	Chief Finance Officer		X		x		x
Board Designations report	Company Secretary				X		
Statutory and Regulatory Papers							
Maternity Workforce Oversight Report	Chief Nursing Officer		X			X	
Maternity CNST Compliance Assurance Report - Updates and Actions	Chief Nursing Officer		X		X	X	
Perinatal Quality Surveillance Report	Chief Nursing Officer	X	X		X		X
Perinatal Culture Leadership Report	Chief Nursing Officer	X	X		X		X
Maternity; Claims, Incidents, Complaints Triangulation Report	Chief Nursing Officer	X	X		X		X
Annual Learning From Deaths report	Chief Medical Officer						
Health and Safety Annual Report	Chief Nursing Officer		X				
Safe Staffing	Chief Nursing Officer						X
Emergency Preparedness, Resilience and Response – Policy	Chief Operating Officer	X					

Trust Board Work Plan Annual Work Plan 2026 -27

Item	Lead	2026				2027	
		May	Jul	Sept	Nov	Jan	Mar
Emergency Preparedness, Resilience and Response - Annual Assurance Rating	Chief Operating Officer				X		
Medical Education Annual Report	Chief Medical Officer				X		
Safeguarding Annual Report	Chief Nursing Officer			X			
Data Security Protection Toolkit	Deputy Chief Executive			X			
Medical Examiner - To Attend Board	Chief Medical Officer			X			X
Learning from Deaths – Quarterly Structured Judgement Review (Board Development session)	Chief Medical Officer		X		X		X
Annual Learning from Deaths report: 2025/26 (September 2026) and 2026/27 in March /May 2027	Chief Medical Officer			X			X
Medical Education (focus on Paediatrics and General Surgery)	Chief Medical Officer						
Information Governance Annual Report	Deputy Chief Executive		X				
Freedom to Speak Up Annual Report	Freedom to Speak Guardian		X			X	
Annual review of Constitution	Company Secretary		X				
Annual review of Board effectiveness	Company Secretary						X
Annual review of Board committee terms of reference	Company Secretary		X				
Annual report of Board Committee Chair and outcome of effectiveness review	Committee Chairs	X					
Provider License Undertakings update	Company Secretary			X		X	
Regulatory and statutory horizon scanning report	Company Secretary		X			X	
Gender Pay Gap report	Chief People Officer	X					
Annual review of register of interests	Company Secretary				X		
Strategies (as and when required) some to be approved virtually as directed	Director of Strategy			x		x	x
Ratification of Policies: a) Trust Risk Management Framework b) Freedom of Information c) Safeguarding Complaints d) Standards of Business Conduct e) Integrated Governance f) Health and Safety g) People	Company Secretary	X					
Medical Appraisal and Revalidation - Annual Report	Chief Medical Officer			X			
League of Friends - Annual Update	League of Friends				X		

Trust Board Work Plan Annual Work Plan 2026 -27

Item	Lead	2026				2027	
		May	Jul	Sept	Nov	Jan	Mar
Annual Guardian of Safe Working Report	Chief Medical Officer			X			X
Annual Business Plan	Deputy Chief Executive	X					
PLACE Assessment Action Plan	Chief Operating Officer						
Green Plan – Review	Chief Executive	X					
Kent and Medway NHS Strategy 2024/25 – 2029/30	Deputy Chief Executive						
Finance Report	Chief Finance Officer	X	X	X	X	X	X
Integrated Improvement Plan	CE/Deputy CE				X	X	X
Standing Financial Instructions and Scheme of Delegation	Chief Finance Officer		X				
Annual Accounts – Review	Chief Finance Officer						X
Annual Report and Accounts	Chief Financial Officer/Company Secretary		X				
Questions from the Public	Chair	X	X	X	X	X	X
Matters to report to the Council of Governors	Chair	X	X	X	X	X	X
Reflection	Chair	X	X	X	X	X	X
Any Other Business	Chair	X	X	X	X	X	X
Removed Items							

MEDWAY NHS FOUNDATION TRUST
TRUST BOARD REGISTER OF INTERESTS
JULY 2026

Name	Position	Organisation	Nature of Interest
John Goulston	Chair	Kent Community Health NHS Foundation Trust – Chair <i>From 1/11/2018 to 30/6/26</i>	Non-Financial Professional Interests from November 2018 [Extended contract for six months from July 2025]
		NHS London Procurement Partnership – Chair	Non-Financial Professional Interests from January 2019
		Medinet Ltd – Advisor	Financial Interests from July 2023
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Jenny Chong	Non-Executive Director/ Senior Independent Director	Knightingale Consulting	Managing Partner from Sept 2019
		Vitalis Ortho	Board Observer from June 2026
		Imperial College London, Imperial Venture Mentoring Services	Deputy Chair, Board Member, Mentor and Advisor since July 2020
		Imperial College London, Engineering Faculty, Imperial Technology Expert Services	Industry Expert since September 2020
		The Design Museum	Co-opted Member of the Finance and Operations Committee since November 2020
		Lightning Social Ventures	Board Advisor since Jan 2021
		NHS Innovation Accelerator	Mentor since October 2021
		Egypt Exploration Society	Trustee, co-opted Member of Finance Committee since Nov 2020
		Healthcare Excellence Through Technology	Steering Committee Member since Jan 2023
		Orthopaedic Research UK	Board Trustee 11 June 2023
		National Institute for Health Research: Invention for Innovation (i4i) Product Development Awards Committee B	Funding Panel Committee Member since 23 November 2023
		Shuri Network	Steering Committee Member since November 2023
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Paulette Lewis	Non-Executive Director		
		Caribbean Nurses and Midwives Association (UK)	President since January 2021
		Management/Leadership Consultant	Since September 2008
		Croydon BME Forum	Chair since April 2019
		Member CNO BME Strategic Committee	From 2008
		Non-Financial Fellow of the International Information Management	From 2024

Name	Position	Organisation	Nature of Interest
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Gary Lupton	Non-Executive Director	Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Mojgan Sani	Non-Executive Director	Non-Executive Director Sussex Community NHS Foundation Trust	Non-Executive Director
		South East Coast Ambulance Service	Non-Executive Director
		University of Portsmouth	Visiting Professor (honorary role, no salary)
		Care Quality Commission (supporting inspections as required)	Specialist Advisor since 2016
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Helen Wiseman	Non-Executive Director	BID Corporation	Non-Executive Director on the board.
		SFI Investment Trust (Pty) Ltd	Director since September 2021
		INSEAD International Directors Network	President since December 2019
		INSEAD International Directors Club	Director since November 2022
		Imalia Pty Ltd Insurance Services	Executive Director since December 2010
		Wisewoman Pty Ltd – Consultancy	Executive Director since July 2004
		Cook Management Pty Ltd	Executive Director since July 2004
		Nine on Purpose Pty Ltd	Executive Director since July 2018
		Elancial Ltd – Consultancy	Executive Director since February 2022
		Canterbury Cathedral	Chair of Audit and Risk Committee
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
		Non-Executive Director Kent and Medway Social Care Partnership	Trading/Potential Shared Clients since April 2020
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
		Acute Hospital Member on the Kent and Medway ICB Board	April 2023
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Alison Davis	Chief Medical Officer	Hospitaller, St Johns Ambulance, Kent County Priory Group	Non-financial personal interest
		CQC Specialist Advisor Ophthalmology	Secondary employment (CQC)
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Simon Wombwell	Chief Finance Officer (Interim)	Luxhay Ltd – Consultancy services to NHS	Director/Shareholder
		Worksights Ltd/Role My Shift	Partner is a Director/Shareholder
		St. Vincent's Consulting	Advisor
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Sheridan Flavin	Chief People Officer	Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Darren Palmer	Interim Chief Operating Officer	Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Evonne Hunt	Chief Nursing Officer	Kent and Medway ICB	Husband works for Kent and Medway ICB

Name	Position	Organisation	Nature of Interest
	(seconded Dec '23)	Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Siobhan Callanan	Interim Chief Executive	Dartford Gravesham Trust Medway NHS Foundation Trust Charitable Funds	On secondment from Dartford Gravesham Trust Member of the Corporate Trustee
Sheridan Flavin	Chief People Officer	Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Frances Woodroffe	Deputy Chief Executive	Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee

Meeting of the Trust Board in Public

1 July 2026

Title of Report	Annual review of Constitution	Agenda Item	6.4
Author and Job Title	Interim Company Secretary		
Lead Executive	Chief Executive		
Executive Summary	Approval	X	Assurance
			Noting
	The Constitution has been subjected to an annual review process and changes are set out in section 2 of this report and reflected in the updated document attached as Appendix A of this document. Of particular relevance to the Board are the changes highlighted in section 5.2 of the Board's Standing Orders in relation to joint committees. Following the National Health Service Act 2006 being amended by the Health and Care Act 2022, which mainly came into effect on 1 July 2022, ICB Boards, their NHS providers and local authorities can now explore the powers set out in ss.65Z5 and 65Z6 to implement joint working arrangements between the ICB, NHS providers '[and local authorities to work together more closely, including by delegating or jointly exercising some statutory functions Other changes have been made in order to enable consistency with the updates to the governance infrastructure		
Proposal and/or key recommendation:	The Board is asked to : 1. Note and endorse the proposal to change the maximum term of a governor from six to nine years as set out in section 13.3 of the constitution and summarised in section 2 of this report 2. Note and endorse the proposal to change the appointment term of a lead governor from two years to either two or three years from the next appointment process 3. Note and endorse the incorporation of the provision relating to Joint Committees in the Standing Orders of the Board to enable the formation of joint committees 4. Note and endorse the proposed changes to the Constitution as incorporated in appendix A		
Governance Route Meeting: Date submitted:	Following consideration of the proposed Constitution by the Board it will then be submitted to the Council of Governors on 22 nd July , and onto the Annual Members Meeting in September as one of the changes relates to the role of governors		
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:	Not applicable			
Sustainability and/or Public and patient engagement considerations:	None			
Integrated Impact assessment	Yes	No		N/A
				X
Freedom of information status	Disclosable	x	Exempt	
For further information please contact:				

1.0 Background and Context

The Constitution has been reviewed as part of an annual process to ensure an alignment with the Standing Financial Instructions and the Corporate Governance infrastructure.

In addition, the Standing Orders of the Council of Governors have been updated to enable governors to serve the maximum term of nine years, and the Lead Governor to serve either a two- or three-year term, depending on their overall term of office.

It is worth noting that neither of the changes to the Council of Governors Standing Orders cannot be retrospectively applied, and will take effect for future appointments after the agreement of the document.

The document is submitted as a consultation document ahead of its submission to Board in July 2026 and the Council of Governors for ratification in the same month, with the exception of the provisions relating to the term of office for governors.

The document also incorporates the Nominations Committee, which is featured separately on this agenda.

Changes to the document are set out in section 2 of this report.

Procedurally, Section 41 of the constitution requires that any changes or amendments to the duties, role or powers of the Governors are approved at the Annual Members Meeting in September

2.0 Summary of Changes to Constitution

The Constitution has been reviewed as part of the refresh of the Governance Framework of the Trust .

Trust Constitution Section	Provision change
13. Council of Governors – tenure	
Section 10.1 – Annual Members meeting	Added provisions relating to the requirement to present the annual accounts and annual report to the Annual Members meeting. Incorporated the requirement for changes relating to the role, powers and duties of governors to be approved at the Annual Members meeting.
Section 13.3 term of office of a governor	This section has been changed to reflect the maximum term for a governor An elected Governor shall only be able to serve a maximum of three terms or nine years (This was previously 2 three-year terms)
Section 14 : Appointment and removal of Non-Executive Directors	Change of number of governors on interview panel from 4 to 2, and removal of the CPO and Company Secretary as a requirement on the panel
15. Appointment of a lead governor	
Section 15.4 term of a lead governor	This provision has been amended to enable the Council of Governors the flexibility to appoint a Lead Governor for either a two year or three-year term
36 Audit and Risk Committee	
	Reference to Audit and Risk Committee amended to Audit Committee to reflect the change in role of the Committee
Annex 4 :Standing Orders of Council of Governors	
Section 4.13.5	reference to Audit and Risk Committee amended to Audit Committee
Section 5 Appointment of Committees	Section 5.25 has been updated to reflect Nominations Committee as a committee of the Council of Governors (all other 12 prior references to Nominations and Remuneration Committee have been updated accordingly)
Annex 5: Standing Orders of Trust Board	
Section 5.1: Appointment of Committees	This section has been updated to incorporate all the committees of the Board which are: • Audit Committee • Remuneration Committee • Quality Assurance Committee • Finance, Planning and Performance Committee • People Committee

Section 5.2 Joint Committees	Section 65Z5 of the NHS Act 2022 provides the statutory mechanism and new powers for statutory NHS bodies – NHSE, ICBs, NHS trusts and NHS foundation trusts (FTs) – to delegate their functions to each other, and to local authorities and combined authorities.

3.0 Recommendations

The Board is asked to

1. Note and endorse the proposal to change the maximum term of a governor from six to nine years as set out in section 13.3 of the constitution and summarised in section 2 of this report
2. Note and endorse the proposal to change the appointment term of a lead governor from two years to either two or three years from the next appointment process
3. Note and endorse the incorporation of the provision relating to Joint Committees in the Standing Orders of the Board to enable the formation of joint committees
4. Note and endorse the proposed changes to the Constitution as incorporated in **appendix A**

Formatted: Font: 11 pt

Medway NHS FoundationTrust
Constitution

List of amendments (~~August 2024~~)

Document reference	Description of amendment
S. 22.2.2(~~August 2024~~)	Number amended to reflect the current board composition.
Annex - 5 S.2.8.1 (~~August 2024~~)	Number amended to reflect the current board composition.
<u>Amendments in May 2026</u>	<u>Document updated to align to the corporate governance infrastructure and to incorporate governor maximum term and also flexibility of either a two or three year term on Lead governor appointment</u>

Formatted: Font: 11 pt

Contents

Paragraph	Page
1. Interpretations and definitions	4
2. Name	6
3. Principal purpose	6
4. Powers	6
5. Membership and constituencies	6
6. Application for membership	6
7. Public constituency	7
8. Staff constituency	7
9. Restriction on membership and termination of membership	8
10. Annual Members Meeting	9
11. Council of Governors – composition	9
12. Council of Governors - election of Governors	9
13. Council of Governors – tenure	9
14. Council of Governors - disqualification and removal	10
15. Appointment of a lead governor	12
16. Casual vacancies	12
17. Indemnity	12
18. Dispute resolution procedure	12
19. Council of Governors - duties of governors	13
20. Council of Governors – meetings of governors	13
21. Council of Governors – travel expenses	14
22. Board of Directors – composition	14
23. Board of Directors - General duties	14
24. Board of Directors - appointment and removal of Non-Executive Directors, including the Chair	14
25. Board of Directors - appointment of Deputy Chair	15
26. Board of Directors - appointment and removal of the Chief Executive and other Executive Directors	15
27. Board of Directors – disqualification	16
28. Board of Directors – meetings	17
29. Board of Directors - conflicts of interest of Directors	17
30. Board of Directors - remuneration and terms of office	18
31. Registers	18
32. Admission to and removal from the registers	18
33. Registers - inspection and copies	18
34. Documents available for public inspection	19
35. Auditor	19
36. Audit and Risk Committee	19
37. Annual accounts	19
38. Annual report, forward plans and non-NHS work	19
39. Presentation of the Annual Accounts and Reports to the Governors and members	20
40. Instruments	20
41. Amending the Constitution	21
42. Mergers etc., significant transactions	22

ANNEX 1 - THE PUBLIC CONSTITUENCY	23
ANNEX 2 - THE STAFF CONSTITUENCY	24
ANNEX 3 - COMPOSITION OF COUNCIL OF GOVERNORS	25
ANNEX 4 – STANDING ORDERS – COUNCIL OF GOVERNORS	26
ANNEX 5 - STANDING ORDERS - BOARD OF DIRECTORS	40

1. Interpretation and definitions

- 1.1 Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this constitution shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022.
- 1.2 Words importing the masculine gender only shall include the feminine gender; words importing the singular shall include the plural and vice-versa.
- 1.3 In this constitution:

Formatted: Font: (Default) Arial

In 2006 Act	Means the National Health Service Act of 2006
In 2012 Act	Means the Health and Social Care Act of 2012
In 2022 Act	Means the Health and Care Act of 2022
Accounting Officer/Accountable Officer	Means the person who from time to time discharges the functions specified in paragraph 25 (5) of Schedule 7 to the 2006 Act
Annual Members Meeting	Is identified in paragraph 10 of the Constitution
Auditor	Means the person appointed to audit the accounts of the Foundation Trust, who is called the auditor in the 2006 Act
Board of Directors	Means the Board of Directors as constituted in accordance with the Constitution.
Constitution	Means this Constitution and annexes to it
Co-opted Governor	Means those Governors appointed by partners of the Foundation Trust
Council of Governors	Means the Council of Governors as constituted in accordance with this constitution, which has the same meaning as the Board of Governors in the 2006 Act
Director	Means a member of the Board of Directors
Elected Governors	Means those Governors elected by the public and the classes of the staff constituency
Financial Year	Means each successive period of 12 months beginning on 01 April
The Trust	Means Medway NHS Foundation Trust
Health Service Body	Shall have the meaning ascribed to it in Section 65 (1) of the 2006 Act

License	Means a license issued by NHS England under Section 88 of the Health and Social Care Act 2012
Member	Means a member of the Foundation Trust
NHS Foundation Trust	Means the Code of Governance published by NHS
Code of Governance	England or such similar or further guidance as may be published from time to time
Public Governor	Means a Governor elected by the members of one of the public constituencies
Registered dentist	Means a registered dentist within the meaning of the Dentists Act 1984
Registered Medical Practitioner	Means a fully registered person within the meaning of the Medicines Act 1983 who holds a license to practice under the Act
Regulatory Framework	Means the 2006 Act, the 2012 Act, the Constitution and the Trust's license as granted by NHS England
Secretary	Means the Company Secretary of the Foundation Trust or any other person appointed to perform the duties of The Company Secretary, including a joint, assistant or deputy secretary
Significant Transaction	Means investments, divestments or other transactions compromising more than 25% of the assets, income or Capital of the NHS Foundation Trust in line with NHS England's Compliance Framework
Staff Constituency	Means (collectively) those members comprising of the Staff constituency
Staff Governor	Means a Governor elected by the members of one of the classes of the staff constituency

This document should be read in conjunction with the model rules for the elections for Governors.

2. Name

- 2.1 The name of this foundation Trust is Medway NHS Foundation Trust (the Trust).

3. Principal purpose

- 3.1 The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

3.2 The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The Trust may provide goods and services for any purposes related to:

3.3.1 The provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

3.3.2 The promotion and protection of public health

3.4 The Trust may also carry on activities, other than those mentioned in the above paragraph, for the purpose of making additional income available in order better to carry on its principal purpose.

4. Powers

4.1 The powers of the Trust are set out in the 2006 Act, the 2012 Act and the 2022 Act.

4.2 The powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

4.3 Any of these powers may be delegated to a committee of directors or to an executive director.

5. Membership and constituencies

5.1 The Trust shall have members, each of whom shall be a member of one of the following constituencies:

5.1.1 A public constituency

5.1.2 A staff constituency

6. Application for membership

6.1 An individual who is eligible to become a member of the Trust may do so on application to the Trust.

7. Public Constituency

7.1 An individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a member of the Trust.

7.2 Those individuals who live in an area specified as an area for any public constituency are referred to collectively as the Public Constituency.

7.3 The minimum number of members in each area for the Public Constituency is specified in Annex 1.

7.4 Membership of a public constituency is subject to Section 9 (Restriction on membership

7.47.5 and Termination of Membership).

7

Formatted: Not Expanded by / Condensed by

Formatted: List Paragraph, Right: 0 cm, No bullets or numbering, Tab stops: Not at 1.46 cm

8. Staff Constituency

- 8.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a member of the Trust provided they:
- 8.1.1 are employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or
 - 8.1.2 have been continuously employed by the Trust under a contract of employment for at least 12 months
- 8.2 Individuals who exercise functions for the purposes of the Trust otherwise than under a contract of employment with the Trust, may become or continue as members of the staff constituency provided such individuals have exercised these functions continuously for a period of at least 12 months.
- 8.3 Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Staff Constituency.
- 8.4 The Staff Constituency shall be divided into nine descriptions of individuals who are eligible for membership of the Staff Constituency, each description of individuals being specified in Annex 2 and being referred to as a class within the Staff Constituency.
- 8.5 The minimum number of members in each class of the Staff Constituency is specified in Annex 2.
- 8.6 An individual who is:
- 8.6.1 Eligible to become a member of the staff Constituency; and
 - 8.6.2 Invited by the Trust to become a member of the Staff Constituency and a member of the appropriate class within the Staff Constituency, shall become a member of the Trust as a member of the Staff Constituency and appropriate class within the Staff Constituency without an application being made, unless they inform the Trust that they do not wish to do so.
- 8.7 Membership of the staff constituency is subject to Section 9 (Restriction on membership and Termination of Membership).

9. Restriction on membership and Termination of membership

- 9.1 An individual who is a member of a constituency or of a class within a constituency, may not while membership of that constituency or class continues, be a member of any other constituency or class.
- 9.2 An individual who ceases to reside in any area specified in Annex 1 shall cease to be a member of the constituency.
- 9.3 A person may not become or continue as a member of the Trust if they;
- 9.3.1 are under 16 years of age;
 - 9.3.2 are detained at one of Her Majesty's prisons;
 - 9.3.3 have had his/her name added to and not removed from a list prepared under the Sexual Offenders Act 1997;

- 9.3.4 fail or cease to fulfil the criteria for membership of any of the constituencies;
- 9.3.5 have been involved in an act of violence against staff or other members of the Trust or an act of damage against its property;
- 9.3.6 have been identified as a vexatious complainant against the Trust;
- 9.3.7 do not uphold the values of the Trust;
- 9.3.8 have been previously expelled from membership and have not been subsequently re-admitted by the Council of Governors.
- 9.4 The Trust's decision is final as to whether or not an individual qualifies for membership of the constituency.
- 9.5 A member of the Trust will cease to be a member if they;
- 9.5.1 resign by notice to the Membership Officer;
- 9.5.2 fail to demonstrate that they wish to continue as a member following enquiries made in accordance with a process approved by the Council of Governors;
- 9.5.3 dies;
- 9.5.4 are expelled from membership by a resolution of two-thirds of the Council of Governors. Once expelled no person will be re-admitted as a member unless a resolution to that effect is approved by a resolution of more than half of the Council of Governors.
- 9.6 It is the responsibility of each member to ensure that they are and remain eligible for membership of the Trust and if a member becomes aware of their ineligibility they should inform the Trust as soon as practicable. However, if the Trust is on notice that a member may be disqualified from membership, the Trust shall make reasonable enquiries to establish the case.
- 9.7 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.

10. Annual Members' Meeting

- 10.1 The Trust shall hold an annual meeting of its members ('Annual Members' Meeting').
The Annual Members' Meeting shall be open to members of the public.

- 10.2 At least one Director shall attend the meeting and present the following documents to the Members at the meeting:
- the annual accounts;
 - any report of the auditor on them; and
- the annual report.

11.1

- 10.2 Where an amendment has been made to this Constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust), at least one Governor shall attend the next annual

9

Formatted: Not Expanded by / Condensed by

Formatted: Font: 11 pt

Formatted: Indent: Left: 0 cm, Hanging: 1.27 cm

Formatted: Bulleted + Level: 1 + Aligned at: 0.63 cm + Indent at: 1.27 cm

Formatted: Font: (Default) Arial, 11 pt

Formatted: Font: 11 pt

Formatted: No bullets or numbering

Formatted: Font: (Default) Arial, 11 pt

public meeting to be held, at which the Governor shall present the amendment and the Members shall be entitled to vote on whether they approve the amendment.

10.3 If more than half of the Members voting approve the amendment, the amendment shall continue to have effect; otherwise it shall cease to have effect and the Trust shall take such steps as are necessary as a result.

2.1. Council of Governors – composition

2.1.1 The Trust is to have a Council of Governors, which shall comprise both elected and appointed Governors.

2.2.1.2 The composition of the Council of Governors is specified in Annex 3.

2.3.1.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of Governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 3.

3.2. Council of Governors - election of Governors

3.1.2.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Rules for Elections.

3.2.2.2 The Model Rules for Elections, as published from time to time by the Department of Health, form part of this constitution. The Model Election Rules should be read in conjunction with this constitution.

3.3.2.3 A subsequent variation of the Model Election Rules by the Department of Health shall not constitute a variation of the terms of this constitution for the purposes of paragraph 41 of the constitution (amendment of the constitution).

3.4.2.4 An election, if contested, shall be by secret ballot.

4.3. Council of Governors – tenure

4.1.3.1 An elected Governor may hold office for a period of up to 3 years.

4.2.3.2 An elected Governor shall be eligible for re-election at the end of his/her 3-year term.

4.3.3.3 An elected Governor shall only be able to serve a maximum of two-three terms or 6-nine(six) years.

4.4.3.4 An elected Governor shall cease to hold office if they cease to be a member of the constituency or class by which they was elected.

4.5.3.5 An appointed Governor may hold office for a period of up to 3 years per term for a maximum of nine years.

4.6.3.6 An appointed Governor shall be eligible for re-appointment at the end of his/her 3-year term.

4.7.3.7 An appointed Governor shall only be able to serve a maximum of two-three terms or 6-nine(six) yearsnine years.

Formatted: Font: 11 pt

Formatted: Font: (Default) Arial

Formatted: List Paragraph, Right, Indent: Left: 1.48 cm

Formatted: Font: (Default) Arial, 11 pt

Formatted: List Paragraph, Outline numbered + Level: 2 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.21 cm + Indent at: 1.48 cm

~~4.83.8~~ An appointed Governor shall cease to hold office if the appointing organisation withdraws its sponsorship of him/her.

5.4. Council of Governors - disqualification and removal

~~5.14.1~~ A person may not become or continue as a member of the Council of Governors if they have, or are:

~~5.1.14.1.1~~ been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.

~~5.1.24.1.2~~ had a moratorium period under a debt relief order applied (under Part 7A of the Insolvency Act).

~~5.1.34.1.3~~ made a composition or arrangement with, or granted a Trust deed for, his/her creditors and has not been discharged in respect of it.

~~5.1.44.1.4~~ within the preceding five years been convicted in the British Isles of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him/her.

~~5.1.54.1.5~~ failed to attend three general meetings of the Council of Governors in a ~~12-month~~~~12-month~~ period, unless the Council of Governors is satisfied that the absences were due to reasonable causes and that attendance at future meetings will begin again immediately or within a reasonable period of time.

~~5.1.64.1.6~~ been dismissed within the preceding two years, otherwise than by reasons of redundancy, from employment with a public body (paid or otherwise).

~~5.1.74.1.7~~ been appointed as an executive or non-executive Director of the Trust or a Governor, non-executive Director, Chair or Chief Executive of another NHS organisation.

~~5.1.84.1.8~~ the spouse, partner, parent or child of a Governor.

~~5.1.94.1.9~~ a member of a Local Authority's Scrutiny Committee covering health matters.

~~5.1.104.1.10~~ a person who is a medical practitioner and who has been removed from the register of medical practitioners held by the General Medical Council in accordance with the Medical Act 1983, or has been suspended from that register, and not subsequently had his/her name returned to that register.

~~5.1.114.1.11~~ incapable by reason of continuing mental incapacity, illness or injury of managing and administering his/her property and affairs.

~~5.1.124.1.12~~ refused to sign a declaration in the form specified by the nominated Member's Office of the particulars of their qualification to vote as a member and that they are not prevented from being a member.

~~5.1.134.1.13~~ refused to undertake without reasonable cause any training that the

Council of Governors requires all Governors to undertake.

~~5.1.144.1.14~~ failed to sign and deliver to the Nominated Officer a statement in the prescribed form confirming acceptance of the Code of Conduct for Governors.

~~5.1.154.1.15~~ any conflicts of interest that may make them unsuitable.

~~5.1.164.1.16~~ fail to disclose any conflict of interest required to be disclosed in meetings of the Council of Governors.

~~5.1.174.1.17~~ a person whose name has been added to and not removed from a list prepared under the Sexual Offences Act 1997.

~~5.1.184.1.18~~ no longer eligible to be a member of a constituency or if appointed, that person is no longer sponsored by the relevant organisation.

~~5.1.194.1.19~~ had their name removed from a relevant list of medical practitioners pursuant to Paragraph 10 of the National Health Service (Performers Lists) Regulations 2004 or Section 151 of the 2006 Act (or similar provision elsewhere), and has not subsequently had their name included in such a list.

~~5.1.204.1.20~~ subject to disqualification under the Company Directors Disqualification Act 1986.

~~5.1.214.1.21~~ been convicted of an offence under the Bribery Act 2010, the modern Slavery Act 2015 or a crime involving dishonesty.

~~5.24.2~~ Governors must be at least 16 years of age at the date that they are nominated for election or appointment.

~~5.34.3~~ A Governor may resign from office at any time during his/her term of office by giving notice in writing to the Chair such notice specifying the date of resignation.

~~5.44.4~~ A Governor may be removed from office by resolution of two-thirds of governors present at a Council of Governors General Meeting in the following circumstances:

~~5.4.14.4.1~~ For any of the reasons listed in section 14.1 above.

~~5.4.24.4.2~~ They is found to act in way which contravenes the Code of Conduct.

~~5.4.34.4.3~~ They acts in a way that is incompatible with the values of the Trust or is prejudicial to the reputation of the Trust or the NHS or fails to discharge his/her responsibilities as a Governor.

~~5.54.5~~ A staff Governor who is suspended from staff duties for any reason will also be suspended from their role as a Governor for the duration of their suspension. Whilst a staff Governor is under suspension, They cannot attend meetings of the Council of Governors in any capacity, but missing any meetings of the Council of Governors will not count as failure to attend for the purpose of 14.1.5 above

~~6.5.~~ Appointment of a Lead Governor

~~6.15.1~~ The Trust may appoint a Lead Governor.

~~6-25.2~~ The duties of the Lead Governor shall be:

~~6-2-15.2.1~~ To lead the Council of Governors only in circumstances where it is not appropriate for the Chair, the Deputy-Chair / Senior Independent Director or other non- executive Director to do so.

~~6-2-25.2.2~~ To act as the point of contact for the regulator in circumstances where it would inappropriate for the regulator to contact the Chair.

~~6-35.3~~ The Lead Governor shall have no other duties unless agreed otherwise by the Board of Directors and the Council of Governors.

~~6-45.4~~ The Lead Governor ~~shall normally~~will hold office for a period of either a two year or three year term depending on the decision of the Council of Governorss

7-6. Casual Vacancies

~~7-16.1~~ A casual vacancy is a vacancy that arises because a Governor does not complete his/her term of office for any reason. A vacancy that arises because the term of office of a governor has expired and they has not been re-elected or re-appointed is not a casual vacancy.

~~7-26.2~~ The validity of any act of the Council of Governors is not affected by any vacancy amongst the Council of Governors or by any defect in the appointment of any Governor.

~~7-36.3~~ Where there is a casual vacancy of the Council of Governors for whatever reason:

~~7-3-16.3.1~~ Where the vacancy is for an appointed Governor, the appointing organisation will be requested to appoint a replacement to hold office for the remainder of the term in accordance with the agreed appointment processes; and

~~7-3-26.3.2~~ Where the vacancy is for an elected Governor, the next highest polling candidate at the most recent elections to fill the seat will be invited to take up the seat for the remainder of the period of office at which time they may seek re-election.

8-7. Indemnity

~~8-17.1~~ Members of the Council of Governors who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their official functions, save where they have acted recklessly. Any costs arising in this way will be met by the Trust. The Trust may purchase and maintain insurance against this liability for its own benefit and for the benefit of the members of the Council of Governors.

9-8. Dispute resolution procedure

~~9-18.1~~ The Trust is to establish a dispute resolution procedure in respect of any disputes arising between the Council of Governors and the Board of Directors that shall be approved by both the Council of Governors and the Board of Directors.

10-9. Council of Governors – duties of Governors

~~10-19.1~~ The duties of the Council of Governors as set out in the amendments to the 2006

Act made by the 2012 Act are:

~~10.1.19.1.1~~ To hold the non-executive directors individually and collectively to account for the performance of the Board of Directors. Refer to the Terms of Reference for the Council of Governors for further detail on the mechanisms which enable the Non-Executive Directors to be held to account.

~~10.1.29.1.2~~ To represent the interests of the members of the Trust as a whole and the interests of the public.

~~10.29.2~~ The duties of the Council of Governors as set out in the 2006 Act are:

~~10.2.19.2.1~~ To appoint or remove the Chair and the other non-executive directors at a general meeting.

~~10.2.29.2.2~~ Decide the remuneration and allowances, and the other terms and conditions of office, of the non-executive directors.

~~10.2.39.2.3~~ Appoint or remove the auditor at a general meeting.

~~10.2.49.2.4~~ Approve the appointment of a chief executive.

~~10.2.59.2.5~~ Receive the annual accounts, any report of the auditor relating to the annual accounts, and the annual report at a general meeting.

~~10.2.69.2.6~~ Provide their views to the Board of Directors in relation to the forward plan for the Trust.

~~10.2.79.2.7~~ Approve significant transactions.

~~10.2.89.2.8~~ Approve mergers, acquisitions or dissolutions.

~~10.2.99.2.9~~ Consider and vote on amendments to the constitution.

~~10.39.3~~ The Trust must take steps to secure that the Governors are equipped with the skills and knowledge they require in their capacity as such.

~~11.10~~ Council of Governors - meetings of Governors

~~11.110.1~~ The Chair of the Trust (i.e. the Chair of the Board of Directors, appointed in accordance with the provisions of paragraph 24) or, in his/her absence, the Deputy Chair (appointed in accordance with the provisions of paragraph 25), shall preside at meetings of the Council of Governors.

~~11.210.2~~ Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

~~11.310.3~~ For the purposes of obtaining information about the Trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the Trust's or directors' performance), the Council of Governors may require one or more of the Directors to attend a meeting.

~~11.410.4~~ The standing orders for the practice and procedure of the Council of Governors, as may be varied from time to time, are attached at Annex 4.

12.11. Council of Governors - travel expenses

12.11.1 Governors shall not receive remuneration for acting as Governors but the Trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the Board of Directors.

13.12. Board of Directors – composition

13.12.1 The Trust is to have a Board of Directors, which shall comprise both executive and non-executive Directors.

13.12.2 The Board of Directors is to comprise:

13.12.2.1 A Non-Executive Director Chair

13.12.2.2 No fewer than 5 (five) nor more than 6 (six) other non-executive Directors; and

13.12.2.3 A maximum of 6 (six) executive Directors.

13.12.3 The Chief Executive shall be the Accounting Officer.

13.12.4 One of the Executive Directors shall be the Chief Finance Officer.

13.12.5 One of the Executive Directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

13.12.6 One of the Executive Directors is to be a registered nurse or a registered midwife.

13.12.7 The Board of Directors should include an appropriate combination of Executive and Non-Executive Directors (and in particular, independent Non-Executive Directors) such that the Non-Executive Directors should be in a majority.

13.12.8 The Board of Directors may appoint suitable persons from Academic institutions or from industry or commerce as Associate Non-Executive Directors as required from time to time to assist the Board and its Committees. The Associate Non-Executive Directors shall not be voting members of the Board nor count towards a quorum and attend only by invitation from the Board.

14.13. Board of Directors – General Duty

14.13.1 The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the Trust as a whole and for the public.

14.13.2 The Board of Directors will also have regard to the content of the NHS Foundation Trust Code of Governance 2014 and any future versions.

15.14. Board of Directors - appointment and removal of Non-Executive Directors, Associate Non-Executive Directors, including the Chair

15.14.1 A person may be appointed as a Non-Executive Director, Associate Non-Executive Director only if:

~~10.1.1~~ They are a member of the Public or patient Constituency, or

~~15.1.1~~~~14.1.1~~ They are not disqualified by virtue of paragraph 27 below.

~~15.2~~~~14.2~~ The Council of Governors at a general meeting of the Council of Governors shall appoint the Chair of the Trust and the other Non-Executive Directors, Associate Non-Executive Directors, by approval of a majority of those present.

~~15.3~~~~14.3~~ Removal of the Chair or another Non-Executive Director, Associate Non-Executive Director shall require the approval of two-thirds of those present at a Council of Governors' General Meeting.

~~15.4~~~~14.4~~ The appointment and terms of appointment of a Non-Executive Director, Associate Non-Executive Director, including the Chair, will be overseen by a ~~Governors Nominations and Remuneration Committee~~Nominations Committee as set out in Annex 4 of this constitution and will be overseen by the Chair of Council of Governors.

~~15.5~~~~14.5~~ Non-Executive Directors, Associate Non-Executive Director, including the Chair, should be determined as independent on appointment. The Chair's independence on appointment to the role of Chair should consider any previous tenure served as a non-Executive Director. The criteria for independence are set out in the NHS Foundation Trust Code of Governance.

~~15.6~~~~14.6~~ The Council of Governors should keep the independence of Non-Executive Directors and Associate Non-Executive Directors under review. This will predominantly be undertaken by the ~~Governors Nominations and Remuneration Committee~~Nominations Committee, overseen by the Council of Governors.

~~15.7~~~~14.7~~ Non-Executive Directors and Associate Non-Executive Directors should serve a maximum of two three-year terms. Only in exceptional circumstances should a further term of 12 (twelve) months be granted.

~~15.8~~~~14.8~~ A ~~Governors Nominations and Remuneration Committee~~Nominations Committee overseen by the Chair will review the appointments process in advance of each recruitment process, however this will include as a minimum:

~~15.8.1~~~~14.8.1~~ A shortlisting and interview panel comprised of ~~four to six Governors~~two Governors.

~~10.1.2~~ Inclusion of non-voting panel members at each stage of the process to include an external advisor, ~~the Chief People Officer (or deputy), the Chair or Senior Independent Director, and Company Secretary (or deputy).~~

~~14.8.2~~

~~16.15~~ Board of Directors - appointment of the Deputy Chair

~~16.1~~~~15.1~~ The Non-Executives and the Council of Governors will be consulted by the Chair in relation to the appointment of a Deputy Chair.

~~17.16~~ Board of Directors - appointment and removal of the Chief Executive and other Executive Directors

Formatted: Right, Indent: Left: 3.25 cm, No bullets or numbering

Formatted: Indent: Left: 1.46 cm, Hanging: 1.79 cm, Space Before: 0.1 pt, Outline numbered + Level: 3 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1.5 cm + Indent at: 2.77 cm

~~17.1~~16.1 The Non-Executive Directors shall appoint or remove the Chief Executive Officer.

~~17.2~~16.2 The appointment of the Chief Executive Officer shall require the approval of a simple majority of the Council of Governors.

~~17.3~~16.3 The Trust Nominations ~~and Remuneration~~ Committee shall appoint or remove the other Executive Directors.

~~18.17.~~ Board of Directors – disqualification

~~18.1~~17.1 A person may not become or continue as a member of the Board of Directors who:

~~18.1.1~~17.1.1 has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.

~~18.1.2~~17.1.2 a moratorium period under a debt relief order applied (under Part 7A of the Insolvency Act 1986).

~~18.1.3~~17.1.3 has made a composition or arrangement with, or granted a Trust deed for, his/her creditors and has not been discharged in respect of it.

~~18.1.4~~17.1.4 within the preceding five years has been convicted in the British Isles of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him;

~~18.1.5~~17.1.5 Is a member of the Council of Governors;

~~18.1.6~~17.1.6 Is the spouse, partner, parent or child of a member of the Board of Directors;

~~18.1.7~~17.1.7 Is the subject of a disqualification order made under the Company Directors Disqualification Act 1986;

~~18.1.8~~17.1.8 is a medical practitioner and who has been removed from the register of medical practitioners held by the General Medical Council in accordance with the Medical Act 1983, or has been suspended from that register, and not subsequently had his/her name returned to that register;

~~18.1.9~~ In the case of a non-executive Directors they are no longer a member of one of the public or patient constituencies;

~~18.1.10~~17.1.9 has within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;

~~18.1.11~~17.1.10 has had a tenure of office as a Chair or as a member or Director of a health service body terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings or for non-disclosure of a pecuniary interest;

~~18.1.12~~17.1.11 In the case of a non-executive Director they have refused without reasonable cause to fulfil any training requirement established by the Board of Directors;

~~18.1.13~~~~17.1.12~~ has refused to sign and deliver to the Nominated Officer a statement in the prescribed format confirming acceptance of a Code of Conduct for Directors.

Formatted: Font: 11 pt

~~19.18.~~ Board of Directors – meetings

~~19.1.18.1~~ Meetings of the Board of Directors shall be held in public unless the Board determines otherwise.

~~19.2.18.2~~ Before holding a meeting in public, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting in public, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

~~19.3.18.3~~ The standing orders for the practice and procedure of the Board of Directors are attached at Annex 5.

29 Board of Directors - conflicts of interest of Directors

29.1 The duties that a Director of the Trust has by virtue of being a director include the duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust. A duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity:

The duty referred to in sub-paragraph 29.1 is not infringed; if

~~19.3.1.18.3.1~~ The situation cannot reasonably be regarded as likely to give rise to a conflict of interest; or

~~19.3.2.18.3.2~~ The matter has been authorised in accordance with the constitution

~~19.3.3.18.3.3~~ The duty referred to in sub-paragraph 29.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

~~19.3.4.18.3.4~~ In sub-paragraph 29.2, "third party" means a person other than:

29.1.1.1 The Trust

29.1.1.2 A person acting on its behalf

~~19.3.5.18.3.5~~ If a director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the director must declare the nature and extent of that interest to the other directors.

~~19.3.6.18.3.6~~ If a declaration under this paragraph proves to be, or becomes, inaccurate, incomplete, a further declaration must be made.

~~19.3.7.18.3.7~~ Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

~~19.3.8.18.3.8~~ This paragraph does not require a declaration of an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.

~~19.3.9.18.3.9~~ A director need not declare an interest:

29.1.1.3 If it cannot reasonably be regarded as likely to give rise to a conflict of interest.

29.1.1.4 If, or the extent that, the directors are already aware of it.

29.1.1.5 If, or to the extent that, it concerns terms of the director's appointment that have been or are to be considered.

- By a meeting of the Board of Directors, or
- By a committee of the directors appointed for the purpose under the constitution

Formatted: Font: 11 pt

30 Board of Directors - remuneration and terms of office

30.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other non-executive Directors.

30.2 The Trust Nominations ~~and Remuneration~~ Committee shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other executive directors.

31 Registers

31.1 The Trust shall have:

31.1.1 a register of members showing, in respect of each member, the constituency to which They belongs and, where there are classes within it, the class to which They belongs;

31.1.2 A register of members of the Council of Governors;

31.1.3 A register of interests of Governors;

31.1.4 A register of Directors and Non-Executive Directors; and

31.1.5 A register of interests of the Directors and Non-Executive Directors.

32 Admission to and removal from the registers

32.1 The ~~Trust Secretary~~Company Secretary will oversee the arrangements for additions and removals from the registers.

33 Registers - inspection and copies

33.1 The Trust shall make the registers specified in paragraph 31 above available for inspection by members of the public, except in the circumstances set out at paragraph 34 or as otherwise prescribed by regulations.

33.2 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of:

33.2.1 Any other member of the Trust, if they so requests.

33.3 So far as the registers are required to be made available:

33.3.1 They are to be available for inspection free of charge at all reasonable times; and

33.3.2 A person who requests a copy of or extract from the registers is to be provided with a copy or extract.

33.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

34 Documents available for public inspection

34.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

- i. A copy of the current constitution;
- ii. A copy of the latest annual accounts and of any report of the auditor on them;
- iii. A copy of the latest annual report;

34.2 All documents required by paragraphs 22(1)(g) to 22(10)(p) inclusive of Schedule 7 to the 2006 Act (relating to special administration) shall be available for inspection by members of the public free of charge at all reasonable times.

34.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

34.4 If the person requesting a copy or extract under this paragraph is not a Member of the Trust, the Trust may impose a reasonable charge for providing the copy or extract.

35 Auditor

35.1 The Trust shall have an auditor.

35.2 The Council of Governors shall appoint or remove the auditor at a general meeting of the Council of Governors by approval of a simple majority of those present.

36 Audit and Risk committee

36.1 The Trust shall establish a committee of non-executive Directors as an Audit and Risk Committee to perform such monitoring, reviewing and other functions as are appropriate.

37 Annual accounts

37.1 The Trust must keep proper accounts and proper records in relation to the accounts.

37.2 NHS England may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

37.3 The accounts are to be audited by the Trust's auditor.

37.4 The Trust shall prepare in respect of each financial year annual accounts in such form as NHS England may with the approval of the Secretary of State direct.

37.5 The functions of the Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

38 Annual report, forward plans and non-NHS work

- 38.1 The Trust shall prepare an Annual Report and send it to NHS England.
- 38.2 The Trust shall give information as to its forward planning in respect of each financial year to NHS England and the Integrated Care Board.
- 38.3 The document containing the information with respect to forward planning referred to in paragraph 38.5 shall be prepared by the directors.
- 38.4 In preparing the document, the directors shall have regard to the views of the Council of Governors.
- 38.5 Each forward plan must include information about –
- i. The activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on; and
 - ii. The income it expects to receive from doing so.
- 38.6 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 38.5.1 the Council of Governors must:
- i. Determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions, and
 - ii. Notify the directors of the Trust of its determination.
- 38.7 A Trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the Council of Governors of the Trust voting approve its implementation.

39 Presentation of the Annual Accounts and Reports to the Governors and members

- 39.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:
- i. The annual accounts
 - ii. Any report of the auditor on them
 - iii. The annual report
- 39.2 The documents shall also be presented to the members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.
- 39.3 The Trust may combine a meeting of the Council of Governors with the Annual Members' Meeting.

40 Instruments

40.1 The Trust shall have a seal.

40.2 The seal shall not be affixed except under the authority of the Company Secretary or the Chief Executive of the Trust.

41 Amending the Constitution

41.1 The Trust may make amendments of its constitution only if:

- i. More than half of the members of the Council of Governors of the Trust voting approve the amendments, and
- ii. More than half of the members of the Board of Directors of the Trust voting approve the amendments.
- iii. Amendments made under paragraph 41.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.
- iv. Where an amendment is made to the constitution in relation the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):

1. At least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment, and
2. The Trust must give the members an opportunity to vote on whether they approve the amendment.
3. If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.
4. Amendments by the Trust of its constitution are to be notified to NHS England. For the avoidance of doubt, NHS England's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

Formatted: Font: 11 pt

42 Mergers etc., significant transactions

42.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the council of governors.

42.2 The Trust may enter into a Significant Transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transition.

42.3 In paragraph 42.2, the following words have the following meanings:

- i. "Significant Transaction" means a transaction which meets all of any one of the tests below:
 1. The fixed asset test; or
 2. The turnover test; or

Formatted: Font: 11 pt

3. The gross capital test (relating to acquisitions or divestments).

- ii. The fixed asset test is met if the assets which are subject of the transaction exceed 25% of the fixed assets of the Trust.
- iii. The turnover test is met if, following the completion of the relevant transaction, the income of the Trust will increase or decrease by more than 25%.
- iv. The gross capital test is met if the gross capital of the company or business being acquired or divested represents more than 25% of the capital of the Trust following completion (where "gross capital" is the market value of the relevant company or business shares and debt securities, plus the excess of current liabilities over current assets, and the Trust's capital is determined by reference to its balance sheet).
- v. For the purposes of calculating the tests in this paragraph 42, figures used to classify assets and profits must be the figures shown in the latest published audited consolidated accounts.
- vi. A transaction:
 - 1. Includes all agreements (including amendments to agreements) entered into by the Trust.
 - 2. Excludes a transaction in the ordinary course of business (including the renewal, extension or entering into an agreement in respect of healthcare services carried out by the Trust).
 - 3. Excludes any agreement or changes to healthcare services carried out by the Trust following a reconfiguration of services led by the commissioners of such services.
 - 4. Excludes any grant of public dividend capital or the entering into of a working capital facility or other loan, which does not involve the acquisition or disposal of any fixed asset of the Trust.

Formatted: Font: 11 pt

Formatted: Font: 11 pt

Formatted: Font: 11 pt

Formatted: Font: 11 pt

Formatted: Font: 11 pt

Formatted: Font: 11 pt

Formatted: Font: 11 pt

Formatted: Font: 11 pt

5. ANNEX 1 - THE PUBLIC CONSTITUENCY

1.1 The Trust has three public constituencies. Members of the public shall be eligible for membership of the Public Constituencies as shown in the table below:

Area	Minimum number of members
Medway	70
Swale	30
Rest of England and Wales	10

The overall number of public members will not fall below 400 in total nor below the minimum in each area identified in this Annex.

ANNEX 2 - THE STAFF CONSTITUENCY

2.1 The minimum number of Members for the Staff Constituency is set out below:

Formatted: Font: 11 pt

Staff Constituency	Minimum number
Total	1,950

ANNEX 3 - COMPOSITION OF COUNCIL OF GOVERNORS

The Council of Governors will consist of 25 Governors, which shall comprise of both elected Governors and appointed Governors as set out below: Appointed Governors	Number
Local Authority (represented by a member of the Kent Health and Wellbeing Board)	1
Local Authority (represented by a member of the Medway Health and Wellbeing Board)	1
Local Authority – Swale Borough Council	1
University of Kent	1
Canterbury Christchurch University	1
University of Greenwich	1
Charity Representative (League of Friends)	1
Elected Governors (staff members)	Number
Staff Members	5
Elected Governors	Number
Medway	9
Swale	4
Rest of England and Wales	1

Formatted: Font: 11 pt

ANNEX 4 - STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

CONTENTS

- 1. Statutory Authority**
- 2. Interpretation**
- 3. Composition of the Council of Governors**
 - 3.1 Composition of the Council of Governors
 - 3.2 Role of the Chair of the Trust
 - 3.3 Role of the Deputy-Chair of the Trust
 - 3.4 Removal of the Chair and Deputy-Chair
- 4. Meetings of the Council of Governors**
 - 4.1 Frequency of Meetings
 - 4.2 Duration of Meetings
 - 4.3 Admission of the Press and Public
 - 4.4 Calling Meetings
 - 4.5 Notice of Meetings
 - 4.6 Setting the Agenda
 - 4.7 Chair of the Meeting
 - 4.8 Notices of Questions
 - 4.9 Notices of Motions
 - 4.10 Chair's Ruling
 - 4.11 Voting
 - 4.12 Minutes
 - 4.13 Suspension of Standing Orders
 - 4.14 Record of Attendance
 - 4.15 Quorum
- 5. Arrangements for the Exercise of Functions by Delegation**
 - 5.1 Emergency Powers
 - 5.2 Appointment of Committees
- 6. Confidentiality**
- 7. Declaration of Interests and Register of Interests**
 - 7.1 Declaration of Interest
 - 7.2 Register of Interests
- 8. Disability of Governors in proceedings on account of pecuniary interest**
- 9. Disputes between the Council of Governors and Board of Directors**
- 10. Variation and Amendment of Standing Orders**

1. STATUTORY AUTHORITY

- 1.1. Medway NHS Foundation Trust is a public benefit corporation established under the NHS Act 2006 and authorised by NHS England on 1 August 2006 to act as an NHS Foundation Trust.
- 1.2. The Constitution requires the Council of Governors to adopt Standing Orders for the regulation of its procedures and business. These Standing Orders have been agreed by the Board of Directors and the Council of Governors and have been approved by NHS England.
- 1.3. Governors are required to comply with the requirements of these Standing Orders at all times.

2. INTERPRETATION

- 2.1 Save as permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Executive and Company Secretary).
- 2.2 Words importing the masculine gender only shall include the feminine gender and words importing the singular shall import the plural and *vive-versa*.
- 2.3 Any expression to which a meaning is given in the Health Service Acts or in the Regulations or Orders made under the Acts shall have the same meaning in this interpretation and in addition:
 - a) **Accounting OFFICER** shall be the officer responsible and accountable for funds entrusted to the Trust. They shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.
 - b) **BOARD** means the Board of Directors, formally constituted in accordance with this Constitution and consisting of a Chair, and Non-executive Directors, appointed by the Council of Governors and the Executive Directors, appointed by the Non-executive Directors and (except for his/her own appointment) by the Chief Executive.
 - c) **BUDGET** shall mean a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.
 - d) **CHAIR** is the person appointed by the Council of Governors as a Non-Executive Chair to lead the Board of Directors, and Council of Governors, to ensure it successfully discharges its overall responsibility for the Trust as a whole.
 - e) **CHIEF EXECUTIVE** shall mean the Accounting officer of the Trust.
 - f) **COMMITTEE OF THE COUNCIL OF GOVERNORS** means a committee formed by the Council of Governors with specific Terms of Reference, chair and membership.

Formatted: Font: 11 pt

Formatted: Font: 11 pt

- g) **COMMITTEE OF THE BOARD** means a committee formed by the Board with specific Terms of Reference, Chair and Membership.
- h) **DIRECTOR** means a person appointed to the Board of Directors
- i) **DIRECTOR OF FINANCE** shall mean the Chief Finance Officer of the Trust who will ensure compliance with Standing Financial Instructions.
- j) **FUNDS HELD ON TRUST** shall mean those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under Schedule 3 and 4 para 14.1c National Health Service Act 2006. Such funds may or may not be charitable.
- k) **GOVERNOR** means a person elected or appointed to the Council of Governors.
- l) **COUNCIL OF GOVERNORS** means the Council of Governors, formally constituted in accordance with this Constitution meeting in public and presided over by the Chair.
- m) **MEMBER** means a person registered as a member of one of the constituencies of the Trust as outlined in this Constitution.
- n) **NHS ENGLAND** is the body corporate known as NHS England under the 2022 Act.
- o) **MOTION** means a formal proposition to be discussed and voted on during the course of a meeting.
- p) **NOMINATED OFFICER** means an officer charged with the responsibility for discharging specific tasks within Standing Orders in line with the Health Acts.
- q) **NON-EXECUTIVE DIRECTOR** is a person appointed by the Council of Governors to be a member of the Board of Directors. This includes the Chair of the Trust.
- r) **OFFICER** means an employee of the Trust
- s) **SOs** means Standing Orders
- t) **SFIs** means Standing Financial Instructions
- u) **TRUST** means Medway NHS Foundation Trust.
- v) **TRUST SECRETARY** this role will act as independent adviser to the Board and NHS England the Trust's compliance with its terms of authorisation and constitution.
- w) **DEPUTY-CHAIR** means the Non-Executive Director appointed by the Council of Governors to carry out the duties of the Chair if they are absent for any reason.

Formatted: Font: 11 pt

3. COMPOSITION OF THE COUNCIL OF GOVERNORS

3.1 The composition of the Council of Governors shall be in accordance with the Trust's Constitution.

3.2 Role of the Chair of the Trust

The Chair shall not be a member of the Council of Governors however, in accordance with the regulatory framework; they will preside over meetings of the Council of Governors.

3.3 Role of the Deputy-Chair of the Trust

In respect of meetings of the Council of Governors, where the Chair has died or has otherwise ceased to hold office or where they have been unable to perform his/her duties as a Chair owing to illness, absence from England and Wales or any other cause, references to the Chair shall, so long as there is no Chair able to perform his/her duties, be taken to include to the Deputy-Chair.

3.4 Removal of the Chair or Deputy-Chair of the Trust

It shall be for the Council of Governors to determine the period of office for the Chair and Deputy-Chair, which shall normally be for a period of up to three years after which the Council of Governors shall review the appointment. Should there be the requirement to remove the Chair or Deputy-Chair of the Council of Governors this shall be carried out in accordance with SO 4.9.6.

4. MEETINGS OF THE COUNCIL OF GOVERNORS

4.1 Frequency of Meetings

The Council of Governors will meet in a general meeting on no less than four occasions each year at times and places that the Council of Governors may determine.

4.2 Duration of Meetings

The business of meetings will be conducted efficiently and in a timely manner and will not last longer than three hours. Any business not conducted within three hours will be adjourned until the next meeting.

4.3 Admission of the Public and Press

4.3.1 Meetings shall be open to members of the public and the press. Members of the public and press shall be required to withdraw from the meeting upon the Council of Governors resolving as follows:

"Representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of business to be transacted, publicity on which would be prejudicial to the public interest."

- 4.3.2 The Chair shall give such directions as They thinks fit in regard to the arrangements for meetings and accommodation of the public and the press so as to ensure that the business of the Council of Governors is conducted without interruption and disruption. Without prejudice to the power to exclude on the grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Council of Governors resolving as follows:

"That in the interests of public order the meeting adjourn for [the period specified] to enable the Council of Governors to complete business without the presence of the public."

- 4.3.3 The Chair may exclude any member of the public from a meeting of the Council of Governors if they are interfering with or preventing the reasonable conduct of the meeting.
- 4.3.4 Nothing in these Standing Orders shall require the Council of Governors to allow members of the public or press to record proceedings in any manner, other than in writing, or to make any oral report of proceedings as they take place without the prior agreement of the Council of Governors.
- 4.3.5 The Council of Governors may invite the Chief Executive and Directors of the Trust to attend any meeting of the Council of Governors to respond to questions from Governors on the affairs of the Trust.

4.4 **Calling Meetings**

Notwithstanding section 4.1 above, the Chair may call a meeting of the Council of Governors at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of Governors, has been presented to him, or if without so refusing, the Chair does not call a meeting within fourteen days after such requisition to do so, such one-third or more Governors may call a meeting forthwith. A requisition from Governors under this section may be submitted electronically provided that such requisition includes the names and electronic signatures of the Governors issuing it.

4.5 **Notice of Meetings**

- 4.5.1 Before each meeting of the Council of Governors, a notice of the meeting, specifying the business proposed to be transacted at it and signed by the Chair or by an officer of the Trust authorised by the Chair to sign on his/her behalf, shall be delivered to every Governor or sent by post to the normal place of residence of such Governor to arrive at least five clear working days before the meeting.
- 4.5.2 Lack of service of the notice on any Governor shall not affect the validity of the meeting.
- 4.5.3 In the case of a meeting called by the Governors in default of the Chair, the notice shall be signed by those Governors and no business shall be transacted at the meeting other than that specified in the notice.
- 4.5.4 Before each meeting of the Council of Governors a public notice of the time and place of the meeting, along with the agenda, shall be available on the

Trust's website, at least seven days before the meeting.

4.6 Setting the Agenda

- 4.6.1 The Council of Governors may determine that certain matters shall appear on every agenda for a meeting of the Council of Governors.
- 4.6.2 A Governor who wishes for an item to be included on an agenda for a meeting of the Council of Governors shall make a written request to the Chair at least ten clear working days before the meeting. Requests made less than ten clear working days before a meeting may be included on the agenda solely at the discretion of the Chair.
- 4.6.3 The Council of Governors will agree an annual schedule of work proposed by the Board of Directors to ensure that the Council of Governors discharge their statutory responsibilities as Governors.

4.7 Chair of the Meeting

- 4.7.1 At any meeting of the Council of Governors, the Chair, if present, shall preside. If the Chair is absent from the meeting, or if they are disqualified from participating because of a declared conflict of interest, the Deputy- Chair, if they are present, shall preside. If both the Chair and Deputy- Chair are absent or disqualified, the Council of Governors may choose an appropriate individual from among the remaining non-executive Directors or the Lead Governor to preside.

4.8 Notice of Questions

4.8.1 Governors may ask the Chair, a Non-Executive Director, another Governor or Executive Director questions about matters which are directly in relation to a matter over which the Council of Governors has powers or duties or which affects the area covered by the Trust, either in advance of the meeting or during the course of the Council of Governors business.

4.8.1.4.8.2 In the event that a response cannot be given during a formal Council of Governors meeting, it will be issued prior to the next meeting.

4.8.2 A Governor may only ask a question under paragraph 4.8.1 if either;

- a) ~~they have given at least 14 working days' notice in writing of the question to the Company Secretary. For the purposes of this Standing Order, receipt of any such questions via electronic means is considered acceptable;~~
- b) ~~the question relates to urgent matters, they have the consent of the person to whom the question is to be put and the content of the question is given to the Company Secretary by 10.00am on the day of the meeting (if the meeting is scheduled for the afternoon) or by 2.00pm on the preceding day (if the meeting is scheduled for the morning). Urgent is defined as a matter which will adversely affect the Trust within the next seven days.~~

Formatted: Not Expanded by / Condensed by

~~4.8.3 A Governor may ask any question through the Chair without notice upon a report from an Executive Director, or other officer of the Trust, when that item is being received or under consideration by the Council of Governors. Unless the Chair decides otherwise no statements will be made other than those which are strictly essential to define the question, which should last no longer than three minutes. The Chair may reject any question from any Governor if in his/her opinion the question is substantially the same as the question which has already been put to the meeting or a previous meeting of the Council of Governors.~~

~~4.8.4 An answer may take the form of a direct oral answer; where the desired information is in a publication of the Trust or other published work, a reference to that publication; where the reply cannot conveniently be given orally, a written answer circulated later to the questioner; or a brief oral answer supplemented by a written answer circulated later to the Governor who has raised the question.~~

~~4.8.5 A Governor asking a question under paragraphs 4.8.1 above may ask one supplementary question (lasting no longer than three minutes) without notice of the person to whom the first question was asked. The supplemental question must arise directly out of the reply~~

4.9 Notices of Motion

4.9.1 A Governor of the Trust desiring to move a motion shall send a written notice thereof at least ten clear days before the meeting to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda, subject to SO 4.5.

4.9.2 A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

4.9.3 Notice of motion to amend or rescind any resolution (or the general substance of any resolution), which has been passed within the preceding six calendar months, shall bear the signature of the members of the Council of Governors who give it and also the signature of four other members of the Council of Governors. When any such motion has been disposed of by the Council of Governors it shall not be competent for any member of the Council of Governors, other than the Chair, to propose a motion to the same effect within six months.

4.9.4 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto. The mover of a motion shall have strictly no more than five minutes to move a motion and strictly no more than three minutes for a right of reply.

4.9.5 When a motion is under discussion or immediately prior to discussion it shall be open to a member of the Council of Governors to move:

- a) An amendment to the motion.
- b) The adjournment of the discussion or the meeting.
- c) That the meeting proceeds to the next business.
- d) That the motion shall be now put.

Such a motion, if seconded, shall be disposed of before the motion which was originally under discussion or about to be discussed.

No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

In the case of motions under c) and d), to ensure objectivity motions may only be put by a member of the Council of Governors who has not previously taken part in the debate.

4.9.6 A motion to remove the Chair or a non-executive Director must be seconded by 10 members of the Council of Governors.

4.9.7 The following motions may be moved without notice:

- a) in relation to the accuracy of the minutes;
- b) to change the order of business in the agenda;
- c) to refer something to an appropriate body or individual;
- d) to appoint a working group arising from an item on the agenda for the meeting;
- e) to receive reports or adopt recommendations made by the Board of Directors;
- f) to withdraw a motion;
- g) to amend a motion;
- h) to proceed to the next business;
- i) that the question be now put;
- j) to adjourn a debate;
- k) to adjourn a meeting;
- l) to suspend a particular Standing Order; a rule may be suspended by motion on notice or without notice if at least one half of the whole number of Governors of the Council of Governors are present. Suspension can only be for the duration of the meeting;
- m) to exclude the public and press in accordance with Standing Orders 4.3

- n) to not hear further a Governor, or to exclude them from the meeting. If a Governor persistently disregards the ruling of the Chair by behaving improperly or offensively or deliberately obstructs business, the Chair may move that the Governor be not heard further. If seconded, the motion will be voted on without discussion. If the Governor continues to behave improperly after such a motion is carried, the Chair may move that either the Governor leaves the meeting room or that the meeting is adjourned for a specified period. If seconded, the motion will be voted on without discussion;
- o) to give the consent of the Council of Governors where its consent is required by the Constitution.

4.10 Chair's Ruling

- 4.10.1 Statements of members or Governors made at the meetings of the Council of Governors shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

4.11 Voting

- 4.11.1 Every question at a meeting shall be determined by a majority of the votes of the Governors present and voting on the question with the exception of a decision to remove the Chair or a non-executive Director which requires the approval of two thirds of the Governors present and voting.
- 4.11.2 In the case of an equality of votes, the person presiding over the meeting shall have a second or casting vote.
- 4.11.3 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Governors present so request.
- 4.11.4 If at least one-third of the Governors present so request, the voting on any question may be recorded to show how each Governor present voted or abstained.
- 4.11.5 In no circumstances may a Governor, who is absent at the time of the vote, vote by proxy.

4.12 Minutes

- 4.12.1 The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.
- 4.12.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.
- 4.12.3 Minutes shall be circulated to all Governors. The minutes of meetings shall be made available to the public except for minutes relating to business conducted when members of the public are excluded under the terms of

section 4.3 of these Standing Orders.

4.13 Suspension of Standing Orders

- 4.13.1 Except where this would contravene any statutory provision, any one or more of the Standing Orders may be suspended at any meeting, providing that at least two-thirds of the Governors are present and that a majority of those present vote in favour of suspension.
- 4.13.2 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.
- 4.13.3 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Governors.
- 4.13.4 No formal business may be transacted while Standing Orders are suspended.
- 4.13.5 The Audit ~~and Risk~~ Committee shall review every decision to suspend Standing Orders.

4.14 Record of Attendance

- 4.14.1 The names of the Governors present at the meeting shall be recorded in the minutes.

4.15 Quorum

~~4.15.1~~ No formal business shall be transacted at a general meeting of the Council of Governors unless at least one-third of the Governors are present ~~including at least one-third of the Governors from the public constituency.~~

~~4.15.1~~

~~4.15.2~~ If a Governor has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest, they shall no longer count towards the quorum.

5

6 A Governor who attends the meeting by electronic means allowing simultaneous communication with all other persons attending the meeting (whether in person or by electronic means) shall be deemed to be present

7

~~7.9.1~~

~~4.15.27.9.2~~ If a quorum is not then available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at the meeting. Such a position shall be recorded in the minutes of the meeting. The meeting will then proceed to the next business.

~~4.15.27.9.3~~ For the clarification of doubt, the requirements of this section will not apply to development meetings of the Council of Governors, held for briefing and training purposes, unless such a meeting intends to act as a general meeting and transact formal business. In that event these Standing Orders apply in full to the consideration of any such business.

4.15.3 The Chair of a meeting of the Council of Governors may adjourn a meeting

Formatted: Body Text, Justified, Right: 0.42 cm, Space Before: 0 pt, Outline numbered + Level: 3 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1.45 cm + Indent at: 2.72 cm, Tab stops: 2.72 cm, Left

Formatted: Not Expanded by / Condensed by

Formatted: Font: 11 pt

Formatted: Not Expanded by / Condensed by

of the body if a quorum is either not present within thirty minutes of the appointed time of commencement or is not maintained for the duration of the meeting.

5. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

5.1 Emergency Powers

- 5.1. The powers which the Council of Governors has retained to itself within these Standing Orders may in emergency be exercised by the Chair after having consulted at least five elected members of the Council of Governors. The exercise of such powers by the Chair shall be reported to the next formal meeting of the Council of Governors for ratification.

5.2 Appointment of Committees

- 5.2.1 The Council of Governors may appoint to the committees described in section 5.2.5 of these Standing Orders, consisting wholly of Governors.
- 5.2.2 The Standing Orders of the Council of Governors, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-committees established by the Council of Governors.
- 5.2.3 Each committee shall have such terms of reference and powers and be subject to such conditions as the Council of Governors shall determine. Such terms of reference shall have effect as if incorporated into the Standing Orders.
- 5.2.4 The Council of Governors shall approve the appointments to each of the committees it has constituted.
- 5.2.5 The standing committees to be established by the Council of Governors are:
- a) ~~(Nominations, Committee~~

6 CONFIDENTIALITY

- 6.1 A member of the Council of Governors or an attendee on a committee of the Council of Governors shall not disclose a matter dealt with by, or brought before, the committee without its permission or until the committee shall have reported to the Council of Governors or shall otherwise have concluded on that matter.
- 6.2 A member of the Council of Governors or a non-member of the Council of Governors in attendance at a committee shall not disclose any matter dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Council of Governors or committee resolves that it is confidential.

7 DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

7.1 Declaration of Interests

If a Governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the

Council of Governors, the Governor shall disclose that interest to the members of the Council of Governors as soon as They becomes aware of it.

7.1.1 Interests referred to in 7.1 which should be regarded as "relevant and material" include but are not restricted to:

- a) Directorships, including non-executive directorships held in limited companies (with the exception of dormant companies);
- b) Ownership, part-ownership or directorships of companies, businesses or consultancies that carry out or are likely to carry out business with the Trust;
- c) Majority or controlling shareholdings in an organisation that carries out business with the Trust or is likely to carry out business with the Trust;
- d) A position of authority in a charity or voluntary organisation in the field of health or social care that carries out business with the Trust or is likely to carry out business with the Trust;
- e) Any connection with a voluntary or other organisation contracting or likely to contract for Trust services;
- f) To the extent not covered above, any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to, lenders or banks.

7.1.2 If Governors have any doubt about the relevance of an interest, this should be discussed with the Chair or ~~Trust Secretary~~Company Secretary who will advise on whether or not the interest should be disclosed.

7.1.3 For the avoidance of doubt, the above relevant and material interests extend to the spouse or partner of a Governor and declaration of such interests will be required.

7.1.4 At the time Governors' interests are declared, they should be recorded in the minutes of the Governor Body meetings. Any changes in interests should be declared at the next board meeting following the change occurring.

7.1.5 During the course of a meeting, if a conflict of interest is established, the Governor concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

7.2 Register of Interests

7.2.1 The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Governors. The Register will include details of all directorships and other relevant and material interests which have been declared by Governors, as defined in SO 7.1.

7.2.2 Governors must notify the ~~Trust Secretary~~Company Secretary of any changes

to their declared interests. Such notification must be made to the ~~Trust Secretary~~Company Secretary within seven days of the change becoming known.

7.2.3 The ~~Trust Secretary~~Company Secretary will ensure that such notifications are entered into the Register within seven days.

7.2.4 The ~~Trust Secretary~~Company Secretary will conduct an annual review of the Register and report the outcome to the Council of Governors

7.2.5 The Register will be available for inspection by members of the public at the Trust's headquarters.

8. DISABILITY OF GOVERNORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

8.1 Subject to the following provisions of this Standing Order, if a Governor has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Council of Governors at which the contract or other matter is the subject of consideration, They shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

8.2 The Trust shall exclude a Governor from a meeting of the Council of Governors while any contract, proposed contract or other matter in which They has a pecuniary interest, is under consideration.

8.3 For the purpose of this Standing Order a Governor shall be treated, subject to SO 8.4, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

- They, or a nominee of his/her, is a Director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or
- They is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration; and
- In the case of married persons living together the interest of one spouse shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

8.4 A Governor shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

- Of his/her membership of a company or other body, if they have no beneficial interest in any securities of that company or other body.
- Of an interest in any company, body or person with which They is connected as mentioned in SO 7.3 above which is so remote or insignificant that it cannot

reasonably be regarded as likely to influence a director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

8.5 Where a Governor:

- Has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and
- The total nominal value of those securities does not exceed 5% of the total nominal value of the issued share capital of the company or body.
- If the share capital is of more than one class, the total nominal value of shares of any one class in which They has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class
- This Standing Order shall not prohibit him from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to his/her duty to disclose his/her interest.

8.6 Standing Order 8 applies to a committee or sub-committee of the Council of Governors as it applies to the Council of Governors itself and applies to any member of any such committee or sub-committee (whether or not They is also a Governor) as it applies to a Governor.

9 DISPUTES BETWEEN THE COUNCIL OF GOVERNORS AND THE BOARD OF DIRECTORS

9.1 Conflicts between the Board of Directors and the Council of Governors will be resolved through the Trust's Dispute Resolution Procedure.

10. VARIATION AND AMENDMENT OF STANDING ORDERS

10.1 These Standing Orders shall be amended only if:

- 10.1.1 A notice of motion under Standing Order 4.8 has been given; and
- 10.1.2 A majority of three-quarters of Governors present at the meeting at which the matter is put vote in favour of the changes; and
- 10.1.3 The variation proposed does not contravene a statutory provision or a direction made by the Regulator of NHS Foundation Trusts; and
- 10.1.4 The amendment is agreed by the Board of Directors; and
- 10.1.5 The amendments agreed by the Board of Directors are approved by NHS England.

ANNEX 5 - STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

CONTENTS

1. Introduction

- a. Statutory Framework
- b. Delegation of Powers

2.	SO1	Interpretation
	SO2	The Board of Directors
	SO3	Meetings of the Board of Directors
	SO4	Arrangements for the exercise of functions by Delegation
	SO5	Committees
	SO6	Declaration of interests and register of interests
	SO7	Disability of Directors in proceedings on account of pecuniary interest
	SO8	Standards of Business Conduct
	SO9	Standards of Business Conduct
	SO10	Signature of Documents
	SO11	Miscellaneous

1. Introduction

a) Statutory Framework

The Medway NHS Foundation Trust (the Trust) is a public benefit corporation which is established under the NHS Act 2006 and authorised by NHS England on 1 August 2006 to act as a NHS Foundation Trust. The principal places of business of the Trust is Medway Maritime Hospital.

The Constitution requires the Board to adopt Standing Orders for the regulation of its proceedings and business. In addition the "Directions on Financial Management in England" (HSG (96)12) require health bodies to adopt Standing Financial Instructions setting out the responsibility of individuals. Although not mandatory on NHS Foundation Trusts, the Board will continue to apply them as a key element of its governance arrangements.

b) Delegation of Powers

Under the Standing Orders relating to the Arrangements for the Exercise of Functions SO 4 the Board exercises its powers to make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee appointed by virtue of SO 5 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Board thinks fit or as NHS England may direct. Delegated Powers are covered in a separate document (Reservation of Powers to the Board and Delegation of Powers). That document has effect as if incorporated into the Standing Orders.

2. Standing Orders

SO1 Interpretation

- 1.1 Save as permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Executive and Company Secretary).
- 1.2 Words importing the masculine gender only shall include the feminine gender and words importing the singular shall import the plural and vice-versa.
- 1.3 Any expression to which a meaning is given in the Health Service Acts or in the Regulations or Orders made under the Acts shall have the same meaning in this interpretation and in addition:
 - a) **ACCOUNTABLE ACCOUNTING OFFICER** shall be the officer responsible and accountable for funds entrusted to the Trust. They shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.
 - b) **BOARD** means the Board of Directors, formally constituted in accordance with this Constitution and consisting of a Chair, and Non-Executive Directors, appointed by the Governors' Body and the Executive Directors, appointed by the Non-Executive Directors and (except for his/her own appointment) by the Chief Executive.

- c) **BUDGET** shall mean a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.
- d) **CHAIR** is the person appointed by the Council of Governors as a Non-Executive Chair to lead the Board of Directors, and Council of Governors, to ensure it successfully discharges its overall responsibility for the Trust as a whole.
- e) **CHIEF EXECUTIVE** shall mean the accountable officer of the Trust.
- f) **COMMITTEE OF THE COUNCIL OF GOVERNORS** means a committee formed by the Council of Governors with specific Terms of Reference, chair and membership.
- g) **COMMITTEE OF THE BOARD** means a committee formed by the Board with specific Terms of Reference, Chair and Membership.
- h) **DIRECTOR** means a person appointed to the Board of Directors
- i) **DIRECTOR OF FINANCE** shall mean the Chief Finance Officer of the Trust who will ensure compliance with Standing Financial Instructions.
- j) **FUNDS HELD ON TRUST** shall mean those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under Schedule 3 and 4 para 14.1c National Health Service Act 2006. Such funds may or may not be charitable.
- k) **GOVERNOR** means a person elected or appointed to the Council of Governors.
- l) **COUNCIL OF GOVERNORS** means the Council of Governors, formally constituted in accordance with this Constitution meeting in public and presided over by the Chair.
- m) **MEMBER** means a person registered as a member of one of the constituencies of the Trust as outlined in this Constitution.
- n) **NHS ENGLAND** is the Independent Regulator of NHS Foundation Trusts appointed under the Health and Care Act 2022.
- o) **MOTION** means a formal proposition to be discussed and voted on during the course of a meeting.
- p) **NOMINATED OFFICER** means an officer charged with the responsibility for discharging specific tasks within Standing Orders in line with the Health Act.
- q) **NON-EXECUTIVE DIRECTOR** is a person appointed by the Council of Governors

Formatted: Font: 11 pt

Formatted: Font: 11 pt

to be a member of the Board of Directors. This includes the Chair of the Trust.

- r) **OFFICER** means an employee of the Trust
- s) **SOs** means Standing Orders
- t) **SFIs** means Standing Financial Instructions
- u) **TRUST** means Medway NHS Foundation Trust.
- v) **TRUST/COMPANY SECRETARY** this role will act as independent advisor to the Board and NHS England on the Trust's compliance with its terms of authorisation and constitution.
- w) Trust Nominations ~~and Remuneration~~ Committee means a Committee of the Non-Executive Directors.
- x) **DEPUTY-CHAIR** means the Non-Executive Director appointed by the Chair to carry out the duties of the Chair if they are absent for any reason.

Formatted: Font: 11 pt

SO2 The Board of Director

- 2.1 All business shall be conducted in the name of the Trust.
- 2.2 All funds received in Trust shall be in the name of the Trust as Corporate Trustee. In relation to funds held on Trust, powers exercised by the Trust as Corporate Trustee shall be exercised separately and distinctly from those powers exercised as a Trust.
- 2.3 The Trust has the functions conferred on it by the NHS Act 2006, 2012 and 2022 and by its authorisation.
- 2.4 The Board of Directors is the Corporate Trustee for the Charity. Accountability for charitable funds held on Trust is to the Charity Commission and to the Secretary of State for Health. Accountability for non-charitable funds held on Trust is only to NHS England.
- 2.5 The Trust has resolved that certain powers and decisions may only be exercised or made by the Board in formal session. These powers and decisions are set out in "Reservation of Powers to the Board" and have effect as if incorporated into the Standing Orders.
- 2.6 The Board of Directors will function as a unitary Board. The Board is collectively responsible for discharging the powers and for the performance of the Trust. Executive and non-executive Directors will have joint responsibility for every decision of the Board regardless of their individual skills or status.
- 2.7 The Role of Directors:

- 2.7.1 The role of the Directors as members of the Board is to set the direction of the Trust and NHS England and manage its performance in carrying out its statutory and other functions.
- 2.7.2 The executive Directors will exercise their authority in accordance with the terms of these Standing Orders, the Trust's Standing Financial Instructions, the Scheme of Reservation and Delegation.
- 2.7.3 The Chief Executive is responsible for the overall performance of the executive functions of the Trust. They is the Accounting Officer for the Trust and is responsible for ensuring that the requirements of the NHS Accounting Officer Memorandum are met.
- 2.7.4 The Chief Finance Officer is responsible for the provision of financial advice to the Trust and for the supervision of systems for financial accounting and control.
- 2.7.5 The Non-Executive Directors will not be granted nor seek to exercise any individual executive powers on behalf of the Trust. They may exercise authority when acting as members of, or when chairing, a committee of the Trust which has delegated powers.
- 2.7.6 The Chair is responsible for the operation and performance of the Board and will chair meetings of the Board when present. The Chair has certain delegated powers and must act within the terms of his/her appointment, the Standing Orders and the Standing Financial Instructions in exercising those powers and carrying out his/her duties.
- 2.7.7 The Chair will ensure that the business of the Board is dealt with in an effective and timely manner and that the Board is provided with appropriate information and advice to inform debate and decision.
- 2.7.8 The Board shall approve and keep under review a Statement of Division of Responsibility between the Chair and the Chief Executive which sets out the division of responsibility between them.
- 2.7.9 The Chair is also responsible for the leadership of the Council of Governors and for ensuring that it and the Board work effectively together.

2.8 Composition of the Board of Directors

- 2.8.1 The composition of the Board of Directors is set out in section 22 of the Trust's Constitution:
- A non-executive Director Chair
 - A maximum of six other non-executive Directors; and

- A maximum of six executive Directors including:
 - The Chief Executive Officer (the Chief Accounting Officer)
 - One Executive Director of Finance (the Chief Finance Officer)
 - One Executive Director who is a registered medical or dental practitioner
 - One Executive Director who is a registered nurse or midwife

2.8.2 The Company Secretary (or nominated deputy) will be in attendance at all meetings of the Board.

2.8.3 Other officers of the Trust may attend meetings of the Board by invitation.

2.9 Appointment of the Chair and Directors

2.9.1 The Chair and Non-Executive Directors are appointed by the Governors Nominations and remuneration Committee overseen by the Lead Governor of the Council of Governors.

2.9.2 The Trust Nominations ~~and Remuneration~~ Committee will appoint the Chief Executive Officer of the Trust subject to the approval of the Council of Governors.

2.9.3 The Trust Nominations ~~and Remuneration~~ Committee will appoint the Executive Directors.

2.10 Terms of Office of the Chair and Directors

2.10.1 The remuneration and terms of office of the Chair and Non-Executive Directors shall be decided by the ~~Governors Nominations and Remuneration Committee~~ Nominations Committee.

2.10.2 The remuneration and terms of office of the Executive Directors will be determined by Trust Nominations ~~and Remuneration~~ Committee.

2.11 Appointment of Deputy- Chair and Senior Independent Director

2.11.1 The Chair may appoint one of the Non-Executive Directors to be Deputy-Chair for such a period, not exceeding the remainder of their term as Non-Executive Director of the Trust, as they may specify on appointing him/her.

2.11.2 The Board of Directors may appoint one of the Non-Executive Directors to be Senior Independent Director for such a period, not exceeding the remainder of

their term as Non-Executive Director of the Trust, as they may specify on appointing him/her.

- 2.11.3 Any Non-Executive Director so elected to the above roles, may at any time resign from the office by giving notice in writing to the Chair, and the Directors of the Trust may thereupon appoint another Non-Executive Director as Deputy-Chair and/or Senior Independent Director in accordance with paragraph 2.9.

2.12 Powers of the Deputy- Chair

Where the Chair of an NHS Trust has died or has otherwise ceased to hold office or where They has been unable to perform their duties as Chair owing to illness, absence from England and Wales or any other cause, references to the Chair in these Standing Orders shall, so long as there is no Chair able to perform their duties, be taken to include references to the Deputy-Chair. ~~The Deputy Chair will normally be the chair of the Trust Nominations and Remuneration Committee and the Governors Nominations and Remuneration Committee.~~ Nominations Committee.

~~2.13~~ The role of the Senior Independent Director

~~2.13.12.12.1~~ The Senior Independent Director ('SID') is a role undertaken by one of the Trust's independent Non-Executive Directors. The SID should be available to all stakeholders, particularly governors and members, should they have concerns which they feel unable to resolve via normal channels, such as through contact with the Chair or Chief Executive, or in circumstances in which such contact would be inappropriate.

~~2.13.22.12.2~~ The Senior Independent Director shall meet with the Trust Chair at least annually to evaluate their performance.

~~2.14~~ 2.13 Joint Directors

Where more than one person is appointed jointly to a post in the Trust which qualifies the holder for executive directorship or in relation to which an executive Director is to be appointed, those persons shall become appointed as an executive Director jointly, and shall count as one person for the purpose of Standing Order 2.9.

3 MEETINGS OF THE BOARD OF DIRECTORS

- 3.1 The Board will meet at sufficient intervals to properly discharge its duties. Meetings of the Board will be held in public unless the Board determines otherwise.

- 3.2 The public and representatives of the press shall be afforded the opportunity to attend all formal public meetings of the Board of Directors but shall be required to withdraw upon the Board resolving as follows:

3.2.1 *"That representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960)."*

- 3.2.2 The Chair shall give such direction as seen fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such

Formatted: Body Text, Indent: Left: 1.48 cm, Right: 0.2 cm, No bullets or numbering, Tab stops: Not at 1.45

as to ensure that the Board's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on the grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board resolving as follows:

3.2.3 *"That in the interests of public order, the meeting adjourn for (the period) to enable the Board to complete business without the presence of the public' (Section 1(8) Public Bodies (Admission to Meetings) Act 1960)."*

3.3 Nothing in these Standing Orders shall require the Board to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place without the prior agreement of the Board.

3.4 Where the public is invited to attend a meeting of the Board, the Chair may exclude any member of the public from that meeting if they are interfering with or preventing the proper and reasonable conduct of the meeting.

3.5 Attendance at meetings by members of the press or public does not confer any right to ask questions or otherwise participate in the meeting unless invited to do so by the Chair.

3.6 Calling Meetings

3.6.1 Meetings of the Board shall be held at such times and places as the Board may determine.

3.6.2 The Chair may call a meeting of the Board at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of Directors, has been presented to him, or if without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to him, at the Trust's Headquarters, such one third or more Directors may forthwith call a meeting.

3.7 Notice of Meetings

3.7.1 Before each meeting of the Board, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair or by an officer of the Trust authorised by the Chair to sign on his/her behalf shall be delivered to every Director, or sent by post to the usual place of residence of such Director, so as to be available to him at least five clear working days before the meeting.

3.7.2 Lack of service of the notice on any Director shall not affect the validity of a meeting.

3.7.3 In the case of a meeting called by Directors in default of the Chair, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice.

3.7.4 Failure to serve such a notice on more than three Directors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post.

3.7.5 A public notice of the time and place of the meeting shall be displayed on the Trust's website at least five working days before the meeting.

3.7.6 Before holding a meeting, the Board of Directors will send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

3.8 Setting the Agenda

3.8.1 The Board may determine that certain matters shall appear on every agenda for a meeting of the Board and shall be addressed prior to any other business being conducted.

3.8.2 A director desiring a matter to be included on an agenda shall make his/her request in writing to the Chair at least ten clear working days before the meeting, subject to Standing Order 3.6. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Chair.

3.9 Chair of Meeting

3.9.1 At any meeting of the Board, the Chair, if present, shall preside. If the Chair is absent from the meeting the Deputy-Chair, if there is one and they is present, shall preside. If the Chair and Deputy-Chair are absent such Non-Executive Director as the Directors present shall choose shall preside.

3.9.2 If the Chair is absent from a meeting temporarily on the grounds of a declared conflict of interest the Deputy-Chair, if present, shall preside. If the Chair and Deputy-Chair are absent, or are disqualified from participating, such Non-Executive Director as the Directors present shall choose shall preside.

3.10 Annual Members Meeting

3.10.1 The Trust will publicise and hold an annual members meeting, in accordance with the terms of the Constitution.

3.11 Notices of Motion

3.11.1 A Director desiring to move or amend a motion shall send a written notice thereof at least ten clear days before the meeting to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda subject to Standing Order 3.6.

3.12 Withdrawal of Motion or Amendments

A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

3.13 Motion to Rescind a Resolution

Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Director(s) who gives it and also the signature of four other Directors. When any such motion has been disposed of by the Board, it shall not be competent for any Director other than the Chair to propose a motion to the same effect within six months

3.14 Motions

3.14.1 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

3.14.2 When a motion is under discussion or immediately prior to discussion it shall be open to a Director to move:

- a) An amendment to the motion
- b) The adjournment of the discussion or the meeting
- c) That the meeting proceed to the next business
- d) The appointment of an ad hoc committee to deal with a specific item of business
- e) That the motion be now put

No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

3.15 Chair's Ruling

Statements of Directors made at meetings of the Board shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevance, regularity and any other matters shall be observed at the meeting.

3.16 Voting

3.16.1 Every question at a meeting shall be determined by a majority of the votes of the Directors present and voting on the question and, in the case of any equality of votes, the person presiding shall have a second or casting vote.

3.16.2 The arrangements for the casting of votes by joint Directors is set out in 3.17 below

3.16.3 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Directors present so request.

3.16.4 If at least one-third of the voting Directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained.

3.16.5 If a Director so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

3.16.6 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

3.16.7 An officer who has been appointed formally by the Board to act up for an executive Director during a period of incapacity or temporarily to fill an executive Director vacancy, shall be entitled to exercise the voting rights of the executive Director. An officer attending the Board to represent an executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the executive Director. An officer's status when attending a meeting shall be recorded in the minutes.

3.16.8 Directors on the Board of Directors will have no formal voting rights on a decision nor the personal accountabilities associated with full Board membership.

3.16.9 No resolution shall be passed if it is opposed by all the Non-Executive Directors present or by all of the executive Directors present.

3.17 Joint Directors - Where a post of executive Director is shared by more than one person:

3.17.1 Both persons shall be entitled to attend meetings of the Trust; either of those persons shall be eligible to vote in the case of agreement between them;

3.17.2 In the case of disagreement between them no vote should be cast;

3.17.3 The presence of either or both of those persons shall count as one person for the purposes of determining the quorum of the meeting.

3.18 Minutes

3.18.1 The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

3.18.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

3.18.3 Minutes shall be circulated in accordance with the wishes of the Board and made available to the public.

3.19 Suspension of Standing Orders

3.19.1 Except where this would contravene any statutory provision or any direction made by NHS England, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Board are present, including one executive Director and one non-executive Director, and that a majority of those present vote in favour of suspension.

3.19.2 A decision to suspend Standing Orders shall be recorded in the minutes of the

meeting.

3.19.3 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Directors.

3.19.4 No formal business may be transacted while Standing Orders are suspended.

3.19.5 The Audit Committee shall review every decision to suspend Standing Orders.

3.20 Variation and Amendment of Standing Orders

3.20.1 These Standing Orders shall be amended only if:

- A notice of motion under Standing Order 3.11 has been given;
- No fewer than half the total of the Trust's non-executive Directors vote in favour of amendment;
- At least two-thirds of the voting Directors are present;
- The variation proposed does not contravene a statutory provision or provision of the authorisation or of the Constitution

Formatted: Font: 11 pt

Formatted: Font: 11 pt

3.21 Record of Attendance

The names of the Directors present at the meeting shall be recorded in the minutes.

3.22 Quorum

3.22.1 No business shall be transacted at a meeting of the Board unless at least one-third of the whole number of the voting Directors are present including at least one executive Director and one non-executive Director.

3.22.2 An officer in attendance for an executive Director but without formal acting up status may not count towards the quorum.

3.22.3 If a Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see Standing Order 6 and 7) They shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least one executive Director to form part of the quorum shall not apply where the executive Directors are excluded from a meeting (for example, when the Board considers the recommendations of the Remuneration and Terms of Service Committee).

3.22.4 The Chair may adjourn a meeting of the Board if a quorum is either not present within thirty minutes of the appointed time of commencement or is not maintained for the duration of the meeting.

4. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

4.1 General Provision

Subject to a provision in the authorisation or the Constitution, the Board may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee, appointed by virtue of SO 5 below or by a Director or an officer of the Trust in each case subject to such restrictions and conditions as the Board thinks fit.

4.2 Emergency Powers

The powers which the Board has retained to itself within these Standing Orders (SO 2) may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two non-executive Directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board for ratification.

4.3 Delegation to Committees

The Board shall agree from time to time to the delegation of executive powers to be exercised by committees or sub-committees, which it has formally constituted. The constitution and terms of reference of these committees, and their specific executive powers shall be approved by the Board.

4.4 Delegation to Officers – Scheme of Delegation and Reservation of Powers

- 4.4.1 Those functions of the Trust which have not been retained as reserved by the Board or delegated to an executive committee or sub-committee shall be exercised on behalf of the Board by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate officers to undertake the remaining functions for which they will still be accountable to the Board.
- 4.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board as indicated above.
- 4.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board or the Director of Finance or other executive Directors to provide information and advise the Board in accordance with any statutory requirements.
- 4.4.4 The arrangements made by the Board as set out in the "Reservation of Powers to the Board and Delegation of Powers" shall have effect as if incorporated in these Standing Orders.

5. COMMITTEES

5.1 Appointment of Committees

- 5.1.1 Subject to SO 2 and such directions as may be given by the regulator, the Trust may and, if directed by him, shall appoint committees of the Trust, consisting wholly or partly of Directors of the Trust or wholly of persons who are not Directors of the Trust.

- 5.1.2 A committee appointed under SO 5.1.1 may, subject to such directions as may be given by the regulator or the Board appoint sub-committees consisting wholly or partly of members of the committee (whether or not they include Directors of the Trust) or wholly of persons who are not members of the Board committee (whether or not they include Directors of the Trust).
- 5.1.3 The Standing Orders of the Board, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-committee established by the Board.
- 5.1.4 Each such committee or sub-committee shall have such terms of reference and powers and be subject to such conditions, as the Board shall decide. Such terms of reference shall have effect as if incorporated into the Standing Orders.
- 5.1.5 Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the Board.
- 5.1.6 The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines that persons, who are neither Directors nor officers, shall be appointed to a committee, the terms of such appointment shall be determined by the Board.
- 5.1.7 Where the Board is required to appoint persons to a committee and/or to undertake statutory functions as required by the Secretary of State or NHS England, and where such appointments are to operate independently of the Trust such appointment shall be made in accordance with the regulations laid down by the Secretary of State.
- 5.1.8 Without prejudice to the formation of any other committees ~~or sub-committees~~ as the Board may see fit, the following committees shall be established by the Board:
- Audit and ~~Risk~~ Committee
 - ~~Trust Nominations and~~ Remuneration Committee
 - ~~Charitable Funds~~ Committee
 - Quality Assurance Committee
 - Finance, Planning and Performance Committee
 - People Committee

5.2 Joint Committees Working and Delegation Arrangements

5.2.1 The Trust may make arrangements for the joint exercise of any of its functions jointly with any other person.

5.2.2 For the purposes of exercising of its functions jointly with any other or more of the following bodies:

5.2.3.1 a Relevant Body:

5.2.3.2 a Local Authority;

5.2.3 .3A combined authority

The Trust may:

Formatted: Font: 11 pt

Formatted: Indent: Left: 0 cm, Hanging: 1.27 cm

Formatted: Font: 11 pt

Formatted: Font: 11 pt

Formatted: Font: (Default) Arial, 11 pt

Formatted: Font: (Default) Arial, 11 pt

Formatted: Indent: Left: 1.48 cm, No bullets or numbering

5.2.4. establish a joint committee with the relevant body or bodies and arrange for the relevant functions to be exercised by that joint committee;

5.2.4. arrange for one or more of the bodies, or a joint committee of the bodies, to establish and maintain a Pooled Fund

5.2.5 The Trust must have regard to any guidance published by NHS England under section 65Z7 of the NHS Act 2006.

5.2 5.3 Confidentiality

5.2.1 5.3.1 A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board or shall otherwise have concluded on that matter.

5.2.2 5.3.2 A Director of the Trust or a member of a committee shall not disclose any matter reported to the Board or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board or committee shall resolve that it is confidential.

6. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

6.1 Declaration of Interests

6.1.1 If a Director has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Board, the Director shall disclose that interest to the Board as soon as They becomes aware of it.

6.1.2 Interests which should be regarded as "relevant and material" are:

- a) Directorships, including non-executive directorships held in limited companies (with the exception of dormant companies);
- b) Ownership, part-ownership or directorships of companies, businesses or consultancies that carry out or are likely to carry out business with the Trust;
- c) Majority or controlling shareholdings in an organisation that carries out business with the Trust or is likely to carry out business with the Trust;
- d) A position of authority in a charity or voluntary organisation in the field of health or social care that carries out business with the Trust or is likely to carry out business with the Trust;
- e) Any connection with a voluntary or other organisation contracting or likely to contract for Trust services;
- f) To the extent not covered above, any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to, lenders or banks.

6.1.3 If Directors have any doubt about the relevance of an interest, this should be discussed with the Chair.

6.1.4 At the time Directors' interests are declared, they should be

Formatted: Font: 11 pt

Formatted: Indent: Left: 0 cm, Hanging: 1.27 cm

Formatted: Font: 11 pt

Formatted: Font: (Default) Arial, 11 pt

Formatted: Font: (Default) Arial, 11 pt

Formatted: Font: (Default) Arial, 11 pt, Not Bold

Formatted: Font: 11 pt, Not Bold

Formatted: Font: (Default) Arial, 11 pt, Not Bold

Formatted: Font: (Default) Arial, 11 pt, Not Bold

Formatted: Font: 11 pt, Not Bold

Formatted: Indent: Left: 0 cm, Hanging: 1.27 cm

Formatted: Indent: Left: 0 cm, Hanging: 1.27 cm, No bullets or numbering

Formatted: Indent: Left: 1.48 cm, No bullets or numbering

Formatted: Indent: Left: 2 cm, No bullets or numbering

recorded in the board minutes. Any changes in interests should be declared at the next board meeting following the change occurring.

- 6.1.5 Board directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the board's annual report.
- 6.1.6 During the course of a board meeting, if a conflict of interest is established, the Director concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

6.2 Register of Interests

- 6.2.1 The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Directors. The Register will include details of all directorships and other relevant and material interests which have been declared by Directors, as defined in SO 6.1.
- 6.2.2 Directors must notify the Company Secretary of any changes to their declared interests. Such notification must be made to the Company Secretary within ten days of the change becoming known.
- 6.2.3 The Company Secretary will ensure that such notifications are entered into the Register within seven days.
- 6.2.4 The Company Secretary will conduct an annual review of the Register and will report the outcome to the Board.
- 6.2.5 ~~The Register~~The Register will be available for inspection by the public at the Trust's headquarters.

7. DISABILITY OF DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

- 7.1 Subject to the following provisions of this Standing Order, if a Director has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board at which the contract or other matter is the subject of consideration, They shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.
- 7.2 The Board shall exclude a Director from a meeting of the Board while any contract, proposed contract or other matter in which They has a pecuniary interest, is under consideration.
- 7.3 For the purpose of this Standing Order a Director shall be treated, subject to SO 7.4, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:
 - They, or a nominee of his/her, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be

made or which has a direct pecuniary interest in the other matter under consideration; or

- They is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration; and
- In the case of married persons living together the interest of one spouse shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

7.4 A Director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

- Of his/her membership of a company or other body, if They has no beneficial interest in any securities of that company or other body;
- Of an interest in any company, body or person with which he/her is connected as mentioned in SO 7.3 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

7.5 Where a Director:

- Has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and
- The total nominal value of those securities does not exceed 5% of the total nominal value of the issued share capital of the company or body, and
- If the share capital is of more than one class, the total nominal value of shares of any one class in which he/her has a beneficial interest does not exceed 5% of the total issued share capital of that class,

7.6 Standing Order 7 applies to a committee or sub-committee of the Board as it applies to the Board itself and applies to any member of any such committee or sub-committee (whether or not he/her is also a Director of the Trust) as it applies to a Director of the Trust.

8. STANDARDS OF BUSINESS CONDUCT

8.1 All staff must comply with the requirements of the Trust's Policy on Business Conduct and Ethical Standards for Commercial Sponsorship. The following provisions should be read in conjunction with this document.

8.2 If it comes to the knowledge of a Director or an officer of the Trust that a contract in which he/her has any pecuniary interest not being a contract to which he/her is himself a party, has been, or is proposed to be, entered into by the Trust he/her shall, at once, give notice in writing to the Chief Executive of the fact that he/her is interested therein. In the case of married persons [or persons] living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

8.3 An officer must also declare to the Chief Executive any other employment or business or other relationship of his/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

- 8.4 The Chief Executive will ensure that the interests, employment or relationships declared by staff shall be entered in a register of interests of staff. The Register of Interests of Staff will be maintained by the Company Secretary.
- 8.5 Canvassing of Directors of the Trust or members of any committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.
- 8.6 A Director of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this Standing Order shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.
- 8.7 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.
- 8.8 Candidates for any staff appointment shall when making application disclose in writing whether they are related to any director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.
- 8.9 The Directors and every officer of the Trust shall disclose to the Chief Executive any relationship with a candidate of whose candidature that director or officer is aware. It shall be the duty of the Chief Executive to report to the Trust any such disclosure made.
- 8.10 On appointment, Directors (and prior to acceptance of an appointment in the case of executive Directors) should disclose to the Trust whether they are related to any other Director or holder of any office under the Trust.
- 8.11 Where the relationship of an officer or another director to a Director of the Trust is disclosed, the Standing Order headed 'Disability of Directors in proceedings on account of pecuniary interest' (SO 7) shall apply.

9. CUSTODY OF SEAL AND SEALING OF DOCUMENTS

- 9.1 The Common Seal of the Trust shall be kept by the Company Secretary in a secure place.
- 9.2 The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board, or of a committee thereof, or where the Board has delegated its powers.
- 9.3 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Director of Finance (or an officer nominated by him) and authorised and countersigned by the Chief Executive (or an officer nominated by him who shall not be within the originating directorate).
- 9.4 An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealing shall be made to the Trust at least quarterly. (The report shall contain details of the seal number, the description of the document and date of sealing).

10. SIGNATURE OF DOCUMENTS

- 10.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.
- 10.2 The Chief Executive or nominated officers shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board or committee or sub-committee to which the Board has delegated appropriate authority.

11. MISCELLANEOUS

- 11.1 It is the duty of the Chief Executive to ensure that existing Directors and officers and all new appointees are notified of and understand their responsibilities within Standing Orders and SFIs. Updated copies shall be issued to staff designated by the Chief Executive. New designated officers shall be informed in writing and shall receive copies where appropriate of SOs.
- 11.2 Standing Financial Instructions and Reservation of Powers to the Board and Delegation of Powers shall have the effect as if incorporated into Standing Orders.
- 11.3 Standing Orders shall be reviewed annually by the Trust. The requirement for review extends to all documents having the effect as if incorporated in Standing Orders.

BOARD OF DIRECTORS

BOARD AND COMMITTEE MEMBERSHIP AND DESIGNATIONS

From 01 July 2026

1. Introduction and purpose of the report

The Constitution of Medway NHS Foundation Trust (the Trust) sets out the composition and makeup of the Board of Directors (the Board) both in terms of Executive and Non-Executive Directors roles. In addition, there are several other roles which are either required by NHS regulators or recommended as part of a system of good governance.

This paper provides an update on Non-Executive Director designations and Board Committee membership to take account of the changes of the Executive. This report also includes the up-to-date position on Executive Director designations and Committee membership. For ease of reference, updates are in red.

2. Non-Executive Director Terms of Office

The appointment of Non-Executive Directors is the responsibility of the Council of Governors. The Nominations Committee of the Council of Governors will consider the recommended extension of tenure for a second term for Mojgan Sani and Gary Lupton. Peter Conway, Chair of the Audit and Risk Committee resigned on 31 March 2026. The Trust has commenced the process for recruiting his replacement.

The terms of office for the Non-Executive Directors, as of 01 July 2026, are detailed in table 1 below.

Table 1 - terms of office for the Non-Executive Directors

Name	Surname	Start date	(re) Appointment to the Board	Period of appointment	End date appointment
John	Goulston	01/06/24		3 years	31/05/27
Paulette	Lewis	01/11/25	second term	3 years	31/10/28
Jenny	Chong	01/04/24		3 years	31/03/27
Mojgan	Sani	01/09/23	Recommended for second term	3 years	31/08/26
Gary	Lupton	01/09/23	Recommended for second term	3 years	31/08/26
Helen	Wiseman	01/05/25		3 years	30/04/28
Associate Non-Executive (non-voting)					
Jane	Perry	01/11/24		3 years	31/10/27

3. Board Membership

The Constitution sets out that the Board is made up of a Non-Executive Chair, up to a maximum of six Non-Executive Directors (NEDs) and up to a maximum of six Executive Directors. The Remuneration Committee has approved the recommendations of the Interim Chief Executive (CEO) to appoint Jeremy Davis as Acting Chief Medical Officer and for Darren Palmer to step up from Deputy Chief Operating Officer to Acting Chief Operating Officer. Both Jeremy and Darren will be voting members of the Board. As there is one Non-Executive vacancy, one fewer executive can

have voting rights. Table 2 below shows the Board composition which takes the NED vacancy into account.

Table 2 Board Composition

Non-Executive Directors <i>(As of 01 July 2026)</i>	Executive Directors <i>(As of 01 July 2026)</i>
John Goulston, Chair	
1. Paulette Lewis	Siobhan Callanan, Interim CEO
2. Jenny Chong	Darren Palmer, Interim Chief Operating Officer (COO)
3. Mojgan Sani	Jeremy Davis (Acting CMO)
4. Gary Lupton	Evonne Hunt Chief Nurse (CNO)
5. Helen Wiseman	Simon Wombwell, interim Chief Finance Officer ((CFO)
6. Vacant	
Non-voting board members	
Associate NED - Jane Perry (nominated by Canterbury Christ Church University)	Sheridan Flavin, Interim Chief People Officer (CPO)

4. Membership of Board Committees

From **01 July 2026**, the membership of Board Committees is set out in table 3 below.

Table 3 - Membership of Board Committees from 1 April 2026

Board Member	Audit and Risk Committee <i>(2 NEDs required for quoracy)</i>	Corporate Trustee/ Charitable Funds <i>(1 NED required for quoracy)</i>	Finance, Planning and Performance Committee <i>(2 NEDs required for quoracy)</i>	Quality Assurance Committee <i>(2 NEDs required for quoracy)</i>	People Committee <i>(2 NEDs required for quoracy)</i>	Remuneration Committee
John Goulston,		Attendance	Member	Attendance	Attendance	Chair
Paulette Lewis		Member		Chair	Member	Member
Jenny Chong (SID)		Member		Member	Chair	Member
Mojgan Sani	Chair	Member		Member		Member
Gary Lupton	Member	Chair	Member		Member	Member
Helen Wiseman	Member	Member	Chair			Member
Jane Perry				Attendance	Attendance	
Siobhan Callanan		Member				Attendance
Jeremy Davis		Member	Member	Member	Attendance	
Evonne Hunt	Attendance	Member	Attendance	Member	Member	
Simon Wombwell	Attendance	Member	Member			
Darren Palmer		Member	Member	Member		
Sheridan Flavin		Member	Attendance	Attendance	Member	

Executive directors will use their deputies where necessary to ensure attendance and use specific expertise. All Board members including the Chair, Chief Executive and Deputy Chief Executive are encouraged to attend at least one meeting per year of the Board's Assurance Committees that they are not formal members of.

5. Chairs and Deputies of Board Committees

As detailed in Table 4 each of the Board committees has a chair. In the interests of good governance, each committee should also have a deputy chair. Table 4 proposes the deputy chair for each Board committee.

Table 4 - Chairs and Deputy Chairs of Board Committees

Committee	Chair	Deputy Chair
Audit and Risk	Mojgan Sani	Helen Wiseman
Quality Assurance	Paulette Lewis	Mojgan Sani
Finance, Planning and Performance	Helen Wiseman	Gary Lupton
People	Jenny Chong	Gary Lupton
Corporate Trustee/ Charitable Funds	Gary Lupton	Mojgan Sani
Remuneration	John Goulston	Jenny Chong (SID)

The Remuneration Committee will be chaired by the Chair of the Trust with the Senior Independent Director as the Deputy Chair of the Committee.

6. Other Non-Executive Board Leadership responsibilities

6.1 Deputy Chair and Senior Independent Director

Paragraph 24.2 of the Trust's Constitution states that "The Council of Governors at a general meeting of the Council of Governors shall appoint the Chair of the Trust and the other Non-Executive Directors, Associate Non-Executive Directors, by approval of a majority of those present."

Deputy Chair means the Non-Executive Director appointed by the Council of Governors to take on the Chair's duties in accordance with paragraph 13.2 of the Constitution if the Chair is absent for any reason. The Chair is in discussion with a NED regarding being nominated to the Council of Governors as Deputy Chair of the Trust.

The Board of Directors (Paragraph 2.11.1) appoints the Senior Independent Director (SID). The NHS England code of conduct for NHS providers recommends that the SID should not be the Chair of the Audit and Risk Committee. Jenny Chong, Chair of the People Committee is the SID.

6.2 Non-Executive Director Champion roles

In addition to the responsibilities in section 6.1 and table 4; there are the following assigned NED champion / lead roles and responsibilities:

- Maternity – Paulette Lewis
- Staff Health and Wellbeing – Jenny Chong
- Freedom to Speak Up – Mojgan Sani
- Security Management – Gary Lupton

- Resident Doctors – Jenny Chong

All Non-Executive and our Associate NED are champions for the 5 work streams in the Cultural Transformation Programme.

In addition, under the 2003 *'Maintaining High Professional Standards in the modern NHS: A Framework for the Initial Handling of Concerns about Doctors and Dentists in the NHS'* and the associated Directions on Disciplinary Procedures 2005, there is a requirement for chairs to designate a NED member as "the designated member" to oversee each case to ensure momentum is maintained. There is no specific requirement that this be the same NED for each case. The framework was issued to NHS foundation trusts as advice only. Medway NHS Foundation Trust follows the framework and will appoint a NED on a case-by-case basis to fulfil this role.

The above arrangements reflect the guidance issued by the NHS in December 2021 on NED champion roles ("A new approach to Non-Executive director champion roles" December 2021 - https://www.england.nhs.uk/wp-content/uploads/2021/12/B0994_Enhancing-board-oversight-a-new-approach-to-non-executive-director-champion-roles_December-2021.pdf).

This guidance sets out the approach to ensuring board oversight of critical issues by discharging the activities and responsibilities previously held by some NED champion roles, through committee structures. It also describes which roles should be retained (see above) and provides further sources of information on each issue. Table 5 sets out the Board Committees that will champion/lead on these roles.

Table 5 – Committee leadership roles

Role	MFT Committee	Guide suggests
Organisational Culture	People	
Hip fractures, falls and dementia	Quality	Quality
Palliative and end of life care	Quality	Quality
Resuscitation	Quality	Quality
Learning from deaths	Quality	Quality
Health and safety	Quality	Quality
Safeguarding	Quality	Quality
Safety and risk	Quality	Quality
Lead for children and young people	Quality	Quality
Counter fraud	Audit and Risk	Audit and Risk
Emergency preparedness	Audit and Risk	Audit and Risk
Procurement	Finance, Planning and Performance	Finance
Cyber security	Finance, Planning and Performance	Finance/ Board
Security management – violence and aggression	People	Workforce

Safety and risk are led by the Quality Assurance Committee, which has an effective link to the corporate assurance management and corporate and quality compliance arrangements. It is not therefore proposed to change this arrangement.

Finance, Planning and Performance Committee (FPPC) oversees digital, including cyber security risk component, which is now part of an overall BAF risk.

7. Recommendations

The Board is asked to note:

7.1. The Non-Executive and Executive Director membership of committees as set out in section 4, Table 3 effective from **1 July 2026**.

7.1.1. The changes to the Executive directors' designations following Alison Davies retiring and Frances Woodroffe leaving the Trust on 30 June 2026 as detailed in table 2.

8. Next steps

The Board is asked to note:

8.1. The composition of the Board and its voting membership as set out in section 3.

8.2. This report will be forwarded to the Council of Governors meeting on **22 July 2026** for the Council to note the updated Board designations and Committee membership.

8.3. Mojgan Sani and Gary Lupton are both being recommended by the Nominations Committee to Council of Governors meeting on 22 July 2026 to be offered a second term of 3 years from 1 September 2026.

8.4. A further update will come to the Board on 2 September 2026 and then the Council of Governors, to reflect the executive changes with Mark Orchard commencing as Chief Executive on 1 October 2026.

8.5. Interviews for the vacant Non-Executive Director position are being held on 29 June 2026. The outcome will also be reflected in the 2 September Board designations update.

8.6. At the point of having a full complement of Non-Executive Directors, the Chair will propose a Deputy Chair to the Council of Governors.

June 2026

Chair, John Goulston

Medway NHS Foundation Trust

Meeting of the Trust Board in Public

Meeting Date: 01 July 2026

Title of Report	Patient Safety Incident Backlog and Prevention of Future Deaths update report			Agenda Item	6.6
Stabilisation Plan Domain	Culture	Performance	Governance and Quality	Finance	Not Applicable
			✓		
CQC Reference	Safe	Effective	Caring	Responsive	Well-Led
	✓	✓	✓	✓	✓
Author and Job Title	Tamara Brett – Head of Patient Safety & Improvement				
Lead Executive	Evonne Hunt, Chief Nursing Officer				
Purpose	Approval		Briefing		Noting ✓
Proposal and / or key recommendation:	Approval has been sought to proceed with a structured Patient Safety Incident backlog recovery programme, including implementation of a 6–9 month reduction trajectory, strengthened governance and oversight, targeted resource support, and a comprehensive reset of data quality, KPIs, and PSIRF delivery; the Board is also asked to note the significant organisational, regulatory, and patient safety risks associated with the current backlog and system weaknesses, and to provide strategic support and oversight to enable timely recovery and sustained improvement.				
Executive Summary	The report identifies a significant backlog of approximately 428 open patient safety investigations, including 113 high-level cases, with delays, overdue Duty of Candour requirements, and data inaccuracies creating a risk of false organisational assurance and non-compliance with PSIRF expectations. These issues are underpinned by inconsistent processes, variable divisional engagement, gaps in investigator capability, limited human factors expertise, and weaknesses in governance, data quality, and oversight, collectively impacting the Trust’s ability to effectively manage risk, demonstrate assurance, and embed learning.				
	This position presents a material organisational, regulatory, and patient safety risk; however, it also provides a critical opportunity to strengthen systems and restore confidence through a structured recovery programme. Key actions include implementing a time-bound backlog reduction plan with clear ownership, improving data quality and reporting, enhancing governance and oversight, increasing capability through targeted training and resource, and embedding a consistent, mature PSIRF approach to support sustainable improvement in patient safety and organisational assurance				
Issues for the Group/Committee/Board Attention:	There are no areas of outstanding performance identified at this stage, and limited evidence of sustained improvement or embedded learning. The current position reflects significant and escalating concerns, including a backlog of approximately 428 open investigations (113 high-level), prolonged delays (average 192 days), and overdue Duty of Candour requirements, which collectively present material risks to patient safety, regulatory compliance, and organisational assurance				

	In addition, data quality weaknesses and system inconsistencies are creating a risk of false assurance, compounded by gaps in workforce capability and variable divisional engagement, requiring urgent Board-level oversight and support to mitigate risk and enable recovery		
Meetings at which this paper has been discussed / approved: Date:	This paper has been submitted to the Trust Leadership Team, and Quality Assurance Committee		
Board Assurance Framework / Risk Register:	The risks identified in this report are not yet formally recorded against a specific Risk ID, however they represent a high-rated corporate risk relating to patient safety backlog, regulatory compliance, and data quality, and require escalation to the Trust Risk Register to ensure appropriate oversight, scoring, and mitigation planning.		
Financial Implications:	There is a potential adverse financial impact associated with the current position, including increased risk of litigation and claims, possible regulatory penalties linked to Duty of Candour non-compliance, and the requirement for short-term investment in additional resource and system improvements to support backlog recovery and strengthen PSIRF delivery, which may place pressure on both divisional budgets and the wider Trust financial position.		
Integrated Impact Assessment (IIA) implications	The issues identified have significant implications for patient safety, quality, and workforce, including delays in learning and risk mitigation, gaps in staff capability and capacity, and potential impact on equitable and consistent investigation processes across divisions; no additional equality risks of significance have been specifically identified at this stage, but this will require ongoing review as improvement actions are implemented.		
Freedom of Information status:	Disclosable		Exempt

PATIENT SAFETY INCIDENT BACKLOG AND ASSURANCE REPORT (PSIRF ALIGNMENT AND RECOVERY ACTIONS)

May 2026

Report prepared by:

Tamara Brett Head of Patient Safety & Improvement Team



Situation:

Since commencing in post as Head of Patient Safety and Improvement (PSI) on 21st April 2026, an initial review of the service and data has identified a number of system-level themes relating to backlog management, data accuracy, and assurance processes.

Current position indicates:

- A defined backlog has been agreed as incidents reported and investigations declared prior to 31st March 2026, with a proportion of cases dating back to 2024.
- Approximately 428 open investigations across the Trust
- Of these, ~ 113 incidents require high-level investigation (above local level)

There are also critical discrepancies in the incident management system, including cases being recorded as “finally approved” while investigations remain ongoing, which may give an inaccurate level of assurance at organisational level.

Division/Care Gro	PSIRF - PSII	PSIRF - MDT	PSIRF - AAR	PSIRF - SWARM	A3	MNSI	Verbal update to IRG	Standard /Local review	Grand Total
Medicine and Emergency Care	27	15	23	16	2			6	89
Women, Children and Young People	3	1	4			3	1	5	17
Surgery and Anaesthetics	4	1	3	2	1			3	14
Cancer and Core Clinical Services		2	4					1	7
Central Operations	1								1
Corporate								1	1
Grand Total	35	19	34	18	3	3	1	16	129

Background:

Under PSIRF (Patient Safety Incident Response Framework), organisations are expected to:

- Undertake timely scoping via a Duty of Candour (DoC) and safety decision-making process
- Progress investigations proportionately and within clearly defined timeframes (typically 60 working days for full investigations unless otherwise justified)
- Ensure accuracy, transparency, and learning-driven outputs

Current data shows:

- ~ 59 high-level incidents have not had DoC completed within expected timeframes
- Variation in data validation approaches and historic recording practices has been identified

A backlog that has developed over time within a system where oversight, coordination, and improvement focus have not been consistently embedded across the organisation.

PSIRF was implemented in February 2024; however, current findings indicate variability in the maturity and consistency of its application across the organisation. This is further reflected in the recent independent assurance review (Steve Lennox), which highlights that current arrangements are not yet fully robust.

Duty of Candour Conversation Compliant (Within 10 Working Days)	PSIRF - PSII	PSIRF - MDT	PSIRF - AAR	PSIRF - SWARM	A3	Verbal update to IRG	Standard /Local review	Grand Total
No	26	9	18	4	1		1	59
Yes	6	3	3	6		1	1	20
Grand Total	32	12	21	10	1	1	2	79

Metric	Current	Target
Open incidents	428	Reducing trajectory
Investigations	113	↓ monthly
DoC overdue	59	0
>6 month overdue investigation	46	0
Average investigation age	192 days	<60 working days
Cases incorrectly closed	TBC	0
Learning actions overdue	TBC	<10%

Assessment:

The current position presents significant organisational risk:

Organisational Alignment & Capability

- Operationalisation of PSIRF requires urgent review
- Limited alignment between corporate PSI functions and divisional teams has reduced the consistency of approach and pace of improvement.
- Opportunities exist to strengthen capability, visibility, and specialist expertise within the PSI function to support sustained delivery.
- Current arrangements may not yet provide sufficient organisational grip or visibility of risk and progress.

Regulatory, Financial & Legal Risk

- Direct correlation to concerns raised through coronial processes
- Inability to meet well led, safe, effective caring, responsive domain for CQC.
- Financial penalty due to non-compliance with DoC – fixed penalty notices or criminal
- Increase in claims due to lack of timely investigation and learning to prevent recurrence

Workforce & Capability Concerns

- Investigator competency gaps
- Need for PSIRF training, including use of the template
- Lack of human factors expertise and dependency on a few individuals
- Variability in divisional engagement

Patient Safety & Learning

- Delayed investigations are hindering identification of systemic risks
- Lack of robust process for capturing and monitoring the current QIPs
- Limited evidence of embedded improvement activity or learning dissemination

Operational Capacity

- Current Patient Safety Incident Team (PSIT) staffing requires review and mapping to meet National Standards
- Addressing backlogs may require additional resource
- Ongoing inflow of incidents

Data Reliability

- Variation in data accuracy and recording standards
- Risk of false assurance
- Historic errors will require systematic validation and correction

Divisional Assurance

- Divisional ownership of investigations
- Role of Divisional Directors of Nursing and Medical Directors
- Expectations for speciality-level engagement
- Escalation expectations



Medway

NHS Foundation Trust



Response & Action Summary:

1. Backlog Recovery Plan

- Establish a formal recovery programme with divisional ownership
- Suggested recovery trajectory: 6–9 months
- Development of prioritisation framework based on risk, harm, and external scrutiny (e.g. coronial cases)

2. Immediate Resource Support

Business Intelligence (BI):

- Urgent support to validate dataset and produce accurate reporting

Administrative support:

- Temporary investigation resource

3. Governance and Risk Escalation

- Trust Risk Register (high rating)
- Quality Committee and Board oversight
- Engagement with CQC and ICB

4. Data Quality and KPI Reset

- Introduction of clear Trust-wide KPIs, including:
- Investigation completion timelines
- DoC compliance
- Quality of reports and learning outputs
- Implement routine audit and assurance processes

5. PSIRF Delivery Strengthening

- Urgent review of PSIRP to ensure compliance with National Standards
- Review, refresh and strengthen QIP process
- Strengthen visibility and comms
- Clarify roles and responsibilities across corporate and divisional teams

6. PSIRF backlog

- Structured desktop review of all open cases
- Appropriate categorisation and response pathway
- Close or re-scope cases where appropriate

PFD (Prevention of Future Deaths) – Current Position & Assurance Gap

Purpose:

Following report at QAC further update required for board specifically focusing on governance and oversight of Prevention of Future Death (PFD) reports (Coroners and Justice Act 2009 – statutory duty to respond within 56 days). During backlog review further identified gaps in oversight and monitoring of potential and issued PFD.

Jan 2024 – May 2026:

Trust had received 1 PFDs;

Case 1 (WP) - **PFD issued on 16/12/2025**, received by Trust March 2026.

PFD Position update and identified gaps :

- Fragmented governance between Legal Services and Patient Safety
- No single Trust-wide PFD register or standardised reporting framework is currently in place.
- Absence of consistent management and reporting to all relevant subcommittees, Quality Assurance Committee (QAC) and Board
- Inconsistent application of CMO/CNO sign-off of action plans (within 56 days)
- Lack of systematic approach to developing improvement action plans as result of PFD, monitoring of action completeness resulting in missed organisational learning.
- Lack of designated Leads and Medical spokespersons for Coroners Inquests

Emerging themes from PFDs:

Recurring PFD themes relate to deteriorating patients, ED pathways, clinical monitoring and nutrition and hydration.

PFD Governance, Oversight & Forward Model

Recovery Plan:

Introduction of proposed new Governance process which standardises, end-to-end Governance framework to ensure clear accountability, consistent oversight, and auditable assurance to Board.

Defined Governance Process (Going Forward):

- PFD issued by Coroner → **CEO** → **CMO / CNO**
- → **IRSG** (formal presentation and action leads assigned)
- → **Governance, Risk & Compliance subcommittee** and **QIP Scrutiny subcommittee** (PFD action implementation and monitoring) →
- **QAC** → **Board**

This establishes a clear, auditable line of sight from coronial findings to Board-level assurance and executive accountability.

Updated Governance process will include:

1. Implementation of a formal Trust-wide PFD register
2. Weekly meetings between Legal Services and Patient Safety Teams for monitoring of high risk coronial cases.
3. CMO/CNO approval of all action plans prior to being sent to coroner (as part of proposed Governance structure).
4. Defined ownership, delivery timescales, and escalation triggers.
5. Routine reporting of action completion and impact
6. Digital tracking to support transparency and auditability

This model moves the Trust from informal, relationship-dependent oversight to a standardised, controlled system, strengthening regulatory compliance, organisational learning, and Board assurance.

Meeting of the Trust Board in Public

Meeting Date: 01 July 2026

Title of Report	Strategic Asset Management Plan, Backlog Maintenance			Agenda Item	6.7	
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	Neil Adams, Deputy Director of Estates and Facilities					
Lead Executive	Siobhan Callanan, Chief Executive (interim)					
Purpose	Approval		Briefing		Noting	x
Proposal and / or key recommendation:	This organisation is committed to excellence in asset management to deliver safe, efficient, and sustainable healthcare infrastructure. We will: • Prioritise Safety: Maintain assets to protect patients, staff, and visitors from harm • Enable Clinical Services: Ensure infrastructure reliability supports uninterrupted care delivery • Optimise Value: Balance cost, risk, and performance across asset lifecycles • Ensure Compliance: Meet all statutory, regulatory, and NHS standards • Drive Sustainability: Achieve net zero carbon and environmental stewardship • Enable Transformation: Align estate with evolving healthcare models • Continuous Improvement: Apply ISO 55000 principles and learn from performance data					
Executive Summary	The Estates and Facilities Directorate commissioned a comprehensive, non-intrusive six-facet survey of the Medway Maritime Hospital estate in 2023. This was the first full survey undertaken in more than 15 years and established the Trust’s backlog maintenance liability at £120 million.					
	A formal review and update of the survey was completed in December 2025. Based on this reassessment, the Trust’s provisional backlog maintenance requirement has increased to £147.5 million. This represents a 23% rise over a two-year period, driven primarily by inflationary pressures and continued deterioration of the estate. For context, general inflation over the same period is estimated at approximately 5.8%, indicating that the majority of the increase reflects the ageing condition of the built assets.					
	Year	Backlog Maintenance (£m)		High		
	Risk	Significant				
Risk	Moderate Risk		Low			
Risk						
2023	120	0.2	52.8	42.8	24.2	
2025	147.5	(+24%)	0.25	(+25%)	64.4	(+22%) 56.4 (+31%) 26.5 (+9%)

	Table 1: Comparison between the 2023 and 2025 backlog condition survey results In addition, issues identified during recent capital projects suggest that further investment will be required to address potential fire compartmentation deficiencies across the site. Initial estimates indicate a requirement of approximately £15 million, subject to confirmation through a separate intrusive survey. If the backlog maintenance and fire compartmentation estimates are combined, the Trust’s total backlog liability is projected to be £162.5 million. While ongoing capital investment programmes—such as the decarbonisation scheme and the Safety Fund—will reduce elements of the backlog, the overall impact is not expected to materially alter the total liability. A detailed recalculation will be undertaken upon completion of these projects. This paper details strategic asset management plan.																																																
Issues for the Group/Committee/Board Attention:	Internal Factors: • Aging estate with 60% of buildings exceeding 25 years old • Significant deferred maintenance creating operational and safety risks • Competing demands for capital investment Workforce capacity constraints for estate management • Legacy infrastructure systems requiring modernisation External Factors: • NHS England estate strategy and net zero commitments • Regulatory compliance (CQC, HSE, fire safety, water safety) • Sustainability targets: Net Zero by 2040-2045 • Capital funding constraints and Treasury approval processes • Clinical service transformation and changing healthcare models • Patient safety and experience expectations																																																
Meetings at which this paper has been discussed / approved: Date:	Estates and Facilities Infrastructure Meeting.																																																
Board Assurance Framework / Risk Register:	Risk Register entry 2158																																																
Financial Implications:	<table><tr><th colspan="6">Investment Strategy (5-Year Plan)</th></tr><tr><th>Year</th><th>Critical Risk</th><th>High Risk</th><th>Moderate Risk</th><th>Lifecycle/Planned</th><th>Total Annual Investment</th></tr><tr><td>1</td><td>£20M</td><td>£15M</td><td>£0</td><td>£2M</td><td>£37M</td></tr><tr><td>2</td><td>£20M</td><td>£15M</td><td>£0</td><td>£3M</td><td>£38M</td></tr><tr><td>3</td><td>£18M</td><td>£10M</td><td>£6M</td><td>£3M</td><td>£37M</td></tr><tr><td>4</td><td>£8M</td><td>£10M</td><td>£10M</td><td>£4M</td><td>£32M</td></tr><tr><td>5</td><td>£0</td><td>£6M</td><td>£11M</td><td>£4M</td><td>£21M</td></tr><tr><td>Total</td><td>£66M</td><td>£56M</td><td>£27M</td><td>£16M</td><td>£165M</td></tr></table>	Investment Strategy (5-Year Plan)						Year	Critical Risk	High Risk	Moderate Risk	Lifecycle/Planned	Total Annual Investment	1	£20M	£15M	£0	£2M	£37M	2	£20M	£15M	£0	£3M	£38M	3	£18M	£10M	£6M	£3M	£37M	4	£8M	£10M	£10M	£4M	£32M	5	£0	£6M	£11M	£4M	£21M	Total	£66M	£56M	£27M	£16M	£165M
Investment Strategy (5-Year Plan)																																																	
Year	Critical Risk	High Risk	Moderate Risk	Lifecycle/Planned	Total Annual Investment																																												
1	£20M	£15M	£0	£2M	£37M																																												
2	£20M	£15M	£0	£3M	£38M																																												
3	£18M	£10M	£6M	£3M	£37M																																												
4	£8M	£10M	£10M	£4M	£32M																																												
5	£0	£6M	£11M	£4M	£21M																																												
Total	£66M	£56M	£27M	£16M	£165M																																												

Integrated Impact Assessment (IIA) implications	Organisational Objectives Alignment (ISO 55000 Clause 6.2)			
	Organisational Objective	Asset Management Objective	Key Performance Indicators	
	Deliver safe patient care	Eliminate critical infrastructure risk	Critical backlog £0 by Year 5	
	Maintain operational resilience	Achieve 99.5% uptime for critical systems	Unplanned downtime <0.5%	
	Meet regulatory standards	100% compliance with statutory requirements	Zero regulatory enforcement actions	
	Achieve Net Zero by 2045	Reduce carbon emissions 80% by 2040	Annual 4% carbon reduction	
Freedom of Information status:	Support service transformation	Release 10% space through better utilisation	Estate footprint to 87,300m ² by Year 5	
	Disclosable	x	Exempt	

Strategic Asset Management Plan

NHS Estate Portfolio

Document Version: 1.0
Date: September 2025
Compliance Framework: ISO 55000:2014 Asset Management

Executive Summary

The Estates and Facilities Directorate commissioned a comprehensive, non-intrusive six-facet survey of the Medway Maritime Hospital estate in 2023. This was the first full survey undertaken in more than 15 years and established the Trust’s backlog maintenance liability at **£120 million**.

A formal review and update of the survey was completed in December 2025. Based on this reassessment, the Trust’s provisional backlog maintenance requirement has increased to **£147.5 million**. This represents a **23% rise** over a two-year period, driven primarily by inflationary pressures and continued deterioration of the estate. For context, general inflation over the same period is estimated at approximately 5.8%, indicating that the majority of the increase reflects the ageing condition of the built assets.

Year	Backlog Maintenance (£m)	High Risk	Significant Risk	Moderate Risk	Low Risk
2023	120	0.2	52.8	42.8	24.2
2025	147.5 (+24%)	0.25 (+25%)	64.4 (+22%)	56.4 (+31%)	26.5 (+9%)

Table 1: Comparison between the 2023 and 2025 backlog condition survey results

In addition, issues identified during recent capital projects suggest that further investment will be required to address potential fire compartmentation deficiencies across the site. Initial estimates indicate a requirement of approximately **£15 million**, subject to confirmation through a separate intrusive survey.

If the backlog maintenance and fire compartmentation estimates are combined, **the Trust’s total backlog liability is projected to be £162.5 million**.

While ongoing capital investment programmes—such as the decarbonisation scheme and the Safety Fund—will reduce elements of the backlog, the overall impact is not expected to materially alter the total liability. A detailed recalculation will be undertaken upon completion of these projects. This paper details strategic asset management plan.

Executive Summary

This Strategic Asset Management Plan (SAMP) establishes the framework for managing a 97,000m² NHS estate portfolio with a critical maintenance backlog position. The plan aligns organisational objectives with asset management practices to deliver safe, sustainable healthcare infrastructure that supports clinical excellence and patient care.

Key Portfolio Metrics:

- Total estate: 97,000m²
- Asset age profile: 40% year 2000 construction, 60% pre-2000
- Backlog maintenance: £163,000,000
- Critical infrastructure risk: £65,000,000 (50% of total backlog)
- Estimated asset replacement value: £388,000,000 (being revalued by insuraers)

1. Context of the Organisation

1.1 Organisational Context (ISO 55000 Clause 4.1)

Internal Factors:

- Aging estate with 60% of buildings exceeding 25 years old
- Significant deferred maintenance creating operational and safety risks
- Competing demands for capital investment Workforce capacity constraints for estate management
- Legacy infrastructure systems requiring modernisation

External Factors:

- NHS England estate strategy and net zero commitments
- Regulatory compliance (CQC, HSE, fire safety, water safety)
- Sustainability targets: Net Zero by 2040-2045
- Capital funding constraints and Treasury approval processes
- Clinical service transformation and changing healthcare models
- Patient safety and experience expectations

1.2 Stakeholder Needs and Expectations (ISO 55000 Clause 4.2)

Stakeholder Group	Key Expectations	Engagement Method
Patients & Public	Safe, clean, accessible facilities	Patient feedback, PALS, surveys
Clinical Staff	Reliable infrastructure supporting care delivery	Clinical engagement forums, safety reporting

Stakeholder Group	Key Expectations	Engagement Method
Trust Board	Risk management, compliance, value for money	Board reports, KPI dashboards
NHS England/ICB	Strategic alignment, backlog reduction	Performance meetings, capital bids
Regulators (CQC)	Statutory compliance, patient safety	Inspections, evidence submissions
Local Authority	Planning, environmental standards	Planning liaison, partnership boards

1.3 Asset Management System Scope

Assets in Scope:

- Buildings and structures (97,000m²)
- Engineering infrastructure (mechanical, electrical, critical systems)
- Medical equipment and devices
- Energy systems and utilities
- External works and grounds
- Information technology infrastructure supporting estates

Exclusions:

- Clinical consumables and pharmaceuticals
- Standalone IT systems (managed separately)
- Leased third-party facilities

2. Leadership and Asset Management Policy

2.1 Asset Management Policy (ISO 55000 Clause 5.2)

Policy Statement:

This organisation is committed to excellence in asset management to deliver safe, efficient, and sustainable healthcare infrastructure. We will:

1. **Prioritise Safety:** Maintain assets to protect patients, staff, and visitors from harm
2. **Enable Clinical Services:** Ensure infrastructure reliability supports uninterrupted care delivery
3. **Optimise Value:** Balance cost, risk, and performance across asset lifecycles
4. **Ensure Compliance:** Meet all statutory, regulatory, and NHS standards
5. **Drive Sustainability:** Achieve net zero carbon and environmental stewardship
6. **Enable Transformation:** Align estate with evolving healthcare models
7. **Continuous Improvement:** Apply ISO 55000 principles and learn from performance data

2.2 Leadership Commitment (ISO 55000 Clause 5.1)

Governance Structure:

- **Trust Board:** Strategic oversight and risk acceptance
 - **Estates & Facilities Committee:** Asset strategy approval and performance monitoring
 - **Capital Planning Group:** Investment prioritisation and business case development
 - **Senior Responsible Owner (SRO):** Director of Estates
 - **Asset Management Team:** Operational delivery and continuous improvement
-

3. Strategic Asset Management Objectives

3.1 Organisational Objectives Alignment (ISO 55000 Clause 6.2)

Organisational Objective	Asset Management Objective	Key Performance Indicators
Deliver safe patient care	Eliminate critical infrastructure risk	Critical backlog £0 by Year 5
Maintain operational resilience	Achieve 99.5% uptime for critical systems	Unplanned downtime <0.5%
Meet regulatory standards	100% compliance with statutory requirements	Zero regulatory enforcement actions
Achieve Net Zero by 2045	Reduce carbon emissions 80% by 2040	Annual 4% carbon reduction
Support service transformation	Release 10% space through better utilisation	Estate footprint to 87,300m ² by Year 5

3.2 Risk-Based Prioritisation Framework

Critical Infrastructure Risk (£65M) - Immediate Priority:

- Life safety systems (fire, emergency power)
- Clinical service continuity (theatres, critical care)
- Statutory compliance failures (water safety, electrical safety)
- Building fabric failures (roofs, structural issues)

High-Risk Backlog (£71) - Years 1-3:

- Major system failures with service impact
- Progressive deterioration requiring intervention
- Compliance improvements (ventilation, access)

Moderate-Risk Backlog (£27M) - Years 3-5:

- Planned lifecycle replacement
- Efficiency improvements
- Quality enhancements

4. Asset Management Strategy

4.1 Strategic Approach by Asset Age

Year 2000 Assets (38,800m² - 40%):

- Strategy: **Optimise and Extend**
- Approach: Preventive maintenance, system upgrades, energy efficiency improvements
- Investment: £12M over 5 years (£31/m²)
- Expected lifecycle extension: 15-20 years

Pre-2000 Assets (58,200m² - 60%):

- Strategy: **Risk Mitigation, Selective Replacement, Rationalisation**
- Approach: Critical system replacement, consolidation where feasible, decommissioning obsolete space
- Investment: £109M over 5 years (£187/m²)
- Target: Reduce to 48,000m² through disposal/repurposing

4.2 Investment Strategy (5-Year Plan)

Year	Critical Risk	High Risk	Moderate Risk	Lifecycle/Planned	Total Annual Investment
1	£20M	£15M	£0	£2M	£37M
2	£20M	£15M	£0	£3M	£38M
3	£18M	£10M	£6M	£3M	£37M
4	£8M	£10M	£10M	£4M	£32M
5	£0	£6M	£11M	£4M	£21M
Total	£66M	£56M	£27M	£16M	£165M

Funding Strategy:

- NHS England capital allocation: £100M
- Trust revenue-funded capital: £40M
- Asset rationalisation: £10M
- Sustainability and transformation funding: £15M

4.3 Lifecycle Management Approach

Acquisition/Development:

- Business case development aligned with clinical strategy
- Whole-life costing and sustainability assessment
- Design quality standards and BIM Level 2 minimum
- Post-occupancy evaluation embedded

Operation & Maintenance:

- Risk-based preventive maintenance programmes
- Condition monitoring and predictive analytics
- Energy management and optimisation
- Space utilisation monitoring (target 65% overall)

Renewal/Replacement:

- Lifecycle replacement planning (25-40 year building cycle)
- Critical system replacement (10-20 year equipment cycle)
- Technology obsolescence management
- Value engineering and modern methods of construction

Disposal/Rationalisation:

- Estate rationalisation target: 10,000m² reduction
- Disposal prioritisation: lowest utilisation, highest maintenance burden
- Capital receipts reinvested in retained estate
- Sustainable decommissioning practices

5. Asset Management Plans

5.1 Critical Infrastructure Programme (£66)

Phase 1: Immediate Life Safety (Months 1-12, £24M)

- Emergency electrical infrastructure replacement: £6M
- Fire safety system upgrades: £10M
- Critical medical gas infrastructure: £3M
- Emergency generator replacement: £3M
- Water safety compliance (legionella control): £2M

Phase 2: Clinical Service Continuity (Months 13-24, £22M)

- Theatre ventilation and control systems: £9M
- Critical care infrastructure: £5M
- Main electrical distribution: £4M
- Boiler and heating system replacement: £4M

Phase 3: Structural and Compliance (Months 25-36, £15M)

- Roof replacements (water ingress risk): £6M
- Building management system replacement: £4M
- Lift and patient transfer systems: £3M
- Access and DDA compliance: £2M

Phase 4: Resilience and Contingency (Months 37-48, £5M)

- System redundancy improvements: £3M
- Contingency reserve: £2M

6. Performance Management and Improvement

6.1 Key Performance Indicators (ISO 55000 Clause 9.1)

Asset Health Indicators:

- Backlog maintenance value and categorisation (monthly)
- Estate condition grade (six-facet survey, biennial)
- Critical infrastructure risk score (monthly)
- Statutory compliance status (100% target, weekly)

Performance Indicators:

- Asset availability/uptime: Target >99.5% for critical systems
- Maintenance response times: Emergency <2hrs, Urgent <24hrs
- Planned preventive maintenance completion: >90%
- Energy consumption: kWh/m² and carbon emissions tCO₂e
- Space utilisation: % occupancy by zone

Financial Indicators:

- Total cost of ownership per m²: Target £160/m²
- Maintenance cost per m²: Target £57/m²
- Energy cost per m²: Target £41/m²
- Capital investment delivery: >90% spend achievement

Value Indicators:

- Patient and staff satisfaction with facilities (quarterly survey)
- Clinical service disruption events (zero target)
- Regulatory inspection outcomes
- Sustainability performance (net zero trajectory)

6.2 Management Review (ISO 55000 Clause 9.3)

Quarterly Reviews:

- Performance dashboard review
- Investment programme progress
- Risk register updates
- Emerging issues and horizon scanning

Annual Review:

- SAMP effectiveness assessment
- Alignment with organisational strategy
- Resource adequacy review
- Continuous improvement planning
- External benchmarking (ERIC returns, NHS model hospital)

7. Risk Management

7.1 Asset Risk Framework (ISO 55000 Clause 6.1)

Risk Assessment Methodology:

- Consequence assessment: Safety, service, compliance, financial
- Likelihood assessment: Condition data, maintenance history, age
- Risk matrix: 5×5 scoring (consequence × likelihood)
- Tolerance thresholds: Critical risks require executive acceptance

Critical Risks (Current State):

Risk	Consequence	Likelihood	Score	Mitigation Strategy
Major electrical failure	Service loss, patient harm	High	20	Phase 1 replacement programme
Legionella outbreak	Patient/staff harm, regulatory	Medium	15	Enhanced monitoring, remediation
Theatre ventilation failure	Service closure, cancelled ops	High	16	Year 2 replacement
Boiler failure (winter)	Service disruption, hypothermia	High	20	Year 2 replacement with redundancy
Roof failure (water ingress)	Service disruption, equipment damage	High	16	Year 3 replacement programme

7.2 Business Continuity Integration

- Critical asset registers linked to business continuity plans
- Single points of failure identified and mitigated
- Emergency response procedures for asset failures
- Mutual aid agreements with neighboring trusts

- Annual resilience testing and scenario planning
-

8. Compliance and Assurance

8.1 Statutory and Regulatory Requirements

Compliance Framework:

- Health and Safety at Work Act 1974
- Regulatory Reform (Fire Safety) Order 2005
- Health Technical Memoranda (HTMs)
- Building Regulations and CDM Regulations
- Environmental Protection Act and waste management
- Equality Act 2010 (access requirements)

Assurance Processes:

- Authorised Person (AP) and Competent Person (CP) regime
- Annual compliance declarations to Trust Board
- Internal audit programme (estates compliance)
- Third-party technical audits (electrical, water, ventilation)
- Regulatory inspection preparation and response

8.2 Asset Information Management (ISO 55000 Clause 7.5)

Information Systems:

- Computer-Aided Facilities Management (CAFM) system
- Six-facet condition survey database (updated 3-yearly)
- Energy monitoring and targeting system
- Document management system (O&M manuals, drawings)
- Geographic Information System (GIS) for site mapping

Information Requirements:

- Asset register (location, specification, age, condition)
- Maintenance history and work orders
- Performance data (energy, utilization, failures)
- Compliance certificates and inspection records
- Financial data (capital value, depreciation, costs)

Data Quality Standards:

- Accuracy >95% for critical asset data
- Currency: Real-time for critical systems, monthly updates for general estate
- Accessibility: Role-based access for operational teams
- Annual data quality audits

9. Organisational Enablers

9.1 Competence and Resources (ISO 55000 Clause 7.2)

Workforce Requirements:

- Estates leadership: Director, Deputy, Technical Leads
- Technical specialists: Mechanical, electrical, building fabric
- Compliance and safety: Authorised Persons, health & safety
- Contract management: Service delivery and performance
- Asset information: Data management and analysis

Competence Framework:

- Professional qualifications (IHEEM, RICS, CIBSE)
- Statutory training (AP/CP, health & safety)
- Asset management awareness (ISO 55000 principles)
- Continuous professional development
- Succession planning for critical roles

9.2 Stakeholder Engagement (ISO 55000 Clause 7.4)

Communication Plan:

- Trust Board: Quarterly performance reports
- Clinical divisions: Monthly operational meetings
- Staff: Planned works notifications, disruption management
- Patients: Visible improvement communications
- External: NHS England returns, peer network engagement

10. Implementation Roadmap

Year 1: Foundation and Critical Risk (2026-27)

- **Q1-Q2:** Critical infrastructure risk assessment completion; Phase 1 works mobilisation
- **Q3-Q4:** Emergency electrical infrastructure replacement; fire safety upgrades; governance framework embedded
- **Target:** £27M invested; critical risk reduced to £40M

Year 2: Continuity and Compliance (2027-28)

- **Q1-Q2:** Theatre and critical care infrastructure replacement
- **Q3-Q4:** Heating system replacement; energy programme commencement

- **Target:** £31M invested; critical risk reduced to £20M; 10% carbon reduction

Year 3: Transformation and Optimisation (2027-28)

- **Q1-Q2:** Structural works (roofs, fabric); space optimisation projects initiated
- **Q3-Q4:** Estate rationalisation; disposal programme
- **Target:** £33M invested; critical risk reduced to £5M; 5,000m² space reduction

Year 4: Modernisation and Efficiency (2028-29)

- **Q1-Q4:** Lifecycle replacement programmes; energy efficiency completions
- **Target:** £27M invested; critical risk eliminated; 30% carbon reduction

Year 5: Sustainability and Consolidation (2029-30)

- **Q1-Q4:** Final modernisation works; net zero pathway established
- **Target:** £19M invested; backlog reduced to <£15M; 10,000m² estate reduction achieved

11. Monitoring and Review

This Strategic Asset Management Plan will be reviewed annually and updated to reflect:

- Changes in organisational strategy and clinical services
- Performance against KPIs and investment delivery
- Emerging risks and opportunities
- Changes in regulatory requirements
- Lessons learned and continuous improvement opportunities

Document Control:

- Owner: Director of Estates and Facilities
 - Review frequency: Annual (or following major strategic change)
 - Approval: Trust Board
 - Next review date: September 202
-

12. Conclusion

This SAMP establishes a comprehensive framework for managing the NHS estate in accordance with ISO 55000 principles. By addressing the critical £60M infrastructure risk over the next 3-4 years while simultaneously pursuing estate modernisation and rationalisation, the organisation will achieve:

- **Safe and compliant infrastructure** supporting high-quality patient care

- **Operational resilience** with reduced risk of service disruption
- **Financial sustainability** through reduced backlog and improved efficiency
- **Environmental responsibility** on the pathway to net zero
- **Strategic alignment** enabling service transformation

Success requires sustained leadership commitment, adequate investment, and systematic performance management. This plan provides the roadmap to transform the estate from a position of significant risk to one of strategic enablement.

Document Approval:

Role	Name	Signature	Date
Director of Estates			
Chief Finance Officer			
Chief Executive			
Trust Board Chair			

Meeting of the Trust Board in Public

Meeting Date: 01 July 2026

Title of Report	Perinatal Surveillance Quarterly Report (Q4: 2025 - 2026) (including Saving Babies Lives Care Bundle Q3)			Agenda Item	6.8
Stabilisation Plan Domain	Culture	Performance	Governance and Quality	Finance	Not Applicable
			X		
CQC Reference	Safe	Effective	Caring	Responsive	Well-Led
	X	X	X	X	X
Author and Job Title	Alison Herron, Director of Midwifery				
Lead Executive	Evonne Hunt, Chief Nursing Officer				
Purpose	Approval	X	Briefing		Noting
Proposal and / or key recommendation:	Trust Public Board is asked to approve the Quarter 4 2025–2026 Perinatal Quality Surveillance Report, including the Q3 2025- 2026 Saving Babies Lives Care Bundle (SBLCB), and triangulated findings across maternity and neonatal services. Noting the key risks, themes, and required actions relating to safety, quality, equity, and workforce.				
Executive Summary	This report provides a triangulated overview of perinatal safety and quality for Quarter 4 (2025/26) and Q3 of the SBLCB, drawing together intelligence from PMRT (Perinatal Mortality Review Tool), MNSI (Maternity & Newborn Safety Investigations), AAR (After Action Review), CRIG (Clinical Review Incident Group) reviews, incident reporting, red flag monitoring, patient experience, and workforce data. Key findings include: ➤ Stable maternity activity with no concerning trends in stillbirths or neonatal deaths. ➤ 1 stillbirth and 5 neonatal deaths in Q4; PMRT reviews show no significant care concerns in maternity and B-graded contributory factors in neonatal cases. ➤ 0 perinatal losses meeting MOSS (maternity outlier signal system) criteria in March 2026. Annual drill 'MOSS Testing' to be completed as per NHSE recommendations. ➤ Incident reporting remains stable, with 90.8% no-harm incidents and one moderate harm case (shoulder dystocia with humeral fracture). ➤ CRIG reviews increased slightly (51 in Q4), with PPH (Post-Partum Haemorrhage) continuing as the dominant theme and disproportionate impact on Black mothers (21.4% vs 9.93% birth rate). ➤ Red Flags remain concentrated in induction delays and time-critical activity, reflecting capacity and flow pressures. ➤ Risk/Issue register: Maternity issues: 19 open, 0 overdue. Key maternity issue: Inability to access patient records at community antenatal clinics. Rated 4 High: Mitigations in place, including IT and broadband leads involvement and pre-loading of records prior to clinics. Wifi upgrade in progress with Virgin Media. Key Maternity risk: CNST Year 8 compliance				

changes to mid-year training compliance check for CTG, PROMPT & NBLs and risk re community connectivity issues acknowledged; ongoing monitoring confirmed. Neonatal issues: Five open issues, no overdue. Highest-scoring (4) concern relates to availability of neonatal transport ventilators, with active PID and supplier mitigation including loan equipment.

- Patient experience remains highly positive, with 85.2% “Very Good” FFT responses and strong feedback on dignity and respect.
- Workforce pressures persist in both maternity and NICU, including sickness, high maternity leave and skill-mix challenges.
- Medication safety remains a key theme in NICU, with targeted actions underway.
- Equity themes are increasingly visible, particularly in relation to PPH and deprivation.
- Overall, triangulation demonstrates a maturing safety culture, consistent learning themes, and clear areas requiring strengthened governance oversight.

CNST Year 8–Relevant Highlights

➤ Safety Action C (Perinatal Review & Learning)

All eligible cases reviewed; no overdue PMRT reports for Q4.

Published report compliance trajectory remains on track.

One potential missed published report from Oct 2025 under review (will not impact year 8 compliance).

➤ Safety Action F (Safety Intelligence, Culture & Risk)

Triangulated learning from PMRT, CRIG, incidents, complaints, PALS, and red flags.

Live Perinatal Culture Improvement Plan in place and monitored.

Maternity & Neonatal Risk Register updated with no new high scoring risks.

➤ Safety Action B (Training)

Training compliance monitored against July and November checkpoints.

IFH and ABC alignment progressing.

➤ Safety Action A (Safe Staffing)

Red flag analysis shows flow related delays as primary driver.

Workforce pressures mitigated through redeployment and escalation.

➤ Safety Action D (Service User Voice)

FFT ethnicity representation broadly aligned with birth rate.

Underrepresentation in some groups noted; actions underway.

Safety Action E - MCB (maternity care bundle) & SBLCBv3.2 (Saving Babies Lives Care Bundle)

MCB - Not yet due for full compliance; preparatory work underway with quarterly reporting to commence from Q1 26/27.

SBLCB - CNST year 8 requires quarterly Trust Board oversight of progress against implementation of SBLCBv 3.2. Q3 25/26 is the final quarter to be assessed by the ICB, with compliance sitting at 94% overall.

Element 6 – Diabetes in Pregnancy remains a challenge at 67%, with need to review staffing model to include diabetes specialist nurse within the service, alongside the need to formalise collaboration with adult diabetes specialist pump nurses to implement Hybrid Closed Loop system for all

	pregnant type 1 diabetics. Post is currently progressing through Vacancy Control Process with a view to internal recruitment of 0.6wte.			
Issues for the Group/Committee/Board Attention:	<u>Areas of Strong Assurance</u> ➤ PMRT compliance with timely reviews and clear learning. ➤ High patient experience scores and strong dignity/respect metrics. ➤ Robust governance flow through IRG, CRIG, and maternity governance. ➤ No MOSS (Maternity outcomes signal System) outliers since its launch in November 2025. <u>Areas Requiring Strengthened Oversight</u> ➤ Induction delays (59% of red flags) indicating capacity and flow constraints. ➤ Equity concerns: PPH disproportionately affecting Black mothers (21.4% vs 9.93% birth rate). High deprivation representation (67.34%) consistent with booking population but requiring targeted action. ➤ Medication safety in NICU (16 incidents in March). ➤ Documentation reliability, identified in CRIG and claims learning. ➤ Workforce fragility, including sickness, high maternity leave and skill mix gaps. <u>Strategic Issues</u> ➤ National Dinoprostone shortage requiring temporary induction pathway changes back to using Propess. ➤ CNST Year 8 published report compliance remains under close monitoring. ➤ Infrastructure constraints (estates, equipment, digital systems).			
Meetings at which this paper has been discussed / approved: Date:	• Maternity and Neonatal Quality and Safety Sub-Committee (MNQSSC)– 1 May 2026 • Quality Assurance Committee, 15 June 2026			
Board Assurance Framework / Risk Register:	N/A			
Financial Implications:	N/A			
Integrated Impact Assessment (IIA) implications	N/A			
Freedom of Information status: Mark X if this can be made public if a FOI request is received	Disclosable	X	Exempt	

Perinatal Surveillance Quarterly Report – Q4 2026



Data measures – Perinatal Quality Oversight Tool



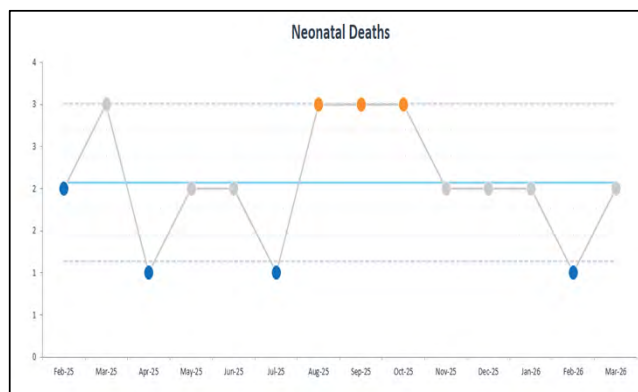
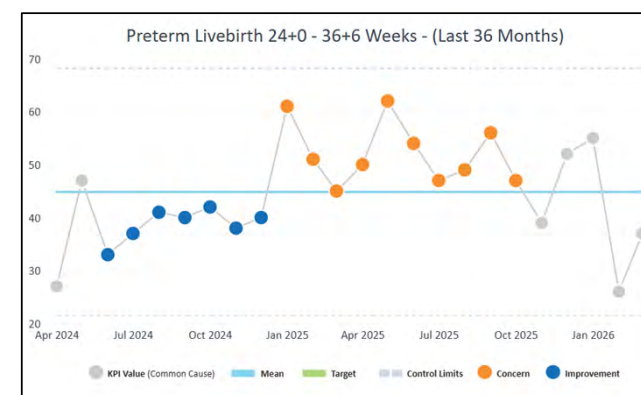
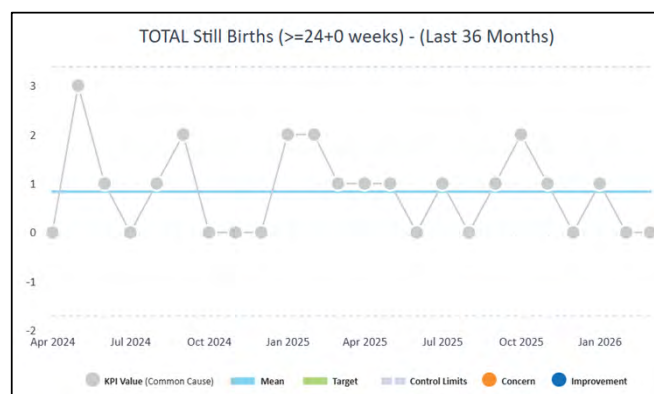
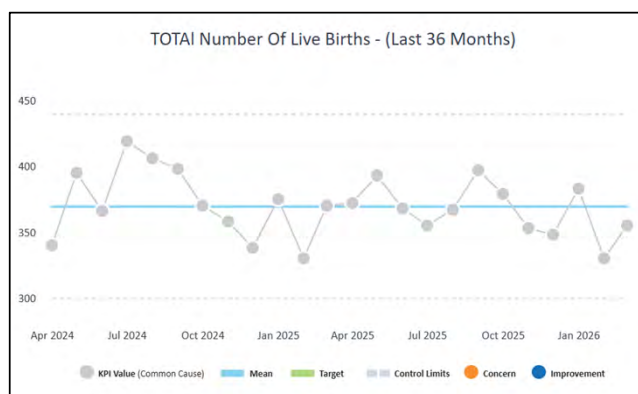
Slide No.	CNST Safety Action	Metric	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Notes
4-21 And 63-72	C F	1. Review of all perinatal deaths, including notification and completed published reports within timeframe, including parental engagement and themes/learning, with triangulation, using national reporting tools (MOSS, SPEN)													
	F	1a. Findings of review of all cases eligible for referral to MNSI (Including number)	0	0	0	0									
22-35	C	1b. Learning from patient safety incident logs, including MNSI investigations, with service-wide action plan and/or improvement tracker, aligned with wider priorities for quality, safety and equity													
63-72	C	1c. Quarterly Board-level thematic report summarising learning and progress on actions arising from MNSI, NHSR EN reports, local PMRT and PSIRF reviews, MOSS safety checks, NHSR claims scorecards and relevant national reports (including demographic data)	n/a	n/a	n/a										
	C	1d. PMRT external review threshold 60%													
109	B	2. Training compliance (covering fetal monitoring, maternity emergencies and neonatal resuscitation) for all staff groups in maternity 1st Check Point Trajectory – 30th July													
		2nd Check point Trajectory – 30th November													
Not Due	B	2a. Including hospital and community setting in-situ simulations x 2 during MIS reporting period													
105	B	2b. Impacted Fetal Head (IFH) scenarios to align with Avoiding Brain Injury in Childbirth (ABC) implemented in emergency training prior to Nov 2026													
43 and 58	A	3. Minimum safe staffing in maternity services and neonatal services in one multi-professional action, to include consultant cover, anaesthetic cover, neonatal staffing and locum use, gaps in rotas and midwife/neonatal minimum safe staffing planned cover versus actual prospectively, including maternity red flags													

Data measures – Perinatal Quality Oversight Tool

Slide No.	CNST Safety Action	Metric	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Notes
105 - 109	A	3a. Operational capacity monitoring (annual demand-capacity mapping, monitoring capacity risks), including elective caesarean activity via SitRep													
105 - 109	A	3b. Progress towards peri-operative team models													
102- 104	D	4. Service user voice feedback, including MNVP involvement, with strengthened focus on communication equity, using local data to identify groups with poorer access or outcomes, addressing identified gaps, with quarterly Board reporting													
Verbal	F	5. Staff feedback from frontline champion and walk-about - themes													
110- 112	F	6. MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust													
	ALL	7. Progress in achievement of CNST Year 8 (6 Safety Actions)													
Not Due	E	8. MCB implementation by March 2027 plan with quarterly board oversight													
Not Due	E	8a. Quarterly SBLCBv3.2 reports with board oversight, reflecting local progress, implementation, incidents and safety intelligence													
Not Due	E	8b. Standardised, equitable and governance approved guideline for neonatal pulse oximetry testing, aligned to BAPM framework													
Not Due	F	9. Live Perinatal Culture Improvement Plan with quarterly Board review													
44-57	F	10. Maternity and Neonatal Risk/Issues Registry													
		11. Dashboard													

Perinatal Surveillance Quarterly Report – Q4

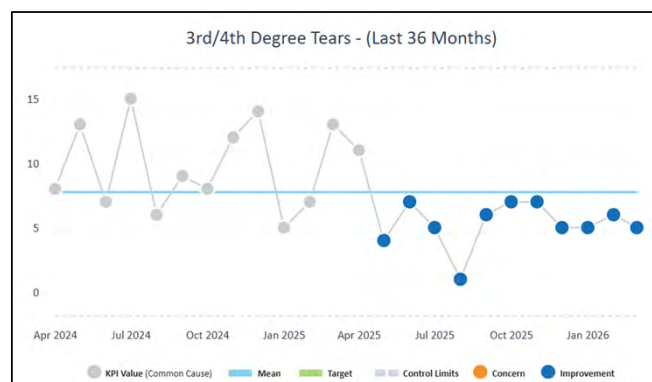
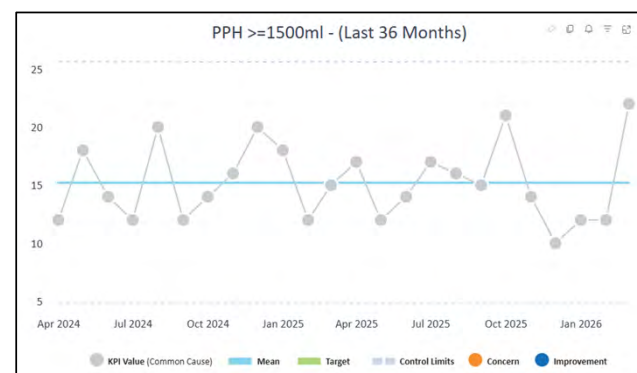
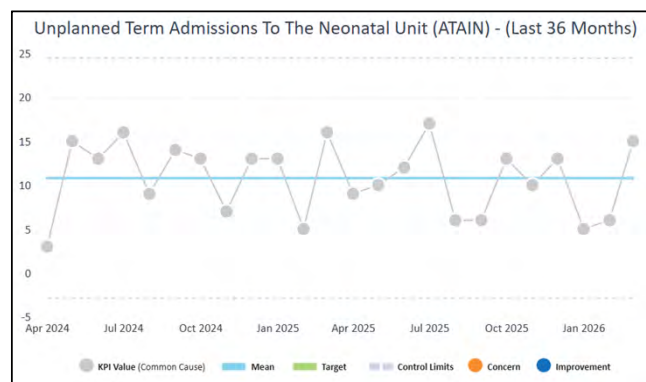
Maternity Overview:



- Overall activity remains stable across the quarter, with live births and preterm rates broadly in line with expected ranges
- Stillbirths and neonatal deaths remain low, with no sustained upward trends observed
- Some month-to-month variation is present but within normal limits, with no immediate concerns identified
- Monitoring will continue to ensure early identification of any emerging trends or risks

Perinatal Surveillance Quarterly Report – Q4

Maternity Overview:



- ATAIN admission and PPH show expected fluctuation with no sustained deterioration – both showing a variation not a trend (3 dots required before concern)
- 3rd and 4th degree tears show continued improvement

Perinatal Loss Reporting Compliance – CNST Year 7 and CNST Year 8

CNST Year 7 MBRRACE Summary	Reporting Compliant	Standard b parents informed	Standard b parents input sought	Standard c - Review Started Complaint	Standard c- Report published Compliant	External Member present	CNST Year 8 MBRRACE Summary	Reporting Compliant	Standard b parents informed	Standard b parents input sought	Standard c - Review Started Complaint	Standard c- Report published Compliant	External Member present
Met	55	41	41	35	28	29	Met	9	7	7	3	0	0
Not Yet Met	0	0	0	0	8	7	Not Yet Met	0	0	0	0	5	2
Not Met	0	0	0	3	1	0	Not Met	0	0	0	0	0	0
Not Applicable	5	19	19	19	19	20	Not Applicable	0	1	1	1	1	1
Total Eligible Cases	55	41	41	38	37	36	Total Eligible Cases	9	7	7	3	5	2
Total Compliant Cases	55	41	41	35	28	29	Total Compliant Cases	9	7	7	3	0	0
Compliant Trajectory Numbers	55	41	41	35	36	36	Compliant Trajectory Numbers	9	7	7	3	5	2
Current Compliance	100%	100%	100%	92%	76%	81%	Current Compliance	100%	100%	100%	100%	0%	0%
Compliance Trajectory	100%	100%	100%	92%	97%	100%	Compliance Trajectory	100%	100%	100%	100%	100%	100%

Key Messages:

- 'Standard C – Report published compliant' showing at 0% as the published report date is not yet due. Trajectory compliance of 100% for 2026 deaths. Weekly compliance meetings continue to monitor progress and compliance
- Year 8 CNST compliance remains at 95% for published reports

Issues, Concerns and Gaps:

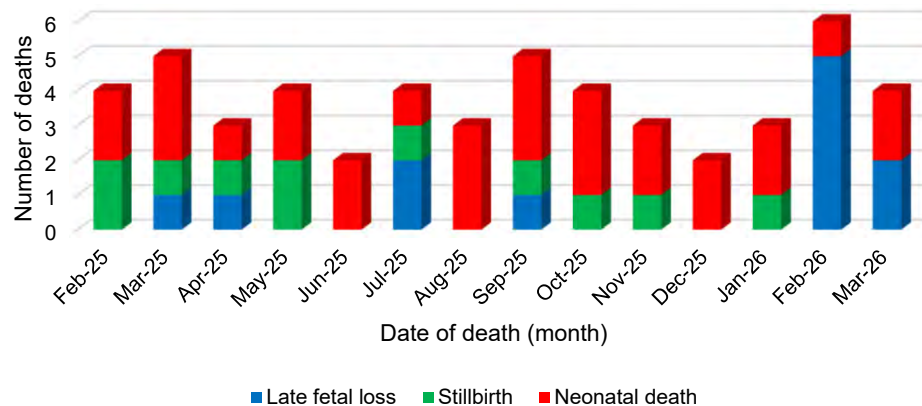
- Awaiting confirmation of potential missed 'published report' compliance for baby who died in October 2025 (Year 7 CNST), but reporting period for 'published report' date falls into CNST Year 8 – weekly monitoring continues for oversight

Perinatal Losses - Maternity

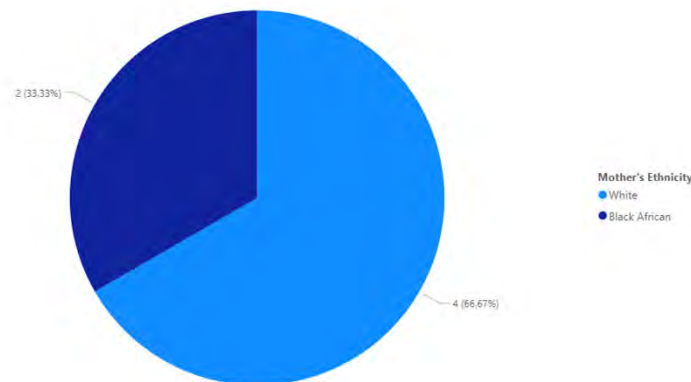


Perinatal Losses Feb 2025-March 2026

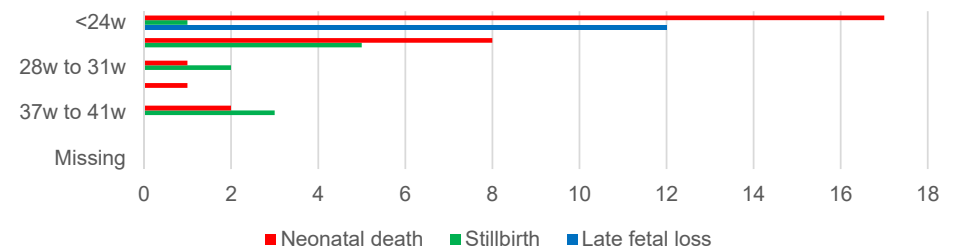
Number of deaths by Type of death and Date of death



Number of Deaths by Mother's Ethnicity Jan - Mar Q4



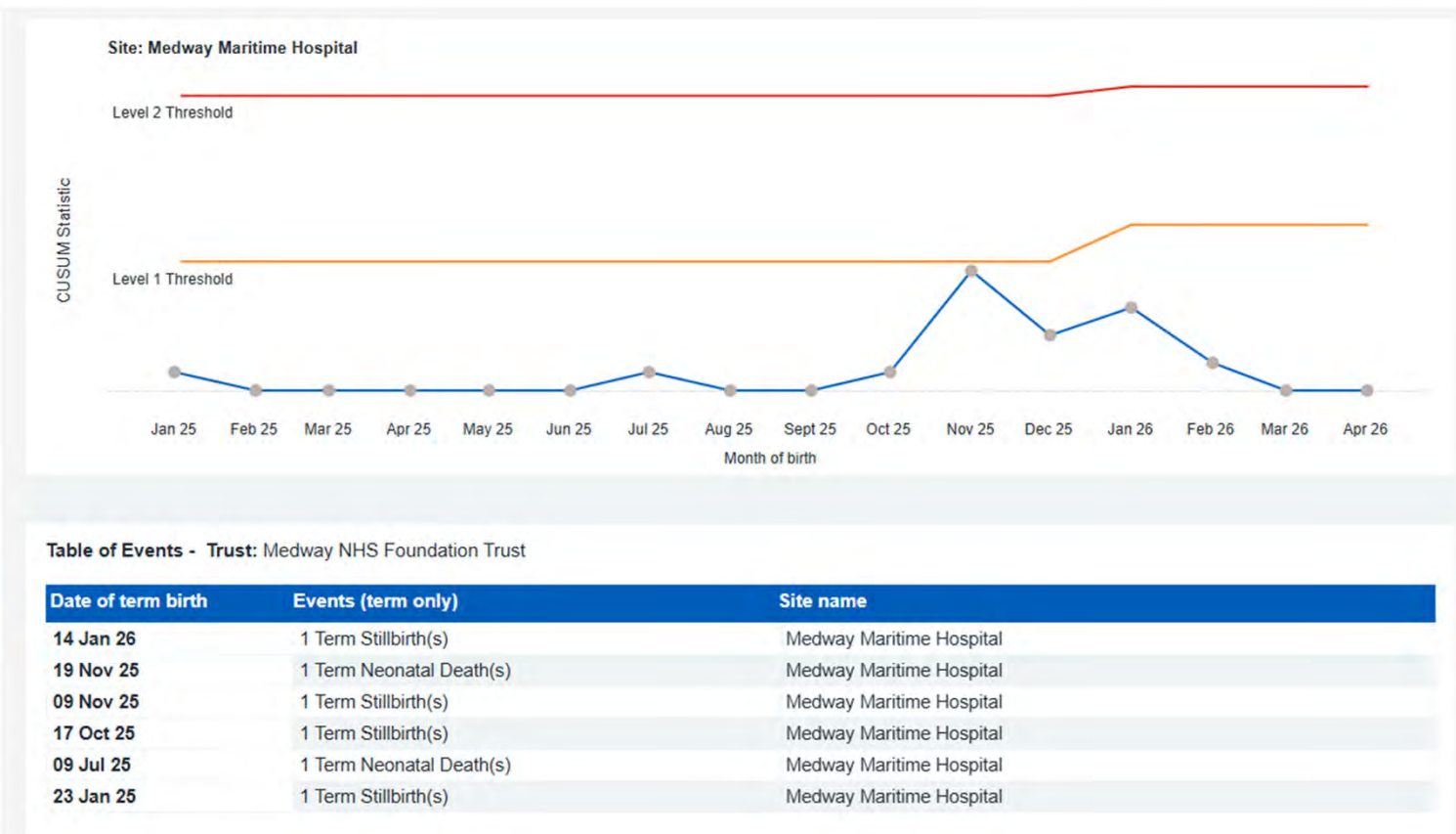
Number of deaths by Gestational age and Type of death



Key Messages:

- Q4 – 1 Stillbirth and 5 Neonatal death
- 4 were from White British mothers (66.67%), and 2 from Black mothers (33.33%)
- 2 were not MBRRACE reportable (1 x triplet 22+4 gestation and 1 x 17+6 TOP)

Maternity Outlier Signal System (MOSS) – March 2026



Key Messages:

- 0 perinatal losses meeting MOSS criteria in March 2026
- Annual drill 'MOSS Testing' to be completed as per NHSE recommendations

Perinatal Losses – Maternity – Q4

MBRRACE Reportable – 1 = Jan, 0 = Feb, 2 = March 2026

Description	Maternal Ethnicity	Deprivation Score	Language
• Stillbirth at 39+4 weeks (Jan)	White		English
• Triplets 2&3 – NND at 22+4 (March)	Black African	1	English

MBRRACE Not Reportable – 6 = Jan, 10 = Feb, 8 = March 2026

Description
• Miscarriage: • X 7 (13+2, 17+1, 17+5, 13+2, 15+5, 15+4, 13+1) • Late Fetal Loss: • X 4 (18+5, 22+4 triplet 1, 21+5, 18+1) • TOP: • X 13. 12 of which were due to fetal anomaly (14+4, 13+2, 21+1, 22+0, 16+6, 15+4, 16+6, 13+3, 12+6, 15+0, 17+1) and 1 which was a social TOP who changed her mind post medication and attended with cord prolapse and SROM. • NND: • X 1 – Following TOP for fetal abnormality

PMRT GRADING

- Grading of care of the mother and baby up to the point that the baby was confirmed as having died:
 - Grading of the care of the baby from birth up to the death of the baby:
 - Grading of care of the mother following confirmation of the death of her baby:
-
- **A** - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died
 - **B** - The review group identified care issues which they considered would have made no difference to the outcome for the mother or baby
 - **C** - The review group identified care issues which they considered may have made a difference to the outcome for the mother or baby
 - **D** - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother or baby

Perinatal Losses – Maternity Q4

2 PMRTs reported in Jan 2026

	Description	Maternal Ethnicity	Deprivation Score	Language
1	25+1 Stillbirth (twin 2). Booked at DVH and sent in-utero to MFT. DCDA pregnancy with severe FGR for twin 2. Cause of death – Severe FRG <3rd centile, oligohydramnios	Black African		English
2	38+5 weeks Intrapartum Stillbirth (Case also meets MNSI criteria.) Attended delivery suite in with contractions, RFM and vomiting. SRM with clear liquor. Unable to auscultate fetal hear, USS and FSE confirmed IUD. Cause of death - concealed placental abruption	Black African		

NB, All ethnicities, language and deprivation scores will be recorded for all cases moving forward from April 2026

Learning from PMRT Review

	Description	Grading	Issues Concerns and Gaps	Actions and Improvements
1	25+1 Stillbirth	<u>Grading of care of the mother and baby up to the point that the baby was confirmed as having died: D</u> <u>Grading of care of the mother following confirmation of the death of her baby: B</u>	System – (DVH) Inappropriate management of transfer to MFT. Patient instructed to make her own way, no appointment made and transfer previously declined due to capacity at MFT. Clinical – (DVH) Inappropriate management/screening of baby on FGR pathway Patient Experience – (MFT) Management of postnatal pathway for bereaved parents receiving care within the hospital and having a baby on NICU Equalities – Black African	DVH to review and address system and clinical issues raised in this case. Family issued formal complaint. Matron and bereavement midwife at MFT to review postnatal care pathway for clinical care following bereavement.

Perinatal Losses – Maternity Q4

Learning from PMRT Review

	Description	Grading	Issues Concerns and Gaps	Actions and Improvements
2	38+5 weeks Intrapartum Stillbirth	<u>Grading of care of the mother and baby up to the point that the baby was confirmed as having died: B</u> <u>Grading of care of the mother following confirmation of the death of her baby: C</u>	System – Mother unable to get through to Call the Midwife line as phone line had been diverted to The Birth Place due to acuity and the midwife was on another call. No wheelchairs available at main entrance Clinical – No concerns identified Patient Experience – Communication from a member of the MDT team negatively impacted on the patient's experience. Equalities – Black African	- Consultant Midwife review of Call the Midwife service as part of ongoing QIP. Mother initially unable to contact but her call was returned as per protocol. - Discuss wheelchair provision with porters and Estates colleagues. - Discussion with individual member of staff and opportunity for reflection. - Debrief with all staff involved in care to address communication issues. - Awaiting MNSI report and recommendations.

Perinatal Losses – Maternity Q4

1 PMRT reported in Feb 2026

	Description	Maternal Ethnicity	Deprivation Score	Language
1	38+6 Stillbirth Cause of death – Placental Abruption	White British		English

NB, All ethnicities, language and deprivation scores will be recorded for all cases moving forward from April 2026

Learning from PMRT Review

	Description	Grading	Issues Concerns and Gaps	Actions and Improvements
1	38+6 Stillbirth	<u>Grading of care of the mother and baby up to the point that the baby was confirmed as having died: A</u> <u>Grading of care of the mother following confirmation of the death of her baby: A</u>	System: No issues Identified Clinical: No Issues Identified Patient Experience: No issues Identified Equalities: Nil	No action plan required

Perinatal Losses – Maternity Q4

1 PMRT reported in March 2026

	Description	Maternal Ethnicity	Deprivation Score	Language
1	39+4 Stillbirth Cause of death – undetermined	White British		English

NB, All ethnicities, language and deprivation scores will be recorded for all cases moving forward from April 2026

Learning from PMRT Review

	Description	Grading	Issues Concerns and Gaps	Actions and Improvements
1	39+4 Stillbirth	<u>Grading of care of the mother and baby up to the point that the baby was confirmed as having died: A</u> <u>Grading of care of the mother following confirmation of the death of her baby: A</u>	System – No issues Identified Clinical – No Issues Identified Patient Experience – Parental feedback overall very positive about their experience, naming several staff members by name in their feedback. Noted some confusion around sharing results ahead of consultant meeting as requested by parents – discussion with RA to streamline this whilst continuing to meet families needs. Equalities – Nil	Bereavement team and FMU lead to streamline processes for sharing results with parents.

Perinatal Losses - Neonatal



Perinatal Losses - Neonatal

1 deaths in Jan 2026

Description	Maternal Ethnicity	Deprivation Score	Language
1. 23+2 (twin pregnancy) Booked at East Kent/QEQM. Died day 7 MCCD: NEC with perforated viscus, Extreme prematurity, Spontaneous premature rupture of membranes Due to twin passing away at QEQM the East Kent Bereavement team are providing care to family.			

1 PMRT reported in Jan 2026

NB, All ethnicities, language and deprivation scores will be recorded for all cases moving forward from April 2026

	Description	Maternal Ethnicity	Deprivation Score	Language
1	24+6 Neonatal Death, Booked at MTW, Inutero transfer, Died day 18 - Cause of death: a. E-Coli sepsis, b. extreme prematurity, c. preterm spontaneous rupture of membranes	White British		English

Learning from PMRT Reviews

NB, All ethnicities, language and deprivation scores will be recorded for all cases moving forward from April 2026

	Description	Grading	Issues Concerns and Gaps	Actions and Improvements
1	24+6 Neonatal Death	<u>Grading of care of the mother and baby up to the point of birth of the baby: B</u> <u>Grading of care of the baby from birth up to the death of the baby: A</u> <u>Grading of care of the mother following confirmation of the death of her baby A</u>	Clinical: Received a late USS (MTW) System: Partogram not used to monitor the mother's progress during labour Patient Experience: No concerns identified. Equalities: No concerns identified	To be escalated in top 5 to remind staff regarding the use of amended Partogram for any cases over 22 weeks

Perinatal Losses - Neonatal

0 deaths in Feb 2026

Description	Maternal Ethnicity	Deprivation Score	Language

3 PMRTs reported in Feb 2026

NB, All ethnicities, language and deprivation scores will be recorded for all cases moving forward from April 2026

	Description	Maternal Ethnicity	Deprivation Score	Language
1	37+ 4 Neonatal Death Booked at MMH. Died day 5 Cause of death: a. Acrania and Anencephally	White British		English
2	23+1 Neonatal Death Booked at MMH, Died day 4. Referred to coroner due to antenatal concerns Cause of death: a. Extreme prematurity b. Spontaneous pneumothorax, RDS, Persistent pulmonary hypertension c. Premature labour	Black Caribbean		
3	28+4 Neonatal Death Booked at MMH. Died day 8. Cause of death: a. Prematurity b. Pulmonary haemorrhage c. Staph Aureus sepsis	White British		English

Perinatal Losses - Neonatal

Learning from PMRT Reviews

	Description	Grading	Issues Concerns and Gaps	Actions and Improvements
1	37+ 4 Neonatal Death	• <u>Grading of care of the mother and baby up to the point of birth of the baby: A</u> • <u>Grading of care of the baby from birth up to the death of the baby: B</u> • <u>Grading of care of the mother following confirmation of the death of her baby: A</u>	Unable to facilitate discharge home as no community services available until after the weekend.	Awaiting clarification around the reason for service unavailability.
2	23+1 Neonatal Death	• <u>Grading of care of the mother and baby up to the point of birth of the baby: C</u> • <u>Grading of care of the baby from birth up to the death of the baby: B</u> • <u>Grading of care of the mother following confirmation of the death of her baby: B</u>	• Mother should have been seen in pre term clinic but this did not happen • Documentation unclear around reason for further doses of surfactant • Maternity team informed by Mother of baby's passing rather than NICU team	• Maternity are dealing with maternal complaint • NICU staff are being reminded to inform the maternity team when a baby passes away
3	28+4 Neonatal Death	• <u>Grading of care of the mother and baby up to the point of birth of the baby: A</u> • <u>Grading of care of the baby from birth up to the death of the baby: C</u> • <u>Grading of care of the mother following confirmation of the death of her baby: A</u>	Review process noted the extravasation of the low lying UVC and issues surrounding documentation of the line position.	• Duty of candour to be completed • To discuss finding with the ME

Perinatal Losses - Neonatal

0 deaths in March 2026

Description	Maternal Ethnicity	Deprivation Score	Language

NB, All ethnicities, language and deprivation scores will be recorded for all cases moving forward from April 2026

2 PMRTs reported in March 2026

	Description	Maternal Ethnicity	Deprivation Score	Language
1	25+0 Neonatal Death. Booked at Lewisham. Died day 42 (corrected gestation 30+6) at Brighton. Referred to the coroner Cause of death: a. NEC b. Prematurity	White British		English
2	23+5 Neonatal Death. Booked at MMH, born at DVH. Died day 6 Cause of death: a. Extreme prematurity b. Bilateral Grade 4 IVH	White British		English

Perinatal Losses - Neonatal

Learning from PMRT Reviews

	Description	Grading	Issues Concerns and Gaps	Actions and Improvements
1	25+0 Neonatal Death	• <u>Grading of care of the mother and baby up to the point of birth of the baby: A</u> • <u>Grading of care of the baby from birth up to the death of the baby: B</u> • <u>Grading of care of the mother following confirmation of the death of her baby: A</u>	Medication errors (both at MMH and Brighton)	Medication error had already been dealt with during ongoing NICU monthly medication meetings.
2	23+5 Neonatal Death	• <u>Grading of care of the mother and baby up to the point of birth of the baby: A</u> • <u>Grading of care of the baby from birth up to the death of the baby: B</u> • <u>Grading of care of the mother following confirmation of the death of her baby: A</u>	DVH have no facilities to humidify gases on transfer from CDS	No actions for MMH

Incident Reporting Jan – Mar Q4 2026

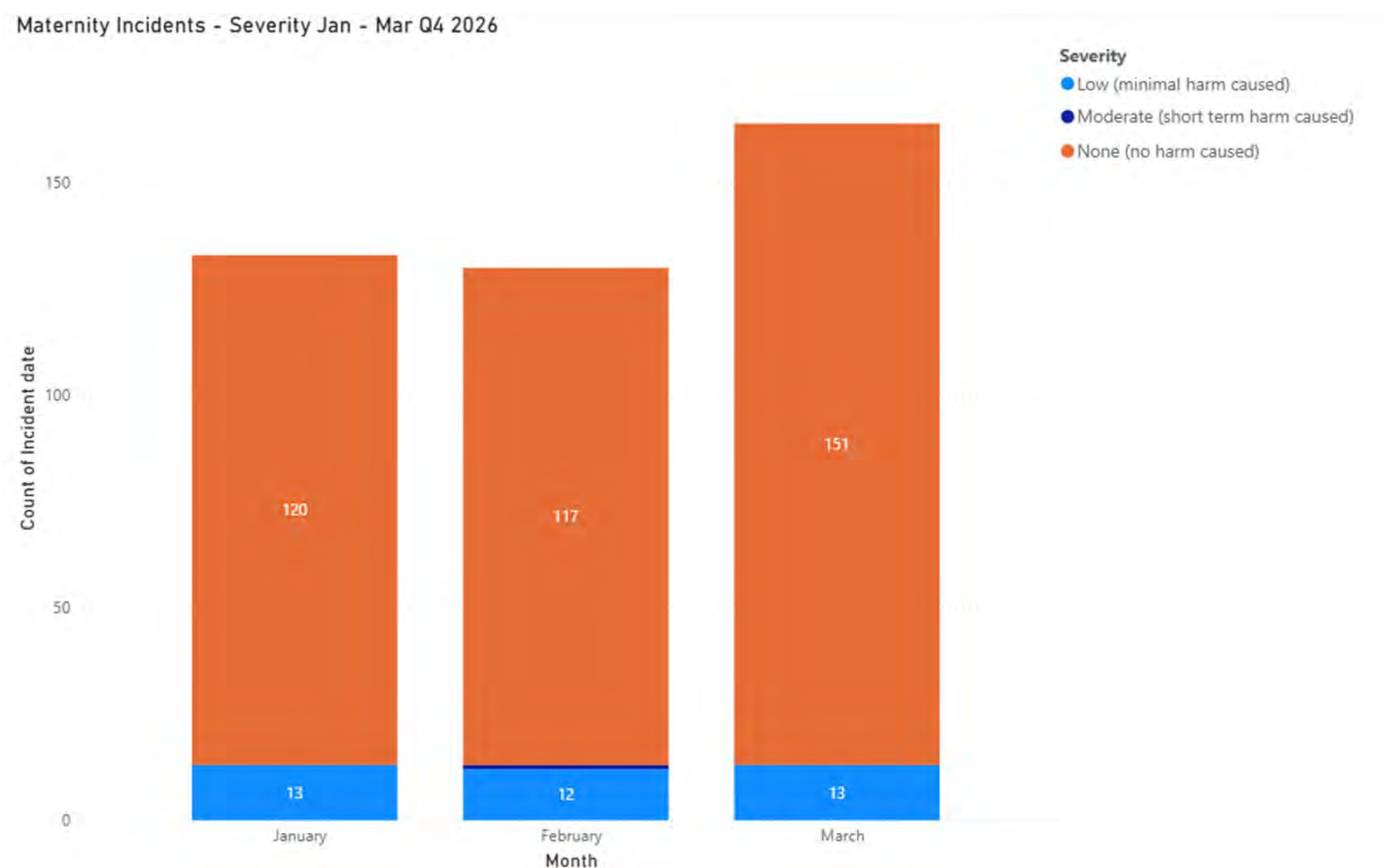


Perinatal Surveillance Quarterly Report – Q4

Maternity Incidents:

Key Messages:

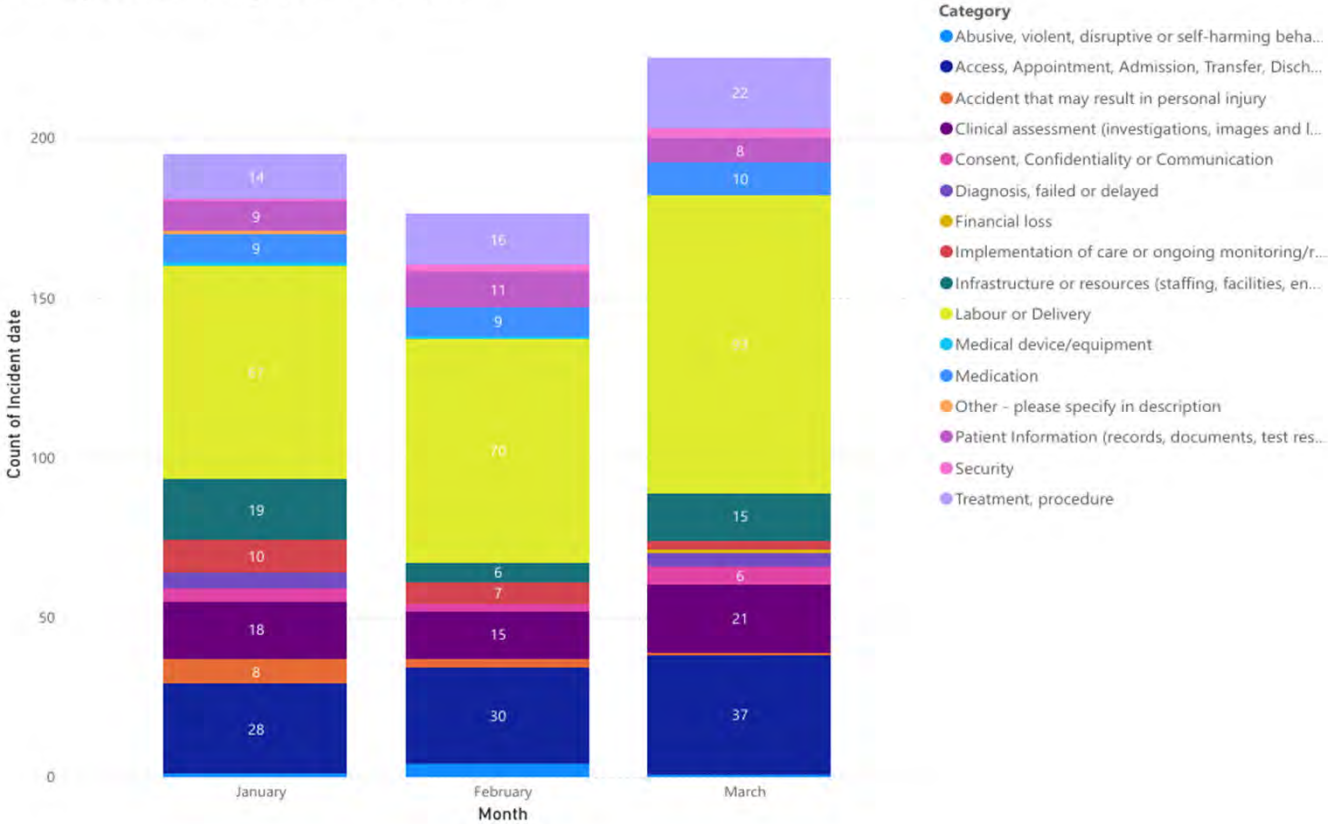
- Majority of incidents classed as no harm (90.8%) in Q4
- Low harm incidents remain stable in Q4
- 1 x Moderate Harm in Q4 – Shoulder Dystocia with baby sustaining left humeral fracture



Perinatal Surveillance Quarterly Report – Q4

Maternity Incidents:

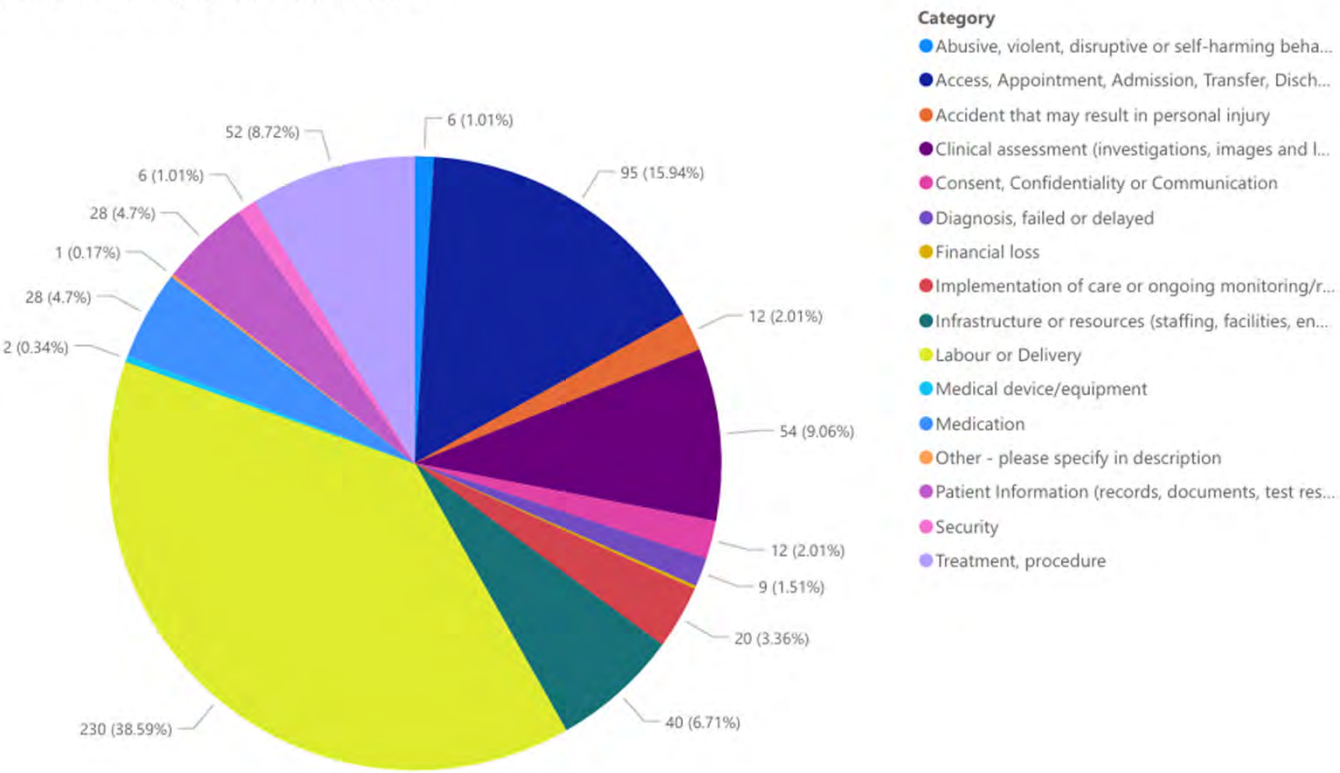
Maternity Incidents - Category Jan - Mar Q4 2026



Perinatal Surveillance Quarterly Report – Q4

Maternity Incidents:

Maternity Incidents - Category Jan - Mar Q4 2026



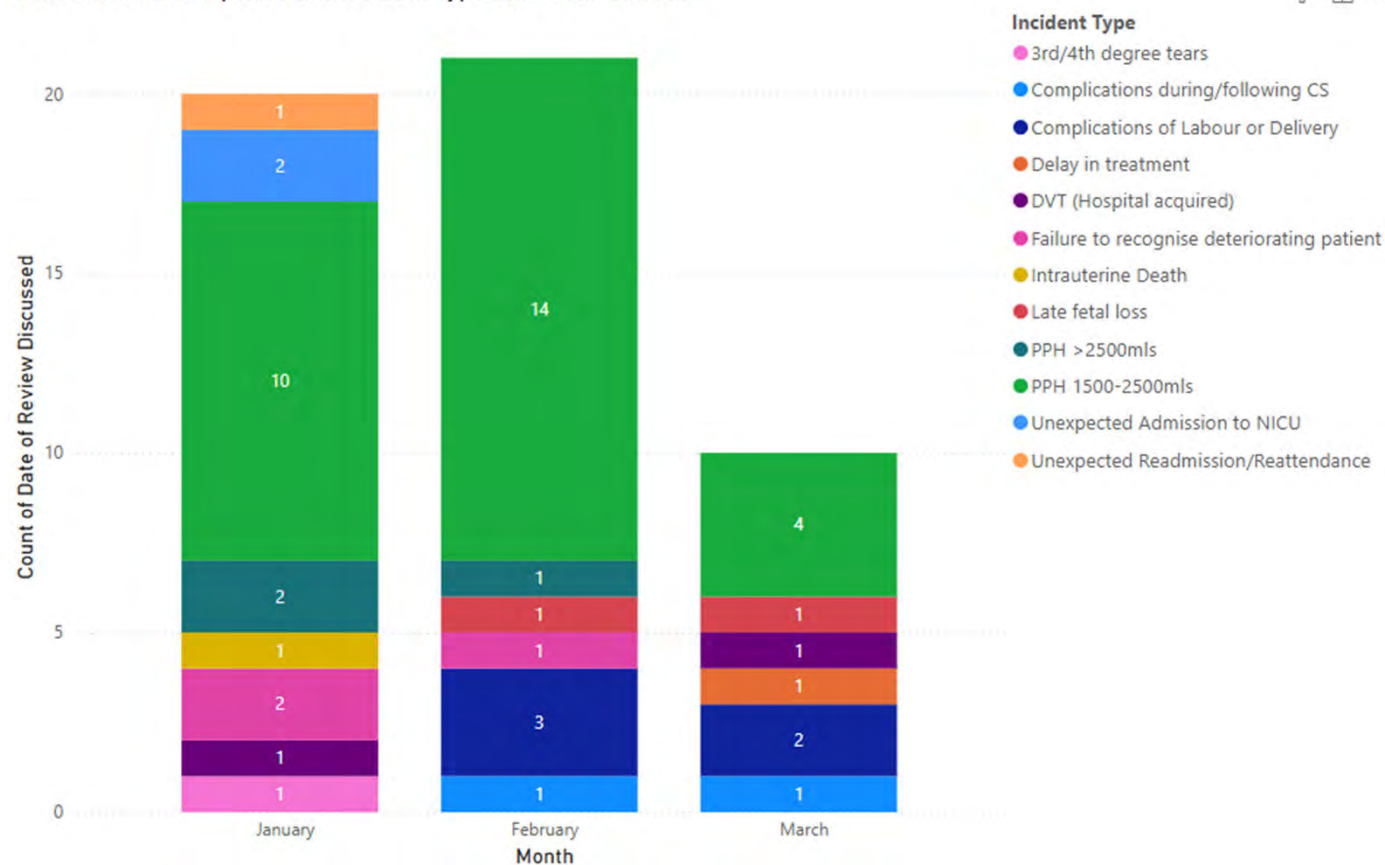
Perinatal Surveillance Quarterly Report – Q4

CRIG Reviews:

Key Messages:

- No of CRIG reviews completed remains stable compared to previous quarter (Q3 = 45, Q4 = 51)
- PPH continues to account for the majority of CRIG reviews in Q4
- 3 x PPH >2500mls review in Q4.
Ethnicity + Deprivation score –
 - 3 x White British
 - 9, 2, 4 Deprivation score
- 10 cases reviewed at CRIG for March 2026 due to Dr strike and Dr availability
- 3 ATTAIN cases reviewed at CRIG for Q4, however ad-hoc additional MDT reviews taken place to ensure timely review

CRIG Reviews Completed and Incident Type Jan - Mar Q4 2026



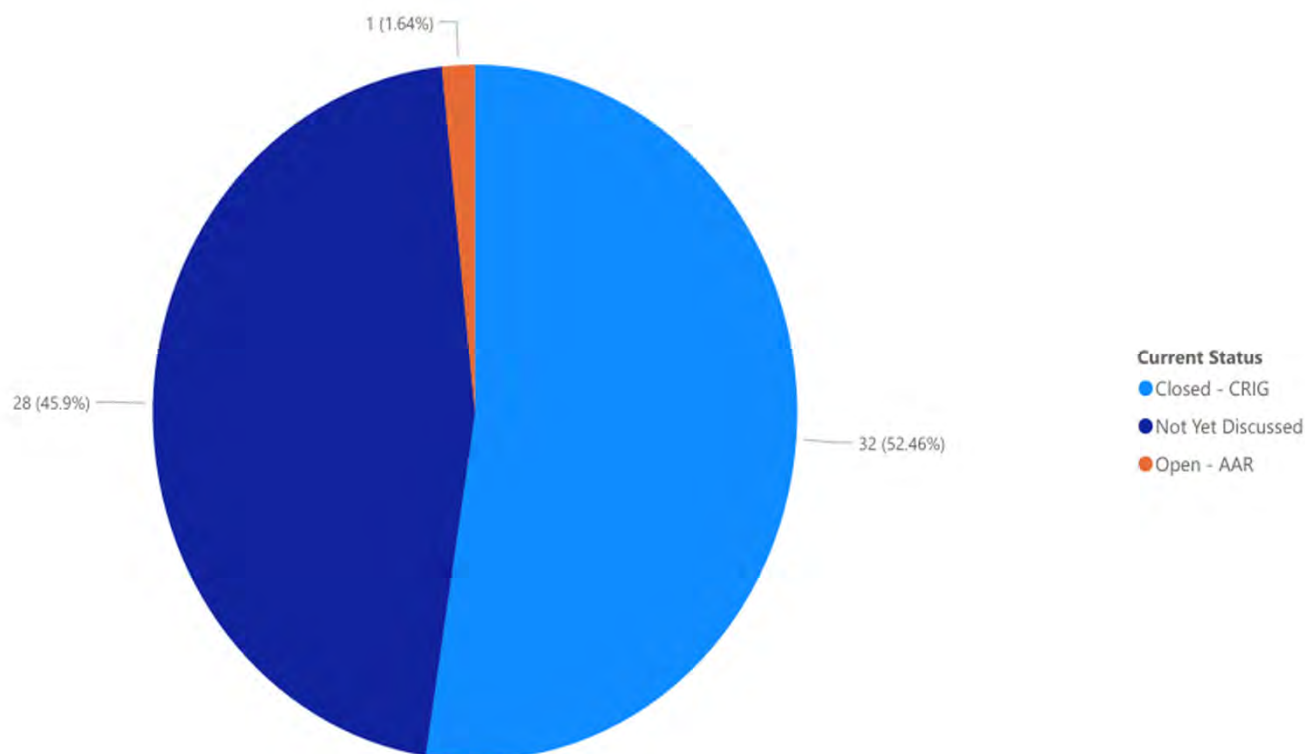
Perinatal Surveillance Quarterly Report – Q4

CRIG Reviews:

CRIG Reviews Jan - Mar Q4 2026 - Current Status

Key Messages:

- 1 x MNSI referral in Q4 but declined by parents
- 1 x AAR open case in Q4. (Parents declined MNSI investigation). Case has been presented at IRG and declared AAR case with associated learning and actions to follow



Perinatal Surveillance Quarterly Report – Q4

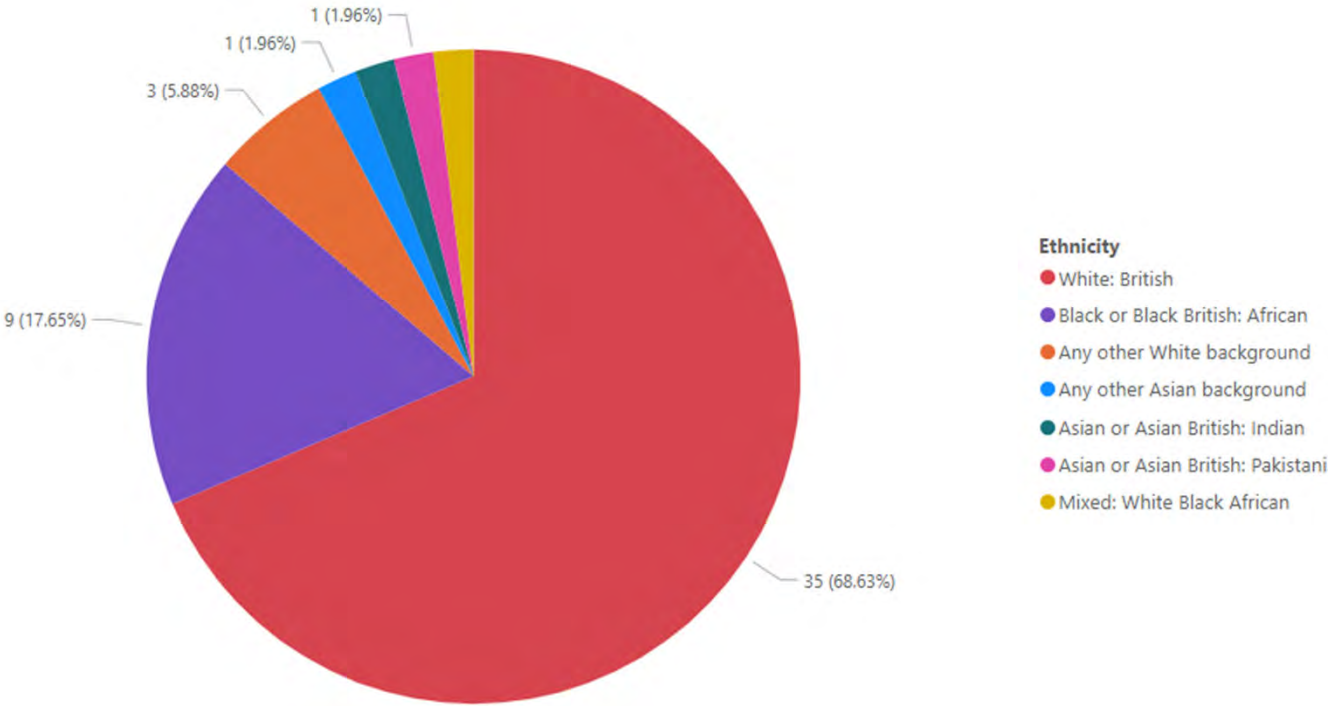
CRIG Reviews:

CRIG Reviews Jan - Mar Q4 2026 - Ethnicity

Key Messages:

- CRIG Reviews – Ethnicity compared to 2025 birth-rate

Ethnicity	Q4	2025 Birth-rate
White British	68.63%	70%
Black or Black British including African and any other black background	19.61%	9.93%
Asian or Asian British, including Indian, Bangladeshi and any other Asian background	5.88%	7.23%



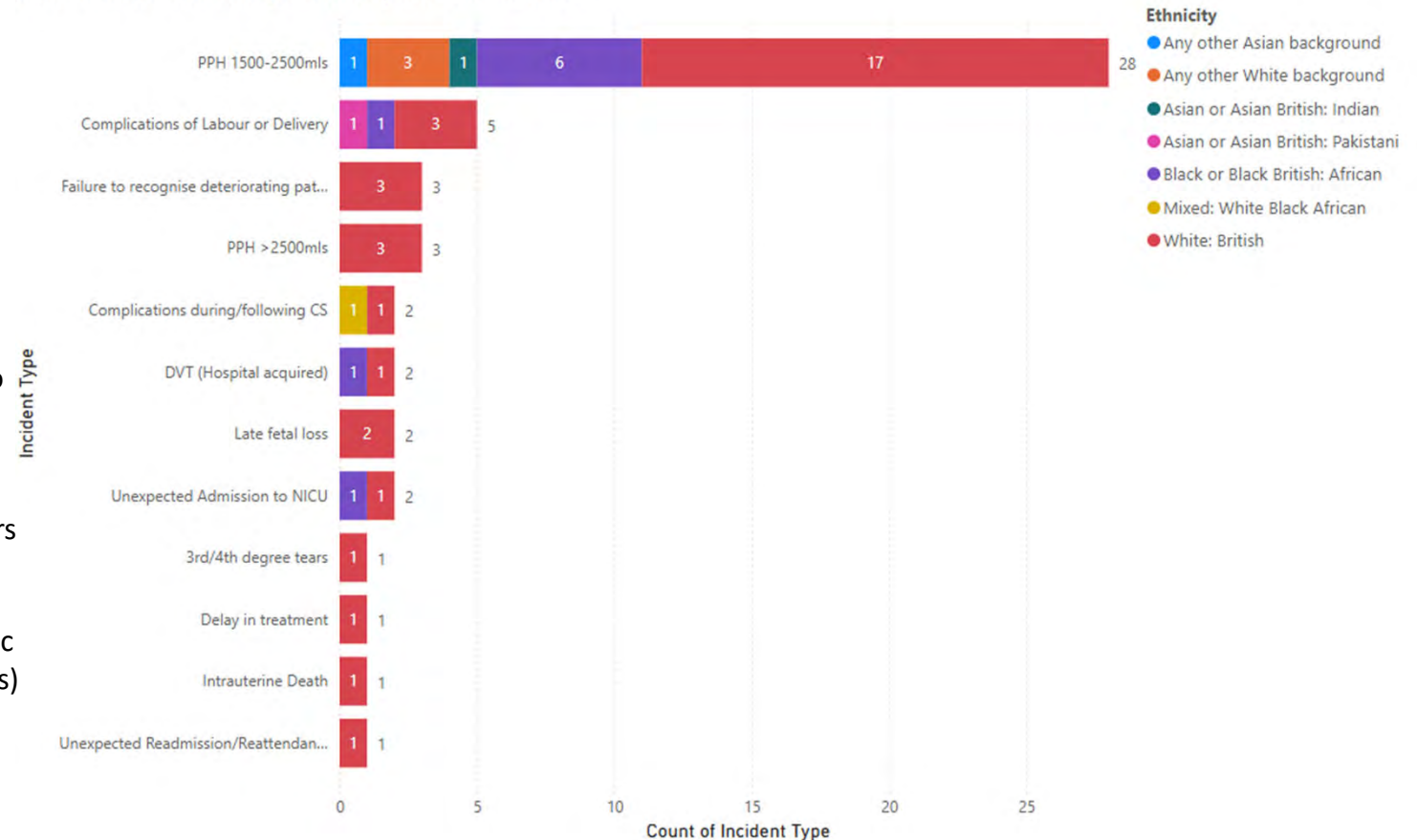
Perinatal Surveillance Quarterly Report – Q4

CRIG Reviews:

Key Messages:

- No of PPH CRIG Reviews
 - Q2 = 32, Q3 = 26 (↓), Q4 = 28 (↑)
- 2 x PPHs >2500mls reviewed at CRIG in Q4 – all were White British
- 6 PPHs in Q4 experienced by black mothers (21.4%)
- This continues to be disproportionate to from their 9.93% contribution of 2025 birth-rate
- The PPH QIP working group continue 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.
- PPH QIP continues – add more here

CRIG Reviews - Incident Type/Ethnicity Jan - Mar Q4 2026



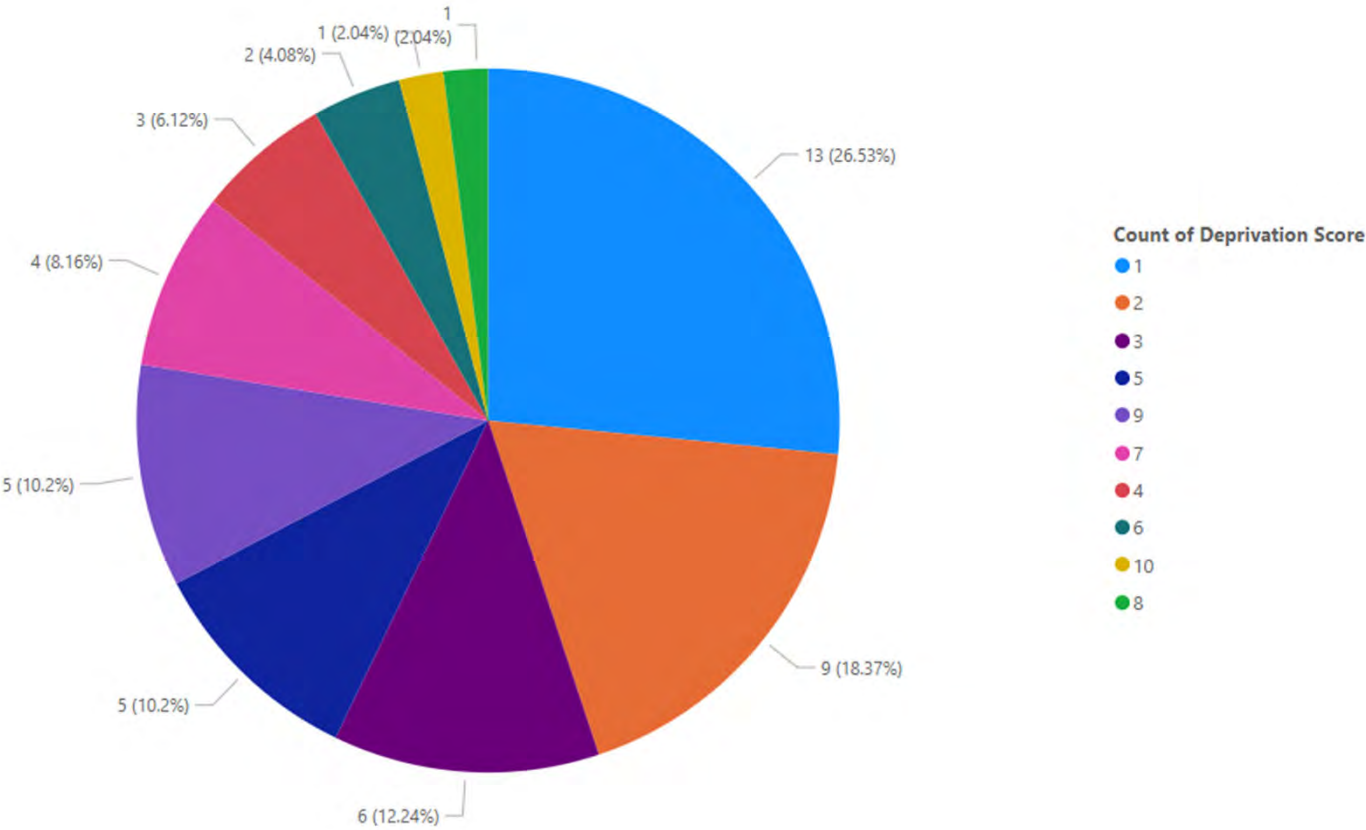
Perinatal Surveillance Quarterly Report – Q4

CRIG Reviews:

Deprivation score Jan - Mar Q4 2026

Key Messages:

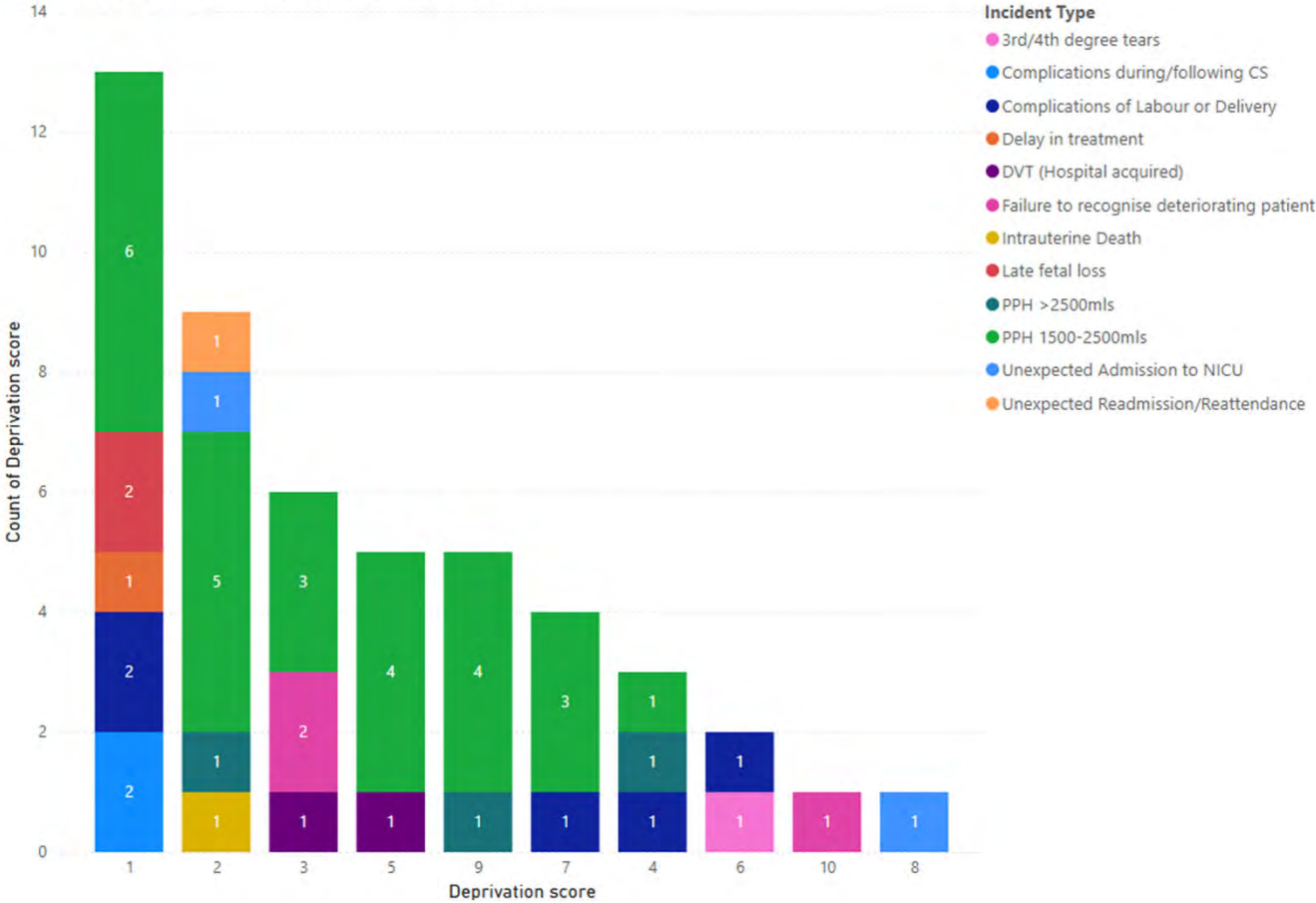
- 67.34% of CRIG reviews in Q4 were from the lowest 5 centiles of deprivation which is comparable to the 69% of booking population in 2024/2025 being in the lowest 5 centiles



Perinatal Surveillance Quarterly Report – Q4

CRIG Reviews:

Incident Type and Deprivation Score Jan - Mar Q4 2026



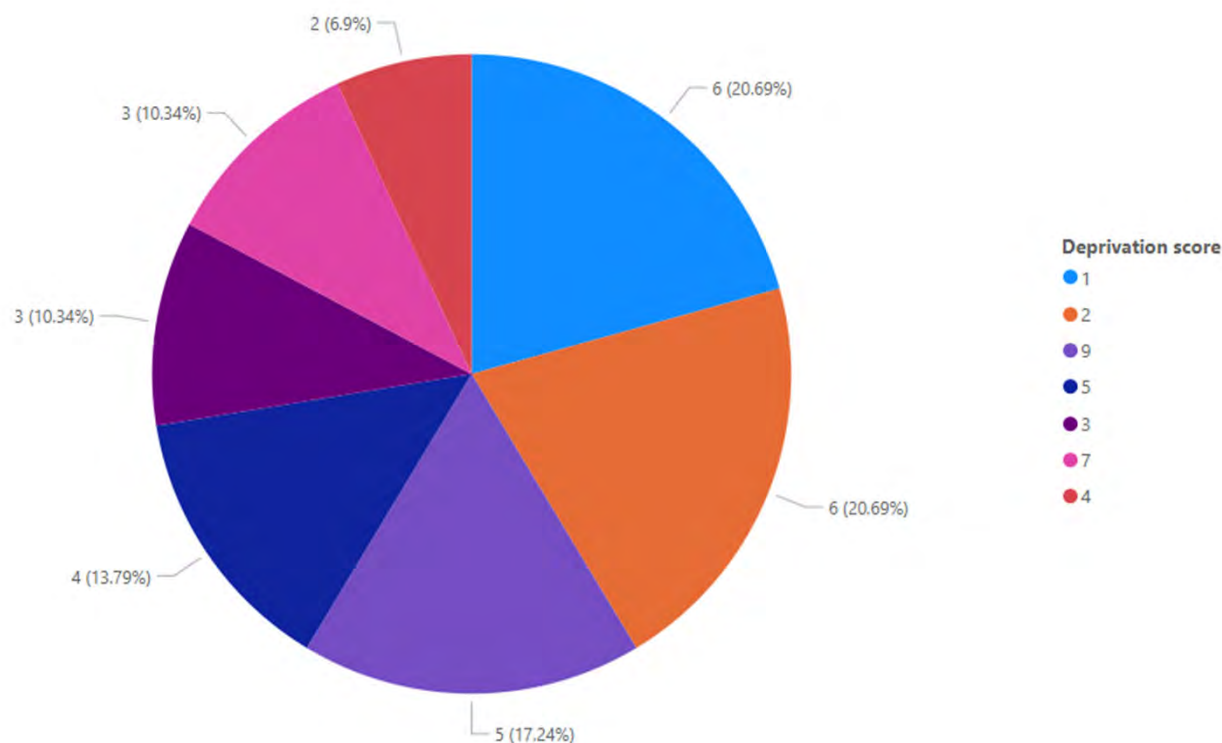
Perinatal Surveillance Quarterly Report – Q4

CRIG Reviews:

Deprivation score and PPH >1500mls Jan - Mar Q4 2026

Key Messages:

- 72.41% of PPH >1500mls were from MDD Score 1-5, which is a reduction from 76% in Q3
- PPH QIP will include auditing demographic details and additional risk factors these groups may have to ensure appropriate risk management



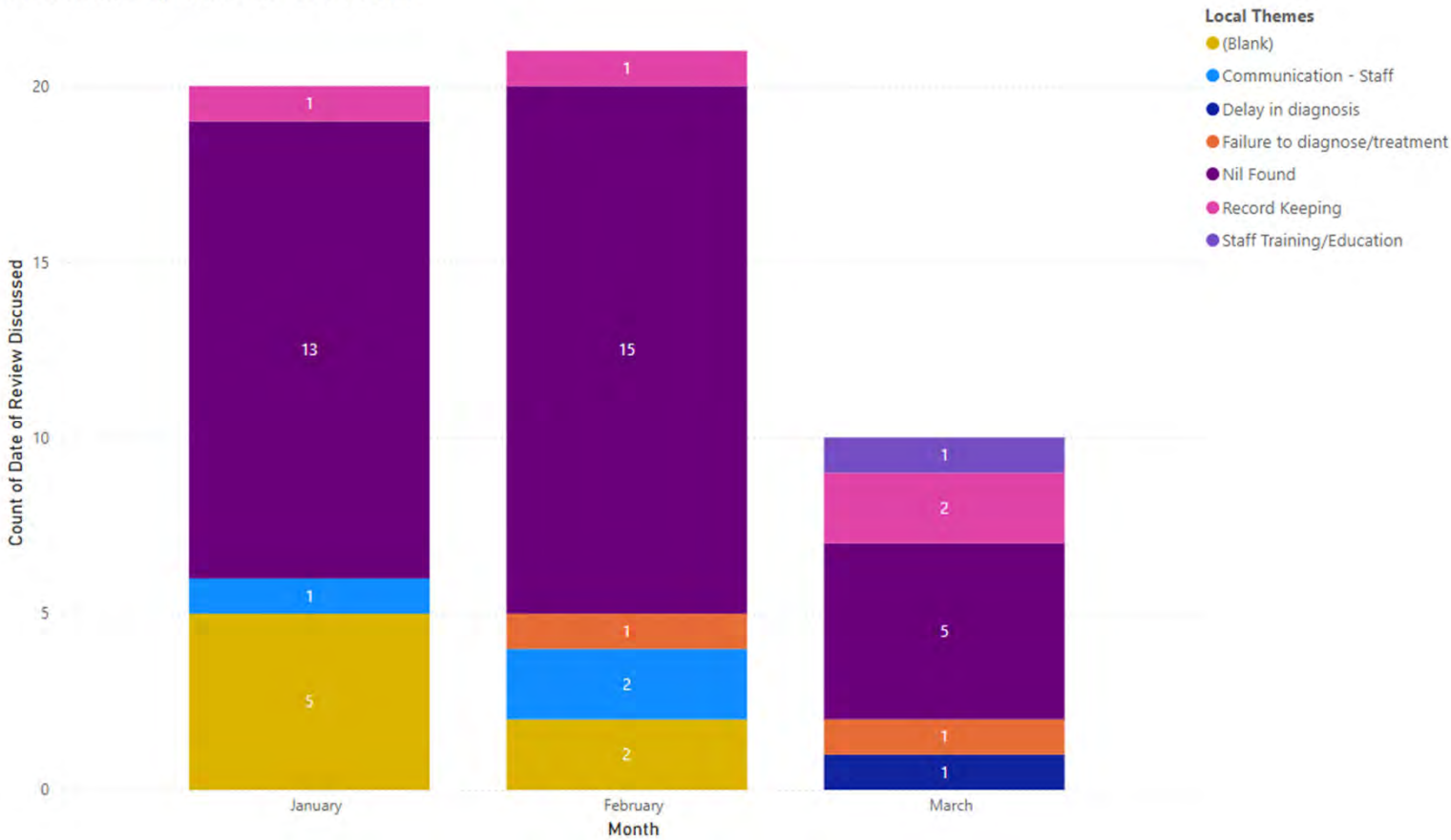
Perinatal Surveillance Quarterly Report – Q4

CRIG Reviews:

Key Messages:

- Majority of CRIG reviews for Q4 found no theme
- 4 incidents found record keeping as a theme
- 3 incidents found communication as a theme
- 2 incidents found failure to diagnose/treatment as a theme

Local Themes by Month Jan - Mar Q4 2026



Complaints and PALS

3 Complaints in Q4 (↓ Q3 = 10)

Complaints Themes Q4				
	Subject	Sub-Subject	Location	Actions and Improvements
1	All aspects of clinical treatment	- Pressure Sores x 1 - Lack of general medical care and attention x 2	- The Birth Place - Delivery Suite	Communications sent to staff regarding importance of position changes during labour when epidural in-situ Reminder for daily Purpose T completion

16 PALS in Q4 (↓ Q3 = 46) – 3 PALS were compliments for Maternity

PALS Themes Q4				
	Subject	Sub-Subject	Location/Staff	Actions and Improvements
1	All aspects of clinical treatment x 6	- Caesarean related complications/problems - Delays in treatment - Lack of medical care & treatment during pregnancy - Unsatisfied with treatment given - Lack of food/pt not offered food - Safeguarding Concern - Adult	Pearl Ward Kent Ward Delivery Suite	- Reinforce intrapartum shared decision making and documentation standards in safety huddles. - Ensure consultant oversight is visible and timely for complex or escalating cases. - Ensure safeguarding documentation is accurate, timely and clearly linked to clinical decision making. - Review whether discharge summaries consistently include all medications supplied.
2	Aids & appliances, equipment, premises, access x 1	Premises	Kent Ward	Include ward environment checks in daily matron walkabouts
3	Communication/ information to patients x 5	- Verbal communication to patient - No contact from department - Unable to contact Pathway Coordinator / Secretary - Written communication to patient/family	Radiographer Midwifery Staff Administration Staff Nursing Staff	- USS concerns shared at team meeting for reflection and learning of the case and communication approach. - Ensure timely communication between Trusts for patient transfers - Increase Birth Reflections facilitator list temporarily if backlog persists. - Improved inbox monitoring of referrals and timely allocation for Birth Choices Specialist Midwife - Develop plain language summary with MNVP lead of the PMRT process. - Offer all families a follow up call with the Bereavement Midwife or PMRT Lead.
4	Patients' property & expenses x 1	Loss/damage to other personal property	Kent Ward	Staff reminder to ensure patient is discharged with notes

Complaints and PALS

3 Compliments in Q4

Compliments Themes Q4				
	Subject	Sub-Subject	Location	Actions and Improvements
1	Compliments via PALS x 3	Compliments via PALS x 3	Midwifery Staff	- Pt passing on her thanks to maternity x 2 - Pt wanting to pass her thanks on to the Maternity team for the excellent she received

BI Dashboard for Women's Care

Domain	Sub Domain	Key Performance Indicator	V	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Patients	Complaints	Complaints		5	4	5	3	4	6	3	4	6	1	4	2
		Complaints Closed		4	4	5	4	4	4	7	3	0	7	1	2
		Complaints Open - Month End		8	8	8	7	7	9	5	6	12	6	9	9
		Complaints Re-Opened		0	0	0	0	0	0	1	0	0	0	0	0
		Complaints Acknowledged Within 3 Working Days %		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
		Complaints Breached %		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	66.7%	33.3%	57.1%	100.0%
	Compliments	Compliments		3	6	2	4	1	2	4	5	5	0	1	3
		Compliments to Complaints Ratio		0.60	1.50	0.40	1.33	0.25	0.33	1.33	1.25	0.83	0	0.25	1.50
PALS	Patient Advice and Liaison Service (PALS) Concerns	PALS Closed		34	32	36	26	18	33	39	30	33	14	24	26
		PALS Open - Month End		2	3	2	1	1	0	3	3	1	1	1	2
		PALS Converted to Complaints		0	0	0	0	0	0	0	0	0	0	0	0

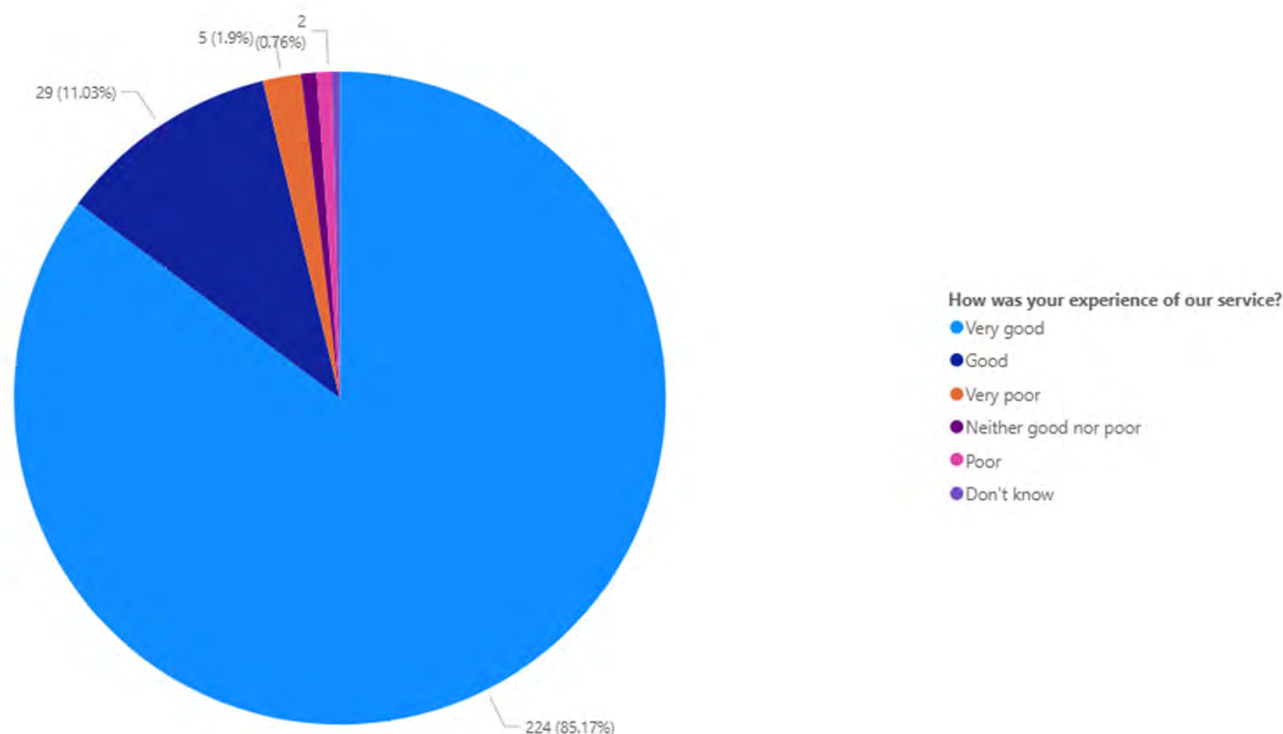
Perinatal Surveillance Quarterly Report – Q4

Maternity FFTs:

Maternity FFT - Overall Experience - Jan - Mar Q4 2026

Key Messages:

- Patient experience is overwhelmingly positive, with 85.2% rating care as “Very good”
- A further 11.0% rated care as “Good”, indicating strong overall satisfaction
- Negative and neutral responses are minimal (each under 2%), with very few reporting poor experiences
- Overall, feedback reflects a high level of patient satisfaction with maternity services



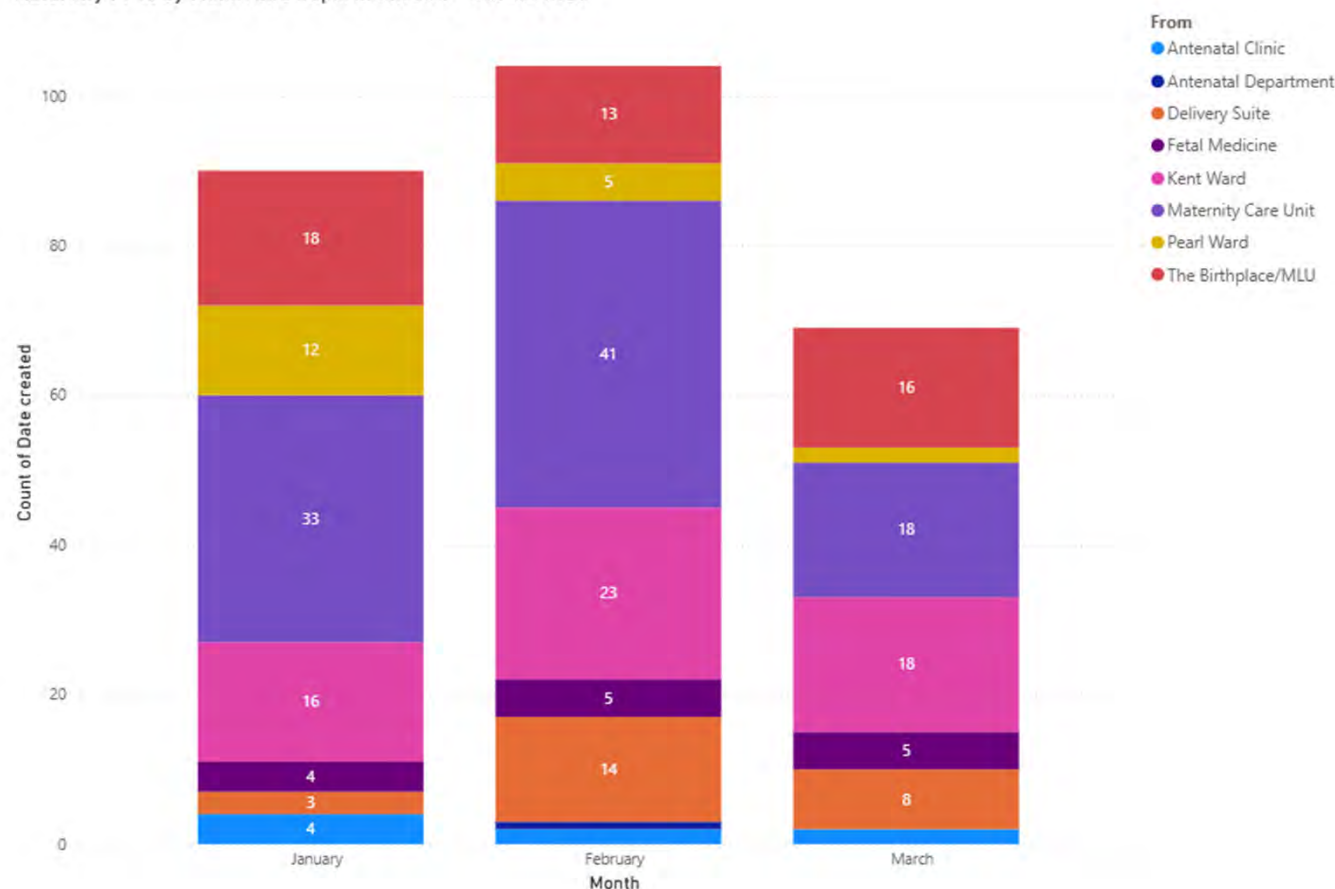
Perinatal Surveillance Quarterly Report – Q4

Maternity FFTs:

Key Messages:

- Maternity Care Unit and Kent Ward contributed the highest number of responses across all months
- Smaller contributions from other areas (e.g. Pearl Ward, Fetal Medicine, Antenatal)
- Overall, strongest engagement in core maternity wards

Maternity FFTs by Month and Department Jan – Mar Q4 2026



Perinatal Surveillance Quarterly Report – Q4

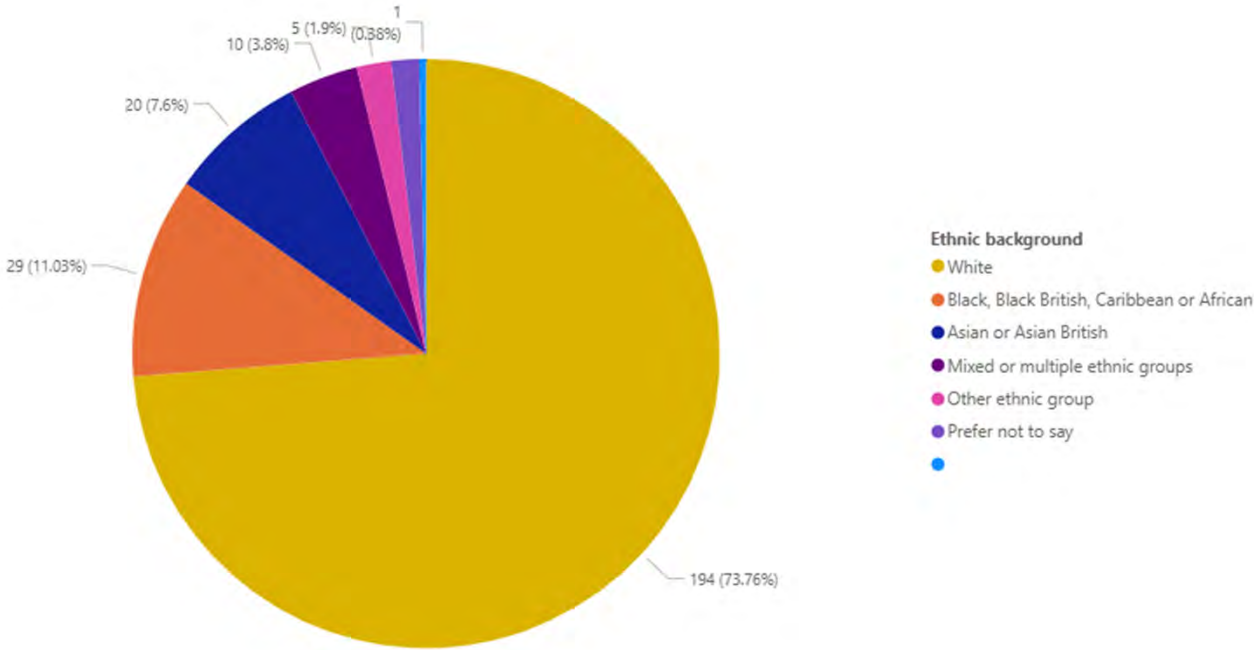
Maternity FFTs:

Key Messages:

- Majority of FFT responses are from White patients (73.8%)
- Black, Asian, and minority ethnic groups are represented but at lower levels (largest: Black 11.03%, Asian 7.6%). However, representation is in line with Birth rate for 2025
- Small proportions from mixed/other ethnic groups and those preferring not to say
- Indicates underrepresentation of some ethnic groups, suggesting a need to improve engagement and inclusivity in feedback collection

Ethnicity	Q4 FFT	2025 Birth-rate
White British	73.8%	70%
Black or Black British including African and any other black background	11.03%	9.93%
Asian or Asian British, including Indian, Bangladeshi and any other Asian background	7.6%	7.23%

Maternity FFT responses and Ethnic Background Jan - Mar Q4 2026



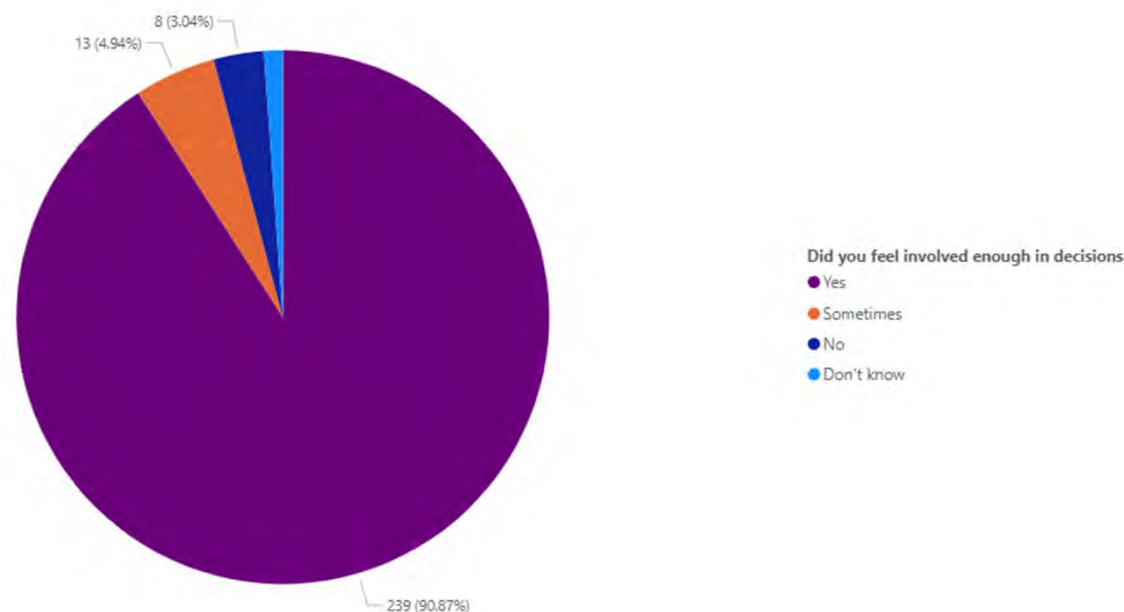
Perinatal Surveillance Quarterly Report – Q4

Maternity FFTs:

Maternity FFT Jan - Mar Q4 2026 - FFT question - Did you feel involved enough in the decisions made about you?

Key Messages:

- High level of involvement reported, with 90.9% of patients feeling involved in decisions
- Small proportion felt only sometimes involved (4.9%)
- Very few patients reported not feeling involved or were unsure (~4%)
- Overall reflects strong performance in shared decision-making, with minor scope for improvement



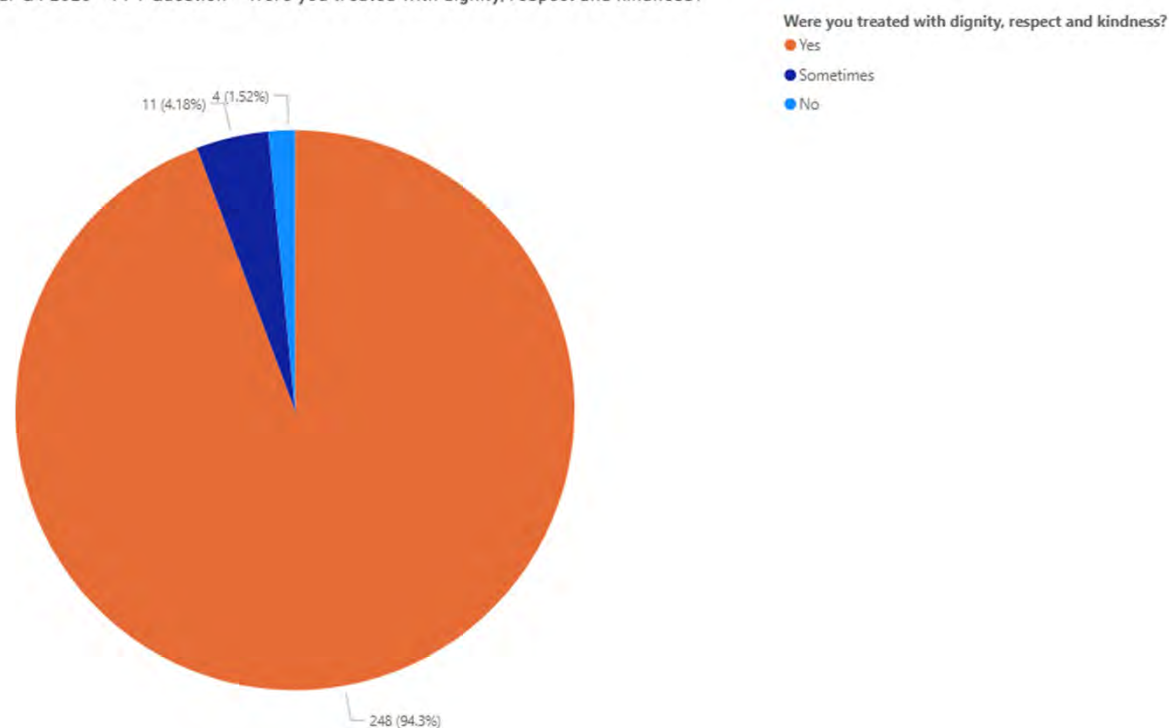
Perinatal Surveillance Quarterly Report – Q4

Maternity FFTs:

Maternity FFT Jan - Mar Q4 2026 - FFT Question - Were you treated with dignity, respect and kindness?

Key Messages:

- Very high positive feedback, with 94.3% of patients feeling treated with dignity, respect, and kindness
- Small proportion reported “sometimes” (4.2%)
- Very few patients reported not being treated appropriately (1.5%)
- Overall indicates excellent patient experience, with minimal areas for improvement



Perinatal Surveillance Quarterly Report – Q4

Maternity FFTs:

Positive Word Count - Community



Positive Word Count - Hospital



Staffing Vacancy Rates



Staffing Vacancy Rate

Staffing Group	Vacancy Rate
Midwifery	3.25 WTE
Midwife Support workers	3.68 WTE
Obstetric consultants	1 WTE – anticipated start date Summer 2026
Obstetric Resident doctors	0 WTE
Neonatal Nurses	4 WTE B5, 1 WTE B6
ANNP	0 WTE
QIS	56.59% QIS trained (BAPM recommended target of 70%) – Further 6 nurses started QIS in Sept 2025 and 7 more on the trajectory to enrol in Sept 2026
Neonatology consultants	0 WTE
Neonatal Resident doctors *inclusive of paediatrics	0 WTE
Obstetric anaesthetists Consultants	0 WTE
Obstetric anaesthetists Resident doctors	0 WTE

Maternity Issues & Risks

March 2026



Maternity Issues

Issues –

Closed: 4

New Risks: Nil

Amended risk scoring following review: Nil

Current Open Issues:
19 (12 Maternity)

Overdue Issues:
0

Issues Open Over 12m:
9

Issue Movement	
No of Issues ↑	2
No of Issues ↓	0
No of Issues (-)	12
No of closed Issues	3

Approved Issues by Priority Rating	
5 - Significant	0
4 - High	10
3 - Moderate	6
2 - Low	3
1 - Insignificant	0
Total	

Issue ID + Rating	Issue Added Date	Date Issue was Approved	Issue Description	Mitigations Update
ID 1300 4	15/11/21	06/04/22	Inability to access patient records at community antenatal clinics	Successfully moved towards engineer deployment but identified issues requiring further installation planning. Lead IT and Lead Broadband identified – working closely with Community Matron and HOM
ID 2206 4	25/09/24	22/11/24	Delays and clinical ineffectiveness in patient care due to insufficient estates footprint for Maternity & Ambulatory Gynaecology	Options being explored for rearrangement of current locations to support implementation of BSOTS
ID 2386 4	18/03/25	21/05/25	Lack of dedicated C-Arm for Abnormally Invasive Placenta Pathway	

Maternity Issues

Issue ID + Rating	Issue Added Date	Date Issue was Approved	Issue Description	Mitigations Update
ID 2488 4	23/06/25	16/07/25	Cross-Trust Antenatal Care and Delivery Planning	Increasing numbers of women are booking to deliver their babies at other NHS Trusts while receiving antenatal care at our Trust. This creates clinical risk due to differing guidelines, care pathways, and documentation systems between Trusts. DOM meeting with regional DOMs to create joint SOP
ID 2578 4	11/09/25	15/10/25	Shortage of CTG Machines in Maternity Department Affecting Timely Fetal Monitoring	New wireless telemetry CTG machines delivered to Delivery Suite and in use. Creating opportunity to move CTG machines from DS to Antenatal Ward to create surplus CTGs on Antenatal ward
ID 2579 4	11/09/25	15/10/25	Lack of Dedicated Diabetes Nurse in Maternity Team Prevents Access to Recommended Hybrid Closed Loop Technology for Pregnant Patients	CLOSED Merged with Risk ID 2620 – “Non-Compliance with Saving Babies Lives (SBL) Care Bundle Due to Diabetes in Pregnancy Service Deficiencies”
ID 2599 4	29/09/25	15/10/25	Women's Care Consultant Vacancies	5 consultant vacancies – 4 consultants recruited into post, remaining post due to be recruited into by June 2026
ID 2623 4	17/10/25	19/11/25	Recurrent Network Connectivity Failures Affecting Follow Me Printers in the Fetal Medicine Department	CLOSED All maternity staff being issued ‘follow me’ pins in readiness for maternity roll out

Maternity Issues

Issue ID + Rating	Issue Added Date	Date Issue was Approved	Issue Description	Mitigations Update
ID 1025 3	30/09/18	07/04/22	Euroking maternity system not fit for purpose, impacting patient safety data quality, stat analysis, CNST & clinical info	Anticipate move to K2 in summer 2026. Euroking contract end date extended to Dec 2026 to allow cross cover during K2 rollout period
ID 2205 3	25/09/24	22/11/24	Intermittent Faults in Bleep System Across Maternity and Neonatology	Trust Bleep system rollout continues. Mitigated by mobile phones given to key staff in the event of bleep failure
ID 2384 3	18/03/25	21/05/25	Lack of Air conditioning in Fetal Medicine and Maternity Care Unit	Air Conditioning installed, awaiting final service checks before utilising
ID 2575 4	11/09/25	14/10/25	Inadequate Desk Space in Maternity Department Impacting Staff Productivity and Wellbeing	MERGE – to Issue ID 2206 relating to overall lack of space in Maternity and Gynae and increase Issue Rating to 4 Works ongoing to transform unused space into filing room, to create additional 'hot desk' space in maternity
ID 1128 4	13/04/21	06/04/22	There is a lack of community office space for community midwifery teams	Increase to moderate risk rating due to lack of resolution
ID 1737 2	03/08/23	16/08/23	Inconsistent and inaccurate data being shared outside the organisation	Manual data cleansing continues
ID 2079 2	17/05/20 24	16/07/202 4	Current Glucose Meters Not Suitable for Neonatal Use	Due into Trust June 2026 – then for rollout

Maternity Risks

Risks –

Closed: 3

New Risks: Nil

Amended risk scoring following review: Nil

Current Open Risks:
3

Overdue Risks:
0

Risks Open Over 12m:
3

Risk Movement	
No of Risks ↑	0
No of Risks ↓	0
No of Risks (-)	3
No of closed Risks	3

Approved Risks by Current Score	
Extreme (scoring 15+)	0
High (scoring 8-12)	3
Moderate (scoring 4-6)	0
Low (scoring 1-3)	0
Total	3

Risk ID + Rating	Risk Description	Mitigations Update	Target Rating	Target Closure Date
ID 2619 12	Failure to achieve CNST compliance due to failure to meet Safety Action 1 targets and Safety Action 8 training shortfalls	CLOSED – CNST Year 7 finished – to review CNST Year 8 and add new risk if appropriate	CLOSED	
ID 2078 12	Risk of service disruption in Fetal Medicine from aging equipment	5 x scanners delivered and in use – 1 x triage, 1 x DS, 1 x MCU, 2 x Fetal Med (propose close on next Care Group)	1 x 3 3	31/03/26
ID 2420 9	Potential Breach of HTA Guidance Due to Inability to Input Baby Names in Tele Tracking System for Porter Transfers	Ability to record name of baby in the Tele tracking system has gone live. Needs to be audited over the next month.	3 x 1 3	10/04/26
ID 2621 9	Risk of compromised Maternity Care due to Inexperienced Midwifery Workforce Skill Mix	CLOSED – Risk reduced to 3 x 2 (6) and closed	CLOSED	

Maternity Risks

Risk ID + Rating	Risk Description	Mitigations Update	Target Rating	Target Closure Date
ID 2620 9	Non-Compliance with Saving Babies Lives (SBL) Care Bundle Due to Diabetes in Pregnancy Service Deficiencies	CLOSED – To merge risk with existing Issue ID 2579 “Lack of Dedicated Diabetes Nurse in Maternity Team Prevents Access to Recommended Hybrid Closed Loop Technology for Pregnant Patients”	CLOSED – Merged with Issue 2579	
ID 1864 8	Risk of service disruption due to inadequate Maternity System and contract expiry	Installation of K2 anticipated Summer 2026 Euroking contract extended until Dec 2026	2 x 2 4	29/05/26

NICU Issues & Risks

May 2026



NICU Issues

Issues -

Closed: Nil

New Risks: Nil

Amended risk scoring following review: Nil

Current Open Issues:

5

Overdue Issues:

0

Issues Open Over 12m:

3

Triangulations with Incidences:

- 3 Datix relating specifically to transport ventilator issues (2024 – present)
- 5 Datix relating specifically to transport ambulance logistics (2024 – present)
- 7 Datix relating specifically to staffing (2024 – present)

Issue Movement	
No of Issues ↑	0
No of Issues ↓	0
No of Issues (-)	5
No of closed Issues	0

Approved Issues by Priority Rating	
5 - Significant	0
4 - High	1
3 - Moderate	4
2 - Low	0
1 - Insignificant	0
Total	5

Issue Rating	Issue	Mitigations
3	Upgrade ITU Gantry system	
3	Lack of available space in NICU for equipment storage	
3	Logistical challenges of ODN ambulance provision	
3	QIS trained staff on Neonatal Unit	
4	Inadequate ventilators for the safe transfer of neonates	Work collaboratively with ODN & EME Work with supplier to ensure we have loan equipment when needed

Issues are reviewed monthly including associated actions

NICU Risks



Risks -
Closed: Nil
New Risks: Nil
Amended risk scoring following review: Nil

Current Open Risks:
0

Overdue Risks:
0

Risks Open Over 12m:
0

Issue Movement	
No of Issues ↑	0
No of Issues ↓	0
No of Issues (-)	0
No of closed Issues	0

Approved Issues by Priority Rating	
5 - Significant	0
4 - High	0
3 - Moderate	0
2 - Low	0
1 - Insignificant	0
Total	0

Risk Rating	Risk Description	Mitigations

Risks are reviewed monthly including associated actions

Risk level (current)	Rating (current)	Issue Title	Issue Description	Issue Priority Rating	Date Approved	Risk Owner	Last Review Date	Next Review Date	Approval status
● High	9	Upgrade of NICU Gantry System (ITU)	Current Gantry system has been in place in ITU since 1999. The systems run throughout the entire ITU room supplying power and gases to all 12 cot spaces. It is important to ensure this system is updated in line with the increasing requirement of the developments in care. The amount of varied equipment that is required to allow us to provide excellent ITU care is ever increasing – the current Gantry system does not allow for the developing needs. The space required to work has increased and the current infrastructure does not allow for this change. A new gantry system will allow us to ensure the ITU is future proof, allowing us to improve practice and patient experience. Recently we have also struggled with infection outbreaks. The IPC team supports this upgrade – as wear and tear of the current system, means there are loose, broken areas which prevents us being able to ensure the areas are thoroughly cleaned.	3 – Moderate	17/04/2024	Sarah Clarke	07/04/2026	07/05/2026	● Approved

Action Plan

Action ID	Module	Linked record ID	Action Title	Action Description	Action Lead	Action Due Date	Action Completed	Action Status	Done date
1732	Risk Register	1984	current mitigations	Ensure additional cleaning is carried out, making sure current gantry system is as clean as possible. Move equipment in and out of the nursery as required to ensure the room does not become cluttered, also ensuring that there is enough electric points / gas points for the equipment currently in use.	Sarah Clarke	14/08/2024	14/08/2024	Complete	
2327	Risk Register	1984	Project management update	Met with estates project manager - discussed the need for more quotes on the replacement project. He contacted companies to provide quotes. site meeting arranged, the companies will visit the NICU and cost up the works giving us a new up to date quote. 3 companies have been contacted. Once the quotes have been received the PID will be updated	Sarah Clarke	24/02/2025	12/06/2025	Complete	
2962	Risk Register	1984	Planning of works	Scoping meeting to take place on 16/06/25 to plan out the works.	Sarah Clarke	31/12/2025	23/03/2026	Complete	
3475	Risk Register	1984	Mitigations / Plan for works	The mitigations and plans that are in place for when the works start	Sarah Clarke	03/08/2026		Ongoing	Complete

● High	8	Lack of available space in NICU for equipment storage	Equipment which is being used regularly in NICU is being stored in: 1. Corridors - equipment is covered and stored in corridors which pose an IPC and health and safety risk. 2. Bedroom 3 - equipment is currently stored in bedroom 3, meaning that a parent is unable to stay on site. Not meeting GIRFT recommendations. 3. NICU seminar room and impacting on team meetings and social distancing.	3 – Moderate	06/04/2022	Sarah Clarke	07/04/2026	07/05/2026	● Approved

Action Plan

Action ID	Module	Linked record ID	Action Title	Action Description	Action Lead	Action Due Date	Action Completed	Action Status	Done date
1731	Risk Register	1148	Storage mitigation	Clear the 2 side storage rooms in seminar room to prepare for the works to be completed. Use screens in seminar room to separate area to store equipment	Sarah Clarke	14/08/2024	14/08/2024	Complete	
2344	Risk Register	1148	Funding for Storage works	Secure funding for storage.	Sarah Clarke	03/08/2026		Ongoing	<button>Complete</button>

QIS trained staff on Neonatal Unit	In line with CNST requirements, QIS nurse staffing on the NICU currently not reaching BAPM national standards. Requirement is 70%, currently 64.5% of nursing staff are QIS trained. 6 staff each year are enrolled on to training. Trajectory of achieving 70% in September 2025, when current cohort complete the training. Action plan in place. Added to risk register in line with CNST requirement as below: CNST safety action 4: Neonatal Workforce • Where neonatal (nursing and medical) staffing does not meet the relevant BAPM national standards there is an action plan with progress against any previously developed action plans and this is monitored via a risk register.				3 – Moderate	12/03/2025	Sarah Clarke	07/04/2026	07/05/2026	● Approved

Action Plan

Action ID	Module	Linked record ID	Action Title	Action Description	Action Lead	Action Due Date	Action Completed	Action Status	Done date
2591	Risk Register	2371	Continue to train and monitor	Continue to train staff and monitor those staff undertaking training to achieve the 70% target	Sarah Clarke	03/08/2026		Ongoing	Complete

Inadequate Ventilators for the Safe Transfer of Neonates

Current situation: 1 Transport rig with Fabian HFO ventilator, having recurrent system failures with poor provision of maintenance, and repairs. 1 Transport rig with F120 ventilator - which has been decommissioned 2024 1 Transport rig with F120 ventilator - which is intermittently showing faults with achieving pressures - with no assurance of what is being delivered. Recent situation - ALL VENTILATORS FAILED AT THE SAME TIME, leaving the transport service with no provision of respiratory support. meaning the service was unable to run safely. All of the ventilators are no longer covered by any maintenance service, due to the provider changing management companies multiple times. These ventilators are also no longer commissioned. These issues have been previously mitigated by always having at least 1 working ventilator. This most recent incident, of all ventilators failing at the same time, has highlighted the patient safety issue surrounding these old pieces of equipment. The transport rigs are used by the Kent transport team as part of the Kent Surrey & Sussex Neonatal Transport Service commissioned by NHSE to provide transfers of sick and preterm babies across Kent Surrey &

4 - High

15/10/2025

Sarah Clarke

07/04/2026

07/05/2026

Approved

Action Plan

Action ID	Module	Linked record ID	Action Title	Action Description	Action Lead	Action Due Date	Action Completed	Action Status	Done date
3324	Risk Register	2606	Working closely with EME	to work with the equipment services department to ensure the equipment we have is in working order and issues are fixed in a timely manner.	Sarah Clarke	03/08/2026		Ongoing	Complete
3325	Risk Register	2606	To secure Loan equipment as needed	To secure Loan equipment as needed from supplier which is at a cost and is not always available.	Sarah Clarke	03/08/2026		Ongoing	Complete
3326	Risk Register	2606	Work with other transport services	Work with other transport services in Sussex and Surrey and London to help cover if our ventilators are not working.	Sarah Clarke	03/08/2026		Ongoing	Complete

Logistical Challenges with ODN Ambulance Provision	Increased incidences due to staff unfamiliarity of vehicles due to the need to swap and share box ambulances across the ODN. Logistical concerns ensuring each transport team have the correct equipment on board to provide a safe and effective transport service. Leading to delays in transfer, impacting the safety of the babies in our care.	3 – Moderate	12/11/2025	Sarah Clarke	07/04/2026	07/05/2026	Approved

Action Plan

Action ID	Module	Linked record ID	Action Title	Action Description	Action Lead	Action Due Date	Action Completed	Action Status	Done date
3330	Risk Register	2611	Working with BEARS and KSS transport teams	<u>Working with BEARS and KSS transport teams to ensure the right ambulance is in the right place for the right team.</u>	Sarah Clarke	03/08/2026		Ongoing	Complete

Red Flag Report – Q4 2025/26



Perinatal Surveillance Quarterly Report – Q4

Red Flags – Delivery Suite:

Number of Red Flags recorded

01/01/2026 to 31/03/2026

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	35	31%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	2	2%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	2	2%
RF5	Delay between presentation and triage	5	4%
RF6	Full clinical examination not carried out when presenting in labour	1	1%
RF7	Delay between admission for induction and beginning of process	67	59%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	1	1%
RF10	Coordinator unable to maintain supernumerary status	0	0%
TOTAL		113	

*The % is rounded to nearest whole number

Number of Staffing Factors

01/01/2026 to 31/03/2026

Factors	Breakdown of Factors	Times occurred	Percentage
SF1	Unexpected Midwife absence / sickness	112	28%
SF2	Unexpected support staff absence	33	8%
SF3	Unable to fill vacant shifts	143	35%
SF4	Midwife on transfer duties	3	1%
SF5	Midwife redeployed to other area	45	11%
SF6	Support staff less than rostered number	51	13%
SF7	Support staff redeployed to other area	20	5%
SF8	Continuity of care MW unavailable	0	0%
SF9	Continuity of care midwife available	0	0%
TOTAL		407	

*The % is rounded to nearest whole number

Key Messages:

- Overall Red Flag compliance for Q4 = 75.19% (113 recorded red flags)
 - Main drivers are 'delay between admission and induction starting' (59%) and 'delayed/cancelled time-critical activity' (31%). All other red flags are low frequency ($\leq 4\%$)
 - Red flags are heavily concentrated in delays to induction and time-critical care, suggesting a capacity/flow issue .
 - Total staffing factors for Q4 = 407 occasions
 - Main pressures 'unable to fill vacant shifts' (35%) and 'midwife sickness/absence' (28%). 'Support staff below rostered levels' showed 13% and 'midwives redeployed' showed 11%
 - Staffing gaps are primarily driven by maternity leave and unplanned sickness, with further impact from redeployment and reduced support staff, indicating workforce capacity pressures.

Perinatal Surveillance Quarterly Report – Q4

Red Flags – Delivery Suite:

Number of Clinical Actions
01/01/2026 to 31/03/2026

Actions	Breakdown of Actions	Times occurred	Percentage
CA1	Decline in-utero transfer	37	16%
CA2	Delay in accepting transfers	1	0%
CA3	Delay in commencing IOL (as per Trust guidance)	180	79%
CA4	Delay/ Cancel planned procedure	2	1%
CA5	Delay in transfer of cases to theatre	8	3%
CA6	Delay Elective LSCS >24 hours	1	0%
TOTAL		229	

*The % is rounded to nearest whole number

Actions and Improvements:

- IOL QIP is ongoing and has shown a reduction in bottle neck between 'suitable for ARM' and 'transfer to Delivery Suite'.
- Staffing is close to full establishment; however, short-notice sickness and absence continue to impact allocation, requiring internal redeployment to maintain safe service delivery. A full BR+ review is planned for 2026.

Issues, Concerns and Gaps:

- A national shortage of Dinoprostone (Prostin) has required a temporary return to Propess for IOL. Ongoing audit is in place to monitor safety and impact

Number of Management Actions
13/04/2026 to 19/04/2026

Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeploy staff internally	18	62%
MA2	Redeploy staff from community	1	3%
MA3	X Do not use	0	0%
MA4	Redeploy staff from training	0	0%
MA5	Staff unable to take allocated breaks	0	0%
MA6	Staff working beyond rostered hours	0	0%
MA7	Specialist Midwife working clinically	0	0%
MA8	Manager/Matron working clinically	0	0%
MA9	Staff sourced from bank/agency	0	0%
MA10	Utilise on call Midwife	6	21%
MA11	Escalate to Manager on call	4	14%
MA12	Maternity Unit on Divert	0	0%
TOTAL		29	

*The % is rounded to nearest whole number

Key Messages:

- Total number of clinical actions recorded 229 for Q4
 - Majority recorded 'delay in commencing induction of labour' (79%) with a secondary factor of 'declining in-utero transfers' (16%)
 - Clinical delays are dominated by delays in starting induction, reinforcing a significant flow/capacity issue, with some impact on transfer decisions.
- Total number of management actions recorded – 29 for Q4
 - Main response was 'internal staff redeployment' (62%) as well as 'use-of on-call midwife' (21%) and 'escalation to manager on call' (14%)
 - 0 unit diverts required in Q4
 - Pressures are being managed primarily through internal redeployment and escalation, indicating reactive workforce management to maintain service flow rather than use of external or higher-level escalation measures.

Perinatal Surveillance Quarterly Report – Q4

Red Flags – The Birth Place:

Number of Red Flags recorded

01/01/2026 to 31/03/2026

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	0	0%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	0%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	0	0%
RF5	Delay between presentation and triage	1	33%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	0	0%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	2	67%
TOTAL		3	

*The % is rounded to nearest whole number

Number of Staffing Factors

01/01/2026 to 31/03/2026

Factors	Breakdown of Factors	Times occurred	Percentage
SF1	Unexpected Midwife absence / sickness	17	9%
SF2	Unexpected support staff absence	4	2%
SF3	Unable to fill vacant shifts	7	4%
SF4	Midwife on transfer duties	11	6%
SF5	Midwife redeployed to other area	136	73%
SF6	Support staff less than rostered number	10	5%
SF7	X Do not use	0	0%
SF8	Support staff redeployed to other area	1	1%
SF9	Continuity of care Midwife unavailable	0	0%
SF10	Continuity of care Midwife available	0	0%
SF11	Unable to fill vacant support staff shifts	0	0%
TOTAL		186	

*The % is rounded to nearest whole number

Key Messages:

- Total red flags in Q4 = 3
 - Main drivers are 'lack of 1:1 care in established labour' (2 cases = 67%,) with 1 case of 'delay between presentation and triage' (33%).
 - Suggesting isolated staffing-related impact on 1:1 care
- Total staffing factors for Q4 = 186 occasions
 - Main pressures 'midwives redeployed to other areas' (73%) with other contributors being 'midwife sickness/absence' (9%), 'midwife on transfer duties' (6%) and 'support staff below rostered levels' (5%)
 - Staffing pressures are predominantly driven by internal redeployment.

Perinatal Surveillance Quarterly Report – Q4

Red Flags – The Birth Place:

Number of Clinical Actions

01/01/2026 to 31/03/2026

Actions	Breakdown of Actions	Times occurred	Percentage
CA1	Delay in discharge	3	75%
CA2	Delay in accepting transfers	0	0%
CA3	Transfer / Divert to Delivery Suite	1	25%
TOTAL		4	

*The % is rounded to nearest whole number

Number of Management Actions

01/01/2026 to 31/03/2026

Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeploy staff internally	6	43%
MA2	Redeploy staff from community	1	7%
MA3	Redeploy staff from training	0	0%
MA4	Staff unable to take allocated breaks	2	14%
MA5	Staff working beyond rostered hours	0	0%
MA6	Specialist Midwife working clinically	0	0%
MA7	Manager / Matron working clinically	1	7%
MA8	Staff sourced from bank / agency	0	0%
MA9	Utilise on call Midwife	4	29%
MA10	Escalate to Manager on call	0	0%
MA11	Maternity unit on divert	0	0%
TOTAL		14	

*The % is rounded to nearest whole number

Key Messages:

- Total number of clinical actions recorded 4 for Q4
 - Main issues of 'delay in discharge' for 3 occasions (75%) and 1 occasion of 'transfer/delay to delivery suite' (25%)
 - Indicating discharges are going ahead as planned, since adjusted staffing numbers to include 1 additional midwife to the number of labouring women to oversee postnatal care and discharge
- Total number of management actions recorded – 14 for Q4
 - Main response was 'internal staff redeployment' (43%) as well as 'use-of on-call midwife' (29%)
 - 0 unit diverts required in Q4
 - Pressures are being managed through internal redeployment and use of on-call staff, with some impact on staff breaks.

Issues, Concerns and Gaps:

- Minimal Red flag instances noted for Q4

Actions and Improvements:

- Targeted action to improve completion percentage to ensure capturing operational challenges

Triangulated Quality Overview Q4 (2025/26)

Triangulated Quality Overview Q4

This report is a triangulated overview of perinatal quality and safety for Quarter 4 (2025/26), drawing together intelligence from staff feedback, patient experience, and perinatal leadership work. It outlines the key themes emerging from PMRT, MNSI, CRIG, incident reporting, red flag monitoring, and workforce data, and sets out the next steps and action plan required to strengthen safety, culture, and governance across maternity and neonatal services.

Triangulation will include examining -

- Q4 incident data, Datix themes, CRIG reviews, red flags, PMRT, MNSI, AAR
- Patient experience (FFT, complaints, MNVP feedback, bereavement feedback, PALS and Claims)
- Perinatal leadership intelligence (PMRT, MNSI, AAR, national themes)
- Workforce intelligence (midwifery & NICU staffing, QIS, red flags)

Summary -

- Triangulation of Q4 data demonstrates a high degree of consistency across staff reported incidents, patient and family feedback, and perinatal leadership intelligence. The dominant themes are:
 - Communication reliability
 - Documentation and record keeping
 - Escalation and clinical oversight
 - Medication safety (NICU)
 - Capacity and flow pressures (particularly induction of labour)
 - Equity considerations, especially in relation to PPH

Cultural signal -

- The consistency of themes reflects a maturing safety culture with increasing transparency, but also highlights gaps in workforce resilience, and escalation confidence.

Triangulated Quality Overview Q4

Triangulation: Communication

Staff Feedback	Claims Learning	Patient Feedback	Perinatal leadership intelligence
• Communication identified in CRIG themes • Confusion around sharing results with bereaved families (PMRT). • Medication errors linked partly to communication gaps between areas • AAR case: escalation communication delays	Several claims highlight communication failures, including: • Inadequate explanation of risks • Poor documentation of discussions • Lack of written duty of candour • Insufficient communication post incident	• Bereavement feedback positive overall but highlighted communication clarity. • FFT themes continue to emphasise desire for regular updates.	• PMRT and AAR cases highlight communication as a contributory factor. • Nationally, communication failures remain a core theme across Ockenden, Kirkup, East Kent and Nottingham.
Cultural interpretation			
Communication: Q4 shows improvement in tone and compassion, but inconsistency in clarity and timeliness.			

Triangulated Quality Overview Q4

Triangulation: Documentation & Record Keeping

Staff Feedback	Claims Learning	Patient Feedback	Perinatal leadership intelligence
• 4 CRIG cases identified documentation as a theme. • Incident reporting shows documentation gaps linked to prescribing and triage.	Multiple claims highlight: • Missing consent documentation • Inadequate recording of risk discussions • Poor intrapartum documentation • Missing placental examination records	• Bereavement reviews highlight documentation gaps • Missing documentation of birth plans • Incomplete records of monitoring decisions • Lack of documentation around pressure area care	• PMRT/MNSI reviews continue to cite documentation as a recurring factor. • Nationally, documentation reliability is a CNST and SBLCBv3.2 priority.
Cultural interpretation			
Documentation is a safety behaviour, not an administrative task. Q4 shows improvement but still variable reliability across teams.			

Triangulated Quality Overview Q4

Triangulation: Escalation & Clinical Oversight

Staff Feedback	Claims Learning	Patient Feedback	Perinatal leadership intelligence
- Red flags dominated by delays to induction and time critical activity (59% and 31%). - NICU: medication errors, humidification gaps at DVH, and transport issues. - CRIG: 2 cases identified failure to diagnose/treat.	Several cases involve: - Delayed CS - Missed opportunities for senior review - Inadequate escalation during abnormal CTG - Failure to recognise risk factors (e.g., shoulder dystocia)	- Families report delays in updates and uncertainty during escalation episodes. - Delayed response to pain or deterioration	- PMRT gradings (B) indicate care issues that may have influenced outcomes. - AAR case in Q4 reinforces need for strengthened escalation culture. - Nationally, escalation reliability is a key theme in all major maternity reviews.
Cultural interpretation			
Escalation is a cultural norm, not a procedural step. Q4 shows pockets of strong escalation but inconsistency during high acuity periods.			

Triangulated Quality Overview Q4

Triangulation: Compassionate, Person Centred Care

Staff Feedback	Claims Learning	Patient Feedback	Perinatal leadership intelligence
• Staff attitude raised in CRIG themes. • NICU staff praised for compassion and support.	• Psychological harm claims linked to traumatic birth experiences • Importance of trauma informed, consent based care	• Bereavement feedback overwhelmingly positive, naming staff individually. • FFT continues to highlight kindness, support and communication.	• PMRT reviews show strong compassionate care in most cases. • Nationally, person centred care is a core expectation of the Maternity & Neonatal Safety Improvement Programme
Cultural interpretation			
Compassion is a strength, but consistency varies during periods of operational pressure.			

Triangulated Quality Overview Q4

Triangulation: Safety Signals & Learning Themes (Q4)

Staff Feedback	Claims Learning	Patient Feedback	Perinatal leadership intelligence
1 moderate harm incident (shoulder dystocia with humeral fracture). - Medication errors remain a NICU theme. - PPH continues to dominate CRIG reviews (28 cases). - Disproportionate PPH in Black mothers (21.4% vs 9.93% birth rate).	- Consent failures - Missed risk factors - Inadequate intrapartum decision making - Poor documentation - Delayed escalation	Families report information overload and desire for clearer explanations.	- PMRT: neonatal cases graded B for care issues that may have influenced outcomes. - MNSI: 1 referral declined; 1 AAR case declared. - Nationally, fetal monitoring, escalation and equity remain top themes.
Cultural interpretation			
- Safety themes are consistent across all sources, indicating a reliable learning system. - Equity themes emerging strongly in Q4 require sustained focus.			

Triangulated Quality Overview Q4

What This Triangulation Tells Us About Our Perinatal Culture

Strengths	Cultural vulnerabilities	National alignment
- Compassionate, family centred care - Strong neonatal FFT performance - Increasing transparency and learning - Robust PMRT processes - Clear, consistent learning themes - Equity analysis improving (PPH, deprivation, ethnicity)	- Communication reliability - Documentation accuracy - Escalation confidence - Medication safety - Capacity/flow pressures (IOL, DS delays) - Governance gaps (CRIG attendance, workforce strain)	Q4 themes mirror national maternity and neonatal findings, confirming focus on the right areas.
Actions and Priorities for Q4 (Triangulation Driven + Nationally Aligned)		
<u>1. Communication Culture</u> - Standardised update expectations for families - Joint maternity–NICU communication improvement - Strengthen bereavement communication pathways	<u>2. Documentation Reliability</u> - Triage documentation review - Updated drug and fluid charts - Record keeping in Essential Skills 2026	<u>3. Escalation & Clinical Oversight</u> - Strengthen escalation behaviours - Improve senior visibility - Neonatal transport escalation pathway - Embed AAR learning
<u>4. Medication Safety</u> - Monthly medication incident reviews - Checking stickers and PN prompts - Education on line security and prescribing	<u>5. Equity & Risk</u> - Deep dive PPH equity audit - Targeted risk management for high risk groups - Strengthen SBLCBv3.2 compliance	<u>6. Workforce & Culture</u> - Support QIS trajectory - Strengthen psychological safety - Embed national perinatal culture improvement expectations

Triangulated Quality Overview Q4

Scorecard - 2025

Medway NHS Foundation Trust

Selection Criteria: CNST claims received with an Incident Date between 01/04/2015 and 31/03/2025

Specialty drop down list: **Obstetrics**

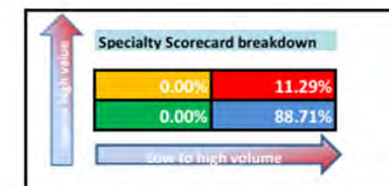
Notification Window (Years)		
Specialty	2.17	The average notification window for Obstetrics claims is 0.06 year(s) shorter than the average notification window for all claims received by the trust.
Trust	2.23	

Specialty - Volume of Claims
62

Specialty - Value of claims (£)
90,313,790

% of Trust Clinical Claims - Volume
12%

% of Trust Clinical Claims - Value
47%

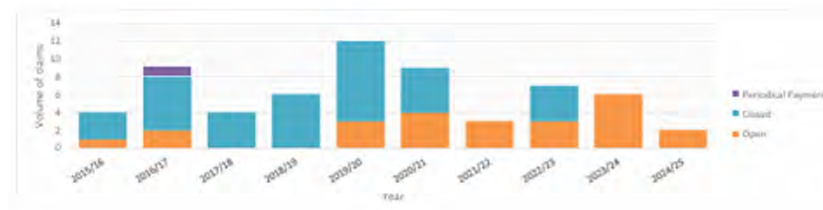


Specialty - Ave. Claim Value (£)
1,456,674

% Trust - Ave. Clinical Claim Value
406%

Volume of claims by Incident Year (Incidents Excluded)

Year	Open	Closed	Periodical Payments
2015/16	1	3	0
2016/17	2	6	1
2017/18	0	4	0
2018/19	0	6	0
2019/20	3	9	0
2020/21	4	5	0
2021/22	3	0	0
2022/23	3	4	0
2023/24	6	0	0
2024/25	2	0	0
Total	24	37	1

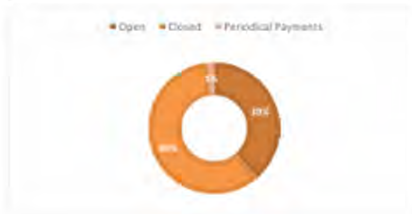


Triangulated Quality Overview Q4

Scorecard - 2025

Current Status (Incidents Excluded)

	Volume
Open	24
Closed	37
Periodical Payments	1
Total	62



Claim Outcomes (Incidents Excluded)

	Volume	Value	Ave Total Value	%
Closed - Nil Damages	20	114,301	5,715	57%
Settled - Damages Paid	14	901,713	64,408	40%
Periodical Payments	1	26,637,518	26,637,518	3%
Total	35	27,653,532	790,101	



Top 5 injuries by volume for Obstetrics

	Injury	Volume	Value	Ave Claim Value	% of Specialty	
					Volume	Value
1	Unnecessary Pain	10	759,322	75,932	16%	1%
2	Stillborn	7	490,530	70,076	11%	1%
3	Loss Of Baby	6	435,639	72,606	10%	0%
4	Brain Damage	5	33,112,307	6,622,461	8%	37%
5	Adtnl/unnecessary Operation(s)	5	308,769	61,754	8%	0%
Total Top 5 injuries by Volume for Obstetrics		33	35,106,566	1,063,835	53%	39%

Top 5 injuries by value for Obstetrics

	Injury	Volume	Value	Ave Claim Value	% of Specialty	
					Volume	Value
1	Brain Damage	5	33,112,307	6,622,461	8%	37%
2	Cerebral Palsy	2	25,820,000	12,910,000	3%	29%
3	Psychiatric/Psychological Dmge	2	13,090,000	6,545,000	3%	14%
4	Developmental Delay	1	12,910,000	12,910,000	2%	14%
5	Fistula	1	2,215,000	2,215,000	2%	2%
Total Top 5 injuries by Value for Obstetrics		11	87,147,307	7,922,482	18%	96%

Top 5 causes by volume for Obstetrics

	Causes	Volume	Value	Ave Claim Value	% of Specialty	
					Volume	Value
1	Fail / Delay Treatment	16	13,493,237	843,327	26%	15%
2	Failure/Delay Diagnosis	4	210,008	52,502	6%	0%
3	Fail Antenatal Screening	3	186,104	62,035	5%	0%
4	Fail To Recog. Complication Of	3	78,850	26,283	5%	0%
5	Foreign Body Left In Situ	3	124,008	41,336	5%	0%
Total Top 5 causes by Volume for Obstetrics		29	14,092,207	485,938	47%	16%

Top 5 causes by value for Obstetrics

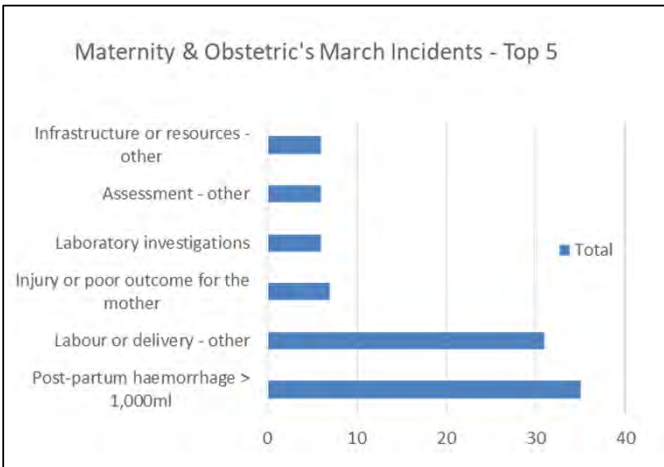
	Causes	Volume	Value	Ave Claim Value	% of Specialty	
					Volume	Value
1	Fail To Make Resp To Abnrm FHR	2	26,650,942	13,325,471	3%	30%
2	Fail / Delay Treatment	16	13,493,237	843,327	26%	15%
3	Inappropriate Treatment	3	12,912,092	4,304,031	5%	14%
4	Fail To Act On Abnorm Test Res	1	12,910,000	12,910,000	2%	14%
5	Inappropriate Discharge	1	12,910,000	12,910,000	2%	14%
Total Top 5 causes by Value for Obstetrics		23	78,876,270	3,429,403	37%	87%

Maternity Governance

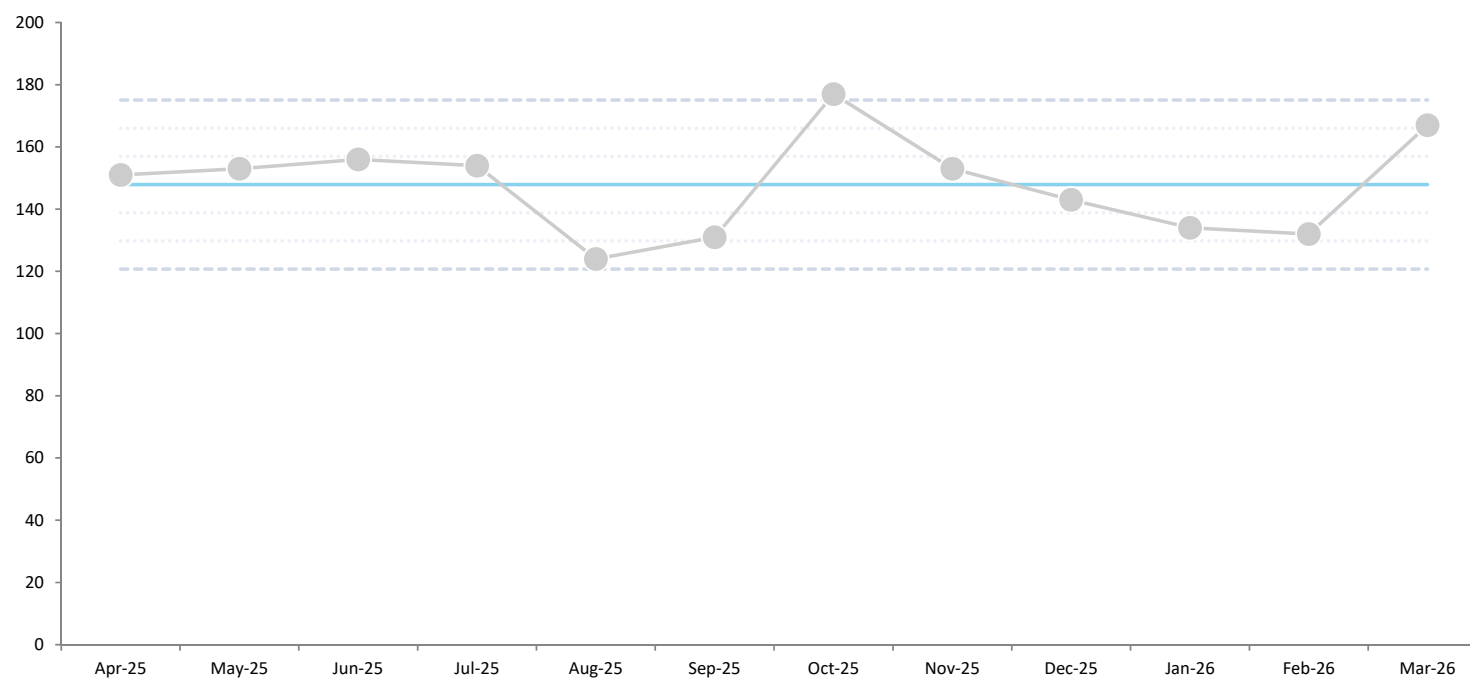


Maternity Governance

167 reported incidents for March 2026 - ↑ from February (132)

Key Messages	Issues/Concerns/Gaps	Actions/Improvements/Next Steps														
1 New MNSI Referral made in March, but rejected due to family consent 167 ↑ (132 Feb) Incidents reported in March 2026 2 Active MNSI Investigations open 1 Moderate Harm (MNSI referral) Nil severe harm incidents declared. - Incident reported in March, 470 per 1000 births ↑ from 400 per 1000 births in February. Maternity & Obstetric's March Incidents - Top 5 <table><thead><tr><th>Incident Category</th><th>Total Incidents</th></tr></thead><tbody><tr><td>Post-partum haemorrhage > 1,000ml</td><td>35</td></tr><tr><td>Labour or delivery - other</td><td>31</td></tr><tr><td>Injury or poor outcome for the mother</td><td>7</td></tr><tr><td>Laboratory investigations</td><td>6</td></tr><tr><td>Assessment - other</td><td>6</td></tr><tr><td>Infrastructure or resources - other</td><td>6</td></tr></tbody></table>	Incident Category	Total Incidents	Post-partum haemorrhage > 1,000ml	35	Labour or delivery - other	31	Injury or poor outcome for the mother	7	Laboratory investigations	6	Assessment - other	6	Infrastructure or resources - other	6	- During the current supply interruption of dinoprostone due to quality issues, a number of temporary actions are being put into place to ensure safe and effective patient care. - Hospital Procurement Teams are being asked to review existing stock of all Prostin® E2 preparations and arrange urgent ordering of unlicensed imports where available. - Remaining supplies of Prostin® E2 vaginal gel will be prioritised for patients where alternative options are contraindicated or unsuitable, such as those with ruptured membranes. - Clinicians are advised to limit repeat prostaglandin inductions where labour does not commence and to consider mechanical methods where pharmacological induction is inappropriate or unsuccessful. - Trust will need to update local guidelines and patient group directions (PGDs) to reflect these interim changes, and ensure that all affected staff receive appropriate training in any revised procedures. - In addition, the Trust must confirm that appropriate storage and handling processes are in place to support any changes in practice. These measures are to be implemented by 20 April 2026 and will remain in place only until supply issues are resolved (forecasted Sep 2026)	- A 29-year-old female undergoing an IOL developed suspected chorioamnionitis and required an EMCS. Delivery was delayed (decision-to-delivery interval 2 hours 4 minutes) due to a concurrent maternal collapse and Category 1 emergency, resulting in limited theatre capacity. The baby was delivered in poor condition following a difficult Impacted Fetal Head (IFH) at caesarean, baby requiring resuscitation and therapeutic cooling for HIE. - Key learning relates to the impact of competing emergencies on theatre access, the importance of clear escalation and communication, and preparedness for complex operative delivery. Actions include review of escalation and theatre capacity processes, strengthening communication pathways, and consideration of implementing IFH Training to support complex operative delivery.
Incident Category	Total Incidents															
Post-partum haemorrhage > 1,000ml	35															
Labour or delivery - other	31															
Injury or poor outcome for the mother	7															
Laboratory investigations	6															
Assessment - other	6															
Infrastructure or resources - other	6															

Maternity Incident Reporting – Monthly Trend



Variation



Assurance

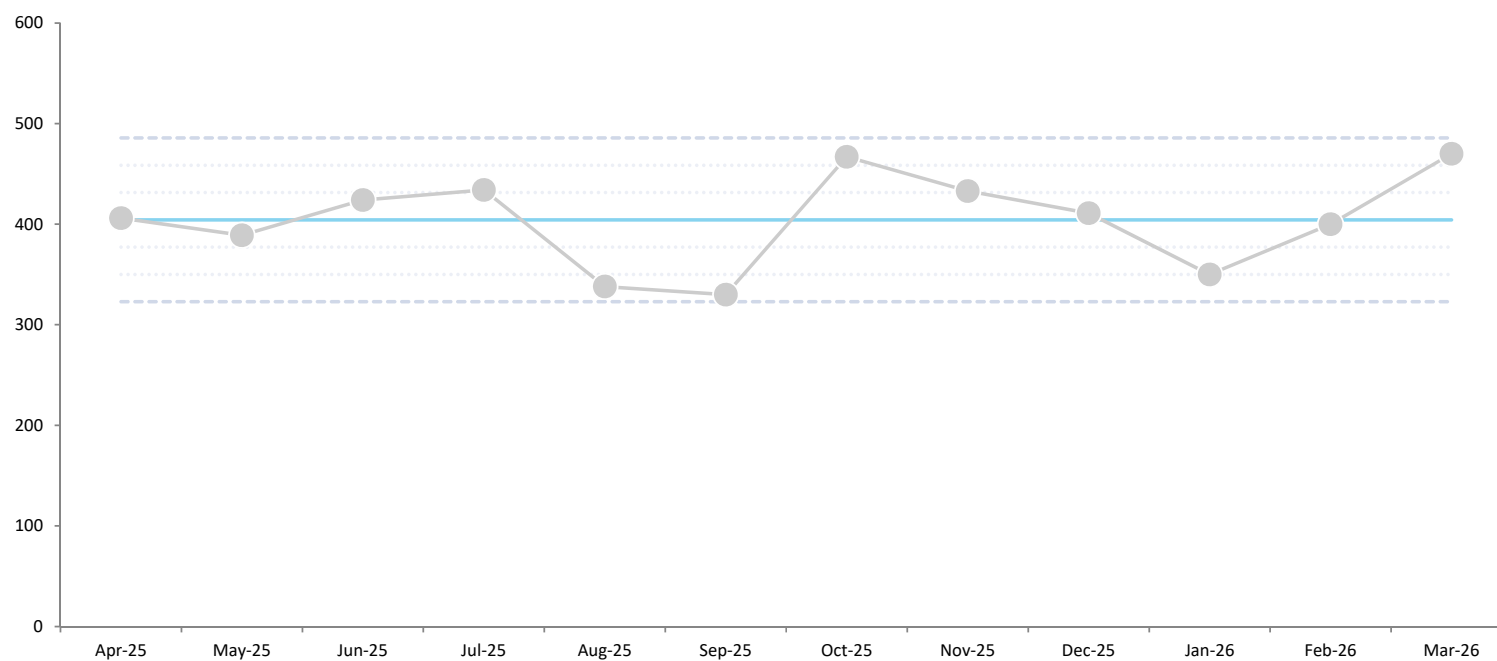


Mean: 147.9

Lower Is Better

Monthly incident reporting demonstrates expected variation around a mean of 148 incidents per month, with no evidence of special cause variation

Maternity Incident Rates per 1000 Births – Monthly Trend



Variation



Assurance

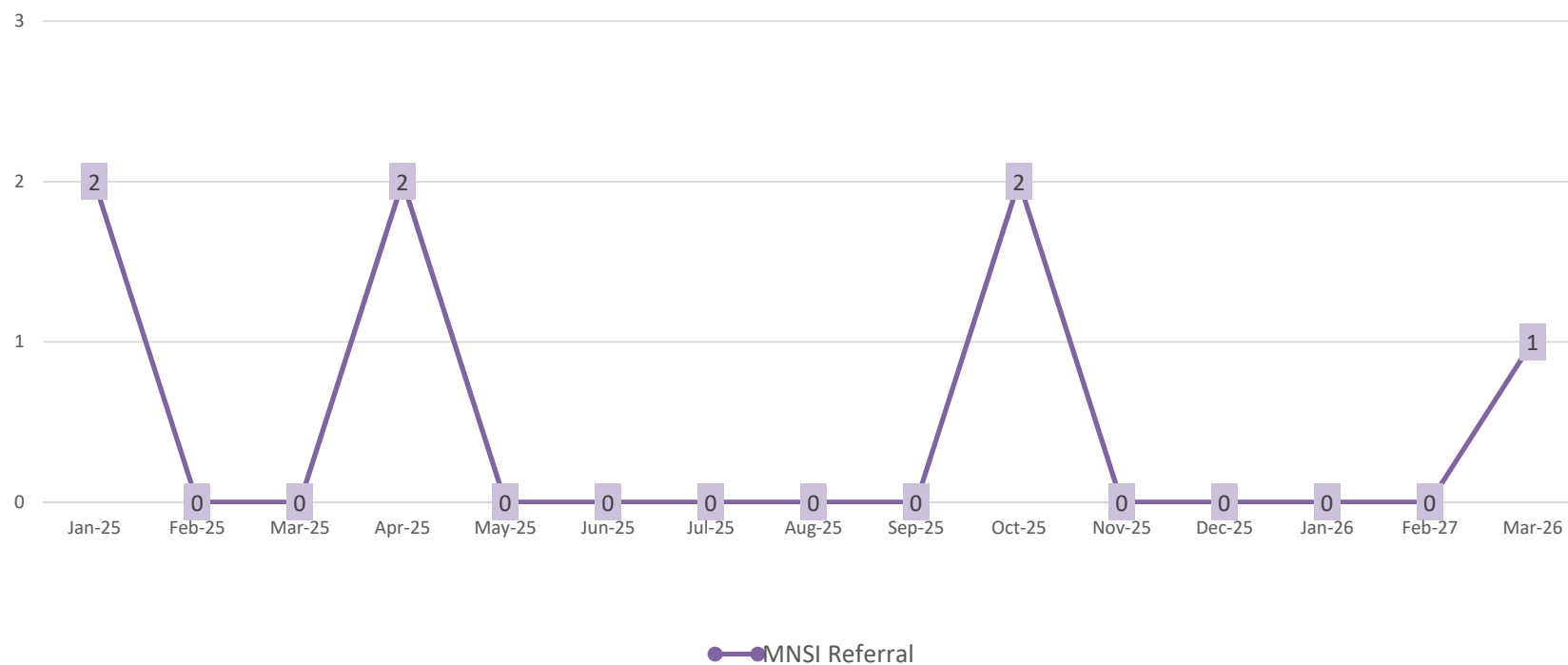


Mean: 404.3

Lower Is Better

Incident rates per 1000 births show a similar pattern of variation, indicating no sustained increase when adjusted for activity.

MNSI MFT Referrals



MNSI referrals remain low in frequency, with several months showing no referrals. This may reflect the rarity of cases; however, a failsafe process is being explored to ensure all eligible cases are identified and referred appropriately

Continuation of the MNSI programme to 2030



- The Department of Health and Social Care has confirmed that the Maternity and Newborn Safety Investigations (MNSI) programme will continue until at least 2030
- The announcement will enable MNSI to fully implement its 2025–27 strategy [MNSI Programme strategy 2025-27 - Building a safer future through partnership and prevention](#)
- Since its establishment in 2018, MNSI has carried out more than 4,600 independent investigations
- At a national level, the themes emerging will continue to inform policy, clinical guidance, and system-wide efforts to reduce inequalities in maternity and newborn care
- MNSI will be able to provide expert learning and insight into the recently announced
- In addition, MNSI will be able to provide expert learning and insight into the recently announced National Maternity and Neonatal Taskforce [National Maternity and Neonatal Taskforce - GOV.UK](#)

MNSI Strategy Link click here ➡ [MNSI Programme strategy 2025-27 - Building a safer future through partnership and prevention](#)

Our impact on safety

- Over 4,600 safety investigations completed since 2018.
- Overall, 55% of investigations are completed within 6 months, 77% are completed within 7 months.
- For investigations excluding external delays, 74% are completed within 6 months, 91% are completed within 7 months.
- Learning shared through safety spotlights, webinars, conferences, and briefing papers.
- All recommendations published on the MNSI website for transparency alongside the annual report.
- Collaborating on national work – maternal care bundle, homebirths, ambulance pre-hospital care.

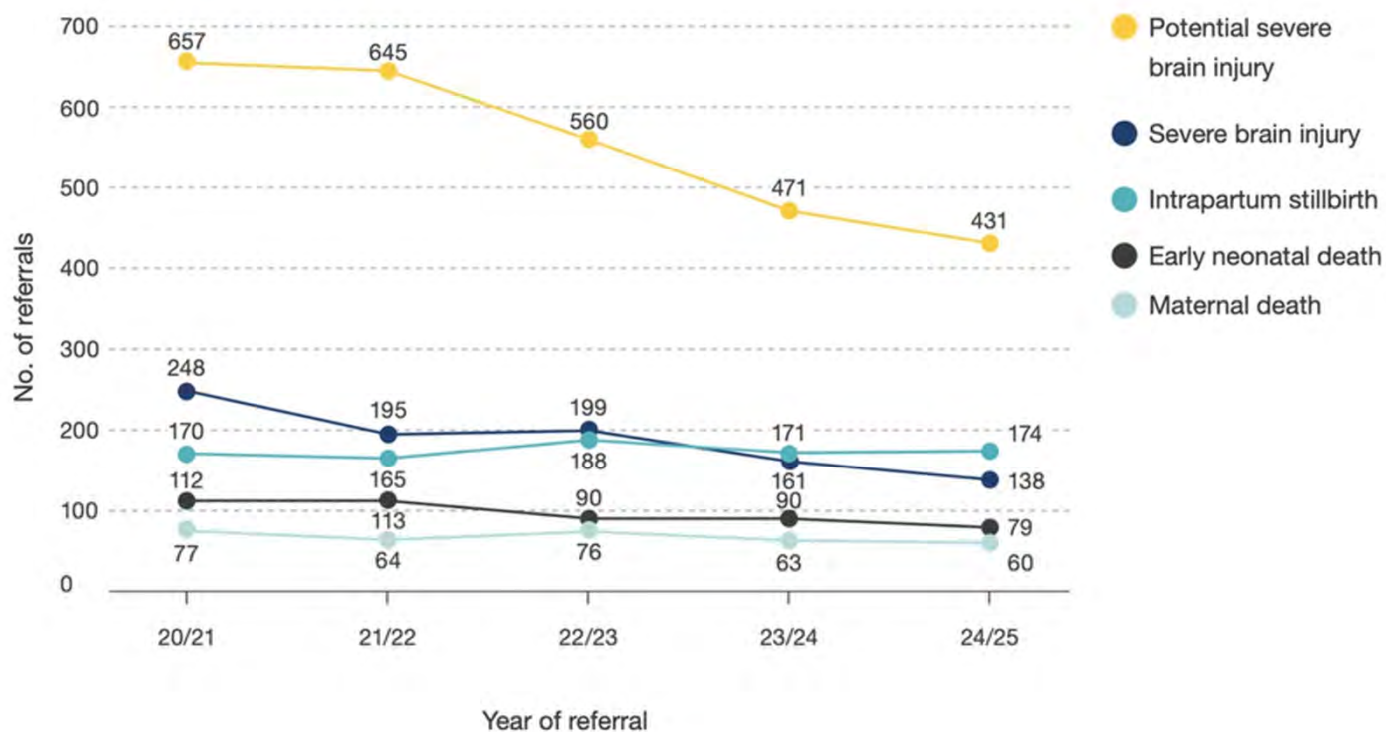
Frequent themes from MNSI recommendations:

- Clinical assessment
- Guidance
- Escalation
- Clinical oversight
- Communication

86% of NHS trusts said MNSI investigations are improving safety and culture in maternity and newborn care

MNSI data show a fall in reported cases of HIE in England

All referrals to MNSI which met referral criteria

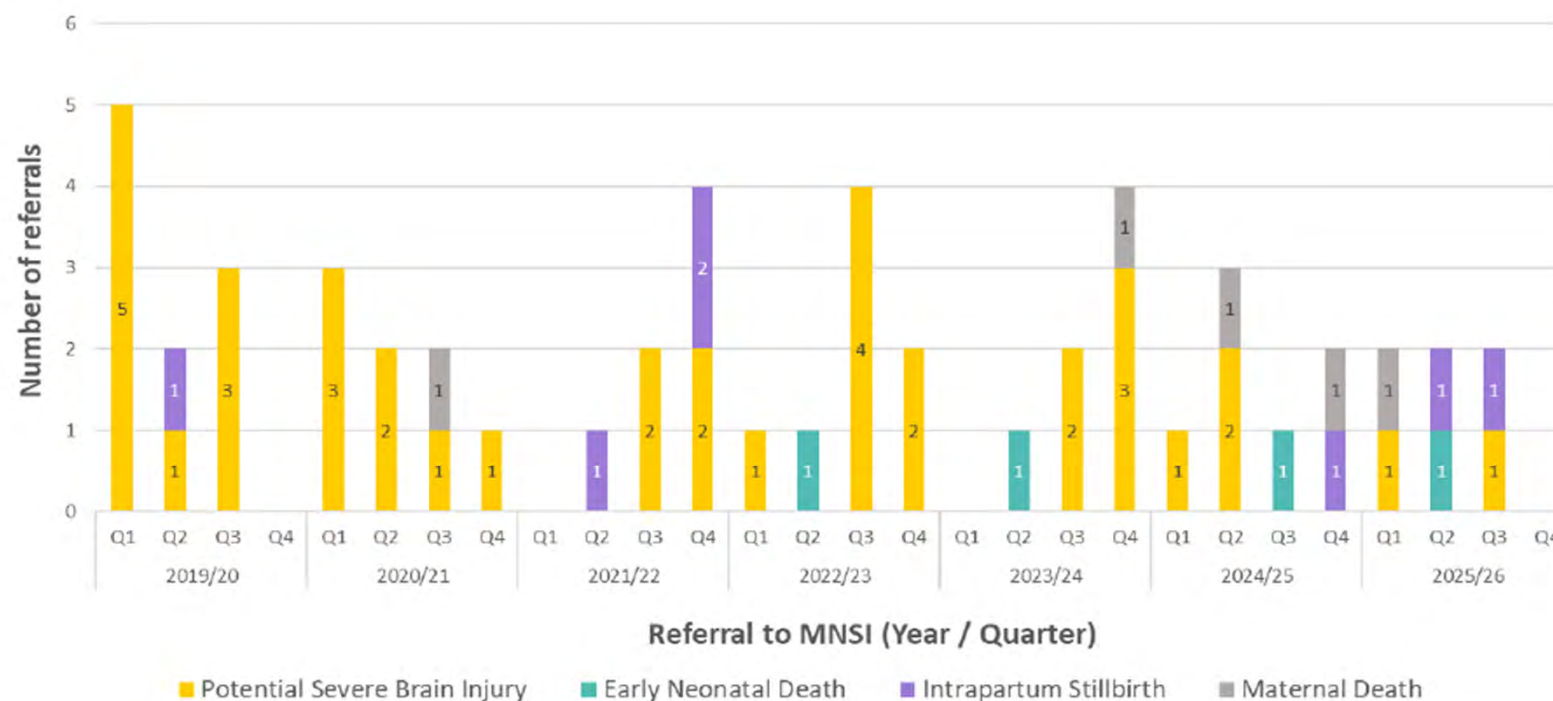


Maternity referrals - Trust



There were 54 referrals in total. **53** met criteria* and 1 did not meet criteria**

The chart below shows the referrals that met criteria (01 Apr-19 to 03 Feb-26):



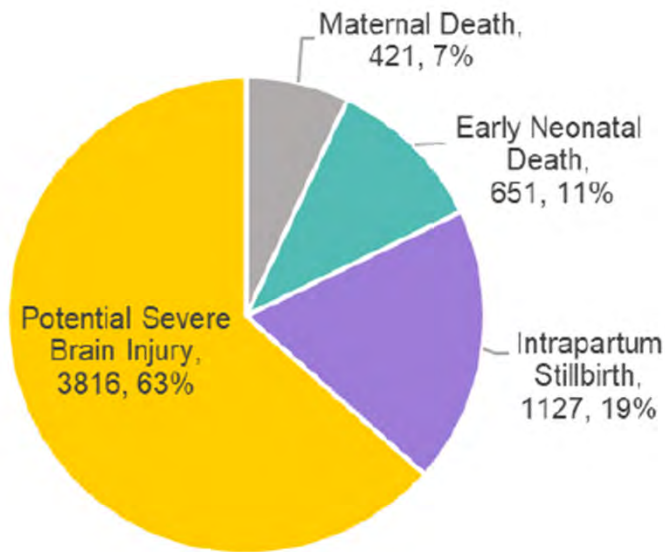
*Referrals that met criteria would either be progressed to investigation or rejected as either 'no family consent' or 'no severe brain injury or trust/family concerns'

**Referrals that did not meet criteria would be rejected as either 'duplicate', 'congenital abnormalities', 'MNSI criteria' or 'sudden infant death syndrome'

Maternity referrals that met criteria*

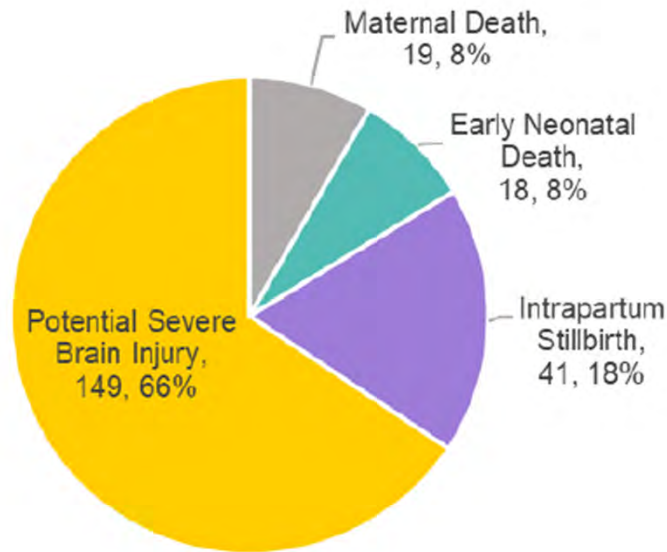


National
01 Apr-19 to 31 Dec-25



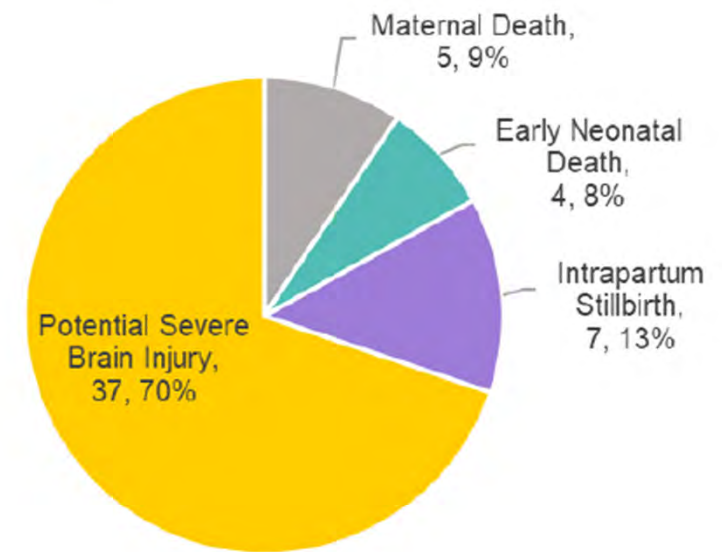
6,015 referrals

Kent and Medway LMNS
01 Apr-19 to 31 Dec-25



227 referrals

Trust
01 Apr-19 to 03 Feb-26



53 referrals

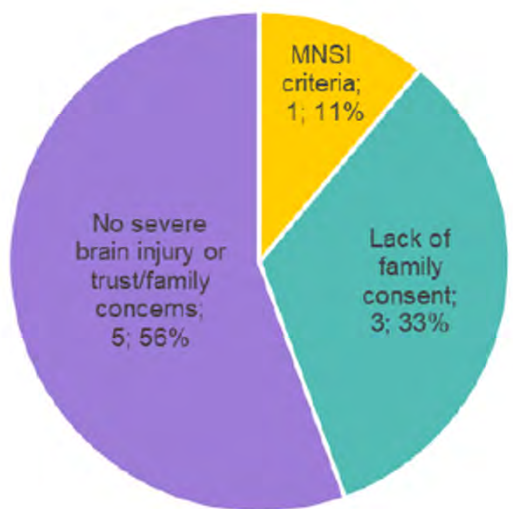
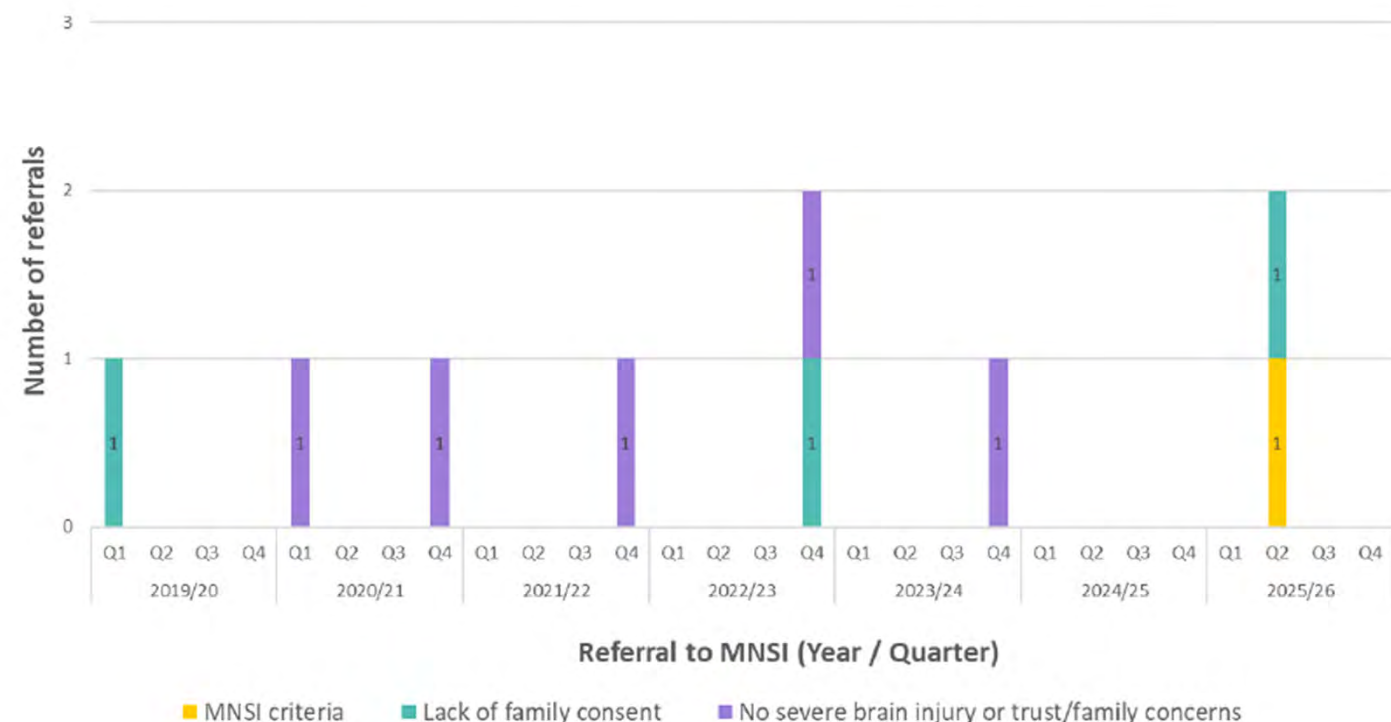
*Referrals that met criteria would either be progressed to investigation or rejected as either 'no family consent' or 'no severe brain injury or trust/family concerns'

Maternity referrals rejected - Trust

Breakdown of all rejected referrals



The charts below show 9 referrals that were rejected (01 Apr-19 to 03 Feb-26):

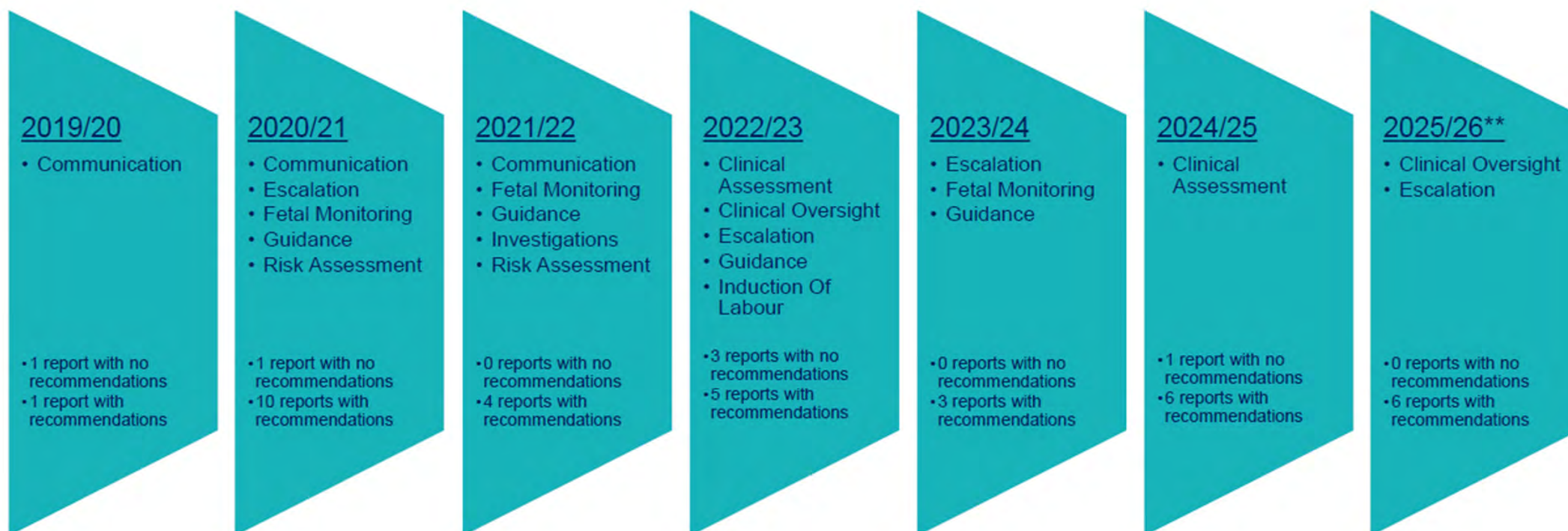


Trust top recommendations*

41 completed reports (2 investigations shared a joint report):

6 reports **did not have** recommendations for the primary healthcare provider.

35 reports **did have** recommendations for the primary healthcare provider.



*In alphabetical order and based on the year of report publication. The number of top recommendations listed may vary depending on their frequency.

**2025/26 is not a full financial year (Apr-Mar).

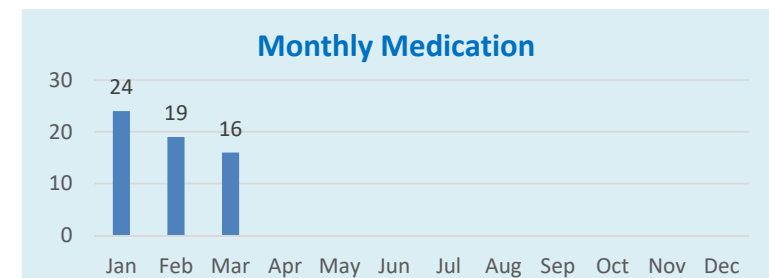
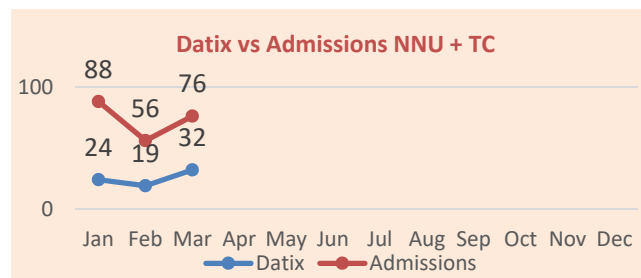
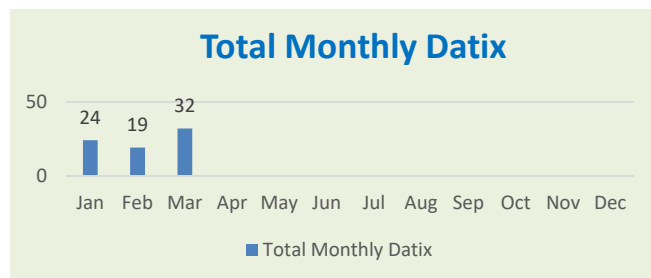
NICU Governance



NICU Governance

32 reported incidents for March 2026 - ↑ from February (19)

Common Theme	Level of Harm	Formal Reviews/Investigation
- Medication Incidents – 16 (significant increase from last month). - Infrastructure and resources (5) - Consent, confidentiality and communication (4) - Medical Device/equipment (3) - Patient information (2)	4 cases reported with 'Low Harm' 28 reported as 'No Harm'	1 MDT for Hypoglycaemia 1 MDT for Gentamicin Overdose 1 Thematic Analysis for UVC/LL malposition



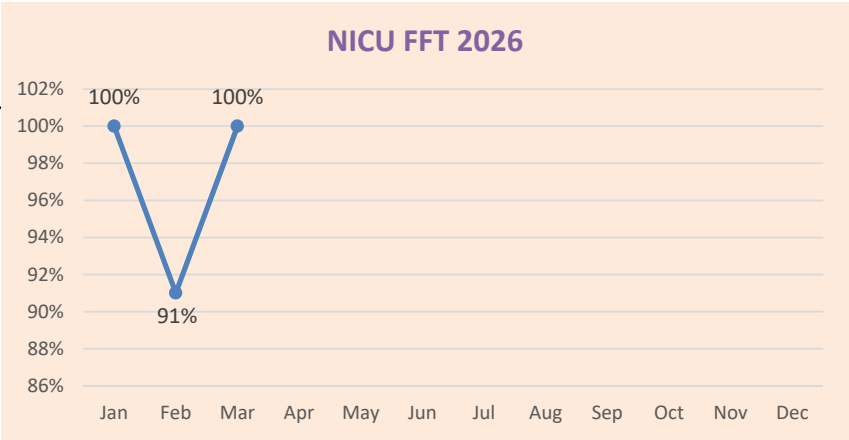
FFTs and Complaints - NICU

0 Complaints in March 2026

Complaints Themes Q4				
	Subject	Sub-Subject	Location	Actions and Improvements
1				

30 FFTs received – 100% recommended rate

Feedback	Issues/Concerns/Gaps	Actions/Improvements/Next Steps
- Lots of positive feedback from parents - Helpful & caring staff - Well informed throughout - Amazing friendly staff - Regular updates – great communication	- Some Negative comments highlighted: - Some staff with poor attitude - Communication – with elements being missed at handover - Long wait for blood results	- We will continue to work on communication and address poor staff attitude. - We will continue to work with families as partners in care, ensuring their voices are heard and families are cared for in a holistic way. We continue to promote parent lead ward round on a Wednesday.



NICU Governance

Theme	Issues/Concern/Gaps	Actions/Improvements/Next Steps
Medication Datix	- Administration (7); Prescription (2) Other (7) - Incorrect medication on discharge summary for GP. - Medication not signed - Rooming in mum gave double dose of ferrous due to miscommunication. - Fluid chart did not correlate with running fluids. - Guardrails not changed to reflect prescription leading to one under dosing of medication and 1 overdosing of medication.	- Continued bi-weekly review of medication incident - Have completed a MDT for gentamicin and have actions in place to complete. - Updating of drug and fluid charts to prevent prescribing errors – We have created double checking stickers for re-prescription and reviewing long term and short term drug chart. ➤ We have had no datixes since January since stickers implemented.
Medical Device / Equipment	- UVC nicked during manipulation of line - UVC/LL malpositioned - TPN Filter leaking – one off incident	Thematic Analysis taking place to review on-going care of central lines.
Consent, confidentiality and communication	- Missed increase of oxygen due to delay in communication of sleep study - Delay in alerting NICU about fault in gases 2 sets of notes in one babies folder	Community team are putting a flow chart and time line for sleep study reviews and actions to streamline timely responses and treatments.
Infrastructure and resources	- Hospital Gas supply Fault 3 shifts short of nurse by 2 to 3	
Patient Information	- Wrong notes written in a Babies EPR - Mums stickers used for babies drug chart	
		Other – - MDT for Hypoglycaemia taken place and actions have been created to improve recognition and response to low Blood sugars. - Have commenced care group weekly datix reviews to discuss actions and appropriate investigation which is presented at IRG.

NICU Workforce Report



NICU Workforce

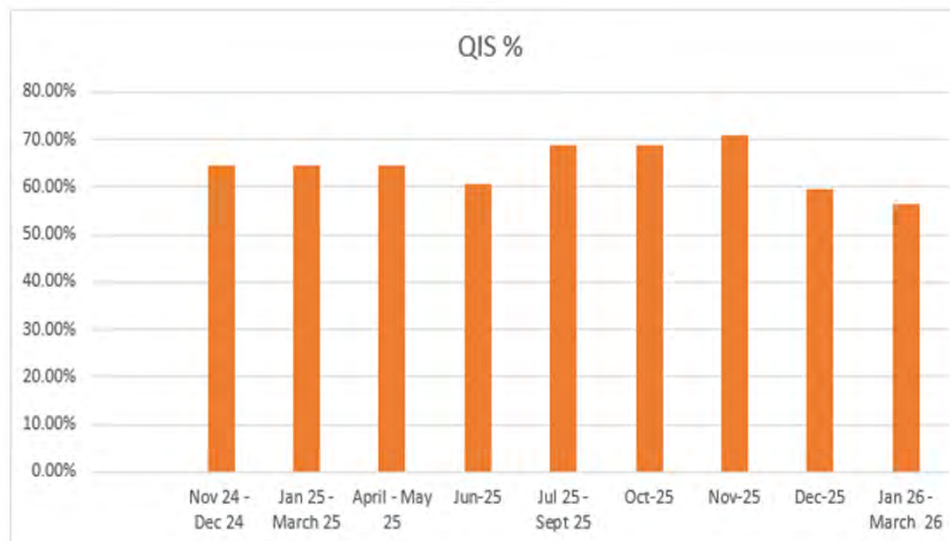
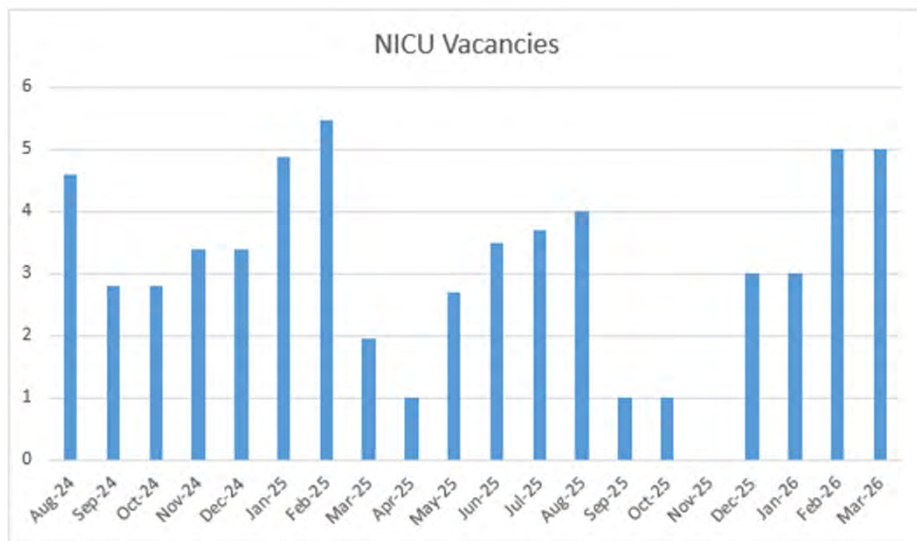
Group	Description	Next Steps
Nurse	Vacancy - 4 WTE B5, 1 WTE B6	- Review and offer flexible working to aid retention - Offer a range of learning and role development opportunities – staff to continue to grow and develop within their role - Ensure appraisals are completed and career progression, including learning opportunities are identified
QIS Trained Staff	Current trained staff 56.59%	
Annual Leave	AL has been evenly taken over the 4 quarters Q1 – 20.04%, Q2 – 26.37%, Q3 - 21.89%, Q4 - 25.77% - staff only able to carry AL over to the next year in extenuating circumstances.	
Bank Booking System	Bank booking system – heavy scrutiny and reviewed every 12 hours – only booked if needed due to acuity after all other mitigations have been explored	
Opportunities		Next Steps
- Staff all follow correct procedure for reporting sickness. Staff are managed with the support of ER. No clear theme with sickness ranging from cold / flu, surgery, stress (home related), gastro, Back related, pregnancy, and Gynae - Interview and recruit to the band 5 and band 6 vacancies - Further 6 nurses started QIS in Sept 2025 and 7 more on the trajectory to enrol in Sept 2026 - Ongoing Psychologist debrief processes as well as offering band specific targeted support - Wellbeing team on NICU		- Work collaboratively with the ODN and other NICUs within the Network, ensuring opportunities for staff are equitable and comparative. - Unit well being team offering regular support to the team – bespoke to each person - Encourage staff to participate in supervision sessions, supporting wellbeing

NICU Workforce

Identified Challenges	Next Steps
• Sickness increased from 7.62% in Feb - 8.35% in March. 9 staff on long term sick – certified sickness. • Mat leave is stable • Study leave reduction from 2.06% - 1.07% • Bank spend increased compared to February but reduced compared to Nov 25 & Jan 26	• Ensure appraisals are completed holistically including SMART objectives for learning and development • Staff to sign a learning contract before commencing training, to aid retention

Risks	Next Steps
• 4 Datix reporting staffing levels in March • Achieving QIS at 70% will enhance patient care and ensure patient safety and experience. • QIS nurse rate on risk register	• Ensure education pathway is planned each year • Ensure appraisals are fully inclusive, supporting role development • Work closely with the universities

NICU Workforce



Key Messages	Issues, Concerns and Gaps	Actions and Improvements
- Total vacancy 5 - QIS 56.59% *ROLLING TRAINING OF NURSES EACH YEAR CONTINUES*	Aim for 70% compliance	- Retain staff - Recruit staff - At least 6 members of staff complete training each year – recurring each September

NICU Workforce – Action Plan

Action No.	Action Required	Update	Owner	Target Date	Completion Date	Current Position
Recruitment						
1	Support staff to complete specialty course to support achieving > 70% QIS.	for September QIS being 64% with an additional 6 to start in September 2024. If no changes to current establishment >70% 18/06/25 Rolling training continues 6 nurses in current cohort. Due to complete in September 2025 - With staff movement, NICU currently at 64.5% QIS trained. The trajectory is to reach 70% in September 2025 SEPT 2025 QIS percentage 68.75% 6 more nurse enrolled to complete the QIS course Sept 2025 cohort. Dec 2025 - QIS % reached 71% in Nov 2025 - 3 band 6 QIS staff left the trust reducing the QIS % to 56.59% in Dec 2025. We will recruit internally to fill the band 6 vacancies and then will recruit into the vacant band 5 posts - we will continue to enrol at least 6 nurses each year onto the Qualified in Specialty Course April 2026 - QIS % 56.59% reduction due to staff turn over. Rolling training continues. ^ nurses within current cohort and 7 due to commence training in 2006	NICU Matron	01/09/2026		

Overdue		
On Target		
Near Completion		
Complete		

NICU Workforce – Action Plan

2	Recruit Additional QIS staff.	Continue recruitment and retention payments for QIS staff to recruit to additionally funded posts (16 WTE new QIS posts funded by network – 3 recruited to) Rolling advertisement in place for QIS Band 6. Education team increased to provided additional support induction and supervision for new staff October 2023 Current band 6 Vacancy now 7 WTE. Rolling advertisement in place for QIS Band 6. July 2024 - Band 6 Vacancy now 0.89 WTE	NICU Matron	01/09/2024	30/07/2024	
3	Recruit to Band 5 vacancy	Ensure band 5 vacancies are advertised and recruited to in a timely way to optimise staffing. Advertised to ensure newly qualified student nurses are eligible to apply. Current band 5 vacancy 1 WTE Oct 2023 – current band 5 vacancy 0 June 2024 - Band 5 vacancy remains 0 - 33 band 5s in workforce July 2024 - Band 5 vacancy 1.8WTE	NICU Matron	30/09/2023	30/09/2023	
4	Workforce Review	Establishment review including Dinning tool which takes into consideration acuity and cot days in individual neonatal units. Sept 2023 Workforce review completed.	NICU Matron	30/09/2023	30/09/2023	

Overdue		
On Target		
Near Completion		
Complete		

NICU Workforce – Action Plan

5	Support staff wellbeing with employment of clinical psychologist to support reflective practice sessions with staff.	Clinical psychologist commenced in February 2024 and is now established in post and conducting reflective practice sessions with staff (and parents).	NICU Matron	30/06/2024	01/05/2024	
6	Strengthened PDN team to support staff to undertake training and development opportunities.	PDN team now consists of 5 members of staff and support nursing staff with accessing internal and external opportunities.	NICU Matron	30/11/2024	01/12/2024	
7	Ensure there is a climate of psychological safety across unit and support staff to share feedback and concerns	SCORE survey undertaken November 2023 and to be re-surveyed in Autumn 2024. Staff developed action plan in place, with NICU specific deep dive of responses. Maternity and Neonatal Collaborative Hour Launched April 2024 to promoted shared learning and working across maternity and neonatal services and encourage staff to share both clinical and personal reflections. 06/01/2025: Psychologist now in post supporting both staff and families	NICU Matron	30/11/2024	06/01/2025	
8	Full establishment reached April 2025 - To Retain staff	Continue R&R payments. Seek staff feedback to identify training and development needs Utilise PDN team to develop training and development plans for staff. Support opportunities for staff to understand other roles within the unit to encourage career development and progression within the unit.	NICU Matron	01/09/2025	10/09/2025	

Overdue		
On Target		
Near Completion		
Complete		

NICU Workforce – Action Plan

9	Band 6 fully established, currently 4 band 5 vacancies - recruit staff to these posts and retain staff	Band 5s have been promoted to band 6 roles within the NICU Ensure band 5 vacancies are advertised and recruited to in a timely way to optimise staffing. Advertised to ensure newly qualified student nurses are eligible to apply. Current band 5 vacancy 4 WTE	NICU Matron	01/12/2025	01/12/2025	
10	QIS staff left the trust - x 3 band 6s and x1 band 7 governance lead	Current vacancy 3 band 6s with the band 7 governance lead working their notice. Will recruit internally to fill the band 6 vacancies Will then continue recruitment to fill the created band 5 vacancies	NICU Matron	01/05/2026	01/02/2026	
11	QIS Nurse successfully achieved PDN role in NICU band 5 vacancies created by nurses being promoted in to vacant band 6 roles & 1 nurse leaving creating 4 band 5 vacancies	Current vacancies 1 band 6 (QIS) and 4 band 5 Will recruit internally to fill the band 6 vacancies Will then continue recruitment to fill the created band 5 vacancies	NICU Matron	01/07/2026		

Overdue		
On Target		
Near Completion		
Complete		

Maternity Workforce Report



Maternity Workforce

SIOR	Next Steps
<u>Successful Deliverables</u> - Midwifery vacancy consistently low for last 6 months - Sustained improvement in both Midwife and MSW retention - Consistent support from education team for newly qualified midwives on the wards	- Recruit to vacancy - Action plan to be created for incivility staff survey, to support continued retention of staff
<u>Identified Challenges</u> - Current reduction in MECU trained staff to cover shifts due to course unavailability - Appraisal rate 85.19% down from 88.4% previous month. Specific areas for improvement identified - Removal of NIPE roster at short notice - Significant amount of staff requiring flexible working	- Specific areas for appraisals identified and targeted work begun - Targeted supervision of newly qualified midwives to increase NIPE staff availability – working well so far - Close supervision of rosters by SS and timely reviews of flexible work agreements
<u>Opportunities</u> - MECU course sourced at DVH until local course developed - Increased provision of hot and cold staff debriefs to support staff wellbeing following incidents	5 midwives attending MECU course in June
<u>Risks</u> - Removal of agency midwives – potential for staffing gaps particularly on night shifts - Mandatory training	Close supervision of fill rates and staffing gaps

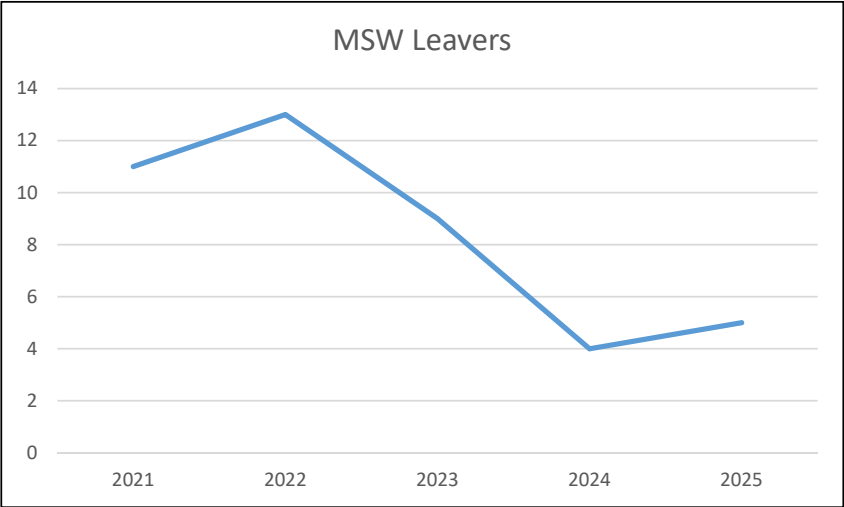
Maternity Workforce

	Jan 2026	Feb 2026	March 2026
Vacancy	0 WTE	2.29 WTE 	3.25 WTE 
Not in post	3.56 WTE on secondment 1 WTE on career break	3.56 WTE on secondment 1 WTE on career break	3.56 WTE on secondment 1 WTE on career break
Maternity Leave	14.75 WTE	14.11 WTE 	15.15 WTE 
Overall Sickness Rate		4.58%	4.39% 
Pipeline	2.92 WTE recruited All with February start dates	0 WTE	0 WTE – VCP requested for 3.25 WTE Students due to qualify in September
Leavers	1 Leaver for health reasons	1 leaver for work life balance	0 leavers 
Expected leavers in next 3 months	1 expected	2 expected 	3 expected 

Maternity Workforce

Retention over the last 5 years

Sustained improvement in retention for both Midwives and Midwifery Support workers over the last 5 years



Maternity Workforce

Triangulation – Staffing and Incidents	
<u>Staffing shortages</u> - Ran short by more than one midwife on 16 days in March. Highest shortage was on the 23rd when we were 5 short on the Early and 2 short on the Late due to sickness. - Ran short by more than one midwife on 7 nights in March. Highest shortages were on the 13th, 24th and 28th when we ran 3 midwives short - Sustained improvement in both Midwife and MSW retention - Good support from education team for newly qualified midwives	<u>Reported Incidents</u> - Average number of reported incidents on day shifts was 2.65 - On the days with shortages of more than one, the average number of reported incidents was 2.88 - Average number of reported incidents on night shifts was 1.45 - On the nights with shortages of more than one, the average number of reported incidents was 0.86
<u>Ward Clerk shortages</u> - Significant issue and risk for maternity at present - Night shifts all covered as only require 1 across the unit - Days were significantly short: 5 days were fully staffed 13 days were 1 out of 4 short 11 days were 2 out of 4 short 2 days were 3 out of 4 short	<u>Information governance or security breaches</u> 7 incidents in March related to information governance or issues with discharge information reaching community staff

Saving Babies Lives Care Bundle Q3 2025/26



Saving Babies Lives Care Bundle Update - 2026

Key Messages

- The Saving babies' lives care bundle provides evidence-based best practice for providers and commissioners of maternity care across England to reduce perinatal mortality
- Aims to support earlier identification and timely management of risk
- Central to improving perinatal safety, quality of care, and outcomes for babies and families
- **Element 1: Reducing Smoking in Pregnancy**
 - Support to identify and reduce maternal smoking to improve fetal outcomes
- **Element 2: Risk Assessment & Surveillance for Fetal Growth Restriction (FGR)**
 - Early identification and monitoring of babies at risk of poor growth
- **Element 3: Raising Awareness of Reduced Fetal Movement (RFM)**
 - Encouraging timely reporting and clinical response to concerns about baby's movements
- **Element 4: Effective Fetal Monitoring During Labour**
 - Improving CTG interpretation and response to reduce intrapartum harm
- **Element 5: Reducing Preterm Birth**
 - Identification and management of women at risk of preterm labour
- **Element 6: Management of pre-existing Diabetes**
 - Multidisciplinary team pathways for women with Type 1 or Type 2 diabetes

Saving Babies Lives Care Bundle Update - 2026

Current position

- Substantial improvement from baseline (35% → 94–96%), demonstrating strong programme impact since 2023
- All elements show marked progression from low starting points, particularly Elements 1, 3, 4, and 6
- Elements 2, 3 and 4 now at sustained 100% compliance, indicating full embedding of key processes
- Element 1 improved from 20% to stable 90%, reflecting consistent high compliance
- Element 5 shows strong gains (48% → 92–100%), but not yet consistently at full compliance
- Element 6 improved significantly (17% → 83%); subsequent reduction in compliance during 2025/26 reflects updated measurement requirements rather than deterioration in practice
- Overall position:** high compliance achieved and sustained, with targeted improvement required in Elements 5 and 6 and continued monitoring and improvement for Element 1

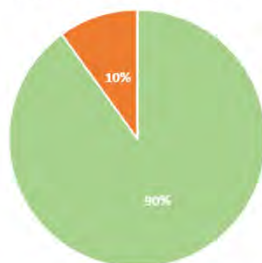
	Baseline Assessment	Assessment 9	Assessment 10	Assessment 11
Review Quarter	Initial Sub	Q1 2025/26	Q2 2025/26	Q3 2025/26
Assurance Review Date	10/10/2023	03/11/2025	12/02/2026	
Element 1	20%	90%	90%	90%
Element 2	35%	100%	100%	100%
Element 3	0%	100%	100%	100%
Element 4	20%	100%	100%	100%
Element 5	48%	92%	100%	96%
Element 6	17%	83%	67%	67%
TOTAL	35%	94%	96%	94%

% of Interventions Fully Implemented (LMNS Validated)

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Partially Implemented	90%	Partially Implemented	90%
Element 2	Fetal growth restriction	Fully implemented	100%	Fully Implemented	100%
Element 3	Reduced fetal movements	Fully implemented	100%	Fully Implemented	100%
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%
Element 5	Preterm birth	Fully implemented	100%	Partially Implemented	96%
Element 6	Diabetes	Partially implemented	83%	Partially Implemented	67%
All Elements	TOTAL	Partially Implemented	97%	Partially Implemented	94%

Saving Babies Lives Care Bundle Update - 2026

Element 1: proportion of interventions implemented



Element 1: Reducing Smoking in Pregnancy

- **Outcome indicator - Verified Quite Rate:** Successful quarter showing improvement from Q2 (66.7%) to 70.4% in Q3. (Requirement is 50%)
- **Outcome indicator – Percentage of smokers at booking who are identified as non-smokers via CO reading at 36 weeks:** 100% of those taking part in National Smoke free pregnancy incentive scheme or swap to stop successfully quit in Q2
- **Outcome indicator – Percentage of smokers who are referred for tobacco dependence treatment who set a quit date:** SBL requirement is for quit rates set against total referrals = 33.3% (Q2 = 23.5%), however, 38.3% of those referred declined the service and 17.3% we were unable to contact.
- When the quit dates are set against those who engaged with the service you can see there is a significant increase to 83.9% - this would meet threshold for SBL this quarter. (Requirement is 60%)

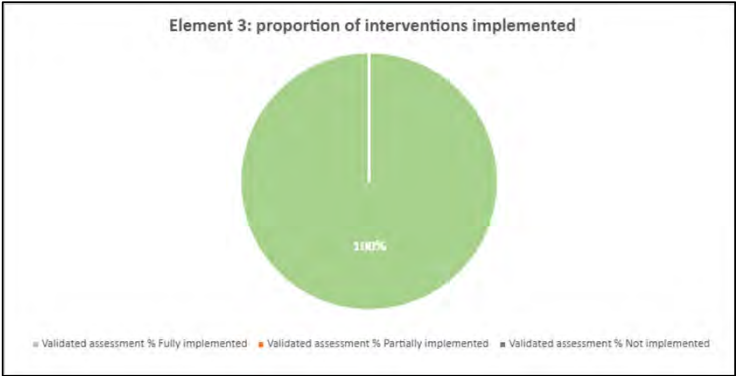
Element 2: proportion of interventions implemented



Element 2: Risk Assessment & Surveillance for Fetal Growth Restriction (FGR)

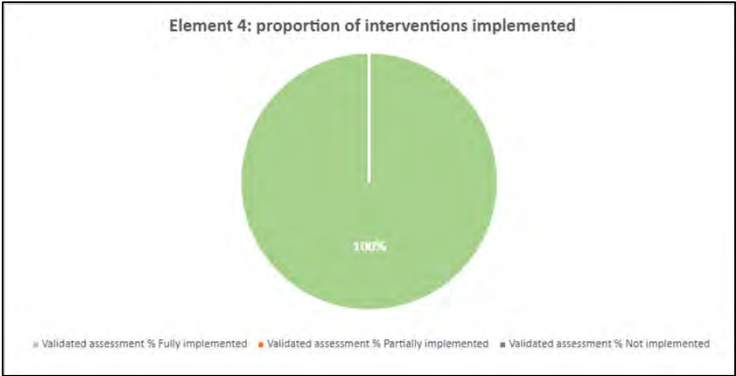
- Fully Implemented

Saving Babies Lives Care Bundle Update - 2026



Element 3: Raising Awareness of Reduced Fetal Movement (RFM)

- Fully Implemented



Element 4: Effective Fetal Monitoring During Labour

- Fully Implemented

Saving Babies Lives Care Bundle Update - 2026

Element 5: proportion of interventions implemented



■ Validated assessment % Fully implemented ■ Validated assessment % Partially implemented ■ Validated assessment % Not implemented

Element 5: Reducing Preterm Birth

- **Outcome indicator – Guideline evidencing that each woman with a history of preterm birth is reviewed to determine whether this was associated with placental disease and prescribing aspirin takes place:** New guideline updated and submitted as evidence – however Q3 submission feedback received that the guideline doesn't appear to include placental disease and use of aspirin. To discuss with Preterm SBLCB leads

Element 6: Management of pre-existing Diabetes

- **(6.1) Process indicator – The multidisciplinary team should consist of, as a minimum: obstetric consultant, diabetes consultant, diabetes specialist nurse (DSN), diabetes dietician, diabetes specialist midwife (DSM):**
And
- **(6.2) Process indicator – Demonstrate appropriate expertise to onboard and manage pregnant women using pregnancy specific HCL:**
- Both received feedback from Q3 submission as partially implemented, due to MDT not including the required DSN. Action plan in place aiming to review several barriers to providing this service at Medway, including collaborative working with the Adult Diabetes Specialist Pump Nurses, training for the Specialist Diabetes Midwives, review of funding sources and access to vital programmes associated with HCL systems. This action plan also includes a review of current staffing to support this service.

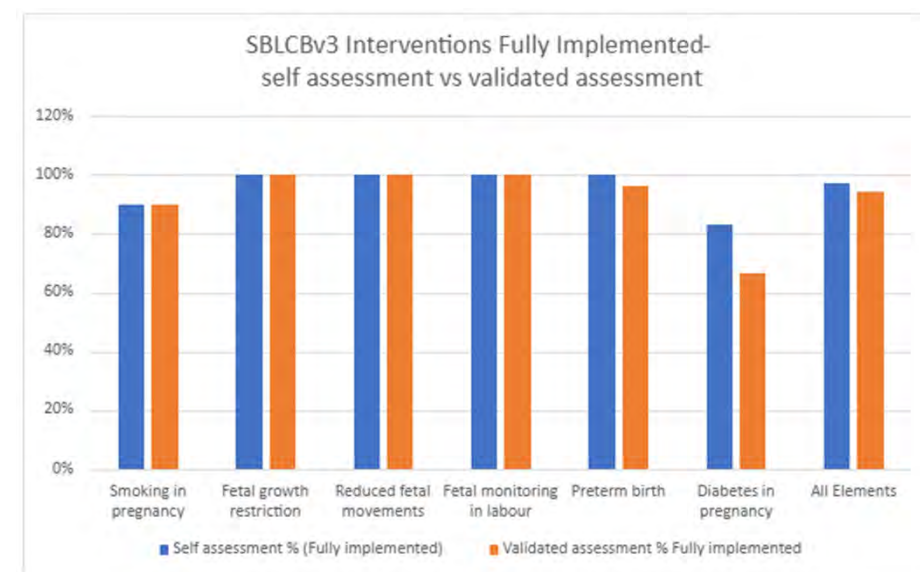
Element 6: proportion of interventions implemented



■ Validated assessment % Fully implemented ■ Validated assessment % Partially implemented ■ Validated assessment % Not implemented

Saving Babies Lives Care Bundle Update - 2026

Issues, Concerns and Gaps	Next Steps
• Element 1: Large drop-off between referral → engagement → quit date, impacting overall compliance • Variation between reported and actual effectiveness. Meets threshold when measured against engagement, but not against total referrals (SBL requirement) • Element 5: Guideline gap identified - Although an updated guideline was submitted, Q3 feedback indicates it does not clearly evidence assessment of placental disease or inclusion of aspirin prescribing. • Element 6: MDT not fully compliant with SBLCB requirement due to absence of Diabetes Specialist Nurse (DSN) impacting Element 6.1 compliance • Partial implementation of HCL pathway (Element 6.2). Limited specialist expertise available to safely onboard and manage patients • Workforce and capacity gaps. Current staffing model does not fully support required service delivery	• Element 1: Strengthen referral conversation quality (clear messaging, personalised support) and implement early, proactive follow-up within 24–48 hours, including multi-channel contact approach (call, text, digital) • Element 5: Engage with Preterm SBLCB leads to validate required standards and expectations and ensure alignment with national SBLCB guidance • Element 6: Review staffing model and recruitment options to secure DSN input • Continue to explore formalised collaboration with Adult Diabetes Specialist Pump Nurses



Meeting of the Trust Board in Public

Date: 01 July 2026

Title of Report	Resident Doctor Working Lives – NHS England 10-Point Plan Progress Update			Agenda Item	6.9
Stabilisation Plan Domain	Culture	Performance	Governance and Quality	Finance	Not Applicable
	X	X	X	X	
CQC Reference	Safe	Effective	Caring	Responsive	Well-Led
		X		X	X
Author and Job Title	Dr Ashike Choudhury, Director of Medical Education				
Lead Executive	Alison Davis, Chief Medical Officer				
Purpose	Approval	X	Briefing	X	Noting
Proposal and/or key recommendation:	The Board is asked to: 1. Note progress against the NHS England 10-Point Plan based on the December 2025 return. 2. Note the current assurance position and risk profile. 3. Approve development of a Resident Doctor Wellbeing Practitioner business case. 4. Approve formal adoption of the Safe Learning Environment Charter (SLEC). 5. Note future updates including benchmarking and outcome measures. 6. Note governance arrangements, including Senior Lead, Peer Lead and NED support.				
Executive Summary	This paper provides an update on the Trust's delivery of NHS England's 10-Point Plan for Resident Doctor Working Lives. The Trust has demonstrated a positive improvement trajectory, achieving 76% compliance (+13pp improvement) with no red-rated areas. Progress includes improvements in wellbeing infrastructure, payroll processes, exception reporting implementation, and governance. Delivery is formally aligned to Board Assurance Framework Item 14 (Culture), which remains at risk score 12 (High) with around 75% of actions complete, reflecting ongoing delivery and the need for sustained embedding before measurable risk reduction. Residual risks relate to equity of workforce experience, including annual leave, protected breaks, and facilities. These align with regional system pressures.				

	The paper seeks approval for SLEC adoption and progression of a wellbeing practitioner model, supporting transition from compliance to sustained improvement and cultural change.			
Issues for the Board/Committee Attention:	• Positive trajectory with no red risks • BAF Item 14 remains high risk (score 12) despite progress • Financial risk from exception reporting reforms (£250–£500 fines) • Persistent system-wide workforce issues Increasing national scrutiny			
Committee/ Meetings at which this paper has been discussed/ approved: Date:	People Committee- 20 May 2026			
Board Assurance Framework/Risk Register:	This programme aligns to BAF Item 14 (Culture – Resident Doctors), which remains rated 12 (High) with ~75% actions complete, reflecting delivery progress but need for sustained embedding before risk reduction.			
Financial Implications:	No material financial impact at present. However, exception reporting reforms introduce financial exposure, including: £250 fines (Feb 2026) £500 fines (Aug 2026) Mandatory response timelines (10 → 7 days) Effective compliance is therefore both a financial control and workforce priority.			
Equality Impact Assessment and/or patient experience implications	Positive impact through improved wellbeing, safety, and workforce experience. No adverse impacts identified.			
Freedom of Information status:	Disclosable	x	Exempt	

1. Background and Context

In August 2025, NHS England issued a national letter titled “Getting the Basics Right for Resident Doctors” to all Trusts in response to widespread concerns raised by resident doctors. These concerns, identified through national surveys, workforce engagement, and industrial relations discussions, highlighted persistent operational and cultural challenges affecting working conditions.

The issues identified included:

- Payroll errors, particularly during rotational changes
- Delays and inconsistency in rota and work schedule communication
- Limited or inequitable access to annual leave
- Inadequate access to rest facilities, lockers, and accommodation
- Poor access to food, particularly out of hours
- Duplication of mandatory training requirements across organisations
- Barriers to exception reporting
- Concerns regarding psychological safety and learning culture

NHS England emphasised that these were basic, solvable issues, but that failure to address them had direct consequences for workforce morale, recruitment, retention, and patient care. It was made clear that trusts could not pay lip-service to these issues and that they should be taken as a real priority.

2. NHS England 10-Point Plan

The accompanying 10 Point Plan set out clear expectations for all Trusts, including:

1. Improving workplace wellbeing and facilities
2. Ensuring compliance with rota notice requirements
3. Supporting fair access to annual leave
4. Appointing named senior and peer leaders
5. Eliminating payroll errors
6. Preventing duplication of mandatory training
7. Strengthening exception reporting systems
8. Improving reimbursement processes
9. Reducing the impact of rotations
10. Expanding the Lead Employer model

Trusts were expected to deliver initial improvements within 12 weeks, with ongoing national monitoring and reporting

Oversight is provided through:

- People Committee
- Escalation to Trust Board by exception
- Regular engagement with resident doctors through structured forums

This ensures clear alignment with NHS England requirements for Board-level accountability and engagement.

4. Delivery Against the Plan

Strengths

Wellbeing infrastructure

- Access to rest facilities, 24/7 food, and accommodation

Payroll

- Reduction in errors following provider changes and monitoring improvements

Exception reporting

- New system embedded with oversight mechanisms

Training

- Acceptance of training completed elsewhere- in line with national policy (Memorandum of Understanding)

Governance

- Clear leadership roles and escalation pathways

Ongoing Challenges

Annual leave access

- Tension between patient safety risks in maintaining safe staffing levels

Protected breaks

Parking and facilities

5. Performance and Benchmarking

Trust Position

76% score

+13pp improvement

No red actions

Submission fully supported by Resident Doctor Peer Lead

Improving Doctors Working Lives Programme - The 10 Point Plan

Provider: MEDWAY NHS FOUNDATION TRUST

Amenities	Baseline survey	12-week progress
Access to Lockers	Yes, <50%	Yes, <50%
Rest facilities	Yes	Yes
Designated on-call parking access	No	Yes
Access to hot and cold food 24/7	Yes	Yes
Access to cold food 24/7	Yes	Yes
Inductions specifically designed to meet the needs of Resident Doctors	Yes, <50%	Yes, >50%
Beds/sleeping pods available free of charge	Yes	Yes
Are Resident doctors able to work from home for portfolio and self-directed learning?	No	No
Access to free psychological support treatment?	Yes	Yes
Positive feedback mechanisms in place to reward and promote staff?	Yes, <50%	Yes
Protected breaks?	Yes, <50%	Yes, <50%
Do you promote the Safe Learning Environment Charter?	No	Plan to
Sexual safety/harassment training and awareness?	No	Plan to

Appointing senior leads to take action on Resident Doctor issues	Baseline survey	12-week progress
Has your Trust Board appointed a senior named, accountable Resident Doctor Lead?	Yes	Yes
Has your Trust Board appointed a Resident Doctor Peer Lead?	No (consult with LNC/ equiv. bodies)	Yes
At what levels of your organisation have you reviewed and discussed the following surveys? (None, Executive team, Trust Board, People Committee, Two out of Three, or All)		
GMC Training survey	All	All
NETS survey	People Committee	People Committee
National Staff Survey		All
National Student Survey		None

Annual Leave	Baseline survey	12-week progress
Is there a local policy to encourage good annual leave management which references resident doctors?	Yes	No
Good annual leave practice covered at resident doctor induction?	Yes	Yes
Allow resident doctors to carry over annual leave between rotations?	Yes (internal rotations)	Yes (internal rotations)
Do rostering systems for Resident Doctors allow for self/preferential rostering?	Yes	No

Payroll and Expenses	Baseline survey	12-week progress
Implemented local SLAs and introduced board-level governance for tracking/reporting payroll errors?	No	Yes
Changes in payroll errors over the last 12 months?	Decrease in errors	Decrease in errors
Processing of course related expenses?	After course attendance	When course is booked

Mandatory Training & Learning	Baseline survey	12-week progress
Do you accept resident doctors' mandatory training from other sites and follow the People Policy Framework (May 2025)?	Yes, MOU only	Yes, both
Does the Resident Doctor Peer Lead support the findings as set out in this survey?	Fully supports	

* 12-week progress survey

76%

(Improvement of 13pp)

* The survey score is calculated by averaging the percentage scores of each scored question. Please refer to the points scheme for specific scoring criteria.

Regional Context (South East)

26/26 Trusts (100%) submitted follow-up returns
100% of Trusts provide access to free psychological support
Common regional challenges include:

- Designated on-call parking
- Protected breaks
- Promotion of SLEC

Medway's performance is consistent with or better than peers, with no outlier risk identified

6. Exception Reporting Reforms

The new framework introduces:

Mandatory processing deadlines
Financial penalties (£250–£500)
Enforceable compliance

This shifts from reputational risk → financial and regulatory risk.

6.4 BAF Alignment (Item 14)

“Failure to implement the 10 Point Plan could significantly undermine... wellbeing and retention of resident doctors.”

Current score: 12
75% actions complete
Risk unchanged
Indicates need for embedding not just delivery

7. Culture and Safe Learning Environment Charter (SLEC)

SLEC supports:

- Psychological safety
- Learning culture
- Speaking up

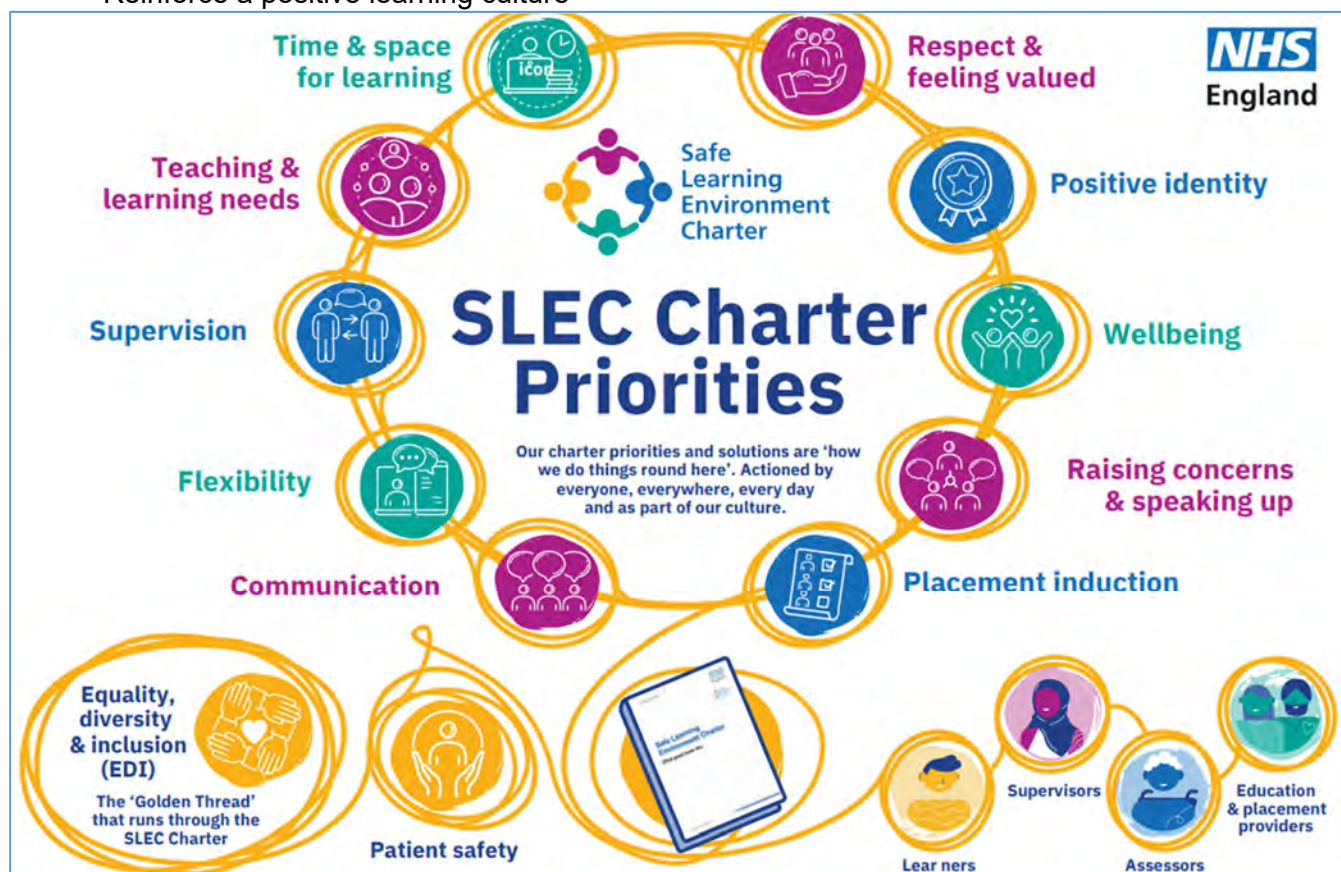
At Medway, the Charter's principles are already embedded through the Faculty of Clinical Education, comprising:

- Medical Education
- Organisational Development
- Nursing Education
- Library Services
- Resuscitation Services

Formal Board adoption will:

- Provide clear organisational endorsement
- Strengthen CQC Well-Led assurance

- Reinforce a positive learning culture



8. Local Learning

Examples:

Simulation-based induction (Simway Hospital)

- Associated with reduced anxiety-related sickness absence

Enhanced wellbeing provision including:

- Staff mess
- 24/7 food access
- "Too tired to drive" facilities

Regular senior leadership engagement with resident doctors. These demonstrate a shift from reactive to preventative approaches.

9. Risks and Mitigation

Risk	Mitigation
Failure to fully implement the NHS England 10-Point Plan (BAF Item 14 – Culture) may negatively impact resident doctor wellbeing, retention, and organisational reputation	Structured delivery via action log with named leads; People Committee and Board oversight; adoption of SLEC; measurable improvement demonstrated (+13pp)
Exception reporting non-compliance may result in financial penalties (£250–£500 per breach) and reputational risk	Implementation of new exception reporting system; regular oversight meetings; strengthened governance and monitoring
Inconsistent workforce experience (annual leave, breaks, facilities) may impact staff wellbeing and retention	Policy standardisation, SOP development, monitoring through surveys and feedback mechanisms
Dependency on national NHSE programmes (rotations, lead employer model) may limit local control	Ongoing engagement with regional/national workstreams and local mitigation where possible
Increased external scrutiny and reporting may lead to reputational risk if progress is not sustained	Continued improvement trajectory, transparent reporting, and benchmarking against regional peers

10. Next Steps

- Resident Doctor Wellbeing practitioner business case
- Continued delivery
- Benchmarking vs peers
- BAF alignment
- External reporting readiness

10.1 Resident Doctor Wellbeing Practitioner – Business Case Development

As part of the Trust's next phase of delivery, a proposal is being developed to introduce a Resident Doctor Wellbeing Practitioner role, funded through the medical education budget.

Rationale

While significant progress has been made in addressing operational issues through the 10-Point Plan, resident doctor feedback and national evidence indicate that:

- Many concerns escalate late, once issues have become entrenched
- Existing support structures (educational supervisors, line management) may not always provide independent or psychologically safe routes for disclosure
- Cultural issues, including those addressed through the Safe Learning Environment Charter, require ongoing proactive support mechanisms

The proposed role addresses this gap by providing confidential, independent, and accessible support, aligned to NHS England's wider workforce wellbeing expectations.

Proposed Role and Functions

The Resident Doctor Wellbeing Practitioner would:

- Provide independent pastoral and wellbeing support, separate from training and supervisory hierarchies
- Offer early intervention to prevent escalation of concerns (including those that may otherwise result in exception reporting or formal complaints)
- Support resident doctors to navigate organisational systems (e.g. HR, occupational health, educational support)
- Contribute to thematic learning and feedback, identifying systemic issues and informing improvement actions
- Work closely with the Director of Medical Education, Guardian of Safe Working, and People function, while maintaining confidentiality boundaries

Strategic Benefits

The introduction of this role is expected to:

- Improve staff experience and psychological safety, aligned with SLEC principles
- Support reduction in escalation of workforce issues, including exception reporting disputes
- Reduce organisational and financial risk, particularly in the context of the new exception reporting fine regime
- Strengthen BAF Item 14 mitigation, supporting movement from delivery to sustained embedding
- Enhance recruitment and retention of resident doctors, supporting workforce sustainability

Financial and Governance Considerations

The business case will:

- Be developed within existing medical education funding envelopes, minimising additional financial pressure
- Set out clear governance arrangements, reporting through Medical Education structures and People Committee
- Include evaluation metrics, such as:
 - Uptake and utilisation
 - Resident doctor feedback
 - Trends in exception reporting
 - Workforce retention indicators

11. Conclusion

The Trust has delivered credible early improvement, with:

- Strong governance
- No red risks
- Measurable progress

Next phase requires sustained delivery and cultural embedding.

Meeting of the Trust Board in Public

Meeting Date: 01 July 2026

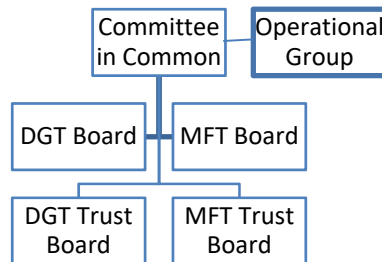
Title of Report	Committee in Common Terms of Reference			Agenda Item	6.10
Stabilisation Plan Domain	Culture	Performance	Governance and Quality	Finance	Not Applicable
			x		
CQC Reference	Safe	Effective	Caring	Responsive	Well-Led
	x	x	x		
Author and Job Title	Victoria Moore, Deputy Trust Secretary, DGT				
Lead Executive	Fiona Wise, NHSE Board Advisor, MFT				
Purpose	Approval	x	Briefing		Noting
Proposal and / or key recommendation:	The Boards are asked to AGREE the Terms of Reference, including the proposed reporting arrangements and establishment of an Operational Group to support delivery of the Committee's workplan.				
Executive Summary	This paper presents the draft Terms of Reference (ToR) for the proposed Committees in Common (CiC) arrangement between Dartford and Gravesham NHS Trust (DGT) and Medway NHS Foundation Trust (MFT). The CiC provides a lawful governance mechanism to enable aligned, timely and coordinated decision-making across both organisations in support of the developing Group model, while preserving the statutory accountability of each Trust Board.				
Issues for the Group/Committee/Board Attention:	Key considerations include: - The April Board-to-Board meeting approved the establishment of a Committee in Common as the preferred governance mechanism to support the next phase of joint working. - The draft ToR have been developed and refined following discussion with the Chairs and Chief Executives of both Trusts, including clarification of delegated authority, decision-making, escalation and reporting arrangements. - The ToR confirm the establishment of an Operational Group, reporting into the Committee in Common, with responsibility for delivery of the Committee's agreed workplan. - The interim CEO's at DGT and MFT have now met and have agreed a draft set of terms of reference for the proposed Operating Group and supporting Principles Charter. It is their intention to convene an early meeting of the Operational Group to agree these TOR and agree a work-plan, taking account of other initiatives across the Kent & Medway System. - Once a work-plan has been drafted and subject to the Board agreement to establish the Committee in Common they will ask for the Committee in Common to meet to agree the terms of				

	reference for the Operational Group and its associated work-plan. Thus is likely to be in early July 2026			
Meetings at which this paper has been discussed / approved: Date:				
Board Assurance Framework / Risk Register:	- Establishing clear, effective joint governance arrangements is expected to improve patient experience by enabling more consistent clinical pathways, reduced variation, and stronger cross-trust coordination. - No adverse impacts on patient experience or health inequalities are anticipated. - Clear governance mitigates risks of inconsistent decision-making across the Group, supporting equitable access to care.			
Financial Implications:	- No direct financial impact arises from selecting a governance mechanism. - However, the chosen model may influence the pace and effectiveness of joint business cases, transformation schemes, and cross-trust efficiencies. - A Joint Committee may streamline approvals for joint investments but must operate within the lowest SFI limit across both Trusts (MFT FT limits prevailing).			
Integrated Impact Assessment (IIA) implications				
Freedom of Information status:	Disclosable		Exempt	

COMMITTEE IN COMMON

Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust

MAY 2026



Summary of Purpose	• The Committees-in-Common (“CiC”) are established by Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust to enable aligned, timely and coordinated decision-making across both organisations in support of the developing Group model. • Each Trust remains an independent statutory body with its own Chair, and Chief Executive. • The CiC provide a formal and lawful mechanism for both organisations to consider matters on a shared agenda and to take decisions in parallel, within the limits of authority delegated by each Trust Board. This model supports greater collaboration, consistency of clinical and corporate standards, and more efficient delivery of agreed Group priorities, while preserving the statutory accountability of each Board. • The CiC will focus on areas where coordinated decisions add value, including shared clinical pathways, joint improvement programmes, and enabling functions, and will operate in line with NHS England guidance on good governance and collaboration, ensuring clarity, transparency, robust delegation and set a clear case for benefit realisation. • The CiC do not replace the statutory responsibilities of either Trust Board; rather, they provide a structured forum through which the two organisations can work together effectively and lawfully to progress Group ambitions and improve outcomes for the populations they serve and the wider Kent and Medway system.
Legal and Policy basis	• CiC is an arrangement permitted under the NHS framework for delegation and joint working, provided each body decides independently and within lawful delegations. The arrangement must

	comply with the Health and Care Act 2022 and NHS England's statutory guidance on delegation and joint exercise of functions. • Governance must align to the NHS Provider Licence (good governance) and each Trust's Standing Orders / SoRD / SFIs. • The ToR adopts established practice from "meetings-in-common" models used nationally where merger is not possible but single-conversation leadership is desired.
Authority	• Each trust establishes its own statutory committee, meeting concurrently with the other ("Committees-in-Common"). • Each Committee makes decisions for its own trust only, even if the decisions are identical. • Delegated powers derive from each Trust's Scheme of Reservation & Delegation (SoRD) and Standing Financial Instructions (SFIs). • The CiC is not a joint committee and does not constitute a new legal entity. • FT-specific: Nothing in these ToR fetters the statutory independence of the MFT Board or contradicts the MFT Constitution. The FT participates in CiC subject to Provider Licence governance conditions (NHS2/FT4). (see <i>Annex A</i>)
Membership	Each Trust retains a separate Chair and a separate Chief Executive, the following structure preserves accountability and manages conflicts: When committees in common which include at least one Foundation Trust (FT), then, membership of the FT's committees is restricted to voting directors of the FT only. DGT Committee • Chair: DGT Chair • Members: ○ DGT CEO ○ DGT Deputy CEO ○ DGT Chief Medical Officer ○ DGT Chief Nursing Officer ○ DGT Chief Finance Officer ○ Two DGT NED (nominated) MFT Committee • Chair: MFT Chair • Members: ○ MFT CEO ○ MFT Deputy CEO ○ MFT Chief Medical Officer ○ MFT Chief Nursing Officer ○ MFT Chief Finance Officer

	○ Two MFT NED (nominated) Attendees (Non-Voting): • DGT and MFT Chief Operating Officers • DGT and MFT Chief People Officers • DGT Director of Transformation • Group and Trust governance leads • Other attendees agreed by the Chair • If the Committee Chairman is absent from the meeting, another Non-Executive Director, as the members present shall choose, shall preside. • Other staff may be co-opted to attend meetings as considered appropriate by the committee on an ad hoc basis as recommended by the operational group. • Regular attendees to be invited to attend at the discretion of the Committee Chair. • The names of the members of the Committee shall be published in the Trust's Annual Report. • Member and attendees are required to fully participate and contribute to the meetings thereby enabling the Committee to comply with its Terms of Reference.
Quorum	• Each committee must include at least one NED, one executive, and the Chair (or nominated Chair). • If quorum is lost for one trust, no "group" decision can be taken.
Chairing Arrangements	• Chairs of each committee convene jointly and open/close meetings simultaneously.
Meeting Arrangements	• Meetings are held at the same time, sharing identical agendas and papers. • Each committee maintains its minutes ○ Minutes will contain: ▪ "DGT decision" ▪ "MFT decision" ▪ "Decision-in-Common: Yes/No" This approach mirrors NHSE/NHSI's established <i>meetings-in-common</i> model.

Attendance	• <i>Members must attend a minimum of 75% of meetings across a 12 month period.</i> • An officer in attendance for an Executive Director may count towards the quorum of either committee, if the Chair of the is advised and agrees at the commencement of the meeting. It will be recorded in the minutes of the meeting that the officer is deputising for the Executive Director and forms part of the committee's quorum for that meeting only • Each committee Chair will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the meetings and may change, alter or vary these terms and conditions as it deems fit.
Frequency of Meetings	• The meetings will take place at least 2 times a year • At the discretion of the Committee Chairman, additional meetings may be convened to fulfil its main functions.
Status of Meeting	• Meeting of the Committee in Common will be held in private. Matters discussed at the meeting should not be communicated outside the meeting without prior approval of the chair of the committee. A summary escalation report from each meeting will be reported to the public session of each Trust Board unless they contain information which relates to an individual patient or member of staff or that it is commercially sensitive. • Where a matter is considered confidential, submission of a Part 2 report to DGT and MFT Trust Boards will be undertaken.
Responsibilities/Main Duties	Clinical and Operational Transformation • Approval of shared clinical service models, pathways, standards and specifications for selected specialties Group-level Strategy & Delivery • Endorsement/approval (within delegated limits) of joint business cases, service improvement proposals, pathway reconfiguration for Board ratification where required. • Group-wide productivity and efficiency programmes. Shared Enabling Functions • Diagnostics, pathology, procurement, digital architecture, estates interoperability. Workforce & Leadership • Joint workforce models, shared recruitment strategies, cross-site rota harmonisation (where lawful).

	Benefit Realisation - All cases should be supported by a clear benefit realisation statement Risk - Associated risks and mitigations
Out of Scope (Non-Delegable)	The CiC must not take decisions in the following areas (to remain with each Trust Board): - Statutory functions prohibited from delegation under the Health & Care Act 2022 regulations, including specified regulatory duties. - Approval of annual accounts, annual report, quality account, significant transactions, or regulatory submissions. - Appointment or removal of the Chair, NEDs, CEO, or Executive Directors. - Audit, remuneration, and nominations matters. (Consistent with national rules: joint audit/remuneration committees are not permitted.) FT-specific: appointment/removal of the FT Chair, Non-Executive Directors or Chief Executive; significant transactions as defined in the FT Constitution; any matter reserved to the FT Board or requiring Governor engagement/approval. (<i>see Annex A</i>)
Conflicts of Interest	- All members must declare interests. - Dual roles (e.g., shared CEO, Non-Executive Directors) must be explicitly noted. - Chairs may request the CEO to step out for particular items to maintain integrity.
Decision Making	- Each committee makes its own decision; no automatic alignment is assumed. - A “Decision-in-Common” is achieved only when both committees approve substantively identical resolutions. - If one committee does not approve this ~~is escalated to both Board~~ it is initially escalated to a meeting of the Chairs and CEOs of each Trust to seek resolution. The outcome of this discussion to be reported to Both Boards for ratification if required.
Escalation Procedure	Escalation required when: - Committees disagree; - Delegation limits exceeded;

	3. A conflict prevents a fair decision. - Route: CiC to Trust Chairs to Both Boards. Possible mediation via CEO's and Trust Secretaries. FT-specific: Any item that triggers significant transaction tests or Governor-related requirements must escalate to the MFT Board, regardless of CiC discussions. (see Annex A)
Committee in Common Reporting Lines	Reporting In - An Operational Group will be established by both Chief executive Officers to support delivery of the Committee's agreed workplan and will report into the Committee. - The membership and terms of reference of the Operational Group will be agreed by the Committee once the workplan has been established, to ensure appropriate representation and expertise aligned to the programme of work. Reporting Out - The Chair of the Committee should provide an update at the next available meeting of the Trust Board on the key matters discussed at the last Committee and should include: - Decisions taken - Items escalated - Risks and Mitigations - Benefits realisation progress - If the Committee wishes to make recommendations to the Trust Board, it should be prepared to supplement the Committee Chair's verbal report with a written report, outlining the basis for its recommendations. The need for such a written report should be determined by the Trust Board, but if necessary (due to timing), should be determined following discussion between the Committee Chair and the Chair of the Trust Board.
Reporting and Review	- An escalation report from each meeting will be presented to the respective Trust Board for ratification and will be published as part of the Trust's Board papers. - Terms of Reference will be reviewed at least annually - Once agreed the Terms of Reference will be received by and ratified by each Trust Board. - The Committee will carry out an Annual review of its effectiveness and provide an annual report to the Board on its work in discharging its responsibilities, delivering its objectives and complying with its terms of reference, specifically commenting on relevant aspects of the Board Assurance Framework and relevant regulatory frameworks.

	The Board can amend, change or dissolve the Committee in accordance with the Trust's Standing Orders.
Administration	- Trust Secretaries of both Trusts will jointly manage agendas, paper circulation, minutes, escalation and compliance. - Agendas and papers to be distributed in advance of the meeting. - The Committee members will approve the minutes of the previous meeting at the start of the next meeting.

Revision History	
1	First draft shared with Board to Board April 2026
2	Revised draft shared with Board to Board May 2026 seeking recommendation to DGT and MFT Boards for approval
3	Amended following Joint Board meeting on 5 May 2026
4	Amended following discussion with Chief Executives and Chairs May 2026

Annex A — Medway NHS Foundation Trust Specific Provisions

These provisions apply to Medway NHS Foundation Trust as a Foundation Trust participating in the CiC. They should be read in addition to the integrated ToR above.

1. **Statutory independence of the FT Board**
Nothing in the CiC fetters or diminishes the FT Board's statutory independence under the NHS Act 2006 and the FT Constitution. The FT participates in CiC subject to its own Reserved Matters and constitutional requirements.
2. **Council of Governors**
The Council of Governors does not participate in CiC decisions. CiC arrangements must not undermine the Governors' duty to hold the NEDs to account and represent members/the public. The FT Board will ensure the Governors are appropriately informed about CiC as part of routine governance communications.
3. **Provider Licence (NHS2 / formerly FT4)**
CiC participation must comply with the Provider Licence governance condition, maintaining effective systems of corporate governance, internal control and risk management. The FT will evidence this in its Annual Governance Statement.
4. **Restrictions on delegation**
The FT shall not delegate via CiC:
 - Appointment/removal of the FT Chair, NEDs or Chief Executive;
 - Approval of the FT Annual Report/Accounts or Quality Account;
 - Determination of Significant Transactions as defined by the FT Constitution;
 - Any other matter expressly reserved to the FT Board or prohibited by law/NHSE guidance.
5. **Distinct delegation limits**
FT decisions via CiC are bounded by the FT SoRD/SFIs (limits may differ from the NHS Trust). When an item exceeds FT limits, it must escalate to the FT Board, irrespective of the other CiC committee's decision.
6. **Significant transactions & Governor engagement**
Where a proposal may constitute a Significant Transaction for the FT, it will escalate to the FT Board for determination and, where the Constitution requires, Governor engagement/approval before any decision is finalised.
7. **Reporting to FT Board and Annual Report**
The CiC will provide a formal report after each meeting for the FT Board, supporting the Board's assurance to the Council of Governors and disclosures in the Annual Governance Statement/Annual Report in line with the FT ARM and Code of Governance.
8. **Conflict management**
Dual roles (e.g., shared Chief Executive or Non-Executive Directors) will be managed through declaration, alternative chairing or recusal as needed to protect the FT Board's independence and the Governors' oversight role.
9. **Prevail clause**
In any conflict between these ToR and the FT Constitution, the FT Constitution prevails for all matters applying to the Foundation Trust.