East Kent Hospitals University NHS Foundation Trust

BOARD OF DIRECTORS (BoD) ASSURANCE REPORT

Committee: **Women's Care Group Maternity and Neonatal Assurance Board (MNAB) Chair's Report**

Meeting dates: **2 April 2026**

Chair: **Sarah Hayes, Chief Nursing and Midwifery Officer (CNMO)**

Paper Authors: **Hannah Smith, Acting Director of Midwifery (DoM)**

Quorate: **Yes**

Appendices:

None

Declarations of interest made:

None

Assurances received at the Committee meeting:

Papers for discussion /approval	Summary
Clinical Negligence Scheme for Trusts (CNST) Compliance	CNST compliance was shared with the Trust Board in February 2026. All safety actions (SAs) were reported as compliant with SA 4 – Clinical workforce planning – having a supporting action plan to achieve British Association of Perinatal Medicine (BAPM) nursing and medical staffing standards. To be eligible for payment Trusts must have submitted their completed Board declaration by 12 noon on 3 March 2026 which was achieved. Year 8 standards will be published on 24 April 2026.
Perinatal Quality Oversight Model (PQOM) April 2026- December 2025 and January 2026 Data	The PQOM report is presented to the Board in keeping with the Ockenden recommendation. It contains the minimum dataset that the Board required oversight of. • The total number of babies born in December was 511 and January 440. • Supernumerary status compliance was reported at 100% at both sites in December 2025 and January 2026. • Compliance of 1:1 in Labour was reported at 100% at both Queen Elizabeth the Queen Mother Hospital (QEQM) and William Harvey Hospital (WHH).

We care

	• Neonatal Death (NND) rate remained at 1.02 / 1.03 (0 NNDs reported in December or January). • Significant increase in stillbirth rate to 4.09 (four Stillbirths reported in January). This rate is now above the MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK comparator average. With a further Level 1 Maternity Outcomes Signal System (MOSS) signal being generated. • Overall extended perinatal rate increased to 5.11 Hypoxic-ischaemic encephalopathy (HIE) rate remains stable at 1.4 (one HIE Grade 2 in December). **Patient Experience** Friends and Family (FFT) had a 30.4% response rate in December Your Voice is Heard (YVIH) data showed: • 89.9% of people spoken to were positive about their Antenatal care. • 91.6% of people spoken to were positive about their Intrapartum care. • 81.7% were positive about Postnatal care. • 100% were positive about Neonatal care. Positive themes included care by staff, quality of treatment and information given. Negative themes included communication, waiting times and lack of continuity. **Training and Education** • Training remains on the Care Group risk register (Risk Reference 3764), the contract for the lease for St Paul's has been retracted and the service is currently scoping capacity to deliver training within Trust estate. • Obstetric doctor and Anaesthetists compliance is below 90% in January but is set to increase to greater than 90% as of February 2026. • Newborn Life Support (NLS) compliance for the neonatal / paediatric nursing teams appears below 90% (may be data entry issue) as speciality data demonstrates Special Care Baby Unit (SCBU) 87%, Neonatal Intensive Care Unit (NICU) 97% compliance.
Feedback from ESO visit	**Executive Summary** • **Leadership**: A formal transition away from Maternity Safety Support Programme (MSSP) to ESO has taken place with a continued Multi-Disciplinary Team (MDT) approach, and the leadership team recognises its challenges while maintaining active engagement with improvement work. • **Culture**: The impact of historic scrutiny, including the Kirkup Report and restorative circles, continues to influence service users and staff, with concerns about repeated revisiting of legacy events and the need for clarity on the purpose of restorative justice.

	• **Triage and Birmingham Symptom-specific Obstetric Triage System (BSOTS)**: Standardisation work is underway following Maternity and Newborn Safety Investigations (MNSI) concerns, supported by regular audits, a triage dashboard, weekly metric reviews, and preparations for full BSOTS alignment when K2 arrives in August 2026. • **Clinical Governance**: Audit activity, action plans, diabetic care pathways, and stillbirth external review processes are well established, with structured review timelines and clear governance oversight. • **Transitional Care (TC):** TC provision meets the required criteria across both sites, with further development planned through estates redesign and a dedicated workforce, governance and scorecard model. • **Smoking Cessation**: The smoking cessation service has recently expanded but remains below referral and quit rate targets, with optout referral processes and staffing gaps requiring further work. • **Assurance and Safety**: Key assurance frameworks, including MOSS and CNST, remain on track with phased improvement demonstrated and safety monitoring in place. **Examples of good practice identified during the visit include:** • Triage audit and assurance processes; • Integrated TC workforce model; • Structured external review approach; • Homebirth governance and safety oversight. **Next steps:** MS Teams meetings: March and April 2026. Site visit QEQM: May 2026.
Maternity and Neonatal Improvement Programme (MNIP) highlight reports and overview of programme	A programme level highlight report and six individual reports including culture, safety culture, clinical pathways, listening to women and families, workforce and infrastructure were shared for Maternity at MNAB in the month of March. **Highlights for March from the Maternity Programme include**: • Phase 3 of restorative work with families and workforce; • Values-based awaydays; • Clearing of historical patient safety related backlogs; • Patient Safety Incident Response Framework (PSIRF) Year 2; • TC process mapping day – 10 February 2026; • FFT response rate of 40.8% / YVIH – 91.3% happy to return / 100% patient satisfaction with Homebirth care and experience; • Reduced sickness absence to 6.3% (lowest since February 2025); • Interviews for Maternity Incentive Scheme (MIS) Senior Project Manager.

	Areas of focus: • Remaining Ockenden Immediate and Essential Actions (IEA): post-mortem consent (consideration to roll-out wide than specialist team). • Delayed launch of Antenatal Education programme. • Delays to relocation of WHH Suite causing delays to reconfiguration of Triage area at WHH (Care Quality Commission (CQC) 'must do').
SA 6 Saving Babies Lives (SBL)	Self-assessment for Q10 was submitted on 07 January 2026 and the Local Maternity and Neonatal System (LMNS) validated result with feedback meeting was received on 19 February 2026. • Element 1: 90% implementation. There is one outstanding intervention; relating to compliance of women engaging with the in-house smoking cessation service. Including the number of women who set a quit date, are CO verified non-smokers at four weeks and at 36 weeks. • Element 2: 100% compliance. • Element 3: 100% compliance. • Element 4: 100% compliance. • Element 5: 100% compliance. • Element 6: 100% compliance. • Total compliance has been assessed as 99%. • Quarterly meetings with the Integrated Care Board (ICB) are ongoing for support and oversight of implementation.
SA 3 Avoiding Term Admissions into Neonatal Units (ATAIN)	The Trust has a TC policy which is compliant with the specified requirements. This guideline is fully implemented and relevant audits have been conducted. There are weekly cross-site meetings to review all term admissions into SCBU/NICU attended by either the Labour Ward (LW) or Postnatal Ward Manager (PNW) manager, senior neonatal nurses from each site and senior clinical leads from each site. Quarterly audits are completed and presented to MNAB, BoD and the LMNS/ICB.
Maternity and Neonatal PSIRF Plan	The PSIF plan was presented and agreed at the March MNAB. Next steps are to finalise the project plan.
Matters to escalate to Quality & Safety Committee (Q&SC) and Board	• MNIP V2 to be developed with DoM and Associate Medical Director (Women's Services) to provide updates, as they become available. • Full CNST Declaration presented by the DoM to February BoD. Full submission to NHS Resolutions (NHSR) achieved in the required timeframe. New Year 8 standards expected on 24 April. • PQOM: overdue incidents, MOSS, stillbirth and maternal death reviews in progress. • Maternity vacancies with plans to mitigate the risk, particularly B3 Maternity Support Workers (MSWs). • Congratulations on achievements through the SBL Care Bundle; now anticipate further work at ICB level.

	• Maternity and Neonatal PSIRF Plan 2026/27 approved. • Escalation of delayed E3 upgrade and how this can be progressed / worked through. • Safety Champion feedback focused on Community midwifery and Non-Executive Director (Ffion Griffith) joined Community Midwives (CMW) values-based awaydays; the leadership team was very responsive to enable Ffion to share back with the community teams. Monthly acute visits due to be planned for 2026/27; Chief Nursing and Midwifery Officer (CNMO) had already completed a visit to maternity and neonates at WHH, which was very positive despite the unit being busy but people felt it was well managed and controlled. • The Board was updated on the January signal, which was related to a term pregnancy which was disrupted following feticide GSTT in response to a genetic abnormality. The Trust raised whether cases where feticide was involved should be included as a signal with the national team. Their response advised that unfortunately, at the moment, they are unable to screen out feticides in the data set for MOSS as this information is not available in the feed, so please do note this contextual information on the check. MOSS are planning a switch to using Submit a Perinatal Event Notification (SPEN) data over the coming months where they will be able to identify terminations and exclude from the data set in the future. On 18 March 2026 we received a further Moss Level 2 signal following a term stillbirth at QEQM a rapid review on 18 March 2026 which did not identify any significant concern or gaps in care. We are submitting the required documentation which is due by 30 March in line with the eight working day timeframe. This will be included in the external independent review. Due to additional cases being added to this review expected completion is now May 2026 at the earliest.

Other items of business: None

Items to come back to the Committee outside its routine business cycle:

There was no specific item over those planned within its cycle that it asked to return.

Items referred to the BoD or another Committee for approval, decision or action:

Item	Purpose	Date
MNAB asks the Board of Directors to discuss and **NOTE** this MNAB Chair Assurance Report.	Assurance	2 April 2026

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Care Quality Commission (CQC) Update Report**

Meeting date: **2 April 2026**

Board sponsor: **Sarah Hayes, Chief Nursing and Midwifery Officer (CNMO)**

Paper Author: **Emma Kelly, Compliance and Assurance Manager for Director of Quality Governance**

Appendices:

None

Executive summary:

Action required:	**Assurance**
Purpose of the Report:	This report provides an update on CQC inspection activities, oversight, assurance and related improvement work. This report covers the period January 2026 to mid-March 2026 and covers: • CQC inspections; • CQC engagement meetings; • Summary of progress with the CQC self-assessment and check and challenge meeting programmes; • Ward and clinic accreditation update; • Update on performance against the CQC inspection reports from May and July 2023, published in December 2023; • Update on performance against 'historical' open CQC action plans (2018, 2020 and 2021); • Summary of CQC queries; • Recent CQC publications.
Summary of key issues:	The CQC have completed three unannounced inspections. Urgent and Emergency Care (UEC) and General Medicine at Queen Elizabeth the Queen Mother Hospital (QEQM) and UEC at William Harvey Hospital (WHH). These inspections were all under the Winter Pressures Programme and outside of the usual standard inspection regime and standard single assessment framework. Provider Information requests for all inspections have been submitted to the deadline. Following the visit to the QEQM UEC 9 January 2026 the Trust received a Letter of Intent that required submission of an action plan on 12 January 2026. The Trust have committed to provide the CQC and the Board of Directors with weekly reporting on the progress of the priority action plan.

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	A review of the UEC self-assessment tool is underway, ensuring it includes additional elements that formed part of the Winter Pressures inspection. This will be completed by the end of March 2026. Work continues with the UEC and Care Group Leadership team. This included an Emergency Department (ED) external peer review visit that took place on 6 March 2026. There are three historical actions pending closure once approved by the CMNO. (Two Should Do and one Must Do). There are now only 4% of actions remaining open from the 2023 inspections. Multiple actions are associated with medical compliance with statutory and mandatory training (UEC and medical care) which is still not at Trust target. Leadership is being provided by the Chief Medical Officer (CMO) and performance is being monitored via the Performance Review Meetings (PRMs). The remaining Must Do action is around pharmacy staffing and there is one outstanding Should Do in relation to Allied Health Professionals (AHP) staffing levels, although the latter is recommended for closure. Updates are provided within the paper in relation to these remaining open actions.
Key recommendations:	The Board of Directors is asked to receive and **NOTE** the attached report and the assurance provided in relation to query management, and the self-assessment and check and challenge meeting programme.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients
Link to the Trust Risk Register:	There is a risk of non-compliance with CQC regulations which would have an impact on registration and may lead to repeat enforcement action, improvement notices and a critical report (ref 3636). Residual Risk 12 (moderate).
Resource:	Y: Two outstanding CQC requirements relate to pharmacy (Must Do) and AHP staffing (Should Do). There is currently reduced resource within the Corporate Quality Governance team for CQC/regulatory oversight work due to long term sickness absence and a resignation within the team. Work is being prioritised by remaining team members. The Head of Quality Assurance, Compliance and Risk post has been approved for internal advert in the first instance.
Legal and regulatory:	Y: Inability to provide assurance to our regulators impacting on the quality and safety of care provided to our patients and service users.
Subsidiary:	N

Assurance route:

Previously considered by:

26/14

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Regulatory Oversight Group (23 February 2026).

Oversight and Assurance meeting (3 March 2026)

A bi-monthly Chairs report is received from Regulatory Oversight Group to Trust Management Committee (TMC) (including CQC escalations). This was last received at Trust Management Committee (TMC) on 7 January 2026. Due to a much-reduced Quality and Operational Assurance TMC on 4 March 2026 this will be received by TMC for the 1 April 2026 meeting. Escalations are made as appropriate outside of the meeting.

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Care Quality Commission (CQC) Update Report

1. Purpose of the report

1.1 This report provides an update on CQC inspection activities, oversight, assurance and related improvement work. This report covers the period January 2026 to Mid-March 2026 and includes:

- CQC inspections;
- CQC engagement meetings;
- Summary of status of the CQC self-assessment and check and challenge meeting programmes;
- Ward and clinic accreditation update;
- Update on performance against the CQC inspection reports from May and July 2023, published in December 2023;
- Update on performance against 'historical' open CQC action plans (2018, 2020 and 2021);
- Summary of CQC queries;
- Recent CQC publications.

2. Background

2.1 The CQC rated the Trust as 'requires improvement' following Core Service and a Trust wide Well Led inspection in May and July 2023. The Maternity Core Service was inspected in December 2024 with a 'Good' rating for both the QEQM and the WHH sites. Continuing to improving our CQC rating is a Trust Strategic Initiative and a key part of the Quality Strategy and Quality Priority objectives as outlined in the Quality Account 2024/25.

3. CQC inspections

3.1 On 6-7 January 2026, the CQC undertook an unannounced inspection of the Urgent and Emergency Care Core Service at the QEQM. This inspection, and the subsequent inspections on the 27-28 January and 2-3 February 2026 were all under the Winter Pressures Programme and outside of the usual standard inspection regime and standard single assessment framework.

3.2 Following the visit on 9 January 2026 the Trust received a Letter of Intent that required submission of an action plan on 12 January 2026. The Trust have committed to provide the CQC and the Board of Directors with weekly reporting on the progress of the priority action plan. The report summarises the overall position and the week to date for the submission made on Friday 6 March 2026.

Theme	Number of actions due w/e					Action Status			
	16-Jan	23-Jan	30-Jan	06-Feb	13-Feb				
1.Safe care and treatment in temporary escalation areas	26	1	2	3	1	19	1		13
2.Flow of patients within the ED		2							2
3.Staffing (medical)	6	1	1	2		8	2		
4.Staffing (Mental Health)	6					1			5
Total number of actions	38	4	3	5	1	28	3		20

3.3 There are currently three actions that remain in progress (based on w/c 23 February 2026 reporting). These are as below:

3.3.1 Same Day Emergency Care (SDEC) is currently open until 8pm (7 days per week) but with locum cover on weekends. Meeting took place on 17/2/26 to finalise planning for a four-week pilot. Nursing staff review currently underway before pilot can start.

3.3.2 Strengthen the EPIC and NIC board round process by further standardisation. Rhythm of the Day has been revised and was approved at the Consultants Meeting on 28.01.26. Action taken to write the underpinning document that describes how the Rhythm of the day and recordings should be used. Action ongoing through implementation. This action also links to the Introduction of new board round documentation.

3.3.2 As a Medium sized ED, Royal College of Emergency Medicine (RCEM) guidance states 16-25 Whole Time Equivalent (WTE) Consultants will be required. A full business case is to be developed, including an implementation plan to increase substantive Consultant staffing to meet RCEM guidance. The business case is being drafted to go through the Trust governance processes.

3.4 The CQC submitted a provider information request (PIR) for 60 pieces of evidence in relation to QEQM UEC Core Service on the 15 January 2026 with a submission date of 22 January. The Trust requested an extension, this was granted with the exception of five evidence requests which were submitted within the designated time. The remaining requests were submitted within the extended deadline.

3.5 On 27- 28 January 2026, the CQC undertook an unannounced inspection of the General Medicine Core Service at the QEQM. The CQC submitted a PIR for 101 pieces of evidence on the 30 January 2026 with a submission date of 13 February 2026. All evidence was submitted within the deadline.

3.6 On 2-3 February 2026, the CQC undertook an unannounced inspection of the UEC Core Service at the WHH. The CQC submitted a PIR for 84 pieces of evidence on the 10 February 2026 with a due date of 24 February 2026. This deadline was met bar two requests which were submitted the following day.

3.7 Brief written feedback has been received following each inspection which the Trust has formally responded to ensure clarity and provide evidence of assurance in place. Improvement work continues whilst we await draft reports for factual accuracy purposes.

3.8 A review of the UEC self-assessment tool is underway, ensuring it includes additional elements that formed part of the Winter Pressures inspection. This will be completed by the end of March 2026.

3.9 A mock inspection of QEQM ED was completed on 6 March 2026 with a range of stakeholders in response to inspection feedback.

4. CQC Engagement meeting

4.1 The last CQC Engagement meeting took place on 4 November 2025. It was reported in the last paper to the Board of Directors that the CQC would like to have bi-monthly meetings instead of quarterly and a meeting schedule was agreed for the year.

4.2 The CQC Engagement meeting was scheduled for 15 January 2026, but this was subsequently stood down due to information requests following the Emergency Care Core Service inspection and the General Medicine Core Service inspection which took place at the QEQM.

4.3 The next CQC engagement meeting was scheduled for the 17 March 2026 but this was also stood down by the CQC on 6 March 2026 and a request was made to reschedule in April. Dates are currently being confirmed.

5. CQC Self-Assessment Programme and Check and Challenge Meetings

5.1 The self-assessment Check and Challenge meetings, chaired by the CNMO, and attended by the CMO, Chief Operating Officer (COO), Director of Quality Governance, Associate Director of Quality Governance and members of each Care Group's leadership team, commenced in May 2024.

5.2 The percentage of quality statements rated as fully met are shown in the below table.

5.3 There has been some slippage to the self-assessment programme due to the postponement of Check and Challenge meetings due to availability of core members. The annual schedule is being refreshed at present and will be re-circulated during March 2026 to give teams adequate time to complete and present.

Date of meeting last meeting	No of assessments completed	Percentage of Quality Statements rated as fully met					
			Safe	Effective	Caring	Responsive	Well Led
19.08.25	2	CYP	44%	50%	100%	79%	88%
09.07.24	2	Women's Health	81%	75%	90%	71%	75%
24.09.25	17	CCASS	68%	89%	88%	87%	95%
06.01.25	17	KCVH	72%	80%	81%	81%	86%
03.02.25	2	EOLC	25%	42%	40%	7%	56%
04.03.25	4	QEQM	38%	63%	65%	54%	57%
16.12.25	2	WHH	69%	58%	70%	64%	74%
14.04.25	17	DCB	57%	76%	80%	70%	80%

5.4 The intention was for all of the Self Assessments to be completed on an electronic system (InPhase) but this project has been terminated. The Compliance and Assurance team are reviewing the current documentation and any further improvements that can made locally to the process.

5.5 The self-assessment for urgent care will be reviewed by the compliance and assurance team in the next two weeks following the recent CQC inspections.

6. Ward and clinic accreditation update

6.1 Since October 2025, the programme has largely transitioned into Round 2 accreditation delivery, with a growing number of areas entering Round 3 reaccreditation in line with accreditation timeframes.

6.2 Of 55 eligible inpatient areas, 49 have completed Round 2 accreditation assessments.

6.3 Round 3 activity is now underway, with 32 areas eligible and nine assessments completed to date. Please see a summary of outputs below as reported through the March Ward and Clinic Accreditation Steering Group:

Accreditation Status Summary (October 2025 – 30 January 2026)

Inpatient Areas

Round 1: All completed (reported in Fundamentals of Care (FoC) paper October 2025)

Round 2 (Eligible N = 55; Completed n = 49):

- 3 areas achieved Silver.
- 30 areas achieved Bronze following reassessment.
- 16 areas remain White requiring some level of reassessment.
- 6 areas are scheduled for Round 2 assessment.

Round 3 (Eligible N = 33; Completed n = 9):

- 1 area achieved Silver.
- 7 areas currently White requiring a level of reassessment.

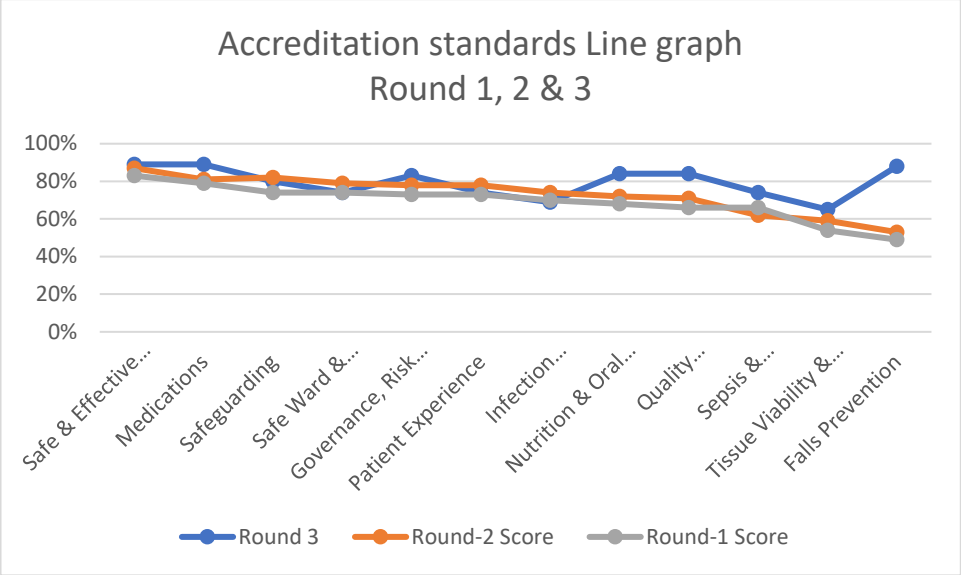
Trust-Wide Performance Averages (Inpatient and non-inpatient areas)

- Round 1: 69% (67% non-inpatient).
- Round 2: 73% (4% increase).
- Round 3: 79% (6% increase).

6.4 Non-inpatient accreditation has continued to expand, with 45 Round 1 assessments completed, although manual processes continue to impact cycle time and reporting efficiency.

6.5 There has been an improvement in performance against many of the standards across the Accreditation rounds as demonstrated in the table and graph presented below.

Accreditation Standards	Round 1	Round 2	Round 3
Safe & Effective Workforce	83%	87%	89%
Medications	79%	81%	89%
Safeguarding	74%	82%	80%
Safe Ward & Environment	74%	79%	74%
Governance, Risk and Incident Management	73%	78%	83%
Patient Experience	73%	78%	74%
Infection Prevention & Control	70%	74%	69%
Nutrition & Oral Hygiene	68%	72%	84%
Quality Improvement & Innovation	66%	71%	84%
Sepsis & Deteriorating Patient	66%	62%	74%
Tissue Viability & Pressure Ulcers	54%	59%	65%
Falls Prevention	49%	53%	88%



6.6 The Trust-wide Culture and Leadership standard currently averages at 55%, reflecting a continued improvement priority. Other priority improvement areas following Round 3 are Sepsis and the Deteriorating Patient (74%), Infection Prevention and Control (IPC) (69%) and Tissue Viability (65%).

6.7 The following challenges continue to affect the pace and sustainability of Ward & Clinic Accreditation delivery. Mitigations are managed via the Ward and Clinical Accreditation Steering Group and the FoC Committee:

- **Reassessment burden:** High volumes of reassessments driven by mandatory criteria non-compliance continue to place pressure on programme capacity and ward engagement.
- **Peer reviewer availability**: Variable peer participation and late cancellations impact delivery reliability and assessment scheduling.
- **Digital enablement limitations**: Ongoing reliance on manual processes, particularly for non-inpatient areas, extends cycle time and limits timely analysis and reporting.
- **Staff experience and engagement**: Repeated reassessments and White outcomes risk disengagement if benefits and learning are not consistently visible.
- **Digital platform transition risk**: The current Tendable platform has been extended to June 2026; a longer-term digital solution is still under exploration, presenting continuity risk if not resolved.

7. Update on performance against the 2023 CQC inspection report

7.1 Reports from the inspections that took place in May 2023 (medical care, children and young people and UEC at WHH and QEQM) and July 2023 (well

led) were published in January 2024 and an action plan was developed by each Care Group/speciality. The following action plans are in place:

- 2gether action plan - **closed**
- CYP action plan - **closed**
- DCB action plan
- QEQM GM action plan
- QEQM UEC action plan
- WHH GM action plan
- WHH UEC action plan
- Well Led action plan - **closed**
- Corporate Nursing/Medical/Operations action plan - **closed**

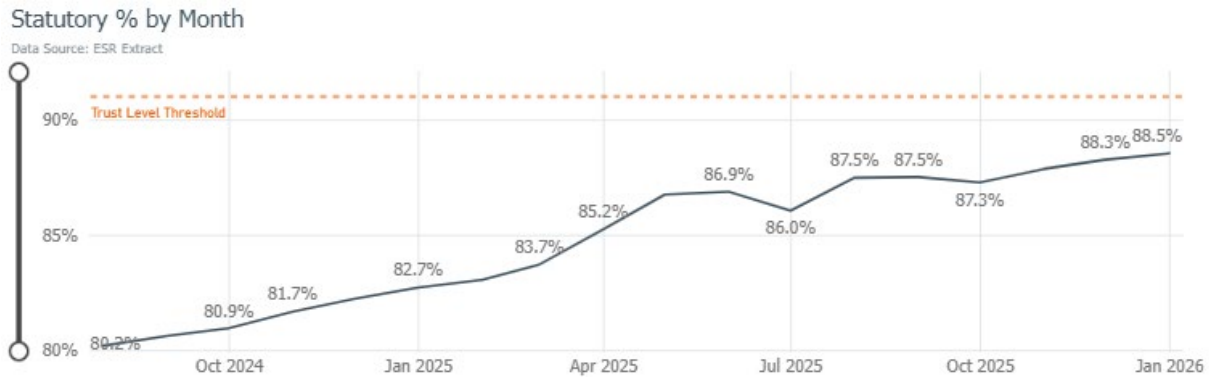
7.2 Monthly reports showing progress and status of each action plan have been provided to the CQC Oversight and Assurance Group and on to the Regulatory Oversight Group (ROG) and Quality and Safety Committee since the plans' commencement in January 2024. A fortnightly meeting is held with the CNMO and Director of Quality Governance.

7.3 This report includes the current status of the Must and Should Do requirements, and how many associated actions remain open. It shows the status on 7 January 2026 as reported at TMC.

7.4 Statutory and mandatory training for doctors had an extended target date of 30 September 2024, as agreed by the CMO. This target was not met and the CMO was informed. Actions are in place to recover this this. January 2026 data is presented below.

7.5 There has been a slight increase in performance in month but further work is required to recover the position with a focus on UEC and Medicine. For UEC and Medicine data please see point 8.2 below.

Statutory training for medical staff:



Mandatory training for medical staff:

7.6 There are five Must Do (out of 28) and one Should Do (out of 25) requirements that remain open (some requirements feature on multiple action plans or on two sites). There is a total of eight out of 206 (4%) actions open across all action plans, as shown in the table below.

OPEN REQUIREMENTS AND ACTIONS

Action plan	Open Must Do Requirements	Open Should Do Requirements	Total number of actions on plan	Number of open actions (05/03/2026)
Well led	0 of 4 (0%)	0 of 8 (0%)	56	0
2gether	0 of 4 (0%)	N/A	7	0
QEQM UEAM	1 of 6 (17%)	0 of 3 (0%)	26	1
QEQM GM	1 of 7 (7%)	0 of 5 (0%)	26	1
WHH GM	2 of 8 (25%)	0 of 4 (0%)	33	2
WHH UEAM	1 of 4 (25%)	0 of 2 (0%)	13	1
WCYP	0 of 11 (0%)	0 of 9 (0%)	28	0
DCB	1 of 11 (9%)	1 of 1 (100%)	12	3
Corporate	0 of 4 (0%)	0 of 1 (0%)	5	0
TOTAL			**206**	**8 (4%)**

7.7 Of these eight open actions:

- Five relate to medical training compliance. A six-month extension to 30 September 2024 was agreed for medics to achieve the compliance rates seen across nursing, midwifery, allied health professionals and clerical and managerial groupings. This was not met. Additional actions have been put into place to improve compliance. Data as reported above.

- Three actions relate to staffing (AHPs and pharmacy):

- Pharmacy: A meeting was held with the CQC Pharmacy Advisor this month and alternative models are being considered to decrease the risk

(on wards with no cover) as the level of investment proposed in the business case to close the Must Do is not feasible at present. Director of Pharmacy is looking at how Electronic Prescribing and Medicines Administration (EPMA) can be used to plan staffing, input and optimise current pharmacists. The first phase of this work is a project to increase consistency and reporting of medicines reconciliation (MR). This was completed in January 2026. A recent national benchmarking report will enable a re-set of expectations around the MR rate – and following this a proposed redistribution of resources (Phase 2) which will be complete by March 2026.

- AHPs: An AHP Workforce Review has been undertaken by the Deputy Chief AHP, an update paper was presented to TMC on 5 November 2025 which focused on delivery of a 7 day a week service. A view is required by the CNMO as to whether ongoing work against the agreed plan should be managed as part of Business As Usual (BAU) rather than via the CQC plan.

8. Update on performance against 'historical' open action plans (2018, 2020 and 2021)

8.1 There are four open inspection action plans relating to CQC inspections that took place between 2018 and January 2023. These action plans are also subject to regular review and update by the specialities, supported by the Compliance & Assurance Team (C&AT). There are three actions pending closure once approved by CMNO. (Two Should do and one Must do).

8.2 The following requirements remain open:

Care Group (CG) and Speciality	**Requirement**	**Status**
WHH UEC 2020	MD01.UEC.WHH The trust must ensure staff complete their mandatory training and each module meets their compliance targets, including; Mental Capacity Act training, life support training, and dementia training. (Also, on May 2023 action plan) MD28.UEC.QEQM & WHH.2023	Data 05/03/2026 **Medical compliance WHH UEAM**: January 2026 Statutory compliance – 85.6% (target 91%) 7 of 8 courses below Trust target Mandatory compliance – 79.6% (target 85%) 7 of 12 courses below Trust target
WHH UEC 2020	SD05.UEC.WHH The trust should ensure all staff have access to the training needed for their role including advanced life support.	Data 05/03/2026 **Medical:** January 2026 RESUS Adult 86.5% (target 85%) RESUS Paed 87.3% (target 85%) **For closure once approved by CMNO**

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Care Group (CG) and Speciality	Requirement	Status
WHH GM 2021	SD02.MED.Kent & Canterbury Hospital (K&C)& WHH.2021 The trust should ensure that all staff complete their mandatory training. (Also, on May 2023 action plan)	Data 05/03/2026 **Medical WHH GM** January 2026 Statutory compliance – 94.0% (target 91%) 3 of 8 courses below Trust target Mandatory compliance – 85.7% (target 85%) 5 of 11 courses below Trust target **For closure once approved by CMNO**
K&C GM 2021	SD02.MED.K&C & WHH.2021 The trust should ensure that all staff complete their mandatory training. (Also on May 2023 action plan)	Data 05/03/2026 **Medical K&C** January 2026 Statutory compliance – 84.9% (target 91%) 8 of 8 courses below Trust target Mandatory compliance –78.6% (target 85%) 10 of 14 courses below Trust target.
WHH UEC 2020	MD16.UEC. WHH The trust must ensure critical fluids and medicines are administered and recorded in a timely manner.	Discussions ongoing with CMO and Director of Pharmacy. Further pharmacy support for ED WHH recruited. Missed Dose Dashboard used to monitor compliance and reported through Medicines Safety Group. **Recommendation to close this requirement and for BAU oversight and monitoring via the new dashboard.**
QEQM UEC 2020	MD01.UEC.WHH The trust must ensure staff complete their mandatory training and each module meets their compliance targets, including; Mental Capacity Act training, life support training, and dementia training. Also on 2023 action plan MD28.UEC.QEQM & WHH.2023	Data 05/03/2026 **Medical QEQM UEAM** January 26 Statutory compliance – 89.2% (target 91%) 4 of 8 courses below Trust target Mandatory compliance – 81.3% (target 85%) 9 of 12 courses below Trust target
WHH & QEQM UEC 2020	SD03.UEC.QEQM & WHH The trust should ensure medicines reconciliation is undertaken in a timely manner	Discussions ongoing with CMO and Director of Pharmacy to ascertain outcome measures to provide assurance that this can be closed. This remains an issue due to long waiters as full reconciliation happens on admission. Mitigating actions proposed to ensure review of high priority patients.

Care Group (CG) and Speciality	Requirement	Status
EOLC 2018	MD37 Ensure that consent to care and treatment is always sought in line with legislation and guidance in relation to records of mental capacity assessments relating to decisions regarding 'Do not attempt cardiopulmonary resuscitation' (DNACPR).	Deputy CMO is co-chairing a task and finish group with the Trust Mental Capacity Act (MCA) Lead to address the issues identified. **Awaiting confirmation that actions are in place to be managed by task and finish group.**

9. CQC Queries Update

9.1 There were 15 queries received from the CQC during January and February 2026. During that period, five were fully responded to and one did not require a response.

9.2 Seven of these queries had deadlines set by the CQC, three of which were met (two ahead of deadline) and one is currently ongoing but still within due date. Two queries did not meet the target date set by the CQC. At the end of February 2026, two responses remain open for 2024, nine responses remain open from 2025 and nine remain open from 2026.

10. CQC publications

10.1 The CQC have shared the following publications. These updates have been shared at the CQC Oversight and Assurance Group and Regulatory Oversight Group.

- Tell us what maternity care is like for you in 2026 - Published 12.12.25
- Rebuilding CQC: progress during 2025 - Published 23.12.25
- CQC to continue to lead on programme of Independent Care (Education) and Treatment Reviews (ICETRs) - Published 17.12.25
- Monitoring the Mental Health Act in 2024/25 - Published 29.01.26
- Our January update - Published 29.01.26
- Give feedback on care online now - Published 30.01.26
- Professor Sir Mike Richards steps down as CQC Chair - Published 06.02.26
- New guidance for inspectors on care in non-clinical spaces - Published 12.02.26

11. Conclusion

11.1 The Board of Directors is asked to receive the attached report and note the assurance within it.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Safeguarding Assurance Committee Report**

Meeting date: **2 April 2026**

Board sponsor: **Sarah Hayes, Chief Nursing and Midwifery Officer (CNMO)**

Paper Author: **Salli Alihodzic, Associate Director of Safeguarding**

Appendices:

Appendix 1: Safeguarding Briefing Note – Government Response to Baroness Louise Casey's 2026 Safeguarding Social Care Speech
Appendix 2: Board Committee Assurance Report to the Quality and Safety Committee (Q&SC)

Executive summary:

Action required:	**Assurance**
Purpose of the Report:	To provide the Board with the assurance that the Trust is meeting the statutory Safeguarding responsibilities and progressing the EKHUFT safeguarding strategy.
Summary of key issues:	• The Trust is meeting our statutory responsibilities, schedule 4 responsibilities and contractual requirements. • Completion of Safeguarding Adults self-assessment and the good feedback about progress in this area. Key Challenges: • Safeguarding level 3 training compliance. • Number of local statutory safeguarding reviews and impact on services. • Performance in the Mental Capacity Act (MCA)/Deprivation of Liberty Safeguards (DoLs) - Recording detail/standards around MCA/DoLs including best Interest decision making. • Safeguarding Administration challenges. • Impact of delayed digital transformation and lack of administrative capacity.
Key recommendations:	The Board of Directors is asked to discuss and **NOTE** this Safeguarding Assurance Committee Report and the following: • Consider how the Trust can build safeguarding competence into yearly appraisal system for all registrants. • Consider the impact of delays in digital transformation and new recruitment processes around administrative staff for parts of the organisation such as Safeguarding which have a large number of external information requests and a heavy statutory reporting responsibility. • Consider recommendations from Casey Review.

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Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Trust Risk Register:	None
Resource:	Y - Increased administrative support and digital transformation.
Legal and regulatory:	Y – Statutory responsibility
Subsidiary:	N

Assurance route:

Previously considered by: Safeguarding Assurance Committee

26/15 – APPENDIX 1

East Kent Hospitals University NHS Foundation Trust

SAFEGUARDING BRIEFING NOTE

Subject: Government Response to Baroness Louise Casey's 2026 Safeguarding and Social Care Speech

Date: March 2026
Prepared for: Executive lead for Safeguarding / Executive Team
Prepared by: Head of Safeguarding

1. Purpose of this Briefing

This briefing summarises key points from Baroness Casey's Nuffield Trust Summit speech and the Government's formal response.

2. Background

Baroness Casey highlighted systemic failures in social care governance, underfunding, fragmented structures, and the absence of a national safeguarding architecture.

3. Key Points from Baroness Casey's Speech

- Systemic safeguarding failures are national, not just local.
- Call for a National Safeguarding Board.
- Urgent review of adult safeguarding statutory duties and powers.
- Safeguarding identified as an area of immediate national action.
- Social care requires a foundational creation moment.

4. Government Response (5 March 2026)

- Acceptance of a new National Safeguarding Board.
- Urgent statutory review of safeguarding duties and practitioner powers.
- Acknowledgement of deep systemic failures requiring reform.
- Ongoing engagement through Casey Commission's future reports.

5. Implications for NHS Trusts

- Increased national scrutiny of safeguarding performance.
- Need to align governance structures with national expectations.
- Strengthened assurance requirements.
- Potential legislative changes.

East Kent Hospitals University NHS Foundation Trust

6. Recommendations

- Note Government acceptance of recommendations at next safeguarding assurance.
- Complete an internal governance review of our Adult safeguarding function.
- Update safeguarding assurance framework when requirements of change are published.
- Monitor Department of Health and Social Care (DHSC) announcements.
- Strengthen Executive ownership of safeguarding culture.

7. Conclusion

The Government's response signals major national safeguarding reform. We should prepare for enhanced oversight and legislative changes.

East Kent Hospitals University NHS Foundation Trust

BOARD COMMITTEE ASSURANCE REPORT TO THE QUALITY AND SAFETY COMMITTEE (Q&SC)

Committee: Safeguarding Assurance Committee

Meeting date: 8 January 2026

Chair: Sarah Hayes, Chief Nursing and Midwifery Officer (CNMO)

Paper Author: Salli Alihodzic, Associate Director of Safeguarding

Quorate: Yes

Appendices:

N/A

Declarations of interest made:

No

Assurances received at the Committee meeting:

Agenda item	Summary
Agenda item 1 (Chairs Welcome and Apologies)	• This was a face to face meeting, members reminded to contact the Safeguarding team if they have any issues attending the meeting. • A number of Apologies received quoracy confirmed.
Agenda item 2 (Minutes from previous meeting)	• Approved 4 November 2025 Minutes.
Agenda item 3 (Action Log)	10.01 – Outstanding 5.2a – Outstanding, Steering Group to be held next week, follow up thereafter. 4.3 – Outstanding, amend name to Peter Davies, Director of Digital Transformation and Information Technology. 5.4 – Outstanding, meeting to be booked. 5.8 – Outstanding, contact Diagnostics, Cancer and Buckland (DCB) Managing Director (MD) and Chief Medical Officer (CMO). 10.1 – Mortuary visits booked, ongoing. 10.2 – Outstanding, meeting booked with the designate from the child death review team 09.01.2025 to discuss the coroner and Memorandum of Understanding (MOU).

East Kent Hospitals University NHS Foundation Trust

Agenda item 4 (Care Act and Children Act Safeguarding Activities)	**4.1 Safeguarding Operational Group Chair's Report and items for escalation** Staffing Updates – Partially assured • EW is in post (0.6 Whole Time Equivalent (WTE)), 8a Named Nurse for Safeguarding Children. • LM is acting up as the 8a for the 0.4 WTE of the 8a Named Nurse for Safeguarding Children role. • Vacancy – Safeguarding Administrator. • Long term sickness within the adult safeguarding practitioner team. **4.2 Safeguarding Strategy - Partial Assured** Focused on Safeguarding Sustainability • Kent and Medway Safeguarding Adults Board (KMSAB) Safeguarding Assurance Framework (SAF) submitted. Outcome one Amber action around Co-occurring conditions. • Statutory reporting Self-assessment against Safeguarding Accountability and Assurance Framework (SAAF), Provider Safeguarding Commissioning Assurance Toolkit (PSCAT), Looked After Children (LAC) submission. • Training compliance at level 3 discussed. Safeguarding operations, escalated at Trust Management Committee (TMC), Board aware - plan now in place with the medical education team to improve, achieve and sustain compliance. This remains on the risk register. • There was the learning from Safeguarding Adult Reviews (SARs) and Domestic Homicide Reviews (DHRs). Pressure continues at operational level due to number published in Kent and the challenge to embed learning. • Datix revised, trial to commence in February. Key Challenges/Risks • Recording safeguarding activity with reduced safeguarding administrative staff. • Progress of Paper lite/Digital transformation – Safeguarding recording – Sunrise. • Supervision – particularly community midwives. • Current levels of Training compliance. Voice of the child/Adult • Patient Participation Partner attends Safeguarding Operational and Safeguarding Assurance Committee. • Safeguarding team attend Babies, Children and Young People Board – Top and Pants feedback. • Feedback through complaints. Listening

	• Participation in Complaints Reponses and Local Risk Management (LRM) where safeguarding is included in the complaint. Think Family • Emergency Department (ED) Think Family documentation was launched last year, this is due to be reviewed and refreshed. • Duty system. • Policy provision – acknowledged within the SAF. • All tools on sunrise under review. Trauma informed Safeguarding • Agenda item at operational group. • Workshop ED. Making Safeguarding Personal • Policy. • Intranet guidance. • Site based and duty support. • Quality Assurance (QA) - System to be established. **4.3 Statutory Reporting** Shared our SAAF Self-Assessment Integrated Care Board (ICB) provided feedback on completed EKHUFT six monthly SAAF. Benchmarking completed by ICB Designated Professionals for Safeguarding Adults and Children as part of the step down from the recovery support programme for safeguarding. The Designates felt assured through attending EKHUFT safeguarding meetings, communication with the team and updates from Associate Director of Safeguarding. Communication between EKHUFT and ICB is strong and transparent.
Agenda item 5 (Safeguarding Operational Task and Finish Groups/ Workstreams Updates)	• **Update from Named Safeguarding Doctors - Assured** • Additional level three training scheduled for February 2026. • **MCA/DOLS - Limited assurance** • 2025 training sessions now on Electronic Staff Record (ESR) – Bespoke sessions by request / availability. • Request from General Surgery Medical team (Queen Elizabeth the Queen Mother Hospital (QEQM) 5/11/25) \ Anaesthetic Request for MCA training \ MCA & Consent request William Harvey Hospital (WHH) Acute Medical Unit (AMU). Sessions arranged **MCA Audit** - Work required to present Action plan to Associate Director of Safeguarding in January.

	• **Safeguarding Children - Assured** • High Level of contact to the team. • Work with ED around Trauma Informed Practice. • Ongoing work on Access to Records team Subject Access Requests Standard Operating Procedure (SOP) – additional work for the team. • Additional safeguarding training for doctors being offered. • Work with ED around Child Sexual Exploitation (CSE) and recognising concerns. • Additional supervision for specific cases in paediatrics and ED practitioners being provided. • **Safeguarding Maternity** • Safeguarding paperwork in use on the maternity wards. Peer Review additional support requested. • Joint training being offered with Children's Social Care Team around removal at birth. One session delivered second postponed due to staff unavailability. • Supervision figures have improved in last quarter, additional virtual sessions to be offered in October, November and December to support community midwives in achieving compliance. • Complex maternity tool Audit in progress. • **Safeguarding Adults - Assured** • Kent Adult Safeguarding Concern Form (KASCF) referrals to EKHUFT. • ICB designates to meet with Named nurse for adults to discuss the increase in community KASCFs and themes. • **Domestic Abuse - Assured** • Discussions have been had in the operational group to raise the Hospital Independent Domestic Violence Advocate (HIDVA) profile. • New Managers in place at WHH. • Number of direct referrals to the HIDVA service. • Number of Multi-Agency Risk Assessment Conference (MARAC) flags added to Allscripts. • HIDVA will be joining the Adult Safeguarding Week walk around • 16 days of action to raise the profile. • High Sheriff attended QEQM to meet the HIDVAs. • **Prevent - Assured** • The Safeguarding Teams did not make any PREVENT referrals. • The Safeguarding Teams provided information to the Channel panel for five PREVENT cases for under 18s and 13 for over 18s since last Safeguarding Assurance. • The team trained 216 in August and 188 September staff in PREVENT during this timeframe.

	• Designates for ICB discussed that although health do not make many referrals, we do continue to locate intelligence.
Agenda item 6 (Safeguarding Assurance Reports (Adult & Child)	**6.1 Joint Child and Adult Business Report - Partially Assured** • Female Genital Mutilation (FGM) reporting completed. • Training compliance at levels 1, 2, and 4 is over 85% for child and L1,2,4 adult, L3 Children and adult 82% (November 2025). • Audit activity has been undertaken one audit is delayed. • Assurance activity to meet schedule four requirements have been undertaken and has remained consistent. **6.2 Section 42 Activity** • Section 42 data was discussed – Improved timely completion and receipt of Terms of Reference (TOR). • Section 42 internal team audit due, from initial identification of a safeguarding concern through to supervision following submission. **6.3 Mental Health and Learning Disability Update** Not received due to no representation the Committee will ensure Associate Director Nursing for Mental Health is invited to all Safeguarding Assurance Committee Meetings. **6.4 Domestic Abuse (DA)** • HIDVAs in place at WHH and QEQM - increase to community provision at QEQM, they will also cover the HIDVA during sickness and annual leave. • The DA policy under review changes include updating the contact details of the HIDVA, strengthen the information around non-fatal strangulation as well as additional training that the HIDVAs are able to offer. • Support for staff hasn't altered in terms of safety and the HR process. Query raised around EKHUFT engagement with Employers Initiative for Domestic Abuse. Lead for Domestic Abuse to find out if EKHUFT are signed up to the Employers Initiative for Domestic Abuse. **6.5 Terms of Reference (TOR)** TOR approved by those present. TOR were updated to state a representative from the ICB would attend this meeting, rather than both designates to attend. The Mental Health Associate Director of Nursing (ADoN) added to the TOR.

	For CMNO final approval. **6.6 Audit -** Safeguarding Team RAG/Social Round Paperwork Review of Compliance.
Agenda item 7 (Learning from Reviews)	**LEARNING FROM REVIEWS** **7.1 Safeguarding Adults Exception Reports SARs, Domestic Abuse Related Death Review (DARDR), DHRs** • No overdue actions. • Overview spreadsheet designed and being populated. • Monthly SAR/DARDR meeting between Associate Director for All Age Safeguarding and Named Nurse for Safeguarding & MCA Lead to review new requests and actions. • New SAR publications since previous Safeguarding Adults Collection (SAC). • Kent and Medway SAB - Safeguarding Adult Reviews **7.2 Safeguarding Children Exception Report – Child Protection Information Sharing (CPSR) and RR** • Three Open CSPR. • Three recommendations completed. • One recommendation overdue. • CSPR Action - Audit of complex maternity tool Audit to present to the operational group in February.
Agenda item 8 (Risk Register – All Age Safeguarding Risk Register Update)	• Two Safeguarding Risks • Safeguarding training for safeguarding adults is below 85%. • Digital Record transformation -Timely transfer of safeguarding record keeping on Electronic Patient Record (EPR) impacted by administrative staff shortage equipment and digital solution.

Agenda item 9 (Statutory Self-Assessment)	**9.1 Kent and Medway Safeguarding Adult Board – Self Assessment Framework - Assured**
	
	Outstanding Action – co-occurring conditions:
	1. Strengthen Recording of Co-occurring Conditions in EPR:
	  ○ Implement improved recording functionality for co-occurring conditions within the EPR.
	  ○ Identify and document at least one viable digital solution.
	  ○ Engage with IT and clinical informatics teams to scope

options.
    - Enhances safeguarding and clinical decision-making for complex cases.
    - Complete exploration and present recommendations within Six months.
2. Improve communication with Liaison Psychiatry Service:
    - Establish data-sharing process to understand the number of patients referred by EKHUFT to the Co-occurring Conditions Panel.
    - Obtain and analyse referral data from LPS within the agreed timeframe.
    - Schedule meetings with LPS leads and agree on reporting format.
    - Supports compliance with safeguarding board policy.
    - Complete liaison and produce summary report within three months.

The designated professionals praised EKHUFT for this SAF submission, it was very well received by the board panel. The feedback given was that this was the best SAF submitted and that they'd like to use it as an exemplar for other organisations. This was an exceptional piece of work.

9.2 Kent Safeguarding Children Multi-Agency Partnership – Section 11 assured

- All staff/volunteers have a clear understanding of their responsibilities, which is outlined in their job descriptions, and to whom they should go if they have any concerns.
- *Action: Audit of 10 staff audited to determine if they know who to contact* – ***Completed.***
- The development of services considers the need to safeguard and promote the welfare of all children.
- *Action: Completion of phase 2 of CP-IS implementation 31-12-2024* ***completed****.*
- All individuals who come into contact with children and young people on an individual basis have regular, documented supervision (including safeguarding practice reflection) and can access further support when required.
- *Actions: Delivery of supervisee training to Community Midwifery teams* – ***completed****.*
- *Policy to reviewed and to become an all age safeguarding supervision policy* – ***completed****.*
- Organisations can demonstrate that agencies that are commissioned to provide services on their behalf rigorously apply safer recruitment and employment practices.
- *Action: Update escalation matrix to new Managing allegations policy – this is reflected on the new policy.*
- There are processes and systems in place to ensure the "voice of the child" and families' views are captured and used to inform

	individual case decisions, plans and/or services they receive. • *Action; review if there is an engagement strategy in place for Children and Young People (CYP) Trust wide. This action has been shared with Managing Director and the Child Health team are working with the engagement team to move this forward. Outstanding* Work being undertaken with the community regarding 'Little Voices'. Children attend and become mini inspectors, they try the food and give feedback about their experience. This will feed into future steps and how we look at services being delivered. The designate for children was praised for this work and recommended this was shared with other organisations. The section 11 plan for 2026 remains the same, this will be requested in May with submission in September.
Agenda item 10 (Policies)	**10.1 Mental Capacity Act Policy (MC)** Draft Policy discussed, welcoming comment. Key Changes • Changed the two-stage test order to reflect The Mental Capacity (Amendment) Act 2019 so the functional test is performed first followed by the diagnostic test if required. • Amended guidance regarding length of urgent Authorisation from seven days plus seven day extension to automatic 14 day request (including DoLS flowchart). • Updated guidance on when to escalate need for formal DoLS assessment to LA DoLS office. • Updated associated documentation. • Strengthened guidance on when an Independent Mental Capacity Advocate (IMCA) is required. • Strengthened guidance on interface between Mental Health Act (MHA) and MCA. • Included DoLS not applicable to patients currently serving custodial sentence. • Once ratified by Policy Authorisation Group (PAG) policy will be due for review February 2029. • Policy may be reviewed sooner dependent on outcome of DHSC consultation on Liberty Protection Safeguards and MCA Code of Practice (Early 2026). **10.2 Safeguarding Adult Policy** **10.3 Standard Operating Procedure (SOP) - Access to Records**

	SOP is for use within the safeguarding team when we are asked by the Access to Records team to review/provide records. DM ask for any comments to be sent directly to her within the next seven days. **10.4 DA Policy** The children asked for comment on the Domestic Abuse Policy. **10.5 – Missing Persons Policy** has been updated by the Mental Health team. **10.6 – Managing Allegations Policy** extended by PAG until the end of April 2026, to ensure the people and culture team are involved in the update.

Agenda item 11 (KMSAB and Kent Safeguarding Children Multi-Agency Partnership (KSCMP) Updates)	**Kent Safeguarding Children Multi-Agency Partnership (KSCMP)**
	EKHUFT Intranet Page Link - KSCMP
	
	Kent and Medway Safeguarding Adult Board (KMSAB)
	EKHUFT Intranet Page Link - KMSAB
	
	• Following its scheduled review, the KMSAB's **When Adults at Risk Abuse Each Other in Settings Where Care is Provided** protocol (previously named 'When Adults at Risk Abuse Each Other') has now been published to the KMSAB website.
	• This document provides guidance to agencies and services who have to address safeguarding concerns raised when adult(s) at risk abuse each other. It aims to provide advice about:
	  • Reporting concerns outside your service i.e. to adult social care services or to the police.
	  • How to address the concerns within the organisation.
	  • Sharing information in the best interests of the adults at risk.
	  • The decision making process regarding the actions to be taken to support and protect both the adult(s) at risk and the adult causing concern.
	  • To view the updated protocol, visit the **KMSAB website**.
	
	KMSAB Homelessness Audit Findings Presented:
	
	In May 2024, a Ministerial letter highlighted the considerable overlap between rough sleeping and the presence of safeguarding concerns. Most adults who are rough sleeping are at significant risk of abuse, neglect, and severe escalation of health and care needs.
	
	In response, the KMSAB Quality Assurance Working Group (QAWG) conducted a small sample multi-agency audit to review cases involving

	people at risk of or experiencing homelessness. Learning points identified were in relation to: **Legal Literacy** Understanding and application of the duty to refer and opportunities for earlier intervention. There were also challenges when duty to notify was undertaken but the housing authority had discharged their duty to accommodate, Mental Capacity Assessments. **Quality of professional curiosity, information sharing including referrals, individuals' communication needs and methods** Agencies to consider the communication needs and routes of communication for individuals who are homeless, sharing this information within the referral, Discharge to GP where not registered. **Multi-agency working** Lack of consideration of alternative pathways beyond section 42, such as self-neglect and co-occurring conditions. How to support individuals who do not meet the criteria for housing or social care. Link to KMSAB Newsletter (December 2025) for more details - Sway
Agenda item 12 (Integrated Care Board (ICB))	• Designates are in the process of undertaking the six month SAAF mapping review. • New NHS Kent and Medway ICB Chief Executive Officer (CEO), Adam Doyle, has commenced in post. • Kent County Council have informed the ICB that Ofsted will be visiting the front door from Monday 3/11/2025 for an inspection set out in Inspecting Local Authority Children Services (ILACS). • Designates have provided feedback on the Chane 2025 Safeguarding Good practice Document via the regional safeguarding network to the national team. • NHS Kent and Medway continue to represent the health system within the families first partnership programme board and a health working group is being established to support co design and implementation. Change 25, the safeguarding practice documents came out nationally, there was concern around adult safeguarding within those documents as well as the quality of the document. The adult designate network have produced a letter of concern through to the national.
Current Issues for Escalation to Quality & Safety Committee (Q&SC)	Service level agreement for the Child Protection Medicals. There are concerns about where the legal support sits if they are being undertaken on behalf of EKHUFT. • All Age Safeguarding Training.

Other items of business

Actions taken by the Committee within its Terms of Reference:

The Committee **APPROVED** actions to be progressed and workstreams.

Items to come back to the Committee outside its routine business cycle:

Fuller report.

Items referred to the BoD or another Committee for approval, decision or action:

Item	Purpose	Date
Safeguarding Assurance Committee asks the Q&SC to discuss and **NOTE** this Assurance Report, and to note: • Delays in digital transformation impacting safeguarding record keeping; • TOR.	Assurance	24 March 2026

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Acting Chief Medical Officer's (CMO's) Report**

Meeting date: **2 April 2026**

Board sponsor: **Helen Mackie, Acting CMO**

Paper Author: **Tynita Patterson, Senior Business Operational Manager**

Appendices:

None

Executive summary:

Action required:	Assurance
Purpose of the Report:	This report provides an annual update to the BoD on activity across the CMO portfolio, including medical education, professional development, appraisal and workforce development.
Summary of key issues:	• Medical Education: Work is ongoing to support training quality, with actions in place to address areas identified through national survey feedback. • Professional Development: Leadership development programmes continue to support consultants and clinical leads. • Appraisal and Revalidation: Appraisal compliance remains at around 90%, with established processes in place to support revalidation. • Professional Standards: There are no significant new issues to report in relation to the General Medical Council (GMC) or Maintaining High Professional Standards (MHPS) cases, with established processes in place to manage professional standards. • Workforce Development: Mortality oversight continues through established processes, with ongoing work to support clinical governance. Plans are also in place to strengthen the capacity of the CMO Office.
Key recommendations:	The Board of Directors is asked to **NOTE** the Acting CMO's report.

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Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People
Link to the Trust Risk Register:	N/A
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: N/A

East Kent Hospitals University NHS Foundation Trust

Acting Chief Medical Officer's (CMO's) Report

1. Purpose of the report

This report provides an update to the BoD on general activity across the CMO portfolio, including Medical Education, professional development, appraisal and revalidation, and workforce development.

2. Background

This report provides an overview of activity across the CMO portfolio over the past year. It reflects ongoing work to support medical workforce development, education, appraisal and revalidation, and clinical governance.

3. Medical Education

Work is ongoing to support training quality across the Trust, with actions in place to address areas identified through national survey feedback and ongoing review processes.

4. Professional Development

Leadership development programmes continue to support consultants and clinical leads, with ongoing delivery aligned to organisational priorities.

5. Appraisal and Revalidation

Appraisal compliance remains at around 90%, with established governance arrangements in place to support revalidation and ongoing quality assurance.

6. Professional Standards

There are no significant new issues to report in relation to GMC or MHPS cases, with established processes in place to manage professional standards.

7. Workforce Development

Mortality oversight continues through established governance arrangements, with ongoing work to understand variation and support improvement in patient outcomes.

A business case has been submitted to strengthen the capacity of the CMO Office to support clinical governance and oversight across the Trust.

8. Conclusion

The BoD can be assured that appropriate processes are in place across the CMO portfolio, with ongoing work to support workforce development, education and clinical governance.