NHS
East Kent Hospitals University
NHS Foundation Trust

Quality Account 2024/25

We care

Contents

Part 1. Statement on Quality from the Chief Executive and Chair

Welcome to the 2024/25 Quality Account for East Kent Hospitals University NHS Foundation Trust (EKHUFT).

Over the last 12 months we have made significant progress in enhancing clinical performance, improving quality and patient outcomes and strengthening operational efficiency. These accomplishments are a testament to the commitment of our staff in the face of ongoing challenges and we want to thank them for their dedication and support.

Throughout the year we have focused on reducing waiting times for patients and have made significant and sustained progress.

The national standard for providing planned care asked that no patient waited more than 65 weeks for their care and that this was delivered by the end of March 2025. While we recognise any wait for treatment has an impact on the patient and their family, at the end of March, there were 33 patients who had waited longer than this timeframe, which marks a significant reduction from a peak of 2,698 in January 2024.

It remains a key priority that we continue our drive to reduce the waiting times for planned care and the Trust's goal for the next year will be to treat 60% of patients

within 18 weeks and reduce the number of people waiting more than a year to no more than 1% by the end of March 2026.

We have also made significant progress this year in achieving national standards for diagnostic tests and cancer diagnosis and treatment times.

Our emergency and urgent care services and ‘flow’ of patients through our hospitals remained an area of significant pressure throughout the year. We achieved improvements in the number of people being seen, discharged or admitted to hospital within the four-hour standard, but with hospitals full to capacity, high numbers of patients waited more than 12 hours for a bed.

This is not what we want for our patients, and we are working hard this year, with our partners in health and social care, to address the many issues that contribute to these long waits.

Our finances

The Trust remained on track to reduce its deficit throughout the year. We had a significant cost savings improvement programme target of £49m to deliver as part of a longer-term plan to return to financial balance. This was achieved and the Trust ended the year meeting its agreed financial deficit of £85.8m.

Meeting our financial target for 2025/26 represents a challenge for the Trust to deliver as it works to improve patient care and meet NHS national standards. It is, however of critical importance that we continue to take action and make strides forward in 2025/26 to return to financial balance in the coming years.

Quality and safety

The Care Quality Commission (CQC) inspected maternity services at William Harvey Hospital and the Queen Elizabeth The Queen Mother Hospital in December 2024 and rated both hospitals 'good' for being caring, effective, responsive and well-led and ‘good’ overall. They had previously been rated as inadequate, the lowest possible rating.

The CQC found that the service had made ‘significant improvements’ to safety, leadership, culture, the environment and staffing levels since its last inspection in 2023. The inspection team also found that the women and babies were protected and kept safe; that the units were clean and well-maintained; that there were enough staff who were well-trained; and that the units had a good learning culture, where people could raise concerns.

This is an important milestone in our continuing work to improve services and embed the lessons outlined in the ‘Reading the Signals’ report into the Trust, published by

Dr Kirkup in 2022, and ensure we always listen to patients, their families and staff when they raise concerns. We thank the families that have played such an important part in helping us to do this and the maternity teams and many supporting teams who have worked extremely hard to achieve these improvements.

Recently we transferred the Freedom to Speak Up service to an external, independent 24/7 provider, The Guardian Service, in March 2025. The service supports staff to speak up about issues affecting patient care and safety and poor practice, or where they have experienced bullying and harassment or not being treated fairly.

During the year, we re-launched our ward and clinical accreditation scheme, which assesses wards on 13 patient care standards. These include patient experience, recognition and escalation of deteriorating patients, medication safety and the culture and progressiveness of the wards. The scheme increases staff engagement, pride in their wards and a culture of patient safety as they work through the levels of accreditation to reach bronze, silver and finally gold accreditation.

Our people

This year's staff survey saw higher levels of engagement, with 63% of staff taking part in the survey. The survey provides valuable feedback to leaders and managers across the Trust, enabling them to improve the experience of staff and consequently, enhance the quality of patient care. Crucially, by using the feedback and working with staff we can identify key areas for improvement and make positive changes in response.

However, our survey results varied a great deal between wards and departments. In some areas we had results that reflect national best practice, whereas others had real challenges. Importantly, understanding the variation in responses from different teams and departments will enable us to tailor and direct support to those areas.

Across the Trust, the results told us staff want us to do more to ensure they are actively listened to, involved and can be confident that their concerns are acted on. They also showed a need to feel proud of working in our Trust. We are focusing on these two things this year, alongside improving the consistency of leadership that staff experience across the Trust. For example, we are reviewing leadership training, to make sure compassionate leadership is at the front and centre of all our leadership training programmes, ensuring staff have a greater voice through the introduction of a new Staff Congress and launched a Trust-wide awards scheme.

Developing our ten-year strategy

During the year, we asked staff, patient representatives and partner organisations to help us begin the development of our Trust strategy. People shared their thoughts with us at dedicated events, through a survey, and in individual conversations.

This feedback was analysed and used to shape a new high-level draft strategy for the Trust, outlining our shared vision to be a place that patients trust, our staff choose as a place to work and be treated and our partners value. We are now working on the clinical, estates, digital and people strategies which will provide a detailed plan aligned with the NHS 10-year strategic plan.

Finally, we would like to thank all our staff, governors, partners and the many volunteers who continue to support the Trust in so many ways. We have once again benefitted from the East Kent Hospitals Charity, Leagues of Friends and a wide range of community, voluntary and charitable organisations. Their contributions have made a meaningful difference to both patients and staff. Thank you for all that you do in support of our patients and the communities we serve.

Dr Annette Doherty OBE FRSC
Chair

Tracey Fletcher
Chief Executive

Purpose of the Quality Account

Providers of NHS healthcare are required, by law, to publish a quality account each year. Quality accounts help us to improve public accountability for the quality of care we provide.

Our report incorporates mandatory statements and sections which cover areas such as our participation in research, clinical audits, a review of our quality performance indicators and what our regulator says about the services and care we provide. We describe some of our quality priorities, what we have achieved over the last year, and what we plan to improve next year.

Every quality account includes a statement from the most senior person in the organisation, as well as feedback from some of our stakeholders such as Healthwatch and our commissioning organisation, Kent and Medway Integrated Care Board (ICB).

Purpose and activities of the Foundation Trust

We are a very large hospitals Trust, with five hospitals and a number of community clinics serving around 720,000 people in East Kent. We also provide specialist services for a wider population of over a million, including renal services in Medway and Maidstone, the county's specialist vascular surgery service and a cardiac service for all of Kent based at William Harvey Hospital, Ashford. We employ 10,230 staff.

We provide a number of services in the local community, including in people's own homes. This includes home dialysis, community paediatrics, mobile chemotherapy and stoma care.

As a teaching Trust, we play a vital role in the education and training of doctors, nurses and other healthcare professionals, and are working in partnership with the Kent and Medway Medical School. We will continue to work with our long-term partner, King's College University in London and with St George's Medical School.

We value participating in clinical research studies, and we consistently recruit high numbers of patients into research trials. Kent and Medway's Clinical Trials Unit is based in our Queen Elizabeth The Queen Mother Hospital, Margate.

Our hospitals

Buckland Hospital provides a range of local services. Its facilities include an urgent treatment centre, outpatient facilities, renal satellite services, day hospital services, child health and child development services, ophthalmology surgery and a community diagnostic centre, which includes CT and MRI scanners.

Kent and Canterbury Hospital (K&CH) provides a range of surgical and medical services. It is a central base for many specialist services in East Kent such as elective orthopaedics, renal, vascular, interventional radiology, urology, dermatology, neurology, stroke and haemophilia services. It also provides a 24/7 urgent treatment centre. K&CH has a postgraduate teaching centre and staff accommodation.

Queen Elizabeth The Queen Mother Hospital, Margate (QEQMH) provides a range of emergency and elective services and comprehensive trauma, obstetrics, general surgery and paediatric services. It has a specialist centre for gynaecological cancer and modern operating theatres, Intensive Therapy Unit (ITU) facilities, children's inpatient and outpatient facilities, a cardiac catheter laboratory, a renal satellite service and cancer unit. QEQMH host the county's Clinical Trials Unit, has a postgraduate teaching centre and staff accommodation. On site there are also co-located adult and elderly mental health facilities run by the Kent and Medway NHS and Social Care Partnership Trust (KMPT).

The Royal Victoria Hospital, Folkestone provides a range of local services including an urgent care centre (provided by Kent Community Health NHS Foundation Trust), a thriving outpatients department, the Derry Unit (which offers specialist gynaecological and urological outpatient procedures), diagnostic services, and mental health services provided by KMPT.

The William Harvey Hospital (WHH), Ashford provides a range of emergency and elective services, including a trauma unit, as well as comprehensive maternity, paediatric and neonatal intensive care services. The hospital has a renal satellite service, a specialist cardiology unit undertaking angiography and angioplasty, a state-of-the-art pathology analytical robotics laboratory that reports all East Kent's General Practitioner (GP) activity and a robotic pharmacy facility. A single Head and Neck Unit for East Kent includes centralised maxillofacial services with all specialist head and neck cancer surgery co-located on the site. WHH has a postgraduate teaching centre and staff accommodation.

Our vision and values

In 2024, we worked with patients, our staff and partners to develop our organisational strategy. We developed our purpose, mission and vision:

- Our **purpose**: to provide excellent healthcare for all our communities
- Our **mission**: having well-supported, dedicated people working together and with our partners, to deliver healthcare where and when it is needed.
- Over the next 10 years, we want to get to our **vision**: to be a place that patients trust, staff choose and partners value.

Our values are:

- People feel **cared for** as individuals
- People feel **safe**, reassured and involved

- People feel teamwork, trust and **respect** sit at the heart of everything we do
- People feel confident we are **making a difference**.

History of the Foundation Trust and statutory background

East Kent Hospitals Trust was formed in 1999 when three hospital trusts covering Thanet, Canterbury, Ashford, Swale, Shepway and Dover merged.

A major reconfiguration of hospital services followed and we now have five hospitals, the William Harvey in Ashford, the Queen Elizabeth The Queen Mother in Margate, Buckland Hospital in Dover, Royal Victoria in Folkestone and Kent and Canterbury in Canterbury.

The Trust achieved University Hospital status in 2007 and became a foundation trust in 2009. It received its formal certificate of registration in June 2010 by the CQC under the Health and Social Care Act 2008.

East Kent Hospitals is regulated by NHS England – the organisation responsible for authorising, monitoring and regulating NHS trusts.

During 2024/25 the Trust was being supported under NHS England's recovery support programme (RSP).

The latest CQC inspection of our Trust took place in December 2024 when the CQC inspected our maternity services at William Harvey Hospital and the Queen Elizabeth The Queen Mother Hospital. They rated both hospitals 'good' for maternity overall.

The CQC found that the service had made 'significant improvements' since its last inspection in 2023. It rated both units as 'good' for being caring, effective, responsive and well-led and requires improvement for safety. They had previously been rated as inadequate, the lowest possible rating.

The Trust's overall rating remains at 'requires improvement'.

Part 2: Priorities for Improvement and Statements of Assurance from the Board

This section of the quality account describes the progress we have made against the quality priorities we identified last year.

We describe our overarching Trust priorities, and the improvement methodology we use. Some of the Trust priorities are described in more detail elsewhere in this document.

Trust and Quality Priorities

We Care, our Improvement Methodology

Our Trust is dedicated to supporting staff in identifying ways to make care better for patients and encouraging them to put those changes in place. Over the last four and a half years the Trust has been training and coaching staff in the implementation of a

Trust-wide improvement approach that we call We Care. We Care aims to select a small number of important metrics for the organisation to focus on; this is done by empowering multi-disciplinary teams at frontline, specialty, and Care Group level to think about how they can make improvements that will improve quality of care and performance. The approach encourages a culture of continuous improvement through collaborative team work and staff engagement; and a 'Golden Thread' that embeds a focus on the Trust strategy as part of the way all of us work.

A True North Strategic Objective

The True North is our strategic vision and captures the selected organisation wide priorities and goals that should guide all improvement work across our Trust.

Examples of our Strategic Objectives are:

- Reducing Harm and delivery safe services
- Patients, families and community voices. Timely access to care

A True North Measure

Under each True North objective, sits a True North Measure. These are the metrics that summarise how the Trust will measure and monitor its progress against achieving the Strategic Objectives.

For the Objectives mentioned above, the Measures are:

- Reduce the number of harms from Pressure Damage
- Reduce the number of patients who spend 12hrs in ED

Annual Objectives

Part of the We Care approach involves agreement of Annual Breakthrough Objectives for us to focus on. For the year 2025/26 the annual objectives and focus for improvement are aligned to a set of priorities that were agreed with NHS England; these are part of our Integrated Improvement Plan and our focus on improving quality of care for our patients following the publication of 'Reading the Signals' report.

Other metrics have been selected and watched as part of the Trust performance monitoring meetings but these were identified as the areas for specific improvements. To support the delivery of these metrics we challenged our Care Group leadership teams to focus on the areas that they and their departments feel could have the greatest impact. These targets for improvement were then managed through a series of performance meetings that focused on performance and quality.

Measure / Aim

Driver Metrics (or measures) are closely aligned with True North. They are specific metrics that Care Groups, services and frontline choose to actively work on to “drive” improvement in order to achieve a target.

We Care, our Quality Improvement Training

The training of frontline teams continued this year with 16 teams being trained and coached in the We Care system taking the total number of teams trained in ‘We Care’ quality improvement methodology to 72, including 9 teams being retrained as part of the relaunch of ‘We Care’. Across all improvement training over 1,880 staff have attended one of our in-house training courses, with more than 600 staff attending in the past year. All improvements, undertaken by frontline teams, relate directly to a Trust annual or strategic objective, ensuring that improvement is embedded throughout the organisation. Successes are captured by the teams and shared using Trust News and are published on the internal improvement team website. This has contributed to some great quality improvements and efficiency savings over the course of the year:

- **People:** Special Care Baby Unit (SCBU) purchased two large filtered water dispensers (funded by East Kent Hospitals Charity) to ensure staff and parents have access to clean cold water, improving staff wellbeing and delivering a better visitor experience.
- **People**: We introduced peer-to-peer talks to improve the Foundation Year 1 (FY1) Surgical Induction, with 100% of participants subsequently reporting that they agreed/strongly agreed that the induction clearly outlined the role of a surgical FY1 (up from 42.7% agreeing and 7.1% strongly agreeing initially).
- **People:** An improvement project on ensuring all training resources used by the Improvement & Transformation team is accessible and inclusive, which resulted in compliance scores for training slides increasing by over 20% and cost savings of £4,476 by booking the most accessible rooms.
- **Patients**: Made improvements to the process for triaging patients with Frailty in WHH Emergency Department (ED), cutting the average wait time by a third.
- **Patients**: Padua ward enhanced training and created a Process Standard Work around discharges, thus improving the percentage of patients discharged before 15:00 from 43% to 57%.
- **Patients**: Developed a day-case pathway in Orthopaedic Trauma, resulting in the number of successful day cases increasing from 56% to 82%, resulting in better patient experience.
- **Sustainability:** Introduced a recycling system in Critical Care at QEQM which resolved the issue of waste not being disposed of correctly and resulted in savings of over £700 within the first 7 months.
- **Sustainability:** KCH Day Surgery made savings of around £1,500 by making the swap to reusable trays in theatres.

- **Quality and Safety:** Improved the use of National Emergency Laparotomy Audit (NELA) Patient Data Entry tool from 11.7% to 86.2%.
- **Quality and Safety:** A ward achieved a reduction in falls – 8 consecutive months under target (3 falls or less).
- **Quality and Safety:** Improved efficiency of orthotic appointment bookings by developing a paperless process and ensuring responsibilities for booking and procurement were divided and allocated to specific staff groups, resulting in utilisation increasing to 103% and the number of empty clinics dropping to 0%.

Trust Priorities for 2025/26

For 2025/26, the annual objectives and focus for improvement are aligned to the priorities that have been agreed with NHS England as part of our Integrated Improvement Plan.

We will continue to use a nationally recognised quality improvement approach to provide the framework through which the Trust will manage the oversight and delivery of the annual objectives for 2025/26.

We will also add an extra strategic domain called research which aims for our Trust to be a centre of research excellence, further details will be developed over the course of the year.

Tables below show the True North Strategic Objectives, Annual Breakthrough Objectives together with the Measure/Aim for 2025/26. Some of these will be the focus of our Quality Priorities for 2025/26 and more information on these is shown from pages 37-41.

Quality and Safety

True North Strategic Objective	True North Measure	Annual Breakthrough Objective	Measure/ Aim
Reducing harm and the delivery of safe services (see pages 21-22 and 37).	To be in the top 20% of trusts with the lowest mortality. Reduction in harms.	• Improve performance in falls. • Improve performance in hospital acquired pressure damage.	• Being finalised.

Patients

True North Strategic Objective	True North Measure	Annual Breakthrough Objective	Measure/ Aim

Timely access for all to planned and unscheduled care (see pages 34, 38 and 92-95).	75% of patients seen and treated or discharged from ED within 4 hours. 85% of patients receive cancer treatment within 62 days. No patient will wait longer than 18 weeks for treatment.	• To reduce the number of type 1 patients waiting more than 4 hours in ED. • To reduce the number of patients waiting more than 12 hours in ED. • To reduce the number of patients with an extended wait for diagnostics and planned care. • To improve the waiting times for cancer treatment. • Improve the percentage of patients waiting no longer than 18 weeks for treatment.	• Type 1 performance consistently better than 50%. • 12 hour waits less than 8% of all attendances. • Less than 1% 52 week waits. • 62 day > 75%. • Less than 60%

People

True North Strategic Objective	**True North Measure**	**Annual Breakthrough Objective**	**Measure/ Aim**
Our staff feel cared for as individuals and that teamwork, trust and respect sit at the heart of everything we	To be in the top 25% of NHS organisations for the staff engagement score	Demonstrable improvement of the culture of the organisation.	Staff Engagement Score improvement.

do (see pages 40 and 88-89).

Partnerships

True North Strategic Objective	True North Measure	Annual Breakthrough Objective	Measure/ Aim
Working collaboratively to improve the health and outcomes of the local population and reduce health inequality.	TBC	Development of organisational strategy for clinical pathways.	Draft Strategy by May 2026.

Sustainability

True North Strategic Objective	True North Measure	Annual Breakthrough Objective	Measure/ Aim
To deliver financial sustainability.	Achieve a sustainable breakeven, or better, position.	Delivery of the 2025/26 Financial Plan.	Delivery of the Cost Improvement Programme (CIP) and Expenditure Plans.

Research and Innovation

True North Strategic Objective	True North Measure	Annual Breakthrough Objective	Measure/ Aim

To be a research centre of excellence.	To note: This is a newly added strategic domain and the work is underway to agree the Strategic and Annual Objectives (see page 50).

Our objectives will be delivered through a series of programmes of improvement looking at cross-cutting themes and challenging Care Group teams from leadership to frontline to focus on the areas that can have the greatest impact. This will be supported by an organisation-wide relaunch of We Care that will provide training and coaching to staff and ensure a focus on improving behaviours and making improvement part of our routine ways of working.

Progress against some of last year's objectives is included within this report.

2.1 Quality Priorities for Improvement for 2024/25

In this section we provide an update against the quality priorities we identified last year, and whether we achieved them. We outline those areas of improvement and priorities that will continue to next year.

Implementing national patient safety strategy (prioritising Patient Safety Incident Response Framework (PSIRF)) as part of the National Patient Safety Strategy

PSIRF implementation

Our 2024/25 goal	Target	2024/25	2023/24	Outcome
We will implement the Patient Safety Incident Response Framework.	Implement new investigation methodology. Improved patient and staff engagement.	N/A	N/A	Partially achieved (Transition June 2024)

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. It was first published by NHS England (NHSE) in August 2022.

This year we have continued to focus on the implementation of the transformational work required to fully implement PSIRF. This approach links perfectly to the We Care methodology as both encourage teams to identify key contributing factors, tackling the most significant first.

The Plan and Policy for PSIRF was approved by the ICB, and the Trust launched PSIRF in early June 2024. The broad areas of transformation from PSIRF includes:

- Improving safety culture.
- Prioritising patient and staff engagement.
- Changing how we respond to our incidents by reducing the investigation burden and increasing the level of improvement as a result of new learning responses to incidents.
- Transforming the oversight both within the Trust and from our commissioners, the ICB.

Our plan describes how respond to incidents. All national and legally required responses remain as previously required and responses at Trust level will fall into one of five categories:

- **National or Regulatory** required Patient Safety Incident Investigation (PSII).
- **Key Theme** where we are conducting a deep dive into the theme to identify the key contributory factors and develop an overarching improvement plan, using the We Care improvement toolkit. Anything that falls within our four key themes will not be re investigated and the time will be used to make the improvements. Our four key themes include: deteriorating patient in maternity (mother and neonate), medication using the Electronic Prescribing and Medicines Administration (EPMA) system, pressure damage and delay or failure to treat or diagnose.
- **Continuous Improvement Approach** includes seven workstreams already in place across the Trust, these include: inpatient falls, pressure damage, nutrition and hydration, dementia, infection prevention and control, deteriorating patient and venous thromboembolism.
- **Identifying improvement workstreams across the Trust** that align to the incident and include the same issues.
- **Those incidents that require a proportionate learning response.** The learning response will be agreed at the Incident Review Panel based on the level of learning potential rather than the level of harm.

Since the transition to PSIRF, our incident management system has been updated to capture the requirements, and our governance processes for incident management

have been updated. When a patient safety incident of concern or interest is identified, it is reviewed by one of three panels feeding into the Trust-wide Incident Review Panel. This is chaired by our Director of Quality Governance or Deputy Chief Medical Officer, with director level medical and nursing, safeguarding and Patient Safety Specialist representation. These panels are supportive and compassionate and run in accordance with the principles of a just and learning culture.

The Learning Response Approval Panel reviews patient safety incident learning responses requiring oversight beyond a single Care Group e.g. national requirements, PSIIs, other complex investigations. This panel also seeks assurance of completion of learning response improvement action plans. This panel is chaired by our Director of Quality Governance or Deputy Chief Medical Officer, with director level medical and nursing and Patient Safety Specialist representation. In addition, our Chief Nursing and Midwifery Officer, supported by the Chief Medical Officer and Chief Operating Officer, review learning responses to fulfil the oversight requirements of PSIRF. Oversight of other learning responses ego After Action Reviews, quality improvement plans, Swarm huddles sits with the Care Group directors.

Progress has been made with the key themes:

- Deteriorating patient in maternity (mother and neonate) – learning from the reviews of incidents and learning responses has been incorporated into the Maternity and Neonatal improvement plan workstreams.
- Medication using the EPMA system – a project reviewing the impact of the introduction of EPMA on safety prescribing is progressing.
- Pressure damage – the first year focused on ensuring that the existing Trust-wide improvement plan was fit for purpose. The ICB was supportive of the initiative for the second year to focus on the incidence of patients admitted to our hospitals with pre-existing pressure damage. We are participating in a system group involving other Trusts, community, primary care and ICB colleagues.
- Delay or failure to treat or diagnose – this covers a wide range of issues. The main recurrent theme was the timely follow up and actioning of imaging or test results. Our Chief Medical Officer has initiated a group, to review the issues and develop solutions. This group involves medical staff, representation for pathology and radiology, information systems, patient safety and quality improvement.

The seven continuous improvement workstreams continue. The inpatient falls, pressure damage and nutrition and hydration specialist teams have worked with clinical colleagues supported by the quality improvement team to review and re-focus the improvement priorities for 2025/26.

We have not yet introduced Patient Safety Partners within the Trust or undertaken the planned work in relation to understanding health inequalities. These will be a priority for our second year of PSIRF.

The annual review of the PSIRF plan and policy is planned for April to June 2025.

Falls

Our 2024/25 goal	Target	2024/25	2023/24	Outcome
Reduce the numbers of moderate and above harms from falls.	By 10% based on total of moderate and above harms from falls from 2023/24 baseline.	65	49	Not achieved (32% increase).

Across the year we have seen fluctuation in the number of falls occurring, the majority with no harm. In May 2024 we held a falls summit for the multi-disciplinary team with a focus on patients who have had falls prior to hospital and the trauma response this can cause, deconditioning that can occur for patients prior to and whilst in hospital, and its impact on mobilisation and how we respond when a patient has a fall.

We have undertaken reviews of our toilet and ward facilities using patient perspective to guide us, this has led to changes being made alongside a large decluttering programme.

We held a Trust-wide stakeholder event on 14 March 2025, utilising improvement methodology to formulate an improvement plan for 2025/26 focussing on key areas.

Reduction in falls will continue to be a quality priority for 2025/26 (see page 37) with revised measures.

Pressure ulcers

Our 2024/25 goal	Target	2024/25	2023/24	Outcome
Reduce the numbers of moderate and above harms related to pressure ulcers.	By 10% based on total of moderate and above harms related to Pressure Ulcers from 2023/24 baseline.	20	17	Not achieved (17% increase).

There is a correlation between the increase in ED stay, increase in patient acuity and length of stay that all have an impact on pressure ulcer numbers. The increased

frailty of our patient group is more at risk of developing deeper pressure ulcers and we have seen an increase in our unstageable ulcers.

We held a Trust-wide stakeholder event on 26 February 2025, utilising improvement methodology to formulate an improvement plan for 2025/26.

Reduction in pressure ulcers will continue to be a quality priority for 2025/26 (see page 37).

Maternity services improvements

The Care Quality Commission (CQC) inspected our maternity services at William Harvey Hospital and the Queen Elizabeth The Queen Mother Hospital in December 2024 and found that we had made significant improvements since our last inspection in 2023. It rated both units as 'good' overall. This replaces the previous 'inadequate' ratings of 2023; these improvements are testament to the commitment and dedication of staff to drive the changes. The leadership and culture were praised by the CQC, as well as the high level of positive feedback from women post-birth.

Positive culture: Build an inclusive culture where staff feel safe, valued, listened to and supported

Target	2024/25 status	Outcome
• Implement the NHS England perinatal culture and leadership programme (PCLP).	Completed and presented to Board April 2025.	Achieved.
• Promote freedom to speak up (FTSU) training within the department.	86.4% compliance.	Achieved.
• Roll out leadership training.	43 managers enrolled/completed people managers training.	Achieved.
• Undertake values-based recruitment and appraisals.	85.7% appraisals completed by 31/03/25 (using values-based templates). Recruitment uses values-based templates.	Achieved.

Our Care Group perinatal senior leadership team is referred to as a 'quadrumvirate' (Quad). Our Quad has completed the PCLP and a summary of inputs and outputs were presented to our Trust Board on 03 April 2025. Our Quad is promoted through our MNIP Booklet alongside the Trust values and behaviours:

We have continued to promote the completion of Freedom to Speak Up (FTSU) eLearning, to promote awareness and understanding of how and why to 'speak up' about professional concerns, and our completion rate in March 2025 within maternity was 86.4% against a target of 85%.

Through their appraisal meetings all managers have discussions about their professional development needs and where identified are being enrolled onto the Trust Leadership Development Programme to provide them with the essential skills and knowledge to successfully carry out their management role and lead teams in line with the Trust's values; as at March 2025 there were eighteen colleagues either enrolled or who have completed their training, with a further 25 people who had either completed or were working through their Essential People Manager Skills training.

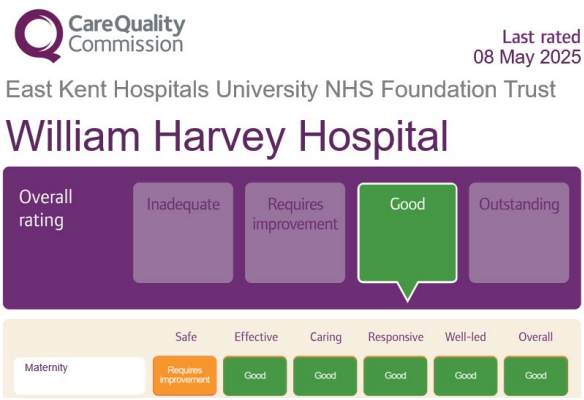
All appraisals and recruitments use templates that are values-based to support our work on building a positive culture.

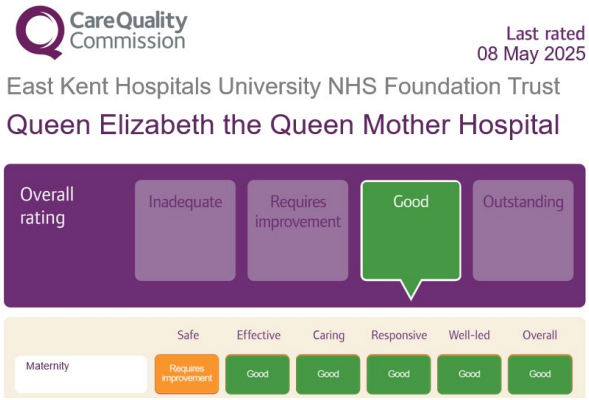
Safety Culture: Embed robust governance structures that underpin continuous improvement and delivery of high quality, person centred care

Target	2024/25 status	Outcome
• Achievement of the national maternity ambition to halve the	Improved (see table A below)	Partially achieved

number of stillbirths, neonatal deaths and brain injury		
• Obtaining a 'Good' rating from the CQC with sustained compliance	Overall rating of "Good" achieved for WHH and QEQM	Achieved
• introduce and embed PSIRF in our maternity services	Progressing, due date extended to June 2025	Partially achieved
• Sustain compliance with Ockenden recommendations.	82% completion (75 actions) with 17 actions to complete	Partially achieved

The CQC inspected our maternity services at William Harvey Hospital and the Queen Elizabeth The Queen Mother Hospital in December 2024 and found that we had made significant improvements since our last inspection in 2023. It rated both units as 'good' for being caring, effective, responsive and well-led, and 'good' overall for each site. Safe was rated 'requires improvement' for each site due to the outdated hospital buildings and facilities. A business case is progressing for development of the maternity unit at QEQM to increase the size of the labour rooms and provide a second obstetric theatre. It will also extend the maternity triage area in the next phase of refurbishment at WHH.





In 2023, we published a Maternity Quality and Safety Framework that sets out good governance across the service; this includes roles and responsibilities, a formalised governance structure with reporting lines for Trust Board oversight (ward to Board) and terms of reference for each of the governance forums. Furthermore, we implemented PSIRF in maternity in 2024 and developed a maternity-specific PSIRF plan with clearly defined objectives, timeframes and quality measures to raise the standards of quality and safety for the deteriorating woman/birthing person. This plan

was due to complete by March 2025 but will carry over to June to set the foundations for ongoing improved clinical outcomes and contribute to the development of the next maternity PSIRF plan for 2026/26.

With regards to clinical outcomes, there is also progress against the national maternity and neonatal ambition to halve the number of stillbirths, neonatal deaths and brain injury by 2025 with the recent exception for maternal mortality. The figures are shared in the table below:

East Kent progress against national maternity and neonatal safety ambition

	2010 East Kent	**MBRRACE Comparator 2022**	**March 2025**
Stillbirths	5.7	3.61	2.39
Neonatal deaths	1.77	1.82	2.05
Brain injury	Not available	2.4-2.8	1.86
Maternal death	1	12.67 per 100,000*	2

*numbers are too low to be comparable so are not available lower than per 100,000 maternal deaths

Clinical Pathways: Progress evidence-based clinical care pathways to consistently deliver personalised, high quality, safe care and treatment.

Target	**2024/25 status**	**Outcome**
• Implement service improvements to antenatal systems and processes.	Several projects completed.	Partially achieved.
• Implementation of the one stop shop and antenatal referral process to obstetrics for diabetes.	Launched One Stop Shop at QEQM, WHH, KCH.	Achieved.
• Improvement in fetal medicine and postnatal care which includes pain management.	Improvement in pain management score in CQC maternity patient survey.	Partially achieved.
• Improvement in new-born and infant physical examination, transitional care, infant feeding, outreach and	ATAIN rates sustained at ‘normal’ average.	Achieved.

avoiding term admissions into neonatal units (ATAIN).

There are numerous clinical pathways included in the three-year maternity and neonatal improvement programme (MNIP) with the aim to complete all service improvements by March 2026.

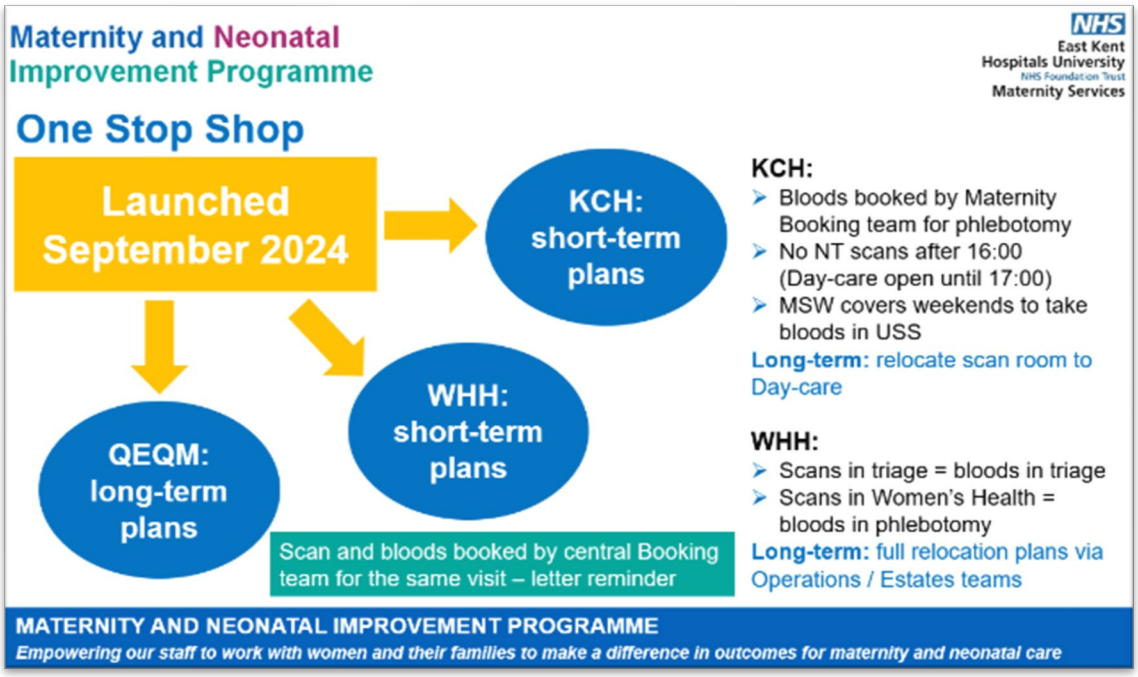
Examples of completed service improvement projects include:

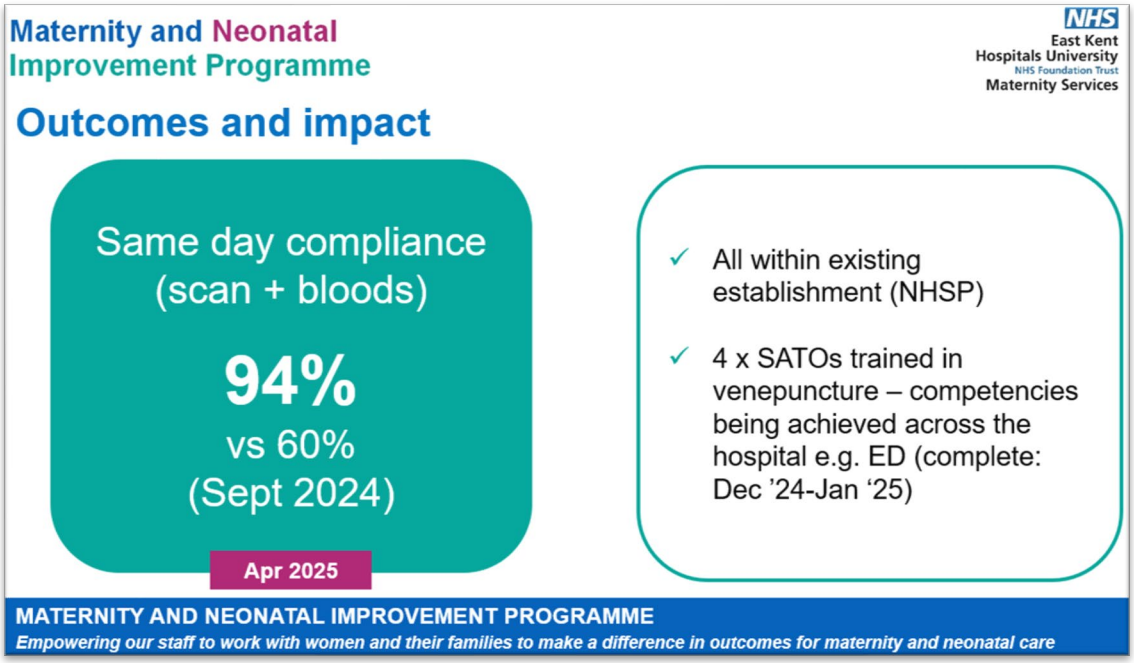
- Wi-Fi connectivity in the community;
- Streamlined referral forms and processes (e.g. pregnancy registration, antenatal clinics, mental health services);
- VTE risk assessment, prevention and management;
- Centralised telephone triage service;
- Re-opening of Midwifery Led Unit at WHH.

Examples of 2025/26 projects include:

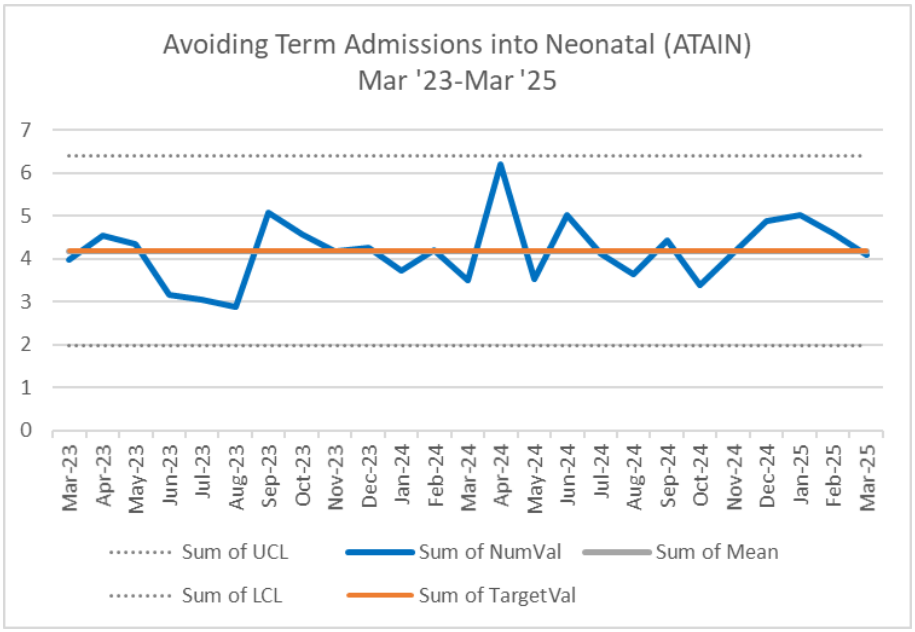
- Patient Administration System (PAS) in the community;
- Patient portal in the community;
- New Maternity Information System;
- PSIRF project plan;
- Diabetes in pregnancy.

We have launched the One Stop Shop at QEQM with similar models at WHH and KCH and this has driven our compliance for same-day screening up from an average of 60% in September 2024 to 87.8% in March 2025.





We have trained more midwives to be able to undertake new-born and infant physical examinations (NIPE), and we continue to train more non-medical prescriber midwives and have recently seen pain management in the postnatal period move from one of our bottom five scores in the CQC maternity patient survey 2023 to one of our top five scores in the 2024 results. Our ATAIN rates continue to be sustained around our 'normal' average, as shown in the graph below.



Listening: Co-design and co-produce, including equality and equity in maternity and neonatal care

Target	2024/25 status	Outcome
• Equality and equity in maternity and neonatal care.	Monthly Maternity and Neonatal Equity & Equality Group formed.	Achieved.
• Implement the accessible information standard.	Analysed language /communication needs Hospital Communication Book circulated.	Achieved.
• Implement NHS reasonable adjustments' flag.	Flag in development, due March 2026.	Partially achieved.
• Identify thematic learning from the CQC maternity survey 2023/24.	Themes identified and included in survey action plan.	Partially achieved.

In March 2024, we formed our monthly Maternity and Neonatal Equity and Equality Group where we review our Equality, Diversity and Inclusion (EDI) scorecard to identify any outliers where women from ethnic minority and / or higher areas of social deprivation may require improved support and access to services for improved clinical outcomes.

Within this scorecard we have observed that approximately 4% of our service users have language and / or communication needs and approximately 1% have learning disabilities so we have circulated a Hospital Communication Book to aid communication. To further enhance our awareness of our demographic and people's needs, we are working with our IT department on readiness for the introduction of reasonable adjustment flags within a new digital maternity information system, which is due by March 2026. In addition, we develop all of our patient information to recommended standards. In the development phase, our patient information leaflets are also shared with a panel of stakeholders, including service user representatives, for their comment and feedback prior to publication.

Each year we participate in the CQC's patient survey of maternity services, and results for 2024 were published in November; we have completed benchmarking against our peer maternity services across the country. In summary, there were two questions where we exceeded the national average score, four areas where we scored below national and regional averages, with the remaining 51 questions scoring in-line with national and / or regional averages. The two questions that we exceeded in were:

- B4. Did you get enough information from either a midwife or doctor to help you decide where to have your baby? EKHUFT score 7.9 vs national score of 6.8.

- C7. During your labour, were you ever sent home when you were worried about yourself or your baby? East Kent score 9.4 vs national score of 9.0 (higher is better).

Our score for question D7 (Do you think your healthcare professionals did everything they could to help manage your pain in hospital after the birth?) moved from our bottom five in 2023 (6.9) to one of our top five scores in 2024 (7.9).

Themes from the lower scored questions were: provision of information about infant feeding in the antenatal period, concerns being taken seriously during the antenatal period, pain management during labour and delayed discharge from hospital. These areas for improvement have been included in our annual CQC maternity survey action plan which is being progressed with the support of our patient experience midwives and the Maternity and Neonatal Voices Partnership (MNVP).

Workforce: Embed a process of continuous review and planning that produces and retains a completed, supported and sustained workforce

Target	2024/25 status	Outcome
• Improve induction procedures.	Project group improving local orientation and induction processes.	Partially achieved.
• Improve access to /support from the Professional Midwifery Advocate (PMA) team.	PMA team re-established via events, supervision.	Achieved.
• Develop recruitment and retention plan.	Succession plan developed. Career cafes held.	Partially achieved.
• Invest in our future,	As above.	Partially achieved.
• Raise standards through competency and training.	3-year TNA published, TNA stakeholder event held.	Partially achieved.

We have recently completed a full workforce review using the Birthrate Plus acuity tool and outputs are being shared across the service to ensure that resources are effectively allocated to where they are needed to support service provision. There is a dedicated project group working on improving local orientation and induction processes for new starters which is progressing well. It includes the sharing of new starter information by our central People and Culture team, the sharing of updated induction and appraisal tools and templates from our central Learning and Development team, and coordination between our maternity Practice Development team and site-based managers to ensure a coordinating approach for all new starters.

Our Professional Midwife Advocate (PMA) team has re-established itself over the last year through recruitment of new members, frontline drop-in sessions and listening events, restorative clinical supervision, and a successful PMA awards ceremony in 2024 (to be repeated in 2025) held on International Day of the Midwife.

We have also hosted career cafes to showcase opportunities across maternity at East Kent, which is underpinned by our succession plan developed in 2024 with our People and Culture department. These are promoted and discussed during appraisal meetings for those wishing to further their careers. We have also published a three-year training needs analysis (TNA) that is refreshed each year with any new training requirements identified through annual TNA stakeholder events. This ensures we meet the ongoing training and competency needs of our workforce. This is all included in the three-year improvement programme for completion by March 2026.

Deteriorating patient improvements

In 2023/24, we received £300,000 from the ICB to support improvements in the deteriorating patient pathway. Following the appointment of the Lead Nurse in December 2023, this money was invested in enhanced training (to meet Resuscitation Council UK quality standards), e-learning (NEWS2), equipment modernisation (resuscitation trollies), and the development of a Critical Care Outreach dashboard. These measures are designed to strengthen clinical response and sustain patient safety.

Increase in earlier identification, escalation and response time to our deteriorating patients

Target	2024/25	Outcome
80% of staff to complete NEWS2 elearning module.	95%	Achieved.
Implement ReSPECT treatment and escalation planning tools.	Complete.	Achieved.
Implement Call for Concern service.	Phase One complete.	Partially achieved.

Implement sepsis screening dashboard by October 2024.	Delayed.	Not achieved.

Patients who are, or become, acutely unwell in hospital require prompt intervention by experienced, healthcare professionals. Timely identification and treatment are critical in preventing deterioration and improving patient outcomes. Sepsis is the most common cause of unplanned, emergency admissions to our critical care units. This trend aligns to national data; however, we recognise the need to address this issue proactively. The deteriorating patient workstream has set a strategic objective to reduce sepsis related critical care admissions during the year 2025/26. A lead nurse for sepsis has been appointed within the Critical Care Outreach Team to drive this improvement, education and clinical leadership in sepsis management. In addition to this role, a dedicated sepsis committee has been established with a consultant microbiologist as chair. This is a multidisciplinary group who will oversee governance, coordinate the trust wide improvement plan, monitor progress and ensure alignment to national best practice with management and treatment of sepsis.

Our deteriorating patient workstream is aligned to NHS England's Prevention, Identification, Escalation, Response (PIER) framework. The PIER framework approach enables the effective management of acute physical deterioration in healthcare and applies to all conditions, clinical settings and specialities. The PIER approach views deterioration as a whole pathway supported by systems rather than only advocating a single strategy for identification.

NEWS2 elearning

The National Early Warning Score 2 (NEWS2) is a score used to elicit a response by the medical/nursing teams to abnormal physiology. It is based on seven parameters: six physiological, plus a weighting score for supplemental oxygen. We use our electronic system, Sunrise, to automatically generate a score from observations recorded at the bedside by nursing staff using an electronic device. NEWS2 is the national score promoted by the Royal College of Physicians.

The NEWS2 Commissioning for Quality and Innovation (CQUIN) audit benchmarks us for completion of NEWS2 against the national standard. Our methodology for data collection is unique nationally as we collect data from the first onset of deterioration, enabling a robust quality improvement initiative. With an increased target of compliance from 30% to 75%, compliance for early identification, escalation and initial response to acute deterioration is improving. There is still a need for improvement to senior response (registrar or consultant) when a patient has a NEWS2 score of 7 or above and this is reflected on the Trust-wide improvement plan. The NEWS2 mandated e-learning module shows compliance >95% for our substantive staff, exceeding the target set at >80%.

A locally-produced deteriorating patient educational programme is on target to commence later this year, aligned to the PIER approach, improving assessment and management of the acutely/critically unwell patient within a multi-disciplinary faculty. This is being led by our Critical Care Outreach Team (CCOT). The team continue to deliver the Bedside Emergency Assessment Course for Healthcare Assistants (BEACH) and the resuscitation team provide the Acute Life-threatening Events Recognition and Treatment (ALERT) course. The resuscitation service lead has completed the process mapping required and the service now conforms to the resuscitation quality standards for volume of courses provided to our frontline staff annually.

Implement ReSPECT

The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) enables patients to agree preferences for care and treatment within a documented plan. This enables healthcare providers to understand and respect patient's treatment preferences and clinical needs in future situations where they might not be able to communicate their wishes. ReSPECT was successfully implemented across the organisation in November 2024 by our deteriorating patient lead nurse. The high volume of promotion and education of this change in practice has resulted in success, as evidenced in the East Kent dashboards which show that 62% of all ReSPECT forms completed regionally within the first month of launch have been done so within East Kent hospitals. The focus is now on improving quality of conversations and a project lead has been identified from the resuscitation service to lead on this.

Implement Call for Concern service

We were an early implementer of Martha's Rule, with phase one piloted at QEQMH and WHH sites. The elements of Martha's Rule are:

Component 1	Patients will be asked, at least daily, about how they are feeling, and if they are getting better or worse, and this information will be acted on in a structed way.
Component 2	All staff will be able, at any time, to ask for a review from a different team if they are concerned that a patient is deteriorating, and they are not being responded to.
Component 3	This escalation route will always be available to patients themselves, their families and carers and advertised across the hospital.

Our Call for Concern service, which aligns to Martha's Rule, is designed to allow patients, families, or carers to seek immediate help if they feel that their health concerns are not being recognised. It has been a success story for the Critical Care Outreach Matron (WHH), the CCOT and the Trust this year. Phase one implementation was completed in March 2025 with components one and two

complete. The service will be advertised by the end of June 2025 to align with availability of national promotional materials. In addition, a QR code and electronic referral system is being created for patients, families or carers who have communication difficulties, to meet component three. To date, the service has responded to three patients requiring critical care admission.

Sepsis screening dashboard

Last year we said we would create a sepsis screening dashboard by October 2024, to support the monitoring of our compliance and effectiveness in identifying, escalating and responding to signs of sepsis. Sunrise, our electronic patient information system, was not equipped with this functionality until February 2025, enabling the IT team to commence building phase so this is now expected to be completed during 2025/26.

In addition, our sepsis committee is collaborating with an artificial intelligence company to detect possible risk factors associated with developing hospital acquired infections up to seven days before symptoms are detectable. If this pilot demonstrates evidence of success, this system will further prevent ‘at risk’ patients from going on to develop sepsis and treatment can be adjusted in a timely manner to benefit our patients. Both the sepsis lead nurse and the lead nurse for deteriorating patient will monitor progress of this pilot.

This will continue as a priority for 2025/26 – see page 38.

Timely access to services

Timely access for all to planned and unscheduled care

Target	Target	2024-2025	2023-2024	Outcome
75% of patients seen and treated or discharged from ED within 4 hours.	A&E: maximum waiting time of 4-hours from arrival to admission/transfer/discharge.	74.81%	71.2%	Partially achieved
85% of patients receive cancer treatment within 62 days.	62-day wait for first treatment from urgent GP referral for suspected cancer.	67.2%	59.8%	Partially achieved

85% of patients receive cancer treatment within 62 days.	62-day wait for first treatment from NHS cancer screening service referral.	69.6%	70.4%	Partially achieved
No patient will wait longer than 18 weeks for treatment.	Maximum time of 18-weeks from point of referral to treatment (RTT) in aggregate – patients on incomplete pathway.	51.6%	50.8%	Partially achieved

As well as including in our Trust priorities, NHSE also define these as specific indicators we must include in the Quality Account, and these are reported from page 92.

These will continue to be quality priorities for us in 2025/26 – see page 37.

Referral to treatment

This year we successfully reduced the number of patients projected to wait beyond 65 weeks from over 2,000 to 33 by the end of the year.

Throughout 2024/25, we worked to align with national guidance aimed at reducing elective treatment backlogs and ensuring no patient waits longer than 65 weeks for treatment. While there is still more to be done, we are proud of the significant progress made. Notably, we successfully reduced the number of patients projected to wait beyond 65 weeks from over 2,000 to 33 by the end of the year.

Emergency Departments

Our Trust is a member of the East Kent Urgent Treatment Centre alliance delivering care jointly across four Urgent Treatment Centres (UTCs) with East Kent primary care partners. This collaborative working has seen a significant increase in our achievements against the 4-hour standard in UTCs. 75% patients presenting to our ED and co-located UTCs achieved this target in March 2025, despite 6.5% overall increase in attendances from 2023/24.

Throughout 2024/25 there has been a renewed focus on improving timely access to treatment for patients attending our A&E departments. We established an Urgent and Emergency Care Transformation Board to oversee the development and implementation of workstreams targeting improving access and flow through not only the ED but throughout our hospitals. This programme has supported us to achieve our trajectory for patients meeting the 4-hour target, with 75% patients presenting to our ED and co-located Urgent Treatment Centres achieving this target in March 2025, despite 6.5% overall increase in attendances from 2023/24.

The length of time patients wait in our EDs for admission does remain a challenge for us however, and whilst we have reduced the number of patients waiting over 12-hours in the department from the previous year, this remains a priority for 2025/26 (see page 36) with an on-going focus on improving flow through the hospitals supported by a reduced length-of-stay patients' experience.

National Institute of Health and Care Excellence (NICE) guidance

During 2024/25 we improved compliance with NICE guidance from 4% at the start of the year to 98%, exceeding our target of 90%.

Compliance with NICE guidance

Target	2024/25	Outcome
90% compliance with NICE guidance published between 01.09.21 and 31.03.25	98%	Achieved

The National Institute of Health and Care Excellence (NICE) produces evidence-based recommendations for the health and social care sector, developed by independent committees, including professionals and lay members, and consulted on by stakeholders.

Ensuring that our patients receive the best quality of care in line with national guidance underpins our strategic objectives of patients, and quality and safety. We will ensure that our recently developed approach and policy to managing NICE guidance is robust and promotes learning across the organisation. The new approach was implemented during 2024/25 and has been fully embedded.

For 2024/25 a trajectory was set in order to achieve 90% compliance for NICE guidance released between 1 September 2021 and 31 March 2025. As of 31 March 2025, 98% compliance had been achieved.

During 2025/26 the Trust will continue to strengthen the processes around the management of NICE guidance and provide evidence of NICE implementation in

order to demonstrate that the Trust is compliant. The clinical measure will be the percentage of compliance with NICE guidance, with evidence of implementation, in relation to those that are applicable to the Trust. In addition to maintaining compliance of 90% for guidelines from 1 September to 31 March 2026 a trajectory has been set for guidelines prior to this date in order to achieve an overall compliance of 90%. This trajectory is achievable with full co-operation from our Care Groups.

Quality Priorities for 2025/26

We describe below at least three measures for patient safety, clinical effectiveness and patient experience that will be areas of focus for us the coming year, as required by the Quality Account guidance.

We have also included three measures for staff experience, as this is an area of significant focus for us.

We will report on progress with these throughout the year through our governance processes, and provide an end-of-year update in our Quality Account for 2025/26.

Patient safety

Reducing harm

Falls

Goal	Aims
Improve performance in falls.	• Reduction in patients who fall whilst using the toilet. • Reduction in patients falling on more than one occasion. • Reduction in patients having unwitnessed falls.

Pressure ulcers

Goal	Aims
Improve performance in hospital acquired pressure damage.	• Decreased shear damage due to poor manual handling. • Ensuring that skin checks under medical devices are undertaken. • Reduction in long gaps in repositioning resulting in pressure ulcer development. • Reduction in delays in risk assessments and the inaccurate and incomplete assessment.

Reductions in pressure ulcers and falls were Trust priorities and quality priorities for 2024/25 and we did not achieve our goals (see pages 21, 22). We have redefined our aims and have comprehensive improvement plans in place, and we will continue to focus on these priorities throughout 2025/26.

Medication safety

Goal	Aims

Reduce harm from missed doses of critical medicines.	• Complete Trust-wide implementation of the missed dose dashboard by Q2 2025/26. • Improve critical medicine dose compliance to at least 85% by Q4 2025/26 (current average is 81.7%).

Medication safety has been chosen as a new area of focus this year. Missed doses of critical medicines are a known contributor to avoidable medication-related harm. We are currently piloting a missed dose dashboard, starting in WHH surgical wards, using Sunrise data to improve visibility, learning, and accountability. This priority means we will focus on medicines where delays or omissions can cause serious harm.

Deteriorating patient improvements

Goal	**Aims**
Increase the compliance of response when a patient's NEWS2 score is 5 or above	• Trajectory of: Year 1 – 35%, Year 2 – 60%, Year 3 – 75% • Publish a digital 'Deteriorating Patient Pathway' to promote the activation of early escalation and appropriate response. • Increase the resources of senior review.

Deteriorating patient improvements were also a quality priority for us during 2024/25 and we achieved some elements of that work (see pages 31-32). We are continuing with this priority for 2025/26 with a new measure that was identified as an area for improvement last year. This was because one parameter was unsuccessful in reaching the target of 75%: "A response in less than 60 minutes when a patient scores NEWS2 5-6 or Senior Review within 30 minutes if a patient scores a NEWS2 score 7 or more." Our compliance with this is currently 22.9%. Reaching compliance with this parameter is imperative to the quality of the deteriorating patient pathway, not only to comply with national standards, but also because this ensures patients' treatment is commenced in a timely manner, without delay, avoiding additional deterioration which could result in prolonged length of stay or harm to our patients.

We anticipate that this dataset will see a reduction of compliance initially as inclusion criteria will significantly increase to all patients with elevated NEWS2 score rather than current inclusion criteria of only unplanned, emergency critical care admissions. The first-year target of compliance reflects this hypothesis. In addition to this, increasing the resources of 'senior review' will be within the first year. The process of creating a sustainable change to this priority will be reviewed yearly, with additional teams aligned to 'advanced practice' to provide senior reviews where required.

Sepsis

Goal	Aims
Reduce preventable harm, morbidity and mortality associated with sepsis.	• Reduce blood culture contamination rate to <3%. • Time from blood culture collection to laboratory load – within 4-hours. • Sepsis screening for patients with NEWS2 5 or above - >80% within 1 hour. • Education to promote best practice in the identification and management of sepsis – delivery of sepsis module for all clinical staff groups

Clinical effectiveness

Timely access to services was a Trust priority and quality priority for us in 2024/25, and significant improvements were made (see pages 31 and 88). This continues to be a priority for us in 2025/26, with renewed aims for this year.

Timely access for all to planned and unscheduled care

Goal	Aims
• 75% of patients seen and treated or discharged from ED within 4-hours.	• Type 1 performance consistently better than 50%. • 12 hour waits less than 8% of all attendances.
• 85% of patients receive cancer treatment within 62-days.	• 62-day > 75%.
• No patient will wait longer than 18-weeks for treatment.	• Treat 60% of patients within 18 weeks. • No more than 1% of patients waiting longer than 1 year, increasing pace of progress to further reduce waiting times.

Patient experience

The priorities below link to the Patient Voice and Involvement strategy and were developed following feedback from and engagement with our patients and communities.

Nutrition

Goal	Aims
Increase the number of patients who say they have their dietary needs met when inpatients. This includes access to food suitable for	• Baseline data: 77.6% of patients said they did in the CQC Adult Inpatient Survey 2024. Target: Increase to 85% by the end of Q1 2027.

diabetics, halal food, gluten free food, kosher food and vegan food.	• To be measured by the Trust's new inpatient ward survey, new ward accreditation patient experience question and CQC 2026 survey results.

Reasonable Adjustments Digital Flag (RADF)

Goal Increase the number of patients with RADF on their patient record, compared to current number with AIS flag, by 50%.	**Aims** • RADF options and flag to go live on PAS. • Communications campaign to raise staff and patient / public awareness of reasonable adjustments and how we can record these on the PAS electronic patient record.

Health Inequalities

Goal Improve access to interpreters for our local communities, in order to support patient safety, improve health outcomes and improve patient involvement in decisions about care and treatment, in line with new NHSE improvement framework for community language interpreting and translation services (May 2025).	**Aims** • Target: Interpreting requests / bookings fulfilment rate to meet KPI of 98% overall for 2025-26. Measured by: Monthly interpreting reports and community feedback. • We will engage with patients, families and communities representing the top 5 most requested languages East Kent in 2024-25. These are Slovak, Nepali, Arabic, Turkish and Romanian. • Identify two community representatives to be included on the tender evaluation panel, along with two clinical service representatives and the contract manager. • Procurement to start in November 2025 and contract to be awarded by April 2026, to commence 1st June 2026.

Staff experience

These key themes were identified during the initial phase of the quality improvement approach to the 2024 NHS Staff Survey. They emerged based on a lack of year-on-year progression, significant gaps to the national standards, and key driver analysis highlighting their direct impact on overall staff engagement.

The overarching aim is to increase staff engagement levels to the national average by 2026/27 and into the upper quartile by 2027/28.

Staff Survey

Goal	Aims
• Enhance our net promotor score so that a majority (>50%) of our people feel proud to work for the Trust, strengthening organisational culture and engagement.	• Input to and continued development of the Trust Strategy and Vision ('trusted, chosen, valued'). • Refresh of Trust values in partnership with Kaleidoscope.
• Strengthen psychological safety across our workforce, ensuring meaningful and sustainable progress from the current baseline.	• Launch of the Resolution Framework & Toolkit: Stop, talk, change campaign. • Establishment of resolution project group, working with expert external partner. • Introduction of The Guardian Service – Independent freedom to speak up service.
• Embed compassionate leadership across the organisation by addressing the variability in experience and support, ensuring all teams uphold high standards of kindness, empathy and care – raising our leadership experience toward the national average of 7.0.	• Extensive review of suite of leadership programmes taking place through compassionate leadership lens. • Identification of areas requiring intensive support to feed into (2-year) organisational development strategic plan.

2.2 Statements of assurance from the board

This section of the report contains a series of statements of assurance with prescribed information that we must, by law, include in our Quality Account.

Item 1: Services and income

During 2024/25 we provided and/or subcontracted 103 relevant health services.

We have reviewed all the data available to us on the quality of care in these services.

The income generated by the relevant health services reviewed in 2023/24 represents 100% of the income generated from the provision of relevant health services by the Trust for 2024/25.

Item 2: National Audit Summary

During 2024/25 58 national clinical audits and 5 national confidential enquiries covered relevant health services that East Kent provides.

During that period we participated in 98% (57) national clinical audits and 100% (5) national confidential enquiries of the national clinical audits and national confidential enquiries which we were eligible to participate in.

The national clinical audits and national confidential enquiries that we were eligible to participate in during 2024/25 are in table B.

The national clinical audits and national confidential enquiries that we participated in during 2024/25 are also in table B.

The national clinical audits and national confidential enquiries that we participated in, and for which data collection was completed during 2024/25 are listed in table B, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry or as a number where percentage not applicable.

Progress against the national audits is monitored through the bi-monthly Clinical Audit Effectiveness Group (CAEG) and monthly at the Quality and Safety Committee (QSC) as part of quality governance reporting requirements.

The reports of 31 national clinical audits were reviewed by us in 2024/25 and we intend to take the following actions to improve the quality of healthcare provided:

Audit	Actions and Improvements
Sentinel Stroke National Audit Programme (SSNAP)	No actions required as EKHUFT are in the top 20% of national teams receiving an overall score of 'A'.

NRAP (National Respiratory Audit Programme): Children and Young People Asthma Secondary Care	Asthma guideline updated and local smoking cessation audit completed with actions including posters for both inpatients and outpatient areas and increased health professional knowledge.
National Lung Cancer Audit (NLCA)	Dedicated Computed Tomography (CT) scans; Daily Two Week Wait (2WW) lung cancer clinics; Increased Endobronchial Ultrasound (EBUS) capacity; Increased number of Lung Cancer Clinical Nurse Specialists.
National Paediatric Diabetes Audit (NPDA)	EKHUFT notified as an outlier for adjusted mean HbA1c data. Actions include implementing new technology such as hybrid closed loop pumps in line with NICE guidance.
National Cardiac Audit Programme (NCAP)	Plans for direct admissions to cardiology wards is underway in order to improve outcomes for patients requiring angiograms. Redesign of Coronary Care Unit (CCU) implemented to reduce ambulance delays on arrival.
National Audit of Dementia (Round 6)	2023-24 national report was published in December 2024 demonstrating higher case number submissions and improvements in: delirium screening within 24 hours; pain re-assessment within 24 hours; discharge planning within 24 hours. Based on national recommendations actions include collaboration with other specialties such as the Emergency Department and Safeguarding team to improve screening on admission, and with the patient voice team to improve education. A pain assessment proforma has been added to the electronic patient management system.

The reports of 177 local clinical audits were reviewed by us in 2024/25 and we intend to take the following actions to improve the quality of healthcare provided:

Themes	Audit Topics	Actions / Improvements Made
Maternity and Neonatal Deteriorating Patient	1. Management of Sepsis in Obstetric Patients 2. Paediatric Early Warning Scores 3. Paediatric Sepsis	1. This re-audit met all of the standards therefore no actions are required. 2. A quarterly audit was completed prospectively by staff on the wards with live feedback given in order to aid learning with posters displayed. 3. Mandatory Sepsis training on the Electronic Staff Record was implemented.
Electronic Prescribing and Medicines Administration	1. Parkinson's Disease (PD) Medication audit 2. Emergency Department (ED) Medication Safety audit	1. A PD time critical medication sticker has been adopted in the Emergency Departments. 2. Results were shared with all relevant teams and new teaching sessions arranged to ensure medication is administered within an hour.
Delays / Transfer of Care Communications	1. Outcomes of non-clinical transfers from and to Intensive Care Unit (ICU) 2. Paediatric Safe Transfers 3. STOP Handover	1. Results demonstrate a reduction in mortality rates. 2. Following a quarterly prospective audit, an instruction video has been created and shared. Simulation training is also given through monthly teaching

Themes	Audit Topics	Actions / Improvements Made
		sessions with further updates provided via a nursing WhatsApp group. 3. All patients transferred who had concerns had them discussed with actions taken therefore no further actions required.
Pressure Ulcers	1. Tissue Viability / Skins Bundle annual audit 2. Pressure Ulcers CQUIN	1. Compliance with heel offloading, communication of risk to patients and use of appropriate mattresses has improved in comparison with 2023 audit results and no further actions were required. 2. An improved risk assessment tool (Purpose-T) has been introduced and implemented with the maternity team and will be rolled out to other areas.
Falls	1. Inpatient Falls – CT Scans 2. Lying and Standing Blood Pressure	1. A standard operating procedure for post fall x-ray and CT management was collaboratively agreed between the Health Care of Elderly People (HCOOP) and Radiology teams. 2. Electronic patient management system changes have been actioned to allow National Early Warning Score (NEWS) 2 documentation to feed into the Multi-Factorial Risk Assessment for Falls (MFRAP) data.
Dementia	1. 4AT Delirium Assessment Compliance	1. A 4AT delirium compliance audit was commissioned as a result of the national audit. Actions included improved collaboration between the Dementia and Falls teams. The 4AT tool has also been added to the electronic patient management system with a notification for completion every 48 hours to help increase compliance with guidance training for staff.
Safeguarding	1. Acute Maternity All Age Safeguarding Review 2. Re-audit Consenting for a Bedside Procedure 3. Section 11 Audit	1. Actions currently being drafted. 2. Following the first cycle of the audit a consent box was installed in the Surgical Emergency Assessment Unit (SEAU) working desks and posters were displayed in SEAU with weekly departmental teaching sessions introduced. As a result, all standards were achieved in the re-audit.

Themes	Audit Topics	Actions / Improvements Made
		3. Safeguarding children's process was audited and reviewed by the Safeguarding Children's Partnerships with completion of CPIS phase 2, delivery of additional supervisee training, trust wide messaging around individual safeguarding responsibilities, communication with the team communication and further work continues of an engagements strategy for children and young people.

Table B: Participation in national clinical audits and confidential enquiries

National Audit	Care Group	EKHUFT Participation (Y / N / N/A)	Cases Submitted
BAUS Penile Fracture Audit	Kent and Canterbury Hospital (K&CH)	Yes	2 cases submitted.
BAUS I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy	Kent and Canterbury Hospital	Yes	All 10 cases
BAUS Environmental Lessons Learned and Applied to bladder cancer care pathway (ELLA)	Kent and Canterbury Hospital	Yes	55/57 eligible cases
Breast and Cosmetic Implant Registry	N/A to EKHUFT	N/A to EKHUFT	N/A to EKHUFT
British Hernia Society Registry	William Harvey Hospital and Queen Elizabeth Queen Mother Hospital	Planned but consultants not yet signed up as registry only went live Nov 24. Participation is not compulsory due to the absence of central funding.	
Case Mix Programme (CMP)	Critical Care, Anaesthetics and Specialist Surgery	Yes	WHH-221, K&CH-117, QEQM-212
Child Health Clinical Outcome Review Programme (NCEPOD) – Emergency (non-elective) surgery in children and young people	Trust-wide	Yes	14/14 cases plus 17/28 clinical questionnaires
Cleft Registry and Audit Network (CRANE) Database	N/A to our services	N/A to our services	N/A to our services

Emergency Medicine QIP: Adolescent Mental Health	William Harvey Hospital (WHH) and Queen Elizabeth Queen Mother Hospital (QEQM)	Yes	WHH-305, QEQM-338
Emergency Medicine QIP: Care of Older People	William Harvey Hospital and Queen Elizabeth Queen Mother Hospital	Yes	WHH-278, QEQM-366
Emergency Medicine QIP: Time Critical Medications	William Harvey Hospital and Queen Elizabeth Queen Mother Hospital	Yes	WHH-379, QEQM-323
Epilepsy 12: National Clinical Audit of Seizures and Epilepsies for C&YP	Women's Health and Children and Young People	No - derogation (not to participate) was approved by the exec team and ICB	N/A
Falls and Fragility Fracture Audit Programme (FFFAP): Fracture Liaison Service Database (FLS-DB)	William Harvey Hospital and Queen Elizabeth Queen Mother Hospital	Yes	567
Falls and Fragility Fracture Audit Programme (FFFAP): National Audit of Inpatient Falls (NAIF)	Trust-wide	Yes	No case numbers provided by provider as yet
Falls and Fragility Fracture Audit Programme (FFFAP): National Hip Fracture Database (NHFD)	Kent and Canterbury Hospital	Yes	QEQM-313. WHH-279
Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)	Trust-wide	Yes	28 RIP referrals
Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE)	Women's Health and Children and Young People	Yes	As at Nov 24, Stillbirths-7, Neonatal deaths-9
Medical and Surgical Clinical Outcome Review Programme (NCEPOD) - 4 Studies	Trust-wide	Yes	i) Acute Limb Ischaemia 9/9, ii) Blood Sodium 15/15, iii) EoL Care 9, iv) Rehab following critical illness 12/12
Mental Health Clinical Outcome Review Programme	N/A to EKHUFT	N/A to EKHUFT	N/A to EKHUFT
National Adult Diabetes Audit (NDA): National Diabetes Core Audit	William Harvey Hospital and Queen Elizabeth Queen Mother Hospital	Yes	820
National Adult Diabetes Audit (NDA): Diabetes Prevention Programme (DPP)	N/A to EKHUFT	N/A to EKHUFT	N/A to EKHUFT
National Adult Diabetes Audit (NDA): National Diabetes Footcare Audit (NDFA)	William Harvey Hospital and Queen Elizabeth Queen Mother Hospital	Yes	69

National Adult Diabetes Audit (NDA): National Diabetes Inpatient Safety Audit (NDISA) – AKA HARMS	William Harvey Hospital and Queen Elizabeth Queen Mother Hospital	Yes	3 Datix
National Adult Diabetes Audit (NDA): National Pregnancy in Diabetes Audit (NPID)	Women's Health and Children and Young People	Yes	WHH-90, QEQM-65
National Adult Diabetes Audit (NDA): Transition and Young People 2 Audit	William Harvey Hospital and Queen Elizabeth Queen Mother Hospital	Yes (Spotlight audit associated with NPDA)	1 eligible case submitted
National Adult Diabetes Audit (NDA): Gestational Diabetes Audit [1]	Women's Health and Children and Young People	Yes	As at Nov 24, 339 cases
National Audit of Cardiac Rehabilitation	N/A to EKHUFT		
National Audit of Cardiovascular Disease Prevention in Primary Care	N/A to EKHUFT		
National Audit of Care at End of Life (NACEL)	Diagnostics, Cancer and Buckland Hospital	Yes	120 cases (40 per hospital site)
National Audit of Dementia (NAD)	William Harvey Hospital and Queen Elizabeth Queen Mother Hospital	Yes	WHH – 70/94 QEQM 70/78
National Bariatric Surgery Registry	N/A to EKHUFT		
National Cancer Audit Collaborating Centre (NATCAN): National Audit of Metastatic Breast Cancer (NAoMe)	Diagnostics, Cancer and Buckland Hospital	Yes	129
NATCAN: National Audit of Primary Breast Cancer (NAoPri)	Diagnostics, Cancer and Buckland Hospital	Yes	1673
NATCAN: National Bowel Cancer Audit (NBOCA)	William Harvey Hospital and Queen Elizabeth Queen Mother Hospital	Yes	525 (To Q2 2024)
NATCAN: National Kidney Cancer Audit (NKCA)	Kent & Canterbury Hospital	Yes	443 (Q2 2024)
NATCAN: National Lung Cancer Audit (NLCA)	William Harvey Hospital and Queen Elizabeth Queen Mother Hospital	Yes	110 (Q1 2024)

[1] Whilst this audit is registered on the NHS England Quality Accounts List for 2024-25, the Healthcare Quality Improvement Partnership (HQIP) Directory guidance document (Nov 24 version) states that it does not form part of the Quality Account List for this year. However, EKHUFT is participating therefore data has been recorded.

NATCAN: National Non-Hodgkin Lymphoma Audit (NNHLA)	Diagnostics, Cancer and Buckland Hospital	Yes	200 (Q2 2024)
NATCAN: National Ovarian Cancer Audit (NOCA)	Women's Health and Children and Young People	Yes	63 as at Dec 24
NATCAN: National Pancreatic Cancer Audit (NPaCA)	William Harvey Hospital and Queen Elizabeth Queen Mother Hospital	Yes	138 (Q1 2024)
NATCAN: National Prostate Cancer Audit (NPCA)	Kent & Canterbury Hospital	Yes	Data not currently available
National Cardiac Arrest Audit (NCAA)	Critical Care, Anaesthetics and Specialist Surgery	Yes	Q1 QEQM – 29 team and 29 individual visits Data for K&CH and WHH awaited.
National Cardiac Audit Programme (NCAP): National Adult Cardiac Surgery Audit (NACSA)	N/A to EKHUFT		
NCAP: National Congenital Heart Disease Audit	N/A to EKHUFT		
NCAP: National Heart Failure Audit (NHFA)	William Harvey Hospital	Yes	Q2 WHH – 253 Q2 QEQM - 175
NCAP: National Audit of Cardiac Rhythm Management (CRM)	William Harvey Hospital	Yes	Q2 WHH – 413 Q2 QEQM -383
NCAP: Myocardial Ischaemia National Audit Project (MINAP)	William Harvey Hospital	Yes	Q2 WHH – 585 Q2 QEQM - 128
NCAP: National Audit of Percutaneous Coronary Intervention (NAPCI)	William Harvey Hospital	Yes	Q2 WHH - 711
NCAP: UK Transcatheter Aortic Valve Implantation (TAVI)	N/A to EKHUFT		
NCAP: Left Atrial Appendage Occlusion Registry (LAAO)	N/A to EKHUFT		
NCAP: Patent Foramen Oval Closure Registry (PFOC)	N/A to EKHUFT		
NCAP: Transcatheter Mitral and Tricuspid Valve Registry (TMTV)	N/A to EKHUFT		
National Child Mortality Database (NCMD)	N/A to EKHUFT		
National Clinical Audit of Psychosis (NCAP)	N/A to EKHUFT		
National Comparative Audit of Blood Transfusion: NICE Quality Standard QS138	Diagnostics, Cancer and Buckland Hospital	Yes	QEQM–50, K&CH–47, WHH-49

National Comparative Audit of Blood Transfusion: Bedside Transfusion Practice	Diagnostics, Cancer and Buckland Hospital	Yes	QEQM–16, K&CH–10, WHH-10
National Early Inflammatory Arthritis Audit (NEIAA)	William Harvey Hospital and Queen Elizabeth Queen Mother Hospital	Yes	As at Jan 25: 1 complete record and 7 incomplete records.
National Emergency Laparotomy Audit (NELA)	Critical Care, Anaesthetics and Specialist Surgery	Yes	As at Q3 end: WHH – 121 cases (106 locked) QEQM – 101 cases (48 locked)
National Joint Registry (NJR)	Kent & Canterbury Hospital	Yes	As at Q2 end: K&CH – 614, QEQM – 300, WHH - 171
National Major Trauma Registry (TARN)	William Harvey Hospital and Queen Elizabeth Queen Mother Hospital	Yes	As at Aug 24: QEQM–51, WHH-95
National Maternity and Perinatal Audit (NMPA)	Women's Health and Children and Young People	Yes	As at Nov 24: Stillbirths-10, 3rd/4th degree tears-48, Unassisted vaginal birth-2048, Assisted vaginal birth-406
National Neonatal Audit Programme (NNAP)	Women's Health and Children and Young People	Yes	Awaiting numbers from provider
National Obesity Audit (NOA)	N/A to EKHUFT		
National Ophthalmology Database (NOD): Age-related Macular Degeneration Audit	Critical Care, Anaesthetics and Specialist Surgery	Yes	As at Q1 end: 3166
National Ophthalmology Database (NOD): Cataract Audit	Critical Care, Anaesthetics and Specialist Surgery	Yes	As at Q1 end: 1976
National Paediatric Diabetes Audit (NPDA)	Women's Health and Children and Young People	Yes	As at Jan 25 - 412
National Perinatal Mortality Review Tool Audit (PMRT)	Women's Health and Children and Young People	Yes	As at Jan 25, Stillbirths-10, Neonatal deaths-18, Late fetal loss-0
National Pulmonary Hypertension Audit	N/A to EKHUFT		
National Respiratory Audit Programme (NRAP): COPD Secondary Care	William Harvey Hospital and Queen Elizabeth Queen Mother Hospital	Yes	WHH–287 and QEQM-399
NRAP: Pulmonary Rehabilitation	N/A to EKHUFT		

NRAP: Adult Asthma Secondary Care	William Harvey Hospital and Queen Elizabeth Queen Mother Hospital	Yes	WHH-48 and QEQM-17
NRAP: Children and Young People Asthma Secondary Care	Women's Health and Children and Young People	Yes	WHH-22 and QEQM-45
National Vascular Registry (NVR)	Kent & Canterbury Hospital	Yes	Cases as at Jan 25: AAA Repair-73, Carotid-31, Bypass-68, Angioplasty-136, Amputation-24
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)	N/A to EKHUFT		
Paediatric Intensive Care Audit Network (PICANet)	N/A to EKHUFT		
Prescribing Observatory for Mental Health (POMH): Rapid tranquillisation of acutely disturbed behaviour	N/A to EKHUFT		
POMH: The use of melatonin	N/A to EKHUFT		
POMH: The use of opioids in mental health services	N/A to EKHUFT		
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Oncology and Reconstruction, Trauma, Orthognathic Surgery and Oral and Dentoalveolar Surgery	Critical Care, Anaesthetics and Specialist Surgery	Yes	TBC
Sentinel Stroke National Audit Programme (SSNAP)	Kent & Canterbury Hospital	Yes	As at end of Q2: 530
Serious Hazards of Transfusion (SHOT): National Haemovigilance Scheme	Diagnostics, Cancer and Buckland Hospital	Yes	19 reports submitted as at Jan 25
Society for Acute Medicine Benchmarking Audit (SAMBA)	William Harvey Hospital and Queen Elizabeth Queen Mother Hospital	Yes	TBC
UK Cystic Fibrosis Registry	N/A to EKHUFT		
UK Renal Registry Chronic Kidney Disease Audit	Kent & Canterbury Hospital	Yes	Submissions have recently switched to prospective. Numbers low?
UK Renal Registry National Acute Kidney Injury Audit	Kent & Canterbury Hospital	Yes	Submissions have recently switched to prospective. Numbers low?

Item 3: Research and Development (R&D)

We launched a new Research and Innovation strategy in 2023, with a vision to place research at the heart of everything that we do, offering all patients opportunities to participate in trials of the very latest treatments and therapies, as well as a wide

range of other studies. To reflect our commitment to research, a sixth Trust priority within the We Care approach was added for 2024/25, continuing into 2025/26 (see page 18). As part of the strategy there was a renewed focus on commercially-funded and interventional trials in 2024/25.

The number of patients receiving relevant health services provided or subcontracted by us in 2024/25 that were recruited to participate in research approved by an ethics committee was 1,834 which was 80% more than our annual target.

In total, we opened 47 new studies, across 18 discrete disease areas. 36 of these were interventional studies trialling new treatments and therapies. This is an increase of 6% on the previous year. We have also continued to maintain a healthy balance with complex interventional (usually randomised controlled) and more straightforward observational and large-scale studies.

There are a number of successes to highlight:

- 3 studies achieved first participant nationally and the first to recruit in Europe to the FREXALT study – comparing frexalimab to placebo in adults with non-relapsing secondary progressive multiple sclerosis.
- We were the highest recruiting site for 5 studies and the highest recruiting site internationally for the SILVER II study – a commercial study of wound dressings.
- The Trust award for Excellence in Research and Innovation was won by the WHH team running the BachB trial – Improving outcomes for babies with bronchiolitis.

The Research and Innovation Department opened the East Kent Clinical Trials Unit in 2022 with its dedicated Clinical Research Facility (CTUF) at QEQMH. The CTU opened 8 new studies in 2024/25 and secured 5 successful grant applications totalling £1.2m.

More information about can be found on our website: Research and Innovation | East Kent Hospitals.

Item 4: Commissioning for Quality and Innovation (CQUIN)

Our income in 2024/25 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation (CQUIN) payment framework because NHS England paused the CQUIN programme for 2024/25 as part of a wider review of incentives for quality. This removed any financial consequences related to CQUIN performance.

In April 2024 NHS England published non-mandatory schemes. As part of a wider improvement portfolio, a number of the non-mandatory CQUINs were agreed with our commissioners with quarterly reporting continuing.

A number of the CQUIN schemes were modified in line with our priorities to better support local improvement work and therefore compliance cannot be measured against the targets set in the non-mandatory schemes. For example, the CQUIN threshold for requiring input for patients from the Frailty Teams, based at the William Harvey Hospital and Queen Elizabeth Queen Mother Hospital sites, is a Rockwood Score of 6 however Trust guidance requires Frailty input if a patient scores 5 resulting in earlier intervention. The score of 5 was used as the basis for compliance rather than the score of 6.

Each CQUIN has had a clinical lead, a multidisciplinary working group and has been supported corporately by the CQUIN Compliance, Assurance and Improvement Facilitator.

NHS England has decided to pause the CQUIN programme for a further year but has not published a set of non-mandatory indicators. The quality improvement work achieved during the 2024/25 period will continue to be built on and overseen within other improvement workstreams.

Items 5, 6, 7: Care Quality Commission (CQC)

We are required to register with the CQC and our current registration status at the time of producing this report, is 'registered'. We had the following conditions on our registration during 2024/25:

- The Section 31 notice from the January 2023 inspection of maternity services issued on 13 February 2023 remained in place during 2024/25. This notice imposed additional conditions on our registration in respect of maternity services, with a requirement to report progress on improvements to the CQC monthly. Monthly updates have been submitted to the CQC since then as required, and the notice has subsequently been lifted (in June 2025).

The CQC re-inspected maternity services in December 2024 and found that the Trust had made significant improvements since its last inspection. It rated both units as 'good'.

The Care Quality Commission has not taken enforcement action against us during the reporting period 2024/25.

We have not participated in any special reviews or investigations by the CQC during the reporting period 2024/25.

The overall Trust ratings are shown here:

Item 8: Secondary Uses Service

We submitted records during 2024/25 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data, which included the patient's valid NHS number was:

- 99.8% for admitted patient care
- 100% for outpatient care and
- 96.7% for accident and emergency care.

The percentage of records in the published data, which included the General Medical Practice Code was:

- 100% for admitted patient care
- 100% for outpatient care; and
- 99.7% for accident and emergency care

Item 9: Data Security and Protection Toolkit

The Data Security and Protection Toolkit (DSPT) enables health and care organisations to assess their compliance with data security and information

governance standards, as mandated by NHS England (NHSE) and the Department of Health and Social Care (DHSC).

For the 2023/24 reporting year, the Trust submitted its DSPT evidence in June 2024 and declared full compliance with all applicable requirements, resulting in a 'Standards Met' accreditation.

For the 2024/25 reporting year, NHSE has aligned DSPT requirements with the National Cyber Security Centre's (NCSC) Cyber Assessment Framework (CAF), which defines a set of high-level objectives to support strong and effective cyber security practices. The Trust's DSPT/CAF evidence submission is due for final submission by 30 June 2025.

To achieve a 'Standards Met' status, the Trust must demonstrate that it meets the required minimum achievement levels across all DSPT outcomes. As part of the DSPT assurance process, the Trust is required to commission an independent external audit of its planned evidence submission. The returned findings from this audit indicate an overall *Low* risk rating across all five CAF objectives, with a *High* confidence level assigned by the independent assessor regarding the veracity of the Trust's self-assessment across the 12 DSPT outcomes. These findings strongly indicate that the Trust is on course to achieve a 'Standards Met' accreditation upon final submission of its DSPT evidence by 30 June 2025.

Item 10: Clinical Coding Error Rate

We were not subject to the Payment by Results or any other external clinical coding audit during the reporting period.

Item 11: Data Quality

We will be taking the following actions to improve data quality:

- Face to face classroom-based training for all eligible new starters on administration of Referral to Treatment (RTT) Pathways.
- Mandatory RTT eLearning for all relevant operational and administrative staff linked to annual appraisal process.
- Task and Finish group in place to review all non-RTT open pathways and cleanse data to ensure a clean waiting list from which operational teams can book patients in chronological order.
- Review and centralisation of administrative Standard Operating Procedures to improve usage across the Trust.
- Review of Terms of Reference and remit of the Information Assurance Committee, in line with governance processes, to ensure appropriate oversight on Data Quality issues.

Items 12-26

See section 2.3 core indicators.

Item 27: Mortality and Learning from Deaths

Mortality

Mortality metrics are complex but monitored and reported nationally as one of many quality indicators of hospital performance. While they should not be taken in isolation, they can be a signal that attention is needed for some areas of care and this can be used to focus improvement in patient pathways through the Mortality Surveillance and Steering Group (MSSG).

Reduction in mortality is one of our key objectives with our aim to reduce mortality rates and be in the top 20% of all Trusts for the lowest mortality rates over the next five years.

Our Hospital Standardised Mortality Rate (HSMR) is published monthly in the Board papers as part of the Integrated Performance Report and discussed at the monthly MSSG and Quality and Safety Committee meetings. In addition, we report the number of cases from 'Learning from lives and deaths – people with a learning disability and autistic people' (LeDeR) every six months to the Safeguarding Assurance Committee. This is also reported via relevant National Clinical Audits.

Learning from Deaths (LFD)

We recognise the importance of 'Learning from Deaths' as described by the National Quality Board as a learning and improvement platform for the Trust. To help us achieve this we are using the nationally recognised Structured Judgement Review (SJR) tool for the review of adult deaths. In the majority of cases, this excludes patient deaths investigated as patient safety incidents via the Serious Incident Framework (SIF) (pre-June 2024) or PSIRF (post-June 2024). Child deaths are investigated via the Child Death Oversight Process. Maternity deaths are investigated by the national Maternity and Neonatal Safety Investigation team.

We have three SJR trainers, supported by the Learning from Death Leads, who train clinical staff in learning to undertake these reviews. The training sessions continue to be delivered to a range of multi-disciplinary staff including consultants and senior nurses over the last year. We have two part-time Learning from Deaths Facilitators who support the clinical teams.

The adult LFD process reviews the deaths of patients screened predominantly by the Medical Examiner team. The specialities complete their SJRs and review the learning at their Mortality and Morbidity (M&M) meetings. We continue to have 27 specialities across the Trust that hold regular M&M meetings. There are five speciality teams that are fully compliant with the Trust M&M Terms of Reference. A maturity matrix has been developed to enable teams to undertake a self-assessment

of compliance with the learning from deaths process and M&M Terms of Reference. This will be implemented during 2025/26 and monitored through the Mortality Surveillance Steering Group which reports to the Operational Quality Governance Committee (formerly the Patient Safety Committee).

Following screening, a first SJR is completed. Any patient who is deemed as having received care that is judged to be poor or very poor overall prior to their death, or having a more than 50:50 probability of being described as a potentially avoidable death, is automatically triggered for a second SJR.

A second SJR is allocated by one of the LFD Facilitators to an experienced reviewer in the specialty the patient's death was related to, or to one of the LFD Leads. Once the review is completed this reviewer then presents the case to the LFD panel which meets twice a month. The panel determine if the case should be considered via the PSIRF process (formerly SIF process). This may include the second reviewer presenting the case at speciality M&Ms.

For deaths reported as incidents and investigated under the SIF or PSIRF, a judgement is not routinely made in relation to whether the death was avoidable. Pages 63, 64 and 71-75 includes a breakdown of incidents and level of harm.

The data below was extracted from the SJR Patient Tracking List (PTL) dashboard report.

During 2024/25, 2526 adult patients died (excludes paediatric and maternity).
Q1 579
Q2 538
Q3 656
Q4 753

By 31 March 2025, 278 case record reviews (Structured Judgement Reviews) had been carried out in relation to 2526 of the deaths included above.

The number of deaths in each quarter for which a case record review was carried out was:
Q1 26
Q2 48
Q3 83
Q4 121

23 (SJR cases) representing 0.8% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:
3 (of 579) representing 0.5% for the first quarter;
0 (of 538) representing 0% for the second quarter;

3 (of 656) representing 0.5% for the third quarter;
14 (of 753) representing 1.8% for the fourth quarter.

Please note this excludes maternity and paediatric deaths as these specialities have their own review process.

The learning from SJRs demonstrates that in 62.9% of cases in 2024/25 there was good/excellent overall care. These include examples of good multi-disciplinary working and family discussions. This was seen especially in pre-emptive discussions regarding the possibility of end of life, particularly in some learning disability cases, and some good responses to deterioration although this was inconsistent.

The key learning themes for 2024/25 include long delays in the Emergency Department affecting care, delays in end of life decision-making, safe discharge, copy and pasting of electronic notes and insufficient documentation of Treatment Escalation Plan/ReSPECT forms. These have all been escalated through the Learning from Death Panel meeting and Mortality Surveillance Steering Group to the appropriate workstreams within the Trust.

Some of the positive and learning themes have also been shared at M&M meetings as well as in Trust messages that are sent to all speciality multidisciplinary teams to share with the wider speciality teams.

The learning from SJRs has been shared with relevant Trust leads and incorporated into quality improvement workstreams e.g. deteriorating patient and end of life care.

The impact of actions taken is evidenced within the section of this report relating to deteriorating patient (page 29).

142 SJR case record reviews completed after 01/04/2024 which related to deaths which took place in 2023/24.

3 cases representing 2% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. These numbers have been estimated using the SJR Patient Tracking List (PTL) dashboard report.

397 SJRs were completed in 2023/24 and 2024/25 period relating to the 2023/2024 reporting period. 8 deaths were judged to be more likely that not to have been due to problems in care, representing 2% of patient deaths for the 2023/2024 reporting period.

2.3 Reporting against core indicators

This section of the Quality Account includes performance against a core set of indicators prescribed by NHSE. We have provided data for the last two reporting periods and, where available, the national average and highest and lowest performing NHS Trust.

Indicator 12: Summary Hospital Level Mortality Indicator (SHMI)

Data source: NHS Digital

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

Trusts have been categorised into bandings indicating whether a trust's SHMI is 'higher than expected' (band 1), 'as expected' (band 2) or 'lower than expected' (band 3).

Measure	Current Dec 23-Nov 24	Previous Dec 22 to Nov 23	Highest comparable NHS trust	Lowest comparable NHS Trust	National average
Ratio of observed mortality as a proportion of expected mortality.	1.142 Band 2	0.957 Band 2	1.147	0.8739	1.0031

Measure	Current April 24-March 25	Previous April 23-March 24	Highest comparable NHS trust	Lowest comparable NHS Trust	National average
The % of patient deaths with palliative care coded at either diagnosis or specialty level.	38.7%	37.3%	67%	16%	43%

The increase in SHMI for the trust from the previous year is largely due to a change in the way in which it is calculated. As an organisation that has traditionally delivered

a lot of palliative care, that these deaths are now included in the measure is largely responsible for the increase. We serve a large, deprived coastal population. We know the medical diagnoses which drive our SHMI and will address those parts of the clinical care pathways we can this year.

Indicator 18 Patient Reported Outcome Measures

Both procedures detailed below - knee replacement and hip replacement - have scores for the EQ-5D™ Index and EQ VAS. Hip replacement and knee replacement procedures each have their own condition-specific measure, which combine into a single score a patient's answers to a number of health questions of particular relevance to their procedure.

The EQ-5D™ Index collates responses given in 5 broad areas (mobility, self-care, usual activities, pain/discomfort, and anxiety/depression) and combines them into a single value. The EQ-5D™ Index was developed by the EuroQol Group. EQ-5D™ is a trademark of the EuroQol Group.

EQ VAS is a 'thermometer'-style measure based on a patient's self-scored general health on the day that they completed their questionnaire, but which provides an indication of their health that is not necessarily associated with the condition for which they underwent surgery and which may have been influenced by factors other than healthcare. The EQ VAS was also developed by the EuroQol Group.

Hip replacement surgery

Data source: NHS Digital

Measure	April 2023-March 2024	April 2022-March 2023	Highest comparable NHS Trust	Lowest comparable NHS Trust	National average
EQ-5D Index:38 modelled records	Adjusted average health gain: 0.454	Adjusted average health gain: 0.43	0.598	0.367	0.453
EQ VAS: 38 modelled record	Adjusted average health gain: 13.405	Adjusted average health gain: 14.086	21.288	6.279	14.1
Oxford Hip Score: 39 modelled records	Adjusted average health gain: 23.055	Adjusted average health gain: 23.987	25.492	18.1	22.3

We remain close to the national average for the health gain metrics, with small gains or small losses in individual measures. We will work towards even greater understanding of the drivers this year and seek to be in the top 25% of Trusts over the next two years.

Knee replacement surgery

Data source: NHS Digital

Measure	April 2023-March 2024	April 2022-March 2023	Highest comparable NHS Trust	Lowest comparable NHS Trust	National average
EQ-5D Index:37 Modelled records	Adjusted average health gain: 0.288	Adjusted average health gain: 0.232	0.4	0.233	0.323
EQ VAS: 39 modelled records	Adjusted average health gain: 7.727	Adjusted average health gain: 9.308	15.977	1.788	7.369
Oxford Knee Score: 41 modelled records	Adjusted average health gain: 15.649	Adjusted average health gain: 12.929	20.115	12.439	16.815

We have made significant improvement in two of the three knee measures, particularly in relation to the Oxford score. We will review our action plan and its delivery and learn where we can further improve over the next 12 months.

Indicator 19: Percentage of patients readmitted within 30-days of being discharged

Measure	April 2024-March 2025	April 2023-March 2024
Patients aged 0-15	7.7%	11.4%
Patients aged 16 or over	9.0%	10.5%

We consider that this data is as described for the following reasons:

- For the 0-15 age group, a marked decline in readmission rate is observed from early 2024 onwards. This coincides with the Same Day Emergency Care (SDEC) recording change implemented in June 2024, where activity previously recorded as Children's Assessment Unit (CAU) admissions began to be recorded as SDEC attendances. This change results in fewer cases

meeting the criteria for inpatient admissions and subsequent readmission, artificially lowering the readmission rate.
- For the 16-plus age group, medical SDEC admissions began being recorded as SDEC attendances in November 2023, and in July 2024 similar changes were applied to gynaecology (GAU and EPU) and surgical (SEAU) units, with these also recategorized as SDEC.

We intend to take the following actions to improve this percentage, and so the quality of services, by:

- There is pathway work underway to improve readmissions, such as the introduction of use of bilirubinometers to reduce readmissions of babies with jaundice.
- In women's health services we are implementing NICE recommended dressings to help reduce readmissions due to wound infections following c-sections.

Indicator 20: Trust's responsiveness to the personal needs of its patients:

Data source: CQC National Inpatient Survey 2023

Inpatient survey question	2023	2022
Q29 Do you think the hospital staff did everything they could to help control your pain?	70%	89%
Q25 To what extent did staff looking after you involve you in decisions about your care and treatment?	67%	79%
Q27 Did you feel able to talk to members of hospital staff about your worries and fears?	75%	94%
Q28 Were you given enough privacy when being examined or treated?	92%	98%
Q41 Did a member of staff tell you about medication side effects to watch for when you went home?	41%	83%
Q43 Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	69%	75%

We consider that this data is as described for the following reasons:

- The reduction in satisfaction levels is likely to be the result of increased pressure on sites from emergency admissions, challenges to patient flow and

increased use of corridor care before admission to a ward. Once on the ward, patients may be moved frequently, which means their additional needs are not always communicated in handovers. There is pressure to discharge medically fit patients, often at short notice, which is likely to lead to lack of involvement in discussions about discharge and what will happen after discharge, including thorough explanations of medications given to be taken at home. This leads to patients having a less person-centred experience, in particular patients with additional needs.

We intend to take the following actions to improve these percentages, and so the quality of services, by:

- Better sign-posting to support for carers and families of patients (we have developed a carers' leaflet).
- Piloting a 'What Matters to Me' communication poster on two wards at each site, starting in late April 2025, which will be evaluated in July 2025. This highlights at a glance any communication needs the patient wishes to share.
- Developing a discharge checklist - work has started on this.
- Improving discharge for vulnerable patients, including people with learning disabilities, autism and dementia. This follows a Kent and Medway wide audit which highlighted poorer discharges and more frequent readmissions for more vulnerable patients.
- Measuring through the ward accreditation programme.

Indicator 21: Staff employed by, or under contract to the Trust who would recommend the Trust as a provider of care to their family or friends

Data source: National Quarterly Pulse Survey

Current period	Value	Previous period	Value
Q1 2024-25	30%	Q1 2023-24	42%
Q2 2024-25	55%	Q2 2023-24	44%
Q3 2024-25	44%	Q3 2023-24	44%
Q4 2024-25	58%	Q4 2023-24	42%

We consider that this data is as described for the following reasons:

- First-hand experience and observation of poor patient care, coupled with a lack of compassion from staff toward patients.

We intend to take/have taken the following actions to improve this percentage, and so the quality of services, by:

- Identifying areas of best practice for learning and celebration, along with areas in need of intensive support.
- Using methodical quality improvement (A3) approach to identify key themes, current state, root causes and necessary countermeasures (actions).
- Tailoring staff survey action plans at three levels; organisational, Care Group and corporate, with a single, central plan and strict governance to ensure accountability.
- Working collaboratively with partners to ensure the voice of almost 6,500 staff helps to co-develop the new Trust strategy.
- Undertaking comprehensive review of the suite of leadership development programmes, adapting to ensure we prioritise compassionate leadership.
- Embedding associated leadership development, culture and experience markers as part of clinical audit taken place across all wards.
- Conducting staff survey workshops to co-develop practical and tangible solutions.

Indicator 23: Percentage of patients who were admitted to hospital and who were risk-assessed for venous thromboembolism (VTE) during the reporting period

Measure	National Target	2024-2025	2023-2024
Percentage of patients who were admitted to hospital and who were risk-assessed for venous thromboembolism (VTE) during the reporting period	95% of all patients to have a mandatory VTE risk assessment on admission to hospital.	93.4%	90.5%

We consider that this data is as described for the following reasons:

- The data comes from electronic VTE risk assessments for each patient on Sunrise (our electronic health record system) and can be verified by checking individual patient records. This is done during the Hospital Associated Thrombosis (HAT) process. A reminder email is also sent to bed-holding consultants if the VTE risk assessment has not been performed, this also is a method of checking that the clinician can undertake.

We intend to take the following actions to improve this percentage, and so the quality of services, by:

- Continuing work with the Sunrise team for better placement of the risk assessment in the electronic documents within the confines of the system.
- Assessment becoming an integral aspect of the clerking system.
- Continuing with the We Care improvement programme and implementation of actions from Getting It Right First Time (GIRFT) and Healthcare Safety Investigation Board (HSIB) recommendations.
- Supporting Women's Health with their quality improvement project focussing on patient education and improving compliance with obstetric standards and MBRRACE recommendations (Women's Health were nominated for a Thrombosis UK award for their achievements).
- Continuing with the implementation plan for VTE under PSIRF.
- VTE team working across Care Groups, reviewing the use of mechanical thromboprophylaxis as a cost saving, in line with GIRFT recommendations.

Indicator 24: The rate per 100,000 bed days of cases of C. difficile infection reported within the Trust among patients aged 2 or over during the reporting period

Current Period	**April 2024-March 2025**	**April 2023-March 2024**
The rate per 100,000 bed days of cases of Clostridium difficile infection reported within the Trust among patients aged 2 or over	105 cases – 73 HOHA 32 COHA	144 cases – 101 HOHA 40 COHA

We consider that this data is as described for the following reasons:

- The data presented in the table accurately reflects the performance and quality of services delivered, particularly relating to Clostridium difficile infections.

We (intend to take/have taken) the following actions to improve this (indicator/percentage/score/data/rate/number), and so the quality of services, by:

- Continuing antimicrobial stewardship to reduce inappropriate use of antibiotics.
- Achieving hand hygiene compliance rate above 90% with ongoing education and support.
- Implementing CLEAN campaign to declutter and support effective environmental cleaning.
- Undertaking IPC audits to monitor compliance with IPC standards.
- Undertaking rapid review of each case, and align processes to PSIRF.
- Holding healthcare associated infection review panel to look at themes and share learning.

Indicator 25: The number and where available, rate, of patient safety incidents reported within the Trust during the reporting period

April 2024-March 2025

Rate per 1000 bed days: 55.18

Number: 23,863

April 2023-March 2024

Rate per 1000 bed days: 59.56

Number: 26,520

Indicator 25: The number and percentage of such safety incidents that resulted in severe harm or death

April 2024-March 2025
Rate per 1000 bed days: 0.22

Number: 96

April 2023-March 2024
Rate per 1000 bed days: 0.20

Number: 90

More information on patient safety incidents is included on pages 71-75.

Part 3: Other information

This section includes some other mandated information, together with other areas we consider relevant to the quality of care we provide.

Mandated updates

Progress in implementing 7-day hospital services

Seven-day services clinical standards were developed to support providers of acute services to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency.

Overall, there are ten clinical standards, of which four are a priority and these include:

- CS2. All non-elective admissions must be seen by a suitable consultant within 14-hours of admission:
    - There is currently no direct measurement of time-to-first-consultant review, however acute services have consultant on-site presence into the evenings and provide rolling review of emergency admission. i.e.

we are structured to deliver consultant-directed assessment for emergency admissions.
    - Professional standards are in place for emergency admissions, written and developed by medical royal colleges which define timescales for specialist review and diagnostic imaging to deliver optimal care. Work is underway with the information team to develop automated reports to evidence delivery of these standards. This work will provide more robust evidence of our delivery against the standards.
    - Whilst there has been improvement in UEC performance over the past year, there remain significant clinical and operational challenges. Emergency departments are extremely over-crowded and there is a risk of harm to patients. Timely review by consultants is also challenged due to the poor flow of patients through the ED and into speciality wards.
    - Medical Examiners have identified themes of poor care related to the difficulty of full assessment of patients with in corridors due to lack of space and privacy for clinical examination.

- CS5. Access to diagnostic tests with a 24-hour turnaround time - for urgent requests this drops to 12 hours and for critical patients to one hour.
    - USS, CT, MRI, endoscopy, echocardiography and microbiology are all available on site at weekends.
    - There is faster turnaround at weekends for inpatient requests for CT scanning. For inpatient MRI scans, there is generally a faster turnaround for requests made on a Thursday to Sunday.

- CS6. Access to specialist, consultant-directed interventions:
    - Intensive care, interventional endoscopy, surgery, renal replacement therapy are all available on site at weekends.
    - Interventional radiology, renal replacement therapy, stroke thrombolysis, percutaneous coronary intervention for myocardial infarction, and cardiac pacing are all available via network at weekends.
    - There are plans for stroke thrombectomy to be available at weekends.
    - Time to treatment for thrombolysis comparing week days to weekends does not show any marked difference – the target time is one hour. Data for April to September 2024 show that this was achieved every month.

- CS8. On-going review by consultant twice daily for high dependency patients, daily for others
    - All acute teams have rosters for weekend consultant reviews or board rounds in all clinical areas.
    - Ward board rounds, with multi-professional attendance are standardised and widely practiced.

- Many clinical team work a rota of “ward weeks “ where the same consultant is present for multiple days in a row including over weekends, enhancing continuity of care.
- Analysis of Job plans demonstrates around 10.8% of consultant PAs are within premium time. This includes predicable and un-predictable on call duties.
- Anecdotal evidence suggests senior review outside ward areas may take longer and in some cases be less reliable than in wards with an established and known medical staff base.

More information can be accessed here: NHS England » Seven Day Services Clinical Standards

Delivery of the seven-day services clinical standards should also support better patient flow through acute hospitals.

There is evidence to indicate that services are designed and delivered across seven days, with access to consultant review and access to key diagnostics and interventions. Therefore, the four priority Clinical Standards are structured to be met, although audit has not yet been performed for most clinical areas to prove where gaps arise.

Development of an automated metric of time-to-first consultant review has been explored with our Information Team. It is feasible to develop a report of time-of-consultant review from Sunrise documentation which is date and time stamped.

Freedom to Speak Up (FTSU)

The NHS Freedom to Speak Up initiative aims to create a safe environment for NHS staff to raise concerns about patient safety and quality of care without fear of retaliation.

We have information on our staffzone pages, and a Freedom to Speak Up Policy which advises staff what to do if they have concerns.

During 2024/25 we reviewed and changed our Freedom to Speak Up service to an external FTSU provider – the Guardian Service – to improve the quality of the service. The Guardian Service is a reputable provider that delivers services to multiple NHS Trusts both in Kent and nationally.

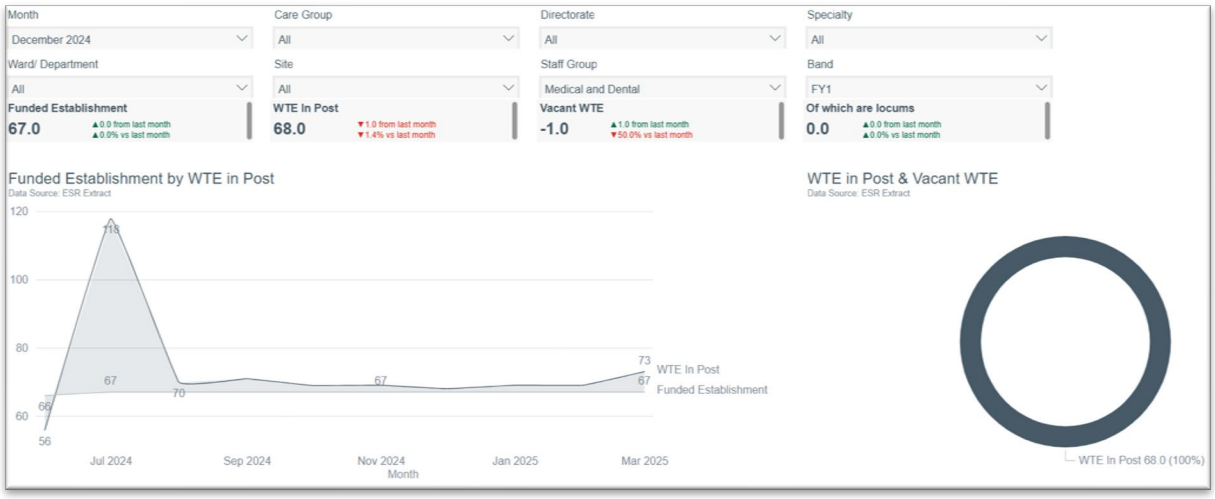
The Guardian Service went live on 17 March 2025. This followed a 6-week mobilisation period. We have a dedicated Lead Guardian for the Trust who has been introduced to Care Group teams. The new service is accessible via a 24-hour phone line and email. We have raised awareness across the Trust to inform colleagues of the new service.

Staff have begun to use the new service and the first monthly report is due in May 2025.

Rota gaps

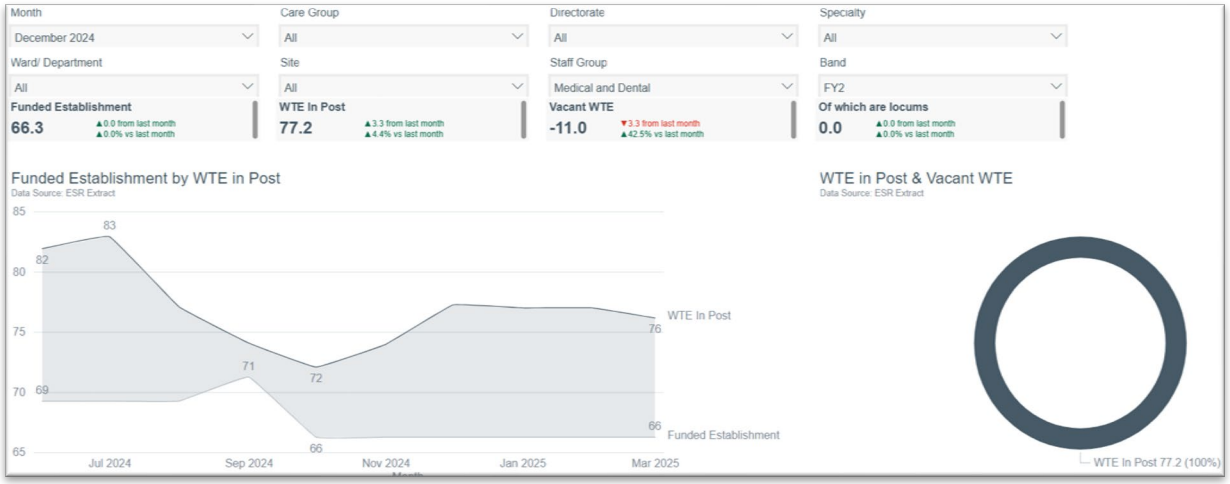
There are terms and conditions of service in place for doctors and dentists in approved postgraduate training programmes under the auspices of Health Education England (HEE). These state that the Quality Account must include a consolidated annual report on rota gaps and the plan for improvement to reduce these gaps.

Establishment & Rota Gaps – FY1 Level (Resident and Local Employed Doctors):

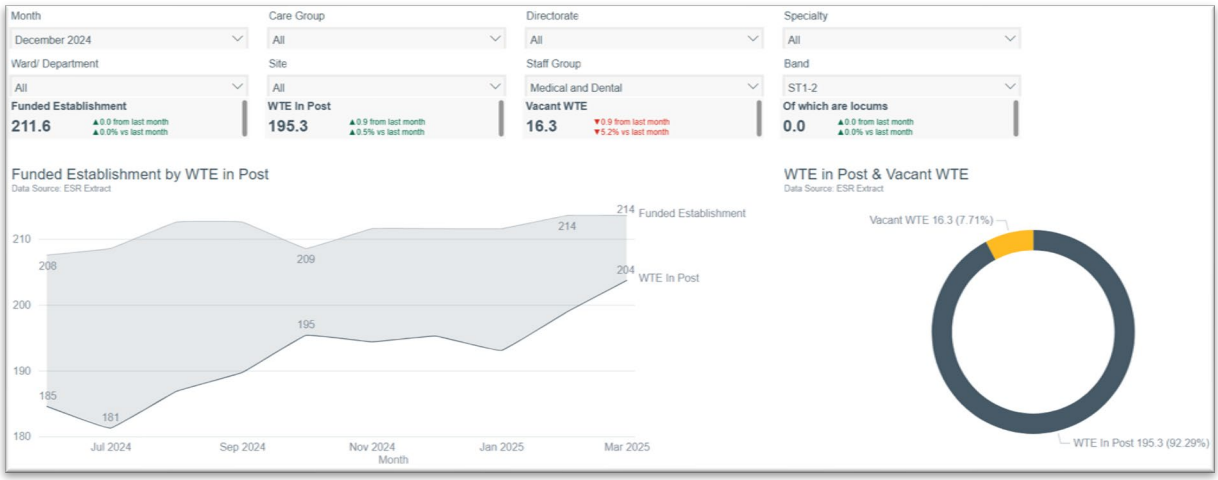


Note: The above data indicates a spike in FY1 doctor numbers in July 2024. This is attributable to the overlap between incoming newly qualified FY1 doctors, who commence in mid-July, and outgoing FY1 doctors, who typically remain in post until early August.

Establishment & Rota Gaps – FY2 Level (Resident and Local Employed Doctors):

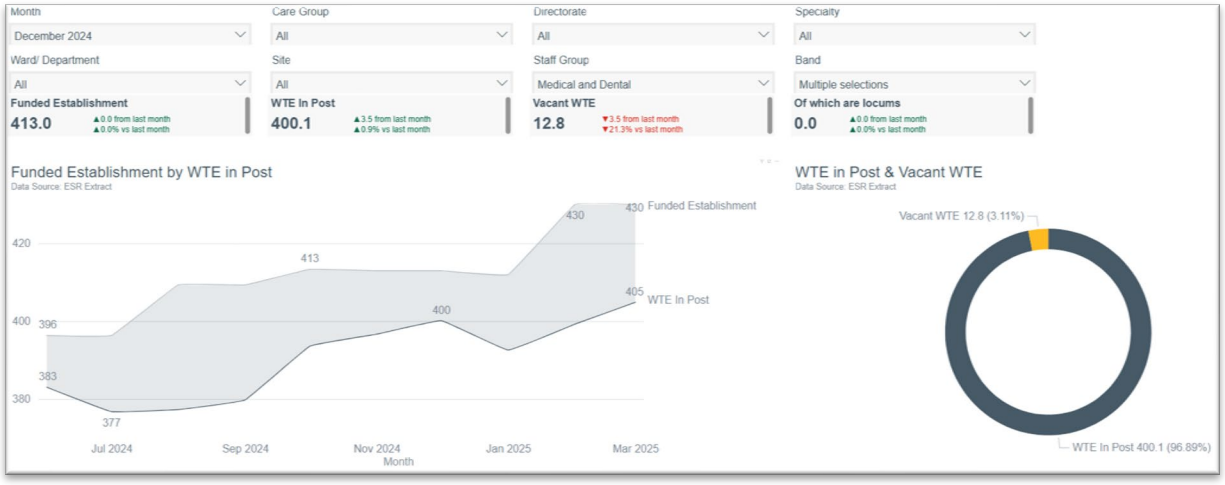


Establishment & Rota Gaps – CT1-2/ST1-2 Level (Resident and Local Employed Doctors):



Note: According to the FY2 diagram, there are 11 posts above the funded establishment. In contrast, the CT1–2/ST1–2 diagram shows a shortfall of 16 posts against establishment. Doctors at FY2/CT1–2/ST1–2 all work on the same rota within a department. This results in a net vacancy position of 5 posts overall.

Establishment & Rota Gaps – ST3-8 Level (Resident and Local Employed Doctors):



Rota Gaps and Recruitment Initiatives

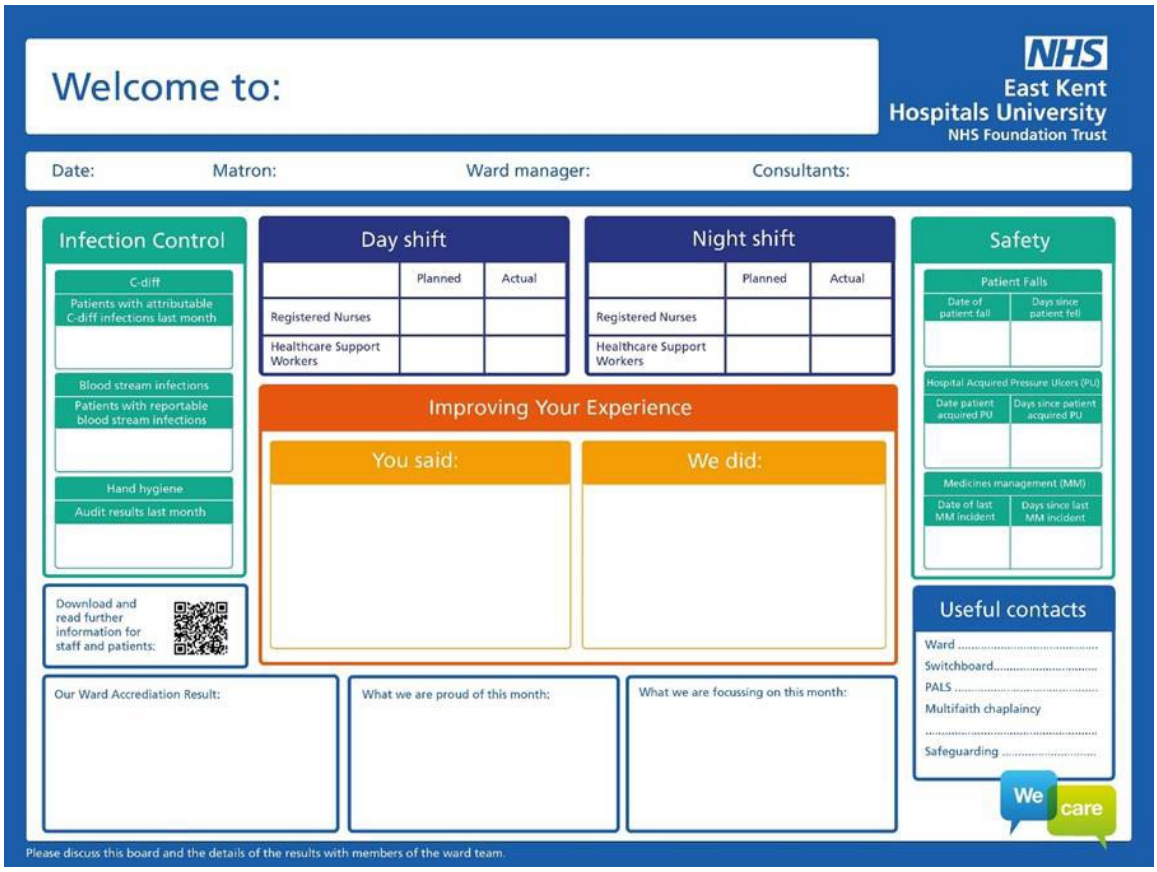
Rota gaps are recognised to have a significant impact on both patient safety and the quality of doctors' training. Medical Resourcing, Medical Education, and the Guardian of Safe Working are committed to reducing these gaps wherever possible.

- East Kent is designated as an under-doctored and deprived area with persistent challenges in medical recruitment. NHS England has implemented a Targeted Enhanced Recruitment Scheme (TERS) to support such areas. As part of this initiative, TERS General Practitioner posts were introduced in Thanet in August 2024, with up to six posts available.
- Each spring, the Kent, Surrey and Sussex Foundation School organises a recruitment fair for prospective FY1 doctors. Our Medical Education Department actively participates in this event to support recruitment efforts.
- Rota gaps are consistently present in Resident Doctor Foundation posts commencing in August. To address this for August 2025, Medical Resourcing has advertised for Locally Employed Doctor (LED) posts at both Foundation and ST1–2 levels. Interviews have been conducted for positions at WHH and QEQMH, with the aim of appointing up to 15 doctors per site. These doctors will form a flexible staffing pool to be allocated to vacant posts in July/August 2025.
- Resident doctor posts should be uploaded to the Trust Rotation Grid (TROG) no later than 90 days (3-months) prior to their start date. Failure to meet this timeline hampers the onboarding process and delays the production of generic rotas. This often results in late filling of posts and short-notice withdrawals by trainees. While this issue is outside of the Trust's direct control, mitigations have been implemented.
- Our medical resourcing team runs weekly social media campaigns to promote LED medical posts and attract prospective candidates.

Our other areas of quality focus

Quality and Safety

Each of our wards now have highly visible quality boards in place which clearly show ward level performance on a range of nursing quality indicators such as infections, pressure ulcers and medication incidents that have occurred on the ward. The intention behind these boards is to make key quality indicators visible to patients, visitors and staff and to show improvements in these measures over time. From experience we know that making these quality indicators visible promotes improvements in care and in turn our staff feel energised to sustain these.



Accreditation

The theatre team at the Kent and Canterbury Hospital became the first NHS site in Kent to receive accreditation by the Association for Perioperative Practice (AFPP), after visiting inspectors praised the safety culture and teamwork. The determines the standards and promotes best practice for operating theatre safety and to be accredited means that organisations have to achieve and evidence that they meet very exacting standards.

Patient Safety Incidents, Never Events

We transitioned to the national system for patient safety events in February 2024 - Learn from Patient Safety Events (LFPSE). These events include incidents, patient outcomes, risks and good care. This system enables automatic notification to the CQC of notifiable safety incidents (moderate, severe and death). During 2024/25 national and organisational level data from the LFPSE system has not been available, however national data was published in April 2025 and organisational level data will be published in May 2025.

Within our Trust:

- We have a process in place for reviewing patient safety incidents through the nomination of named handlers at the point of reporting an incident. Additionally, experienced clinical and non-clinical staff working in patient safety and quality governance ensure all patient safety incidents are reviewed every working day. These staff support the handlers and ensure that incidents of concern or interest are escalated for further review.
- The Maternity and Neonatal Rapid Review meeting occurs three times a week; the Fundamentals of Care Incident Panel (reviewing patient falls, tissue viability and nutrition and hydration issues) meet weekly; and the Pre-Incident Review Panel meets weekly to review all other types of patient safety incidents of concern or interest. These three panels feed into the Incident Review Panel which reviews the determinations and decides the most appropriate method to respond to the patient safety incident in accordance with our PSIRF plan.
- Patient Safety Incidents are automatically uploaded to LFPSE on submission and re-uploaded each time the LFPSE required data is updated. During late 2024 / early 2025, we undertook the LFPSE required data validation exercise to identify data quality issues. This process continues on an ongoing basis to ensure the accuracy of patient safety incident data uploaded. We are changing our electronic local risk management system in 2025 and are optimistic this will address the majority of data quality issues identified.
- Information and learning from patient safety incidents are collated to inform our understanding of trends, themes and the incident-reporting culture within the Trust. This information is reported bi-monthly to the Patient Safety Committee and Quality and Safety Committee.

Incident Reporting Rates for the Trust by year

Patient Safety Incidents	April 2021 to March 2022	April 2022 to March 2023	*April 2023 to March 2024	April 2024 to March 2025
	12 months	12 months	12 months	12 months
Trust total reported incidents (NRLS)	24,282	25,456	NRLS 22,229	Trust 23,854
Trust incidents resulting in severe harm or death	94	99	NRLS 77	Trust 90
% of Trust incidents resulting in severe harm or death	0.4%	0.4%	0.3%	0.4%

*The Trust switched from uploading to the NRLS to LFPSE on 14/02/2024, hence incomplete year data for 2023/24.

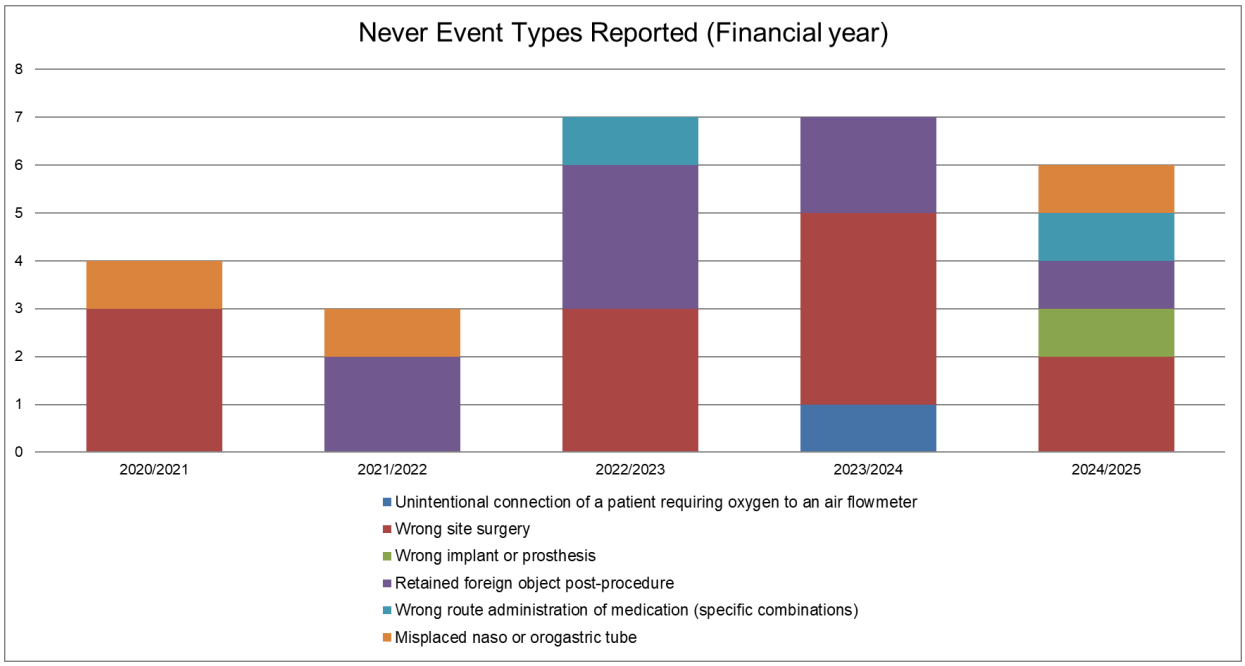
LFPSE harm data had not been published at the time of reporting, therefore data extracted via the Trust Incidents' Dashboard has been included for 2024/25.

The transition from the National Reporting and Learning Service to the LfPSE has not resulted in a significant change to the number of incidents reporting, including the proportion of severe harm and death

Never Events

Never events are described as incidents that are wholly preventable because guidance or safety recommendations, that provide strong systemic protective barriers, are available and should have been implemented by all healthcare providers. NHS England undertook a consultation regarding the Never Events framework in 2024. This was following the findings of reports from the CQC and the HSIB, and further focus groups held by the National Patient Safety Team, which highlighted for several types and sub-types of Never Events the barriers are not strong enough to make an incident wholly preventable. Following closure of the consultation, NHS England is engaging with stakeholders and patient representatives on next steps.

Number and types of Never Events over the past five years



In quarter 2 2024/25, we reported five Never Events. This is the highest number reported in any quarter since Never Events were introduced. Subsequently, an internal review was completed, focusing on the Never Events that occurred between 01 October 2022 to 03 October 2024 and drawing on national information, comparator Trust data and previous internal and ICB reviews regionally of Never Events.

The review identified that the majority of Never Events occurring relate to surgical invasive procedures. These fall into the subtypes of Never Events currently under review as it is recognised that the nationally recommended barriers are not strong enough to prevent an incident occurring as there remains a reliance on the performance of people.

Because of the nature of most Never Events, we invited the Association of Perioperative Practice (AFPP) to undertake a review of theatres across the Trust in 2023. This identified primarily good practice and some areas of improvement. An improvement plan continues with the aim of achieving AFPP accreditation for all theatres in 2025.

We found that our organisational oversight of the implementation and updating of our procedures in accordance with the National Safety Standards for Invasive Procedures 2, required strengthening. As a result, the Chief Medical Officer is leading work to improve consent procedures and the Deputy Chief Medical Officer is leading work to review and refresh our Safety Standards for Invasive Procedures within and outside of theatres. This work will also encompass strengthening the

governance and re-enforcing the requirement for improving staff understanding of how human factors impact within practice and how to effectively manage the associated risks.

Type and learning from the Never Events in 2024/25

Type of Never Event	Description	Learning identified
Misplaced naso or orogastric tube	Feed was commenced without realising that the imaging report stated the tube was not correctly sited	Update the nasogastric tube insertion safety standard documentation. Liaise with the external provide to establish if they can adopt the standard reporting template for nasogastric tube imaging reports.
Wrong site surgery	Wrong mouth lesion biopsied	Embed the Time Out period prior to any surgical procedure commencing to ensure appropriate checks are fully completed. Ensure new clinicians have access to the required IT systems.
Wrong site surgery	Wrong laterality anaesthetic block	Consistent approach to training and supervision in nerve block Safety Standard to be incorporated into anaesthetic specialist training. Review nerve block safety standard documentation to ensure it meets the requirements of NatSSIPs 2. Embed ensuring there is an 'assistant' role for block procedures outside the theatre environment.
Wrong route medication	Oral medication administered intravenously	Flagging patients living with a learning disability for additional pharmacy input. Ensure the Medicines Policy Equality Impact Assessment and content considers patients living with a learning disability. Increased the frequency of updates for staff administering medication from every three years to annually.
Wrong implant or prosthesis	Localisation wire inserted rather than coil	Explore the option of the speciality uploading of the outcome of clinics, directly onto the Electronic Patient Record systems, to ensure notes and referrals are timely. Review and update the vetting process across diagnostic imaging.

Type of Never Event	Description	Learning identified
		Review the consenting and wire insertion Safety Standard to ensure these meet the requirements of NatSSIPs2.
Retained foreign object	Retained throat pack	Investigation ongoing.

Duty of Candour

During 2024/25 we improved our compliance with Duty of Candour and achieved our aim of 100% compliance in the three metrics: verbal conversation, written follow up and sharing findings.

The Duty of Candour is a crucial, underpinning aspect of a safe, open, and transparent culture. The statutory (legal) duty re-enforces the general and ethical duties of openness, honesty and transparency with patients when something may have gone wrong. The CQC regulates the Duty of Candour under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Within the national requirements of the statutory duty (organisational) it states that patients/relevant persons must be informed of notifiable safety incidents in a timeframe that is 'reasonably practicable'. Notifiable safety incidents are incidents that are unintended or unexpected and in the reasonable opinion of a healthcare professional, already have, or might, result in death, or severe or moderate harm to a person receiving care.

The Duty of Candour regulation states that we must:

1. Tell the relevant person, face to face, that a notifiable safety incident has taken place.
2. Apologise.
3. Provide a true account of what happened, explaining whatever you know at that point.
4. Explain to the relevant person what further enquiries or investigations you believe to be appropriate.
5. Follow up by providing this information, and the apology, in writing, and providing an update on any enquiries.
6. Keep a secure written record of all meetings and communications with the relevant person.

In order to discharge these requirements, we undertake a verbal conversation with the patient and offer an apology, provide a follow up letter in a timely manner and provide the patient with a summary or, if applicable, a final report detailing how we have responded to the incident.

We transitioned to the PSIRF in June 2024. The change in learning response (investigation) methodology has ensured that we involve patients and families in the learning responses from the outset. We offer to share the draft learning response reports as they progress and ensure the final report and safety action plan is shared once finalised. We also offer a meeting with the patient or family to discuss the report, should they wish to do so. For incidents which do not require a formal report to be produced, a summary of the investigation findings and learning actions are included in the final duty of candour letter.

In the last year we continued our focus on our compliance with the Duty of Candour. Our Care Group governance teams have actively supported and guided our staff leading the Duty of Candour requirements for individual cases. We have continued with regular meetings each week, to monitor compliance, provide support and problem-solve complex cases. The Duty of Candour dashboard provides a visible system for our staff to see, daily, exactly what is due and when and supports the proactive management of our Duty of Candour requirements.

Throughout the last year, we have seen steady improvements in compliance with our Duty of Candour metrics. We have succeeded in achieving our aim of 100% compliance by March 2025 in the three metrics: verbal conversation, written follow up and sharing findings.

In the next year, our focus will be to improve the quality of how the Duty of Candour requirements are fulfilled. We will do this through ensuring we update our staff about the recent guidance from the CQC and NHS England interpreting notifiable safety incident requirements alongside the Learn from Patient Safety Events harm categorisation. We will also review and update our Duty of Candour Policy to ensure it reflects the NHS England, Engaging and involving patients, families and staff following a patient safety incident.

Safeguarding

During the past year we have made improvements to our safeguarding processes, training levels and cross-site understanding of our safeguarding responsibilities.

The NHS has an oversight framework containing a set of oversight metrics. These are used to ensure alignment of priorities across the NHS and identify where NHS providers may benefit from or require support. Every Trust is allocated to one of four ‘segments’ depending on the level of support required, based on objective criteria and judgement. NHSE and the ICB are responsible for then providing support and oversight.

East Kent safeguarding has been in national oversight levels three and four, which resulted in mandated support and assurance monitoring from the ICB and NHSE. Due to the improvements made we moved from level 4 to level 3 oversight in May 2024, and then to standard oversight at local safeguarding ICB level in April 2025. Our improvement work included:

- Monitoring structure and capability to meet statutory functions.
- Improved evidence around systems and processes through strengthening our dataset and compliance monitoring though safeguarding operational group and our Safeguarding Assurance Committee.

- Improved culture and development of safeguarding within the Trust through local site allocation of safeguarding support.
- Key lines of enquiry developed in response to incidents, appropriateness of response and escalation.
- Reduction in current risks within the Trust
- Benchmarking against National Safeguarding Accountability and Assurance Framework.
- Training compliance maintained overall over 85% at all levels.

Our safeguarding team now supports individuals and families throughout their lifespan when accessing services across our Trust. Within our safeguarding duty service there are specialists for adults, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), maternity and children's safeguarding. This supports a 'think family' approach to safeguarding. Systems and processes are embedded to ensure the recording of safeguarding activity. Safeguarding is now interwoven through all elements of care delivery and is a key factor in strategic planning. There is a series of audits in place to ensure progress is maintained.

Mental health

We appointed an Associate Director of Nursing: Mental Health in November 2024. This was a new position; the Learning Disability and Autism Liaison Nurses and Dementia Team now sit under the new Mental Health team. Work has started on reviewing policies, procedures, staff training and support in relation to promoting quality, safety and wellbeing for patients who present with mental health needs.

Complaints, PALS, Compliments

During 2024/25 we improved the quality of our complaint responses and achieved our target of providing 85% of responses within the agreed timeframe. In 2023/24 our performance was 31%, this improved to 85% by November 2024.

Feedback from patients, families and friends which results in a compliment, complaint or PALS is centrally managed by the Complaints and PALS teams (CPBS). This year, the number of complaints received has increased by 18.27%, and the number of PALS has increased by 7%. There continues to be a complex nature to concerns being raised to the CPBS. This complexity has impacted on the time required for investigations and subsequent responses.

Complaints activity, for comparison purposes, over the last five years

Year received	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025
Total number of formal complaints received	705*	941*	874	1021	1191
PALS contacts received	5837*	7152*	6740	5569	5967
Compliments received	19,392*	27,684	30,850	30,662	25,461
Ratio of complaints to compliments	1:28*	1:29	1:37	1:30	1:21

*Numbers affected by the Covid-19 pandemic

2024-2025 has seen a period of change for complaints management within the Trust, with the aim to improve the experience of complainants. The majority of staff working on complaints within the Care Groups were moved into a central team; following this, the complaint procedure was process mapped and streamlined.

One aim of the review was to meet the requirements of the Parliamentary and Health Services Ombudsman (PHSO) NHS Complaints Standards, introduced in spring 2024. The requirements include providing a quicker and more consistent approach to complaint handing and outcomes. The CPBS work closely together to de-escalate as many concerns as appropriate.

The new complaint process now ensures there is one complaint manager who receives the complaint and supports Care Group staff to examine the issue and provide an outcome, with senior oversight.

Another objective was to improve the quality of responses and to meet the KPI of 85% of complaint responses completed within agreed timescales. A trajectory was set in August 2024, which incrementally aimed to achieve the KPI in December. Good progress was made and the KPI was achieved in December and for the remaining months of the year.

Month	% responded to within agreed timescales
December 2024	85%
January 2025	86.4%
February 2025	87.3%
March 2025	86%

During 2025/26, further focus will be on engagement with Care Groups, supporting staff to provide an early resolution to complaints and PALS. This is good practice

aimed at improving patient experience in a more timely and effective way. Alongside this will be a focus on how to share and review the learning from complaints and PALS. A new electronic Quality Management System, InPhase, will be implemented. The aim of the system is to improve the quality of tracking and reporting of complaints and PALS, alongside any identified learning and outcomes.

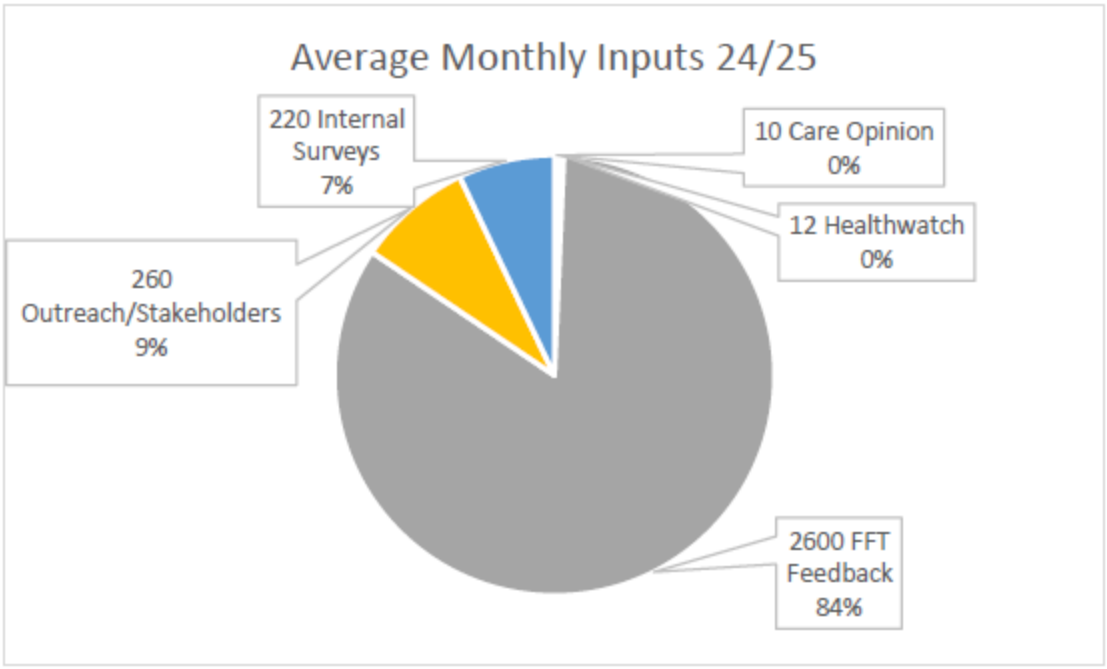
Other Quality and Safety priorities

Patient Voice and Involvement

In 2022 our Board approved a Patient Voice and Involvement strategy and established a Patient Voice and Involvement team.

During 2024/25 the Patient Voice and Involvement Team gathered and/or analysed almost 40,000 pieces of patient feedback and supported colleagues to theme over 60,000 pieces of feedback:

- A third of all written Friends and Family Test (FFT) responses received by the Trust were themed by our team (averaging 2600 a month); the total themed across the Trust in this period was 93,012, a significant increase on last year's 41,645. We have included more information about our FFT results in the section on pages 82-84.
- We have co-produced patient feedback surveys with several clinical and operational teams within the Trust, with an average of 32 surveys running concurrently at any given time (an increase of 20 on last year) and have had 2,621 patient/carer/family/stakeholder responses to these.
- The team has responded to 116 Care Opinion posts and progressed with colleagues, averaging 10 a month (last year's average was 17 a month). We have also received a similar amount of monthly feedback from Healthwatch Kent.
- The team has actively reached out to stakeholder organisations, individual patients and community groups as well as receiving contact from patients via telephone and email. Some of this provides specific or anecdotal feedback we can use and sometimes it is more of a developmental conversation to encourage continued collaborative working; over 2,000 individual people and stakeholder groups have worked with us across our communities.



Our Patient Participation and Action Group (PPAG) now has 19 members, and we continue to recruit passionate people with lived experience to work with us on a more formal voluntary basis. The group still needs to grow in diversity, but the PPAG can respond to ad-hoc requests for their input on the wording of patient information, letter templates, and patient surveys, as well as more involved strategic work like the Patient Portal, Clinical Strategy and Cancer forums.

The team carries out on-going community engagement to gather feedback from a range of local communities, especially those whose voices are not normally heard.

The majority of feedback that we hear across all channels is positive, ranging from around 60% in individual interactions to 90% in the FFT data we review. 93.9% of patients responding to the FFT survey described their experience as Good/Very Good and 88.2% of themed feedback was positive.

The key themes we have heard less positive feedback on are:

- Poor communication and information.
- Poor care given by staff.
- Quality of treatment received.
- Poor staff attitude.
- Long waiting times: on-site at an appointment or in the Emergency Departments and for follow-up treatment.

Responding to feedback from patients on communication and information we have:

- Provided a summary of community and birth partner feedback for the Reading the Signals Oversight Group.

- Delivered a two-hour training session for every member of the William Harvey Hospital's Emergency Department over a six-week period, covering our 'Seeing the Person' presentation.
- Brought IT colleagues to community groups for them to trial the Patient Portal.
- Developed co-produced changes to patient information and treatment pathways for cancer services.

We receive a significant amount of positive feedback in the community for our approach and commitment to hearing the voices of patients, their families and for working with them. On several occasions, a patient who was considering making a complaint has instead worked with us collaboratively to feel heard and see their issues resolved, feeding into our more strategic work.

We have looked at how we can better support carers of our patients and involve them as expert partners in care. This includes providing information for staff to raise their awareness about the importance of recognising and involving carers / families, implementing a carers' policy, and launching a carers' leaflet and a carers' page on our public website and on Staffzone.

The team supports several workstreams related to health inequalities. This includes the implementation of the Accessible Information Standard (AIS), the interpreting and translation service, reporting on the patient related outcomes in the Equality Delivery System (EDS) annual report and on Equality and Health inequalities Impact Assessments (EHIAs). This work is led by the Associate Director of Patient Experience.

During 2025/26 we will be refreshing the Patient Voice and Involvement strategy. This will include incorporating the new NHS England Experience of Care Improvement Framework, which all NHS trusts are required to use to self-assess their work on patient experience by March 2026. We will also reference the new NHS England patient safety healthcare inequalities reduction framework, and the EDS outcomes related to patient experience. By utilising these frameworks we will ensure that our new strategy is focused on improving patient and community access to healthcare, patient and carer / family experience and patient outcomes, especially for people who face significant health inequalities.

Friends and Family Test (FFT)

During 2024/25 patient satisfaction levels were consistently over 93% across our Trust.

To improve the quality of the services we deliver, it is important that we understand what our patients think about their care and treatment. We use a variety of methods

to gain patient feedback. One method is through the Friends and Family Test (FFT). The Friends and Family Test is a national measure required across all NHS Trusts. It asks patients to rate their level of satisfaction with their experience of care at the Trust. When a patient is discharged from hospital or has attended an appointment, they will receive a text message asking the following question, unless they have opted out: "Thinking about your recent stay in hospital (or visit to an out-patient department), overall, how was your experience of our service?"

As well as asking the patient (or their parent if their child received care) to rate their experience on a scale from 'very good', 'good', 'neither good nor poor', 'poor', or 'very poor' and share any comments, the text message will also give patients option to share their feedback anonymously with the Trust or with the clinician in charge of their care. We have exceeded our Trust-wide target of 90% of patients overall rating their experience as 'very good' or 'good' consistently since October 2020.

From April 2024 to March 2025 the satisfaction level was consistently over 93% Trust-wide, with four of the 12 months (August, December, January and March) averaging over 94% satisfaction. There is a variance in satisfaction levels for different types of episodes of care, with patients having day treatment and attending out-patient appointments consistently scoring an average of over 95% satisfaction, inpatients scoring an average of over 90% satisfaction and patients attending emergency departments scoring an average of 83.5% satisfaction during the period April 2024 to March 2025.

Each month the Friends and Family Test (FFT) survey results are posted on the Trust's website. These results show the monthly figures Trust-wide and by hospital site.

How we use your feedback

We gather the results and analyse them to see where we can make improvements or explore your suggestions further. The comments from patients on the FFT surveys are anonymised and are viewable on our in-house patient experience theming tracker. This enables us to theme comments by subject area and as negative or positive.

Of the comments themed in 2024-25, over 87% were positive. This is an improvement on 2023-24 when 80% of comments themed were positive. Positive themes included the care given by staff, the quality of treatment, positive staff attitude, and good communication and information between staff and patients. Negative themes included the time waiting to be seen on site (either in outpatients or in in urgent or emergency care), poor communication related to how long the wait will be or poor communication from clinical staff or about the appointment. There were also some negative comments about the quality of

treatment, waiting times for treatment, the buildings and facilities, poor staff attitude (lack of empathy), and delays in getting pain relief.

The Patient Voice and Involvement team reports on the FFT survey scores and the themes of comments to the Trust's Patient Experience Committee, which provides a regular assurance report to the Quality and Safety Committee and thereby to the Trust Board.

The team have fed back to services the importance of keeping patients updated on waiting times in clinics and in the Emergency Departments and Urgent Treatments Centres. Issues related to timely pain relief and poor communication have also been shared directly with services.

Our Improvements

In the past year we've focused on improving how we meet the communication needs of patients with disabilities, including people with sensory impairments, learning disabilities or physical disabilities (the Accessible Information Standard). Our main electronic patient record system enables staff to record and flag patients' communication needs. This links with our Patient Portal that enables patients themselves to add their communication needs including whether they need a hearing loop, large print, a British sign language (BSL) interpreter or to be communicated with via a carer. To register for the Patient Portal please use the guide on the Trust's website.

Our interpreting and translation service has improved provision for Deaf people who use BSL and as a result more Deaf patients are having an interpreter provided at their appointments. This ensures the episode of care goes smoothly and patients can fully participate in discussions and decisions about their care and treatment.

Carers and family members have told us they are not always included in discussions about their loved one's care, even when their loved one if happy for their involvement. A patient's family / carers will know much more about the patient than our staff will do, including what 'normal' looks like for them and what support they may need to hear, see or communicate. As a result, we worked with carers and local carers organisations to co-design a Carers policy and a carers leaflet. This was launched in Carers Week in June 2024.

The Patient Voice and Involvement team has delivered "seeing the person" sessions to a wide range of staff including staff at William Harvey hospital emergency department, newly qualified doctors, trainee doctors, healthcare support workers and other clinical and support staff. Sessions focus on the importance of using patient feedback to drive improvement and include feedback the team has received from some of our local underserved communities including homeless people, migrant

women and veterans – all people who are less likely to complete an FFT survey or raise a concern.

The Patient Voice and Involvement Strategy and contact details for the team are on our website.

Volunteer Service

There is a long tradition of volunteering in the NHS. Volunteers have supported staff and helped to improve patient experience for decades within our Trust. A team of 2.6 staff supports the volunteers.

Our volunteer numbers, both adult and youth, have increased to 520 over the past year.

Volunteers fulfil a range of roles, all of which enhance patient and staff experience:

- Kindness Companions on Wards (adult and youth volunteers)
- Gardeners
- PALS
- Therapy Dogs
- Outpatient clinics
- ED at QEQMH and WHH
- Meet and Greet
- Linen rooms
- Renal unit at K&CH (adult and youth volunteers)
- Third party Volunteer Groups:
    - Stoma Buddies
    - Emerge Advocacy - Emerge Advocacy
    - Reachable moments, adolescent support
    - Renal support

The Youth Volunteer Programme launched in 2023 has been very successful. We have welcomed almost 100 youth volunteers aged 16-18, volunteering as Kindness Companions on various wards across the three main sites, evenings and weekends.

The programme has recently been awarded a Kent and Medway Healthwatch Recognition Award.

The programme has also been part of a study with Kent and Medway ICB, measuring the benefits to young people, patients and staff.

Music Therapy

As part of a study with Canterbury Christ Church University examining the impact of music for our most vulnerable patients, classical musicians are visiting the critical care unit at WHH.

Patient Led Assessments of the Care Environment (PLACE)

33 volunteers/member of the public took part in these assessments in October 2024.

School Careers Fairs 2024

The volunteer and public services team organised and attended nine school/college careers fairs to promote the Trust. Several departments were in attendance including:

- Resourcing
- Theatres
- Nursing
- Nuclear Medicine
- Renal
- Medical workforce
- Apprenticeships
- Research

School choirs at Christmas

Six schools across East Kent visited our three main sites to entertain patients, staff and visitors over the Christmas period.

Health awareness stands for public and patients in hospital corridors in 2024

- Amputee and Trauma Support
- Diabetes awareness
- G4S awareness
- Inflammatory Bowel Disease (IBD) awareness
- Nutrition and hydration
- Red 4 Research day
- Adult Safeguarding week
- World Glaucoma Week
- Antimicrobial Awareness Week
- Stoptober
- World COPD Day

Corporate Social Responsibility Week 2024

Six local businesses visited our three main hospital sites as part of their corporate responsibility days to paint bus shelters, varnish benches and litter-pick.

Four local schools attended all three main sites for ‘Dump the Junk Week’ to help us with litter-picking in the grounds.

Future projects

- Planting for health - local companies adopting small outside spaces
- Patient visitor programme - matching the right volunteer for a lonely vulnerable patient

Safety Alerts

During 2024/25 we improved compliance with safety alerts, achieving 91% of alert actions implemented within the deadline compared to 69% in 2023/24, and closing 91% of safety alerts within the deadline, compared to 75% in 2023/24.

Safety alerts are issued nationally by the Medicines and Healthcare Products Regulatory Agency (MHRA) when there is a specific safety issue that without immediate action being taken, could result in a serious harm to our patients.

We continue to utilise an electronic platform (Datix Safety Alerts Module (DatixSAM)) for the management of safety alerts, including evidence of action implementation and monitoring. Annual auditing of this process demonstrated good compliance with the received safety alerts and to the approved Trust policy.

Our performance for the implementation of actions arising from the alerts and closing the alerts within deadline has significantly improved since last year as our compliance was 69% and 75% (respectively) for 2023/24 and has risen to 91% in both areas for 2024/25. We are striving to achieve 100%.

The improvements in performance were due to:

- Acknowledging alerts on the Medicines and Healthcare Products Regulatory Agency Central Alerting System (MHRA/CAS) website and opening on DatixSAM at the earliest opportunity.
- Triaging and assessing alerts for relevance as soon as possible after receipt.
- Escalation of outstanding alerts at risk of breaching deadline.

As a result of the national safety alerts we have made significant improvements within the following areas:

- To reduce the risks for transfusion-associated circulatory overload (TACO), we introduced; (1) the national TACO risk assessment at the point of prescribing, within the Electronic and Medicine Administration system (EPMA); (2) an annual TACO risk assessment audit; (3) availability of the NHS Blood and Transport patient information leaflets to aid informed consent, with consent for transfusion now documented electronically on

EPMA; and (4) delivering training to clinical teams on the recognition and prompt management of TACO, with escalation of care as appropriate.

- Within maternity, changes have been introduced to reduce the risk of oxytocin overdose during labour and childbirth by; (1) providing safety prompts for not pre-preparing oxytocin infusions and introducing guidance to support the use of carbetocin as front-line management of postpartum haemorrhage (PPH); (2) having emergency equipment trolleys and PPH kits available and easily accessible in the labour wards and obstetric theatres; (3) the obstetrician now being responsible for the prescription of all oxytocin infusions with the administration undertaken by a trained professional with IV competence; and (4) mothers at increased risk of PPH are highlighted at team briefs, during handovers / ward round reviews and having personalised care plans to support labour / birth management.

For 2025/26;

- CAS Alerts remain a priority area of work and our focus is to strengthen the local process to ensure the alert actions are implemented in a timely manner to meet the alert deadlines. It is envisaged that the introduction of our replacement electronic platform (InPhase) will enhance the timely management and monitoring process for safety alerts within the Trust.

Mixed Sex Accommodation

As an NHS provider we are expected to prioritise the safety, privacy and dignity of all patients and as part of this, eliminate mixed-sex accommodation (MSA).

The MSA breach rate indicator enables us to compare healthcare providers with others, or to compare change over time. It can tell us how a provider is 'performing' in relation to other similar organisations, or the national average, and whether they are improving or getting worse.

The data is published monthly by NHSE. The MSA breach rate is the number of breaches of mixed-sex sleeping accommodation per 1,000 Finished Consultant Episodes. An MSA breach rate indicator was developed because a simple count of the number of MSA breaches does not provide a fair comparison across healthcare providers. Raw numbers alone do not consider the size of an organisation and it would be unfair to classify large acute providers as "worst performing" compared to other, smaller providers, as they handle larger volumes of admitted patients and therefore the possibility of mixing patients is greater.

Total East Kent and national mixed sex breach data

From NHS England Hospital Episode Statistics (HES)

Month	Trust Breaches	Trust Breach rate	National Breach Rate
April 2024	257	17.4	2.9
May 2024	24	1.4	2.4
June 2024	36	2.1	2.2
July 2024	76	4.6	2.2
August 2024	62	3.7	1.9
September 2024	67	4.0	2.1
October 2024	68	3.8	2.3
November 2024	50	2.9	2.1
December 2024	65	4.4	2.7
January 2025	92	5.7	2.7
February 2025	33	2.1	2.4
March 2025	49	2.9	2.4

Our highest number of breaches in 2024 were owing to patients being stepped down from level 2 or level 3 care (high dependency and intensive care) and waiting for >4 hours for a ward bed.

A full review of how we deliver same sex accommodation has taken place across the Trust as previous advice provided to the Trust had led to an unintended consequence of an increase in breaches in new areas; appropriate actions have been taken to address this.

All data is validated by the site Directors of Nursing and the Deputy Chief Nurse prior to external reporting to NHSE.

Staff Survey

In the 2024 staff survey, we achieved our highest response rate, 63%, of staff responding to the survey, exceeding our target of 50% and ahead of the national average of 48%. This was one of the most improved response rates in the country and is another measure of engagement with our staff.

The NHS Staff Survey is one of the largest workforce surveys in the world and is carried out every year to understand and improve staff experiences across the NHS. The survey is aligned to the NHS People Promise and owned by NHS England.

Nationally, the 2024 results have shown no change in the nine themes scores, with all of the People Promise scores remaining broadly similar in 2024 as compared to 2023. This is the main national headline from this year's results.

A new and different approach in 2024 enabled a critical mass of staff to respond locally (*n* = 6,224). This is the highest response rate (63% against a target of 50%) in our history, ahead of the national average (48%) and 22% higher than in 2023 (41%). It is one of the most improved response rates in the country and means that we benchmark in the top 10% of 122 Acute Trusts nationwide. The high response rate significantly enhances the credibility of the results, and is complemented by a majority (50%+) across every Care Group and staff group.

Our results align with national findings, showing that sentiments remain consistent with last year across 87% of questions. Results indicate that our staff remain less likely to choose East Kent as a place to work or be treated and they feel other priorities compete with care. An overview of performance against the nine indicators are provided below:

Overview of performance Staff Survey 2024

People Promise Theme	**2023**	**2024**	**Change**
We are compassionate and inclusive	6.85	6.86	↑ 1 point
We are recognised and rewarded	5.62	5.59	↓ 3 points
We each have a voice that counts	6.21	6.22	↑ 1 point
We are safe and healthy	5.86	5.87	↑ 1 point
We are always learning	5.36	5.43	↑ 7 points
We work flexibly	5.88	5.96	↑ 8 points
We are a team	6.51	6.50	↓ 1 point
Theme			
Staff Engagement	6.34	6.35	↑ 1 point
Morale	5.58	5.58	No change

Organisational-level headlines from the 2024 NHS Staff Survey are as follows:

- East Kent benchmarks better against its Acute and Acute & Community counterparts, with a clearer separation from the worst results nationally.
- Staff engagement levels are equivalent to 2023, but there is significant variation in the experience of colleagues working within the Trust.
- There were no statistically significant changes in any of the nine People Promises/ Themes, with responses reflecting a position that has not changed.

Full results of the NHS Staff Survey are available here. More granular, Trust-level results are shared with staff through ‘Our People Dashboard’ on Staffzone.

Following extensive review of the staff survey feedback, we have identified three key focus areas:

Making East Kent a place staff choose
A minority of staff would recommend the organisation as a place to work (44%) or be treated (46%) – and less than two-thirds (62%) feel that care is the organisations top priority.

Raising and resolving concerns
A minority of staff feel able to make improvements happen in their area of work (48%). A smaller number feel we would act on any concerns they raise (37%).

Compassionate leadership
Leadership is fundamental to culture and responsible for approximately 70% of the variance in team engagement (Gallup 2024). Results indicate that not all staff experience kind, compassionate leaders who trust and inspire.

We have adopted a quality improvement (QI) methodology to drive continuous improvement against each of these. This approach is taking place at three levels; Trust, Care Group and corporate and across parallel staggered workflows.

Infection Prevention and Control (IPC)

We are committed to the development of safe working practices and quality care relating to the prevention of infection and the spread of disease. The Health and Social Care Act 2008 (updated 2022) Part 2: The Code of Practice on the control and prevention of infections, requires all NHS Trusts to have clear arrangements for the effective prevention, detection and control of Healthcare Associated Infections (HCAIs), and the role of infection prevention (including cleanliness) in optimising antimicrobial use and reducing antimicrobial resistance.

There has been a strong and sustained focus on infection prevention and control (IPC) during the last twelve months and resulting progress, despite the context of operational pressures, and a continuing challenge from Covid-19, influenza and norovirus outbreaks. The IPC and antimicrobial stewardship teams are established and work continuously to improve practice and outcomes for patients and staff.

In the last year we have:

- Reviewed the training needs and education for IPC for all staff;
- Continued to develop the IPC Link Practitioner programme;
- Completed the ‘back to basics’ CLEAN campaign – focussing on clean hands, equipment and environmental cleanliness, line care, needle safety and antimicrobial stewardship;
- Embedded the full IPC environmental and clinical practice audit programme;
- Completed annual mattress audit;
- Reviewed our cleaning functional risk ratings;

- Contributed to ongoing reviews of the National Infection Prevention and Control Manual (NIPCM);
- Implemented a new governance structure for infection prevention control and antimicrobial stewardship;
- Reviewed the scope and quality of the surveillance of healthcare acquired infections and started a programme of improvement work;
- Worked collaboratively with system partners to start to implement a Kent and Medway IPC and antimicrobial stewardship strategy;
- Fully implemented PSIRF methodology for all reportable healthcare associated infections;
- Recruited a staff member to undertake fit-testing.

We have achieved success in the following areas:

- The IPC team and antimicrobial stewardship team were fully recruited to;
- Our usage of broad-spectrum antibiotics reduced;
- We reported lowest cases and rates of *Clostridioides difficile* for many years - and were well below the threshold for the year;
- We reduced reportable MRSA bacteraemias by 75%;
- We were below threshold for e-coli blood stream infections (BSI);
- We reduced surgical site infections relating to fractured neck of femur repairs significantly;
- Our hand hygiene training compliance reached >93%.

The remaining challenges and areas of focus include:

- We exceeded thresholds for all other gram-negative blood stream infections (Pseudomonas and Klebsiella);
- We reported 8 increased cases of attributable Meticillin Sensitive Staphylococcus aureus (MSSA) blood stream infections (BSI);
- We have ongoing improvements underway with regards to environmental condition and cleanliness;
- Overall the state of our estate and physical infrastructure remains very challenging and does not support good IPC practice;
- The identified rates of surgical site infections in the current surveillance programme identifies rates which are higher than the national average.

Focus for coming year:

- We will have a focus on environmental improvements across the organisation in the CLEANTOGETHER campaign:
  ‘C’ Clutter reduction in all areas and store rooms
  ‘L’ Laundry, linen and waste – correct care and disposal
  ‘E’ Environmental and equipment cleaning – roles and responsibilities
  ‘A’ Accountability and actions - for all staff, patients and visitors

‘N’ Not walking by – how to report issues to estates and facilities

- We have a focussed improvement plan on learning identified from last year which includes environmental aspects, isolation, sampling and treatment.

Performance against indicators

We report below the performance against indicators and performance thresholds that are mandated by NHSE for inclusion in this section of the report.

Maximum time of 18-weeks from point of referral to treatment (RTT) in aggregate – patients on incomplete pathway

Measure	2024-2025	2023-2024
Maximum time of 18-weeks from point of referral to treatment (RTT) in aggregate – patients on incomplete pathway	51.6%	50.8%

We consider that this data is as described for the following reasons:

Snapshots for RTT metrics are made on weekly and monthly schedules and validated against alternative sources. Abnormal statistical variations are also monitored. These checks are made weekly for the NHSE RTT submission and also, internally, when signing off monthly scorecards.

We have taken the following actions to improve this percentage, and so the quality of services, by:

We have a patients' priority to reduce referral to treatment times and more information on this can be seen from page 34.

Throughout 2024/25, we have worked to align with national guidance aimed at reducing elective treatment backlogs and ensuring no patient waits longer than 65 weeks for treatment as well as improving the overall percentage of patients waiting no more than 18 weeks from the point of referral to treatment (RTT). While there is still more to be done, we are proud of the significant progress made. Notably, we successfully reduced the number of patients projected to wait beyond 65 weeks from over 2,000 to 36 by the end of the year and an improvement from 50.8% to 51.6% of patients waiting 18 weeks.

The areas of greatest concern in 2023/24, where we experienced the highest volumes of patients waiting, receiving focused attention. Over the past year, targeted plans have been implemented to address these challenges, leading to significant improvements in performance. As a result, these areas have now been brought back in line with the performance standards of other services.

As we transition into the next fiscal year, we are committed to building upon the improvements made, increasing the pace of progress to further reduce waiting times. By the end of 2025/26, we aim to ensure that at least 60% of patients will receive treatment within 18 weeks from the point of referral and that no more than 1% of

patients will wait longer than one year for treatment, down from 3.6% currently. Detailed activity plans outlining our planned volumes of work for 2025/26 have been submitted to NHS England to meet the national maximum waiting time standards.

These targets are ambitious, yet achievable, and our Care Groups across remain focused on implementing initiatives that will optimise operational efficiency, continue to reduce the elective backlog, and ultimately meet these goals.

A&E: maximum waiting time of 4-hours from arrival to admission/ transfer/ discharge

Measure	2024-2025	2023-2024
A&E: maximum waiting time of 4-hours from arrival to admission/transfer/discharge	74.81%	71.2%

We consider that this data is as described for the following reasons:

- We have seen an increase in compliance with the 4-hour standard as a result of focused work improving use of Same Day Emergency Care and Urgent Care as well as reductions in length of stay.

We have taken the following actions to improve this percentage, and so the quality of services, by:

- We have a patients' priority and a quality priority for 2025/26 to reduce waiting times in our emergency departments (see pages 16, 35, 36, 39).

All cancers: 62-day wait for first treatment from: urgent GP referral for suspected cancer and NHS cancer screening service referral

Measure	2024-2025	2023-2024
62-day wait for first treatment from urgent GP referral for suspected cancer	67.2%	59.8%
62-day wait for first treatment from NHS cancer screening service referral	69.6%	70.4%

We consider that this data is as described for the following reasons:

- We ensure the accuracy of our NHS data through a structured, two-tier validation process carried out on a monthly basis:
    - Data Validation at Source:
      Real-time validation of patient data is undertaken as individuals progress through care pathways. This ensures that key treatment events and milestones are accurately recorded as they occur. This step

provides the first assurance, that correct and complete data is being entered into the system at the point of care.
    - Monthly Performance Reconciliation:
      At the end of each month, the final performance numerators and denominators are reconciled against the national dataset. This involves cross-checking our submitted data with the nationally published monthly position via the designated upload portal. This second assurance confirms that the final reported outcomes accurately reflect patient activity and align with national records.
- This dual-layered process, validating both input and output, ensures that our reported figures are both trustworthy and nationally consistent.
- During 2024/25 the Trust was subject to a Data Quality and Performance audit. During this audit spot checks were completed on a number of patient records against the nationally report NHSE submission – all data was consistent with the figures reported nationally and internally.
- Cancer compliance is supported by a team of cancer navigators who are provided with extensive training and work in adherence to the cancer compliance standards.

We have taken the following actions to improve these percentages, and so the quality of services:

- 2024/25 has been a positive year for our cancer performance, with improvements seen across all key national cancer metrics including 62-day combined standard, Faster Diagnosis Standard (FDS), and our reported backlog. Reviewing the annualised data from 62-day GP Referral there is a reported >7 percentage point improvement, and for 62-day Screening the annualised position is broadly stable. We reported our lowest ever backlog of patients waiting over 62-days for treatment. Performance against the 62-day combined standard started the year at 66.2% and improved steadily to reach 79.0% by year-end.
- A number of targeted initiatives have underpinned this improvement. Within urology, prostate pathway optimisation has been a key focus. We supported the implementation of new Prostate Specific Antigen (PSA) referral thresholds in primary care and adopted updated national MRI reporting criteria. Alongside these changes, ringfenced MRI capacity was established, with some patients accessing their MRI within two days of referral. This had a marked impact on performance, with 62-day combined urology performance improving from 42.2% in April 2024 to 73.8% by March 2025.
- In lower gastrointestinal, a new cancer pathway was developed and ratified through the Kent and Medway Cancer Alliance, offering clearer guidance on referral criteria and diagnostic practice. While full implementation continues, we have prioritised reducing wait times for first outpatient appointments

(OPAs) and endoscopy. FDS performance for lower GI first OPAs improved from 37.3% in April 2024 to 62.0% at year-end.

- Our breast pathway has benefited from tiered funding, which has been used to expand capacity in support of delivering the gold standard model of care. This has enabled more patients to access one-stop clinics offering consultant review, mammography, ultrasound, and biopsy within a single visit. The additional investment has not only contributed to reducing the routine backlog but has also improved patient flow across our rapid access cancer pathway for breast.
- We also took the proactive step of retiring the two-week wait terminology from cancer pathway vocabulary, reinforcing its ambition for all first OPAs to take place within one week. Closer collaboration between clinical specialties and the Patient Services Centre has enhanced scheduling processes, ensuring appointment booking aligns with available capacity.
- Across all tumour sites, standardised escalation thresholds have now been introduced for radiology booking and reporting, histopathology turnaround, and endoscopy capacity. Additionally, we have revised the format of Patient Tracking List (PTL) meetings, supported by both the specialty teams and cancer compliance, embedding clear action plans and ensuring timely follow-up and increasing operational rigour across all specialties. These changes have improved visibility of emerging issues, enabled swift interventions, and supported dynamic resource allocation where required to maintain and improve performance.
- We have a patients' priority and a quality priority for 2025/26 to reduce 62-day waits for cancer services (see pages 17, 34, 39, 93-95).

Maximum 6-week wait for diagnostic procedures

Measure	2024-2025	2023-2024
Maximum 6-week wait for diagnostic procedures	86.2%	61.2%

We consider that this data is as described for the following reasons:

- Independent cross-checks are made and variation outside of statistical limits are investigated. These checks are made weekly for the NHSE submissions and also, internally, when signing off monthly scorecards.

We have taken the following actions to improve this percentage, and so the quality of services, by:

- We have a patients' priority to reduce the number of patients with an extended wait for diagnostic procedures.
- Throughout 2024/25, we have worked to align with national guidance aimed at ensuring we reduce the volume of patients who wait longer than 6 weeks for

diagnostic tests. While there is still more to be done, we are proud of the significant progress made.

Some key successes from 2024/25 include:

- Significant reduction in number of patients waiting beyond the six-week standard for endoscopy from 7,328 in March 2024 to 258 in March 2025.
- Improvement in percentage of patients waiting longer than six weeks for routine diagnostic tests, such as X-rays, MRIs, and CT scans, from 60.3% in March 2024 to 86.4% in March 2025.

We are committed to building upon the improvements made, increasing the pace of progress to further reduce waiting times for patients waiting for diagnostic tests. Our Care Groups remain focused on implementing initiatives that will optimise operational efficiency and continue to reduce backlog for diagnostic tests.

4.4 Stakeholder and Directors' Statements

Statement of Assurance following review on behalf of Healthwatch Kent

Healthwatch Kent response to the

East Kent Hospitals University NHS Foundation Trust Quality Account 2024/25

Healthwatch Kent is the independent champion for the views of patients and social care users in Kent. Our role is to help patients and the public get the best out of their local Health and Social Care services.

For several years now, local Healthwatch across the country have been asked to read, digest and comment on the Quality Accounts which are produced by every NHS Provider (excluding primary care and Continuing Healthcare providers).

We'd like to take this opportunity to support the Trust by setting out some of the areas we have worked together on in the past year:

- We are grateful to the patient experience team for working with Healthwatch Kent to gather feedback from patients using EKHUFT services; this has included work looking at electronic referrals (EROS)
- This year we recognised the Trust at our awards evening for work which included: perioperative care of older people undergoing surgery and work with giving homeless people a voice.
- We regularly share what we hear from the public directly with the Patient Experience Team and commend their efforts in working hard to ensure the feedback we provide as well as that from their own sources is acted upon.
- The Trust are a key partner in the East Kent Health and Care Partnership and we've worked with them on areas such as Urgent and Emergency Care.

Quality Account

- The patient experience priorities set out for this year show an intention to make the Trust services more accessible for parts of the East Kent population. This includes a focus on the Accessible Information Standard which we have worked with the Trust on previously.

- We would suggest in future to have a section for each priority that clearly states what difference this will mean for people to help them understand what they should expect.

We would also like to take this opportunity to congratulate the Trust on their recent Maternity CQC improvements

Healthwatch Kent June 2025

Statement of Assurance following review on behalf of Kent and Medway Integrated care Board

NHS
Kent and Medway

Private and confidential

Tracey Fletcher
Chief Executive Officer
East Kent Hospital University Foundation Trust
EKHUFT Headquarters
Kent and Canterbury Hospital
Ethelbert Road
Canterbury
Kent, CT1 3NG

Sent via email
6th June 2025

Nursing and System Workforce Division
NHS Kent and Medway
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Kent and Medway Integrated Care Board - East Kent Hospital University Foundation Trust Quality Account 2024/2025 Comments

Dear Tracey,

We welcome the Quality Account for East Kent Hospital University Foundation Trust. Kent and Medway Integrated Care Board (ICB) confirm that this Quality Account has been produced in line with the National requirements and includes all the required areas for reporting.

The annual account demonstrates an overview of quality of care in your focus areas, looking at improving the safety, and effectiveness of your services, as well as improving patient experience. The report has a clear flow that would be easy to follow for members of the public.

We were pleased to see your progress with your quality priorities from 2024/2025, particularly the increase in participation with the staff survey due to your increased engagement. We were proud to see the improvements in your maternity service recognised by the improvement in your Care Quality Commission rating. The Trust set an ambitious target to improve compliance with the National Institute for Health and Care Excellence (NICE) guidelines within the year and we were pleased to see you reached this target. Your deep dive work on Never Events ensured action and learning had been reviewed, implemented and embedded. We were pleased by the way you started to change your culture, utilising the Patient Safety Incident Response Framework (PSIRF). We were pleased to see you achieved your goal from last year to

embed the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) form.

We commend your choice of quality priorities for 2025/2026. We welcome your focus to improve the complaints response experience including maintain a high compliance rate for timely complaints responses. We extol the Trust's plan to increase the use of complaints data in triangulation across patient experience data. We note the new Freedom to Speak Up (FTSU) system you have employed since March 2025. We look forward to seeing the output from this new system and the learning and improvements. Your commitment to improve staff experience by increasing staff engagement levels to the national average can be seen by your expected output and outcomes and we look forward to learning about it.

You have set clear priorities for the coming year, aligned to the aims of the organisation's strategy, objectives and values as an organisation. We invite you to update us on your progress with your quality priorities in the Provider Quality Meetings in 2025/2026.

We would also like to thank you for your ongoing engagement at the Provider Quality Meetings and the System Quality Group, continuing our collaborative partnership for the population of Kent and Medway.

Yours sincerely

Paul Lumsdon
Chief Nursing Officer
NHS Kent and Medway ICB

Feedback from Governors

The Council of Governors are very impressed with the improvement this year in the presentation and content of the Quality Accounts. The details were consistently and coherently addressed and presented appropriately and thoroughly. Questions posed by Governors were answered and taken on board and we are confident that the Quality Accounts are a good representation of the standards and facts.

Just looking at two areas where the Council have noted as improving are, Maternity services where the Council have noted a complete change in culture and leadership which has steadily improved over the last few years. Cancer treatment within the 62 days has also improved over last year with 79% overall rating. However, two areas of concern for the Council are firstly, the length of time that patients have to wait in ED, and the quality of the experience whilst there, and secondly timely access to treatment with patients waiting longer than 18 weeks for treatment.

Going forward for the year 2025/26 the Council of Governors would like to see the continued improvement in Maternity be embedded and used to look at ways of improving other departments as well as in ED where they expect to see a great improvement in the quality patient experience.

21 May 2025
Ratified by Council of Governors

Statement of Directors' responsibilities for the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare quality accounts for each financial year. NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports, which incorporates the above legal requirements and, on the arrangements, that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report. In preparing the quality report, directors are required to take steps to satisfy themselves that:

the content of the quality report meets the requirements set out in the *NHS foundation trust annual reporting manual 2019/20* and supporting guidance *Detailed requirements for quality reports 2019/20* (there has been no updated guidance since that date).

• the content of the quality report is not inconsistent with internal and external sources of information including: – board minutes and papers for the period April 2024 to March 2025.

– papers relating to quality reported to the board over the period April 2024 to March 2025.

– feedback from commissioners dated 06 June 2025.

– feedback from governors dated 21 May 2025.

from local Healthwatch organisations dated June 2025.

– the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 03 October 2024.

– the [latest] national patient surveys:

- Maternity published November 2024;
- Urgent and emergency care published November 2024;
- Adult inpatient published August 2024.

– the [latest] national staff survey published 13 March 2025.

– the Head of Internal Audit's annual opinion of the trust's control environment dated 10 April 2025.

– CQC inspection report dated 08 May 2025.

• the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered

• the performance information reported in the quality report is reliable and accurate

• there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice

• the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review

• the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the board

Date: 26 June 2025 .....

Chairman

Date: 26 June 2025 .....

Chief Executive

Glossary and Abbreviations

2WW	2 week-wait
4AT	A short, four-item tool designed for use in clinical practice to screen for delirium.
A&E	Accident and Emergency
AFPP	Association for Perioperative Practice
AIS	Accessible Information Standard
ALERT	Acute Life-threatening Events Recognition and Treatment
ATAIN	Avoiding Term Admissions into Neonatal Units
AWOC	Aging Without Children
BEACH	Bedside Emergency Assessment Course for Healthcare Assistants
BHD	Buckland Hospital, Dover
BSI	Blood Stream Infections
CAF	National Security Centre's Cyber Assessment Framework
CAS	Central Alerting System
CAU	Children's Assessment Unit
CPBS	Complaints and PALS team
CCOT	Critical Care Outreach Team
CCU	Coronary Care Unit
CDiff	Clostridium difficile infection
CQC	Care Quality Commission
CLEAN	Clutter reduction, Laundry, linen and waste, Environment and equipment cleaning, Accountability and actions, Not walking by
COHA	Community-onset healthcare associated infection
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation

CT	Computed Tomography
CT1-2	Doctors in first or second year of uncoupled core training
CTUF	Clinical Research Unit
DatixSAM	Datix Safety Alerts Module
DoLS	Deprivation of Liberty Safeguards
DSPT	Data Security and Protection Toolkit
EBUS	Endobronchial Ultrasound
ED	Emergency Department
EDI	Equality, Diversity and Inclusion
EDS	Equality Delivery System
EKHUFT	East Kent Hospitals University NHS Foundation Trust
EPMA	Electronic and Medicine Administration System
EPU	Early Pregnancy Unit
FDA	Faster Diagnosis Standard
FFT	Friends and Family Test
FREXALT	Research study comparing efficacy and safety of frexalimab to teriflunomide in adult participants with relapsing forms of multiple sclerosis
FTSU	Freedom to Speak Up
FY1	Foundation Year 1 – first year postgraduate training for newly qualified doctors
FY2	Foundation Year 2
GAU	Gynaecology Assessment Unit
GI	Gastrointestinal
GIRFT	Getting It Right First Time
GP	General Practitioner
HEE	Health Education England
HES	Hospital Episode Statistics
HOHA	Hospital-onset, healthcare associated infection

HSIB	Healthcare Safety Investigation Body
HSMR	Hospital Standardised Mortality Rate
ICB	Integrated Care Board
IPC	Infection Prevention and Control
ITU	Intensive Therapy Unit
IV	Intravenous
K&CH	Kent and Canterbury Hospital, Canterbury
KPI	Key Performance Indicator
KMMS	Kent and Medway Medical School
KMPT	Kent and Medway NHS and Social Care Partnership Trust
LED	Locally Employed Doctor
LeDeR	Learning from lives and deaths – people with a learning disability and autistic people
LFD	Learning from Deaths
LFPSE	Learn from Patient Safety Events
M&M	Mortality and Morbidity meeting
MCA	Mental Capacity Act
MHRA	Medicines and Healthcare Products Regulatory Agency
MMBRACE	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
MNIP	Maternity and Neonatal Improvement Plan
MNVP	Maternity and Neonatal Voices Partnership
MRI	Magnetic Resonance Imaging
MSA	Mixed Sex Accommodation
MSSG	Mortality Surveillance and Steering Group
NCAP	National Cardiac Audit Programme
NELA	National Emergency Laparotomy Audit
NEWS2	National Early Warning Score 2

NHSE	NHS England
NICE	National Institute of Health and Clinical Excellence
NIPE	New-born and Infant Physical Examination
NIPCM	National Infection Prevention and Control Manual
NLCA	National Lung Cancer Audit
NPDA	National Pregnancy in Diabetes Audit
NRAP	National Respiratory Audit Programme
NRLS	National Reporting and Learning System
OPA	Outpatient Appointments
PALS	Patient Advice and Liaison Service
PAS	Patient Administration System
PCLP	Perinatal Culture and Leadership Programme
PHSO	Parliamentary and Health Services Ombudsman
PIER	NHS England's Prevention, Identification, Escalation, Response framework
PLACE	Patient Led Assessment of the Care Environment
PMA	Professional Midwifery Advocate
PPAG	Patient Participation and Action Group
PPH	Post-partum haemorrhage
PSA	Prostate Specific Antigen
PSII	Patient Safety Incident Investigation
PSIRF	Patient Safety Incident Response Framework
PTL	Patient Tracking List
QEQMH	Queen Elizabeth the Queen Mother Hospital, Margate
QSC	Quality and Safety Committee
QSF	Quality and Safety Framework
R&D	Research and Development
RADF	Reasonable Adjustments Digital Flag

RCOG	Royal College of Obstetrics and Gynaecology
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
RSP	Recovery Support Programme
RTT	Referral to Treatment
RVH	Royal Victoria Hospital, Folkestone
SCBU	Special Care Baby Unit
SDEC	Same Day Emergency Care
SEAU	Surgical Emergency Assessment Unit
SHMI	Summary Hospital Level Mortality Indicator
SIF	Serious Incident Framework
SJR	Structured Judgement Review
SSNAP	Sentinel Stroke National Audit Programme
ST1-2	Doctors' in years 1 and 2 of basic specialty training
Staffzone	Our internal intranet pages for staff
TACO	Transfusion-Associated Circulatory Overload
TERS	Targeted Enhanced Recruitment Scheme
TNA	Training Needs Analysis
TROG	Trust Rotation Grid
VTE	Venous Thromboembolism
UEC	Urgent and emergency care
We Care	Trust-wide improvement approach
WHH	William Harvey Hospital, Ashford