East Kent Hospitals University NHS Foundation Trust

OPEN BOARD OF DIRECTORS (BoD) MEETING – THURSDAY 9 OCTOBER 2025

Please find attached the agenda for the next Board of Directors meeting. The meeting will take place by **Webinar videoconference –** commencing at **12.45 pm to 4.50 pm**

AGENDA

25/

OPENING/STANDING ITEMS

No.	Item	Time	Purpose	Type	Presenter
062	Welcome and Apologies for Absence	12.45 (10 mins)	To Note	Verbal	Chair
063	Confirmation of Quoracy		To Note	Verbal	Chair
064	Declaration of Interests		To Note	Enclosure	Chair
065	Minutes of Previous Meeting held on 31 July 2025		Approval	Enclosure	Chair
066	Board of Directors Decisions outside the Board		Approval	Enclosure	Chair
067	Matters Arising from the Minutes on 31 July 2025		Approval	Enclosure	Chair

Patients

No.	Item	Time	Purpose	Type	Presenter
068	Patient Story	12.55 (30 mins)	Discussion	Verbal	Deputy Chief Nurse (CN)

REGULATORY AND GOVERNANCE

No.	Item	Time	Purpose	Type	Presenter
069	Chair's Report	1.25 (5 mins)	Information	Enclosure	Chair
070	Chief Executive's (CE's) Report	1.30 (10 mins)	Discussion	Enclosure	Chief Executive (CE)

No.	Item	Time	Purpose	Type	Presenter
071	Integrated Performance Report (IPR)	1.40 (15 mins)	Discussion	Enclosure	CE/ Executive Directors
071.1	Month 5 Finance Report		Information	Enclosure	Chief Finance Officer (CFO)
072	Integrated Improvement Plan (IIP) Performance Reporting	1.55 (10 mins)	Discussion	Enclosure	Chief Strategy & Partnerships Officer (CSPO)
073	Kent and Medway Pathology Network (KMPN) Joint Venture Contract	2.05 (10 mins)	Approval	Enclosure	CSPO
074	Provider Capability Self-Assessment	2.15 (10 mins)	Information	Enclosure	CE/ CSPO
075	Significant Risk Register Report	2.25 (10 mins)	Assurance	Enclosure	Deputy CN

TEA/COFFEE BREAK 2:35 - 2:45 (10 MINS)

Quality and Safety
Patients

No.	Item	Time	Purpose	Type	Presenter

076	Maternity and Neonatal Assurance Board (MNAB) Chair's Report
	• Clinical Negligence Scheme for Trusts (CNST) Compliance
	  • Avoiding Term Admissions into Neonatal Units (ATAIN)
	  • Medical Workforce (Anaesthetic Workforce)
	  • Saving Babies Lives (SBL)
	  • Claims, complaints and incidents
	• Perinatal Quality Surveillance Tool (PQST)
	• Maternity and Neonatal Improvement Programme (MNIP)
	• NHS England Insight Visit
		2.45 (10 mins)	Assurance	Enclosure	Deputy CN/ Director of Midwifery (DoM)

No.	Item	Time	Purpose	Type	Presenter
077	Nurse Staffing Establishment Review for In-Patient Wards, Acute Medical Units (AMUs) and Emergency Departments (EDs)	2.55 (10 mins)	Approval	Enclosure	Deputy CN
078	Safeguarding Annual Report 2024/25	3.05 (10 mins)	Approval	Enclosure	Deputy CN
079	Patient Safety Incident Investigations (PSIIs)	3.15 (10 mins)	Information	Enclosure	Deputy CN
080	Chief Medical Officer's (CMO's) Report: Medical Appraisal and Revalidation	3.25 (10 mins)	Approval	Enclosure	Chief Medical Officer (CMO)

Patients
Partnerships
Sustainability

No.	Item	Time	Purpose	Type	Presenter
081	Winter Planning and Board Assurance Statement (BAS) 2025/26	3.35 (10 mins)	Assurance	Enclosure	Chief Operating Officer (COO)

Quality and Safety
Patients
People
Partnerships
Sustainability

No.	Item	Time	Purpose	Type	Presenter
082	Board Committee – Chair Assurance Reports:	3.45			Board Committee Chairs
082.1	Nominations and Remuneration Committee (NRC) – Chair Assurance Report	3.45 (5 mins)	Assurance	Enclosure	Chair NRC – Dr Annette Doherty
082.2	Quality and Safety Committee (Q&SC) – Chair Assurance Report	3.50 (10 mins)	Assurance	Enclosure	Chair Q&SC – Dr Andrew Catto
No.	**Item**	**Time**	**Purpose**	**Type**	**Presenter**

082.3	Finance and Performance Committee (FPC) – Chair Assurance Report • Reconfiguration of Stroke Services Full Business Case (FBC)	4.00 (10 mins)	Approval	Enclosure	Chair FPC - Richard Oirschot
082.4	People and Culture Committee (P&CC) – Chair Assurance Report • Equality, Diversity and Inclusion (EDI) (EDI is now a standing item on this committee/board meeting as part of NHSE Equality Delivery System and so EDI can be considered in all meetings and key decisions. Please discuss and consider how this meeting/decision may impact EDI and record this e.g. have an adverse or positive impact on staff or patients with protected characteristics e.g. race, age, disability etc.)	4.10 (10 mins)	Assurance	Enclosure	Chair P&CC – Claudia Sykes /
082.5	Integrated Audit and Governance Committee (IAGC) – Chair Assurance Report	4.20 (10 mins)	Assurance	Enclosure	Chair IAGC – Dr Olu Olasode

CLOSING MATTERS

No.	Item	Time	Purpose	Type	Presenter
083	Any other business	4.30 (5 mins)	Discussion	Verbal	All
084	Questions from the public – questions to be submitted in advance of meeting by 12.00 noon the day before meeting is held	4.35 (15 mins)	Discussion	Verbal	All

Date of Next Meeting: Thursday 4 December 2025


Our vision
Great healthcare from great people
Our values
People feel cared for, safe, respected and confident we are making a difference
Our strategic themes
Quality and safety
Patients
People
Partnerships
Sustainability
Research
Our strategic objectives
Reducing harm and delivering safe services
Patients, family and community voices
Timely access to care
Care and compassion
Teamwork, trust, respect and inclusion
Improving outcomes and reducing health inequality
Financial sustainability
Centre of research excellence

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REGISTER OF DIRECTOR INTERESTS – 2025/26 FROM SEPTEMBER 2025

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
BLISSETT, NORMAN	Chief People Officer	Director and sole shareholder of Gallanach Enterprises Ltd **(1) (3)**	20 January 2025
CATTO, ANDREW	Non-Executive Director	Group Chief Executive Officer, Integrated Care 24 (IC24) **(1)** (including Director of Cleo Systems 24 Ltd, Brightdoc 24 Limited, Idental Care 24 Ltd.) Board Member of east Kent Health and Care Partnership (HCP) **(1)** Director of Transforming Primary Care **(1)**	1 November 2022 (First term)
DESAI, KHALEEL	Director of Corporate Governance	Non-Executive Director/Trustee of The Mines Advisory Group (MAG) Charity **(4)**	29 April 2024
DOHERTY, ANNETTE	Chair	Chair of Maidstone and Tunbridge Wells NHS Trust **(1)**	1 May 2025
FLETCHER, TRACEY	Chief Executive	None	4 April 2022
GIBBS, DAN	Chief Operating Officer	Equity holder in Ignite Data Ltd. **(2)**	7 February 2025
GRIFFITH, FFION	Non-Executive Director	Non-Executive Director, Nexus Infrastructure Plc **(1)**	1 May 2025 (First term)
HAYES, SARAH	Chief Nursing and Midwifery Officer	Charity Trustee, The 1930 Fund for Nurses (Charity) **(4)**	18 September 2023
HOLDEN, DES	Chief Medical Officer	International Advisor, Public Intelligence (Denmark) **(5)** (2018) Advisor/Non-Executive Director, South East Health Technology Alliance **(4)** (2017) Visiting Professor, Clinical and Experimental Medicine, University of Surrey **(5)** (2023 to 2026)	2 January 2024

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REGISTER OF DIRECTOR INTERESTS – 2025/26 FROM SEPTEMBER 2025

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
HOLLAND, CHRISTOPHER	Associate Non-Executive Director	Director of South London Critical Care Ltd **(1)** Shareholder in South London Critical Care Ltd **(2)** Dean of Kent and Medway Medical School, a collaboration between Canterbury Christ Church University and the University of Kent **(4)** South London Critical Care solely contracts with BMI The Blackheath Hospital for Critical Care services **(5)**	13 December 2019 (Second term)
MUSGROVE, ROBERT	Non-Executive Director	Employee of IBM UK Ltd **(1)** Non-Executive Director In-Common, 2gether Support Solutions **(1)**	1 May 2025 (First term)
OIRSCHOT, RICHARD	Non-Executive Director	Non-Executive Director, Puma Alpha VCT plc (July 2019) **(1)** Director, R Oirschot Limited (August 2010) **(3)** Trustee, Camber Memorial Hall (June 2016) **(4)**	1 March 2023 (First term)
OLASODE, OLU	Senior Independent Director (SID)/Non-Executive Director	Executive Chairman, TL First Group (started 9 May 2020) **(3)** Chairman, Governance and Leadership Academy UK (started 11 September 2018) **(1)** Non-Executive Director, Priory Care Group (started 1 June 2022) **(1)** Independent Chair of Audit and Governance, London Borough of Croydon (started 1 October 2021) **(4)**	1 April 2021 (Second term)
STEVENS, BEN	Chief Strategy and Partnerships Officer	None	1 June 2023 (substantive) (20 March 2023 interim)

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REGISTER OF DIRECTOR INTERESTS – 2025/26 FROM SEPTEMBER 2025

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
SYKES, CLAUDIA	Non-Executive Director	Director, Cloudier Skies Ltd **(1)** (started 21 December 2022) Chair, East Kent Health and Care Partnership (HCP) (**1**) (1 January 2024) Chair, Kent and Medway VCSE Alliance **(5)** (September 2022)	1 March 2023 (First term)
van der LEM, ANGELA	Chief Finance Officer	Board Member, NHS Commercial Solutions Management Board **(1)**	6 November 2024
WALKER, CATHERINE	Non-Executive Director	Chair of Advisory Appointments Committee, Kings College NHS Foundation Trust **(1)** Tribunal Member, Ministry of Justice **(1)** Panel Member/Chair, High Speed 2 **(1)** Panel Member/Chair, East West Rail **(1)**	25 October 2024 (First term)
YOST, NATALIE	Executive Director of Communications and Engagement	None	31 May 2016

Footnote: All members of the Board of Directors are Trustees of East Kent Hospitals Charity

The Trust has a number of subsidiaries and has nominated individuals as their 'Directors' in line with the subsidiary and associated companies articles of association and shareholder agreements

Categories:

1 Directorships
2 Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS
3 Majority or controlling shareholding
4 Position(s) of authority in a charity or voluntary body
5 Any connection with a voluntary or other body contracting for NHS services
6 Membership of a political party

UNCONFIRMED MINUTES OF THE ONE HUNDRED AND FOURTY FIFTH MEETING OF THE BOARD OF DIRECTORS (BoD) THURSDAY 31 JULY 2025 1.00 PM HELD IN THE CORPORATE MEETING ROOM, TRUST OFFICES, KENT AND CANTERBURY HOSPITAL (K&C), ETHELBERT ROAD, CANTERBURY, KENT, CT1 3NG AND WEBINAR VIDEOCONFERENCE

PRESENT:

Dr A Doherty	Trust Chair (Chair)/Nominations and Remuneration Committee (NRC) Chair	AD
Mr N Blissett	Chief People Officer (CPO)	NB
Dr A Catto	Non-Executive Director (NED)/Quality and Safety Committee (Q&SC) Chair	AC
Ms T Fletcher	Chief Executive (CE)	TF
Mr D Gibbs	Chief Operating Officer (COO)	DG
Ms F Griffith	NED/NED Maternity Safety Champion	FG
Ms S Hayes	Chief Nursing and Midwifery Officer (CNMO)	SH
Dr D Holden	Chief Medical Officer (CMO)	DH
Mr R Oirschot	NED/Finance and Performance Committee (FPC) Chair	RO
Mr B Stevens	Chief Strategy and Partnerships Officer (CSPO)	BS
Ms C Sykes	NED/Charitable Funds Committee (CFC) Chair/People & Culture Committee (P&CC) Chair	CS
Ms A van der Lem	Chief Finance Officer (CFO)	AvdL
Mrs C Walker	NED	CW

ATTENDEES:

Mr M Blakeman	Improvement Director, NHS England (NHSE)	MB
Mr K Desai	Director of Corporate Governance (DCG) (non-voting Board member)	KD
Ms E Sharp	Guarding of Safe Working (GoSW) *(minute number 25/58)*	ES
Ms A Smith	Deputy Director of Maternity (DDoM) (*representing DoM) (minute number 25/54)*	AS
Mrs N Yost	Executive Director of Communications and Engagement (EDC&E) (non-voting Board member)	NY

IN ATTENDANCE:

Miss S Robson	Board Support Secretary (BSS) (Minutes)	SR

MEMBERS OF THE PUBLIC AND STAFF OBSERVING (BY WEBINAR):

Ms M Bonney	Governor
Mr N Daw	Member of Staff
Ms S F Mahmood	Staff Governor
Ms B Mayall	Governor
Mr P Schofield	Governor
Mr C Shorter	Governor

MINUTE NO.		ACTION
25/043	**CHAIR'S WELCOME AND APOLOGIES FOR ABSENCE** The Chair opened the meeting, welcomed everyone present, and noted apologies received from Professor C Holland, Associate NED (non-voting Board member); Mr R Musgrove, NED (voting Board member), and Dr O Olasode (OO), NED/Senior Independent Director (SID)/Integrated Audit and Governance Committee (IAGC) Chair (voting Board member).	

25/044 **CONFIRMATION OF QUORACY**

The Chair **NOTED** and confirmed the meeting was quorate.

25/045 **DECLARATION OF INTERESTS**

The Chair **NOTED** there were no new interests declared.

25/046 **MINUTES OF THE PREVIOUS MEETING HELD ON 5 JUNE 2025**

DECISION: The BoD **APPROVED** the minutes of the previous meeting held on 5 June 2025 as an accurate record.

25/047 **MATTERS ARISING FROM THE MINUTES ON 5 JUNE 2025**

B/01/25 - Data information differentiating patient attendance against factors around health inequalities and deprivation
The NEDs noted this action was work in progress in respect of the results to be discussed at Board Committees. It was agreed this action would remain open and be reviewed following discussions at the Board Committees.

The BoD **NOTED** the action log, **NOTED** the updates on actions, **NOTED** the actions for future Board meetings, and **APPROVED** the twelve actions recommended for closure.

25/048 **STAFF STORY**

The BoD **NOTED** the Staff Story presentation had been postponed due to personal reasons.

25/049 **CHAIR'S REPORT**

The Chair provided a verbal report highlighting the following key points:

- Reflections over last three months since joining Trust: enjoying working with Board members who are leading organisation effectively, visiting staff and services across all hospital sites. Plan to continue visits to clinical services across the hospital sites;
- There was an opportunity at last month's BoD Strategic Sessions to review the longer-term strategic priorities, finances, and NHS 10 Year Health Plan. Continuing to work with system partners ensuring appropriate patient pathways that meet the needs of the local community, and how to improve delivery of clinical services, whilst recognising the challenges;
- Recognition of the Trust's good improvement work and that of its staff in achieving the Care Quality Commission (CQC) 'Good' rating for its Maternity Services. Continuing to improve its services and culture around embedding learning. Congratulations on successfully exiting the national NHSE's Maternity Safety Support Programme (MSSP);
- Appointment of Jo Hills, Chair of Trust's subsidiary 2gether Support Solutions (2gether), commencing 1 August 2025.

The BoD **NOTED** the verbal Chair's report.

25/050 **CHIEF EXECUTIVE'S (CE's) REPORT**

The CE highlighted the following key issues:

- Significant progress against milestones and exit criteria for the 2024/25 Integrated Improvement Plan (IIP) part of National Oversight Framework

(NoF4) within the Recovery Support Programme (RSP). Evidence presented, being reviewed nationally, and currently awaiting outcome;
- Formal report still awaited on the CQC Spencer Private Hospitals (SPH) inspection, and feedback had been generally positive;
- Thanks to all staff for their hard work providing effective support and cover to deliver services, with robust planning and mitigations put in place during the recent resident doctors' industrial action, recognising the right of staff to take this action. This had resulted in some outpatient appointments being cancelled as well as an impact on elective services.

The COO reported 244 outpatient appointments and 15 planned operations cancelled (half of which had been rebooked), no cancer activity cancelled.

The NEDs also discussed the ongoing challenges with Emergency Department (ED) attendances, expressing concern that despite some reductions, the numbers remained high and required continued focus and targeted improvement efforts. The COO commented this was included in the Integrated Emergency Care Improvement Plan to be presented to FPC and updates to BoD within the FPC Chair report. This would also be covered within the Winter Plan that was currently being worked on and to be presented to a future BoD meeting.

The NEDs enquired about an update on the provision of the William Harvey Hospital (WHH) ED Safe Haven, whether this was up and running, effective and having a positive impact on the experience of mental health patients. There is clearly improvement to be made on visibility of our staff of this service. The BoD noted the availability of this service and the Trust continued to work on this patient pathway ensuring effective support and treatment for mental health patients.

The BoD **NOTED** the CE's report.

25/051 **INTEGRATED PERFORMANCE REPORT (IPR)**

Patients

The COO highlighted the following key performance against metrics:

- Key area of focus to significantly reduce number of patients waiting in the EDs over 12 hours (improvement at Queen Elizabeth the Queen Mother Hospital (QEQM) and decline at WHH). There is also a focus on improving patients seen within 4 hours. The Urgent Emergency Care (UEC) challenges were discussed, with ongoing work with system partners, Same Day Emergency Care (SDEC) improvement work, best practice learning from other organisations to improve patient flow, patient pathways, productivity, timely medical intervention and decision making at the front door around whether to admit, and reduce length of time for bed to be allocated. Working with system partners to increase discharges for patients that no longer fit criteria to reside, around an integrated model for these patients to be supported once discharged;
- Sustaining position of patients waiting greater than 65 weeks (67 at end of June).

The NEDs enquired about support and funding for timely patient discharge plans and the Trust's Winter Plan. The COO reported a reduction of 22% winter funding from the previous year, being managed by the Health and Care Partnership.

Quality & Safety

The CNMO highlighted the following key performance against metrics:

- Number of overdue incidents reduced significantly to 728, recognising there was still more work needed to further reduce these;
- 109 mixed sex accommodation breaches, with increases in patients unable to be stepped down from critical care within the required four hour standard, with continued work to review and reduce these occurrences. Expectation to see a reduction in the next month's IPR;
- Increased number of falls with harm related to WHH, with learning and targeted actions to address areas of concern;
- Healthcare-associated infection (HCAI) trajectories slightly over for *Clostridium difficile* (C. diff) and *Escherichia coli* (E.coli) (*Methicillin-resistant Staphylococcus aureus* (MRSA).

The CMO highlighted the following key performance against metrics:

- Mortality (June 2025): As a Trust as expected for both metrics (Hospital-level Mortality Indicator (HSMR) and Summary Hospital-level Mortality Indicator (SHMI)). However, both QEQM and WHH as expected for HSMR, but sat right on the cusp between as expected and higher than expected for SHMI. NHSE had asked about SHMI and the Trust are doing work to understand which patient groups this referred to. This month no site was above expected.

People

The CPO highlighted the following key performance against metrics:

- Improvement in sickness absence rates to 4.19%, from 4.66%;
- Staff turnover remained at 7.6%, reflecting current environment across the NHS, presented challenge for Trust's workforce reduction plan (given the dependence on staff turnover);
- Appraisal compliance fallen to 72.9% and teams challenged at the Performance Review Meetings (PRMs) to increase compliance.

The NEDs emphasised the importance that staff received annual appraisals (valuing staff and ensuring good morale), corporate groups are highlighted as poor area of compliance. It was also noted that clinicians needed to have up to date job planning to improve efficiency. The CPO commented on the demands on leaders, and therefore there was agreement to extend the appraisal timeframe supporting these to be completed, and provision of support around effectively managing staff. The BoD noted medical staff had been written to prioritise completion of any outstanding job planning.

The BoD discussed and **NOTED** the metrics reported in the IPR.

25/051.1 **MONTH 3 (M3) FINANCE REPORT**

The CFO reported on the following key issues:

- Trust's financial plan included a planned deficit of £64.2m, deficit support funding (DSF) of £57.6m, and a cost improvement programme (CIP) of £80m to meet its annual plan by year end (YE);

- Month 3 deficit for the Group at £27.3m, in line with plan. CIP delivery below plan for Month 3 by £0.05m and on plan YTD;
- Financial plan in second half of year would be more challenging to deliver, need to focus on achieving recurrent savings, annual savings plan continued to be reviewed to ensure delivery by YE;
- Employee expenses £0.1m favourable in-month and £1.3m adverse YTD, substantive staff costs under plan, and temporary staffing, particularly bank staff was driving the overspend;
- Positive reduction in run rate.

The NEDs noted good progress made achieving savings and financial performance however, highlighting only 25% efficiency savings were recurring, and the the importance to increase the percentage of recurrent savings in achieving the YE target. It was also recognised the continued significant challenge and risk meeting the YE financial plan.

The CSPO reported following submission of bids for additional capital critical infrastructure funding that the Trust had been successful, and had a capital plan totalling £71.2m, this included £28.95m against the Urgent and Emergency Care (UEC) project, and infrastructure of £13.2m. The Chair enquired about the feasibility of delivering capital plans and spending annual capital funding by YE. The NEDs asked whether staff resources costs had been incorporated within the schemes. The CSPO assured around learning from previous major capital schemes, robust plans in place to ensure expenditure utilisation of the total annual capital funding, and cost for staff resources to deliver projects had been included.

The Chair enquired about progress of workforce reduction plan and any impact on staff morale. The CFO highlighted opportunities to reduce agency and temporary workforce expenditure, with interventions planned, and monitoring and management of pay bill reductions being critical. The CPO commented on the challenges for staff, impact on morale, supporting staff affected by consultations, Executive Directors visiting areas across the organisation to answer questions from staff. He thanked all staff, recognising their professionalism during this difficult period, those affected and those not, in continuing to support the Trust and provide patient care.

The BoD **NOTED** the financial performance of Month 3.

25/052 **SIGNIFICANT RISK REGISTER (SRR) REPORT**

The CNMO highlighted the following key issues:

- 43 risks currently on SRR, five new risks, six risks with overdue actions escalated and would be followed up on to ensure progress and closure;
- Continued robust monitoring and challenge of actions to reduce risk scores through Board Committees, Trust Management Committee (TMC) and Risk Review Group (RRG).

The NEDs questioned whether the 2025/26 financial plan delivery risk adequately captured the current issues and concerns around workforce reduction risks.

ACTION: Review and revise wording (if appropriate) the 2025/26 financial plan delivery risk and that this adequately captures relevant issues and concerns in respect of workforce reduction risks for presentation to next FPC, P&CC and BoD meetings. — CFO

The DCG reported continued review and oversight of the Trust's risk management process and improvements by IAGC.

The Chair highlighted the risk of further industrial action and the negative potential impact on the Trust's finances if associated costs were not centrally supported. The CFO reported this would be monitored closely and there was no assurance around the compensation of associated costs centrally in the future. The FPC Chair assured continued close monitoring by FPC on any negative impact on finances and operational performance.

The BoD **NOTED** the SRR Report for assurance purposes and visibility of key risks facing the organisation.

25/053 **SYSTEM JOINT COMMITTEE**

The DCG highlighted the following key issues:

- Committee would support taking forward system partnership working around strengthened joint decision-making and governance with the Integrated Care Board (ICB);
- Formal delegation from this BoD to the Committee;
- Future changes may be made to the Terms of Reference (ToR) as presented, BoD to approve delegation of responsibility to the Trust Chair and CE to approve any further changes on behalf of the BoD.

The NEDs supported the direction of travel with this Committee, providing the ambition and support for system working, delivery of financial plans and alignment with the NHS 10 Year Plan. It was highlighted the scope of the Committee as currently provided for in the ToR was very broad and the better course would be to have a small number of specific areas for focus. The Chair acknowledged this, noted there was need to refine the details but the principle was important. Offering one example area to look at around shared services and negotiating as a collective for renewal of contracts (e.g. Electronic Patient Record (EPR)), and the opportunity and need to have a collective work plan in place. The Committee also included representatives from primary care and the community. The CE commented on areas for focus included where efficiency savings could be delivered.

The COO stated the benefits from the Committee in respect of opportunities driving forward system improvement with input from all system partners that included clinical involvement in decisions.

DECISION: The BoD APPROVED:

- EKHUFT's participation in the region-wide Joint Committee and instructed the DCG to negotiate ToR with other proposed members;
- Delegation in accordance with s65Z5 of the National Health Service Act 2006 the principle of the Joint Committee approach and delegated to the CE and Chair to move forward with agreeing the ToR in collaboration with system partners.

25/054 **MATERNITY AND NEONATAL ASSURANCE BOARD (MNAB) CHAIR'S REPORT**

The DDoM highlighted the following key points from the MNAB Chair's Report:

- Clinical Negligence Scheme for Trusts (CNST) Compliance:
    - Perinatal Mortality Review Tool (PMRT)

  - Medical Workforce (Obstetric, Neonatal (Medical & Nursing, and Maternity Workforce)
  - Maternity Serious Incident (SI) Report
- Risk linked to Safety Action 7 (SA7) and requirement for the Maternity and Neonatal Voices Partnership (MNVP) lead to be present at all meetings. Service remained unable to provide adequate MNVP lead time and MNVP funding had been escalated to the Integrated Care Board (ICB), a response was awaited;
- 100% compliance with external reviewers at PMRT meetings;
- No short-term obstetric locums employed over last year, with Standard Operating Procedure (SOP) in place if short-term locum needed to be employed;
- Two long-term locums employed, one middle grade and one consultant in last 12 months, with provision of a formal local induction;
- QEQM Consultant appointed that week;
- Regular audits undertaken on consultant attendance when on call, any failure to attend and datix incident completed, with no issues reported;
- 100% compliance with supernumerary status of the co-ordinator and 1:1 care in labour at both sites;
- Mitigation and escalation plans in place to manage and provide support around any staffing shortfalls;
- Funded establishment within maternity compliant with Birthrate plus (BRplus) calculations for both midwifery and specialist staff;
- 100% of qualifying cases reported to Maternity and Newborn Safety Investigations (MNSI) and to NHS Resolutions (NHSR's) Early Notification Scheme (ENS);
- Perinatal Quality Surveillance Tool (PQST) reports previously reviewed monthly by the National team, going forward to be monthly, with continued oversight and monthly review by the Local Maternity and Neonatal System (LMNS). Level 3 adult safeguarding compliance increased to 93.9%, and child protection remained compliant at 91.4%. Friends and Family Test (FFT) response rate increased from 7.5% to 11.5%;
- Ongoing work to provide an estimated time of discharge to enable patients and their families to appropriately prepare for when discharged;
- Maternity and Neonatal Improvement Programme (MNIP) 74% of the overall programme of work completed;
- Launch of new twinkling stars bereavement facility at WHH;
- Slight increase in number of stillbirths (rate remained below the expected benchmark for comparator sites);
- Moving towards phase two of restorative process for families involved in the Kirkup inquiry;
- Positive progress with estates work, and need to focus on K&C and possible need to decant triage at WHH to facilitate remodelling;
- Risk in relation to renewal of contract at St Pauls that would negatively impact on achieving CNST.

The CMO reported one further QEQM Consultant vacancy, interview to take place the following week and if successful this would eliminate this staffing risk.

The NEDs enquired about the provision of midwifery students. The DDoM stated the last cohort of students with the Trust in July 2025, next cohort to join would be in September, with further cohort in January 2026. The CNMO reported the Trust was working with the Canterbury Christ Church University (CCCU) who have now reintroduced their midwifery programme.

The BoD congratulated the team and all staff for their hard work and great achievement with the improvements across the Maternity services, culture, the CQC Good rating and lifting of the Section 31 notice.

The BoD discussed and **NOTED** the MNAB Chair's Report from the 11 June and 8 July 2025 MNAB meetings.

25/055 **CARE QUALITY COMMISSION (CQC) REPORT**

The CNMO highlighted the following key elements:

- CQC Self-Assessment Check and Challenge meetings in place to support improvement work;
- All wards completed a first assessment for cycle 1 for 2025 in respect of the ward and clinic accreditation programme, achievement of awards, and staff continuing to work hard;
- Remaining Must Do action around pharmacy staffing and one outstanding Should Do in relation to Allied Health Professional (AHP) staffing levels. Workforce review undertaken and outputs to be presented to TMC;
- Ongoing work to address and close open action plans;
- Close working and collaboration with CQC, continued reduction in queries received from CQC.

The NEDs raised concern with medical compliance with statutory and mandatory training not at the required target, noting that although there had been improvements there needed to be additional actions taken to improve compliance. The CMO commented on efforts to improve compliance, including having written to medical staff to prioritise completion of this training, however, with the proviso that staff absences would limit achievement of 100% compliance. The CPO confirmed this was an area of continued active challenge and discussions with Care Groups at the PRMs to ensure improvements in compliance. The CSPO commented the Trust looking at a training passport of compliance to be able to be used by staff when moving to another NHS organisation.

The BoD **NOTED** the CQC Report, assurance provided in relation to positive ratings from the most recent maternity inspection, query management, and the self-assessment and check and challenge meeting programme.

25/056 **INFECTION PREVENTION AND CONTROL (IPC) ANNUAL REPORT 2024-2025**

The CNMO highlighted the following key points:

- IPC discussed in detail at IPC Committee (including this Annual Report) and detailed discussions at Q&SC;
- Improvements with scores throughout the year based on previous yearly audit programmes;
- Norovirus outbreaks at WHH and QEQM, resulting in a number of beds and wards being closed;
- Reduction in healthcare associated *Clostridioides difficile (C. diff),* E. coli healthcare associated infections;
- Two *Methicillin-resistant Staphylococcus aureus* (MRSA) bacteraemia reported, 75% reduction from the previous year, MRSA had a no threshold with 'Zero Tolerance';
- Trust exceeded thresholds for all other gram-negative blood stream infections (Pseudomonas and Klebsiella);

- *Methicillin-Susceptible Staphylococcus aureus Bloodstream Infection* (MSSA BSI) at 87 compared to 72 in the previous year;
- Antimicrobial stewardship (AMS) would be a key area of focus, this remained a continued challenge with some improvements seen;
- Age and state of Trust's estate and physical infrastructure remained challenging and did not support good IPC practice;
- Trust jointly working with 2gether on the successful launch and implementation of the CLEAN campaign, another key focus area going forward (including wound care and hand hygiene) to improve cleanliness standards.

The Q&SC Chair confirmed good progress work with AMS with regular updates presented to Q&SC. The Q&SC received assurance about previous concern with theatre wrap trays and vigorous IPC monitoring of the whole provision pathway to triangulate and identify where the issue was happening during this process.

The NEDs raised the perception of patients and public, of which only 68% felt the environment was clean, and how the patient voice could be reflected in future IPC annual reports in respect of patient feedback, how concerns were raised about cleanliness and engagement to improve patient experience. It was noted the vital role provided by patients and visitors about the standards of cleanliness. The CNMO stated patients able to raise any concerns with staff or PALS team, and areas with gaps for focussed action to address and improve level of cleanliness.

ACTION: Consider how patient voice can be reflected in future IPC annual reports in respect of patient feedback, how to raise concerns about cleanliness and engagement to improve patient experience. — CNMO

The CSPO commented the new oversight framework would include metric on IPC.

The BoD **APPROVED** the IPC Annual Report 2024-2025.

25/057 **COMPLAINTS, PATIENT ADVICE AND LIAISON SERVICE (PALS) AND COMPLIMENTS ANNUAL REPORT 2024-2025**

The CNMO highlighted the following key elements:

- Increase of 15.2% (1,191) new complaints against previous year, deep dive review undertaken to identify reasons discussed at previous Q&SC meeting;
- Review looking at triangulating equality and any barriers with raising complaints;
- Focus to continue to improve performance of responsiveness and quality of responses, noting delay in response for complex cases;
- Future focus to improve accessibility of PALS team enabling an open and welcoming patient experience and supporting prompt local resolution. As well as fully capturing compliments received that were currently not captured in their entirety.

The CE commended the PALS team for their hard work supporting the improved response rate, quality of complaint responses, resulting in better patient experience interacting with the service. Noting the culture shift in staff actively talking and engaging with patients to reduce formal complaints.

The NEDs enquired about undertaking a benchmarking exercise for the 2025-2026 annual report to compare the Trust's compliance with compliant responses within the agreed timescale with other Trusts.

ACTION: Consider undertaking a benchmarking exercise for 2025-2026 annual report on compliance with compliant responses within the agreed timescale in comparison with other Trusts. — CNMO

The NEDs enquired whether space had been identified enabling patients easy access to the PALS team. The CNMO stated it was hoped areas within the main receptions at QEQM and WHH, and that an area at K&C would be more challenging.

DECISION: The BoD **APPROVED** the Complaints, PALS and Compliments Annual Report 2024-25 to be published on the Trust website, for public review.

25/058 **GUARDIAN OF SAFE WORKING (GoSW) QUARTERLY REPORT**

- **QUARTER 2: 1 APRIL 2025 TO 30 JUNE 2025**

The GoSW highlighted the following key elements:

- 12 September implementation of the changes planned for exception reporting had not yet been agreed and the contract changed, this had been delayed due to the industrial action;
- The agreed framework would make completion of exception reporting easier as well as resolution, recognising good practice to exception report and continuing to promote completion of this reporting;
- Increased number of exception reporting from foundation doctors in vascular and urology services reflecting issues of high intensity workload with complex high acuity patients;
- Positive to see completion of exception reports related to educational opportunities, enabling these to be addressed to ensure Trust fulfilled its education and training responsibility for its resident doctors.

The CMO stated the importance of having in place manageable workloads, provision of adequate supervision, and work being progressed to address the increase in vascular and urology exception reporting.

ACTION: Review, explore and present report to future P&CC on a solution addressing high level of exception reporting in vascular and urology services in respect of the staffing model for foundation doctors ensuring adequate support and sustainable manageable workloads to meet capacity and demand. — CMO/ COO

The CPO raised concern about the vacant GoSW post and progress in recruiting to this role. The CMO reported he had written to Consultants about recruitment to this role and had received a number of expressions of interest.

The NEDs enquired about the organisation's culture of exception reporting and whether this was positive. The GoSW reported the Trust supported and promoted exception reporting, completion was inconsistent and not as hoped, utilisation of the Doctors' Voice Group (DVG) meetings to promote the importance and benefits of exception reporting, support from Care Group Consultants and learning from areas where this worked well.

The BoD **NOTED** the GoSW Quarter 2 report and improving the working lives of resident doctors with good rostering practices.

25/059 **BOARD COMMITTEE – CHAIR ASSURANCE REPORTS:**

25/059.1 **QUALITY AND SAFETY COMMITTEE (Q&SC) – CHAIR ASSURANCE REPORT**

The Q&SC Chair reported on the following key issues:

- Inaugural Joint Committee of the Kent and Medway Pathology Network (KMPN) to be held the following day on 1 August 2025;
- Continued focus monitoring mental health, quarterly update report received;
- Continued to scrutinise and monitor the risk in respect of recruitment of sufficient staff resources within the Legal Services, Trust continued to engage with the Coroner, service remained under pressure;
- Concern about non-Referral to Treatment (RTT) and the high number of unresolved pathways (320,870) and risk this presented, currently 510,500 cases, of which 338,377 were overdue beyond their target to be seen date. Actions being taken forward to address this issue, as well as a deep dive review, the COO would provide regular progress updates;
- Update on professional standards noting Information team looking to analyse the data, requested specialist review in ED, and track the time between the request and the review taking place, as well as the ward reviews by consultants. Task and Finish Group being set up to address the current issues concerning how existing systems connect.

The COO reported on non-RTT and unresolved pathways, with action plans in place for patients to receive virtual clinical review and face to face review if needed.

The BoD **NOTED** the 20 May 2025 Q&SC Chair Assurance Report.

25/059.2 **FINANCE AND PERFORMANCE COMMITTEE (FPC) – CHAIR ASSURANCE REPORT**

The FPC Chair reported on the following key issues:

- June report presented as read;
- Verbal update from July 2025 FPC meeting: £80m CIP schemes of which £45m had been risk adjusted, would be significantly challenging to achieve, good performance continued as previously reported. Achieved planned deficit at M3;
- Deep dive review of theatre optimisation improvement programme, encouraging good progress with assurance of achieving 85% by YE, this would continue to be monitored;
- Schemes to be implemented utilising the capital funding provision, some of which could be allocated to be used over two year period.

The BoD **NOTED** the 24 June 2025 FPC Chair Assurance Report and the verbal update from the 22 July 2025 FPC meeting.

25/059.3 **PEOPLE AND CULTURE COMMITTEE (P&CC) – CHAIR ASSURANCE REPORT**

The P&CC Chair reported on the following key issue:

- Reviewed draft People Strategy to be presented and discussed at next BoD Strategic Session in September 2025.

The Chair stated the BoD September 2025 Strategic Session would include a discussion on Equality, Diversity and Inclusion (EDI) and welcomed the P&CC

Chair's input in designing this item. Noting the need for assurance of Trust's workforce reduction plan was not negatively impacting EDI.

ACTION: Liaise with P&CC Chair to provide input/involvement in designing the Equality, Diversity and Inclusion (EDI) session at the September 2025 BoD Strategic Session. — DCG

The BoD **NOTED** the 8 July 2025 P&CC Chair Assurance Report.

25/059.4 **CHARITABLE FUNDS COMMITTEE (CFC) – CHAIR ASSURANCE REPORT**

The CFC Chair reported verbally on the following key issue:

- Approval and recommendation to BoD for approval (due to level of funding required) outside its meeting cycle for the provision of Charity funding improving Celia Blakey environment. This was around increasing capacity to meet increased demand, to improve patient experience. This would be circulated to Board members for approval.

ACTION: Circulate to Board members for approval outside the BoD meeting recommendation from CFC provision of Charity funding to improve the Celia Blakey environment and increase capacity to meet increasing demand. — CFC Chair

The BoD **NOTED** the verbal CFC Chair Assurance Report from the 29 July 2025 CFC meeting.

25/060 **ANY OTHER BUSINESS**

KMPN Joint Committee
The CSPO would be working with the DCG for regular reports to be presented to the Board Committees and BoD on the work of the KMPN Joint Committee, noting the inaugural meeting to be held the following day (1 August 2025).

FPC outside meeting cycle approval
The CFO reported an approval outside the FPC meeting cycle had been circulated to FPC members in respect of capital expenditure for a Digital Order Comms System relating to the KMPN.

Annual Members Meeting (AMM)
The Chair reported the Trust's AMM to be held early evening on Thursday 4 September 2025 providing the opportunity to look at the year ahead as well as the previous 2024/25 year. Encouraging members of the public as well as staff to attend this in person meeting.

25/061 **QUESTIONS FROM THE PUBLIC**

The Chair reported the following question had been received from Mr R Yates:

- Under Clause 4d of 2023 Procurement Acts "Guidance on Exclusions", can exclude procuring from suppliers where there "is a risk that supplier may incur additional costs for the public sector (and therefore the taxpayer) during delivery of public contracts. The Trust had four leases with Discovery Park, one due to end 31 July 2025, and three due to expire 24 January 2026. The question was posed as to whether the Trust would consider excluding further procurement with Discovery Park, under these terms as Discovery Park owed Dover District Council in unpaid business rates. The appropriate decision and communication would need to be made.

- The CFO responded to this question reporting for important procedural reasons Trust could not comment on individual, potential procurement exercises. Provided reassurance that all future procurements covered by Procurement Act 2023 would be conducted in accordance with the processes described in that act. This included application of the mandatory and discretionary grounds for exclusion. In doing so, Trust would continue to treat each procurement in accordance with the principles of Value for Money, Transparency, Equality of Treatment and Proportionality.

The Chair reported the following questions had been received from Mr P Schofield, Governor:

- Understood the Trust would be purchasing pianos for its hospital sites.
  - The CNMO responded to this question noting the therapeutic benefits of music, staff had been working with the Voluntary team around rules of controlled use of the pianos. The WHH and K&C League of Friends (LoF) had provided funding for these to be purchased, and a decision was awaiting from QEQM LoF.
  - The NEDs emphasised the need to ensure controlled use and minimising as much as practically possible any disruption from young children.
- The role of Governors and supporting the NHS 10 Year Health Plan.
  - The Chair responded to this question, assuring the Governors that the focus would be on enhancing engagement with them and our communities. Trust valued the engagement from Governors, and the Chair was fully committed to continuing to work more closely in respect of obtaining their input and patient experience and feedback.
- How Trust was sensitively managing staff through the restructures and redundancies as part of the workforce reduction.
  - The CPO responded to this question confirming an agreed policy in place, learning from previous staff consultation, managers designing consultation, with well-being support available for staff. Any concerns from staff around the process escalated to him directly.
  - The Chair stated the Trust recognised this was a difficult period for staff, and committed to supporting staff through this process.

The Chair closed the meeting at 4.15 pm.

Date of next meeting: Thursday 9 October 2025

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Board of Directors Decisions outside the Board**

Meeting date: **9 October 2025**

Board sponsor: **Annette Doherty, Chair**

Paper Author: **Board Support Secretary**

Appendices:

None

Executive summary:

Action required:	**To Note at public Board**
Purpose of the Report:	The report provides the outcome of Board decisions taken outside the BoD meeting cycle for noting in the open public Board.
Summary of key issues:	Board members considered reports and recommendations for approval outside the meeting cycle as noted below: **Recommendation from Charitable Funds Committee (CFC) meeting on 29 July 2025 – Proposal to use charitable funds to improve Celia Blakey Environment** Improve the Celia Blakey Chemotherapy unit at William Harvey Hospital (WHH) environment and increase the capacity to meet growing demand, approving the use of £174k donation from the East Kent Hospitals Charity (EKHC). **Winter Planning and Board Assurance Statement (BAS) 2025/26** Approved the Winter Plan for 2025/26 and the BAS for submission to the National Urgent and Emergency Care (UEC) team on 30 September. The papers informing this decision are included as an item in the substantive Board agenda to ensure it has public awareness.
Key recommendations:	The BoD is asked to **NOTE** in its open Board meeting the decisions taken outside its meeting cycle: 1. **NOTE** the use of £174k donation from the EKHC to improve the environment and increase the capacity to meet growing demand at the Celia Blakey Chemotherapy unit at WHH. 2. **NOTE** the Winter Plan for 2025/26 and the BAS.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People

East Kent Hospitals University NHS Foundation Trust

	• Partnerships • Sustainability
Link to Trust Risk Register:	Risk Reference:1891 Misalignment between Demand and Capacity across the Trust's urgent and emergency care pathway.
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: CFC 29/07/25, Trust Management Committee (TMC) 17/09/25 and BoD 29/09/25

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Matters Arising from the Minutes on 31 July 2025**

Meeting date: **9 October 2025**

Board sponsor: **Annette Doherty, Chair**

Paper Author: **Board Support Secretary**

Appendices:

None

Executive summary:

Action required:	**Approval**
Purpose of the Report:	The Board is required to be updated on progress of open actions and to approve the closing of implemented actions.
Summary of key issues:	An open action log is maintained of all actions arising or pending from each of the previous meetings of the BoDs. This is to ensure actions are followed through and implemented within the agreed timescales. The Board is asked to note the updates on the action log.
Key recommendations:	The Board of Directors is asked to **NOTE** the action log, **NOTE** the updates on actions, and **APPROVE** the seven actions recommended for closure.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Trust Risk Register:	None
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: None

MATTERS ARISING FROM THE MINUTES ON 31 JULY 2025

1. Purpose of the report

1.1. The Board is required to be updated on progress of open actions and to approve the closing of implemented actions.

2. Background

2.1. An open action log is maintained of all actions arising or pending from each of the previous meetings of the BoDs. This is to ensure actions are followed through and implemented within the agreed timescales.

2.2. The Board is asked to note the updates on the action log as noted below:

Action No.	Action summary	Target date	Action owner	Status	Latest Progress Note (to include the date of the meeting the action was closed)
B/01/25	Provide report at a future Quality & Safety Committee (Q&SC) or Finance and Performance Committee (FPC) meeting on data information differentiating patient attendance against factors around health inequalities and deprivation in the East Kent (EK) communities and any detrimental impact for these patients around poorer outcomes.	~~Jun-25~~/ ~~Jul-25~~/ Oct-25	Chief Operating Officer (COO)/ Chief Strategy and Partnerships Officer (CSPO)	To Close	**May 2025 -** COO has asked the Chief Analytical Officer to review progress. **July 2025 -** Results to be discussed at Board Committees. **October 2025 -** Work in progress, agreed at July 2025 Board meeting action to remain open and review following discussions at Board Committees. **Action for agreement for closure at 09.10.25 Board meeting.**
B/13/25	Review and revise wording (if appropriate) the 2025/26 financial plan delivery risk and that this adequately captures relevant issues and concerns in respect of workforce reduction risks for presentation to next FPC, People & Culture Committee	Oct-25	Chief Finance Officer (CFO)	To Close	A new separate risk that captures the issues and concerns in respect of workforce reductions has been drafted and approved at the Risk Review Group on 16.09.25. Risk 3866 included in the Significant Risk Register Report presented to the 09.10.25 BoD meeting. **Action for agreement for closure at 09.10.25 Board meeting.**

	(P&CC) and BoD meetings.				
B/14/25	Consider how patient voice can be reflected in future Infection, Prevention and Control (IPC) annual reports in respect of patient feedback, how to raise concerns about cleanliness and engagement to improve patient experience.	Jul-26	Chief Nursing and Midwifery Officer (CNMO)	To Close	Feedback taken on board by the IPC team. IPC team now recruiting patient representatives to the IPC Committee, we are awaiting suggested names and people from the Patient Engagement team, and will then have the patient voice front and centre for IPC, which will be reflected in the reports. **Action for agreement for closure at 09.10.25 Board meeting.**
B/15/25	Consider undertaking a benchmarking exercise for 2025-2026 annual report on compliance with compliant responses within the agreed timescale in comparison with other Trusts.	Jul-26	CNMO	To Close	Feedback to be taken on board by the Complaints team for incorporation in the 2025-2026 annual report. **Action for agreement for closure at 09.10.25 Board meeting.**
B/16/25	Review, explore and present report to future P&CC on a solution addressing high level of exception reporting in vascular services in respect of the staffing model for foundation doctors ensuring adequate support and sustainable manageable workloads to meet capacity and demand.	Nov-25	Chief Medical Officer (CMO)/Chief Operating Officer (COO)	To Close	Included on P&CC annual work planner. **Action for agreement for closure at 09.10.25 Board meeting.**
B/17/25	Liaise with P&CC Chair to provide input/involvement in designing the Equality, Diversity and Inclusion (EDI) session at the September 2025 BoD Strategic Session.	Sep-25	Director of Corporate Governance (DCG)	To Close	Action completed, input ahead of the 04.09.25 BoD Strategic Session. **Action for agreement for closure at 09.10.25 Board meeting.**

B/18/25	Circulate to Board members for approval outside the BoD meeting recommendation from Charitable Funds Committee (CFC) provision of Charity funding to improve the Celia Blakey environment and increase capacity to meet increasing demand.	Oct-25	CFC Chair	To Close	**August 2025 -** Circulated and approved outside BoD meeting cycle. **Action for agreement for closure at 09.10.25 Board meeting.**

East Kent Hospitals University NHS Foundation Trust

EKHUFT Board Chair's Report, October 2025

I chaired my first Annual Members' Meeting earlier this month. It was a highlight to meet and share details of the Trust's performance with our Members and the East Kent public more generally. It was also great to see so many of our Governors attending in person. We were able to present the Trust's performance last year and our focus for this year. There were lots of good questions and discussion around the Trust's finances; the Staff Survey; pressures on our Emergency Departments (EDs); and how we continue to strive to improve the experience of our patients.

The Board's strengthened engagement plan for closer working with our Governors is now in place. Governors will observe all of our Board sub-committees and Non-Executive Directors (NEDs) and Governors will meet more frequently. I know this will have increased benefit for the Trust.

As a Board we are spending time designing the Trust's strategy in line with the NHS 10-year Plan and the needs of our community. This includes a focus on our clinical strategy and how we work with our regional partners to achieve the three shifts described in the NHS Strategy. With considerable work already done and informed by colleagues from all services in the Trust, we hope to be in a position to bring our strategy to you in the near future.

The Trust's financial situation also occupies a great deal of focus for the Board. Our £80million savings target is critical to deliver and in a way which ensures safe, high-quality care. The scale of this task is certainly not easy. The EDs – particularly in William Harvey – continues to see the unacceptable situation of corridor care. This is of huge concern to the Board as we anticipate another winter and the pressures that will create. I want to be clear that we are not accepting corridor care and are working extremely hard with our system partners and the Integrated Care Board (ICB) to continue to take steps to address this situation for patients and families.

The Board has been involved in the preparation of the Winter Plan and discussed what will be a challenging winter. We are clear that we require close and collaborative partnership across our Integrated Care System (ICS) to achieve this. We have included the Winter Plan and the accompanying Board Assurance Statement (BAS) as part of the papers for this meeting.

In the period since the last Board, I have continued my weekly visits to services and sites across East Kent in addition to my regular contact with colleagues. I have spent time with a wide range of clinical services including our Pathology Service; Mechanical Thrombectomy; Stroke Services; Clinical Trials Unit; and the Intensive Therapy Unit

(ITU) and theatres at Kent & Canterbury. I am very pleased to have a full schedule of weekly visits across East Kent in place until the end of the year.

There have also been numerous informal and unarranged conversations while walking around on our sites which have also been hugely welcome. I'm pleased more people are approaching me to share their thoughts with me.

These conversations all recognise the progress the Trust has made; as well as being clear about what more needs to be done. The announcement of the Trust's move from segment 4 to 3 in the newly published NHS Oversight Framework in early September bears this out. It is fantastic that the huge collective effort within the Trust has resulted in this improvement but we still have a long way to go.

I also joined the South East Region Senior Leaders Briefing for Chairs in August and September as well as the NHS Confederation all members chairs' group. These cross-Trust opportunities provide an excellent opportunity to share learning and insight.

I also want to thank Rosie Duffield MP for meeting with Tracey and I in August. These meetings with our local MPs are vital in sharing the priorities of the Trust and hearing feedback from the constituents of our MPs.

It was the Trust's Staff Awards last week and it was a great celebration of our staff. With awards such as Excellence in Team-working; Excellence in quality and safety; Excellence in research and innovation; Volunteer of the year award; Compassionate leader award; Outstanding support worker award; Contribution to making East Kent Hospitals a place staff choose; Rising star award; and Special recognition award. Congratulations to all those who were nominated and recognised. I was really humbled to hear all your achievements and how much you have contributed.

I want to finish my report by celebrating Kent and Medway Medical School's Inaugural Graduation Ceremony at Canterbury Cathedral on Wednesday 17 September 2025. My thanks to the Vice-Chancellors of Canterbury Christ Church University and University of Kent for inviting me for what was an exciting and inspiring event. To see so many graduates successfully complete their medical education locally was fantastic. It represents a huge benefit to our Trust and region that medical students trained in our hospitals will return as qualified doctors. Many congratulations to them all and I wish them every success in their futures here in Kent.

Chair
Dr Annette Doherty

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Chief Executive's Report**

Meeting date: **9 October 2025**

Board sponsor: **Tracey Fletcher, Chief Executive**

Paper Author: **Tracey Fletcher, Chief Executive**

Appendices:

Appendix 1 - Three years on from the publication of Reading the signals

Executive summary:

Action required:	Discussion
Purpose of the Report:	The Chief Executive's Report provides a bi-monthly update on key activities and events in the Trust. The report highlights the national context, the Trust's developments, achievements and provides strategic updates.
Key recommendations:	The Board of Directors is requested to **DISCUSS** and **NOTE** the Chief Executive's report.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Trust Risk Register:	The report links to the corporate and strategic risk registers.
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: N/A

East Kent Hospitals University NHS Foundation Trust

CHIEF EXECUTIVE'S REPORT

1. PURPOSE OF THE REPORT

The Chief Executive's Report provides a bi-monthly update on key activities and events in the Trust. The report highlights the national context, the Trust's developments, achievements and provides strategic updates.

2. TRUST MANAGEMENT COMMITTEE

At meetings of the Trust Management Committee (TMC) in August and September the TMC received an update from Gillian Hart (Chair) and Stephanie Park (Vice Chair) on the activity of the Staff Congress and reviewed a draft of the People and Culture Strategy aimed to address key cultural and workforce challenges over the next two to three years.

The Committee also approved an approach to the flu and vaccination campaign for 2025/26 aimed at addressing the Trust's historically low uptake of flu vaccinations amongst staff and approved an extra contractual payments policy for planned care ensuring there is a consistent and transparent approach to commissioning and remunerating extra contractual activities.

3. INTERNAL UPDATE

3.1 Performance update

Our Emergency Department (ED) performance deteriorated last month due to the high pressure experienced in August, with 74.19% of patients across all ED types being admitted, transferred, or discharged within the four-hour standard. This positioned the Trust 58th of the 121 Trusts nationally for combined type performance.

As a Trust, we processed 25,087 attendances across our EDs and Urgent Treatment Centres (UTCs) last month, but saw a growth in the number of 12-hour trolley waits from 1,195 to 1,311 patients.

Early indications for September show performance returning to over 75% for the four-hour standard. Improvement weeks held in September showed a reduction in the number of 12-hour trolley waits to 1,173, although this remains far too high.

We recognise the poor experience that this represents for our patients, particularly when patients are cared for in escalation areas. We sincerely regret that patients have had to be cared for in corridors. This is unacceptable for any patients and we are working hard to stop this. These areas have been risk assessed and patients are clinically assessed before waiting in these areas.

3.2 Finance update

As at month 5 (August) the Group's Financial position remains on plan, -£43.7m pre-deficit support funding (DSF) and -£13.9m post DSF. There is a wider System deficit of -£7.4m YTD, as a result of which there is a significant risk that DSF will be withdraw from the Kent and Medway System in Quarter three (£11.5m impact for EKHUFT), with conversations ongoing between Region and Integrated Care Board (ICB) to understand what system partners are doing to recover the position and to deliver their plan.

Our plan for 2025/26 includes an £80m cost improvement target which represents approximately 7% of the Group's expenditure. We have seen our spend on pay continue to reduce from month 2, which is an indicator that the additional controls embedded across the Trust are starting to take effect, however further significant reductions to our expenditure are required to ensure delivery of the agreed plan.

Detailed finance information is available in the finance report.

3.3 People initiatives

Staff engagement is the foundation of safe, effective care. Each year, the NHS Staff Survey provides a comprehensive insight into how people experience their work, and the value of that insight depends on how representative and accurate it is. Maximising participation across all levels of the organisation in the Staff Survey is therefore critical – not only to ensure that the right priorities are acted upon, but also to capture emerging challenges before they become systemic.

The 2024 national staff survey demonstrated what is possible when engagement is treated as both a cultural and operational priority: a 22% year-on-year improvement in response rates, securing a place among the top ten responding Trusts nationally, and harnessing the voices of almost 6,500 staff. The 2025 programme builds on that foundation, with ten weeks of pre-survey mobilisation and narrative setting, followed by eleven weeks of fieldwork – the longest of any Trust – launched first nationally on Monday 15 September 2025 to maximise the participation window.

Early results are encouraging, with more than 2,000 responses (over 20% of the workforce) in the first two weeks, positioning the Trust as the highest-responding Acute provider at this stage.

4. EXTERNAL UPDATE

4.1 NHS Kent and Medway Integrated Care Board (ICB) update

It has been confirmed that Paul Bentley will be stepping down from his role as Chief Executive of NHS Kent and Medway ICB this autumn.

Since the ICB's establishment in July 2022, Paul has played an important role in shaping the region's integrated care strategy and driving improvements in urgent and primary care services.

I would like to take this opportunity to thank Paul for his support and the collaborative approach taken between the Trust and the ICB during his tenure and I wish him well for the future.

Adam Doyle has been appointed as the new Chief Executive Officer for NHS Kent and Medway ICB and will be joining on 15 October 2025.

4.2 NHS England update

Anne Eden, South East Regional Director, has announced her decision to step down next year after more than a decade in the role. Anne has been instrumental in shaping the regional team, championing collaboration, digital innovation, and tackling health inequalities—particularly during the Covid-19 pandemic.

I would like to extend my thanks to Anne for her support to the Trust over many years, and wish her success in her future endeavours.

4.3 Recovery Support Programme and National Oversight Framework (NoF)

The Trust has been the subject of a range of special measures across a number of years including, most recently in 2024/25, as part of the national recovery support programme. This meant the organisation, and our performance, was under the highest level of scrutiny and we were assigned an Improvement Director by NHS England. I am pleased to report that, following a detailed review of the evidence of our improvement, we were informed by NHS England that the Trust has formally exited the Recovery Support Programme. This reflects the hard work of everyone across the organisation that has delivered improvements across a wide range of services.

At the same time as the assessment of the Trust's progress against the 2024/25 integrated improvement plan was being undertaken, NHS England launched the new NHS oversight framework. The new framework provides a transparent and standardised approach to oversight within the NHS. As part of the new framework all NHS organisations are scored against a defined list of key performance indicators to give an organisational delivery score. Organisations are then ranked and placed into a segment between one and five with one being the best performing and five being the most challenged. East Kent Hospitals delivery score means the organisation is ranked at 101 of 134 acute trusts and is placed in segment three. This is again a positive reflection of the progress that has been made but recognises that there is still much more to do on our improvement journey.

4.4 Confirmation of Tier status – Urgent and Emergency Care (UEC)

Following a review of UEC performance and in agreement with the regional team, the Trust has been confirmed as being in Tier 1 for UEC services for Quarter 2 of 2025/26.

This reflects the Trust's position amongst the most challenged acute providers nationally, based on performance across key metrics including 4-hour and 12-hour waits, and ambulance handovers.

Being in tier 1 involves the Trust participating in regular oversight meetings with both regional and national NHS England colleagues, focused on delivery progress, with improvement support provided by ECIST for a period of up to six months.

Performance will be reviewed on a quarterly basis, with the potential for in-quarter changes to tiering status in exceptional circumstances.

4.5 Maternity and Neonatal Investigations

4.5.1 Reading the Signals

On 19 October 2022, Dr Bill Kirkup published Reading the signals, his independent investigation into maternity and neonatal care provided by our Trust from 2009 to 2020. The importance of the report and its findings remains just as profound and significant today, as we continue to take action to address our devastating failings.

In October 2023 we published a report of our progress. We have updated this report annually to reflect the latest information and data about our maternity service. The latest report is attached as an appendix to my report and will be published on our website.

4.5.2 National Investigation into Maternity and Neonatal Services

In September 2025, the Trust was chosen to take part in the National Investigation into Maternity and Neonatal services across England led by Baroness Valerie Amos. Fourteen trusts have been chosen to take part. One of the criteria for the national review was to learn from reviews which have already taken place. We are one of the three Trusts included in this investigation where previous investigations have taken place and learnings from these will be incorporated in this review.

The investigation will deliver one clear set of national recommendations to achieve consistently high-quality, safe maternity and neonatal care.

We welcome the opportunity to take part in this important review and to share the learnings from our journey to improve maternity services in east Kent and we are committed to continuing this journey to provide the highest standard of care for our communities.

East Kent Hospitals University NHS Foundation Trust

5. OTHER AREAS TO NOTE

5.1 Same Day Emergency Care (SDEC)

The Trust have been awarded in the region of £29m to improve and redesign the SDEC facilities at both the Queen Elizabeth the Queen Mother Hospital (QEQM) and William Harvey Hospital (WHH). This is an ambitious build programme but will help us to deliver improved clinical pathways which in turn will bring improvements to our performance. Both hospital sites will have new, co-located facilities that will enable medical and surgical SDEC teams to work closely together. The overall designs have been agreed for both sites and the builds are expected to complete in June 2026.

Work has started on both sites to decant staff and services out of the areas that are going to be redesigned, to enable the building team to begin these works. At the QEQM, the overall design has been completed and the building works will start week commencing 8 October 2025. At the WHH the decant plans are being finalised, with clinical and non-clinical teams working hard to support changes of location to support the project. In order to support the decant requirements, mobile clinics will be brought onto the WHH site temporarily to ensure that we do not lose capacity through this period, however this is likely to have an impact on parking for which plans are being finalised to mitigate.

We recognise that the impact of this investment is being felt across the Trust and would like to ask staff and patients for their patience and support while these important and significant changes are being made.

5.2 Launch of the Trust's Flu and Vaccination campaign

The Trust's annual flu vaccination campaign launched on Wednesday 1 October 2025, with the Trust-wide ambition of a "flu-free Christmas" and a target of 60% staff uptake before the festive season.

Seasonal flu remains a significant winter pressure, with last year's vaccination programme estimated to have prevented an between 96,000 and 120,000 hospitalisations nationally, in spite of less than 37% of staff having received their vaccination.

This year we have expanded access and made it easier than ever for staff to get their vaccinations with more than 90 Flu VIP peer vaccinators and a new online booking system with appointments available at the William Harvey, QEQM and Kent and Canterbury Hospitals.

5.3 Digital by default patient communication

From the end of September, the Trust will transition to sending most patient letters digitally by default. Patients will receive notifications via text, email, or the NHS App, directing them to view their letters online through the Patient Portal or NHS App using NHS login credentials.

This initiative aims to accelerate delivery times by reducing the reliance on postal services, improve accessibility for patients who find paper communications challenging, while offering a significant cost saving opportunity with more than 22,00 letters sent each week.

Safeguards remain in place to ensure inclusivity; if a digital letter remains unopened within three working days (or one working day for urgent letters), a paper copy will be automatically be issued. Exceptions include letters with specimen kits, communications for children under 13, and patients who opt for paper-only correspondence.

5.4 National recognition for Preceptorship programme

The Trust is among the first in the country to be awarded the National Multi-profession Preceptorship Quality Mark for the support provided to newly qualified staff, which benchmarks NHS organisations against national best practice for nurses, midwives, and allied health professionals.

5.5 Annual Members Meeting

The Trust's 2024/25 Annual Members' Meeting, which brings together Board members, our lead governor, chair and members of the Board, was held at the Kent and Canterbury Hospital on 4 September 2025, with patients, staff and members of the public invited to find out more about our work, the Trust's performance and our future plans.

I would like to thank all those who took the time to attend this meeting either face to face or online and those who submitted questions in advance of the meeting.

The Board of Directors are requested to **DISCUSS** and **NOTE** the Chief Executive's report.

East Kent Hospitals University NHS Foundation Trust

In October 2023, one year on from the publication of Reading the signals, we published a report of our progress. We have updated this report to reflect information and data about our maternity service, three years on from the publication of Dr Kirkup's report.

Three years on from the publication of Reading the signals

On October 19 2022, Dr Bill Kirkup published his independent investigation into maternity and neonatal care provided by our Trust from 2009 to 2020.

The report was deeply shocking, it found that women, babies and their families had suffered significant harm and the experience they endured was unacceptably and distressingly poor. This went on for more than a decade.

The report highlighted care that repeatedly lacked kindness and compassion, both while families were in our care and afterwards, when families were coping with injuries and deaths. We did not listen to women, their families and indeed at times, our own staff.

The investigation found at least eight opportunities where the Trust Board and other senior managers could and should have acted to tackle these problems effectively. This was simply not good enough.

The consequences were devastating. Of the 202 cases that agreed to be assessed by the panel, the outcome for babies, mothers and families could have been different in 97 cases, and the outcome could have been different in 45 of the 65 baby deaths, if the right standard of care had been given.

The Trust Board has apologised unreservedly for the pain and devastating loss endured by the families and for the failures of the Board to effectively act. Losing a baby has an immeasurable impact on women and their families and whilst the Trust Board has apologised, the impact of these outcomes can never be altered and for this we are truly sorry. These families came to us expecting that we would care for them safely and compassionately, but we failed to do that. We accept all that the report says.

We also apologise to those within our communities. We are aware of the anxiety that these failings have caused among those who rely on our services. We remain determined to use the lessons in Reading the signals to put things right, to make improvements and make sure that we always listen to patients, their families and staff when they raise concerns.

At any point following the publication of Reading the signals, the importance of the report and its findings remains just as profound and significant.

We are on a journey to fundamentally transform the way we work. Changing the culture of a large and complex organisation takes time and there is much work still to do, but we are determined to succeed so that we are providing the right standard of care and compassion to everyone who touches our services, every day.

This report describes the work we are doing, the improvements we have made and where we still have work to do. We are grateful to everyone who has been involved in helping us to improve our maternity services, has given feedback and has provided both challenge and encouragement. We look forward to continuing this work with you.

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In September 2025 our Trust was chosen to take part in the national investigation of maternity and newborn baby care across England led by Baroness Valerie Amos.

Fourteen trusts have been chosen to take part. One of the criteria for the national review was to learn from reviews already taken place.

We are one of the three Trusts where previous investigations have taken place and learnings from these will be incorporated in this new investigation.

The investigation will deliver one clear set of national recommendations to achieve consistently high-quality, safe maternity and neonatal care.

We welcome the opportunity to take part in this important review and to share our learning from our journey to improve maternity services in east Kent and we are committed to continuing this journey to provide the highest standard of care for our communities.

The Board of East Kent Hospitals Trust

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Background

In February 2020 the government health minister, Nadine Dorries MP, announced that Dr Bill Kirkup would lead an independent investigation of maternity services in East Kent.

The *Reading the signals* report identified four key areas for action:

- Monitoring Safe Performance
- Standards of Clinical Behaviour
- Flawed Team Working
- Organisational behaviour

There was also a specific recommendation for the Trust to accept the reality of the report's findings, acknowledge in full the unnecessary harm that has been caused and embark on a restorative process addressing the problems identified, in partnership with families, publicly and with external input.

On receiving *Reading the signals* on 19 October 2022 we apologised unreservedly, publicly accepted all of the findings and gave a firm commitment to use the lessons within it to make the improvements needed to consistently deliver the safe and compassionate care local communities should expect, not just in maternity and neonatal services but across the entire Trust.

On 21 October 2022, the Trust Board held an extra-ordinary Board meeting attended both virtually and in person by families, members of the public and the media, formally accepted the report in full and committed to addressing the areas for action in the report and the recommendation for the Trust. The Trust also discussed the report and its findings in public meetings of its Council of Governors, local Health Overview and Scrutiny Committee and all subsequent public Board meetings.

In February 2023, we set out an interim response to the report which was published alongside an open letter of apology to the public and shared with every member of staff, which included immediate, short and long-term actions, include improving how we listen to and involve patients and families and specific, focused work in maternity to improve safety, as well as wider work being taken forward across the Trust.

Dr Kirkup's key areas for action are reflected in our organisational objectives, specifically:

- Patient, family and community voices
- Reducing harm and delivering safe services
- Care and compassion
- Teamwork, trust, respect and inclusion
- Reducing health inequalities

Our maternity service continues to work with families and staff to embed the changes that are needed to make continued and sustained improvement in care and outcomes for women, babies and their families and safer and more compassionate services.

Our Maternity and Neonatal Improvement Programme (MNIP) was developed throughout Spring and Summer 2023 and involved bringing together people who use the service, the maternity leadership team, all grades of midwifery, obstetric and neonatal staff, Kent & Medway Local Maternity and Neonatal System (LMNS), Maternity and Neonatal Voices Partnership (MNVP) and members of NHS England's regional maternity team to ensure it was truly co-produced. The programme was also benchmarked against, and aligned to, requirements of the Three-Year Single Delivery Plan for Maternity and Neonatal Services.

We are grateful to the families and colleagues who supported us as part of the Reading the Signals Oversight Group and for their challenge and involvement; to those currently working

with us as representatives on our new Maternity and Neonatal Assurance Board and those involved in developing the independent restorative process - to ensure there is appropriate engagement with patients, their families and the community to oversee, challenge and advise on how the Trust embarks and embeds the changes needed to address the problems identified in the report.

Patient, family and community voices

Dr Kirkup's investigation found that we did not listen to women, families and at times our own staff, and this contributed significantly to the poor experience of families and in some cases to clinical outcomes.

We continue to work hard to change this in both our maternity and neonatal services and as a Trust.

To help us achieve this we have an embedded patient experience team specifically to work with women, birthing partners and families and staff to improve patient and staff experience. The team is led by a professional midwifery advocate, one patient experience midwife and two non-clinical patient experience administrators.

The maternity Patient Experience team has continued to respond to feedback received through 'Your Voice is Heard', a service developed in collaboration with families, our local Maternity and Neonatal Voices Partnership and a Trust governor, which is unique to East Kent.

The Director and Deputy Director of Midwifery *Walk the patch*, regularly walking around the maternity units to listen to people who use our services, and families to directly hear about their experiences of maternity care. By doing this they are also assessing that the environment is safe and clean, are observing what staff are doing well and what needs improving. They bring their feedback to the heads of midwifery and the matrons so it can be acted upon quickly and/or included in staff training. This is also now undertaken by the Maternity and Neonatal Voices Partnership, separately and during both day and night shifts.

In order to improve quality and any required training, all calls to maternity triage are now recorded, monitored and audited. In this way, not only the quality of information and care can be monitored, but also how service users are engaged with.

Leave your troubles at our door, is as an additional patient experience service providing women and birthing people in hospital with direct access to a senior member of the midwifery team, as someone to speak to if they wish to talk about their care. This is promoted through posters displayed on the wards.

We have increasingly innovative ways of involving people who use our services, in partnership with the Maternity and Neonatal Voices Partnership, including holding Facebook "Live" sessions, a consultant midwife specifically leads work to reduce health inequalities and focus on under-served communities, for example with Lithuanian families. We are pursuing funding for a community bus to go out to our communities and recruiting two maternity support workers in Thanet to support under-served communities.

We also involve families in investigations from the outset, ensuring their voice is heard throughout the investigation process; co-produced our maternity and neonatal improvement programme and new pathways of care with them; and continue to work with families directly involved in Dr Kirkup's investigation.

We want our service to be welcoming, safe, clean, professional, friendly, calm and well organised. The Maternity and Neonatal Voices Partnership lead an annual '15-Steps challenge' with service users on both units and have seen significant improvements. This sees the service through the eyes of people who use it and what they see and experience within 15 steps of entering a department. Improvements include making the units more

welcoming, murals on walls, soft lighting in labour rooms and a co-produced post-natal booklet with information about leaving hospital.

The age and quality of our buildings, and the need for capital funding to improve our estate is an ongoing challenge. We worked with the Kent and Medway Integrated Care Board, local MPs and NHS England regionally to identify sources of funding to improve our maternity units and have been granted funding to finalise the business case for a £25m investment for the development of the maternity unit at Queen Elizabeth The Queen Mother Hospital, which will increase the size of labour rooms and provide a second obstetric theatre for caesarean sections. It will also extend the maternity triage area in the next phase of refurbishment at William Harvey Hospital.

There has also been investment in the relocation and refurbishment of the bereavement suite at William Harvey Hospital. The refurbished Twinkling Stars suite is a dedicated area for families located away from the busy Labour ward, with the work funded by donations to East Kent Hospitals Charity.

Your Voice is Heard

Introduced in May 2022, this initiative is more than just a survey. People who use our maternity service are contacted by phone six weeks after discharge to discuss all aspects of their and their baby's care. Feedback from these follow-up calls is used to recognise what works well and identify where we need to make changes to improve people's experience.

By the end of August 2025, we had heard from 13,243 women who have given birth in our hospitals, and from birth partners, too, an average 71.4% response rate. We want everyone to have a positive experience of all aspects of their care and to be 'happy to return'. There remains work to do to reach this point, in August 2025 89.7% of women were 'happy to return'. Our quality improvement work is aligned to the themes from this valuable feedback in order to achieve this.

Some of the changes we have made are small but practical and important to people using our services, such as introducing soft-close bins to reduce noise on the postnatal wards, offering snack boxes, hot drinks and sleeper chairs for birthing partners, a post-natal booklet and providing a family bathroom on each site.

Feedback has also been used to create a pain management working group, to understand and consider how we respond to the pain relief needs and options of our women and birthing people, including providing these in a more timely way.

We have improved access to antenatal education with online antenatal sessions and the development of face to face sessions delivered in the community by our own team of midwives.

To improve people's experiences of postnatal care we have introduced intentional care rounding which is audited and reported weekly to the Director and Deputy Director of Midwifery. To enable families to leave hospital more quickly, we have more midwives to do new born physical examinations and midwifery-led discharge where appropriate.

We have improved support for infant feeding during evenings, nights and weekends and the information available when leaving hospital. While there is still work to do in this area, our results for women being discharged without delay has increased from 60%-70%.

It is important that we also know where things are going well so we can build on them. By the end of August 2025 more than 6,000 compliments from families had been shared directly with staff. We have also extended Your Voice is Heard to include families whose babies have been in neonatal care.

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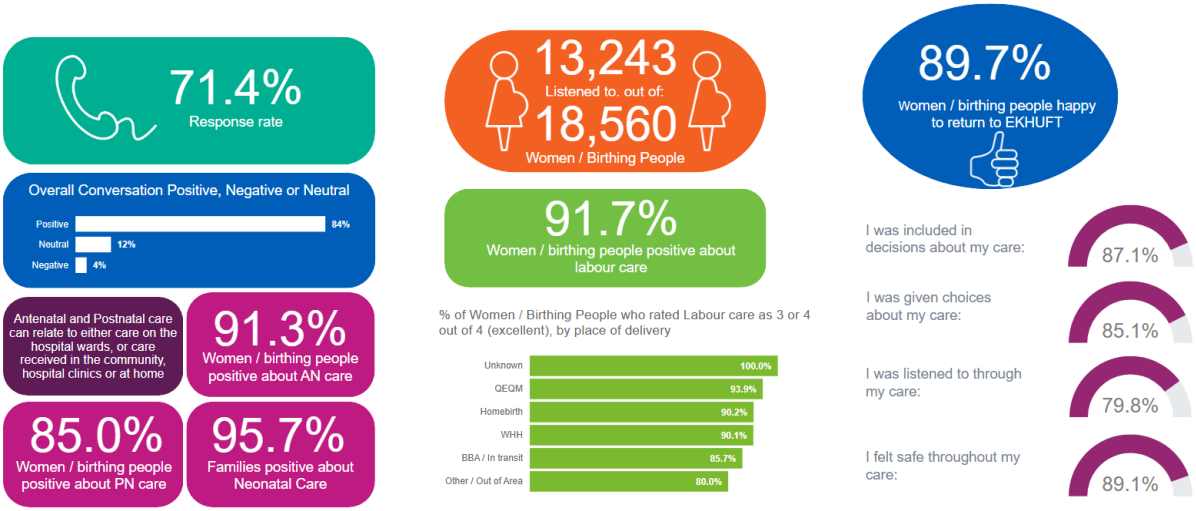
Your Voice is Heard is in addition to the Friends and Family Test surveys and is one of 12 ways we gather and use feedback in maternity. We review the feedback by ethnicity and deprivation to ensure we are hearing from people from a wide range of backgrounds. We also use a theming tool so that all feedback is brought together from all sources, including national surveys although the timeline for receiving these results is much longer.

The latest annual CQC Maternity Services Survey, conducted in 2024, had a response rate of 36%. It showed the areas where improvements were needed were: delays in being able to go home on the day of leaving hospital; enough information provided about feeding; feeling that healthcare professionals did everything they could to help manage pain; feeling that concerns during antenatal care were taken seriously and midwives and/or doctors working well together.

These are areas of focus with improvements having been made, or are being made, since the survey was undertaken in 2024. The 2025 survey results are expected in November 2025.

The areas that scored highest were partners or someone else close to you being able to stay as much as you wanted; being given contact details and advice about potential changes to mental health after birth; not being sent home when you were worried about yourself or your baby and healthcare professionals doing everything they could to manage your pain in the ward after birth.

Your Voice is Heard data since we launched in May 2022



We started Your Voice is Heard in May 2022 and usually speak to between 300 and 400 people each month. In the July and August 2025 we spoke to around 200 people each month, due to temporary staffing problems within the your voice is heard team which we are addressing.

Figure 1: Your Voice is Heard response rate

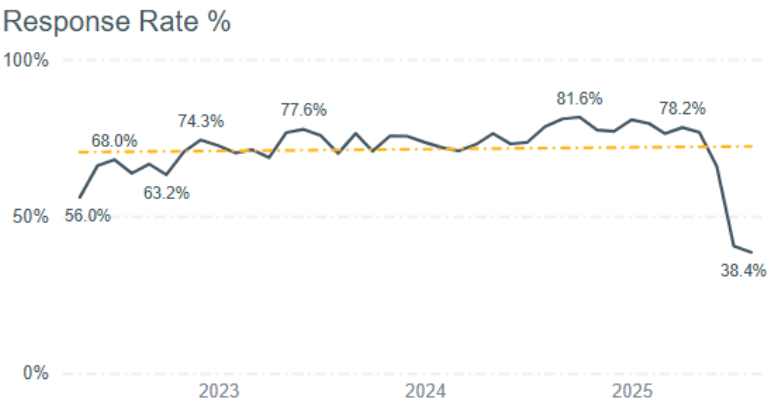
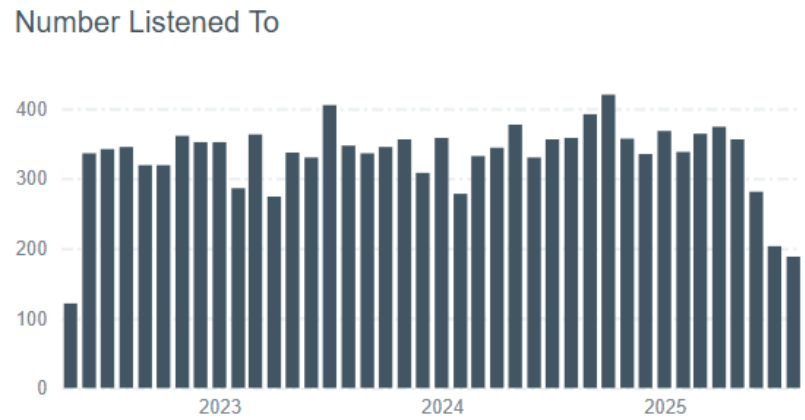
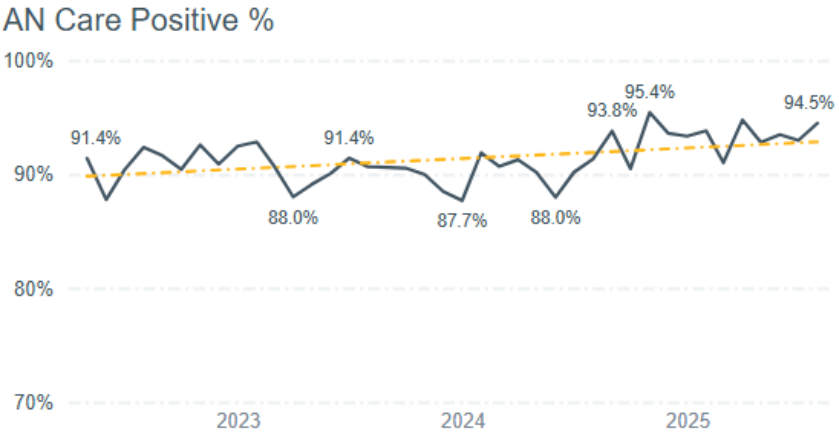


Figure 2: Number of people listened to



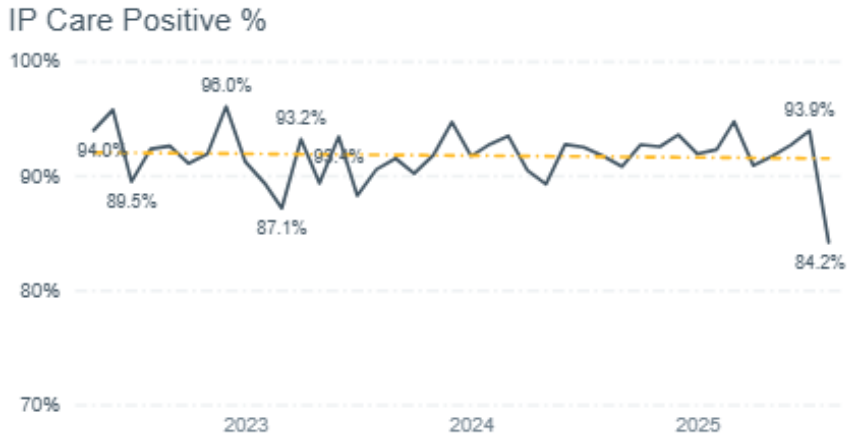
The score for antenatal care has shown a consistent upward trend, reaching a positive response score of 94.5% in August 2025.

Figure 3: Respondents positive about antenatal care



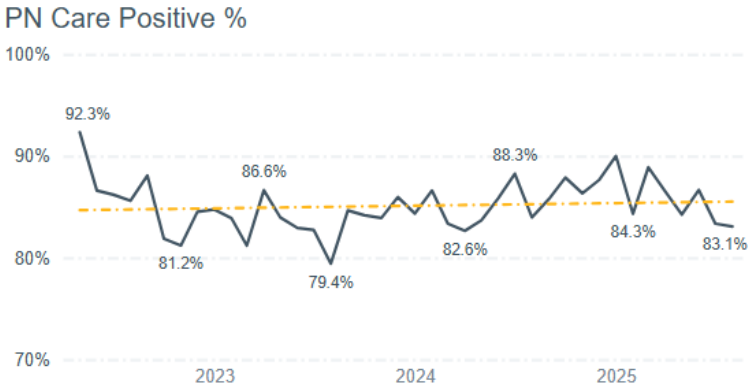
Care on our labour wards has remained steady at around 92%, although there was a decline to 84.2% in August 2025, which we are reviewing to understand the factors that caused this drop.

Figure 4: Respondents positive about care on our labour wards



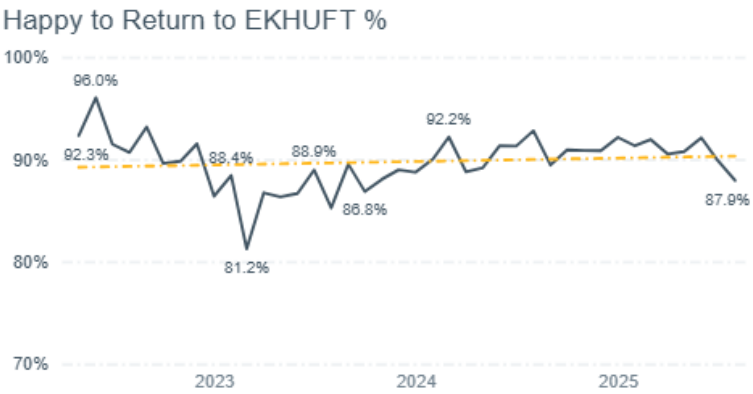
Positive responses for postnatal care have remained around 85%, with some variation.

Figure 5: Respondents positive about postnatal care



The number of women 'happy to return' from May 2022 to August 2025.

Figure 6: Respondents happy to return



Changes across our Trust: Patient Voice and Involvement

The Reading the Signals report has not only affected how we work in maternity, but also within the wider Trust. We established our patient voice and involvement team in August 2022, to help us involve patients, their families and our communities in improving patient and family experience of our services.

The team work across all the Trust's sites with operational and clinical staff to make improvements based on patient feedback from a wide range of sources. This includes using feedback from the Friends and Family Test (FFT) survey, Care Opinion, the NHS website reviews, the national Care Quality Commission (CQC) Patient Surveys and engagement with local communities, including people who are underserved.

Friends and Family Test feedback is themed and reported to services and the Trust's Patient Experience Committee every two months. The quarterly report on Complaints and PALS also goes to the Patient Experience Committee. The themes from FFT, other surveys and Complaints and PALS are generally related to communication, care given by staff, staff attitude, quality of treatment and waiting times on site. Whilst feedback is overwhelmingly positive, there are areas for improvement such as discharge processes, involving carers and families of patients and information for the patient on what will happen after discharge.

The most recent CQC Maternity survey, based on people receiving maternity care in February 2025 shows much improved scores in many areas, and our improved scores puts the Trust in the top three of maternity services who used the same survey provider (3rd

place out of 50 trusts). Maternity Services received a 'Good' overall rating from the CQC earlier in 2025.

Community engagement work has focused on underserved communities, and this has included people with hearing and sight loss and people with learning disabilities. We have co-designed a communication passport for people with sensory loss, and we work with people with learning disabilities to co-design easy read clinical patient leaflets. The Trust's work on the Accessible Information Standard (AIS) has resulted in several awards and recognition by colleagues at NHS England.

As the result of feedback from Trust staff and community groups we've improved our interpreting and translation provision. Our main provider has improved fulfilment of bookings, we can now access video relay interpreting on demand for spoken languages using dedicated tablet devices, and in August 2025 we contracted with an additional provider who is supporting the demand for face to face interpreting in Nepali, Dari, Slovak and Kurdish Sorani.

People can get involved with the team on a voluntary basis by becoming a Participation Partner. Participation Partners get involved in a range of activities – everything from being a member on a Trust group or committee, to being on an interview panel, to co-designing patient surveys to being involved in Ward Accreditation audits or supporting staff training. We now have Participation Partners on the Fundamentals of Care Committee, End of Life Care Committee, the Ethics Committee and Patient Experience Committee. We also have VCSE sector partners on several working groups and committees.

The Patient Participation and Action Group (PPAG) holds us to account for implementing the Patient Voice and Involvement Strategy. Membership of the group is 50% Participation Partners, 30% voluntary community and social enterprise sector (VCSE) representatives and 20% EKHUFT staff.

The team has worked with our services to get them involved in theming the comments from the FFT survey for their service. This has a positive impact on staff morale as most comments are positive but also means they read the comments first hand to help understand what needs to improve.

We send out a 'Five for Friday' each week to three services / care groups. This highlights five positive comments, the themes of patient comments, and their theming compliance. This has encouraged services to look at their FFT feedback more carefully and find areas for improvement.

Where patient comments have highlighted the need for additional training for staff, this has been passed on to the appropriate team to work with the ward or department.

In July 2024 the Trust received our Veteran Aware accreditation. The Patient Voice and Involvement team led this work, including setting up the working group to deliver the changes needed to gain accreditation. There will be on-going work needed to retain accreditation and meet our obligations under the Armed Forces Covenant. The team will continue to support this work.

Reducing harm and delivering safe services

Dr Kirkup's investigation identified unacceptable, poor clinical care in our maternity service. We are committed to providing the safe care that all of our communities need and deserve.

Despite the commitment and hard work of our staff, when the Care Quality Commission (CQC) inspected our maternity service in January 2023, they very disappointingly found that the Trust was not providing the standards of maternity care women and families should expect and the service was rated inadequate.

The service was re-inspected in December 2024 and the maternity services at William Harvey Hospital, Ashford and Queen Elizabeth The Queen Mother Hospital, Margate were upgraded to 'good'. The CQC found that the Trust had made 'significant improvements' since its last inspection in 2023. It rated both units as 'good' for being caring, effective, responsive and well-led.

The inspection team 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.

It also found that the outdated hospital buildings meant some clinical areas and labour rooms in both units are too small and lack ensuite facilities, compromising the care staff are able to give, and that there is currently only one obstetric theatre at Queen Elizabeth The Queen Mother Hospital. It therefore rated the units as 'requires improvement' for 'safe'.

This is being addressed through a £25m development to increase the size of labour rooms and provide a second obstetric theatre at the Queen Elizabeth The Queen Mother Hospital. There will also be an extension of the maternity triage area in the next phase of refurbishment at William Harvey Hospital.

The CQC report was an important milestone in our continuing work to improve our services, embed the lessons in *Reading the Signals* and work to provide the highest standard of care for our communities.

Changes that contributed to this improvement included increased doctor cover in the triage service at William Harvey Hospital, additional training and electronic alerts for staff when a fetal monitoring check is due, regular checking and auditing of emergency equipment, cleaning, hand hygiene and PPE compliance.

Out of the 40 actions recommended by the CQC in 2023, 39 had been fully completed by summer 2025, the remaining action being a second obstetric theatre at QEQM. The CQC lifted its section 31 order and the Trust was removed from NHS England's Maternity Safety Support Programme.

Work to improve the safety of our triage service, following implementation of the Birmingham Symptom Specific Obstetric Triage System, was recognised in a Royal College of Midwifery Award for Outstanding Contribution to Midwifery Services: Digital.

The system is designed to ensure women and birthing people are assessed promptly on arrival at either of our maternity units and triaged appropriately according to their clinical need. The aim is for everyone to be assessed within 15 minutes and given a clinical priority using a recognised colour coding system so that people with the most urgent need(s) are treated first. The timeliness and assessment of the triage service is monitored, to ensure patients are being cared for appropriately. Any breaches of this target are reported and harm reviews completed.

To improve the quality and safety of care we have increased the numbers of midwives and doctors, including specialist roles. We appointed 18 internationally educated midwives and all 56 of our student midwives who qualified in January 2025 have now joined us in permanent positions. We have 7 midwives joining us through the south east coast graduate guarantee scheme

We are also developing our existing workforce, for example by using the NHS Health Education England Maternity Support Worker Competency Framework to upskill the maternity support workforce and provide a clear pathway for career progression.

Medical staff have developed and trained 200 midwives in enhanced maternity care, allowing patients who need enhanced care to remain on the labour ward with their babies in dedicated enhanced maternity care rooms at both William Harvey Hospital and Queen Elizabeth the Queen Mother Hospital.

Well attended multi-disciplinary rapid review meetings are held three times a week to review any incidents reported through datix or other routes of escalation to identify any actions needed.

Doctors have also reviewed and updated all clinical guidelines to improve safety.

In December 2023 we reopened the Singleton Midwife-led Unit at William Harvey Hospital as a place of birth, offering more choice to women in relation to their preferred place of birth. By August 2025, 438 babies have been born in the unit.

To ensure we have the right staff in the right places, we use a workforce acuity tool supported by a live tracker to make sure staff are where they are most needed. In September 2022, staffing met acuity needs 55.7% of the time. This figure was 67.6% in September 2024 and 72.7% in August 2025.

In August 2025 the student midwife course was reinstated at Canterbury Christ Church University. It has been suspended in February 2023 when the Nursing and Midwifery Council (NMC) withdrew its approval for the midwifery programme and students were removed from all Kent and Medway placements. We worked closely with the university on the development of a training needs analysis and training programme.

To improve training for midwives, we increased the practice development team, systems for student support and supervision, and ways students can raise concerns. Students on clinical placement with us are not counted in our staffing numbers, but they are an important part of our team and for our future workforce. We have also trained four of our qualified nurses in a shorter midwifery programme.

Regular staff training and reflection on clinical practice is a crucial part of delivering safe services. We have a monthly staff Safety Summit to share key safety learning. At this forum cases are discussed, themes and learning identified and solutions discussed and shared.

We also have a number of ways to regularly share learning across maternity:

- ‘Hot Topics’ that require immediate dissemination
- ‘Safety Threads’ used in safety huddles and handovers
- ‘Lunch and Learn’ sessions to share learning in a relaxed space
- Monthly ‘Safety Summit’ with Board maternity safety champions, Chief Nursing and Midwifery Officer and Non-Executive Director
- ‘We Hear You’ and consultant forums, which give staff direct access to the senior leadership team.
- A teams group to share education and governance news.

In June and July 2025 the service held a reset week where all senior managers worked in clinical areas to observe clinical practices to reduce the gap between work imagined and work done. This is a widely recognised part of human factors training to improve safety.

We have changed the way we monitor patient safety and our clinical performance, articulated in the *Reading the Signals* report as ‘finding signals among noise’. We now use statistical process charts which plot data over time to help us understand variation and to help us take the most appropriate action. The format of our data is based on best practice, has been externally reviewed and welcomed by NHS England. Using this system led us to ask for an external review into a rise in neonatal deaths to identify any learning. The review found that the care provided was good and the charts now show this trajectory going back down but it is an important example of how statistical process charts help identify variance.

We are one of the first Trusts to adopt Martha’s rule in our acute hospitals in Ashford and Margate, which gives patients, families, carers and staff round-the-clock access to a rapid

review from a separate care team if they are worried about a person's condition. We now also have Martha's rule at Kent and Canterbury Hospital.

We relaunched 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.

Saving babies' lives

Saving Babies Lives is a government ambition to achieve a national 50% reduction in stillbirth and neonatal mortality by 2025, from 2010 figures. To achieve this the stillbirth rate in the UK would need to decrease to 2.6 stillbirths per 1000 total births and neonatal mortality to 1.2 neonatal deaths per 1,000 total births.

Stillbirths and neonatal deaths are measured by MBRRACE-UK. Every year MBRRACE-UK produces a "Perinatal Mortality Surveillance" report which provides rates for all stillbirths over 24 weeks and all neonatal deaths, when the baby was born alive after 24 weeks gestation, but died before 28 days of age.

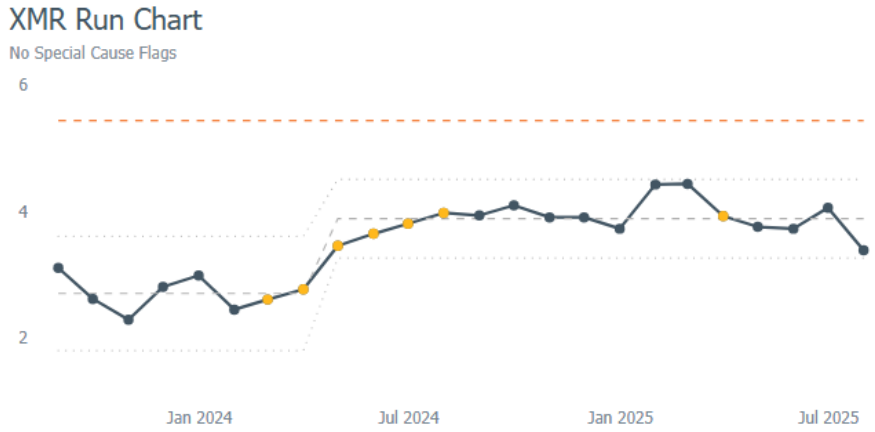
Rates vary between hospitals, particularly if those hospitals care for larger numbers of babies or very sick babies. MBRRACE-UK uses the number of babies born in an organisation, as well as whether they have a neonatal intensive care unit or facilities for surgery for new born babies, in order to group together similar Trusts.

The chart below shows the 12-month rolling rate of MBRRACE reportable stillbirths and neonatal deaths per 1,000 births in East Kent, including births and deaths from September 2023 to August 2025.

Figure 7: Extended perinatal mortality

MBRRACE Ext Perinatal Rate 12m

Timescale	Value	SPC
Sep-24	3.94	
Oct-24	4.10	
Nov-24	3.91	
Dec-24	3.91	
Jan-25	3.73	
Feb-25	4.43	
Mar-25	4.44	
Apr-25	3.93	
May-25	3.76	
Jun-25	3.73	
Jul-25	4.06	
Aug-25	3.39	

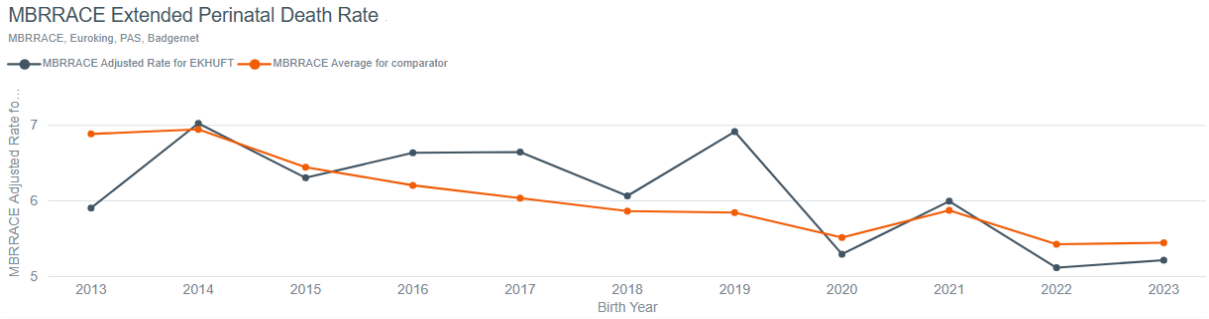


In August 2025, East Kent had 2.71 stillbirths per 1,000 and 0.68 neonatal deaths per 1,000.

Our perinatal mortality cases are reviewed by expert panels, with independent expert review, using the national Perinatal Mortality Review Tool.

The latest nationally-published MBRRACE data (for the year 2023) shows that the rate of stillbirths and neonatal deaths in East Kent in 2023 was 3.39 per 1,000 births. The average for similar trusts was 5.44.

Figure 8: MBRRACE adjusted rate for East Kent and MBRRACE average for comparator group by birth year



The neonatal death rate in East Kent for 2023 was 1.80 per 1,000 births, compared with an average for similar trusts of 1.84.

The stillbirth rate for 2023 was 3.42 per 1,000 births, compared with an average for similar trusts of 3.60.

The tables below show the number of stillbirths and neonatal deaths at our Trust since 2013, alongside the MBRRACE-UK latest available rates.

Stillbirths

Birth year	Stillbirths	Births	EKHUFT Crude Stillbirth Rate	MBRRACE Crude Rate for EKHUFT	MBRRACE Adjusted Rate for EKHUFT	MBRRACE Average for Comparator Group
2013	24	7,039	3.41	3.58	4.28	4.75
2014	31	7,000	4.43	4.85	5.01	4.98
2015	22	7,062	3.12	3.66	4.31	4.41
2016	27	6,953	3.88	3.70	4.12	4.11
2017	21	6,973	3.01	2.72	3.82	3.95
2018	27	6,571	4.11	3.80	4.00	3.95
2019	27	6,413	4.21	4.20	4.07	4.01
2020	20	6,127	3.26	3.60	3.84	3.81
2021	25	6,213	4.02	4.18	4.11	3.92
2022	25	6,246	4.00	3.84	3.65	3.61
2023	8	5,691	1.41	1.41	3.42	3.60

Neonatal deaths

Birth year	Neonatal deaths <28 days	Livebirths	EKHUFT Crude Neonatal Death Rate	MBRRACE Crude Rate for EKHUFT	MBRRACE Adjusted Rate for EKHUFT	MBRRACE Average for Comparator Group
2013	10	7,015	1.43	1.29	1.95	2.09
2014	14	6,969	2.01	1.86	1.93	1.97
2015	14	7,040	1.99	1.62	2.01	2.04
2016	20	6,926	2.89	2.57	2.53	2.10
2017	21	6,952	3.02	3.01	2.84	2.09
2018	11	6,544	1.68	1.68	2.08	1.92
2019	19	6,386	2.98	2.97	2.99	1.84
2020	7	6,107	1.15	0.99	1.56	1.71
2021	9	6,188	1.45	1.45	1.88	1.96
2022	4	6,221	0.64	0.64	1.43	1.82
2023	8	5,683	1.41	1.23	1.80	1.84

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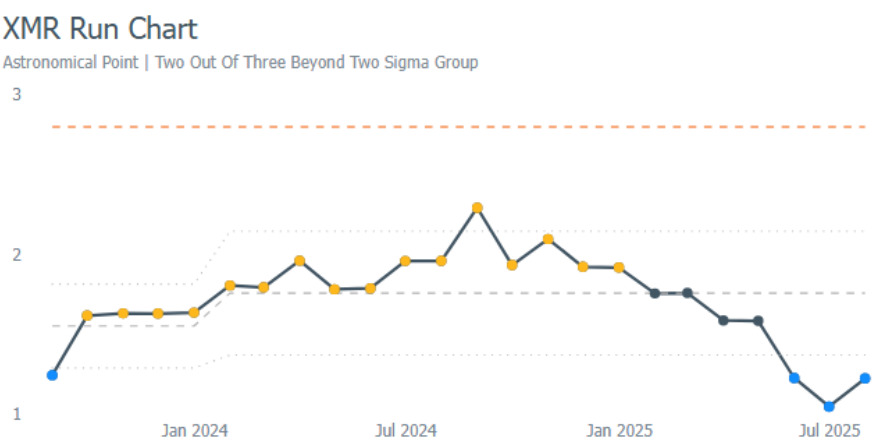
Hypoxic Ischemic Encephalopathy (HIE)

Hypoxic Ischemic Encephalopathy (HIE) - moderate or severe brain damage. The expected range is 2.4- 2.8 per 1,000 live births. The last 12 months rate for East Kent has been 1.2 cases per 1,000 live births.

Figure 9: Hypoxic Ischemic Encephalopathy

HIE Rate Rolling 12m

Timescale	Value	SPC
Sep-24	2.3	
Oct-24	1.9	
Nov-24	2.1	
Dec-24	1.9	
Jan-25	1.9	
Feb-25	1.8	
Mar-25	1.8	
Apr-25	1.6	
May-25	1.6	
Jun-25	1.2	
Jul-25	1.0	
Aug-25	1.2	



Care and compassion

The importance of providing compassionate care, not just clinical care, was a theme running through the entire *Reading the signals* report. We had failed families by not being compassionate when they needed us most.

We co-produced a new bereavement care model in our maternity and neonatal service with families who wanted to ensure other families did not experience a lack of care and compassion. Specialist bereavement midwives worked with families and the Saving Babies Lives charity (SANDS) to improve and expand the emotional and practical support available to families who have tragically experienced baby death or severe injury or illness.

This seven-day service model includes continuity of carer for women and their families during a bereavement but also through any subsequent pregnancies, labour and delivery. This work has been recognised in the National Mariposa Bereavement Awards with a number of colleagues receiving awards.

The remodelling of our bereavement service included the relocation and refurbishment of the Twinkling Stars bereavement suite (a dedicated area for families) at William Harvey Hospital to a location outside of the Labour ward so that women, babies and their families can be cared for in a more considerate and suitable setting, funded by donations to East Kent Hospitals Charity.

There is evidence that a positive working culture improves the safety and quality of care for service users. We have included caring with compassion and respect in routine staff training for maternity and neonatal staff. For example, we adopted ‘Civility Saves Lives’, a national project aimed at promoting kindness and respect within teams, based on evidence about the impact this has on patient safety. Colleagues in different roles and from different departments come together to learn about how the way we behave impacts one another, and the way we make decisions.

As part of the work to improve the culture in maternity services, service leaders completed the NHS Perinatal Culture and Leadership Programme and Band 7 managers completed a “connected” course designed to improve culture and leadership. Band 7 colleagues and above took part in cultural allyship training to promote diversity and inclusion and there is a greater focus on staff health and wellbeing and clinical supervision with the relaunch of the Professional Midwifery Advocates model.

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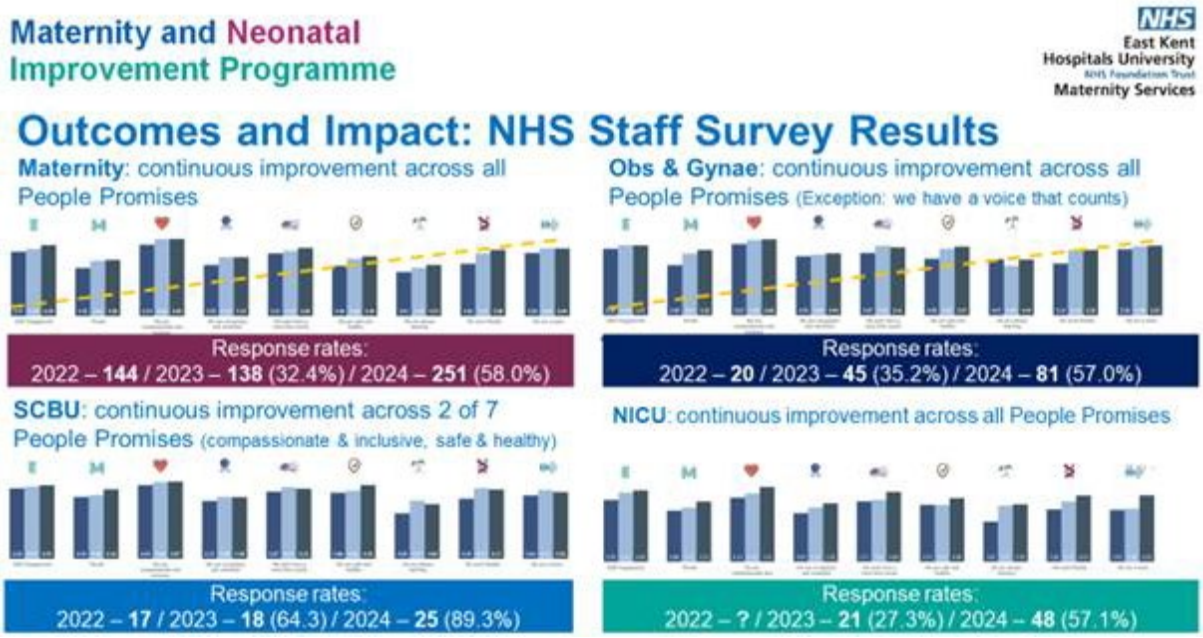
The Royal College of Obstetrics and Gynaecology's Team of the Shift initiative has been introduced at all handovers on the labour and post-natal wards so that everyone on the shift knows each other, their roles and who to escalate to.

The staff survey results for our maternity and neonatal services have been a long way from where we want them to be and demonstrated the amount of work needed for staff to feel involved, engaged and positive about recommending their service and the Trust as a place to work.

While there is still a lot of work to do to in comparison with national averages, the latest staff survey results in maternity have shown sustained improvements across all of the "people promise" areas, as well as much higher uptake of the survey among all staff. We are continuing to work hard to improve the experience of all staff across all areas.



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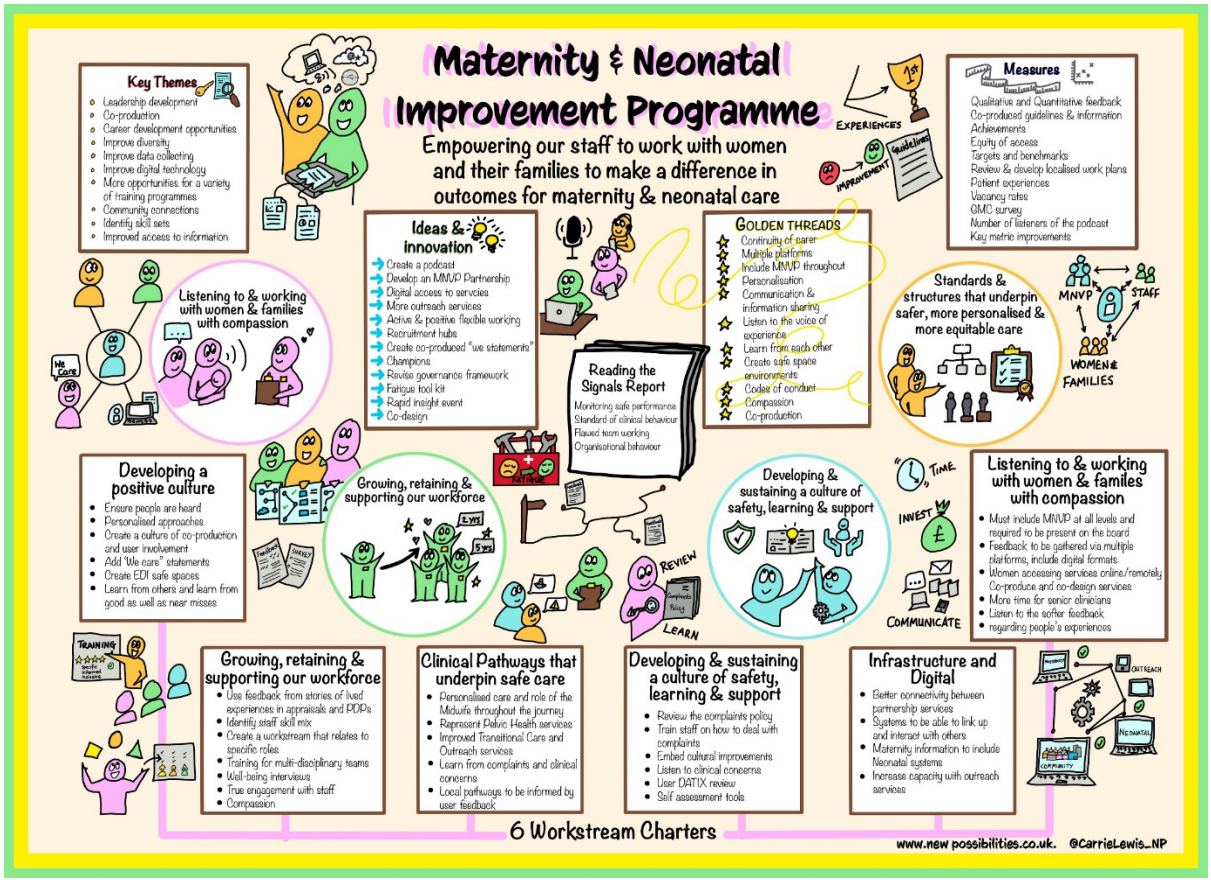
Engagement, listening and leadership

We want to have effective, embedded ways of listening to and involving staff, patients and our partners in decisions about services.

The service has been led by an experienced substantive Director, a Deputy Director and a Medical Director since 2023 and this has strengthened maternity leadership and supported improvements to the service across the Trust.

The maternity and neonatal leadership team worked with families, staff and partners to co-produce a Maternity and Neonatal Improvement Programme for East Kent, bringing together people who use the service, the maternity leadership team, obstetrics, maternity and neonatal staff, the Kent and Medway Local Maternity and Neonatal Service, Maternity and Neonatal Voices Partnership and members of NHS England's regional maternity team to co-produce the vision for the programme.

Figure 9: A visual synthesis of outputs from the co-design event.



The programme has six priority areas, each with executive oversight, approved by Trust Board in September 2023:

1. Developing a positive culture
2. Developing and sustainable culture of safety, learning and support
3. Clinical pathways that underpin safe care
4. Listening to and working with women and families with compassion
5. Growing, retaining and supporting our workforce
6. Infrastructure and digital.

This programme incorporates work developed following the publication of the *Reading the Signals* report and the Care Quality Commission (CQC) inspection in January 2023. It also reflects the national Three-Year Single Delivery Plan for Maternity and Neonatal Services published in May 2023 – a plan that sets out how the NHS will make maternity and neonatal care safer, more personalised and more equitable.

Progress against these priorities is reported through the Maternity and Neonatal Assurance Board and each of the Trust Board's meetings held in public. In the first 2 years 74% of the actions in the programme were delivered with emerging issues and outstanding actions prioritised based on feedback from families and staff, and learning from incidents. The remaining 26% of actions will be delivered in the third year.

Examples of improvements made through the Maternity and Neonatal Improvement Programme include an antenatal one stop shop where bloods, tests and scans are carried out as part of the same appointment; improved access to perinatal mental health services and developing a scorecard to identify and address health inequalities in global majority women and those from deprived communities through personalised care plans.

We recognise the importance of staff feeling listened to, and having easy access to a senior leader if they have any concerns. The leadership team introduced *We Hear You* which gives staff direct access to the Director and Deputy Director of Midwifery, and twice-monthly consultant meetings for colleagues to meet and discuss any concerns they have with the associate medical director for women's health as well as the clinical leads from each hospital site.

These forums are in addition to regular multi-disciplinary patient safety meetings, listening events and safety champion walkabouts involving the Chief Nursing and Midwifery Officer and Non-Executive Director lead for maternity.

Improving culture across our Trust

As part of the commitment to nurture compassionate leaders and effective teams that work well together, the Trust has adopted NHS England's Culture and Leadership Programme developed by the Kings Fund. This programme has been introduced elsewhere in the NHS and there are proven links between compassion in healthcare and outcomes for patients. It is aimed at all levels in the Trust and more than 100 change ambassadors were recruited across the Trust to support this work.

We are acting on the results of a diagnostic carried out by change ambassadors which identified the need to ensure colleagues had a voice, are valued, have a shared vision and we have compassionate, inclusive and collective leadership.

Changes include ensuring staff have a greater voice through the introduction of a new staff congress, relaunching our staff wide recognition scheme, developing our organisational strategy, training all staff in essential leadership skills and making sure that compassionate leadership is at the front and centre of all our leadership training programmes.

At the end of 2022, we launched 'Connectors' across the Trust – a growing network of staff who are trained on a voluntary basis to support their peers and colleagues with any concerns they have at work. Connectors are trained to listen and help staff identify their next steps, which can include raising concerns.

We reviewed how we deliver Freedom to Speak Up (FTSU) to ensure that it is sustainable and meeting the needs of our staff and as a result introduced an independent, externally provided Guardian service in 2025.

We have also introduced a sexual safety campaign making clear what is not acceptable and encouraging all staff to support tackling and reporting incidents.

Developing our organisation

We want to have effective governance processes which create link throughout the organisation, from frontline staff to the Board, where partnership working is embedded and effective, and leadership is open to challenge.

The Maternity and Neonatal Assurance Board, chaired by the Chief Nursing and Midwifery Officer and attended by the non-executive director maternity champion (a senior clinician), reports monthly to the Quality and Safety Committee and directly to the Trust Board quarterly and is attended by multiple stakeholders, including the Maternity and Neonatal Voices Partnership. It provides specific oversight of maternity and neonatal services, including training compliance, the monthly maternity dashboard, maternity and neonatal improvement programme, progress against Clinical Negligence Scheme for Trusts (CNST), Ockenden and CQC actions.

We have implemented the nationally-required role of the Maternity and Neonatal Safety Champion. Our multi-disciplinary Maternity and Neonatal Safety Champions are promoted across the units, as a point of reference and contact for the workforce, our families and stakeholders.

We reviewed governance in maternity and developed a maternity risk management strategy in 2022. To support improved governance systems of control across maternity, we appointed several specialist roles, including a head of governance, patient safety matron, a quality governance and education matron and a compliance midwife.

We are working with our partners across the health and social care system in Kent and Medway, to share our learning across the region and to learn from others.

A governance framework used at all levels of the organisation sets out the Trust's approach to ensuring that roles, responsibilities, reporting and escalation lines are clear and that there are robust systems of governance and accountability in place at all levels to safeguard patients and carers from harm, ensure the care provided by the Trust is in line with regulatory and statutory requirements and provide an effective line of sight from place of care to Board.

Overall, we have taken the first significant steps on our journey and we are continuing to review these and make improvements. This is a continual process but we give our commitment, that we will not stop until we are offering the safe and compassionate care that all of our service users deserve.

Introducing a restorative process

We are being supported to deliver recommendation 5 in Dr Kirkup's report, that "the trust accept the reality of these findings; acknowledge in full the unnecessary harm that has been caused; and embark on a restorative process addressing the problems identified, in partnership with families, publicly and with external input".

The process has been developed by the independent restorative practice team, in consultation with families, staff and current Trust leaders and is offered to anyone who participated in the East Kent investigation. This restorative opportunity offers forums for families to communicate their needs now and options they have for how those needs could be met.

For the Trust this means responding in a way that will improve wellbeing and repair trust, a sincere process of responsibility taking for harms caused and an obligation to now try to put things right to the extent possible in the circumstances.

Examples might include meetings with the right people in the room, to help address unanswered questions you have about your experiences, or make sure people have heard

what you want them to know and understand; forums for collectively agreeing solutions to problems; or a review with a psychologist to understand their emotional and psychological support needs now.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Integrated Performance Report (IPR)**

Meeting date: **9 October 2025**

Board sponsor: **Ben Stevens, Chief Strategy & Partnerships Officer (CSPO)/ Angela van der Lem, Chief Finance Officer (CFO)**

Paper Author: **CSPO**

Appendices:

APPENDIX 1: August 2025 IPR

Executive summary:

Action required:	Discussion
Purpose of the Report:	The report provides the monthly update on Operational Performance, Quality & Safety, Workforce, Financial & Maternity organisational metrics. The metrics are directly linked to the Strategic and Annual objectives. The reported metrics are derived from: 1. Statutory reporting 2. Executive agreed key metrics
Summary of key issues:	The IPR has been subject to a review and refresh and a revised format is being presented from May 2024 onwards. The reported metrics have been grouped to give a detailed view of progress against the quarterly milestones for the Integrated Improvement Plan (IIP) alongside a summary view of metrics falling within each strategic theme. The attached IPR is now ordered into the following strategic themes: • **Patients,** incorporating operational performance metrics. • **Quality and Safety (Q&S),** incorporating Q&S metrics. • **People,** incorporating people, leadership & culture metrics. • **Sustainability**, incorporating finance and efficiency metrics. • **Maternity,** incorporating maternity specific metrics for quality and safety, Friends and Family Test (FFT) and engagement. Key performance points (August Reported Month): **Patients** • 62D compliance (78.5%) remains above the national year-end target of 75% and marginally below the Trust's stretch ambition to reach 80% by year end. Faster Diagnosis

Standard (FDS) will be impacted by the summer break with operational oversight on recovery in place throughout September focussing on clinical reviews and administrative processes to inform patients of their outcome of their cancer diagnosis.

- At the end of August there were 94 patients waiting more than 65 weeks including 10 patients waiting more than 104 weeks and 24 patients waiting more than 78 weeks.
- Overall four-hour compliance has shown a slight decline in August with performance across all types at 74.2% and Type 1 performance reduced to 48.8%.
- The number of patients waiting in our Emergency Departments (EDs) for over 12 hours in August increased with 23% of all Type 1 attendances spending more than 12 hours in the department.
- DM01 performance at the end of August is 73.5%.

Quality & Safety

- There were no never events reported in August.
- The Trust at the end of August had:
  - Six nationally reportable Patient Safety Incident Investigations (PSIIs) ongoing;
  - 11 Local PSIIs;
  - Six externally led investigations requiring Trust support.
- The number of overdue incidents increased to 994 in August.
- There were 51 occurrences of mixed sex accommodation breaches in August.
- Healthcare-Associated Infection (HCAI) trajectories for August 2025 are slightly high for E.coli, C-Dif and *Methicillin-resistant Staphylococcus aureus* (MRSA) (MRSA two cases to date – one in April and one in May).

People

- Sickness absence rates remain stable month-on-month at **4.73%**, sitting below the 5% target.
- Appraisal compliance has fallen back in-month to **74.4%**, reversing last month's modest recovery and remaining well below the 80% target.
- Statutory training compliance continues its upward trajectory, improving to **93.6%.**

Finance

- The month 5 Year to Date (YTD) position achieved by the Group (Pre deficit support funding (DSF)) was a £43.7m deficit. As at month 5 the Group remains on plan.
- As at month 5, the Trust has a small surplus of £0.4m.
- The Trust's YTD month 5 position shows Income from patient care is currently £3.1m higher than planned YTD.

Maternity

	• The extended perinatal rate remains consistently below the threshold of 5.44 per 1,000 births, with the 12 month perinatal rate performance at 3.39 in August. This rate includes both stillbirths and neonatal deaths. • In August, the neonatal death 12 month rate remained static below the MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) across the UK target of 1.84 for the fourth time in the 12 month rolling reporting period, at 0.68. The service reported zero neonatal deaths >24 weeks in month. • Two new qualifying Maternity and Newborn Safety Investigation (MNSI) incidents occurred in September but at the time of writing, we are waiting to hear from the families regarding their consent to proceed with an investigation. • Five moderate /severe patient safety incident were reported in August.
Summary recommendations:	The Board of Directors is asked to **CONSIDER** and **DISCUSS** the metrics reported in the Integrated Performance Report

Implications:

Links to Strategic Objectives:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Trust Risk Register:	**CRR 77:** Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services. **CRR 78:** There is a risk that patients do not receive timely access to emergency care within the Emergency Department (ED).
Resource:	N
Legal and regulatory:	N
Subsidiary:	Y - Working through with the subsidiaries their involvement and impact on We Care.

Assurance route:

Previously considered by: N/A

NHS
East Kent Hospitals University
NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Month 5 (M5) Finance Report**

Meeting date: **9 October 2025**

Board sponsor: **Angela van der Lem, Chief Finance Officer (CFO)**

Paper Author: **Julie Wells, Deputy Director of Finance (DDOF)**

Appendices:

Appendix 1: M5 Finance report

Executive summary:

Action required:	Information
Purpose of the Report:	The report is to update the Board of Directors on the financial performance for August 2025 (Month five).

Summary of key issues:
The Month 5 YTD position achieved by the Group (Pre-Deficit Support Funding (DSF)) was a deficit of (£43.7m), in line in plan, as illustrated below.

£000	YTD Plan	YTD Actual	YTD Variance
Patient care income	£393,555	397393	£3,838
Other income	£31,567	26424	-£5,143
Employee Expenses	-£304,379	-306503	-£2,124
Other operating expenses	-£161,342	-158344	£2,998
Non-operating expenses	-£3,404	-2906	£498
Operating Surplus / (Deficit)	**-£44,003**	**-£43,936**	**£67**
Technical Adjustments	£295	235	-£60
TECHNICALLY ADJUSTED SURPLUS / (DEFICIT) EXCL DEFICIT SUPPORT	**-£43,708**	**-£43,701**	**£7**

The Trust's YTD month 5 position is £387k favourable to plan, as illustrated below.

£000	YTD Plan	YTD Actual	YTD Variance
Patient care income	£386,085	389176	£3,091
Other income	£27,506	28037	£531
Employee Expenses	-£281,600	-283141	-£1,541
Other operating expenses	-£174,268	-176027	-£1,759
Non-operating expenses	-£3,276	-3151	£125
Operating Surplus / (Deficit)	**-£45,553**	**-£45,106**	**£448**
Technical Adjustments	£295	235	-£60
TECHNICALLY ADJUSTED SURPLUS / (DEFICIT) EXCL DEFICIT SUPPORT	**-£45,258**	**-£44,871**	**£387**

The Trust's YTD position shows Income from patient care is £3.1m higher than planned YTD. This includes overperformance on NHS England (NHSE) Chemotherapy (£0.5m) which is paid on a variable basis, overperformance from the Compensation Recovery Unit (£0.3m) as well as additional income for Specialised Commissioning income for Elective Recovery Fund (ERF) performance (£1.5m) and over performance on rechargeable high cost drugs and devices (£1.1m).

Trust other operating income is £0.5m favourable to plan YTD, driven mainly by income from education and training and non-patient care services.

Trust employee expenses are £1.5m adverse to plan YTD. Substantive staff costs are below plan, while temporary staffing, particularly bank staff, is the main driver of the overspend.

Other operating expenses are £1.8m adverse to plan YTD driven by overspends in general supplies and services, and premises. These are partially offset by underspends on clinical supplies and services, purchase of healthcare, clinical negligence and drugs.

2gether Support Solutions (2gether) reported a YTD surplus of £1.1m, £0.3m below plan. The shortfall is mainly driven by lower-than-expected income from Trust capital expenditure, partly offset by favourable non-operating income in the month and year-to-date, due to higher bank interest received.

Spencer Private Hospitals (SPH) reported a YTD surplus of £0.06m, £0.1m below plan. This is driven by higher pay and other operating costs, partially offset by increased patient care income and interest receivable.

The Trust cash balance (excluding subsidiaries) at the end of August was £41.2m. The appendix (as standard) provides the full cash flow forecast for the year.

Key recommendations:	The Board of Directors is asked to review and **NOTE** the financial performance of Month 5.

Implications:

Links to Strategic Theme:	• Sustainability
Link to the Significant Risk Register (SRR):	**SRR 3664**: Failure to deliver the Trust financial plan for 2025/26
Resource:	N Key financial decisions and actions may be taken on the basis of this report
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: Finance and Performance Committee – 30 September 2025

East Kent Hospitals University NHS Foundation Trust

Finance Performance Report 2025/26

August 2025

Chief Finance Officer
Angela van der Lem

We care

Group Summary
Month 05 (August) 2025/26

	Trust			2gether Support Solutions			Spencer Private Hospitals			Consolidation Adjustments			Group		
	Year to Date			Year to Date			Year to Date			Year to Date			Year to Date		
(£'m)	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
NHS Income From Commissioners - exc. D&D	358.437	360.404	1.967	0.000	0.000	0.000	8.665	9.318	0.653	(0.425)	(1.101)	(0.676)	366.677	368.621	1.944
NHS Income From Commissioners - Drugs	24.478	25.515	1.037	0.000	0.000	0.000	0.000	0.000	0.000	(0.770)	0.000	0.770	23.708	25.515	1.807
NHS Income From Commissioners - Devices	3.171	3.257	0.086	0.000	0.000	0.000	0.000	0.000	0.000	(0.001)	0.000	0.001	3.170	3.257	0.087
Other Income	27.506	28.037	0.531	70.051	69.206	(0.845)	0.024	0.018	(0.006)	(66.014)	(70.837)	(4.823)	31.567	26.424	(5.143)
Total Income	**413.591**	**417.213**	**3.622**	**70.051**	**69.206**	**(0.845)**	**8.689**	**9.336**	**0.647**	**(67.209)**	**(71.938)**	**(4.729)**	**425.122**	**423.817**	**(1.305)**
Substantive Staff (inc. Apprenticeship Levy)	(250.851)	(250.506)	0.345	(18.617)	(19.136)	(0.519)	(3.227)	(3.967)	(0.740)	0.301	0.565	0.264	(272.394)	(273.044)	(0.650)
Bank Staff	(20.313)	(22.341)	(2.028)	0.000	0.000	0.000	0.000	(0.028)	(0.028)	0.000	0.028	0.028	(20.313)	(22.341)	(2.028)
Agency/Contract	(10.435)	(10.293)	0.142	(0.897)	(0.618)	0.279	(0.340)	(0.207)	0.133	0.000	0.000	0.000	(11.672)	(11.118)	0.554
Total Employee Expenses	**(281.600)**	**(283.141)**	**(1.541)**	**(19.514)**	**(19.754)**	**(0.240)**	**(3.567)**	**(4.202)**	**(0.635)**	**0.302**	**0.594**	**0.292**	**(304.379)**	**(306.503)**	**(2.124)**
Drugs	(43.433)	(42.880)	0.553	0.000	(0.005)	(0.005)	(1.103)	(1.150)	(0.047)	1.019	1.040	0.021	(43.517)	(42.995)	0.522
Rechargeable Devices	(3.171)	(3.257)	(0.086)	0.000	0.000	0.000	0.000	0.000	0.000	0.001	0.000	(0.001)	(3.170)	(3.257)	(0.087)
Supplies and Services - Clinical	(23.658)	(20.115)	3.543	(24.002)	(27.405)	(3.403)	(0.928)	(0.752)	0.176	1.163	3.585	2.422	(47.425)	(44.687)	2.738
Supplies and Services - General	(58.461)	(64.590)	(6.129)	(13.877)	(9.061)	4.816	(0.104)	(0.117)	(0.013)	62.339	64.716	2.377	(10.103)	(9.052)	1.051
Clinical negligence	(15.737)	(15.126)	0.611	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	(15.737)	(15.126)	0.611
Depreciation and Amortisation	(11.133)	(11.133)	0.000	(0.215)	(0.456)	(0.241)	(0.095)	(0.143)	(0.048)	0.000	(0.000)	(0.000)	(11.443)	(11.732)	(0.289)
Other non pay	(18.676)	(18.926)	(0.250)	(10.970)	(11.719)	(0.749)	(2.677)	(2.873)	(0.196)	2.376	2.024	(0.352)	(29.947)	(31.495)	(1.548)
Total Other Operating Expenses	**(174.268)**	**(176.027)**	**(1.759)**	**(49.064)**	**(48.646)**	**0.418**	**(4.907)**	**(5.035)**	**(0.128)**	**66.897**	**71.365**	**4.468**	**(161.342)**	**(158.344)**	**2.998**
Non Operating Expenses	(3.276)	(3.151)	0.125	(0.079)	0.281	0.360	(0.052)	(0.035)	0.017	0.003	(0.001)	(0.004)	(3.404)	(2.906)	0.498
Profit/Loss	**(45.553)**	**(45.106)**	**0.448**	**1.394**	**1.087**	**(0.307)**	**0.163**	**0.064**	**(0.099)**	**(0.007)**	**0.020**	**0.027**	**(44.003)**	**(43.936)**	**0.067**
Less Technical Adjustments	0.295	0.235	(0.060)	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.295	0.235	(0.060)
Technically Adjusted Profit/Loss	**(45.258)**	**(44.871)**	**0.387** **1**	**1.394**	**1.087**	**(0.307)** **2**	**0.163**	**0.064**	**(0.099)** **3**	**(0.007)**	**0.020**	**0.027** **4**	**(43.708)**	**(43.701)**	**0.007** **5**
Non Recurrent Deficit Support Revenue Allocation	29.766	29.766	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	29.766	29.766	0.000
Deficit Support Adjusted Profit/Loss	**(15.492)**	**(15.105)**	**0.387**	**1.394**	**1.087**	**(0.307)**	**0.163**	**0.064**	**(0.099)**	**(0.007)**	**0.020**	**0.027**	**(13.942)**	**(13.935)**	**0.007**

1. Trust:
The Trust has been allocated non-recurrent Deficit Support Funding (DSF) totalling £57.6m for the year. This non-recurrent allocation reduces the Group's planned deficit from £64.2m to £6.6m. Since this allocation is non-recurrent, the finance report will focus on the deficit prior to the DSF. DSF is shown below the line to maintain emphasis on the recurrent position. Excluding the non-recurrent DSF allocation, the Trust's YTD position as at month 5 is £0.4m favourable. The key drivers of this position include:

- Income from patient care is currently £3.1m higher than planned YTD. This includes overperformance on NHSE Chemotherapy (£0.5m) which is paid on a variable basis, overperformance from the Compensation Recovery Unit (£0.3m) as well as additional income for Specialised Commissioning income for ERF performance (£1.5m) and over performance on rechargeable high cost drugs and devices (£1.1m).
- Other operating income is £0.5m favourable to plan YTD, driven mainly by income from education and training and non patient care services.
- Employee expenses were £1.5m adverse YTD. Substantive staff costs are below plan, while temporary staffing, particularly bank staff, is the main driver of the overspend.
- Other operating expenses are £1.8m adverse to plan YTD, driven by overspends in general supplies and services, premises and other expenditure are offset by underspends on supplies and services clinical, purchase of healthcare, clinical negligence and drugs.

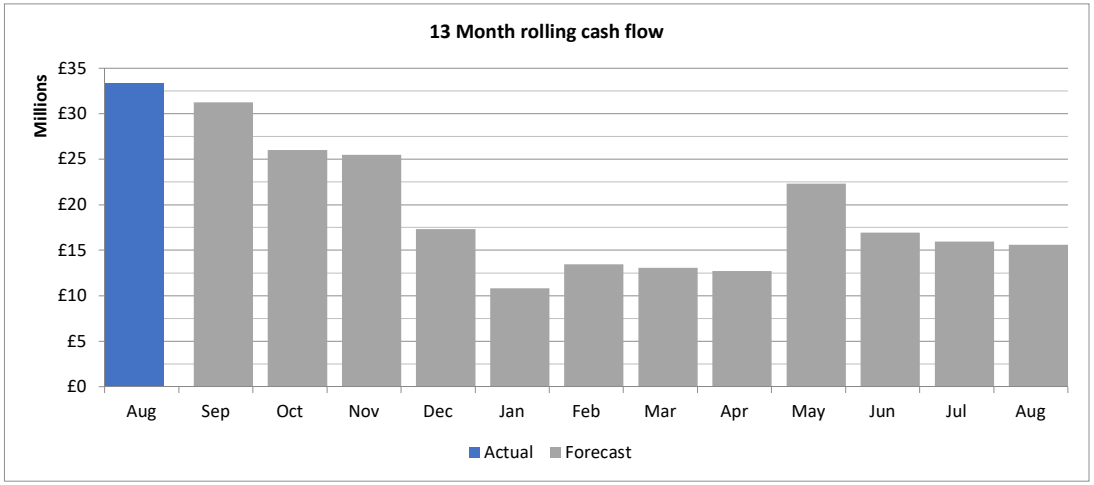
2. 2gether Support Solutions
2gether Support Solutions reported a surplus of £1.1m YTD, which is £0.3m below plan. The shortfall is mainly driven by lower-than-expected income from Trust capital expenditure, partly offset by favourable non-operating income, due to higher bank interest received.

3. Spencer Private Hospitals
Spencer Private Hospitals reported a YTD surplus of £0.06m, £0.1m below plan. This is driven by higher pay and other operating costs, partially offset by increased patient care income and interest receivable.

4. Consolidation Adjustments
Consolidation adjustments are applied to eliminate all inter-company income and expenditure transactions.

5. Group
The YTD deficit for the group as at month 5 stands at £43.7m, which is favourable to plan by £7k.

Cash Flow
Month 05 (August) 2025/26



Unconsolidated Cash balance was £41.2m at the end of August 2025, £5.2m above plan.

Cash receipts in month totalled £98.5m (£10.6m above plan)

- K&M ICB paid £76.9m in August (above plan by £2.6m)
- NHS England paid £7.6m in August, £0.8m above plan
- July and August VAT reclaims were both received in month, £8.0m. (£4.5m above plan)
- Other receipts totalled £6.1m (this includes £4.1m from other NHS organisations and £2.0m from Non NHS debtors)

Cash payments in month totalled £100.2m (£9.7m above plan)

- Creditor payment runs were £24.7m (£0.5m below plan)
- £22.0m payments to 2gether (£6.4m above plan)
- Total payroll was £53.5m (£3.8m above plan in month 5)

2025/26 Cash Plan

The revised plan submitted to NHSE in May 2025 shows a Trust deficit position at the end of 2025/26 of £10.27m.

The cash plan assumes full delivery of £80m cash releasing efficiencies and a £42m Capital PDC programme.

Full receipt of Deficit support funding, £57.6m, is planned into the cashflow from Kent and Medway ICB in the year. Deficit support funding will be received by the ICB on a quarterly basis contingent on continued delivery of the System plan.

Risk to the cashflow

The efficiency delivery, PDC capital programme and the deficit support funding all pose risks to our cashflow.

Any slippage in achieving the efficiencies will have a negative impact on the forecasted cash balances. If these efficiencies are not realised, it will result in reduced payments to creditors and a decline in the Better Payment Practice Code (BPPC) compliance.

Additionally, if the ICS fails to deliver the System plan, full deficit support funding may not be received. This will affect the Trust's ability to make timely payments to creditors.

Moreover, Capital PDC cannot be drawn in advance of need. Therefore, if the PDC capital programme is accelerated ahead of schedule, it will impact the cash available for payments to other suppliers.

Creditor Management

The Trust paid to 30 day creditor terms for suppliers in month 5. At the end of August 2025, the Trust was recording 41 creditor days (Calculated as invoiced creditors at 31st August/Forecast non-pay expenditure x 365).

Statement of Financial Position

Month 05 (August) 2025/26

	Trust			2gether Support Solutions			Spencer Private Hospitals			Consolidation Adjustments			Group		
(£'m)	**Opening**	**To date**	**Movement**	**Opening**	**To date**	**Movement**	**Opening**	**To date**	**Movement**	**Opening**	**To date**	**Movement**	**Opening**	**To date**	**Movement**
Non Current Assets	**360.773**	**355.753**	**(5.020)**	**64.913**	**64.540**	**(0.373)**	**4.349**	**4.245**	**(0.104)**	**(141.301)**	**(140.500)**	**0.801**	**288.734**	**284.038**	**(4.696)**
Inventories	7.546	7.463	(0.083)	6.022	6.022	0.000	0.060	0.118	0.058	0.000	0.000	0.000	13.628	13.603	(0.025)
Trade Receivables	34.729	31.939	(2.790)	17.299	9.594	(7.705)	4.056	4.810	0.754	(21.540)	(16.460)	5.080	34.544	29.883	(4.661)
Accrued Income and Other Receivables	(3.870)	(3.785)	0.085	(0.115)	(0.166)	(0.051)	(0.083)	(0.083)	0.000	0.000	0.000	0.000	(4.068)	(4.034)	0.034
Assets Held For Sale	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Cash and Cash Equivalents	47.695	41.178	(6.517)	24.189	30.492	6.303	3.048	2.944	(0.104)	0.000	0.000	0.000	74.932	74.614	(0.318)
Current Assets	**86.100**	**76.795**	**(9.305)**	**47.395**	**45.942**	**(1.453)**	**7.081**	**7.789**	**0.708**	**(21.540)**	**(16.460)**	**5.080**	**119.036**	**114.066**	**(4.970)**
Payables and Accruals	85.542	84.706	(0.836)	23.409	20.518	(2.891)	4.421	5.019	0.598	(17.889)	(12.758)	5.131	95.483	97.485	2.002
Deferred Income and Other Liabilities	6.262	14.061	7.799	0.000	0.000	0.000	0.000	0.000	0.000	0.000	(0.035)	(0.035)	6.262	14.026	7.764
Provisions	10.424	6.414	(4.010)	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	10.424	6.414	(4.010)
Borrowing	4.244	4.204	(0.040)	2.468	2.278	(0.190)	0.079	0.047	(0.032)	(4.485)	(4.550)	(0.065)	2.306	1.979	(0.327)
Current Liabilities	**106.472**	**109.385**	**2.913**	**25.877**	**22.796**	**(3.081)**	**4.500**	**5.066**	**0.566**	**(22.374)**	**(17.343)**	**5.031**	**114.475**	**119.904**	**5.429**
Provisions	3.724	3.679	(0.045)	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	3.724	3.679	(0.045)
Borrowing	67.533	65.679	(1.854)	48.231	47.388	(0.843)	1.887	1.876	(0.011)	(111.229)	(109.315)	1.914	6.422	5.628	(0.794)
Non Current Liabilities	**71.257**	**69.358**	**(1.899)**	**48.231**	**47.388**	**(0.843)**	**1.887**	**1.876**	**(0.011)**	**(111.229)**	**(109.315)**	**1.914**	**10.146**	**9.307**	**(0.839)**
Net Assets	**269.144**	**253.805**	**(15.339)**	**38.200**	**40.298**	**2.098**	**5.043**	**5.092**	**0.050**	**(29.238)**	**(30.302)**	**(1.064)**	**283.149**	**268.893**	**(14.256)**
Public Dividend Capital	609.877	609.877	0.000	30.267	30.267	0.000	0.048	0.048	(0.000)	(30.315)	(30.315)	0.000	609.877	609.877	(0.000)
Retained Earnings	(394.090)	(409.429)	(15.339)	9.008	10.025	1.017	2.185	2.230	0.045	0.000	0.018	0.018	(382.897)	(397.156)	(14.259)
Revaluation Reserve	53.355	53.355	0.000	0.000	0.000	0.000	2.812	2.812	0.000	0.000	0.000	0.000	56.167	56.167	0.000
Taxpayers Equity	**269.142**	**253.803**	**(15.339) 1**	**39.275**	**40.292**	**1.017 2**	**5.045**	**5.090**	**0.045 3**	**(30.315)**	**(30.297)**	**0.018 4**	**283.147**	**268.888**	**(14.259)**

1. Trust:

Non-Current Assets - Values reflect in-year additions less depreciation charges. Non-Current assets also includes the loan and equity that finances 2gether Support Solutions.

Current Assets - Current assets have decreased by £9.3m compared to 2024/25, primarily due to a £6.5m reduction in cash and a £2.8m reduction in receivables. Further details are provided on the cash and working capital pages.

Current Liabilities - Current liabilities increased by £2.9m, mainly due to a £7.8m rise in deferred income from education-related revenue. This was partly offset by a £4m decrease in provisions and payables. (See the Working Capital sheet for further details.

Non current liabilities - The long-term debt entry relates mainly to the long-term finance lease with 2gether Support Solutions.

Public Dividend Capital - No year-to-date movement in Public Dividend Capital (PDC).

2. 2gether Support Solutions:

Non-current assets - In-year movement reflects year-to-date.

Current Assets - Current assets have decreased by £1.5m, mainly due to a £7.7m decrease in receivables which is partly offset by £6.3m increase in cash.

Current Liabilities - Current liabilities have decreased by £3m, mainly due to a reduction in payables.

3. Spencer Private Hospitals:

Non-current assets - In-year movement relates to depreciation.

Current Assets: Increased by £0.7m, driven by higher trade receivables.

Current Liabilities: Increased by £0.6m, primarily due to a increase in invoice payables.

4. Consolidation Adjustments - Removal of inter-company transactions and loans.

Capital Expenditure
Month 05 (August) 2025/26

Capital Programme	Annual	Annual	Year to Date		
£000	**Plan**	**Forecast**	**Plan**	**Actual**	**Variance**
PEIC (Critical Estates Priorities)	4,000	4,000	1,250	519	731
MDG (Medical Devices Replacement)	3,000	3,000	1,110	190	920
ERP (Equipment Replacement Programme)	3,800	3,275	875	338	537
IDG (IT Hardware and Systems Replacement)	2,300	2,300	1,200	909	291
Fire Compartmentation Strategy	4,930	3,430	1,150	1,543	(393)
Subsidiaries - 2Gether Suport Solutions (2SS)	450	450	105	6	99
Subsidiaries - Spencer Private Hospitals (SPH)	64	64	23	35	(12)
Thanet CDC	4,340	4,340	70	27	43
Hyper Acute Stroke Unit (HASU)	3,580	3,580	834	494	340
Diagnostics Imaging (QEQM MRI) - 2025/26 (Year 2)	2,050	1,850	2,050	1,783	267
WHH Cardiac Catheter Lab	1,190	1,190	70	21	49
Aseptic Suite Remedial Works	750	566	30	202	(172)
Block and Beam replacement - WHH - 2025/26 (Year 2)	350	350	290	234	56
Nursery Major Refurbishment Works	300	0	22	0	22
Maternity Information System (MIS)	125	125	0	0	0
Pathology Pneumatic Tubes - System Replacement	100	0	0	0	0
Procurement of 2x Mobile CT Scanners - 2025/26 (Year 2) - Enabling W	60	0	60	0	60
NHSE Maternity Scheme (Early Release Fees) - 2025/26 (Year 2)	800	800	800	44	756
2025/26 National Diagnostics Programme	1,218	1,218	0	0	0
2025/26 National UEC Programme	23,765	21,200	1,826	195	1,631
2025/26 National CIR Programme	12,637	13,232	2,709	141	2,568
Endoscopy Lease Equipment purchase	0	935	0	0	0
Maternity (CQC) Urgent Works	0	437	0	0	0
Digital Pathology Projects	0	1,612	0	0	0
Donated Assets	600	600	99	344	(245)
Right of Use Assets (RoUA) - IFRS16 Leases	758	758	0	94	(94)
All Other	0	0	0	(66)	66
	71,167	**69,311**	**14,573**	**7,053**	**7,520**

Funded By:	**Plan**	**Forecast**	**Variance**
Operational Capital	29,175	29,698	523
Donations	600	600	0
PDC	38,420	38,062	(359)
	68,195	**68,360**	**164**
Funding Under/(Over) utilisation	**(2,972)**	**(951)**	

The 2025/26 Capital Plan submitted to NHSE in May 2025 **totalled £71.2m** and included £3m of over-programmed schemes against planned funding level. This approach was endorsed by the Trust Board following an internal capital prioritisation process that concluded in March 2025. At the request of NHSE, the capital plan also included **£49m** of indicative external funding allocations based on several capital bids the Trust submitted to NHSE in Q4 2024/25.

Subsequent to the plan submission, a number of changes have been actioned, including:

- revisions to the indicative external funding allocations following the formal confirmation of funding and the associated capital expenditure;
- additional funding streams confirmed (to date, an additional £1.6m has been recognised in relation to the Digital Pathology schemes: Community Order Comms - £1.39m and iRefer - £0.23m);
- changes to the CDEL allocation following developments post-plan submission (including a £0.477m top-slice as a result of confirmation by the national team of the K&M ICS capital envelope for 2025/26 and a subsequent £1m CDEL award for achieving the UEC Incentive targets in 2024/25);
- emergent cost pressures to be accommodated within the current funding envelope (the procurement of the Endoscopy Leased equipment, linked to the delivery of the CIP plan in 2025/26 and urgent Maternity Works required, highlighted by the CQC report);
- further reductions to the planned capital expenditure (some of which are linked to reported underspends, due to lower-than-expected costs or works now covered by external funding), as part of an effort to reduce the planned over-programming element of £2.972m down to a breakeven position.

As part of the month 5 FOT for the year, the **over-programming against available funding has been reduced down to £0.95m.** All of the above adjustments have been submitted to the EMT on 27th August 2025 by the Chief Strategy and Partnership Officer (CSPO) and were endorsed by the group.

The **Group's gross capital YTD spend to the end of Month 5 was £7.05m**, against a YTD plan of £14.57m. Of this £7.52m underspend, circa 66% relates to externally funded schemes that cannot proceed until business cases have been approved by NHSE and funding confirmation received by means of an MOU issued by the DHSC.

A number of **additional funding streams (not currently reflected in the forecast)** are expected to be awarded as follows:

- **£4.7m additional PDC capital funding, awarded under the National Elective Programme**, for further development of the Trust's Robotic Surgery capabilities; MOU is yet to be issued by the DHSC and the funding is contingent upon the approval of a business case to be submitted to NHSE in November 2025
- **£0.285m PDC funding for the development of a Digital Dictation service**; MOU has been issued by the DHSC in August 2025, but the proposal is contingent upon the internal approval of the business case, which is managed by the K&M Pathology Network, hosted by MTW. The Final business case is expected to be presented to the BCSG in October 2025
- **£0.15m PDC Funding for the development of a CDC Liver Disease Pathway**; an MOU is yet to be issued by the DHSC and the business case is expected to be presented to the CIG and BCSG committees in October 2025
- **£2.2m PDC Funding in relation to the installation of estates electrical infrastructure for green energy (i.e. solar panels)**; an MOU is yet to be issued by the DHSC, but notional approval has been confirmed in August 2025

Cost Improvement Summary

Month 05 (August) 2025/26

Delivery Summary

Programme Themes £000	This Month Plan	This Month Actual	This Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	Annual Plan	Annual Forecast	Annual Variance
01. Estate Utilisation & Rationalisation	579	452	(127)	1,023	660	(363)	2,489	2,867	378
02. Procurement	240	387	147	1,095	1,232	137	4,897	6,308	1,412
03. Digital Utilisation & Rationalisation	16	-	(16)	75	-	(75)	715	589	(127)
05. Medical Workforce	272	240	(32)	955	413	(542)	5,803	4,259	(1,544)
06. AHP | Nursing | Midwifery Workforce	74	-	(74)	279	103	(176)	1,506	1,452	(54)
07. Non-Clinical Workforce	81	255	174	363	1,263	900	2,333	9,212	6,879
08. Diagnostics	33	151	118	156	381	225	734	1,149	415
09. Integrated Urgent and Emergency Care	76	103	27	374	364	(10)	2,000	1,108	(892)
10. Theatre Utilisation	47	(92)	(139)	235	-	(235)	1,263	1,214	(49)
11. Outpatients	13	(3)	(16)	64	-	(64)	343	1,024	681
12. Medicines Management and Devices	59	106	47	293	650	358	703	1,263	560
13. Subsidiaries - 2gether	416	-	(416)	2,083	-	(2,083)	5,000	4,461	(539)
14. Subsidiaries - Spencer	7	-	(7)	30	-	(30)	300	600	300
15. Service Efficiency Review	-	-	-	-	-	-	-	525	525
16 to 23 Care Group Led Schemes	2,161	2,253	92	9,493	4,965	(4,528)	51,914	27,404	(24,510)
25. Central	-	229	229	-	6,510	6,510	-	6,732	6,732
26. Miscellaneous	-	-	-	-	-	-	-	7,839	7,839
27. System	-	-	-	-	-	-	-	2,000	2,000
Grand Total	**4,074**	**4,082**	**8**	**16,518**	**16,542**	**24**	**80,000**	**80,006**	**6**

Delivered £000

Month	Target	Actual
April	2,290	2,040
May	3,252	3,549
June	3,308	3,263
July	3,594	3,608
August	4,074	4,082
September	3,803	
October	10,152	
November	9,810	
December	9,845	
January	9,909	
February	9,941	
March	10,022	
	80,000	**16,542**
		20.7%

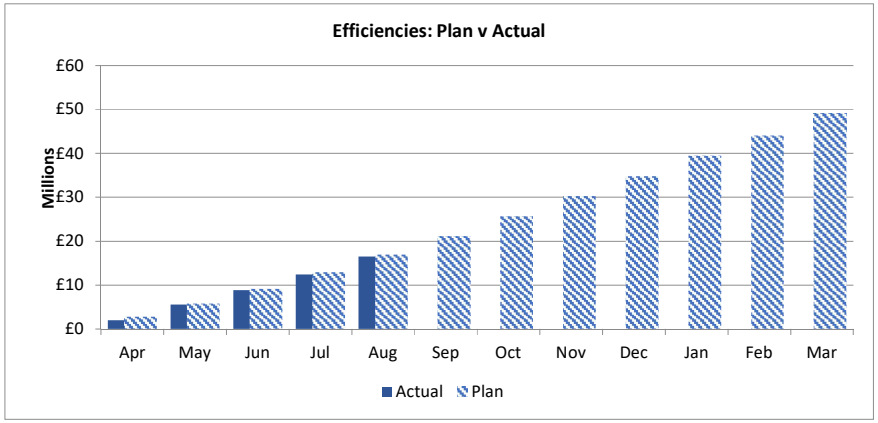
The agreed Efficiencies plan for 2025/26 is £80.0m. CIP delivery is marginally ahead of plan for Month 5 (£8k) and YTD (£24k).

Total savings of £16.5m have been delivered to month 5, with recurrent savings of £8.9m delivered YTD.

The Care Group Led Schemes include the planned allocation of "Fair Share" for the previously unidentified schemes in order to reflect the Efficiency targets in the ledger. This amounts to £33.0m for the year and £4.8m YTD. Subsequently, stretch ideas and opportunities have been agreed by EMT, some of which are included in Miscellaneous and System.

Theme Leads continue supporting the programmes and feed into Executive Sponsors when escalation is necessary. The PMO is working closely with Finance Business Partners and Theme Leads, focussing on delivery of CIPs for the current financial year. Attention will be required to work up the EMT schemes to ensure that there is substance to the plans to deliver in-year.

The focus is now on delivery of the identified schemes and moving pipeline scheme PIDs for FY2526 through the governance gateways for delivery. The key task is to deliver cash out / run rate reductions to ensure there is a real reduction in service costs to meet the required group plan.



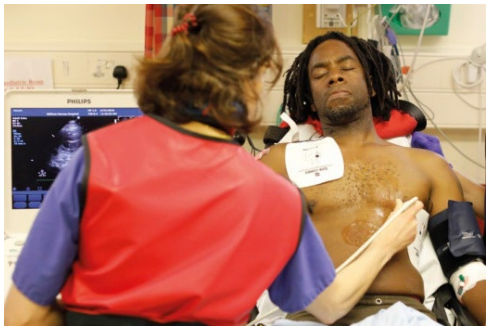
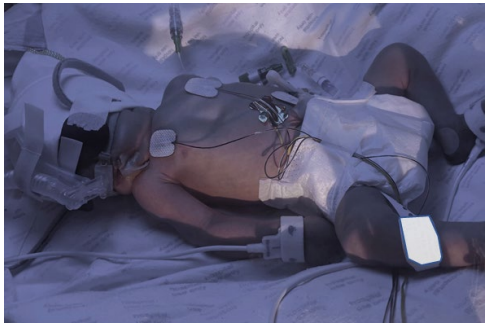
Integrated Performance Report

AUGUST 2025







Integrated Performance Report

Statistical Process Control

The Trust's IPR forms the summary view of Performance against the organisations five strategic themes; Patients, Quality & Safety, People, Partnerships and Sustainability. It also collocates the metrics which are intrinsic to our Integrated Improvement Plan and monitors progress against the quarterly milestones which will enable the organisations exit from National Oversight Framework 4 and Tier 1 monitoring. To do this is uses Statistical Process Control to assess performance.

What is statistical process control (SPC)?

Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in doing so, guides us to take the most appropriate action.

Our Trust Integrated Performance Report incorporates the use of SPC Charts to identify common cause and special cause variations and uses NHS Improvement SPC icons to provide an aggregated view of how each KPI is performing with statistical rigor.

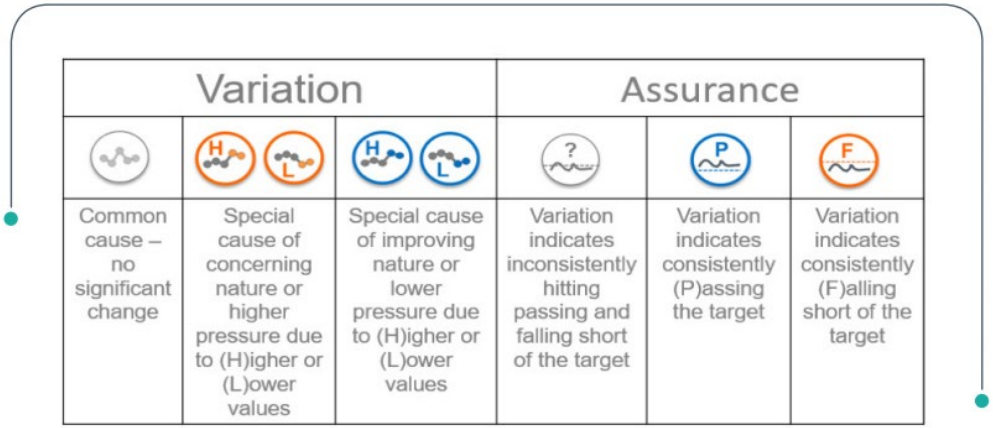
The main aims of using statistical process control charts is to understand what is different and what is normal, to be able to determine where work needs to be concentrated to make a change. The charts also allow us to monitor whether metrics are improving.

Key Facts about an SPC Chart

A minimum of 15-20 data points are needed for a statistical process control chart to have meaningful insight. 99% of all data will fall between the lower and upper confidence levels.

If data point falls outside these levels, an investigation would be triggered.

It contains two types of trend variation: Special Cause (**Concerns** or **Improvement**) and Common Cause (i.e. no significant change.



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

Variation icons: **orange** indicates concerning **special cause variation** requiring action; **blue** indicates where improvement appears to lie, and **grey** indicates no significant change (**common cause variation**).

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

The colours used for data points in the dashboard (tabular view) represent the position of each KPI from an SPC (Variation) perspective. The colours are based on statistically significant movement. The key is as follows:

Statistically significant improving variation	Statistically significant variation of concern	No significant change

Patients

Assurance

Variation

Variation	P — Will consistently pass the target if nothing changes	? — Will not consistently pass or fail the target if nothing changes	F — Will consistently fail the target if nothing changes
H / L — Improving Variation (High or Low)		Cancer 28d Combined Performance Cancer 31d Combined Performance Outpatient DNA Rate	Ambulance Handovers within 30m RTT 1st OPA Performance RTT 52w Breaches RTT 52w Performance RTT Incomplete Performance
No Significant Change		% Beds Occupied 14+ Cancer 62d Combined Performance Cancer Over 62d on PTL ED Compliance RTT 104w Breaches RTT 78w Breaches RTT Total Incomplete Pathways Theatre Session Opp.	12Hr Trolley Waits Cancer Over 104d on PTL Not Fit to Reside (pats/day) RTT 65w Breaches Super Stranded >21D Theatre Uncapped Utilisation
H / L — Concerning Variation (High or Low)		Cancer Rapid Access Perf DM01 Compliance Type 1 Compliance 4hrs	12 Hr Total Time in Department

Patients

Scorecard View

Urgent & Emergency Care Metrics & Cancer Waiting Times

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Patients	NAT		ED Compliance			73.0%	76.8%	74.4%	74.1%	74.4%	73.4%	73.2%	74.6%	76.2%	76.6%	76.4%	76.5%	74.2%
	IIP		Type 1 Compliance 4hrs			56.0%	56.5%	54.1%	53.7%	54.7%	51.0%	50.1%	51.4%	54.2%	54.6%	54.0%	55.2%	48.8%
	IIP		12 Hr Total Time in Department			15.8%	18.0%	18.7%	18.8%	19.4%	21.3%	20.7%	20.8%	21.7%	20.2%	20.6%	20.4%	23.3%
	NAT		12Hr Trolley Waits			0	1,017	1,171	1,121	1,326	1,385	1,177	1,327	1,256	1,210	1,150	1,195	1,311
	NAT		Ambulance Handovers within 30m			95.0%	88.7%	86.6%	90.0%	88.4%	88.2%	87.7%	90.5%	92.7%	93.6%	95.1%	94.9%	93.7%
	IIP		% Beds Occupied 14+			30.0%	34.3%	32.0%	28.2%	29.1%	33.9%	34.9%	35.4%	34.1%	33.2%	29.4%	30.8%	31.2%
	KEY		Super Stranded >21D			107	237	212	178	184	224	239	236	232	219	191	203	209
	NAT		Not Fit to Reside (pats/day)			100.0	197.4	195.5	157.8	155.3	165.7	171.0	172.9	173.0	161.8	154.5	173.7	160.5
	IIP		Cancer 28d Combined Performance			80.0%	69.8%	71.3%	71.9%	74.9%	66.5%	78.5%	76.4%	75.0%	74.9%	76.8%	76.9%	74.7%
	NAT		Cancer 31d Combined Performance			96.0%	95.2%	92.7%	94.3%	97.1%	92.9%	96.2%	97.2%	96.8%	95.7%	95.7%	97.5%	96.2%
	IIP		Cancer 62d Combined Performance			80.0%	72.9%	70.4%	74.1%	73.9%	69.1%	70.8%	77.3%	76.4%	75.6%	72.3%	78.7%	78.5%
	IIP		Cancer Over 62d on PTL			200	215	193	203	216	197	183	167	192	222	170	150	166
	KEY		Cancer Over 104d on PTL			0	50	36	40	33	40	44	46	34	42	38	40	33
	KEY		Cancer Rapid Access Perf			93.0%	92.7%	82.3%	88.1%	93.2%	96.7%	97.7%	94.0%	96.1%	96.5%	92.6%	79.0%	74.7%

Patients

Scorecard View

Referral to Treatment Waiting Times, Diagnostics & Productivity Measures

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
	NAT		RTT Incomplete Performance			55.2%	50.9%	50.5%	51.2%	52.0%	52.5%	52.8%	53.3%	54.0%	54.7%	55.0%	54.9%	54.7%
	NAT		RTT 1st OPA Performance			61.5%	57.8%	57.1%	57.5%	57.4%	58.3%	58.8%	60.4%	61.9%	63.0%	63.5%	64.0%	63.6%
	NAT		RTT 52w Performance			2.0%	4.3%	3.9%	3.6%	3.6%	3.5%	3.2%	2.8%	3.2%	3.0%	2.8%	2.6%	2.9%
	NAT		RTT Total Incomplete Pathways			81.4K	86.7K	86.0K	85.6K	83.0K	81.2K	81.3K	81.0K	83.1K	82.1K	80.7K	80.0K	80.1K
	NAT		RTT 52w Breaches			1,635	3,735	3,353	3,119	2,959	2,861	2,621	2,272	2,648	2,466	2,221	2,087	2,320
	IIP		RTT 65w Breaches			0	572	346	247	216	164	148	33	45	69	67	59	94
	IIP		RTT 78w Breaches			0	34	11	10	7	4	17	6	12	17	8	13	24
	IIP		RTT 104w Breaches			0	0	0	0	0	0	9	1	3	3	4	5	10
	IIP		Endoscopy Backlog				1,304	663	391	373	247	258	206	255	268	314	258	247
	IIP		DM01 Compliance			78.0%	68.5%	77.2%	83.3%	81.0%	83.9%	86.2%	87.0%	82.8%	83.2%	81.5%	79.3%	73.5%
	KEY		Theatre Session Opp.			25	39	44	35	45	36	39	29	30	26	25	32	36
	NAT		Outpatient DNA Rate			7.0%	6.8%	6.6%	6.9%	7.1%	6.7%	6.4%	6.5%	6.6%	6.5%	6.2%	6.0%	5.6%
	NAT		Theatre Uncapped Utilisation			85.0%	77.1%	77.7%	78.0%	76.7%	77.5%	76.6%	78.0%	80.3%	80.1%	80.2%	80.2%	79.0%

Patients

Executive Summary

Urgent and Emergency Care & Planned Care

Urgent and Emergency Care

- Overall four-hour compliance has shown a slight decline into August with performance across all types of department at 74.2% and Type 1 departments experienced a fall at 48.8%. Compliance in Type 1 departments had been above the mean of the two year period now for 12 months with performance consistently above 50%. Control limits on these metrics have been recalculated on the basis of this sustained improvement. This has now improved to date in September.
- The number of patients waiting in our emergency departments for over 12 hours in August has increased. This remains a significant challenge and key operational focus for the Trust and system partners at 23.3%. A stretch trajectory to get to 10% by March 2026 is in place in line with the national UEC plan. Extensive analysis of the 12 hour waits by site, split by admitted and non-admitted, timelines and by speciality has been undertaken to support the hot sites for further steps and plans to be taken forward to reduce the number of our patients waiting over 12 hours.
- Ambulance handover performance was maintained achieving 93.7% of patients handed off to the Emergency Departments within 30 minutes. Performance is now positively alerting demonstrating continued improvements in this measure.
- The occupancy levels of patients spending >7 days on the RTS caseload increased in August. Patients recorded as having No Criteria to Reside (NCTR) and remaining in hospital at midnight was an average occupancy of 160 patients throughout August. Delayed discharges continues to contribute to the increased LOS observed and challenges in flow through the three main sites.

Planned Care

- At a Trust level planned care activity to the end of month four hit or exceeded plan across all points of delivery. There has been a deterioration of activity against Plan in Month 5 continuing into M6.
- 62D compliance (78.5%) remains above the national year end target of 75% and marginally shy of the Trust's stretch ambition to reach 80% by year end. FDS will be impacted by the summer break with operational oversight on recovery in place throughout September focussing on clinical reviews and administrative processes to inform patients of their outcome of their cancer diagnosis.
- The end of August position was that there were 94 patients waiting greater than 65 weeks which is a deterioration on the previous month. The plan remains to achieve and sustain zero patients waiting greater than 65 weeks with a revised target from NHSE to eliminate these by mid December. Care Groups have been asked to enact further mitigations to achieve this. There has also been a deterioration in the volume of patients waiting greater than 52 weeks for treatment linked to the reduction in activity levels during August as well as an increasing level of activity required within the plan. This is being addressed through the work for the 2026/27 Operational Plan. New waiting list initiative controls have been implemented which focuses additional capacity only on activity to expedite long waits, cancer or patients who are otherwise urgent. Work continues to achieve the new standards for 2025/26 i.e. no more than 1% of patients waiting greater than 52 weeks for treatment from the end of March 2026 from a baseline of 3.6%. A series of improvement workstreams are in the process of being initiated to increase productivity.
- Theatre utilisation deteriorated slightly during August although efforts will be refocused on the improvement required through the launch of a rapid improvement event scheduled for late October/early November.
- DM01 performance deteriorated further at the end of August to 73.5%. Key areas for on-going recovery continue to be Cardiac MRI and Echocardiography although further recovery and sustainability plans have also been requested from CT, MRI and Non Obstetric Ultrasound.

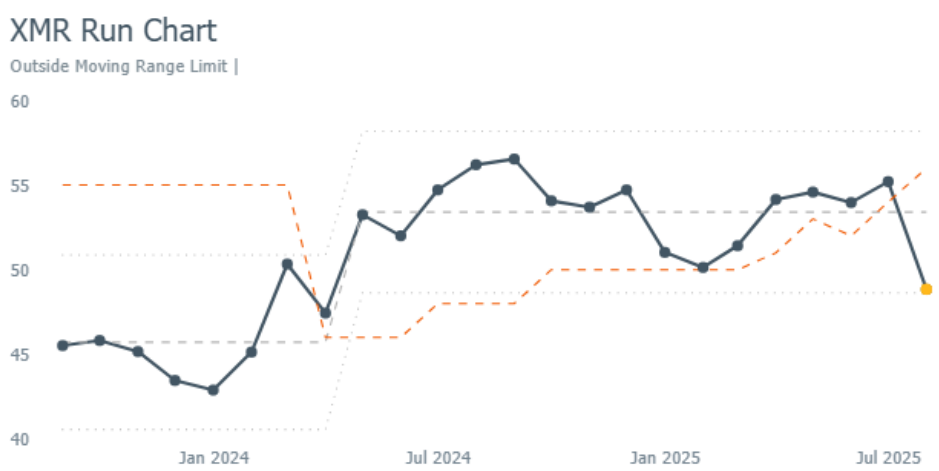
Patients

Urgent & Emergency Care

Type 1 Emergency Department; Four Hour Compliance

Type 1 Compliance 4hrs

Timescale	Value	SPC
Sep-24	56.5%	
Oct-24	54.1%	
Nov-24	53.7%	
Dec-24	54.7%	
Jan-25	51.0%	
Feb-25	50.1%	
Mar-25	51.4%	
Apr-25	54.2%	
May-25	54.6%	
Jun-25	54.0%	
Jul-25	55.2%	
Aug-25	48.8%	



Understanding the Latest Performance

ALERT: Variation flag has changed from Common Cause to Concern

For the month beginning 01/08/2025 the latest Type 1 Compliance 4hrs performance is 48.8% against a Trajectory target of 56.0% (higher is better).

Performance is statisticaly declining, and cannot consistently deliver the target without further intervention (you may need consider if it is time to recalculate the process limits).

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Type 1 Position Attendance Avoidance	• Working with partners to review the revised SPOA model for the impact and successes of the changes to ensure a 7 day service for maximum effectiveness and efficiencies for staff and patients. • Review of direct access pathways to be undertaken with partners.	• Dep COO/ UEC OPS	• Q1 to Q4 • Q1 to Q4	• Performance 48.2 % experienced a fall in August for the first time this year but with improvement to previous levels currently on-going in September. Clinically lead Improvement Weeks for WHH and QEQM are scheduled across 25/26. Week 2 on both hot sites are progressing in September for Alternatives to Hospital and Discahreg with partners. • As part of the SDEC steering group for the new capital builds on both sites, all direct access pathways will be reviewed.
Safe and Effective ED	• Standards and quality indicators will be reviewed on both of the hot sites to ensure timely delivery of patient care within the constraints of the Department. • Review of CDU model on both sites.	• Dep COO UEC • MDs	• Q1 to Q4 • Q1 to Q4	• Internal professional standards have been reviewed and monitored at WHH by the improvement team following Improvement week 1. The outcome is scheduled to be reviewed with the MD in month 3 for further progression. • CDU walkaround at WHH has taken place and enabling changes have taken place in month 6. CDU SOP and timeline to UEC Programme Board end of September.
Admission avoidance	Front door alternatives to ED: • SDEC capital plans being developed for WHH and QEQM with a steering group and workstream mdt approach. • Review UTC models and pathways with partners considering location and GP streaming 7 day service for all walk in patients.	• SiteTri • Dep COO UEC	• Q1 to Q4 • Q2	• Patient flow and pathways for emergency patients will be considered and reviewed as part of the Emergency Village capital development at WHH and QEQM. • UTC's to be co located within the SDEC plans at both sites for walk-in patients with streaming to enable full utilisation of the emergency footprint for patient pathways .

Patients

Urgent & Emergency Care

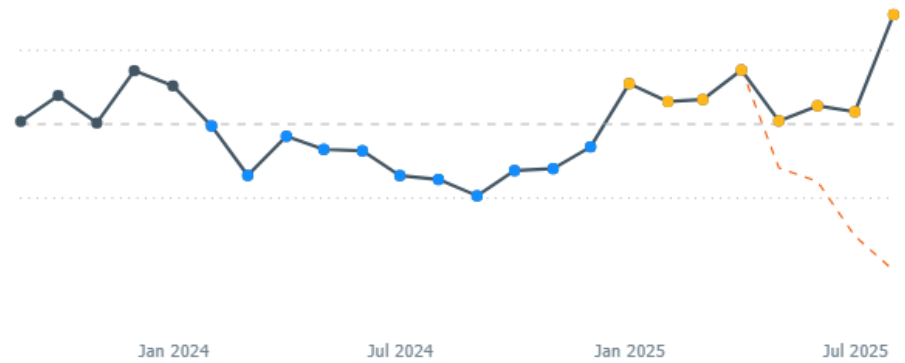
12 Hour Total Time in Emergency Department

12 Hr Total Time in Department

Timescale	Value	SPC
Sep-24	18.0%	
Oct-24	18.7%	
Nov-24	18.8%	
Dec-24	19.4%	
Jan-25	21.3%	
Feb-25	20.7%	
Mar-25	20.8%	
Apr-25	21.7%	
May-25	20.2%	
Jun-25	20.6%	
Jul-25	20.4%	
Aug-25	23.3%	

XMR Run Chart

Above Mean Run Group | Outside Moving Range Limit | Astronomical Point |



Understanding the Latest Performance

Concern flag alerting for more than 4 periods

For the month beginning 01/08/2025 the latest 12 Hr Total Time in Department performance is 23.3% against a Trajectory target of 15.8% (lower is better).

Performance is statisticaly declining, and cannot deliver the target without further intervention (you may need consider if it is time to recalculate the process limits).

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Demand outstrips capacity	• Bed modelling to be developed for the sites around the management of peak demand and the full protocol plans for each site, for example within winter planning. • Patient flow within the Emergency Floor to be enhanced to reduce los with revised processes and equality of access to emergency and acute services. • In line with UEC plan, June 25, reduce 12h waits as per trajectories.	• Senior Ops teams • CG Tri WHH/Q EQM	Q1 to Q4	• Acute sites to have agreed steps and plans in place for surge and/or excess demand with governance and transparency for space and staffing. Winter plan however from the modelling shows a negative bed position of 109 beds currently. • Clinically led SDEC review of protocols for acute sites with SOP's for patient flow to reduce los and admissions has taken place, workshop 1 scheduled in line with ECIST report for opportunities outlined. • Position for 12hrs is not showing the required improvements following implementation of action cards for ED and the site team to agreed escalation points for patients at a 8 hour and 10 hour perspective. Further discussion with site tri's and ECIST support at WHH from August to review processes and modelling. Extensive additional analysis provided to sites of timelines and types for Tier 1 meeting discussions.
Ambulance waiting times	• Maintain handover times with IPS below 30 minutes • Minimise all 30 to 45 minute handover times • All handover waiting times >45 minutes have a zero target, in line with UEC plan June 25, and will be reported upon an individual whilst highlighted in the system.	• CG Tri WHH/Q EQM	Q1 to Q4	• Handover processes to be followed with the utilisation of the above mentioned action cards to be followed when all patients are at a 30 minute wait with ED and site teams. • Validation of all 45 minute waits in place with ICB and SECAMB for both acute sites. • Good performance to date is being maintained.

Patients

Urgent & Emergency Care

12 Hour Total Time in Emergency Department

12h Total Time in EM Dept Actions

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
High number of Mental Health (MH) patients in ED with long waits	• Escalation SOP in place for delays in accessing MH capacity. • ICB support to EKMHT to manage OOA access. • Safe haven roll out underway. • Review framework for all MH patients around admission decision making with partners.	• CG Tri WHH/QEQM	Q1 to Q4	• ED internal processes in place to support patients. Plans in place with HCP/MH to put in 24/7 LPS to the sites/Safe havens to be co-located at QEQM with plans to be established fully by Q4. Plan for Safe Haven at WHH in development. • Focus for 25/26 on escalation and capacity to manage long stayers- SOP for escalation developed by MD for WHH and QEQM.

Patients

Urgent & Emergency Care

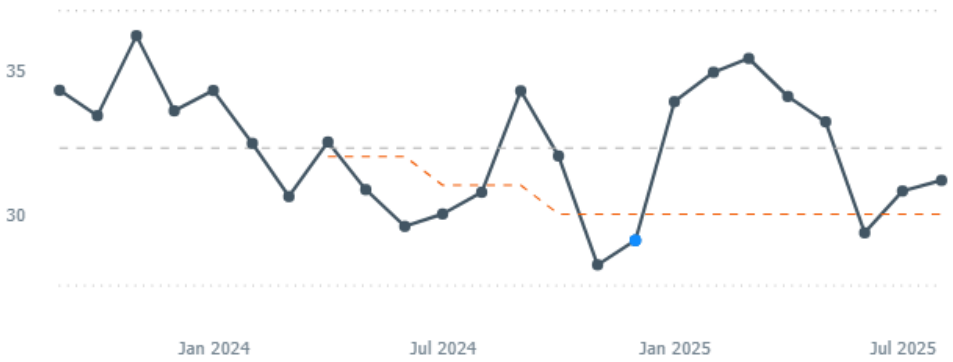
In-Hospital Spells with a Length of Stay over 14 Days

% Beds Occupied 14+

Timescale	Value	SPC
Sep-24	34.3%	
Oct-24	32.0%	
Nov-24	28.2%	
Dec-24	29.1%	
Jan-25	33.9%	
Feb-25	34.9%	
Mar-25	35.4%	
Apr-25	34.1%	
May-25	33.2%	
Jun-25	29.4%	
Jul-25	30.8%	
Aug-25	31.2%	

XMR Run Chart

No Special Cause Flags



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/08/2025 the latest % Beds Occupied 14+ performance is 31.2% against a Trajectory target of 30.0% (lower is better).

Performance is not changing significantly and cannot consistently deliver the target without intervention.

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Alternatives to hospital and discharge with partners	• Develop board round SOP's • Consider out of hospital alternatives for all patients within an acute bed on board rounds on a daily basis. • Review current discharge staffing within the acute sites and partners for the numbers and range of roles and responsibilities together. • Review the role of therapies in relation to discharge and hospital alternatives.	• Dep COO, HCP and MD'S	Q1 to Q4	• Improvement week 2 focus in September on both of the acute sites, pre planning scheduled with MDT approach and the improvement team in support. • Implementation of the SOP's across the wards. • Joint discharge staffing review agreed with partners, options of an integrated team to be considered for example. • Range of alternative services and therapy in a community setting to be discussed. • nCTR patient numbers in total to be monitored and reported upon.
Patients not meeting the criteria to reside > 7 days	• Implement LOS biweekly meetings at QEQM, commencing with a four 4 pilot for >21 & 14 day pts. • BAU at QEQM for > 7 day review biweekly • Review current weekly LOS meeting at WHH • Escalation process to be in place for complex patients or spot purchasing.	• Dep COO, HCP and MD'S	Q1 to Q4	• Conclude outcome of the pilot and success as changes will be made as it progresses to resolve all issues arising by the group and resolved together. TOR to be provided. • Implement at QEQM > 7 days review of patients biweekly with partners from month 4. • Implement outcome of the WHH LOS Meeting review. • Themes of community capacity to be compiled to be reviewed and considered, for example NWB beds and homeless pathway.
Discharge Lounge utilisation	• Review SOP's at both sites for opening hours and facilities, for example beds and chairs capacity. • Golden patients to be identified and agreed daily for end of day bed meetings.	• Deputy COO-UEC • MDs	Q1 to Q4	• Week 1 of the Improvement Programme included a significant focus on the patent flow to the discharge lounge to gain before 10am utilisation. • Build upon the changes and processes as part of the focus. • Maintain and monitor the utilisation.

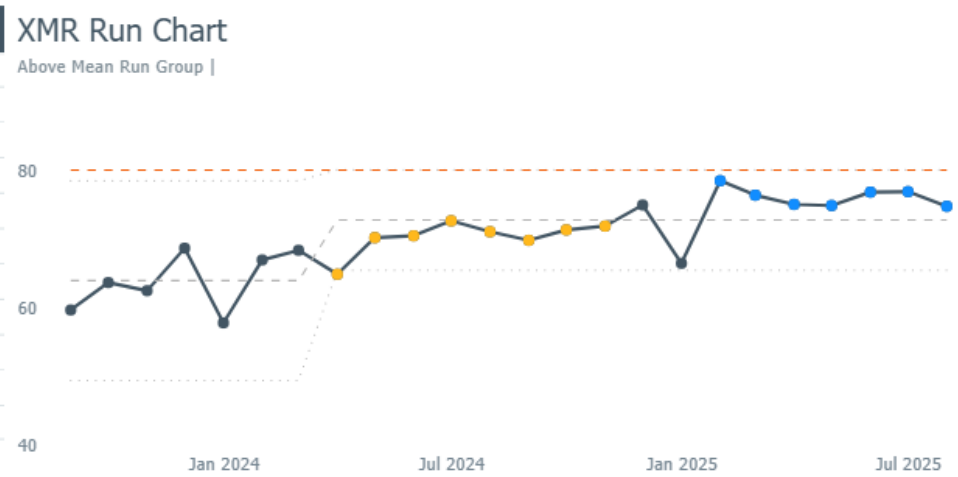
Patients

Cancer Care

Cancer 28 Day Performance

Cancer 28d Combined Performance

Timescale	Value	SPC
Sep-24	69.8%	
Oct-24	71.3%	
Nov-24	71.9%	
Dec-24	74.9%	
Jan-25	66.5%	
Feb-25	78.5%	
Mar-25	76.4%	
Apr-25	75.0%	
May-25	74.9%	
Jun-25	76.8%	
Jul-25	76.9%	
Aug-25	74.7%	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/08/2025 the latest Cancer 28d Combined Performance performance is 74.7% against a static target of 80.0% (higher is better).

Performance is statisticaly improving, but cannot consistently deliver the target without further intervention (you may need consider if it is time to recalculate the process limits).

The biggest contributing factors are: 07 - Lower GI (61.3% , 232*), 11 - Urological (63.9% , 159*), 09 - Gynaecological (62.5% , 157*). *Breaches

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Access to timely diagnostics	• Reduce wait times for CT and US Biopsy, US • Endoscopy booking times • Breast US booking times	• Radiology • Endoscopy	• Ongoing	• Access to diagnostics continues to be monitored through weekly escalation meetings held with Radiology Leads. • £0.5m Cancer Alliance funding confirmed, business case to accept the funding in progress to allow the teams to utilise the funding in a timely manner. Funded schemes will help support Breast pathway (US capacity), LGI (WLIs and nursing support for additional 1st OPAs), Gynae (increased equipment to support 1st OPA clinics), Histopathology consultants.
Letter backlog	• Timely consultant dictation of cancer letters to patients • Timely admin support to process dictated letters	• Cancer compliance • Admin • Consultant	• 25/26	• Ensuring that patients are promptly informed when they do not have cancer remains a key priority for our specialty teams. We recognise the importance of reducing the time between receiving diagnostic results and sending outcome letters. • To support this, weekly escalations are issued to the teams, with prompt clinical requested wherever possible. • Post-summer annual-leave recovery phase in progress – letter backlog has increased to over 500, twice the Trust ambition of maintaining a letter backlog of >250. Administration team challenges due to staff shortages. • Early conversations in progress with LGI teams to support a results inbox job planned to be supported by specialty doctors following the process in place at MTW.
1st OPA Position	• Trust 25/26 ambition to achieve 70% of all 1st OPA within 10 days	• Spec Team	• Q4	• Thrice-weekly meetings with operational teams monitor capacity for 1st OPA. While the Trust had achieved its ambition target in previous months, performance has declined. Key challenges: • Dermatology – Demand exceeds capacity. Working with the Cancer Alliance to implement e-derma/triage clinics in primary care. Breast – Insufficient One Stop capacity. Radiology recruitment underway. Cancer Alliance funding requested for insourced One Stop services. • LGI – Specialties can offer extra clinics, but nursing shortages limit F2F capacity. • Proposed relaunch of ambition in Q3 to increase awareness of ambition and identify needs of the specialties to achieve.

Patients

Cancer Care

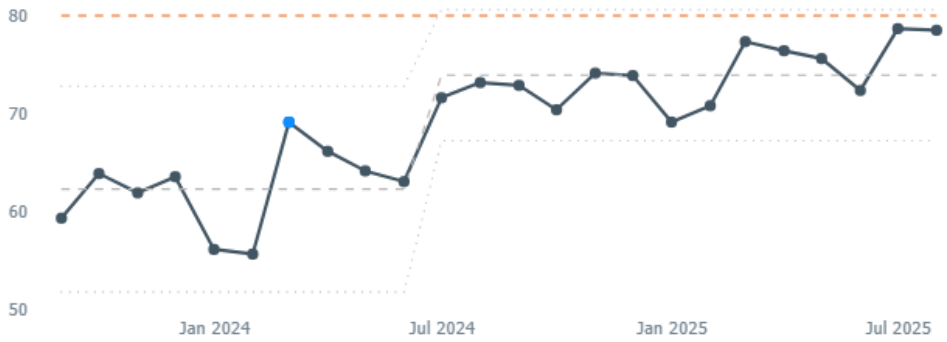
Cancer 62 Day Performance

Cancer 62d Combined Performance

Timescale	Value	SPC
Sep-24	72.9%	
Oct-24	70.4%	
Nov-24	74.1%	
Dec-24	73.9%	
Jan-25	69.1%	
Feb-25	70.8%	
Mar-25	77.3%	
Apr-25	76.4%	
May-25	75.6%	
Jun-25	72.3%	
Jul-25	78.7%	
Aug-25	78.5%	

XMR Run Chart

No Special Cause Flags



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/08/2025 the latest Cancer 62d Combined Performance performance is 78.5% against a static target of 80.0% (higher is better).

Performance is not changing significantly and cannot consistently deliver the target without intervention.

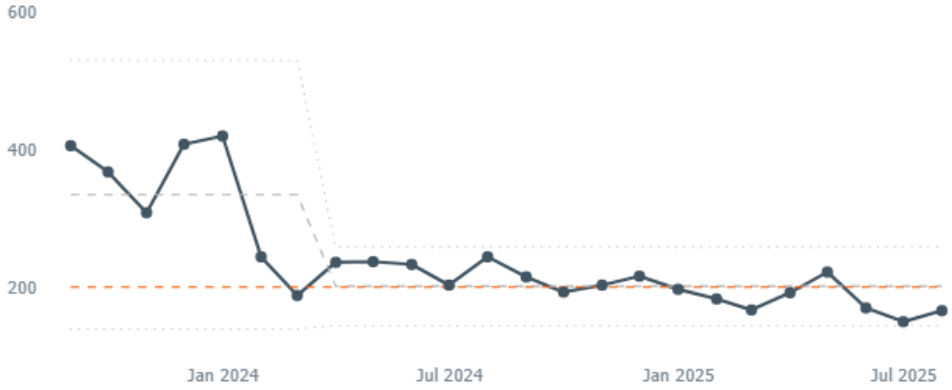
The biggest contributing factors are: 11 - Urological (63.2% , 28*), 01 - Breast (69.6% , 17*), 04 - Haematological (73.8% , 8*). *Breaches

Cancer Over 62d on PTL

Timescale	Value	SPC
Sep-24	215	
Oct-24	193	
Nov-24	203	
Dec-24	216	
Jan-25	197	
Feb-25	183	
Mar-25	167	
Apr-25	192	
May-25	222	
Jun-25	170	
Jul-25	150	
Aug-25	166	

XMR Run Chart

No Special Cause Flags



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/08/2025 the latest Cancer Over 62d on PTL performance is 166 against a static target of 200 (lower is better).

Performance is not changing significantly and cannot consistently deliver the target without intervention.

The biggest contributing factors are: 11 - Urological (51*), 07 - Lower GI (43*), 01 - Breast (25*). *Number

Patients

Cancer Care

Cancer 62 Day Performance; Action Plan

Cancer 62d Performance & >62d PTL Patient Actions

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Grip and control of backlog position	• Clear actions outlined in PTL to progress patients. • Close monitoring of treatment booking times • Escalation through operational access meetings for areas of concern	• Cancer Operational lead/ compliance	• Ongoing	• Targeted escalation for patients against agreed thresholds for Histopathology, Radiology and Endoscopy. All diagnostics types now being escalated after a 7 day period. The majority of reporting is completed within 7 days. • 104 review now completed at operational access meetings with 63-104 watchlist being communicated. 104+ diagnostic reporting being escalated for 24 hour turnaround. • A 25/26 annualised plan to meet the Trust's proposed cancer performance trajectories has been developed and will be monitored through a new format Cancer Access group, likely to meet monthly. Programmes of improvement have been identified cross key areas.

Urology treatment capacity	• Limited consultant robotic capacity
	• Limited oncology capacity
		• Urology	• Q3	• Following a period of increased referrals throughout Q4 24/25, resulting in an increased number of patients breaching 62D, the position is now recovering. Patient numbers in the 62D backlog have reduced week-on-week since early June. Development work across Urology includes
				  • Increased surgical capacity with new Kidney surgeon and increased Prostate operating capacity
				  • Business case in progress to support an additional operating robot – considerations for additional staffing to be part of this business case (surgeon, surgical care practitioners)

Oncology provision	• Extended wait times for Oncology • Excessive patient caseload from some Oncologists • Increase chemotherapy treatments per patient	• MTW SLA Agreement	• Q3	• The Trust has supported the required increase in oncology clinical capacity provided by the Service Level Agreement between MTW and EK for the provision of Oncology services to EK. • The revised SLA for the next three years is in the process of being finalised.
Chemotherapy provision	• Ensuring capacity to meet demand • Project planning Aseptic shutdown	• Cancer Services/ Oncology/ Pharmacy	• Q3	• The K&M Cancer Alliance completed a chemotherapy unit capacity and demand review in late June/early July, with recommendations on required capacity expected in September/October. • The aseptic unit shutdown is currently underway, resulting in all chemotherapy drugs now being sourced externally during the refurbishment, with no on-site compounding available. Thanks to meticulous operational planning, there has been no detrimental impact on patient treatment schedules to date. However, this has required significant patient moves and increased rescheduling to maintain continuity of care. Enormous credit is due to the pharmacy and cancer operations teams for their dedication and adaptability in managing this transition and, most importantly, for ensuring patient safety throughout.

Patients

Planned Care

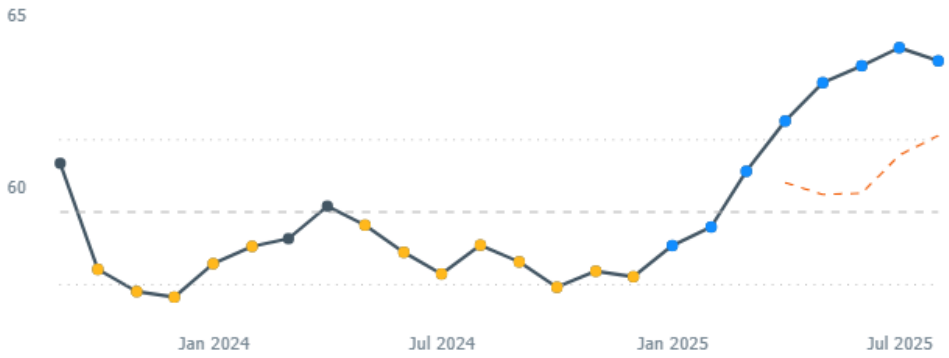
Referral to Treatment Waiting Times; 1st OPA and 52ww Performance

RTT 1st OPA Performance

Timescale	Value	SPC
Sep-24	57.8%	
Oct-24	57.1%	
Nov-24	57.5%	
Dec-24	57.4%	
Jan-25	58.3%	
Feb-25	58.8%	
Mar-25	60.4%	
Apr-25	61.9%	
May-25	63.0%	
Jun-25	63.5%	
Jul-25	64.0%	
Aug-25	63.6%	

XMR Run Chart

Astronomical Point | Two Out Of Three Beyond Two Sigma Group



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/08/2025 the latest RTT 1st OPA Performance performance is 63.6% against a Trajectory target of 61.5% (higher is better).

Performance is statisticaly improving, but cannot deliver the target without further intervention (you may need consider if it is time to recalculate the process limits).

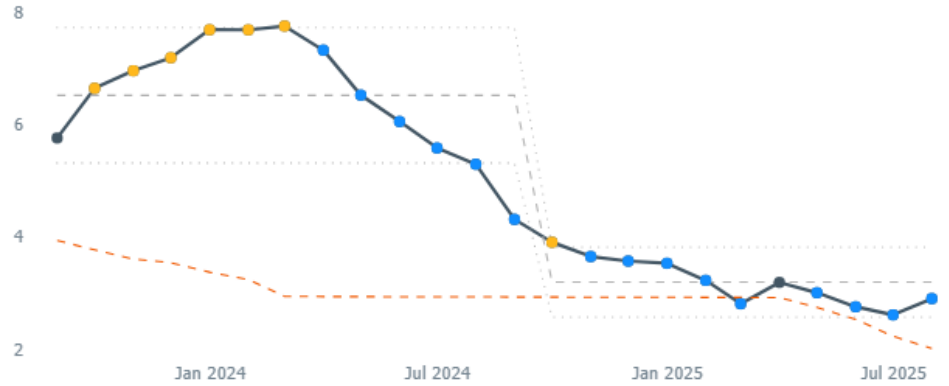
The biggest contributing factors are: 410 - RHEUMATOLOGY (41.9% , 1,970*), 320 - CARDIOLOGY (43.3% , 1,910*), 502 - GYNAECOLOGY (61.0% , 1,650*). *Breaches

RTT 52w Performance

Timescale	Value	SPC
Sep-24	4.3%	
Oct-24	3.9%	
Nov-24	3.6%	
Dec-24	3.6%	
Jan-25	3.5%	
Feb-25	3.2%	
Mar-25	2.8%	
Apr-25	3.2%	
May-25	3.0%	
Jun-25	2.8%	
Jul-25	2.6%	
Aug-25	2.9%	

XMR Run Chart

Two Out Of Three Beyond Two Sigma Group



Understanding the Latest Performance

Improvement flag alerting for 4 periods

For the month beginning 01/08/2025 the latest RTT 52w Performance performance is 2.9% against a Trajectory target of 2.0% (lower is better).

Performance is statisticaly improving, but cannot deliver the target without further intervention (you may need consider if it is time to recalculate the process limits).

The biggest contributing factors are: 110 - ORTHOPAEDICS (1.5% , 6,930*), 120 - EAR NOSE AND THROAT (2.1% , 6,383*), 502 - GYNAECOLOGY (0.5% , 5,741*). *Breaches

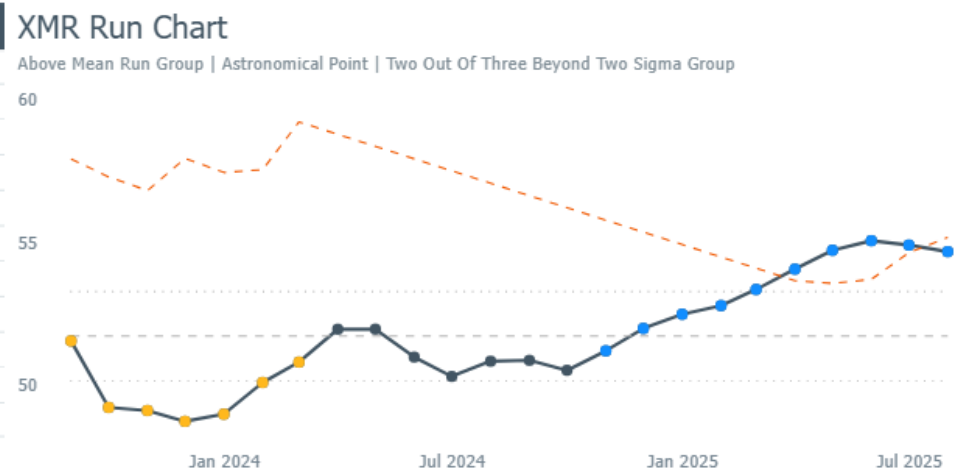
Patients

Planned Care

Referral to Treatment Waiting Times; Incomplete Pathways Performance

RTT Incomplete Performance

Timescale	Value	SPC
Sep-24	50.9%	
Oct-24	50.5%	
Nov-24	51.2%	
Dec-24	52.0%	
Jan-25	52.5%	
Feb-25	52.8%	
Mar-25	53.3%	
Apr-25	54.0%	
May-25	54.7%	
Jun-25	55.0%	
Jul-25	54.9%	
Aug-25	54.7%	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/08/2025 the latest RTT Incomplete Performance performance is 54.7% against a Trajectory target of 55.2% (higher is better).

Performance is statisticaly improving, but cannot deliver the target without further intervention (you may need consider if it is time to recalculate the process limits).

The biggest contributing factors are: 110 - ORTHOPAEDICS (49.2% , 3,579*), 145 - ORAL AND MAXILLOFACIAL SURGERY (43.6% , 3,368*), 320 - CARDIOLOGY (37.5% , 3,317*). *Breaches

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Drive to eradicate 65 week waits and sustain as well as reduce the level of 52 week waits to <1% of PTL from a baseline of 3.6%.	• Weekly clearance against trajectory monitored at Access with clear delivery plans for non-compliance.	• COO	• Ongoing	• Performance shared daily with all specialities, to ensure services are on track against trajectory.
	• Continued drive through daily oversight and management of risk cohort through care group PTL's and into Trust Access meeting.	• COO	• Ongoing	• Weekly Returns/Forecasts shared with ICB/Region • Ongoing clinical engagement, strengthened weekly theatre scheduling and specialty action group meetings. Weekly forward and retrospective review of lists to optimise learning and implement appropriate interventions
	• Theatre programme to improve utilisation to 85% and drive clearance of backlog.	• Dir Planned Care Recovery	• Ongoing	
	• Resetting the Outpatient Improvement Programme	• Dir Planned Care Recovery	• Ongoing	• Continual review of bookings to ensure patients are dated in chronological order and priority.
	• All internal capacity being directed to key risk cohorts from dropped sessions	• All Care Groups	• Ongoing	• Perioperative and Outpatient improvement programmes continue to meet and progress improvements
	• Revised forecast outturn highlights risk to delivery of RTT standards	• All Care Groups	• December	• Enact recovery plans to meet end of year requirements

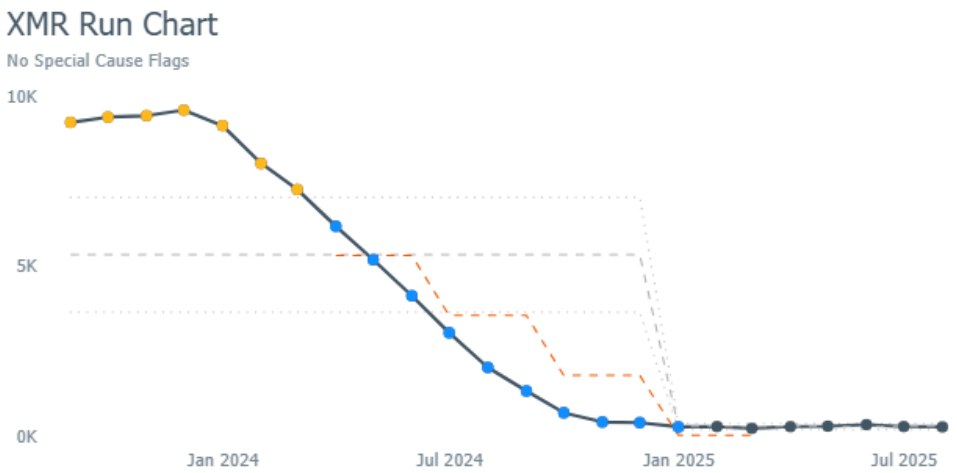
Patients

Planned Care

Endoscopy Backlog; Overdue Surveillance and Routine Waits

Endoscopy Backlog

Timescale	Value	SPC
Sep-24	1,304	
Oct-24	663	
Nov-24	391	
Dec-24	373	
Jan-25	247	
Feb-25	258	
Mar-25	206	
Apr-25	255	
May-25	268	
Jun-25	314	
Jul-25	258	
Aug-25	247	



Understanding the Latest Performance

No Special Cause Variation

There is no target for this measure, and performance is not changing significantly.

The biggest contributing factors are: Dual (76*), Colon (71*), OGD (63*). *Overdue Waiters

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Theatre utilisation and bookings	• Booking staff workforce review completed and discussed in July T&F. Agreement that NHS required until WASP backlog is cleared and then will be reduced. • Business planning agreed for 25/26 to ensure ongoing sustainability.	• Endoscopy GM • HoOPs	• Ongoing	• Activity now sustained at 500 procedures a month (deliberately reduced from previous 550/month) • Forward booking now sustained at 1100 -1400 patients. • Support with substantive posts from workforce review • Reduction in outsourcing spend agreed at £500K for 2025/26
Demand management	• Complex Polyp • GA Activity • WASP Triage	• Endoscopy GM • Clinical Lead • HoOPs	• Ongoing	• A business case is in development, including financial details, to support the growth of the complex polyp service • The above business case will also facilitate increased GA activity at QEQM through the utilisation of Room 4. • WASP triage backlog now fully cleared and regularly monitored through T&F group.
Alternative Diagnostics to support demand	• All three business cases approved to facilitate phase 2 of the Endoscopy recovery plan. • Staffing approved and now out to recruitment for alternative therapies	• Endoscopy GM • Clinical Lead • COO/CNMO/CMO	• Ongoing	• Recruitment of nursing team pending to support service set up • Locations have been confirmed for the commencement of the Transnasal, Cytosponge, and Colon Capsule services.

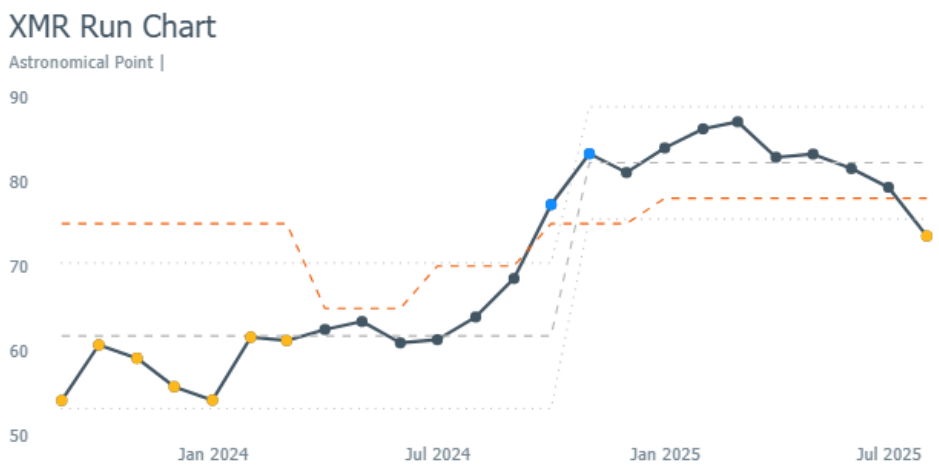
Patients

Planned Care

Diagnostics; DM01 Compliance % Patients Waiting less then 6 Weeks

DM01 Compliance

Timescale	Value	SPC
Sep-24	68.5%	
Oct-24	77.2%	
Nov-24	83.3%	
Dec-24	81.0%	
Jan-25	83.9%	
Feb-25	86.2%	
Mar-25	87.0%	
Apr-25	82.8%	
May-25	83.2%	
Jun-25	81.5%	
Jul-25	79.3%	
Aug-25	73.5%	



Understanding the Latest Performance

ALERT: Variation flag has changed from Common Cause to Concern

For the month beginning 01/08/2025 the latest DM01 Compliance performance is 73.5% against a Trajectory target of 78.0% (higher is better).

Performance is statisticaly declining, and cannot consistently deliver the target without further intervention (you may need consider if it is time to recalculate the process limits).

The biggest contributing factors are: MRI (80.5% , 1,349*), CT (71.3% , 1,298*), Non Obstetric Ultrasound (73.0% , 1,224*).
*Breaches

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Echocardiography Back log	• Ongoing insourcing	• Cardiology GM • Cardiology Lead Clinical Scientist	• Ongoing	• Echo overall finished August at 88.8%, an improvement on last months performance. • Non-achievement driven by complex echo however, waiting list continues to reduce for these modalities. On going echo insourcing continues as part of 25/26 business plans and is anticipated to continue in 26/27 • Activity gap mitigation to be addressed with continued insourcing as required – requires review to ensure maintenance of DM01. • Decline in performance due to some long-term sickness within administrative teams. Now resolving with NHSP in place.
Cardiac MRI Backlog	• Recruitment to vacant consultant posts.	• Cardiology GM	• March 2026	• One post holder goes on mat leave September 2025. One left in June. • Vacancies being interviewed for in October. • Mitigations currently being put in place to sustain current capacity given the above. • Working with radiology to identify potential internal capacity and personnel to improve compliance. • Discussions ongoing around booking processes and chronology, and capacity use. • MTW undertaking non-stress lists to support. • National shortage of adenosine – unable to undertake stress CMRI currently; patients will go to RBH.

Patients

Planned Care

Diagnostics; DM01 Compliance % Patients Waiting less then 6 Weeks

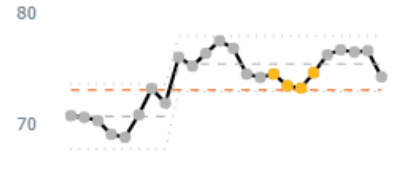
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
MRI	• Centralisation of Radiology booking team • Review process for patients being referred who require sedation or GA's • Radiology service managers and radiology pathway navigator roles have been recruited to • Develop a departmental standard for vetting • Develop a robust standard for consultant rotas within a 6 week period • Review the interpreting policy	• General Manager - Radiology	• 8-12 weeks	• Effective 22/09/25 Radiology bookings team was centralised to the patient service centre, this will: - Maximise the booking workforce to support DMO1 compliance - Reduce DNA rates in the booking of multiple diagnostic imaging without the results of another within a short timeframe - The standardisation of allocation of patients per scanner, to maximise utilisation in minutes - Ensure cancelled patients are rebooked within a timely manner when there is scanner downtime • Update of access policy to support patients being referred for diagnostic imaging without preassessment or best interest meetings • **The service managers & navigators will:** - Liaise with cancer services to ensure diagnostic imaging is booked within national timeframes for compliance - Support with allocation of vetting in a timely manner to ensure the bookings team have a flow of patients to book - Liaise with the booking team to ensure patients are not cancelled due to downtime of equipment and transferred to other sites (where possible) • Departmental standards for vetting will ensure there is daily flow with the number of imaging to be vetted • Timely access to consultant rotas supports the access policy and the ability to book within DMO1 • To provide timely access in line with Accessible Information Standards (AIS) to minimise the wait times of patients who require a interpreter
Non-Obstetric Ultrasound	• Review the policy supporting chaperones for most procedures given the Radiology Department Assistant (RDA) workforce • Review the choose and book policy • Review job plans with clinical lead for US service	• General Manager - Radiology	• 8 weeks	• The absence of chaperones have increased the backlog of 9 weeks for US pelvis' • Choose and book are amongst the longest waiters within the speciality, plan to review the policy and discuss with the ICB over the next 4 weeks • The review of job plans will allow for an increase in activity for the US backlog, as there are procedural rooms at WHH which are under utilised
CT (inc Cardiac)	• Spencer Hospital have agreed to double their capacity in undertaking CT Cardiacs • Review equipment downtime and servicing requirements • Review the slot times associated with procedures	• General Manager – Radiology	• 6 weeks	• There is a meeting next week with the managing director for spencer wing to ensure this action progresses • Radiology GM to meet with Cardiology GM to discuss new ways of working to review if there is capacity to increase activity through consultant job plans • The downtime of CT's have contributed to a number of cancellations, where we have had to book beyond. Service managers with be supported by the modality leads to ensure this happens • Procedural rooms are underutilised at KCH though the workforce are available, due to inaccuracies with time frames for procedures associated with each slot - new booking process to be implemented

Patients

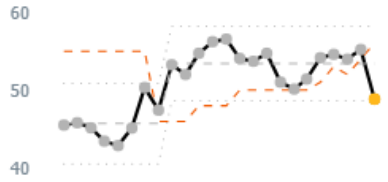
Trend Analysis

Patient Domain Metrics

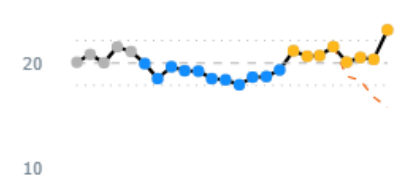
ED Compliance



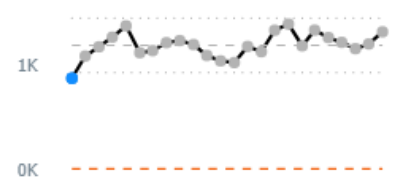
Type 1 Compliance 4hrs



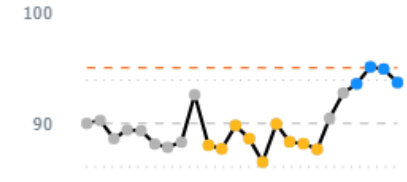
12 Hr Total Time in Department



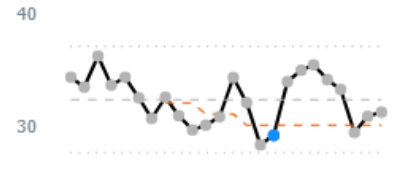
12Hr Trolley Waits



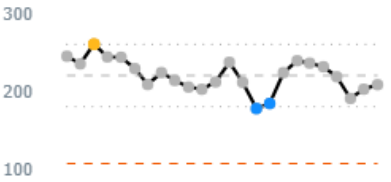
Ambulance Handovers within 30m



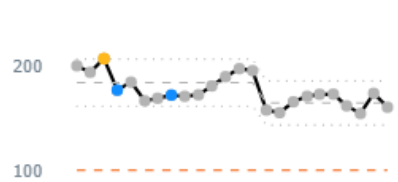
% Beds Occupied 14+



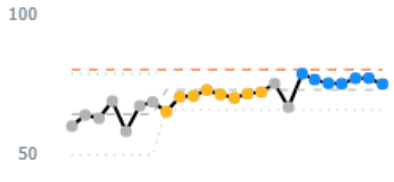
Super Stranded >21D



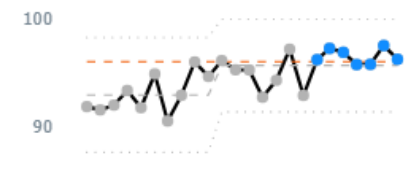
Not Fit to Reside (pats/day)



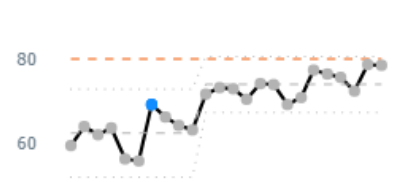
Cancer 28d Combined Performance



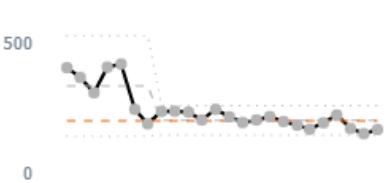
Cancer 31d Combined Performance



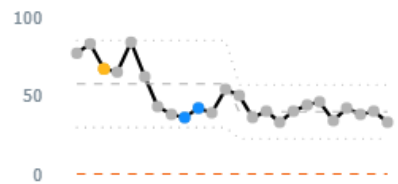
Cancer 62d Combined Performance



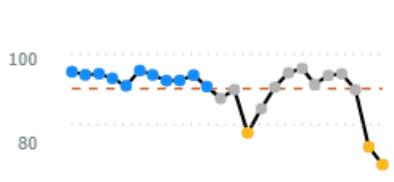
Cancer Over 62d on PTL



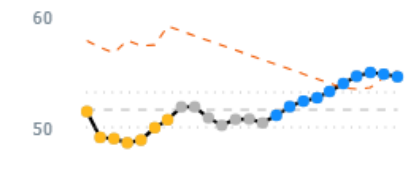
Cancer Over 104d on PTL



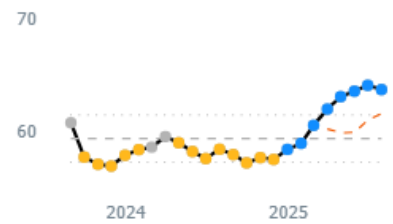
Cancer Rapid Access Perf



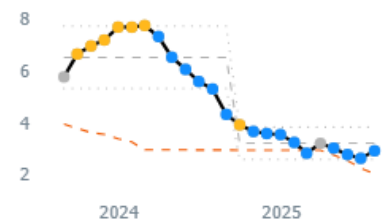
RTT Incomplete Performance



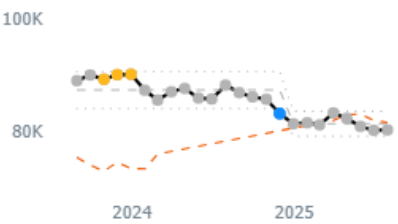
RTT 1st OPA Performance



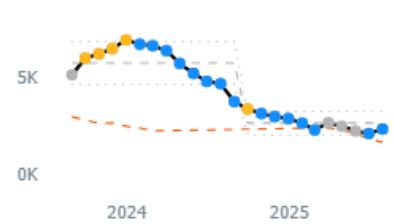
RTT 52w Performance



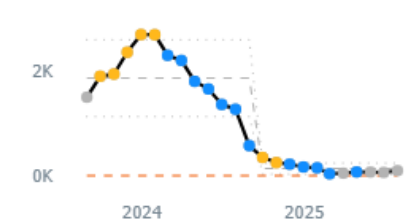
RTT Total Incomplete Pathways



RTT 52w Breaches



RTT 65w Breaches

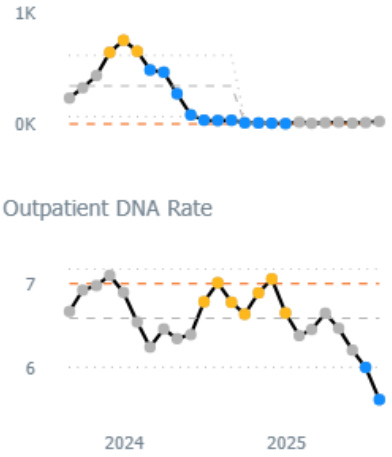


Patients

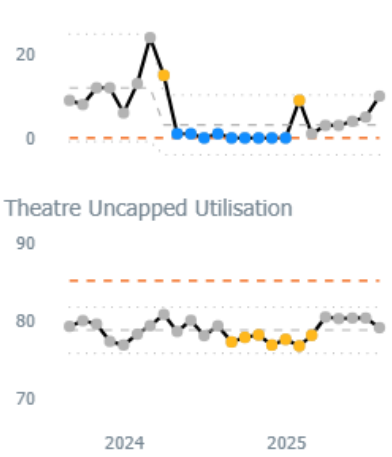
Trend Analysis

Patient Domain Metrics

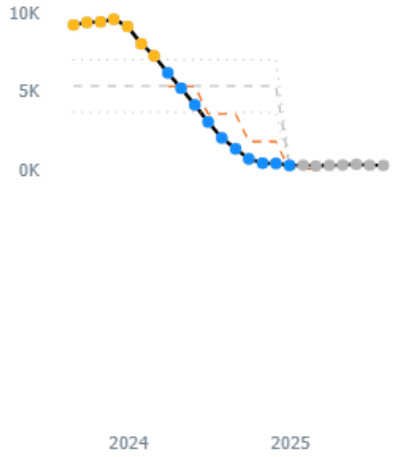
RTT 78w Breaches



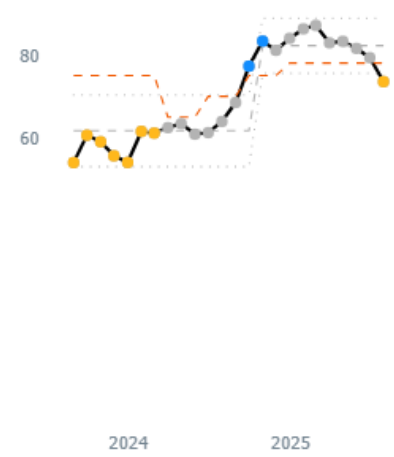
RTT 104w Breaches



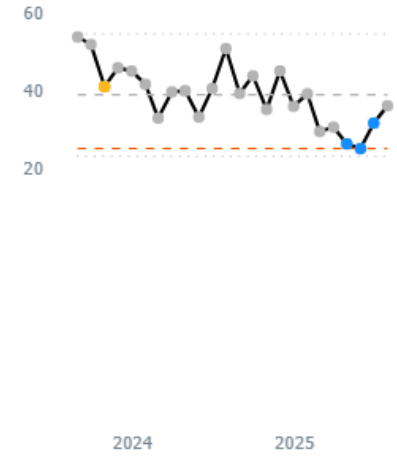
Endoscopy Backlog



DM01 Compliance



Theatre Session Opp.



Outpatient DNA Rate

Theatre Uncapped Utilisation

Quality and safety

Assurance

Variation

	P — Will consistently pass the target if nothing changes	? — Will not consistently pass or fail the target if nothing changes	F — Will consistently fail the target if nothing changes
H / L — Improving Variation (High or Low)		Complaint Response Complaints Number Duty of Candour - Verbal IPC: Pseudomonas Infections Never Events PSII - National VTE Assessment Compliance	AARs Overdue HSMR
No Significant Change	After Action Reviews (AARs) FFT Satisfaction Level - Outpatient	Duty of Candour - Findings Duty of Candour - Written 15wd Falls with Harm FFT Satisfaction Level - Inpatient IPC: CDiff Infections IPC: EColi Infections IPC: Klebsiella Infections IPC: MRSA Infections IPC: MSSA Infections Mixed Sex Breaches Patient Safety Incidents Patient Safety Incidents - Mod/Sev Pressure Ulcers	FFT Satisfaction Level - ED Overdue Incidents
H / L — Concerning Variation (High or Low)	NICE Compliance Safeguarding Adults Training Safeguarding Children Training	SHMI	

Quality and safety

Scorecard View

Incident Reporting, Compliments/Complaints & Safeguarding

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Quality	NAT		Patient Safety Incidents			2,385	1,893	2,114	2,085	2,002	2,181	1,974	1,982	2,176	2,013	2,073	2,300	1,875
	NAT		Patient Safety Incidents - Mod/Sev			65	33	47	39	37	39	62	50	50	36	44	50	61
	KEY		Overdue Incidents			0	688	659	734	757	974	1,202	1,160	965	756	728	813	994
	NAT		PSII - Local			0	0	0	2	0	2	2	2	2	1	1	1	1
	NAT		PSII - National			0	2	2	1	1	0	0	1	1	1	0	0	0
	NAT		After Action Reviews (AARs)			0	5	7	14	15	8	12	13	8	9	9	14	6
	NAT		AARs Overdue			0	23	24	26	25	35	37	42	39	35	25	31	24
	NAT		Never Events			0	2	1	0	0	0	0	0	0	1	0	0	0
	NAT		Duty of Candour - Findings			100%	94.6%	93.8%	100%	100%	100%	100%	100%	90.9%	100%	96.7%	100%	100%
	NAT		Duty of Candour - Written 15wd			100%	88.5%	96.4%	97.2%	100%	100%	96.0%	100%	96.3%	100%	95.5%	87.5%	100%
	NAT		Duty of Candour - Verbal			100%	100%	95.8%	97.1%	100%	100%	96.3%	100%	100%	100%	100%	94.4%	100%
	KEY		Complaints Number			144	90	85	83	94	117	99	97	117	130	129	160	98
	KEY		Complaint Response			85.0%	31.6%	54.1%	71.4%	84.2%	86.1%	87.3%	86.0%	87.5%	85.3%	86.3%	85.4%	89.9%
	NAT		FFT Satisfaction Level - ED			90.0%	83.9%	82.4%	81.3%	81.4%	82.7%	81.8%	84.7%	87.2%	86.7%	84.3%	83.2%	82.2%
	NAT		FFT Satisfaction Level - Outpatient			90.0%	95.7%	95.3%	95.7%	95.7%	96.0%	95.7%	95.4%	95.6%	95.2%	95.5%	95.4%	96.1%
	NAT		FFT Satisfaction Level - Inpatient			90.0%	89.4%	88.9%	91.3%	91.2%	89.2%	88.5%	91.4%	92.1%	92.8%	90.5%	90.4%	89.2%
			SJRs Outstanding													777	732	665

Quality and safety

Scorecard View

IPC, Patient Safety & Mortality

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Quality	NAT		Safeguarding Incidents			57	31	33	38	34	16	25	31	24	32	35	35	23
	NAT		Safeguarding Children Training			90.0%	91.2%	91.3%	91.5%	91.7%	91.7%	91.4%	90.9%	91.1%	90.9%	90.7%	90.5%	91.1%
	NAT		Safeguarding Adults Training			90.0%	92.7%	93.0%	93.1%	93.3%	93.3%	92.9%	92.5%	92.4%	92.4%	91.9%	91.7%	92.4%
	NAT		IPC: EColi Infections			12	16	9	9	13	14	12	10	13	11	17	12	12
	NAT		IPC: CDiff Infections			8	12	11	11	9	11	8	11	7	8	9	5	13
	NAT		IPC: Klebsiella Infections			6	11	5	6	9	6	5	9	5	1	1	5	7
	NAT		IPC: Pseudomonas Infections			2	4	2	7	4	5	1	2	0	2	2	1	2
	NAT		IPC: MRSA Infections			0	0	0	1	0	0	0	0	1	1	0	0	0
	NAT		IPC: MSSA Infections			6	8	5	2	7	9	11	13	5	6	9	4	5
	IIP		Falls with Harm			15	5	7	10	8	1	7	11	2	2	7	1	6
	IIP		Pressure Ulcers			120	77	96	85	85	119	101	101	110	79	76	69	69
	NAT		Mixed Sex Breaches			149	57	68	52	65	92	33	49	118	133	109	86	50
			Theatre recovery Mixed Sex Breaches			2	0	0	0	0	0	0	0	0	7	0	0	1
	KEY		HSMR			96.0	102.1	101.1	101.3	100.1	99.3	100.3	99.8	100.7				
	KEY		SHMI			1.070	1.140	1.140	1.142	1.127	1.114	1.126	1.126	1.119				
	NAT		VTE Assessment Compliance			95.0%	93.9%	94.4%	94.0%	92.9%	94.0%	94.7%	94.2%	94.9%	94.9%	95.7%	94.8%	95.0%
			NICE Compliance			90.0%	50.0%	62.9%	63.4%	74.6%	83.1%	91.9%	98.5%	98.5%	98.5%	96.4%	96.5%	93.2%

Quality and safety

Executive Summary

Patient Safety Incidents & Duty of Candour

Patient Safety Incident Investigations

Incidents are reviewed and investigated under the Trust's Patient Safety Incident Response Framework (PSIRF) Policy and Plan. There are national requirements for which a patient safety incident investigation (PSII) is required; and local requirements where the complexity and the potential learning is deemed to warrant a detailed systems patient safety incident investigation (PSII) is required; and local requirements where the complexity and the potential learning is deemed to warrant a detailed systems causes, and is guided by the principle that people are well-intentioned and strive to do the best they can.

The Trust at the end of July had:

Six (6) nationally reportable PSIIs are ongoing: 1 NE, 1 medication incident identified through LfD, and 4 Maternity and Neonatal Safety Investigations (MNSI).

Eleven (11) Local PSIIs (Three are overdue- two of which are at the final executive approval stage, and one has a date for LRAP booked)

Six (6) externally led investigations which require Trust support

There are currently fifty (50) open AAR's, with eighteen (18) closed in August and six (6) new AARs commenced. Twenty-four (24) are overdue for completion, Quality Governance staff continue to support clinical handlers responsible for completion of the AARs. Progress with AARs is included in the weekly report to executives.

Overdue Incidents:

The number of overdue incidents increased to 994 in August. Despite ongoing work to action and close overdue incidents by the governance teams, a total of 634 incidents became overdue in August. The weekly overdue and anomalies report to QGBP's which is shared with the Tri's, contains information regarding the number of incidents about to become overdue, to support prioritisation within the care groups. The standard operating procedure (SOP) for Incident Management is in place, which aims to ensure that, where necessary, bottlenecks for handlers are identified and managed, and there is oversight (and action) at the appropriate level within the Care Group structures to facilitate timely closure. Governance staff are meeting regularly with handlers with high numbers of overdue incidents to support closure. A review of incidents overdue by 6 months or more has identified that there is a small proportion of incidents open for justifiable reasons, such as safeguarding reviews awaiting KCC outcomes and AAR or PSIIs that are being undertaken.

In terms of monitoring via the PRM we expect to see a month on month reduction for incident closure with an aim to achieve around 400 remaining open by April. It is reasonable for an organisation with a high volume of incident reporting to always have some open incidents.

The expectation is that clinical teams work to show a month on month improvement and the Quality Governance teams are supporting those with high volume and targeting those specific care groups.

Duty of Candour:

In August Doc was 100% compliant for all three components (verbal, written and findings). Weekly reports on DoC due and current compliance is sent out to QGBP's and DQG, to maintain oversight of compliance. Monitoring and compliance continues to be shared in the weekly report to executives to provide assurance.

Never Events:

No new Never Events we reported in August 2025. There is currently one (1) ongoing Never Event PSII investigation due for completion 21/10/2025.

A national comprehensive review of the Never Events framework is being undertaken. Organisations have been advised that rather than automatically undertaking a PSII for Never Events, they should consider the most appropriate proportionate response under the PSIR Framework to investigate the event.

Quality and safety

Executive Summary

Systems Update, Safeguarding & Patient Privacy

Safeguarding :

As a Trust we are bench marked against the national standard of 85%. Our overall training compliance has returned to above 85% on all levels . The professional group with a non-compliant position are the medical and dental staffing groups. We are beginning to see an increase from previous months the overall position is 76.7% for safeguarding children and 68 % for safeguarding adults. This risk is identified on the corporate risk register CR3733 and there have been appropriate escalations through the Care Group PRMs. There is adequate training capacity for all staff to complete the required courses, additional training has taken place for the junior doctor workforce, and more is planned for September and October .

The team are currently monitoring Maternity Safeguarding supervision; levels have improved for August there remains consideration for additional themed supervision sessions if compliance is not improved October

Mixed Sex Breaches

51 breaches occurred in the month.

- There was a decrease in the number of patients being unable to be stepped out of QEQM critical care unit to 8 however there was a also a breach with a critical care patient needing to be transferred to the recovery area in theatres to enable another patient to be admitted to the unit. At WHH the number increased by one to 32 patients being unable to be stepped out within the four hours. All the patients at KCH were stepped out within the four-hour timeframe expected, resulting in 0 breaches.
- SDEC reduced to 10 breaches, with the reconfiguration of services on the QEQM site there is a clear plan for this to be resolved by the end of September 2025.

Infection Prevention and Control:

HCAI trajectories for August 2025 are slightly high for E.coli , C-Dif and MRSA (MRSA 2 cases to date – one in April and one in May).

There was 1 C -dif PII in August 2025, 13 C. diff cases (2 confirmed linked infections WHH. All actions taken and no further cases). 12 cases of E.coli with no obvious linked cases. Klebsiella, 7 cases and Pseudomonas 2 cases.

3 c-dif cases identified on a surgical ward at WHH – 2 confirmed cross infection, full investigation and actions taken place, full ward declutter and clean completed, no further cases.

The IPC team are focussing on working collaboratively with the 'CLEANTogether' campaign focussing currently on decluttering and management of laundry and linen, with ongoing focus on wide range of 'back to basics' related to the environment.

Wards and departments have been reminded to focus on patient hydration / urethral catheter care to support a reduction in E.coli cases.

Executive Summary

Infection Prevention Control

Infection Prevention and Control (con't):
The healthcare associated infection (HCAI) objectives for 2025/26 were issued in June 2025, and a number of the set objectives will prove challenging for the Trust, in particular, C. difficile as in 2024/25 the Trust achieved 105 against an objective of 145. HCAI objectives for 2025/26:

- C difficile 98 (145 in 2024/25)
- E. coli 141 (160 in 2024/25)
- Klebsiella 76 (77 in 2024/25)
- Pseudomonas 24 (24 in 2024/25)
- MSSA 83 (5% reduction on cases in 2024/25 at 87)
- MRSA zero tolerance

Quality and safety

Safe Care

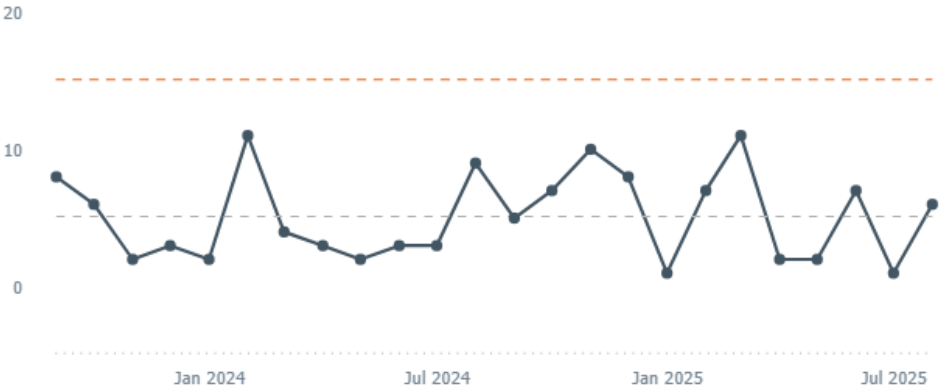
Patient Falls with Moderate or Above Harm Recorded

Falls with Harm

Timescale	Value	SPC
Sep-24	5	
Oct-24	7	
Nov-24	10	
Dec-24	8	
Jan-25	1	
Feb-25	7	
Mar-25	11	
Apr-25	2	
May-25	2	
Jun-25	7	
Jul-25	1	
Aug-25	6	

XMR Run Chart

No Special Cause Flags



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/08/2025 the latest Falls with Harm performance is 6 against a (6 Sigma Threshold) target of 15 (lower is better).

Performance is not changing significantly and cannot consistently deliver the target without intervention.

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
10% trajectory for reduction in falls for 2025/26 – 4 falls in August resulted in moderate harm. 2 falls declared resulting in severe harm 1 within Maidstone renal satellite unit and the other 1 in the SECAMB ambulance on route to the Trust.	• Focussed work in areas with highest number of falls, using MDT approach.	Falls lead/ Care groups	September 2025	• Falls discussed at the August Steering Group and Fundamentals of Care Committee. • Patient safety week and Falls Awareness week 15th September – 19th September, identified hot spot areas to pilot of Dynamic Risk Assessment.
	• Supporting clinical areas with actions within the Trust Wide Improvement Plan.	Falls lead	March 2026	• Themed learning assisted in defining actions for individual areas with action plans. Ongoing action.
	• Development of a Falls Service Level Agreement (SLA)		September 2025	• SLA developed to be shared with care group feedback prior to implementation.

Safe Care

Falls with Harm; Actions Table

Falls with Harm (con't)

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
MFRACP risk assessments are not always fully completed in a timely manner.	• Falls dashboard to be created to include MFRACP completion, including time of medical reviews, radiology reports and status of clinician completing review.	Falls Lead	June 2025	• IT agreed and in queue for Sunrise amendments.
	• Simplify the risk assessment process through triangulation of FOC services within one document to enable fluid streamline documentation into the risk assessment.	FOC lead nurses/IT sunrise	January 2026	• Meeting arranged 2nd October 2025 between Sunrise team and FOC lead nurses.
Identified gap in knowledge regarding undertaking Dynamic Risk Assessments and redeployment of staff as patient's acuity and dependency changes during shift	• Dynamic risk assessment to be developed to support staff with managing shift and mitigation	Falls Lead/ADoN FoC/ADON WDET	September 2025	• 1st draft risk assessment piloted on identified hot spot clinical areas in falls awareness week and patient safety week 15th September – 19th September
		Falls Lead/ADoN FoC/ADON WDET	September 2025	• Feedback sourced to be shared with DCN and ADON WDET.
	• To provide training and education on Dynamic Risk Assessment (DRA) supporting the allocation of staff in real-time safety practice to provide mitigation as conditions change within the shift .	Falls Lead/ADoN FoC/ADON WDET	September 2025	• First simulation training package for DRA to be delivered at Clinical leader away day September 2025.
			October 2025	• Once approved to be presented at NMEC

Quality and safety

Safe Care

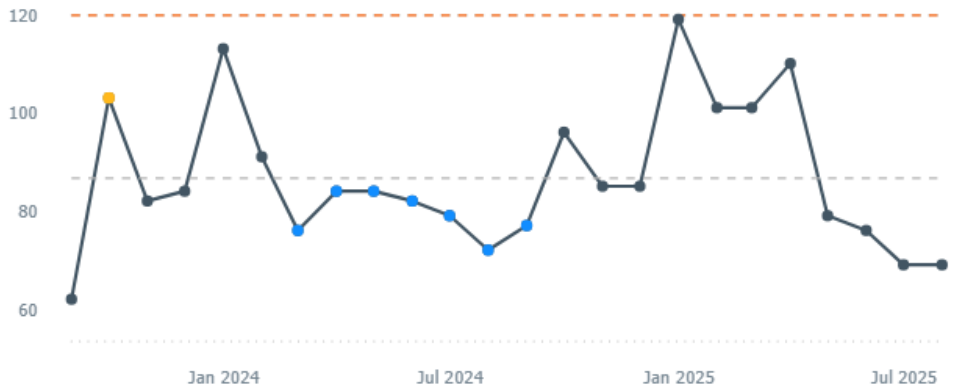
Pressure Ulcers; Hospital Associated

Pressure Ulcers

Timescale	Value	SPC
Sep-24	77	
Oct-24	96	
Nov-24	85	
Dec-24	85	
Jan-25	119	
Feb-25	101	
Mar-25	101	
Apr-25	110	
May-25	79	
Jun-25	76	
Jul-25	69	
Aug-25	69	

XMR Run Chart

No Special Cause Flags



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/08/2025 the latest Pressure Ulcers performance is 69 against a (6 Sigma Threshold) target of 120 (lower is better).

Performance is not changing significantly and cannot consistently deliver the target without intervention.

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
A cluster of section 42 concerns from the local authority, regarding category 3 or above pressure ulcers, reported April-June.	• To be part of a working group through the Kent and Medway network to look at wider issues across the system to improve outcomes for patients in relation to pressure ulcer prevention. • To strengthen and formalise the weekly Adult Safeguarding meeting to include any section 42 concerns. • To have shared data collection spreadsheet to inform both the Tissue Viability and Adult Safeguarding teams. • To ensure outcomes of Section 42 inquiries are fed back to Tissue Viability team and other relevant members of the MDT. • Learning from Section 42 inquiries to be fed back by Care Groups at TVSG. • Associate Director of Safeguarding to liaise with DATIX System Manager regarding creating a Section 42 report	Tissue Viability Lead Tissue Viability & Adult Safeguarding teams Associate Director of Safeguarding Care group ADoNs Associate Director of Safeguarding	January 2026 October 2025 September 2025 November 2025	• Second Pressure Ulcer Task and finish group meeting being arranged by the ICB in due course. • Formalised weekly safeguarding meeting with a structured agenda & shared spreadsheet to include discussions regarding any Section 42 inquires. To trial the impact & effectiveness of this for 3 months. Ongoing action- spreadsheet now in use • Feedback form for steering group has been amended to include learning from section 42 incidents. A member of the Adult Safeguarding team has also been formally invited to attend TVSG. Next meeting scheduled for 17/9/25. • Lead TVN to contact Associate Director of Safeguarding for an update.

Quality and safety

Safe Care

Pressure Ulcers; Action Table

Pressure Ulcers (con't)

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Increased pressure damage noted due to long gaps in repositioning. Contributing to the development of unstageable and moderate harm pressure damage.	• To review current foam mattresses and tender for replacements to ensure all mattresses are of higher specification for higher risk patients. • To review equipment to assist staff in repositioning complex patients, meaning fewer staff are required to reposition these patients appropriately .	Manual Handling & TV Leads Manual Handling Team Manual Handling Lead	September 2025 September 2025 October 2025	• Update at Bed & Mattress meeting September 2025-. Awaiting further information from the company prior to acquisition of new mattresses. • Manual Handling lead is sourcing funding to progress Tubular slide sheet trial. Email sent to CNMO requesting funding to commence the trial. • Manual Handling team to raise awareness of available equipment for repositioning. • Trial to commence on improved patient chairs on 26th August 2025, to run until January 2026. Initial feedback to be presented to FOCC in October 2025. Meeting to discuss barriers to progressing trial to be held 17/9/25.
An increase in heel damage has been noted in the months of April and May with an identified lack of appropriate heel offloading technique.	• Trust wide heel offloading campaign as part of National Stop the Pressure Awareness week & Site based study days (Sept & Oct) to highlight appropriate offloading techniques. • To liaise with Ward Accreditation team to adapt current heel offloading question to focus on effective offloading technique. • Heel offloading compliance and technique audit to be repeated in 6 months.	Tissue Viability Team	November 2025 November 2025 December 2025	• Full Heel Offloading Audit to be presented at FOCC on 23rd September 2025. • Audit was presented in July's TVSG for Care group representatives to disseminate to clinical staff the importance of effective heel offloading techniques.
A consistent theme in audits and incidence data is that risk assessments are incomplete or inaccurate leading to delayed pressure ulcer prevention strategies.	• Risk assessment documentation on admission and dynamic assessments during admission to be reviewed. • Review the Risk assessment process on Sunrise to only save when risk assessment is complete. • Simplify the risk assessment process through triangulation of FOC services within one document to enable fluid streamline documentation into the risk assessment.	TV lead/Chief Nursing Information Officer FOC Lead Nurse/Sunrise team	September 2025 December 2025 January 2026	• Meeting to be arranged between Sunrise team and lead nurses for FOC to discuss simplifying the risk assessment process. • Following meeting with Sunrise team, IT change forms have been completed to make PURPOSE-T completion mandatory & DFRAT placed in separate document. IT Request placed to enable patient/staff alert for patients with pressure damage on Sunrise & email alerts to TV team. • Icon for PTL boards has been added to review list at part of rebuild of whiteboards by IT team. To follow up previous emails for update. • Meeting arranged 2nd October 2025 between Sunrise team and FOC lead nurses

Quality and safety

Safe Care

Pressure Ulcers; Action Table

Pressure Ulcers (con't)

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Missed opportunities for earlier skin inspection and escalation of pressure damage.	• Focus on reporting of category one damage. • ED working group to review initial skin inspection in Emergency Departments • TV team looking at individual actions from recent hospital acquired incidents for shared learning across the trust. • Dynamic risk assessment to be developed to support staff with managing shift and mitigation	Lead Tissue Viability Nurse ED Tissue Viability Team Falls Lead/ADoN FoC/ADON WDET	September 2025 November 2025 November 2025	• Newly updated TWIP includes action for matrons/ward managers to role model categorising of 1 & 2 pressure ulcers. TVSG 9/7/25 feedback- to ensure actions for wards are clear- to create separate tab for ward owned actions for ease. To discuss at TVSG 17/9/25. • First ED working group took place 25/6/25-, however good discission regarding progress ED are making to improve pressure ulcer prevention; lots of positive work to improve skin inspection & documentation, tracker board now set up to highlight at risk patients. Second meeting scheduled for 20th September with focus being on initial skin inspection and utilising medical photography. • 1st draft completed, meeting with wider FoC to be arranged to approve assessment tool. Once agreed will need to be presented through governance processes, Falls Steering Group (FSG) and Fundamentals of Care Committee (FoCC) and NMEC. As part of patient safety week- risk assessment is being trialled on high areas of falls.
Medical device related pressure ulcers at QEQM & WHH	• Provide a targeted approach based on learning from incidents involving face to face training in the appropriate clinical areas • Trials of medical devices/fixation devices to help reduce Medical Device Related Pressure ulcers • Improve ability to evidence repositioning of medical devices.	Matron for ICUs	October 2025	• Trials completed of NG fixation device at WHH, education & support to be offered to QE & K&C ITUs. A reduction in incidence at WHH ITU has been noted as a direct result of the NG trial. Due to incidents of NG securing device not retaining tube, an alternative method of securing is being reviewed. • Rotary ward are presenting at TVSG 17/9/25 on how they have reduced incidents of MDRPUs. • Medical device care guide has been disseminated to all clinical areas. • The tissue viability team have been working with procurement to provide clinical areas with the catheter securing devices to secure the SRC tubing avoiding pressure to the skin. Discussed at recent PAG to explore alternative products.

Quality and safety

Safe Care

Patient Safety Incidents

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Patient Safety Incident Response (PSIR) Framework.	• Annual review of PSIRF policy to update in line with changes to process and updated national guidance on track for completion in September 2025. • Patient safety training programme in place: PSIRF, Swarm, AAR, Incident Investigation, Engagement/Duty of Candour, Human Factors. • The Patient Safety Partners policy is awaiting chairs approval from Operational Quality Governance. , The Job description is finalised and the roles advertised, with interest received. The plan to recruit two Patient safety Partners by end of September. • Training compliance with level 1 of the patient safety syllabus is 92.4% Trust wide, which is above the 85% KPI. Specialties that are non-compliant have been escalated to Care Group Triumvirates and QGBP's.	• Head of Patient Safety and Improvement	30/09/2025	• Weekly report to Executives includes details of PSIIs. • Training Needs Analysis in place. A review of training content has been completed to align with the patient safety syllabus. • Incident Investigation, Swarm and AAR training dates are available on to book on ESR
One local PSII was commenced in August 2025 (IV medication administration incident)	The incident was presented at IRP by CCASS care group • Incident referred to Coroner (inquest case) • DoC has been completed with the NoK • The development of ToR for investigation has been completed • The investigation is led be CCASS and DHOPS	• Head of Patient Safety and Improvement	19/12/2025	Immediate actions: • To ensure the administration of all intravenous infusions are checked and completed by two competent practitioners. • This MUST follow the 7 steps of medication administration as per the Trust Medicines policy. • Separate drip stand required for Noradrenaline • Being raised to senior teams across all three units and to be discussed at daily safety huddles on all units • Updates will be provided in the weekly report to executives.

Quality and safety

Safe Care

Infection Prevention Control & Patient Privacy

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Themes and Trends from patient safety events	• Three (3) Delay/Failure incidents resulting in severe harm (Two discussed at Pre-IRP, with one pending discussion: one aligns with delay/Failure theme work and will be for M&M discussion, one has local learning actions identified) • Tissue viability was the top category for incidents reported in August (482 reported). Of these, admitted with grade 2 PU (186), admitted with other ulcers (not pressure related (43) and admitted with grade 1 PU (38) were the top sub-categories. • The second most reported category was care/treatment incidents (205). The top subcategories were Delay in providing treatment (82), Inappropriate treatment (49) and lack of nursing care identified (33). These have all decreased in numbers compared to previous months data. Eight (8) Care/Treatment incidents were reported as moderate harm, with five (5) discussed at Maternity Rapid Review, and three (3) at Pre-IRP to identify proportionate learning responses.	• Head of Patient Safety and Improvement	30/09/2025	• Trends and themes of reported patient safety events are reviewed monthly and reporting in the Quality Governance report. • Deeper analysis of themes and trends are completed annually to inform the PSIRF plan.
IPC processes across all sites to focus on the reduction of avoidable infections. Thresholds for 25/26 have challenging trajectories, with no more than 98 C. diff cases.	• Environmental and equipment reviews continue • "CLEAN Together" campaign commenced end of April 2025 in collaboration with 2gether and focus on cleaning and decluttering. • Ongoing IPC audits of environment and clinical practices.	IPC Team	Ongoing and measured against monthly trajectories to achieve below 25/26 year end.	- Post infection reviews continue to identify learning - Trust wide review of products used for disinfection and cleaning - Trust wide review of roles and responsibilities for cleaning in process - Trust wide awareness activities around hand hygiene
Mixed sex breaches	• Ward/department moves to occur to enable single sex areas.	• DoN QEQM	• September 2025	• Ward moves occurred. Area now running as single sex.

Quality and safety

Safe Care

Patient Experience; Friends & Family Test (FFT)

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
FFT ED: satisfaction levels remain below the Trust target of 90% satisfaction. Not all patients currently have their communication needs identified and recorded (i.e. those arriving by ambulance)	• Process to identify communication needs of patients arriving by ambulance.	• ED Managers	• By July 2025	**Completed:** • During the registration process, reception staff now ask whether the patient has any communication needs. • If communication needs are identified, they are recorded in the Patient Administration System (PAS). • This information is visible in the Sunrise system, ensuring clinical teams are aware of any requirements. • Logged if SECAmb have identified communication needs – process for those arriving via ambulance still under review
Limited use of telephone interpreters by ED (concerns that family are being used to interpret)	• Staff to be made aware of the importance of using interpreters, especially to gain consent, explain diagnosis and treatment.	• ED Managers with support from Trust interpreting lead	• By May 2025	**Completed:** • New posters promoting the BSL video on demand have been displayed in all areas of ED and UTC on both sites. • Webcams in place for the ED and UTC on both sites to support staff to use BSL video interpreting on demand.
Long waits in ED after triage to be treated remain a source of patient dissatisfaction. Patients are not always kept updated on waiting times.	• Improve communication with patients in ED waiting for treatment but not waiting to be admitted (e.g. Patient information app at WHH)	• ED Matron and senior nurses	• By June 2025	**Completed:** • The ED team has created a patient information platform, which was successfully trialled and is now in use. • Patients can access relevant information about their Emergency Department journey, including waiting times and other key updates.
Care in escalation areas remains a source of negative feedback.	• Comfort packs for patients being cared for in escalation areas. Family to be sign-posted to Carers Support Hospital Service. Carers Leaflet available.	• Assoc Directors of Nursing for UEAM / Heads of Nursing, plus, ED teams to signpost to support for carers	• By July 2025	• Charity application made for care packs for patients with learning disabilities and/or autism, to use in EDs. **QEQM LoF have declined to fund, suggesting a pilot at WHH first. Waiting to hear from Friends of WHH** • We have secured funds for an Information display screen to be put up in the main waiting room in ED at WHH which will display wait times etc. **This action has been delayed.** The Communication Team and Operational Team have not yet agreed the formatting and data sourcing • Carers Support Hospital Service leaflet circulated to DoNs and UEAMs • Screens arrived and waiting to be fixed by estates.
Patient flow through EDs impacts on clinical care and patient outcomes (mobility / skin integrity).	• New Linet trollies to be piloted in ED (to reduce pressure ulcers / falls) • Additional sleeper chairs for side rooms to enable a carer / family member to stay overnight where the patient needs a familiar person to support their care.	• Lead for Moving and Handling /Lead for Tissue Viability • Assoc. Director of Patient Experience / DoNs of K&CH, QEQM and WHH and UEAM senior teams	• By April 2025 • By September 2025	• **Completed**: 4 Linet trollies in use at WHH. • Charitable funding bid to be made for 5 sleeper chairs at each of the three main sites. QEQM LoF has approved the bid. Waiting for decision from Friends of WHH. K&CH LoF meet on 8.10.25 to discuss.

Quality and safety

Safe Care

Patient Experience; Friends & Family Test (FFT)

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
FFT Inpatient: satisfaction levels remain around the Trust target of 90% satisfaction, dipping slightly in January and February 2025. There are significant disparities between satisfaction levels at the three sites, with K&CH scoring much higher than WHH and QEQM. Patient experience once on a ward can be poor (e.g. being moved several times, lack of handover of key information). Lack of carer / family involvement is an on-going theme.	• New inpatient survey to be developed to capture feedback whilst patients are with us (youth volunteers to support getting feedback).	• Patient Voice and Involvement team / Volunteer service	• By end of May 2025	**COMPLETED**: first group of youth volunteers trained. Survey is now live. Youth volunteers started to gather feedback from the last week in May 2025. **Responses dropped over the summer holidays. We aim to improve response numbers from September.**
	• Feedback from the new inpatient survey to be reported to the Patient Experience Committee	• Associate Director of Patient Experience	• From September 2025	ON TRACK: survey data being reviewed regularly. First report will go to PEC on 25th September.
	• Promotion of the carers leaflet and carers survey	• Patient Voice and Involvement team	• June 2025	**COMPLETED:** Leaflet and survey promoted during Carers Week 9-15 June.
			• End of November 2025	**Additional Promotion will take place on Carers Rights Day (20th November 2025)**
		• QIWA team	• By September 2025	**IN PROGRESS:** Additional question re Carers leaflet To be discussed with QIWA team
	• Communication passport for people with hearing or visual impairments to be offered to patients on the wards.	• Associate Director of Patient Experience / Heads of Nursing / Ward staff	• By June 2025	**COMPLETED**: Communication passport for people who are Deaf, have hearing loss or a visual impairment is now available in a PDF. Printed copies are due soon. Also having an editable electronic version created..
	• Pilot 'What Matters to me' communication posters behind patient beds on each site.	• Associate Directors of Nursing for SAGE and GM	• May to July 2025	**ON TRACK**: 'What Matters to Me' posters now being piloted. Wards at QEQM are Seabathing and Cheerful Sparrows female, wards at WHH are Kings D2 and Cambridge M1. Wards at K&CH are Kingston and Harvey wards. **Feedback from wards being sought.**

Quality and safety

Safe Care

Safe Staffing

Staff Type	Vacancy Rate Aug-25 (Target 10%)	Sickness Rate Aug-25 (Target 5%)	Safe Care Red Flags Aug-25
Registered Nursing & Midwifery	4.0%	5.03%	307
Registered Nursing Associate	N/A	N/A	
Health Care Support Worker	20.57%	N/A	

Staff Type	Care Hours Per Patient Day (CHPPD) Aug-25	Avg Fill Rate Day Aug-25	Avg Fill Rate Night Aug-25
Registered Nursing & Midwifery	6.3	84%	89%
Registered Nursing Associate	0.1	100%	100%
Health Care Support Worker	3	86%	98%

Safe Staffing:

CHPPD is calculated by dividing the number of actual nursing (both registered and HCSW) hours by the number of patients on the ward at 23:59; this advises of the 'nursing' or care hours that are available to each patient per day.

The average fill rates for August 2025 remain at an acceptable level overall. St Augustine's QEQM remained closed with staff being redeployed to other areas to provide support and mitigate staffing based on acuity and dependency levels.

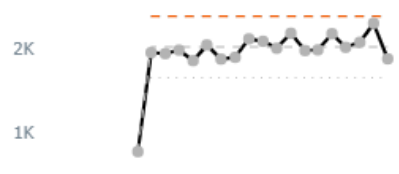
Several areas did work on amber shifts, as defined within our organisation. There were 2 red shifts both in Critical Care, QEQM; 1 night shift (2hr 50 mins) and 1 day shift (6hrs 30mins). Follow up reviews were completed to recognise real time escalation of shifts and to support learning.

Quality and safety

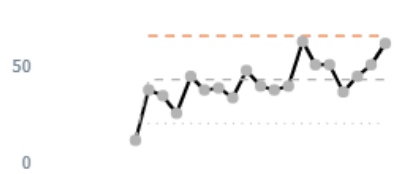
Trend Analysis

Quality Domain Metrics

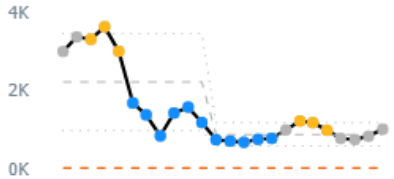
Patient Safety Incidents



Patient Safety Incidents - Mod/Sev

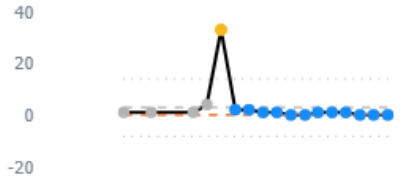


Overdue Incidents

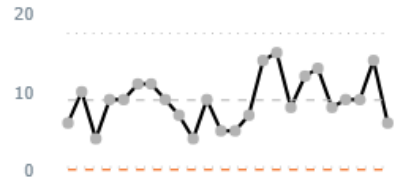


PSII - Local

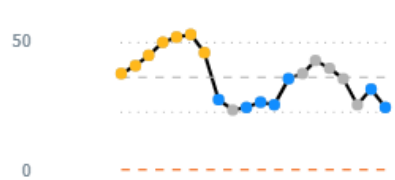
PSII - National



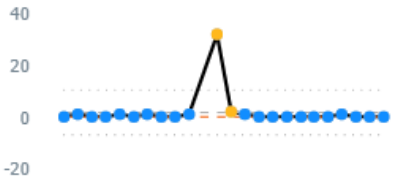
After Action Reviews (AARs)



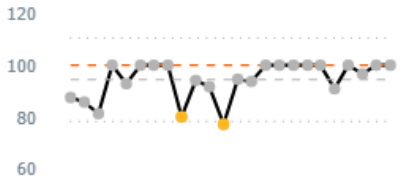
AARs Overdue



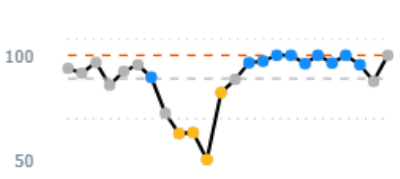
Never Events



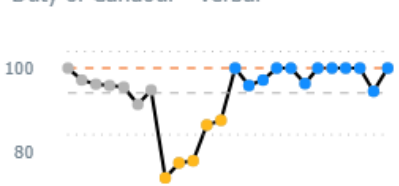
Duty of Candour - Findings



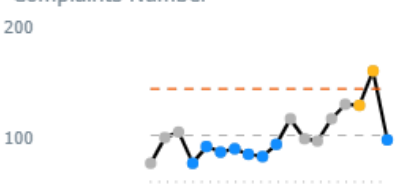
Duty of Candour - Written 15wd



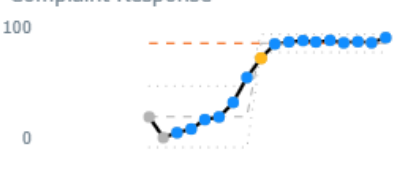
Duty of Candour - Verbal



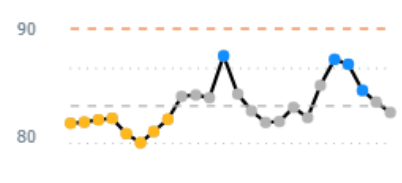
Complaints Number



Complaint Response

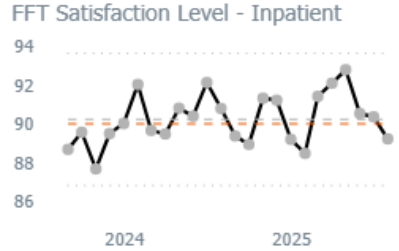


FFT Satisfaction Level - ED



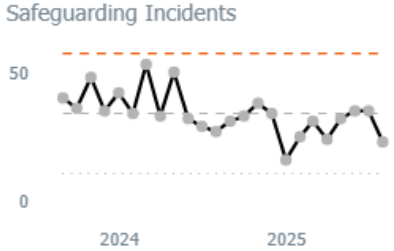
FFT Satisfaction Level - Outpatient

FFT Satisfaction Level - Inpatient



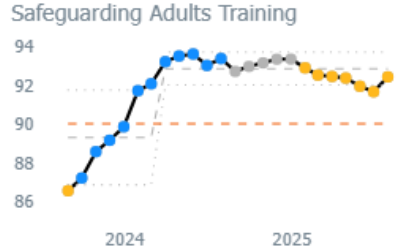
SJRs Outstanding

Safeguarding Incidents



Safeguarding Children Training

Safeguarding Adults Training

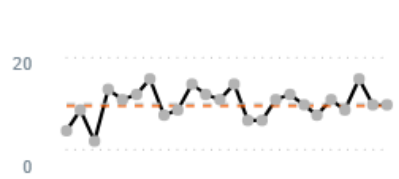


Quality and safety

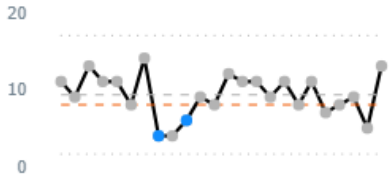
Trend Analysis

Quality Domain Metrics

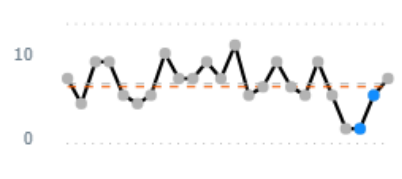
IPC: EColi Infections



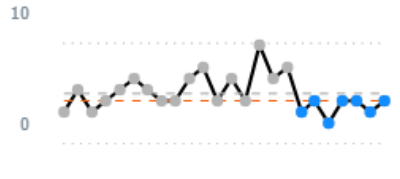
IPC: CDiff Infections



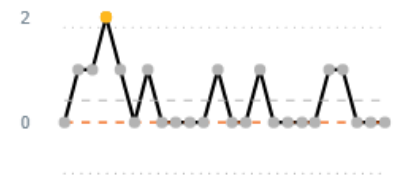
IPC: Klebsiella Infections



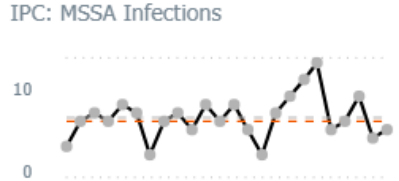
IPC: Pseudomonas Infections



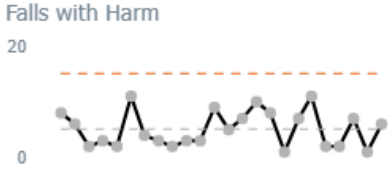
IPC: MRSA Infections



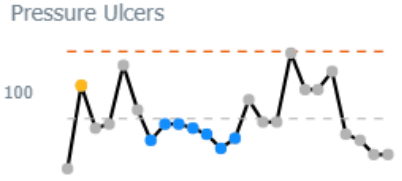
IPC: MSSA Infections



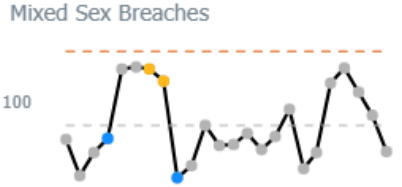
Falls with Harm



Pressure Ulcers

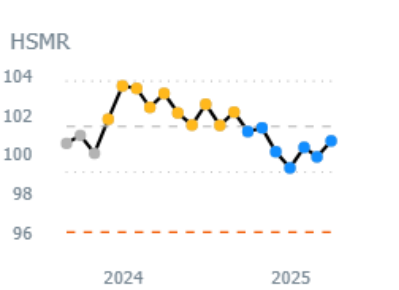


Mixed Sex Breaches

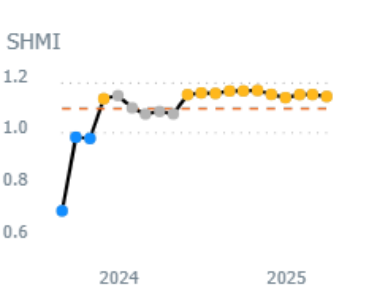


Theatre recovery Mixed Sex Breaches

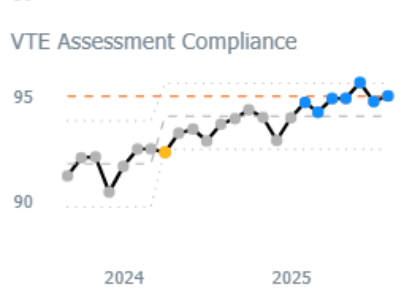
HSMR



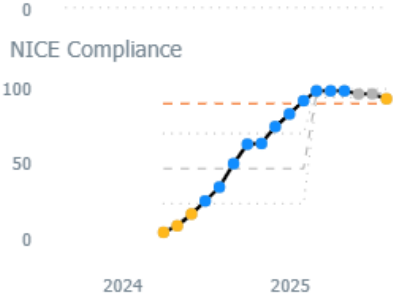
SHMI



VTE Assessment Compliance



NICE Compliance



People

Assurance

Variation

	P — Will consistently pass the target if nothing changes	? — Will not consistently pass or fail the target if nothing changes	F — Will consistently fail the target if nothing changes
H / L — Improving Variation (High or Low)	Premature Turnover Rate Staff Turnover Rate Statutory Training	Hand Hygiene Training	
No Significant Change	Infection Control Training	Sickness Vacancy Rate	Medical Job Planning Rate
H / L — Concerning Variation (High or Low)		Appraisals Compliance	Staff Advocacy Score Staff Engagement Score

People

Scorecard View

Workforce Metrics

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
People	NAT		Sickness			5.0%	4.6%	4.9%	5.2%	5.4%	5.5%	5.0%	4.4%	4.6%	4.5%	4.5%	4.7%	4.7%
	NAT		Vacancy Rate			10.0%	8.7%	8.6%	8.7%	8.8%	9.0%	10.1%	8.9%	9.2%	9.3%	9.0%	8.6%	9.0%
	NAT		Staff Turnover Rate			10.0%	8.9%	8.8%	8.7%	8.4%	8.3%	8.2%	7.8%	7.8%	7.6%	7.6%	7.5%	7.4%
	NAT		Premature Turnover Rate			25.0%	14.8%	14.8%	14.4%	13.5%	13.5%	12.7%	12.1%	12.5%	12.6%	12.9%	13.1%	13.3%
	KEY		Appraisals Compliance			80.0%	77.9%	79.4%	80.3%	80.0%	81.4%	80.8%	80.5%	81.1%	74.8%	72.9%	75.0%	74.4%
	IIP		Staff Engagement Score			6.80	5.95	6.35	6.35	6.35	6.04	6.04	6.04	5.97	5.97	5.97	5.85	5.85
	KEY		Staff Advocacy Score			6.70	5.34	5.80	5.80	5.80	5.55	5.55	5.55	5.49	5.49	5.49	5.29	5.29
	NAT		Statutory Training			91.0%	92.2%	92.2%	92.4%	92.4%	92.5%	92.3%	92.4%	92.8%	93.4%	93.3%	93.4%	93.6%
	KEY		Infection Control Training			90.0%	93.5%	93.4%	93.3%	93.2%	93.1%	92.9%	92.8%	93.1%	93.3%	93.1%	93.1%	93.1%
	KEY		Hand Hygiene Training			85.0%	79.0%	79.1%	93.1%	92.9%	92.7%	91.7%	91.4%	91.7%	91.8%	91.0%	90.8%	90.5%
	KEY		Medical Job Planning Rate			90.0%	32.5%	30.3%	32.0%	27.9%	27.9%	32.1%	31.1%	30.5%	18.0%	36.4%	46.6%	50.1%

People Executive Summary

Workforce Metrics & Statutory Training

Sickness absence rates remain stable month-on-month at **4.73%**, sitting below the 5% target. While this is a positive headline, it represents 2,044 sickness episodes in August alone. Of these, 271 were attributed to stress, anxiety and depression – the leading cause of absence – with a more pronounced increase in areas undergoing workforce consultations. Face-to-face counselling services, which have delivered over 1,500 appointments in the past year, are currently due to conclude this month. This presents a potential risk to our ability to mitigate stress-related absence, particularly given the concentration of cases in consultation-affected teams. Work is underway to secure an extension and ensure continuity of support, with a continued focus on proactive wellbeing measures to help staff remain in work wherever possible.

Vacancy rate has stabilised at or around 9.0% in recent months. The highest vacancy rate is in the KCRVH Care Group (11.6%). The lowest is across the QEQM Care Group (5.6%). It is anticipated that the new VCP process, along with ongoing consultations will impact vacancy rates moving forward. Vacancies will need to be carefully monitored to ensure patient safety and activity are not detrimentally affected.

Overall turnover has eased to **7.4%**, sustaining the positive trajectory we've seen in recent months. However, premature turnover has now increased for the fifth consecutive month (to 13.3%). Taken alongside our engagement data, this pattern suggests that retention may be more a product of the current local, regional and national employment climate than of a step-change in day-to-day experience. We have seen this pattern before: when the wider workforce climate improves, turnover can pivot sharply upward. It is therefore prudent to treat the current position as a watch-point rather than a sustained improvement. Within staff groups, nursing (7.2%) and HCAs (7.7%) remain on encouraging downward trends. That said, interpretation should be tempered by the context – the apparent stability may be masking latent movement that could surface once external conditions shift.

Appraisal compliance has fallen back in-month to **74.4%**, reversing last month's modest recovery and remaining well below the 80% target. This continues to strengthen the case for moving from an annualised cycle to an anniversary-based approach, which would help smooth peaks and troughs in completion rates. Compliance is notably lower in areas significantly affected by workforce reductions – in some cases intentionally – as objective setting is being deferred until new structures and appointments are in-place. No Care Group currently meets the 80% compliancy requirement, with Strategic Development (39.5%) and Corporate (64.5%) standing out as anomalies, each more than 10% below all other groups.

Statutory training compliance continues its upward trajectory, improving to **93.6%.** This represents sustained improvement and positions the Trust well above the 90% threshold in most areas. Corporate remains the only Care Group below threshold at 89.9%. Notably, Medical and Dental compliance has reached 87.5% - the highest level in the past 18 months and now within touching distance of the required threshold for the first time in years. This marks a significant shift in engagement and suggests that recent targeted interventions are beginning to take effect.

People

Integrated Improvement Plan (IIP)

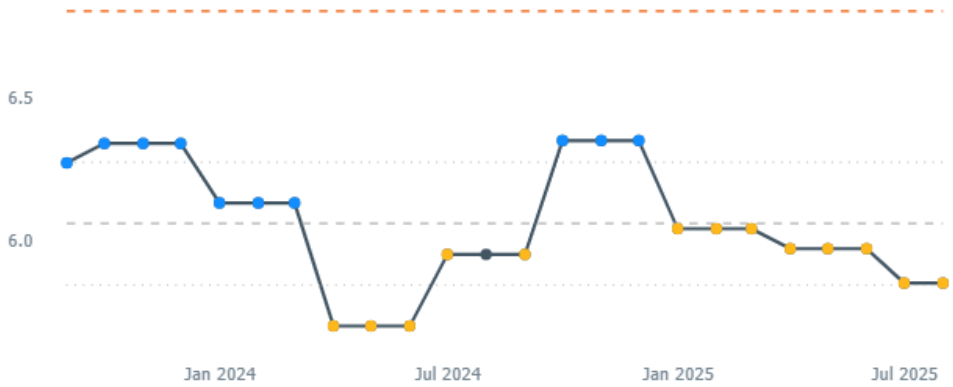
Staff Engagement Score

Staff Engagement Score

Timescale	Value	SPC
Sep-24	5.95	
Oct-24	6.35	
Nov-24	6.35	
Dec-24	6.35	
Jan-25	6.04	
Feb-25	6.04	
Mar-25	6.04	
Apr-25	5.97	
May-25	5.97	
Jun-25	5.97	
Jul-25	5.85	
Aug-25	5.85	

XMR Run Chart

Below Mean Run Group | Two Out Of Three Beyond Two Sigma Group



Understanding the Latest Performance

Concern flag alerting for more than 4 periods

For the month beginning 01/08/2025 the latest Staff Engagement Score performance is 5.85 against a static target of 6.80 (higher is better).

Performance is statisticaly declining, and cannot deliver the target without further intervention (you may need consider if it is time to recalculate the process limits).

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Staff Engagement levels (5.85) are below the national average (6.78).	• Priorities identified through NSS have been acted on, with a wide variety of actions initiated	Head of Staff Experience	End Mar 26	• The 2024 NHS Staff Survey identified three key areas of development; compassionate leadership, raising & resolving concerns, and making East Kent a place where staff felt proud to work. Leadership development has been refreshed to attend to the former, with 329 staff completing the programme and an advocacy rating of >95%. A new resolution framework has been developed, alongside 'stop, talk, change' and a campaign of work around sexual safety (including active bystander training) to enable staff to feel more confident their concerns are heard and acted on. And 54 areas of the organisation that perform above national standards for engagement have been identified, with recent case studies published around the Medical Day Unit and the Coronary Care Unit at QEQM to build pride.
Actions/ interventions initiated to improve staff engagement	• Activity taking place across NSS plan, CLP immediate actions delivery plan and local Care Group People Plans	Head of Staff Experience	End Mar 26	• Priorities from the staff have helped shape the People Strategy – and associated delivery plan. Five priorities have been identified, with associated work being planned/ undertaken. A three tiered engagement plan has been developed for wider engagement-related activity – and 20 areas of the Trust are now receiving intensive support based on a thorough needs analysis. This will continue beyond the launch of the 2025 NHS Staff Survey and across fieldwork to begin to embed the necessary changes.
2025 NHS Staff Survey	• Driving response rates across the 2025 NSS is key to improving engagement and the credibility of results	Head of Staff Experience	End Nov 25	• A comprehensive delivery plan has been developed and enacted for the 2025 NHS Staff Survey. This began with a 10-week pre-fieldwork campaign, which is now complete. This appears to have been successful, with 1,500 staff completing the staff survey in the opening three days – giving a strong opening (**15%**) response rate. A monthly timetable of activity is planned across each of the three months of the survey, with a leader-led approach to complement this. The survey will run until Friday 28th November, with a series of key dates anchoring the campaign.

People

Integrated Improvement Plan (IIP)

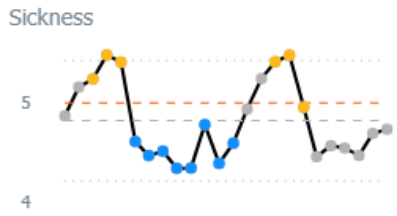
Workforce Metrics

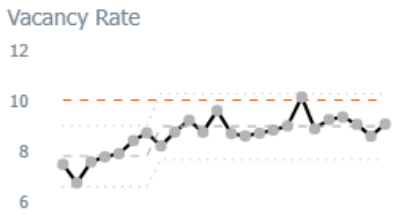
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Ensuring vacancy rate remains below the Trust threshold of 10%.	• Monthly monitoring of vacancies across Care Groups, ensuring that active recruitment is taking place. • Focus on hard to recruit areas and supporting new ways of working to reduce reliance on temporary staffing.	Heads of P&C P&CBPs	• Ongoing	• HCSW vacancies improving following the B2 to B3 uplift. • Working with Finance, Temporary Staffing and the CMO office to target areas of long-term and high-cost medical agency, and alternative ways of working. • Vacancies in maternity are at **8.1%** following the recruitment of student midwives and other positive recruitment.
Keeping Anxiety & Stress related absence to a minimum, and below 15% of all absences.	• Support from Health & Wellbeing Team and Occ Health to focus on areas of high stress related sickness. Improved Return To Work interviews to support intervention.	Heads of P&C, P&CBPs, OH	• Ongoing	• 409 individual staff members have accessed the service, with 1,511 sessions delivered to-date. 85% of staff demonstrated clinically reliable improvement, improving CORE-OM scores by 7.41 points – from 16.28 (moderate clinical distress) to 8.87 (mild non-clinical). The Trust cannot fund an extension of the service, but an item is going to CFC on 21/10 for funding.
Maintaining **Staff Turnover** against a gold standard of 10%	• Improving HCSW, Nurse & Premature retention which are the main contributors to overall turnover	Head of Staff Experience	• Ongoing	• Staff Turnover remains below 8% (**7.4%**) and has achieved the gold standard (10%) for over a year. It is currently at the lowest rate the Trust has seen in 2 years. However, the pattern suggests this level of retention may be more a product of the current local, regional and national employment climate than of a step-change in day-to-day experience
Update calculation used to denote premature turnover as acutely sensitive to improvements in total turnover	• New method of calculation agreed bringing PT in-line with other methods of measure & reducing sensitivity to wider improvements	Head of Staff Experience	• Complete	• Premature turnover (**13.3%**) has increased for the fifth consecutive month, albeit subtly and below the alerting threshold. A new starter insights dashboard has been developed to provide more granular insight to this.
Staff Engagement levels (5.85) are below the national average (6.78)	• Priorities identified through NSS have been acted on, with a wide variety of actions initiated. • Focus on improving engagement and response rate for 2025 staff survey.	Head of Staff Experience	• Nov 25	• Survey feedback has actively shaped the People Strategy – and associated delivery plan, with related work being undertaken (*i.e.* sexual safety initiatives aligned to improving staff experience). Support continues to take place against 20 intensive support areas.
Medical staff levels of statutory training compliance are consistently low at an average of 75%. Has been below 80% for 4 years.	• Identifying those staff who are not compliant, and working with GMs and Clinical Leads to address compliance. • Care Groups contacting individuals directly to support improvement of compliance, particularly with trainee doctors.	CMO	• Dec 24	• Compliance for medical staff has reached **87.5%** - the highest level in the past 18 months and now within touching distance of the required threshold for the first time in years. All Care Groups are targeting improvement within medical staff compliance – with medical staff compliance lowest in the Corporate Care Group (79.2%).

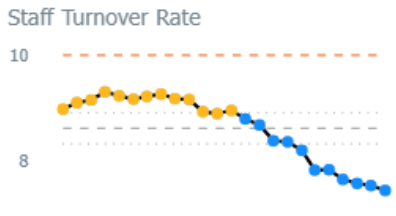
People

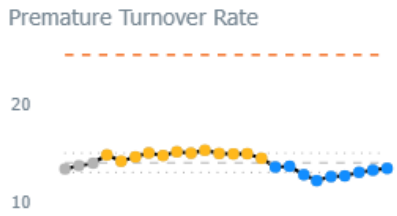
Trend Analysis

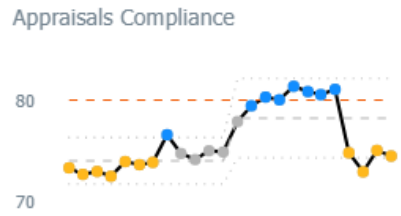
People Domain Metrics

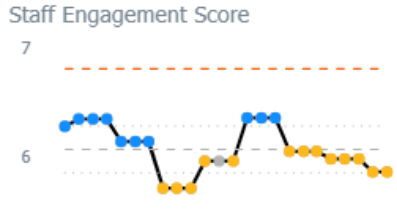


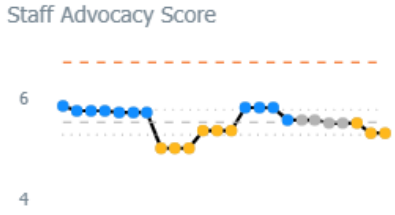


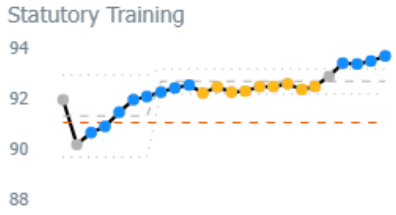


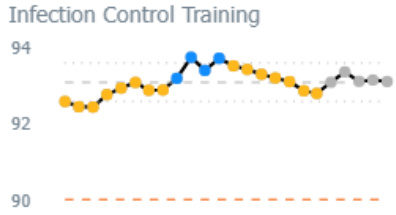


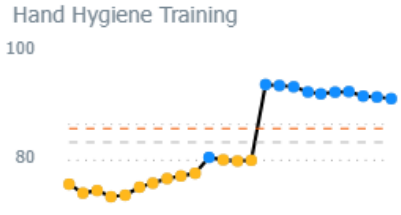


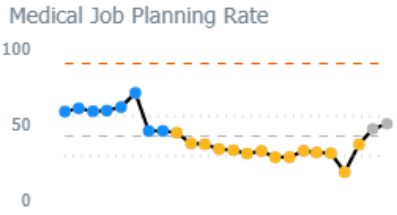












2024 2025 2024 2025 2024 2025 2024 2025 2024 2025

Sustainability

Assurance

Variation

	P — Will consistently pass the target if nothing changes	? — Will not consistently pass or fail the target if nothing changes	F — Will consistently fail the target if nothing changes
H / L — Improving Variation (High or Low)		WTE worked (Premium Pay)	
No Significant Change		Deficit In Month Group (£) Efficiencies YTD Variance (£M) Premium Pay Total Pay Spend In Month Variance to Plan (£) WTE worked (All Pay Spend)	Efficiencies Green Schemes (£M)
H / L — Concerning Variation (High or Low)			

Sustainability Scorecard View

Financial Metrics

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Sustainability	IIP		Deficit In Month Group (£)			8.0M	7.3M	7.5M	9.8M	7.0M	6.5M	4.9M	5.2M	9.7M	8.8M	8.8M	8.4M	8.0M
	KEY		Variance to Plan (£)			0K	1K	-31K	1K	-2,07...	3,990K	-2K	240K	25K	10K	-35K	6K	-10K
	KEY		Premium Pay			9.8M	8.0M	8.6M	8.6M	8.0M	7.6M	8.3M	9.1M	8.7M	8.7M	7.9M	7.8M	7.9M
	KEY		WTE worked (Premium Pay)			1,182	1,017	996	967	975	964	1,072	1,108	1,041	971	864	880	890
	KEY		Total Pay Spend In Month			62M	51M	66M	54M	54M	53M	55M	49M	57M	56M	56M	57M	57M
	KEY		WTE worked (All Pay Spend)			10,329	10,105	10,138	10,096	10,144	10,110	10,237	10,309	10,301	10,219	10,121	10,172	10,169
	KEY		Efficiencies Green Schemes (£M)			40	16	20	25	28	35	40	45	0	6	9	12	17
	IIP		Efficiencies YTD Variance (£M)			0.0	0.3	0.3	0.3	0.3	0.4	0.4	0.5	-1.5	0.0	0.0	0.0	0.0

Sustainability

Executive Summary

Financial Position

The month 5 YTD position achieved by the Group (Pre deficit support funding) was a £43.7m deficit. As at month 5 the Group remains on plan.

As at month 5, the Trust has a small surplus of £0.4m.

The Trust's YTD month 5 position shows Income from patient care is currently £3.1m higher than planned YTD. This includes NHSE Chemotherapy overperformance of £0.5, overperformance from the Compensation Recovery Unit £0.3m, additional income for NHSE ERF performance due to an increase in our contracted financial envelope notified post plan submission (£1.5m) and £1.1m over performance on rechargeable high cost drugs and devices.

Trust other operating income is £0.5m favourable to plan YTD, driven mainly by income from education and training and non patient care services (mainly GP vocational trainee pay recharges).

Trust employee expenses were £1.5m adverse YTD. Substantive staff costs are below plan, while temporary staffing, particularly bank staff, is the main driver of the overspend.

Trust other operating expenses are £1.8m adverse to plan YTD, driven by overspends in general supplies and services. These are partially offset by underspends on clinical supplies and services and purchase of healthcare.

Sustainability

Financial Measures

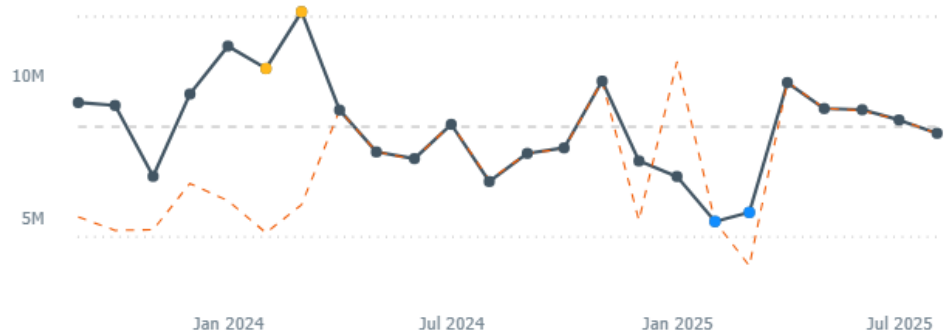
Income & Expenditure Monthly Deficit (Group)

Deficit In Month Group (£)

Timescale	Value	SPC
Sep-24	7.3M	
Oct-24	7.5M	
Nov-24	9.8M	
Dec-24	7.0M	
Jan-25	6.5M	
Feb-25	4.9M	
Mar-25	5.2M	
Apr-25	9.7M	
May-25	8.8M	
Jun-25	8.8M	
Jul-25	8.4M	
Aug-25	8.0M	

XMR Run Chart

No Special Cause Flags



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/08/2025 the latest Deficit In Month Group (£) performance is 8.0M against a Trajectory target of 8.0M (lower is better).

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Achievement of financial plan for 25/26	• Cash out CIP target of £80m is needed to support the agreed £62.4m deficit (Pre Deficit Support Funding) position as submitted on the 30th of April.	• Theme leads • PMO	• On-going	• As at month 5 the Groups financial position is on plan at a deficit of £43.7m • Work is continuing with the Care Groups and Corporate areas to deliver the financial plan along with the workforce and activity plan. • EKHUFT is continuing to support the system wide savings schemes to support the delivery of the K&M ICS financial position. • Increased levels of reporting are being requested from NHSE including reporting greater level of CIP delivery, workforce triangulation and underlying run rate data.

Sustainability

Financial Measures

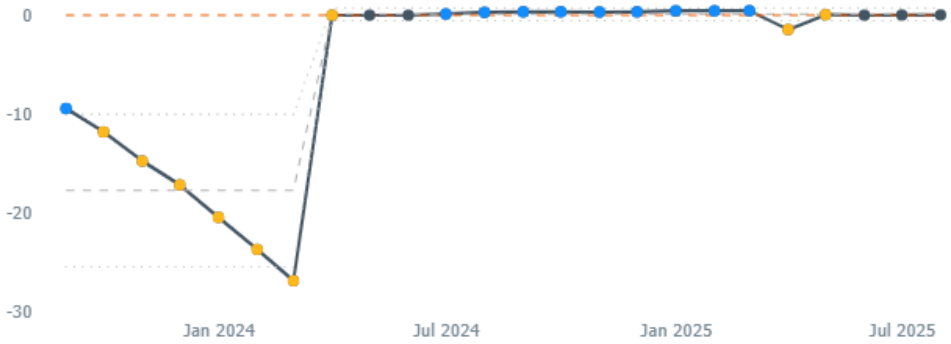
Financial Efficiencies; YTD Variance

Efficiencies YTD Variance (£M)

Timescale	Value	SPC
Sep-24	0.3	
Oct-24	0.3	
Nov-24	0.3	
Dec-24	0.3	
Jan-25	0.4	
Feb-25	0.4	
Mar-25	0.5	
Apr-25	-1.5	
May-25	0.0	
Jun-25	0.0	
Jul-25	0.0	
Aug-25	0.0	

XMR Run Chart

No Special Cause Flags



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/08/2025 the latest Efficiencies YTD Variance (£M) performance is 0.0 against a static target of 0.0 (higher is better).

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Ensure identification of CIP opportunities sufficient to reach the required £80m cash out, recurrent CIP target for 2025/26	• New substantive Director of Financial Sustainability in post 1st September. • Director of Transformation in Post • PMO roles are being recruited to	Financial Recovery Director	• On-going	• The trust has a current pipeline of £80m unadjusted and £56.8m risk adjusted • The £80m CIP plan was transacted in month 2 allocating all (albeit £3.5m still to allocate) of the CIP targets into the care group and corporate areas • Work is continuing to develop PID's and QIA's with the Theme leads & FBPs through the governance gateways to increase the risk adjusted value and support delivery of the CIP programme.
Ensuring robust CIP reporting of achievement	• Streamlined reporting process • Robust CIP Methodology	Financial Recovery Director	• On-going	• CIP Methodology defined for each scheme. • CIP reporting process streamlined. • CIP delivered YTD at month 5 is £16.5m and is on plan, of which £8.9m is recurrent. • CIP forecasting in process of validation with Theme leads and Finance business partners.

Sustainability

Financial Measures

Agency & Temporary Workforce Spend

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
ID Medical finding it challenging to swap out high pay premium medical workers and/or negotiate alternative terms, such as becoming Direct Engagement (DE). Many of the high cost agency have been working with the Trust long term and embedded in the organisation.	• ID Medical Managed Service meeting with each Care Group, reviewing each Medical worker for alternative options. • Working with CMO/DCMO to meet with Managing Directors and Medical Directors to highlight the issue and gain support to reduce premium pay workers. • Need to increase DE workers, making the savings on VAT payments.	CPO	Ongoing	• Joint sessions with ID Medical, CG MDs, Temp Workforce and PMO to review agency usage, agree exit plans and discuss recruitment plans. The number of active agency locums has now reduced to 64. • Monthly meetings are now scheduled with all Care Groups. ID Medical reviewed current rates against the rate caps and discussed plans to reduce these to improve our compliance. Our currently compliance rate against the recently approved ceiling rates is now 64% • Our DE throughput has increased to 96%. Plans are now in place to remove/replace the long term standard placement locums. We now have two standard placement locums remaining. • Notice was served for 7x long term agency locums in August who are looking to migrate to the bank, this is due to be completed in September taking the total to 23 for the financial year to date. • IDM process map developed to incorporate VCP process – shared with teams. • Bank and Agency trackers tools shared with CG's; to be monitored monthly via PMO and CG finance meetings. • CMO meeting with MD's and MMD's on a weekly basis to review line by line plans to reduce long term high cost workers.
Agency management across the South East NHS Region means disparity across Kent and Medway Trusts for AfC rates.	• Sign up to the Kent and Medway Collaborative AFC Rate Card • Areas above cap to work with IDM & South East Temp Staffing Collaborative team to reduce inline with stepping down timescales.	CPO	• Ongoing	• Agency Hours (all staff groups) continued to see a decrease in August 2025, down 39% when compared to April 2025. Overall AfC agency hours also continued to reduce (down 40% compared to April 2025). • New AfC rate card (agency) implemented on the 1st April 2025. The only areas above the new caps are Maternity and Paediatrics. A plan is now in place to remove all agency usage (AfC). This has led to a number of agency staff migrating to the bank (6 in August 2025). • The South East Temporary Staffing Programme has published their next step down rates for both agency and bank, these are now being reviewed with an implementation date of no later than October 2025. • On the 1st March 2025 the Trust will be implemented a restriction on the use of agency staff for bands 2 and 3. Agency hours (AfC bands 2-3) has reduced by 80% since this was implemented. • No off-framework usage recorded. • Working with the ICB, a number of new controls/processes have been implemented to support with controlling overall demand and reduce our reliance on agencies. This will also support the Trust in achieving our objectives in relation to the workforce CIP schemes. We are now looking to implement similar controls for the bank. • Next stage of AFC rate card step down Sept 2025.

Sustainability

Financial Measures

Agency & Temporary Workforce Spend

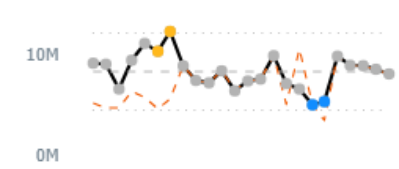
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Agency management across the South East NHS Region means disparity across Kent and Medway Trusts for Medical rates.	• Sign up to the Kent and Medway Collaborative Medical Rate Card • Areas above cap to work with IDM & South East Temp Staffing Collaborative team to reduce inline with stepping down timescales. • Regular meetings now held across the collaborative to current issues as we worked towards rate parity across the region.	CPO	• Ongoing	• New agency AfC ceiling rates approved, with a plan to implement these in September 2025. Our compliance rate against the new ceiling rates is currently 64% with plans in place to improve our compliance against the outliers. • Temp Staffing, PMO & South East Collaboration; weekly meetings scheduled, to progress and implement actions – delivery. • To date the managed service has successfully reduced the hourly rates of 12 long term agency locums. • As a result of tighter controls a number of agency locums are now considering migrating to the bank or joining the Trust substantively. 7 agency locums and 6 AfC agency staff served notice in August with their transition to the bank to be completed in September. • Agreed exit plans discussed and in place for the majority of the remaining agency locums.

Sustainability

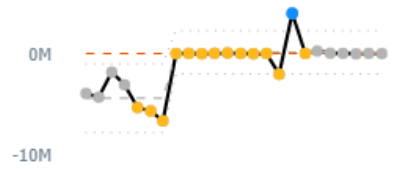
Trend Analysis

Sustainability Domain Metrics

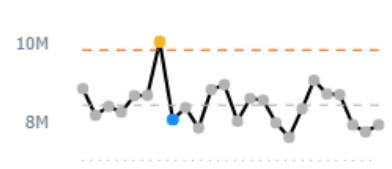
Deficit In Month Group (£)



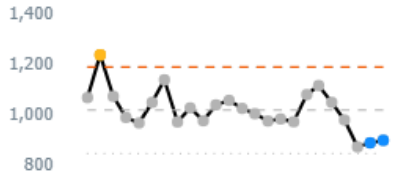
Variance to Plan (£)



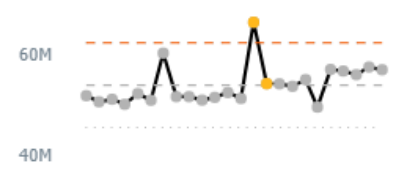
Premium Pay



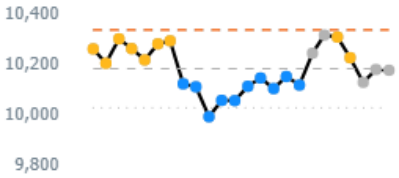
WTE worked (Premium Pay)



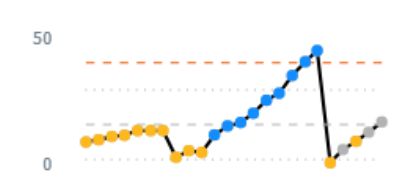
Total Pay Spend In Month



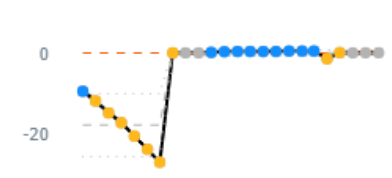
WTE worked (All Pay Spend)



Efficiencies Green Schemes (£M)



Efficiencies YTD Variance (£M)



Maternity

Variation	Assurance: P — Will consistently pass the target if nothing changes	Assurance: ? — Will not consistently pass or fail the target if nothing changes	Assurance: F — Will consistently fail the target if nothing changes
Improving Variation (High or Low)		FFT Maternity Response Rate	
No Significant Change	Extended Perinatal Mortality	FFT Maternity Recommended Mat Patient Safety Incidents Mod/Sev Maternity Complaint Response Maternity Complaints PSII - Local (Maternity) PSII - National (Maternity)	
Concerning Variation (High or Low)		FFT Maternity (IP) Recommended	WH Engagement Score

Maternity: Scorecard View

Maternity Metrics

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Maternity	KEY		Mat Patient Safety Incidents Mod/Sev			7	1	0	3	2	5	5	7	3	4	2	6	6
	NAT		PSII - National (Maternity)			0	0	1	0	1	0	0	1	1	0	0	0	0
	NAT		PSII - Local (Maternity)			0	0	0	0	0	1	0	0	0	1	1	0	0
	KEY		Maternity Complaints			14	13	1	5	2	8	6	7	7	4	5	6	3
	KEY		Maternity Complaint Response			85.0%	50.0%	85.7%	100%	100%	100%	60.0%	80.0%	100%	75.0%	100%	100%	66.7%
	KEY		Extended Perinatal Mortality			5.44	3.94	4.10	3.91	3.91	3.73	4.43	4.44	3.93	3.76	3.73	4.06	3.39
	NAT		FFT Maternity Response Rate			15.0%	8.5%	11.8%	9.7%	7.9%	10.0%	10.3%	11.9%	8.2%	10.6%	9.1%	39.3%	41.0%
	NAT		FFT Maternity Recommended			90.0%	91.7%	95.9%	93.2%	89.8%	92.5%	91.2%	90.5%	90.9%	89.9%	86.2%	89.4%	86.5%
	NAT		FFT Maternity (IP) Recommended			90.0%	96.3%	97.9%	93.3%	93.2%	91.5%	95.3%	94.3%	97.6%	96.0%	95.8%	90.4%	83.9%
	KEY		WH Engagement Score			6.90	6.12	6.40	6.40	6.40	6.19	6.19	6.19	6.03	6.03	6.03	5.78	5.78

Maternity: Executive Summary

Maternity Mortality Measures

The extended perinatal rate remains consistently below the threshold of 5.44 per 1,000 births, with the 12 month perinatal rate performance at 3.39 in August. This rate includes both stillbirths and neonatal deaths.

In August, the neonatal death 12 month remained static below the MBRRACE target of 1.84 for the 4th time in the 12 month rolling reporting period, at 0.68. The service reported 0 neonatal deaths >24 weeks in month. The stillbirth rate reduced in month, from 3.04 in July to 2.71 in August. The stillbirth rate remains below the threshold of 3.60, however the rate remains higher than average. The service reported 0 stillbirths in month.

Morbidity & Mortality | MBRRACE Ext Perinatal Rate 12m

Metric Definition

MBRRACE methodology used. Stillbirths and Neonatal deaths up to 28 days

Rolling 12 month rate. Target is set at the average of Trust's comparator group from the latest MBRRACE report (2024).

MBRRACE NND Rate 12m

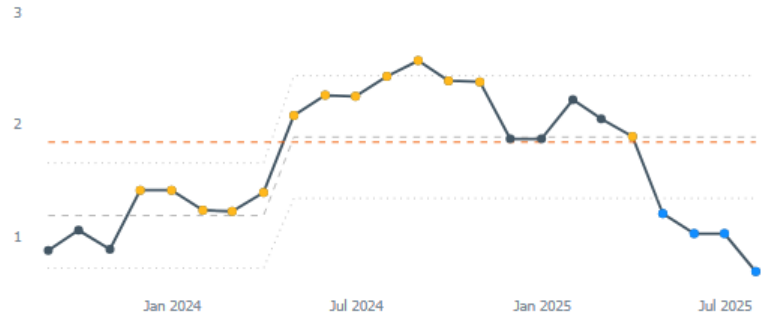
Metric Definition

MBRRACE methodology is used, Babies who were born at EKHUFT and died within 28 days, and which excludes births <24+0 weeks gestation and terminations (even if over 24+0w). The rate is a rolling 12 month measure counting cases per 1000 live births

Datasource: Euroking & PAS
Threshold based on the average of the Trust's comparator group (MBRRACE 2023). Average was 1.84

XMR Run Chart

Astronomical Point | Two Out Of Three Beyond Two Sigma Group



MBRRACE Stillbirth 12m rate

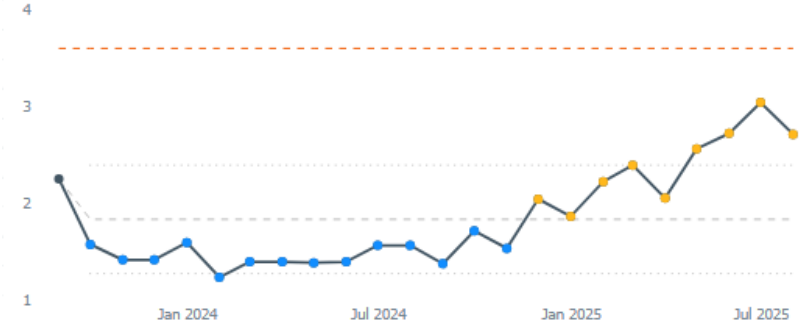
Metric Definition

MBRRACE methodology used. Stillborn babies born 24+0 weeks gestation at EKHUFT, reported by death month. Denominator is all live and stillborn babies 24+0w. Terminations excluded

Rolling 12 month rate. Target is set at the average of Trust's comparator group from the latest MBRRACE report (2023) Average was 3.60

XMR Run Chart

Above Mean Run Group | Astronomical Point | Two Out Of Three Beyond Two Sigma Group



In response to the upward trajectory demonstrated in the stillbirth rate an aggregate review is underway, led by the Associate Medical Director for Women's Health
The findings of the review will be reported through the Maternity and Neonatal Board

All eligible stillbirths and neonatal deaths are investigated utilising the national Perinatal Mortality Surveillance Tool (PMRT)

Maternity: Executive Summary

Maternity Mortality Measures

Two new qualifying MNSI incidents occurred in September but at the time of writing, we are waiting to hear from the families regarding their consent to proceed with an investigation.

Current open MNSI investigations	Progress
Maternal death following collapse, admission to ITU and transfer to Tertiary centre.	MNSI referral made by Tertiary centre therefore this MNSI investigation is not evident in the EKHUFT maternity scorecard - Draft report received for factual accuracy. Awaiting finalisation of comments from staff involved
Maternal death following collapse in community and admission to ITU.	- MNSI investigation complete. Safety Recommendations were made for EKHUFT regarding safety netting advice. There were Safety Prompts for SECAMB but none for EKHUFT

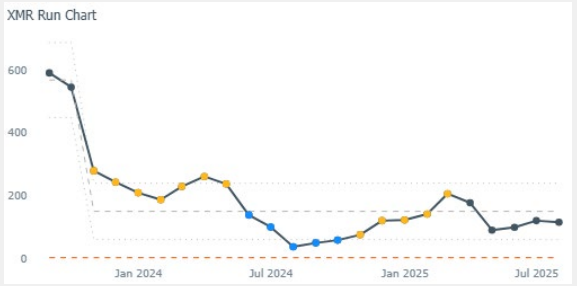
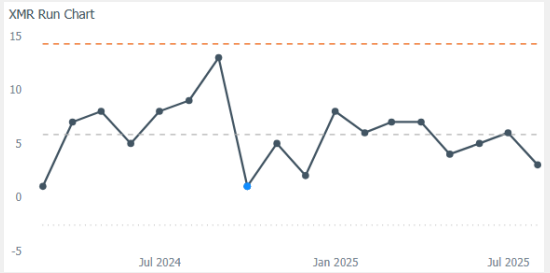
Current open local PSSI's	Progress
Twin birth – 31/40 – Twin 1 admission to NICU	Investigation being commenced
Neonatal death at 24+1 weeks gestation	Investigation completed and report being finalised
Intrauterine death at term	Investigation complete and external independent review complete. To be presented at LRAP in Oct.
Maternal bladder injury and unexpected neonatal admission to NICU	Investigation in progress
Management of pre-term labour and maternal DVT	Previously a PMRT case. Declared a PSII in Sept for additional investigation – to be commenced
Joint neonatal/maternity case. Medical gases availabilty	Declared a PSII in September – investigation to be commenced

5 moderate /severe patient safety incidents were reported in September under the following categories:

- Inappropriate treatment
- PPH >1500mls
- Unplanned return to theatre
- Collapse due to medical condition
- Lack of nursing care identified

Maternity: Maternity Care

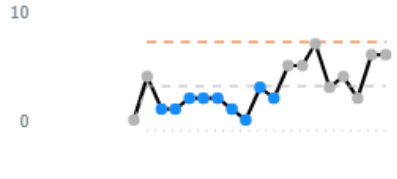
Patient Experience, Incident Reporting & Complaints

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
FFT scores	• Review existing process in relation to the promotion of the FFT	• Patient Experience Team		FFT maternity response rate in August remained significantly high at 41% the highest response rate seen in the 12 month rolling period, above the set performance target of 10% The 'go live' of EDNv2 happened on 28th April where every EDN should have an individualised QR code for women / birthing people to scan prior to discharge unfortunately this aspect has been delayed due to an issue with how to get the Sunrise VisitGUID allowable in the URL web address given to the patient and embedded in the QR code , this action is with Information who believe they now have a solution. We are awaiting a go live date for this. Service users will continue to receive a text for the 36 week, discharge from community and hearing screening elements.
Overdue Incidents	• Email and communication with individual overdue incident and action owners with ongoing monitoring of expected completion date • Agreed with corporate team an understanding that some maternity incidents will remain open for longer than 6 weeks, given the complex nature of some investigations.	• Head of Governance		• The number of maternity overdue incidents in August was 113 • Continued monitoring of incident management with increased surveillance and support through weekly 'Stop the clock' meetings. Performance impacted by need for Matrons and ward managers to work clinically due to high activity and acuity to maintain safety and vacancy / absence within the governance team. • Focus on management of open incidents approaching 6 week threshold to prevent them becoming overdue 
Complaints		• Head of Governance		• Total of 3 maternity complaints received in August against a threshold of 14 • Complaint response rate was 60% in August against a threshold of 85%. 

Maternity: Trend Analysis

Maternity Domain Metrics

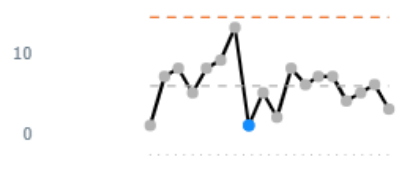
Mat Patient Safety Incidents Mod/Sev



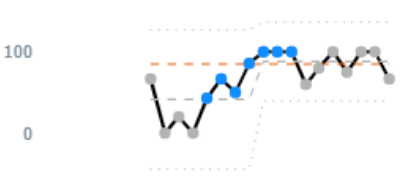
PSII - National (Maternity)

PSII - Local (Maternity)

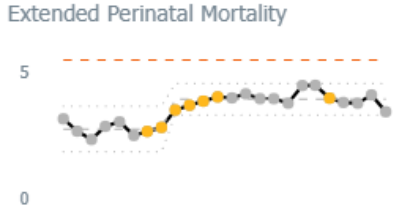
Maternity Complaints



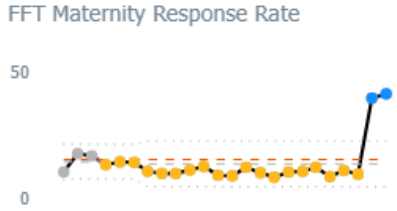
Maternity Complaint Response



Extended Perinatal Mortality



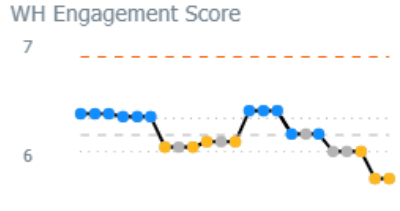
FFT Maternity Response Rate



FFT Maternity Recommended

FFT Maternity (IP) Recommended

WH Engagement Score



East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Integrated Improvement Plan (IIP) Performance Reporting**

Meeting date: **9 October 2025**

Board sponsor: **Tracey Fletcher, Chief Executive**

Paper Author: **Ben Stevens, Chief Strategy and Partnerships Officer (CSPO)**

Appendices:

Appendix 1: **IIP Performance Report**

Executive summary:

Action required:	Discussion
Purpose of the Report:	This report has been provided to update the BoD at EKHUFT on the 2025/26 September position of the IIP following the Organisation's successful exit from the Recovery Support Programme (RSP).
Summary of key issues:	The Trust has now exited RSP and moved into Segment 3 of the National Oversight Framework (NOF). As part of exit discussions, it was agreed that four areas would remain in local oversight contributing to the Organisations continuous improvement. These areas will continue to report through the IIP: Urgent and Emergency Care (UEC), Planned Care, People & Culture and Finance. These will continue to report on a monthly basis (paper attached). The Organisation's breakthrough objectives will now be captured bi-monthly as part of the IIP report, to measure the Trust's improvement against the annual objectives set. This will start to report from next month. The People programme is currently green with three of the four milestones on track and expected to deliver all Q2 milestones as agreed. The Finance programme is currently green and on track, although the report does highlight some risk around the £80m Cost Improvement Programme (CIP) delivery. Both the UEC and Planned Care programmes have been RAG rated Amber which reflects a fall in performance during August. Corrective actions are expected to make a positive impact on the final Quarter 2 (Q2) position in September (see report for further details).
Key recommendations:	The Board of Directors is invited to **DISCUSS** the report.

We care

East Kent Hospitals University NHS Foundation Trust

Implications:

Links to Strategic Theme:	This report aims to support: • Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Significant Risk Register:	N/A
Resource:	No
Legal and regulatory:	Yes – regulatory impact.
Subsidiary:	Yes – in the overall provision of services within the resources available to the Trust.

Assurance route:

Previously considered by: Trust Management Committee (TMC)

NHS
East Kent Hospitals University
NHS Foundation Trust

Integrated Improvement Plan Performance (IIP) Report

September 2025

East Kent Hospitals University NHS Foundation Trust

Integrated Improvement Plan (IIP) Performance Report

As part of the transition planning process from the Recovery Support Programme, it was agreed that the IIP 2025/26 focuses on four key areas: Culture Improvement, Urgent Care, Planned Care and Financial Sustainability.

Domain	Metric	Target
Patients	To reduce the number of type 1 patients waiting more the 4 hours in Emergency Department (ED)	78%
Patients	To reduce the number of patients waiting more the 12 hours in ED	10%
Patients	To improve type 1 performance	58%
Patients	Establish programme to reduce length of stay	30%
Patients	To reduce the proportion of patients waiting no longer than 18 weeks for treatment	60%
Patients	To reduce the proportion of patients waiting more than 52 weeks for treatment	1%
Patients	To improve performance against the 28-day cancer Faster Diagnosis Standard	80%
People	To Improve Staff Engagement	6.40
People	To reduce the incidence of serious discrimination and harassment of staff by colleagues	NSS - Psychological Safety Target 53%
Sustainability	To Improve our financial deficit	£6.5m (after deficit support funding)

Patients

East Kent Hospitals University NHS Foundation Trust

Breakthrough Objectives - To reduce the number of type 1 patients waiting more the 4 hours in ED
To reduce the number of patients waiting more the 12 hours in ED

IIP Objectives - Develop a clear Urgent and Emergency Care (UEC) improvement plan which link to a performance trajectory. Targeted support on system wide discharge and admission avoidance
Maximise opportunities for patients to access Same Day Emergency Care (SDEC) to reduce 12h and Length of Stay (LoS) in line with model hospital and SDEC opportunity tools

Programme Status	

Programme	Urgent Care
SRO	Dan Gibbs
Programme Manager	Alison Pirfo

Progress Update
Type 1 performance has seen an upward trend to July at 55.2%. However, we saw a fall in August to 48.8% for the first time this year but with improvement to previous levels currently on-going in September. 4hr – All types remained positive at 74.2% in August. 12hr – Up until July the breaches remained constant at approx. 20% per month, which is a key operational focus, but with an increase in breach rate to 23.3% in August. LOS – A slight decrease to 8.5 days was seen in August.

Key Milestones				
Milestone	Description	Target Date	Status	Commentary to support any delays/planned mitigations
Operational Performance - Urgent Care				
2.1 - Type 1				
2.1.01	Type 1 - 57.6%	Sep-25		June – 54%, July – 55.2%, August – 48.8%
2.2 - 12 Hour Performance				
2.2.01	12 hour <14.5%	Sep-25		June – 20.6%, July – 20.4%, August – 23.3%
2.3 - 4 Hour Performance				
2.3.01	4h - <77.9%	Sep-25		June – 76.42%, July – 76.48%, August – 74.19%
2.4 - Length of Stay				
2.4.01	Establish programme to reduce length of stay (14+ LoS – 31%)	Sep-25		June – 29.4%, July – 30.8%, August – 31.2%

Patients

IIP Objectives - Improve the percentage of patients waiting no longer than 18 weeks for treatment
Reduce the proportion of people waiting more than 52 weeks for treatment (including strengthening validation processes)
To improve performance against the 28-day cancer Faster Diagnosis Standard (FDS)

East Kent Hospitals University NHS Foundation Trust

Programme Status	

Programme	Planned Care
SRO	Dan Gibbs
Programme Manager	Titus Burwell Alexis Warman

Progress Update

Referral to Treatment (RTT) Recovery Plan Progress

18 weeks Referral to Treatment plans have seen an improvement from the baseline although falling short of plan at 54.7% in August against a target of 55.2%. Improvement initiatives are being tracked through individual performance meetings as well as the Outpatient Improvement Programme which focuses on productivity improvement initiatives as well as work to manage demand.

The 52 week backlog reduced between M1 to 4 although falling short of plan most notably in M5 which increased by 0.3% to 2.9% against a target of 2.0%.
There have been productivity improvements driven through the Perioperative Improvement Programme including Theatre Utilisation and the average number of cases per theatre. Although many specialties are on target, there are particular challenges in Cardiology, General Surgery, Ophthalmology, Trauma and Orthopaedics and Max Fax. Plans are in progress to focus recovery in these specialties as well as maintain improvements in all specialties.

FDS Work in progress:
-Improvement meetings established for majority of specialties and 80% target plans in progress
-Issues with provide the needed additional clinics for 1st OPAs as a result of some clinical shortages, and also the ability to support 'extra' clinics with PSC staffing as NHSP/overtime no longer available.
-Derm 1st OPA demand exceeding capacity. The service has exceeded a key tipping point and will be unable to recover without a step reduction in referrals. Cancer alliance support has been requested to support an education piece with some GPs and increase e-Derma (imagery provision) in the community divert some referrals away from the Trust.
-Escalation processes established in 24/25 continue in this financial year. All services and teams are aware of those patients waiting above prescribed times for diagnostics, reports, reviews and required next steps. There are numerous capacity constraints across the pathways.
- Challenges with Breast Screening capacity - working group established to review with weekly capacity reviews to optimise wait times where possible.
- KMCA bids supported by Cancer Alliance to a value of £0.5m. Business case requested for review at October BCSG to accept the funding - key areas of support for Urology, LGI, Breast US.
62D performance - End of year National Target of 75%, Trust ambition target set at 80% - L3 months performance June (72.33%) validated, July (78.67%) unvalidated, August (78.50%) unvalidated

Key Milestones

Milestone	Description	Target Date	Status	Commentary to support any delays/planned mitigations
Operational Performance - Planned Care				
3.1 - Reduction in 18ww				
3.1.01	Reduction in 18ww – 55.7%	Sep-25		April: 54.0%, May: 54.7%, June: 55.0%, July 54.9%, August: 54.7%
3.2 – Reduction in 52ww				
3.2.01	Reduction in 52ww – 1.7%	Sep-25		April: 3.2%, May: 3.0%, June: 2.8%%, July2.6%%, August: 2.9%
3.3 - To improve performance against the 28-day cancer Faster Diagnosis Standard - 80%				
3.3.10	improve performance against the 28-day cancer Faster Diagnosis Standard - 80%	Mar -26		FDS - End of year National Target of 80% - L3 months performance: June (76.81%/Traj. 77%) validated, July (76.88%/Traj. 78%) unvalidated, August (74.74/Traj. 77%) unvalidated To note the target trajectory dips in August and September recognising seasonal norms of declining FDS due to clinical leave over the summer

People

East Kent Hospitals University NHS Foundation Trust

IIP Objectives - Executive Leadership development programme to be delivered following 360 reviews
Focus development for impact: MD Development programme implementation
Complete a series of 'well led' interviews with Trust executives
Develop Trust wide culture programme informed by key themes from the staff survey that delivers visible, valued improvements, with a short-term response addressing immediate concerns and a longer-term strategy aligned with the People Plan

Programme Status	
Programme	Leadership & Culture Development
SRO	Ben Stevens Norman Blissett
Programme Manager	Abigail Blake Steph Corking Rob Fordham

Progress Update
The objectives, outline and proposal for the Exec Leadership Programme has been written and socialised with both Chief Executive Officer (CEO) and Chief People Officer (CPO). Discussions to take place w/c 15/9 to agree the finalised programme, at which time dates will be set to roll out plan. The MD Development Programme has been successfully implemented, with module one complete and module two started on 12 September. The Executive Team have attended a Well Led discussion session and await next steps. The Culture and Leadership Programme (CLP) has been strategically embedded within the People and Culture strategy and Business as Usual (BAU) operations, signifying commitment to a unified approach, with the CLP team working in close collaboration with Learning and Organisational Development and the Heads of People and Culture teams. This partnership ensures a joined-up effort to drive meaningful culture change across EKHUFT

Key Milestones				
Milestone	Description	Target Date	Status	Commentary to support any delays/planned mitigations
Leadership and Culture Programme Milestones				
1.1 Leadership Development				
1.1.02	Executive leadership programme and individual objectives agreed	Sep-25		Programme to be finalised w/c 15/9
1.1.02	MD Development programme implementation	Sep-25		Module two underway
1.1.03	Series of 'well led' interviews with Trust executives completed	Sep-25		Exec session held on 16th September.
1.2 Culture Development				
1.2.01	Trust wide culture programme developed	Sep-25		This has been fully developed and delivering through the people strategy and BAU.

Sustainability

East Kent Hospitals University NHS Foundation Trust

IIP Objectives - Deliver a Cost Improvement Programme (CIP) of £80M , whilst delivering its deficit plan
Finalisation of the financial sustainability plan

Programme Status	

Programme	Finance
SRO	Angela van der Lem
Programme Manager	Julie Wells

Progress Update
The Group is on plan in terms of Financial Plan and CIP delivery Year to Date (YTD) to Month 5. There is step change in delivery required from Month 7 which is well-sighted across the Trust. A review of the efficiency programme forecasted delivery is currently being undertaken, with recent actions put in place around WLIs and purchase of healthcare. Further interventions for run rate reductions proposed by Care Groups are also being collated, with a full update being presented to the September Finance and Performance Committee. The updated Financial Sustainability Plan (FSP), including fully refreshed assumptions, was signed off by the Trust Board and submitted to the South East Regional NHSE Team and Kent & Medway Integrated Care Board (ICB) in July 2025 (feedback expected by the end of September following their detailed review).

Key Milestones

Milestone	Description	Target Date	Status	Commentary to support any delays/planned mitigations
Financial Sustainability				
4.1 - Financial Governance				
4.1.01	Identification and mobilisation of the full £80m CIP schemes	Sep-25		Whilst the Trust has a plan to deliver the full required £80m savings target, there are some opportunities which remain under development and may not deliver the in year planned values. A detailed review of the savings scheme delivery risk has led to the following further opportunities being developed to help mitigate slippage of in-year delivery: 1. Enhanced 'waiting list initiative' controls 2. Purchase of Healthcare (insourcing / outsourcing of clinical capacity) expenditure review to be undertaken. 3. Further opportunities to reduce the £104m prescribing expenditure run rate 4. Implement revised non-pay control totals across all Care Groups and Corporate functions. 5. Develop an immediate controls policy to significantly reduce the Bank expenditure run rate 6. Further substantive Whole Time Equivalent (WTE) reductions from current vacancies on hold by the vacancy control panel
4.2 - Financial Plan Delivery				
4.2.01	Deliver deficit plan of £51.9m	Sep-25		£7k favourable to plan YTD to Month 5.
4.3 - CIP Delivery				
4.3.01	Deliver £20.3m CIP	Sep-25		£27k favourable to plan YTD to Month 5.
4.4 -Financial Sustainability Plan				
4.4.01	Finalisation of FSP planning assumptions	Sep-25		The updated FSP, including fully refreshed assumptions, was signed off by the Trust Board and submitted to the South East Regional NHS England (NHSE) Team and Kent & Medway ICB in July 2025. Initial CFO to CFO feedback from NHSE in August 2025 has been positive, with further feedback expected by the end of September following their detailed review. It is acknowledged that the FSP will be iterative over the next 12-18 months, particularly as we follow the recently published NHS Planning Framework that sets out the approach to medium-term planning over the next five years starting in planning for 2026/27.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Kent and Medway Pathology Network (KMPN) Joint Venture Contract**

Meeting date: **9 October 2025**

Board sponsor: **Ben Stevens, Chief Strategy and Partnerships Officer (CSPO)**

Paper Author: **Francesca Trundle, KMPN's Managing Director**

Appendices:

Appendix 1: **KMPN Report**

Executive summary:

Action required:	**Approval**
Purpose of the Report:	The Board has previously approved the Trust's participation in the Kent & Medway Pathology Service, together with other providers in the System, resulting in the KMPN Joint Venture (JV) Case for Change. The Trust's NED representative on the joint committee, Dr Andrew Catto, has been nominated as Chair. The KMPN are now submitting for approval a detailed Joint Venture Contract (available separately) for board sign-off.
Summary of key issues:	The Contract is 111 pages and covers all future arrangements relating to the KMPN. The key provisions in the contract are summarised in the accompanying Summary Note produced by Francesca Trundle, KMPN's Managing Director. A consequence of entering into the contract is that member Boards – including EKHUFT - will be delegating on the same terms the following responsibilities to the joint committee: - **Approving** contracts with a total value of less than £1m or approving the commitment of resources up to £1m; - **Recommending** single KMPN business cases with values above £1m directly to Trust Boards for approval; - **Recommending** the final form for Stage 3 of the Kent and Medway JV (the full consolidation of pathology staff and budgets into a host Trust) to the Trusts Boards; - **Approving** changes in the location of or provision of pathology services, including but not limited to the consolidation of any sub-specialties onto certain sites within KMPN.

East Kent Hospitals University NHS Foundation Trust

Key recommendations:	The Board of Directors is asked to **APPROVE** and authorise signature of the agreed Joint venture Contract on the terms summarised in the Cover Note as a member of KMPN and applying equally to all Partner Trust Boards as detailed in the attached report.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Trust Risk Register:	N/A
Resource:	N - No investment required for 2025/26.
Legal and regulatory:	Y legal **-** To strengthen their collaboration and facilitate the performance of the JV Agreement, the Trusts have agreed to jointly exercise their relevant functions and to establish and constitute a joint committee pursuant to sections 65Z5 and 65Z6 of the National Health Service Act 2006 in order to deliver KMPN's priorities and programmes. The committee will be known as the "KMPN Joint Committee" comprising executive and non-executive members of partner Acute Trusts.
Subsidiary:	N

Assurance route:

Previously considered by: N/A

25/73 - APPENDIX 1

Title	**Cover sheet – Kent and Medway Pathology Network (KMPN) Joint Venture Contract**
Date	9 October 2025
Meeting	For Partner Trust Boards – Maidstone and Tunbridge Wells NHS Trust (MTW), East Kent Hospitals University NHS Foundation Trust (EKHUFT), Medway NHS Foundation Trust (MFT) and Dartford and Gravesham Trust (DGT) September/October 2025
Author	Francesca Trundle, KMPN Managing Director

Introduction

Following approval by all Partner Trust Boards earlier in 2025 to the KMPN Joint Venture Case for Change and the initial joint committee meeting, we are now bringing the detailed documentation (the KMPN Joint Venture Contract is available separately) for board sign-off. This cover sheet highlights the key provisions in the contract that boards will be delegating to the KMPN joint committee and what will be retained by Trust boards as well as reminding boards of the financial principles, scope of KMPN and the phased approach to implementation. Many of the provisions in the joint venture contract will be completed or updated over the coming year before the joint venture reaches its final form (Phase 3). Approving this documentation now, however, ensures each partner is aware of its obligations and liabilities through Phase 2.

The contract has been reviewed by a series of different groups with representatives from each organisation. The finance and investment group have reviewed the finance schedule and the joint committee has reviewed the terms of reference. A corporate governance task and finish group has overseen the development, with advice from workforce and governance specialists from DAC Beachcroft, our appointed lawyers. DAC Beachcroft lawyers presented to that group on two separate occasions and it met monthly from October 2024 – January 2025 and then again in June 2025 to finally review, with comments and queries picked up outside the meeting.

The first meeting of the KMPN joint committee took place on 1 August and introduced members to KMPN services and the programme of work required over the next two years' which the committee will support. It included presentations on cellular pathology and microbiology services. The group also discussed the terms of reference and principles of delegated responsibility to the committee.

Delegated responsibilities to the joint committee

This contract (and the joint committee terms of reference included within it) delegates the following responsibilities to the joint committee:

- **Approving** contracts with a total value of less than £1m or approving the commitment of resources up to £1m;
- **Recommending** single KMPN business cases with values above £1m directly to Trust boards for approval;
- **Recommending** the final form for Stage 3 of the Kent and Medway Joint Venture (JV) (the full consolidation of pathology staff and budgets into a host Trust) to the Trusts boards;

- **Approving** changes in the location of or provision of pathology services, including but not limited to the consolidation of any sub-specialties onto certain sites within KMPN.

As well as the approvals above, the following responsibilities remain with each individual Trust board:

- **Approving** the annual KMPN budget and approving spending above the agreed KMPN budget;
- **Approving** material variations to scope of activity delivered through the KMPN;
- **Varying** the KMPN JV Agreement including, in particular, the financial principles;
- **Joining** a new NHS body to the KMPN or collaborating with any other pathology network;
- **Entering into**, renewing or extending any land transaction or loan agreement;
- **Disaggregating** the Committee;
- **Committing** any Trust to a reconfiguration of services which could engage the statutory duties of any Trust such as public consultation or Transfer of Undertakings (Protection of Employment) Regulations (TUPE) consultation;
- **Tendering** for and entering into a new contract with any integrated care board for the delivery of Services through the KMPN;
- **Pooling** the budgets of the Trusts;
- **Resolving** to form a legal entity such as an LLP or company limited by shares to deliver some or all of the activities of KMPN;

Financial principles

With respect to Phase 2 of the Joint Venture the following cost apportionment percentages will apply in line with previous agreements:

	MTW	**EKHUFT**	**North Kent Pathology Service (NKPS)**
Network Costs	25%	25%	50%
Membership Shares	MTW as per the percentage split set out in 2.2.2 below	EKHUFT as per the percentage split set out in 2.2.2 below	NKPS as per the percentage split set out in 2.2.2 below
LIMS	33%	34%	33%
MSC	As incurred	As incurred	As incurred
Outturn	The Partners will finalise the risk sharing profile in respect of any Surplus and/or Deficit in the budget as part of the Mobilisation Plan for Stage 2 and Stage 3. The proposal is that any surplus or deficit will be shared amongst partner organisations. Any variations shall be implemented in accordance with the Change Control Procedure.		

The initial KMPN Membership Shares, using the recurrent 2023/24 In-Scope Services pathology expenditure, are as follows:

	EKHUFT	MTW	NKPS	DGT	MFT	Total
	Actual					
	£k	£k	£k	£k	£k	£k
Recurrent costs less intercompany costs	36,699	27,248	19,282	5,006	3,501	91,736
Percentage of total recurrent costs	40%	30%	21%	5%	4%	100%

Scope of KMPN Joint Venture

The KMPN Joint Venture will include:

- All blood sciences, microbiology, cellular pathology, blood transfusion (including transfusion practitioners) and point of care services within each Trust
    - Phlebotomy services at East Kent

The KMPN Joint Venture will not include:

- Mortuary services
    - Phlebotomy services at Maidstone and Tunbridge Wells, Dartford and Gravesham and Medway
    - The direct employment of and accountability for medical staff (funding for clinical leadership PAs will be included)

Phased approach to implementation

As set out previously, KMPN will move to the joint governance and management approach via the joint committee in Phase 2. It is likely that this will be delayed by three months from October 2025 to January 2026 to align with other local Trust workforce changes but the majority of the preparatory actions for Phase 2 have now been completed and this is being overseen by the existing KMPN Board.

The Joint Venture contract sets out that if there is a delay to moving to Phase 3 (final form of the hosted joint venture), KMPN will remain in Phase 2, unless the partners agree otherwise. During Phase 2, the joint committee will recommend to Trust boards which organisation will be the JV host for Phase 3.

Following approval of this documentation the next updates to Trust boards are likely to be on the proposed award of a network MES contract in Autumn 2025.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Provider Board Capability Self-Assessment**

Meeting date: **9 October 2025**

Board sponsor: **Tracey Fletcher, Chief Executive**

Paper Author: **Khaleel Desai, Director of Corporate Governance**

Appendices:

Appendix 1: *Assessing provider capability: Guidance for NHS trust boards*; and
Appendix 2: Provider Capability Self-Assessment Submission Template

Executive summary:

Action required:	To **NOTE** the expectations of NHS England (NHSE) on completing the **Provider Board Capability Self-assessment** by 22 October and the proposed process for Board discussion and completion.
Purpose of the Report:	The NHS Oversight Framework 2025/26 has been developed with the engagement and contributions of key stakeholders to set out a transparent approach to assessing Integrated Care Boards (ICBs), NHS trusts and foundation trusts, ensuring public accountability for performance and providing a foundation for how NHSE works with systems and providers to support improvement. A component influencing the assessment in the future will be the **Provider Board Capability Self-assessment,** which requires the Trust Board to self-assess and confirm its own level of assurance across six domains (drawn from The Insightful Board). This report highlights how the Board has agreed to approach the completion of the assessment as a unitary Board.
Summary of key issues:	The Trust's segmentation (segment three as at 09/2025) within the NHS Oversight and Assessment Framework (NOF) will, in the future, be informed by (amongst other things) each Board's own assessment of their Trust's capability against six areas derived from *The Insightful Provider Board*, namely: - Strategy, leadership and planning - Quality of Care - People and culture - Access and delivery of services - Productivity and value for money - Financial performance and oversight

The assessments draws the Board's attention to a set of key expectations related to their core functions as well as encourage an open culture of 'no surprises' between trusts and oversight teams. NHSE regional teams will then use the assessment and evidence behind it, along with other information, to derive a view of the organisation's capability under the NOF Framework.

Approach

There are six domains (drawn from The Insightful Board) with 16 lines of enquiry – along with a separate catch-all question of Boards for any other factors impacting the assessment. The key element of the approach is providing the Board's level of assurance.

Our approach to undertaking the self-assessment as a unitary Board involves three stages:

Stage 1 *(completed)*	Over the last few weeks Executive Directors have been working with their teams on their response to each 'line of enquiry' and formulated a narrative response and indicated supporting evidence.
Stage 2 *(Monday 6 October)*	On Monday 6 October the Board separated into groups to consider the six Insightful Board areas and lines of enquiry and discuss what the group's assessment is of our capability – i.e. Confirmed; Partially Confirmed; or Not Met – informed by Executive input formulated in Phase 1. We will then come together to test and agree a final assessment across each area.
Stage 3 *(TBC)*	The Board will be provided with a fully complete document - with narrative and evidence - to approve and authorise submission.

In assessing each of the six Insightful Board thematic areas, the Board approached its analysis using frameworks that asks itself the following types of propositions:

1. "This board is satisfied or not against this thematic area because we are/are not doing…"
2. "We have / do not have this in place and are/are not satisfied it is working because…"
3. "recent independent verification of that has or has not given us confidence... "

This will lead to making assessments along the following lines:

Confirm	Partially Confirm	Not Met/Confirm
The Board Considers that it has the processes and	The Board considers that there	Based on the wording of the area in the

	capability in place across the organisation to cover all the expectations set out in the domain (note: this does not need to reflect the Indicative Lines of Enquiry set out in guidance – these are suggestions). Boards should indicate the relevant evidence giving them this level of confidence	are gaps in assurance – either because there are specific measures not yet in place or because there may issues with the efficacy of these measures.	domain in question, the Board cannot confirm it has any arrangements in place, or the trust is unable to meet the expectations set out under the domain
Key recommendations:	The Board of Directors is asked to **NOTE** the approach to undertaking the Provider Board Capability Self-Assessment and the commitment to submit it to the ICB by the deadline of 22 October.		

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Trust Risk Register:	N/A
Resource:	No
Legal and regulatory:	Yes – regulatory impact.
Subsidiary:	Yes – in the overall provision of services within the resources available to the Trust.

Assurance route:

Previously considered by: N/A

Classification: Official

NHS England

Assessing provider capability

Guidance for NHS trust boards

Publication reference: PRN01888

Contents

Introduction

As part of the NHS Oversight and Assessment Framework, NHS England will assess NHS trusts'[1] capability, using this alongside providers' NOF segments to judge what actions or support are appropriate at each trust. As a key element of this, NHS boards will be asked to assess their organisation's capability against a range of expectations across six areas derived from *The Insightful Provider Board*, namely:

- Strategy, leadership and planning
- Quality of Care
- People and culture
- Access and delivery of services
- Productivity and value for money
- Financial performance and oversight

These will inform a self-assessment which is intended to strengthen board assurance and help oversight teams take a view of NHS trust capability based on boards' awareness of the challenges their organisations face and subsequent actions to address them. The purpose of this is to focus trust boards' attention on a set of key expectations related to their core functions as well as encourage an open culture of 'no surprises' between trusts and oversight teams. NHS England regional teams will then use the assessment and evidence behind it, along with other information, to derive a view of the organisation's capability.

This document is designed to help boards make this self-assessment, set out the process and what organisations can expect along the way.

The self-assessment

This process set out here should not be seen as a 'tick box' exercise. As outlined above, the purpose is to promote self-awareness and transparency at NHS trust boards regarding their organisation's capabilities, strengths, weaknesses and the challenges they face. It also provides a consistent framework for regional oversight teams to engage with NHS trusts, identify key risks and, over time, assess management's track record in delivering performance and/or identifying and addressing issues to ensure strong, sustainable organisations able to deal with challenges as they emerge. Trusts will have 8 weeks to carry out this self-assessment and return it to regions.

Where boards already conduct effectiveness reviews, they should consider the degree to which these overlap with this self-assessment. In addition, and to avoid duplication, relevant

[1] NHS trust is used throughout this document to refer both to NHS trusts and NHS foundation trusts. The expectations set out in the document apply equally to both types of organisation

evidence gathered to support NHS trusts' Annual Governance Statements can also support the self-assessment.

Summary of the capability assessment cycle

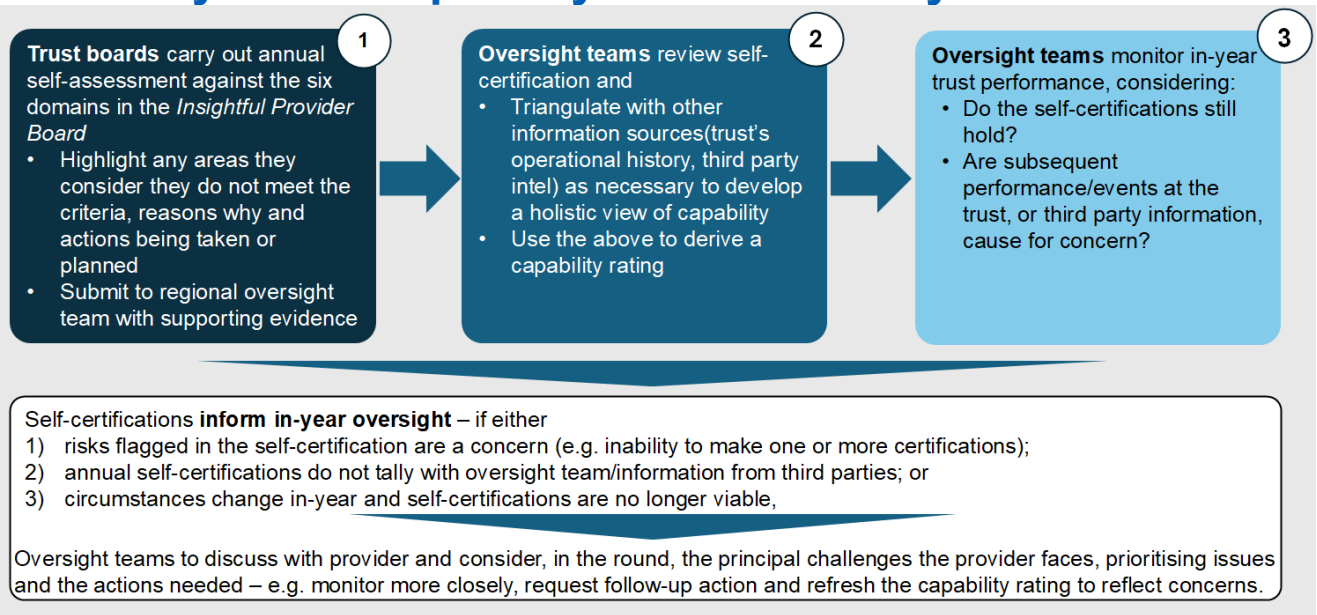


Fig.1: the capability assessment process

Figure 1 above sets out the self-assessment process which will take a number of stages across the year:

1. **NHS trust boards** carry out an annual self-assessment against the 6 domains in the *Insightful Provider Board* and:
   - highlight any areas for which they consider they do not meet the criteria, the reasons why and the actions being taken or planned then, within two months,
   - submit the completed self-assessment template to their regional oversight team with supporting evidence.

2. **Oversight teams** review the self-assessment and:
   - triangulate this with other information including the trust's recent operational history and track record of delivery and third-party intelligence (see below) as necessary to develop a holistic view of capability
   - assign a capability rating to the trust.

   Oversight teams will discuss the capability rating with the NHS trust and consider, in the round, the principal challenges the organisation faces, prioritising issues and the actions needed – for example, monitor something more closely, request follow-up action(s) and/or refresh the capability rating to reflect concerns if necessary.

3. **Oversight teams** will, across the financial year, use the capability assessment to inform oversight, for example where:
    - risks flagged in the self-assessment are a concern (e.g. inability to make 1 or more certifications), or
    - annual self-assessments do not tally with oversight team's views or information from third parties, or
    - subsequent performance/events at the trust or third-party information are a cause for concern such that elements of the self-assessment are no longer valid and, in order to assess 'grip', teams may wish trusts to review the basis on which they made the initial assessment.

The self-assessment

Below we provide indicative examples of the evidence boards should use or lines of enquiry they might consider taking to assess whether they can positively self-certify against each criterion. These should not be seen as exhaustive, and we expect trusts will have developed specific approaches to gain assurance in particular areas.

I. Strategy, leadership and planning

Self-assessment criteria	Indicative evidence or lines of enquiry
1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners	• Are the trust's financial plans linked to and consistent with those of its commissioning ICB or ICBs, in particular regarding capital expenditure? • Are the trust's digital plans linked to and consistent with those of local and national partners as necessary? • Do plans reflect and leverage the trust's distinct strengths and position in its local healthcare economy? • Are plans for transformation aligned to wider system strategy and responsive to key strategic priorities agreed at system level?
2. The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE	• Is the trust currently complying with the conditions of its licence? • Is the trust meeting requirements placed on it by regulatory instruments – for example, discretionary requirements and statutory undertakings – or is it co-operating with the requirements of the national Performance Improvement Programme (PIP)?
3. The board has the skills, capacity and	• Are all board positions filled and, if not, are there plans in place to address vacancies?

experience to lead the organisation	• What proportion of board members are in interim/acting roles? • Is an appropriate board succession plan in place? • Are there clear accountabilities and responsibilities for all areas of operations including quality, delivering access standards, operational planning and finance?
4. The trust is working effectively and collaboratively with its system partners and NHS trust collaborative for the overall good of the system(s) and population served	• Is the trust contributing to and benefiting from its NHS trust collaborative? • Does the board regularly meet system partners, and does it consider there is an open and transparent review of challenges across the system? • Can the board evidence that it is making a positive impact on the wider system, not just the organisation itself – for example, in terms of sharing resources and supporting wider service reconfiguration and shifts to community care where appropriate and agreed?

II. Quality of care

Self-assessment criteria	Indicative evidence or lines of enquiry

5. Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients	• The trust can demonstrate and assure itself that internal procedures:
	  ○ ensure required standards are achieved (internal and external)
	  ○ investigate and develop strategies to address substandard performance
	  ○ plan and manage continuous improvement
	  ○ identify, share and ensure delivery of best practice
	  ○ identify and manage risks to quality of care
	• There is board-level engagement on improving quality of care across the organisation
	• Board considers both quantitative and qualitative information, and directors regularly visit points of care to get views of staff and patients
	• Board assesses whether resources are being channelled effectively to provide care and whether packages of care can be better provided in the community
	• Board looks at learning and insight from quality issues elsewhere in the NHS and can in good faith assure that its trust's internal governance arrangements are robust
	• Board is satisfied that current staff training and appraisals regarding patient safety and quality foster a culture of continuous improvement

6. Systems are in place to monitor patient experience	• Does the board triangulate qualitative and quantitative information, including comparative benchmarks, to assure

and there are clear paths to relay safety concerns to the board	itself that it has a comprehensive picture of patient experience? • Does the board consider variation in experience for those with protected characteristics and patterns of actual and expected access from the trust's communities? • Is the board satisfied that it receives timely information on quality that is focused on the right matters? • Does the board consider volume and patterns of patient feedback, such as the Friends and Family Test or other real-time measures, and explore whether staff effectively respond to this? • How does the organisation involve service users in quality assessment and improvement and how is this reflected in governance? • Is the board satisfied it is equipped with the right skills and experience to oversee all elements of quality and address any concerns? • Is the board satisfied that the trust has a clear system to both receive complaints from patients and escalate serious and/or re-occurring complaints to the relevant executive decision-makers?

III. People and culture

Self-assessment criteria	Indicative evidence or lines of enquiry
7. Staff feedback is used to improve the quality of care provided by the trust	• Does the board look at the diversity of its staff and staff experience survey data across different teams (including trainees) to identify where there is scope for improvement? • Does the board engage with staff forums to continually consider how care can be improved? • Can the board evidence action taken in response to staff feedback?
8. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels	• Does the trust regularly review skills at all levels across the organisation? • Does the board see and, if necessary, act on levels of compliance with mandatory training?
9. Staff can express concerns in an open and constructive environment	• Does the board engage effectively with information received via Freedom To Speak Up (FTSU) channels, using it to improve quality of care and staff experience? • Are all complaints treated as serious and do complex complaints receive senior oversight and attention, including executive level intervention when required?

	• Is there a clear and streamlined FTSU process for staff and are FTSU concerns visibly addressed, providing assurance to any others with similar concerns? • Is there a safe reporting culture throughout the organisation? How does the board know? • Is the trust an outlier on staff surveys across peers?

IV. Access and delivery of services

Self-assessment criteria	Indicative evidence or lines of enquiry
10. Plans are in place to improve performance against the relevant access and waiting times standards	• Is the trust meeting those national standards in the NHS planning guidance that are relevant to it? If not, is the trust taking all possible steps towards meeting them, involving system partners as necessary? • Where waiting time standards are not being met or will not be met in the financial year, is the board aware of the factors behind this? Is there a plan to deliver improvement?
11. The trust can identify and address inequalities in access/waiting times to NHS services across its patients	• The board can track and minimise any unwarranted variations in access to and delivery of services across the trust's patients/population and plans to address variation are in place
12. Appropriate population health targets have been agreed with the ICB	• Is there a clear link between specific population health measures and the internal operations of the trust? • Do teams across the trust understand how their work is improving the wider health and wellbeing of people across the system?

V. Productivity and value for money

Self-assessment criteria	Indicative evidence or lines of enquiry

13. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	• Board uses all available and relevant benchmarking data, as updated from time to time by NHS England, to:
	  ○ review its performance against peers
	  ○ identify and understand any unwarranted variations
	  ○ put programmes in place to reduce unwarranted negative variation
	• The trust's track record of delivery of planned productivity rates

VI. Financial performance and oversight

Self-assessment criteria	Indicative evidence or lines of enquiry
14. The trust has a robust financial governance framework and appropriate contract management arrangements	• Trust has a work programme of sufficient breadth and depth for internal audit in relation to financial systems and processes, and to ensure the reliability of performance data • Have there been any contract disputes over the past 12 months and, if so, have these been addressed? • [Potentially more appropriate for acute trusts] Are the trust's staffing and financial systems aligned and show a consistent story regarding operational costs and activity carried out? Has the trust had to rely on more agency/bank staff than planned?
15. Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes	• Does the board stress-test the impact of financial efficiency plans on resources available to underpin quality of care? • Are there sufficient safeguards in place to monitor the impact of financial efficiency plans on, for example, quality of care, access and staff wellbeing? • Does the board track performance against planned surplus/deficit and where performance is lagging it understands the underlying drivers?
16. The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	• Is the board contributing to system-wide discussions on allocation of resources? • Does the trust's financial plan align with those of its partner organisations and the joint forward plan for the system? • Would system partners agree the trust is doing all it can to balance its local/organisational priorities with system priorities for the overall benefit of the wider population and the local NHS?

Inability to make a positive self-assessment

The board may not be able to make a positive self-assessment either because it considers the risks in a specific area are too great or its organisation is already manifestly failing in a specific area (for example, delivering on access targets). In these situations – and in line with the 'no surprises' ethos – in the self-assessment template boards should provide:

- the reasons why a positive self-assessment cannot be made against specific criteria and the extent to which these have been outside the trust's control to address (for example, industrial action, system-wide factors)
- how long the reasons have persisted
- a summary of any mitigating actions the trust has taken or is taking

- if not already shared with oversight teams, a high-level description of trust plans to address the issue, how long this is likely to take and KPIs or other information the trust will use to assess progress

Oversight teams will use this information to form their view of the overall capability of the trust and tailor their oversight relationship with it.

Material in-year changes

In addition to the annual self-assessment, if the board becomes aware in-year of a significant change to its ability to meet any of the self-assessment criteria – for example, an external report reveals material quality risks or an unforeseen cost will affect its financial performance – it should inform the oversight team along with the actions it is taking to address the issue. Such in-year changes will likely inform the ongoing regulatory relationship with the NHS England region.

The NHS provider trust capability rating

Regional oversight teams will review the trust's submitted self-assessment and consider the statements and evidence. Using a range of considerations, including the historical track record of the trust, its recent regulatory history and any relevant third-party information, the oversight team will decide the trust's capability rating and share this with it, including the rationale for the rating.

Rating	Indicative criteria
Green High confidence in management	• No concerns evident from the self-assessment or subsequent performance • No concerns arising from third-party information • High confidence in the trust's ability to deliver on its priorities based on track record over past 12–24 months
Amber–green Some concerns or areas that need addressing	• After discussion with the trust, some concerns emerging across more than one domain, but these as yet are not affecting quality of care, delivery of core services, finance or the wider reputation of the NHS • Trust has prepared plan(s) to address any problems with associated timeframe for delivery • Historical issues/track record mean NHS England does not (yet) have full confidence in the board
Amber–red Material issue needs addressing or failure to	• Issues with self-assessment or subsequent issues across multiple domains • Failure to deliver on agreed plans to address a material issue • Potentially in breach of licence

address major issues over time	
Red Significant concerns arising from poor delivery, governance and other issues	• Material or long-running concerns at the organisation that management has been unable to grip • NHS trust in breach of licence or likely to be

Third-party information

As set out in the NHS Oversight Framework, third-party information relating to the organisation's governance and risk profile, staff morale and quality of care provided may inform NHS England's view of NHS trust capability. We expect that where **trusts receive information that impacts on their self-assessment** they should share this with NHS England. Relevant third parties include:

- **other bodies with regulatory responsibilities**, where concerns can reflect weaknesses in internal governance and systems of internal control and oversight – including the Information Commissioner, Human Tissue Agency and NHS Blood and Transplant
- **professional representative bodies,** reflecting issues with working conditions, staff morale, operating culture and safety – including the General Medical Council, Nursing and Midwifery Council and Royal Colleges
- **patients and the public,** reflecting issues in areas such as patient experience and culture via groups like Healthwatch
- **staff information,** reflecting issues in internal culture and inability to speak up, for example via staff survey or whistleblowers
- **ICB partners,** covering areas like the trust's willingness to collaborate and deliver shared goals
- **other NHS England teams,** reflecting knowledge from central programmes like quality, cyber assurance or digital maturity
- **relevant oversight groups,** including Joint Strategic Oversight Groups (JSOG) and system and regional quality groups
- **other sources** as relevant to the NHS trust, including coroners, Parliamentary Health Service Ombudsman, Local Government and Social Care Ombudsman, Ofsted, the trust's internal and external auditors and even the police.

For further information on relevant information from third parties please see Annex 1.

Annex 1: Bodies with relevant information on NHS trust capability

Body	Responsibilities	Considerations/areas to look at for NHS trust capability
NHS England	• Uses the conditions in the NHS trust licence it issues to NHS foundation trusts (and which also applies to NHS trusts in shadow form) to regulate trusts across a range of areas, including delivery of services, quality governance and efficiency, economy and effectiveness of management • Oversees the training of healthcare staff. Trusts liaise with it on matters like resident doctor training and NHS England has the power to remove resident doctors from trusts if conditions are unsatisfactory • Operates a cyber assurance service to build cyber security across the NHS, assessing alignment to key standards relating to the cyber assessment framework and indicators of good practice	• Meeting national standards • Compliance with the NHS trust licence • Resident doctor survey • Delivering NHS objectives • Collaborating with NHS trusts • Cybersecurity
Care Quality Commission	• Registers organisations to provide care in England, sets regulations covering the care trusts provide, runs an inspection and monitoring regime and publishes NHS trust ratings With NHS England: • Provides joint strategic leadership and alignment for quality through the National Quality Board (NQB) • As co-signatories of the NQB guidance for system quality management, work together as part of a culture of open and honest co-operation to identify opportunities for improvement, early warning signs, concerns and risks, and take collaborative action, working with systems to mitigate and manage quality • Ensures coherent oversight arrangements are in place for	• Quality of care – are any sites or services operated by the NHS trust classed as 'Inadequate'? • Governance and culture – are there concerns for NHS England arising from the CQC's well-led review across the whole organisation?

	systems, ICBs and NHS trusts to ensure services are safe and effective • Shares learning and information about quality risks/concerns in a timely and proactive way, through system quality groups, regional quality groups and wider discussions, and respecting regulatory frameworks	
Medicines and Healthcare products Regulatory Agency	• Regulates medicines, medical devices and blood transfusion components	• Systems in place to ensure proper and safe use of medical equipment
Human Tissue Authority	• Regulates the removal, storage, use and disposal of human bodies, organs and tissue	• Systems in place to safely and legally handle human tissue
The Human Fertilisation and Embryology Authority	• Regulates and inspects all clinics in the UK providing in vitro fertilisation (IVF), artificial insemination and the storage of human eggs/sperm/embryos – this may include some trusts	• Systems in place to meet standards associated with IVF and related procedures
The Health & Safety Executive	• Has a national remit over matters like workplace safety, estates conditions which covers trusts	• Systems in place to ensure staff, patients and the public work in a safe environment
The Information Commissioner's Office	• Has a national role to uphold information rights in the public interest May be in contact with trusts regarding patient confidentiality, for example setting data requirements	• Systems in place to manage data securely and in compliance with all relevant standards
NHS Counter Fraud Authority	• Investigates reports of fraud, bribery and corruption across the NHS	• Systems and culture in place to ensure zero tolerance of fraud, bribery and corruption at the NHS trust
Professional regulators: • General Medical Council • Nursing and Midwifery Council • General Chiropractic Council	• Together with NHS England, ensure proper standards of practice in respective professions to protect, promote and maintain the health and safety of the public • Most have responsibilities across the UK and all regulate professionals regardless of whether they work in the NHS or the independent sector • As a designated body, NHS England has a statutory duty under the	• Staff can work in and contribute to a safe, sustainable environment that ensures good morale and a healthy working culture that supports high quality care

• General Dental Council • General Optical Council • General Osteopathic Council • General Pharmaceutical Council • Health and Care Professionals Council • Social Work England	responsible officer regulations for GPs on the national performers list and for responsible officers from designated bodies across a wide variety of sector organisations • NHS England must inform professional regulators where professionals fail to meet the standards. This can lead to an investigation and potentially sanctions such as conditions on practice, suspension or removal from a professional register • Responsible for quality assuring the education and training of healthcare professionals. Most can inspect organisations that commission, oversee or provide education, and they have powers to withdraw approval from training programmes, posts or NHS trusts if they are not satisfied that education or training is being provided in a safe or effective way. In April 2023, NHS England took on the previous powers of Health Education England to regulate training NHS trusts and placement hosts	
Local Government and Social Care Ombudsman Parliamentary and Health Service Ombudsman	• Provide an independent complaint handling service	• Evidence of patient or staff concerns at health and care NHS trusts
Health Service Safety Investigations Body	• Investigates serious patient safety risks that span the healthcare system, operating independently of other regulatory agencies	• Quality assurance arrangements at NHS trusts
Healthwatch	• Shares learning and information through system quality groups, regional quality groups and the NQB to ensure that the views and experience of people and the public informs quality improvement and risk management discussions • *Note: The Dash Review recommends abolishing Healthwatch. If followed through, this will need to go through a number of steps before being enacted in legislation, likely in late 2026/early*	• The NHS trust uses patient and public information in reviewing the care provided at the organisation • Is there any evidence of patient concerns that might indicate issues with the provision and oversight of care provided?

	2027. Until then, Healthwatch will continue to gather patient views and evidence and work together with NHS trusts and commissioners to improve local services.	
Ofsted	• Investigates education settings, including secure children's homes and SEND services	• Is there any evidence of patient concerns that might indicate issues with the provision and oversight of care provided at specific sites managed by the NHS trust?
Coroners	• Coroners investigate deaths that are unnatural or violent or where the cause is unknown or that took place in prison, police custody or another type of state detention, such as a mental health hospital	• Is there any evidence of concerns or issues – for example, organisational culture or governance – that may have led to a death at the institution?
Royal Colleges	• The professional bodies that oversee and regulate various medical specialties. These colleges set standards for training, examinations, and continuing professional development for doctors in their respective fields. They also play a role in policy and advisory work related to their specialties.	• Do information from Royal Colleges – e.g. anonymised data from surveys of their members – highlight cultural, quality of care or patient safety concerns at the trust?
Local authorities	• Along with other roles, local authorities help develop the population health needs assessment. Trusts are expected to work with system partners to meet these needs	• Is there any evidence that the trust is not an effective system partner across its geography?

Provider Capability - Self-Assessment Template

	The Board is satisfied that…		*(Mitigating/contextual factors where boards cannot confirm or where further information is helpful)*
Strategy, leadership and planning	• The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners • The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE • The board has the skills, capacity and experience to lead the organisation • The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served	**Confirmed**	*If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*
Quality of care	• Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients • Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	**Confirmed**	*If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*
People and Culture	• Staff feedback is used to improve the quality of care provided by the trust • Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels • Staff can express concerns in an open and constructive environment	**Confirmed**	*If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*
Access and delivery of services	• Plans are in place to improve performance against the relevant access and waiting times standards • The trust can identify and address inequalities in access/waiting times to NHS services across its patients • Appropriate population health targets have been agreed with the ICB	**Confirmed**	*If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*
Productivity and value for money	• Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	**Confirmed**	*If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*
Financial performance and oversight	• The trust has a robust financial governance framework and appropriate contract management arrangements • Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes • The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	**Confirmed**	*If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*
	In addition, the board confirms that it has not received any relevant third-party information contradicting or undermining the information underpinning the disclosures above.	**Confirmed**	*If the Board cannot make this certification, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*

Signed on behalf of the board of directors

Signature

Name

Date

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Significant Risk Register Report**

Meeting date: **9 October 2025**

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

Paper Author: **Emma Kelly, Associate Director of Quality Governance (on behalf of Director of Quality Governance)**

Appendices:

None

Executive summary:

Action required:	Assurance
Purpose of the Report:	This paper presents the current Significant Risk Report (SRR) to ensure Board oversight of those risks rated as high and above (15>). All have an assigned Executive Director and are required to be updated monthly and reported through Trust Management Committee (TMC) and the appropriate Board Sub Committees to Board. This paper demonstrates movement in month, details those risks that have been de-escalated from the Significant Risk Register due to the mitigations in place and new risks.
Summary of key issues:	The majority of the risks contained in the significant risk report have had a 'review' within the last four weeks. As of 26 September 2025, when the Significant Risk Register was extracted there are currently 44 risks on the Significant Risk Register. There are three risks with associated overdue actions. These have been escalated with risk owners and delegates – most actions have recent dates. There have been significant improvements in ensuring records are reviewed and updates provided but it is essential that this process becomes embedded within strengthened business as usual governance arrangements. Monthly meetings are in place with the executive leads for each significant risk (and their deputy/wider team as requested) to ensure regular monthly oversight and scrutiny. The Risk Review Group on 16 September 2025 received a Deep Dive from Kent & Canterbury Royal Victoria Hospital (KCRVH) Care Group and Corporate Operations. Five new risks were approved which are detailed in Section 4.

	There were no escalations from the meeting but Care Group and Corporate leads were asked to ensure that all risks are up to date – with significant risks reviewed at a minimum monthly. Care Groups were also asked to ensure they are reviewing the monthly emerging risk report via their Care Group governance meetings. There have been delays in the rollout In Phase (Quality Management System) for Risk - due to issues with the supplier which have been escalated – but work continues – with Subject Matter Expert Testing and User Acceptance Testing taking place in October 2025.
Key recommendations:	The Board of Directors is asked to receive and **NOTE** the SRR for assurance purposes and for visibility of key risks facing the organisation.

Implications:

Links to 'We Care' Strategic Objectives:	• Our patients • Our people • Our future • Our sustainability • Our quality and safety
Link to the Trust Risk Register:	This paper provides an update on the significant risks (to be known as the 'significant risk report') to the Trust which replaces the Corporate Risk Register (CRR).
Resource:	Yes. Additional resource will be required to mitigate some of the significant risks identified. The position of Head of Risk Management is currently vacant and essential cover is being provided by the Associate Director for Quality Governance ahead of a review and restructure of work within the wider team.
Legal and regulatory:	Yes. The Trust is required to comply with the requirements of a number of legal and regulatory bodies including but not limited to: • NHS England • Care Quality Commission • Health and Safety Executive
Subsidiary:	2gether Support Solutions Spencer Private Hospitals

Assurance route:

This was previously considered by:

The Risk Review Group on 16 September 2025. New approved risks are reflected in this paper to ensure timely reporting but will be formally presented at TMC on 1 October 2025.

Reporting is also received monthly at the Finance and Performance Committee, and bi-monthly at Quality and Safety Committee and People and Culture Committee.

It should be noted that as the Risk Register is a live document the supporting information was extracted on 26 September 2025.

East Kent Hospitals University NHS Foundation Trust

SIGNIFICANT RISK REPORT

1. Purpose of the report

1.1 This report is provided to ensure the Board are aware of all risks rated high (15) and above on the Trust risk register.

1.2 This paper presents movement in month and details those risks that have been de-escalated from the Significant Risk Register due to the mitigations in place.

1.3 The last Risk Review Group took place on 16 September 2025. A deep dive presentation was provided by KCRVH Care Group and Corporate Operations. Several new risks were approved which are detailed in Section 4.

2. Background

2.1 A comprehensive review and refresh of the Corporate, Care Group and Specialty level risk registers was launched in November 2023. This followed an initial review and recommendations made by an External Consultant on behalf of the Trust in October 2023. Phase 1 of this work was concluded at the end of March 2024. Phase 2 will involve embedding the processes and governance improvements introduced and continuing to develop the risk culture in the organisation.

2.2 One of the outputs of the Trust Risk Review was the creation of a Significant Risk Report. The latest is summarised in Section 3 of this report.

2.3 The Risk Review Group was established in early February 2024. The Group, which meets monthly and is chaired by the CNMO. Deep dives are presented by all Corporate and Clinical Care Groups twice a year.

3. Current Significant Risk Register

3.1 There are currently 44 risks in total on the Significant Risk Report (up from 43 in the July Board report).

3.2 There has been an increase of one residual risk score and the decrease of two residual risk scores (one which resulted in a de-escalation from the significant risk register). These are marked on the table below.

3.3 There are overdue actions associated with three of the risks (marked in bold for clarity). These have been escalated for immediate attention with the Risk Owners and Delegates.

3.4 The Significant Risk Register is summarised below:

East Kent Hospitals University NHS Foundation Trust

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to July report	Target Risk Score	Actions summary
678	Care Group - Diagnostics, Cancer and Buckland **Accountable Executive: Chief Medical Officer (CMO)**	Insufficient Pharmacy support for the safe (and secure) use of medicines on wards	High (15)	⟺	Low (4)	Request purchase of Sunrise medicines app for use by pharmacy staff with aim of improving processes on the system which have been impacted when switching to epma e.g. ordering and screening (Home function is required to improve MR process) Awaiting outcome of decision. Note new version will be introduced in 2026 – unclear on impact to pharmacy team Person Responsible: Deputy Lead CS Pharmacist Due: 31 Oct 2025 Review effectiveness and limitations of weekend service (review to be completed) to identify whether any clinical capacity can be released and skill mix is correct (service extended two years ago). Person Responsible: Lead Pharmacist for Clinical Operations and Workforce Due: 01 Oct 2025 Review impact of new workflow procedures and identify how to

						reduce workload for clinical team further in the dispensary Person Responsible: Lead Pharmacist for Clinical Operations and Workforce Due: 01 Oct 2025 Identify causes of late nights for clinical pharmacy staff and identify strategies to reduce the commitment (clinical staff provide a late-night commitment which is Time Off In Lieu (TOIL) based which reduces clinical capacity). Person Responsible: Lead Pharmacist for Clinical Operations and Workforce Due: 01 Oct 2025 Propose a new model of working to support review of most at risk patients. Proposal to include impact on other patients for Care Quality Commission (CQC) and Trust to review Person Responsible: Lead General and Specialist Medicine Pharmacist Due: 1 Oct 2025
679	Care Group – Diagnostics, Cancer and Buckland	Failure to supply, from Pharmacy, scheduled chemotherapy	Extreme (20)	⟺	High (15)	Assurance of completion of Air Handling Unit (AHU) Airis Q action plan by the Accountable pharmacist/Estates/

	Accountable Executive: CMO	treatments to patients				production manager. Action plan and document uploaded and in process via the refurb work planned Person Responsible: Pharmacy Quality Assurance & Quality Control Lead Due: 01 Dec 2025 Create and appoint to a substantive Accountable pharmacist to replace current interim role. Interview set for 11/9/25. Unable to appoint and interim has finished. Director of Pharmacy to cover for interim whilst further recruitment happens. Person Responsible: Director of Pharmacy Due: 30 November 2025 Replacement of the unit with offsite licensed facility as part of the Integrated Care System (ICS) strategy and linked to the national aseptic review. Meetings regarding future state of the Aseptic Services Unit (ASU) for Kent & Medway (K&M) progressing and Trust Chief Executive Officer (CEO) is Senior Responsible Officer (SRO) Person Responsible: Director of Pharmacy Due: 30 Sep 2029

						Completion of the remedial aseptic work at K&C and validation of the facilities at K&C Person Responsible: Director of Pharmacy Due: 19 Dec 2025
1350	Care Group – Diagnostics, Cancer and Buckland **Accountable Executive: CMO**	Failure to provide ward stock medicines in a timely fashion due to obsolescence of Pharmacy TWS Distribution robot	High (15)	⟺	Very Low (3)	Business Case (BC) submitted to Business Case Scrutiny Group (BCSG). Robot continuing to perform although continuing to lose capacity due to 'blindness' Person Responsible: Chief Pharmacy Technician Due: 31 Oct 2025
1628	Care Group – William Harvey **Accountable Executive: CMO** **Proposed that this risk is de-escalated due to mitigations in place. Awaiting Care Group governance approval**	Staffing mix and experience impact on the ability of the Care Group to provide services to paediatric patients in line with the Royal College of Paediatrics and Child Health (RCPH) standards	High (16)	⟺	Low (4)	
1679	Corporate People and Culture **Accountable Executive:**	There is a risk of failure to address poor organisational culture	High (15)	⟺	Low (4)	Development of new People and Culture Strategy and Delivery Plan which will include culture change

	Chief People Officer (CPO)					Person Responsible: Norman Blissett Due: 31 Dec 2025
1814	Corporate – Strategic Development & Capital Planning **Accountable Executive: Chief Strategy & Partnerships Officer (CPSO)**	Loss of access to key operational / clinical systems from threats (cyber air con, break of external circuits, fire, floods etc) for a protracted period	High (15)	⟺	Moderate (10)	Review cyber team roles and responsibilities. Waiting on output from Cyber Assessment Framework (CAF)/ Data Security and Protection Toolkit (DSPT) assessment, which is due to be submitted at the end of June 25. Person Responsible: Head of Infrastructure, Cyber and Frontline Services Due: 30 Sep 2025 Training needs analysis to be undertaken for IT staff in relation to cyber. Person Responsible: Head of Infrastructure, Cyber and Frontline Services Due: 31 Dec 2025 Review and update current IT incident and cyber response plans. Extended date to ensure CAF recommendations are included Person Responsible: Head of Infrastructure, Cyber and Frontline Services Due: 31 Oct 2025 Servicing of Uninterruptible Power Supply (UPS) within data centre

						Person Responsible: J Kelly Due: 30 Sep 2025 Run regular (at least yearly) internal exercises to test plan and response with the IT team. Date extended to align with updated cyber response action Person Responsible: Head of Infrastructure, Cyber and Frontline Services Due: 31 Dec 2025 Bi- annual testing of network Wide Area Network (WAN) resilience for mitigation of external circuit failure Person Responsible: Head of Infrastructure, Cyber and Frontline Services Due: 30 Sep 2025 Annual servicing of air con within data centres Person Responsible: J Kelly Due: 31 Oct 2025 Review privileged access rights to key infrastructure systems (as per DocIT) Person Responsible: Head of Infrastructure, Cyber and Frontline Services Due: 31 Mar 2026

						Review of external facing systems that currently do not support Multi-Factor Authentication (MFA) Person Responsible: Head of IT Applications Due: 31 Mar 2026
1831	Queen Elizabeth Queen Mother Care Group **Accountable Executive: CNMO**	Privacy and dignity will be adversely affected when patients are treated in non-care spaces	High (15)	⟺	Low (6)	Fortnightly Queen Elizabeth the Queen Mother Hospital (QEQM) Urgent and Emergency Care (UEC) delivery Group set-up with a wide range of improvement programmes to support improvements in flow across the site. Person Responsible: Director of Nursing (DoN) Due: 31 Jan 2026 Assess progress of clinical harm reviews and associated learning Structured Judgement Review (SJR) compliance is slowly improving Person Responsible: Associate Medical Director Due: 31 Jan 2026 Reverse boarding in place to identify patients who need resus and those who are well enough to be cared for in a non-care space. Ongoing monitoring against corridor care Standard Operating Procedure (SOP).

						Person Responsible: Deputy Head of Nursing (HoN) Due: 31 Jan 2026 Fundamentals of care training to be completed by staff re privacy and dignity. Training remains ongoing – new starters planned. Person Responsible: Deputy Head of Nursing (HoN) Due: 31 Jan 2026
1891	Corporate Operations **Accountable Executive: Chief Operating Officer (COO)**	Misalignment between Demand and Capacity across the Trust's urgent and emergency care pathway	Extreme (20)	⟺	Low (6)	Demand and capacity modelling to be confirmed by all systems partners for all P1 to P3 patients as part of the system wide better use of beds programme to inform 2526 redesign. Person Responsible: Deputy COO Due: 31 Oct 2025 Conduct a comprehensive review of current Emergency Department (ED) processes and identify areas for improvement – focussing initially on the opportunity to reduce the number of patients spending 12+ hour in ED. Refresh of Clinical Decision Unit (CDU) model as part of Same Day Emergency Care (SDEC) capital build process as an enabler. Colocation of Urgent Treatment Centre (UTC)

						to fully utilise Emergency Floor footprint. Review from September with ECIST support is underway at WHH and areas of good practice with be transferred to QEQM. To be included and referenced in UEC Improvement Plan that now has structure and governance within the Programme Board to TMC. CDU estates changes in progress and nearly complete with a SOP for utilisation. Extensive bed modelling has taken place as part of the winter planning process for Board review in October. A series of improvement weeks across both sites are taking place throughout the year looking to improve ED process and patient flow with partners. From a capital perspective, a new SDEC will be built on both sites from Aug 25 to May 26 and a revised clinical model will be introduced upon completion. Person Responsible: Deputy COO Due: 30 Nov 2025
2123	Care Group – Diagnostics, Cancer and Buckland	Health and Safety Risk to staff and the potential unavailability of records at the point of need	High (15)	⇩	Low (4)	Agreement of new Retention Policy which will reduce the number of physical notes needed to store

	Accountable Executive: CPSO	due to lack of storage space for Health Records.				Person Responsible: Des Holden, CMO Due: 31 Oct 2025 Strategy to be developed and agreed regarding the creation of new health records Person Responsible: Des Holden, CMO Due: 31 Oct 2025 Creation of Health Records Digital Strategy Person Responsible: Director of Digital Transformation and Information Technology Due: 31 Oct 2025 Intention to move Health Records under Digital team (Corporate SD – Director of Information) pending consultation. This will enable alignment with digital strategy Person Responsible: Managing Director of DCB Due: 30 Nov 2025
2158	Care Group - Diagnostics, Cancer and Buckland **Accountable Executive: CMO**	Risk of Patient harm and treatment due to unreported Accident & Emergency (A&E) chest xrays.	High (16)	⟺	Low (4)	**External review to be undertaken by Regional Advisor. Meeting to be arranged with care group leaders to discuss outputs of report.** **Person Responsible: Des Holden, CMO** **Due: 29 Aug 2025**

2234	Care Group – Diagnostics, Cancer and Buckland **Accountable Executive: CMO**	Failure to meet national histopathology Turnaround Time (TAT's) to support cancer pathway	High (16)		Moderate (8)	Kent and Medway Pathology Network (KMPN) Digital Histopathology & AI project to improve performance & resilience. NB: this is an adjunct to maintaining service delivery and performance and NOT all histology cases can be reported using AI. The digital pathology project is on hold at Maidstone and Tunbridge Wells NHS Trust (MTW), but validation of reporting by digital image is proceeding slowly at EKHUFT, with the breast pathologists about to enter phase 2 (live case dual reporting with digital image and microscope). Each pathologist will have to be validated for each sub-discipline they report before they can switch to digital reporting. AI roll out for assisted reporting can only follow after validation of digital reporting. Person Responsible: Head Biomedical Scientist Cellular Pathology Due: 31 Dec 2026 Trust involved in discussions regarding a Kent & Medway Joint Venture. Trust to ensure areas of pressure are

						highlighted and worked up. Rolled out the workload points across all specialities and are working on an analysis of consultant Direct Clinical Care (DCC) reporting availability (according to JPs - >80% done in cell path) vs workload coming in to give an accurate position. On a wider scale, discussion demand management including at Performance Review Meeting (PRM). Person Responsible: Desmond Holden, CMO Due: 30 Sep 2025
2406	Care Group - Diagnostics, Cancer and Buckland **Accountable Executive: CSPO**	Delay to patient diagnosis from potential loss of Nuclear Medicine service at WHH	High (16)	⟺	Low (4)	**Associated work is required to allow camera under NM to open on. discussed at PRM on the 29/08/24 and awaiting update. this Administration of Radioactive Substances Advisory Committee (ARSAC) licence renewal to allow operational services to commence** **Person Responsible: Chief Technologist Nuclear Medicine & Osteoporosis** **Due: 29 Aug 2025**
2599	Corporate – Medical	There is a risk of inadequate medical staffing levels and skills	High (15)	⟺	Moderate (9)	Programmes to support career progression and attraction of consultant posts for long term

	Accountable Executive: CMO	mix to meet patients' needs				locums becoming substantive (i.e. Certificate of Eligibility of Specialist Registration (CESR)). There are now portfolio pathway posts in the Trust. Acute Medicine WHH and Obstetrics & Gynaecology (O&G) QEQM have converted posts and are using this pathway. Person Responsible: Head of Medical Workforce Due: 29 Aug 2025 To develop and implement a standard operating procedure for recruitment for hard to recruit posts Person Responsible: Head of People and Culture Services Due: 31 Oct 2025
2808	Care Group – QEQM	There is a risk of patient harm occurring due to delays in recognising and escalating deteriorating patients in ED due to capacity	High (15)	NEW (escalation)	Low (6)	An ED specific NEWS2 SOP is being developed Risk score increased due to recent incidents relating to lack of escalation Person Responsible: Specialist Nurse Practitioner Due: 31 Oct 2025 Participation in relevant audits relating to deteriorating patients and development and implementation or robust actions to address gaps and identified areas

						where improvement is needed. Audits – sepsis and deteriorating patient – ongoing. Person Responsible: Specialist Nurse Practitioner Due: 31 Jan 2026
2853	Care Group – Kent & Canterbury and Royal Victoria **Accountable Executive: COO**	Renal – Dialysis Capacity	High (16)	⟺	Low (6)	Dialysis matron to support the recruitment of Phase 2 nursing posts for additional twilight at K&C, Maidstone and QEQM plus Home Dialysis expansion Delay to delivery as internal renal nursing establishment review needed to be completed. This is complete and the posts are on TRAC awaiting approval. Person Responsible: Dialysis Matron Due: 30 Sep 2025
3105	Care Group - Critical Care, Anaesthetics and Specialist Surgery **Accountable Executive: CMO**	Patient harm to Head and Neck cancer operations delayed or aborted due to aged Leica microvascular microscope breakdown	High (16)	⟺	Low (4)	Leica Microscope trial still running with a further bid submitted. Meeting to review decisions and submission to Medical Devices Group (MDG) for consideration of funding route. Person Responsible: Procurement Facilitator – Decontamination Contract Manager Due: 31 October 2025
3354	Queen Elizabeth Queen	Clinical environment not fit for	High (16)	⟺	Moderate (9)	Estates issues for all ward areas to be addressed with the Estates team to ensure

	Mother Care Group **Accountable Executive: CSPO**	purpose in many areas				an ongoing programme of maintenance and repair. List of estates issues from closed ward risks attached March 2025 - A comprehensive list of all new Estates work required as well as outstanding estates work is being compiled via the daily Quality Improvement Meetings Handyman has started in post. Evidence of full job list to be requested. Director of Strategy working with care groups to validate estates risks and ensure appropriately reflected on the risk register. To report back to October Risk Review Group. Person Responsible: DoN Due: 30 Sep 2025 Working with 2gether Support Solutions (2gether) to create a clear targeted investment list of areas required to improve environment Person Responsible: Managing Director Due: 30 Sept 2025 Targeted review of heating and cooling needs across the estate to inform a focussed long-term capital investment programme

						Person Responsible: Estates Lead Due: 30 Sept 2025 Creation of a transparent system to see open estates requests and to be prioritised by triumvirate with 2gether Person Responsible: Ben Stevens, CSPO Due: 07 Nov 2025 Pilot of handyman role approved by 2gether to focus on patient and staff environment improvements Person Responsible: Estates Lead Due: 04 Dec 2025 Consider external review of 2gether cleaning service to enhance standards and gain best value for money Person Responsible: Ben Stevens, CSPO Due: 25 Dec 2025
3367	Corporate Medical **Accountable Executive: CMO**	Lack of timely review of diagnostic test results	Extreme (20)	⟺	Low (6)	**Developing the Compass technology for the Inbox on Sunrise for consultants to review and all results that are allocated to them. To trial this functionality within a team or number of users to identify any potential flaws.**

						Person Responsible: Chief Clinical Information Officer **Due: 30 June 2025** **A copy of the radiology results are sent to the requesting clinician. Every week a spreadsheet is generated based on specific Systematized Nomenclature of Medicine Clinical Terms (SNOMED) codes. This is sent to all the Multidisciplinary Meeting (MDM) coordinators who will look for any new cases relevant to their speciality. The MDM coordinators will add it to the MDM list for discussion. Regular audits (weekly) will take place to ensure that MDM coordinators workload is acceptable in identifying new cases relevant to their speciality.** **Person Responsible: Consultant Histopathology** **Due: 31 Jul 2025**
3384	Corporate – Strategic Development & Capital Planning **Accountable Executive: CSPO**	The ability to deliver safe and effective services & implement improvements across Trust estate is compromised due to financial constraints for	High (16)	⟺	Moderate (12)	Progress to full business case for the replacement of maternity facilities at QEQM The Business Case continues to be developed with the new P23 partner (IHP). RIBA Stage 4 is due to complete in Dec/Jan to enable to business case

		capital funding and assets replacement				to be completed and submitted to Trust and NHSE governance Person Responsible: Director of Strategy & Business Development Due: 31 Jan 2026
3386	Care Group – Women, Children and Young People **Accountable Executive: CNMO**	Potential risk of inaccurate records due to Euroking back copying	High (16)	⟺	Low (4)	Work continues to implement MSR 2.1.1 into the Euroking Test environment to then be tested. If the testing is successful, then Trust to decide whether to move this into the live Euroking environment or stick with the current bespoke MSR. Notice to leave Magentus with the procurement of the MIS has been declared. End date of Magnetus support as part of NPSA project unclear, however Trust pushing for the mitigation to take place. Risk review at maternity risk meeting – no further progress with Magentus – everything that can be upgraded has been, except MSR that was rolled back. Person Responsible: Clinical Information Systems (CIS) Manager Due: 25 Dec 2025 Procurement of a new Maternity IT system to ensure adequate reporting integration with current systems and patient accessibility

						Person Responsible: Deputy Director of Midwifery (DoM) Due: 15 Sep 2026
3449	QEQM Care Group	There is a risk that patients who stay in ED for over 24 hours may not receive appropriate assessment and review	High (16)		Low (6)	Plus 24 SOP in place and action to develop and audit tool and audit compliance with this, including quality of and documentation of plans of care and time patient reviewed Person Responsible: Operations Director – UEC QEQM Due: 31 Mar 2026
3553	William Harvey Hospital Care Group **Accountable Executive: CSPO**	Failure of Cardiac Catheter Suite equipment (Lab 1, 2 & 3) WHH	Extreme (20)		Moderate (10)	Working on solution for a new lab that will act as a decent lab initially, to be implemented by end of financial year. Further lab replacements will then be reviewed once this is completed Person Responsible: General Manager Due: 30 Apr 2026 EME to source alternative to mechanical arm – current estimated delivery 20 Dec Person Responsible: Head of Electronics & EME Due: 20 Oct 2025 Capital across 25-26 and 26-27 capital programmes with expected completion of scheme Aug 26. Action and due date extended

						to reflect comments from Director of Strategy Person Responsible: Director of Strategy & Business Development Due: 31 Aug 2026
3556	William Harvey Hospital Care Group **Accountable Executive: CNMO**	Delays in delivery and personal care are resulting in an increased risk of pressure ulcers and falls occurring	High (15)	⟺	Low (6)	Improved access to direct ATED (alternative to ED) pathways Risk being reviewed across site – one risk needed for WHH and QEQM Care Groups (CGs) AD QG to liaise with DoNs. Person Responsible: Head of Operations Due: 30 Sep 2025
3557	William Harvey Hospital Care Group **Accountable Executive: COO**	Increased length of stay for mental health patients awaiting inpatient community beds	High (16)	⟺	Moderate (9)	Senior ED leads to review good practice Discharge to Assess (DTA) framework with Deputy COO that could be used for deciding whether a patient with mental health needs (and no physical health needs) should be admitted into an inpatient bed whilst awaiting an mental health (MH) bed. There are some circumstances where this might be appropriate, therefore having a best practice framework would be helpful. Person Responsible: Deputy COO Due: 31 March 2026
3700	Corporate – Finance &	Failure to agree a Medium-term	Extreme (20)	⟺	Moderate (12)	Agreement of the Medium Term Financial

	Performance Management **Accountable Executive: Chief Finance Officer (CFO)**	Financial Recovery Plan with System / Region and National Partners				Plan (MTFP) with Board, ICB & NHSE. MTFP has been to the Board (Aug 25) and ICB. Awaiting agreement. Date extended to reflect this – end of Dec 25 with regular updates Person Responsible: Angela van Der Lem, CFO Due: 31 Dec 2025
3702	Care Group – Critical Care, Anaesthetics and Specialist Surgery **Accountable Executive: COO**	Delayed discharge of patients from Critical Care when medically fit to be transferred to the ward	High (16)		Moderate (8)	Work with site triumvirate on priority for critical care wardables to be discharged from Critical Care Implementation date changed. We care project now underway, process mapping exercise commenced to understand the responsibilities Person Responsible: DoN Due: 31 Oct 2025
3719	Care Group – Diagnostics, Cancer and Buckland **Accountable Executive: CMO**	There is a risk of patient harm from availability, delays and errors in Systemic Anti-Cancer Therapy (SACT) prescribing for adults due to system failures with the ARIA medonc system being out of date at Kent and Medway	High (15)		Low (5)	ARIA system failure to be included in local business continuity plans Local business continuity plans (BCP) sent to emergency planning to review Person Responsible: Clinical Matron Due: 01 Jan 2026 New e-prescribing system to be procured and implemented across the Cancer Alliance.

		Cancer Collaborative (KMCC)				Digital Transformation Group leading on the work to mitigate this risk Person Responsible: Head of Operations Due: 30 Sept 2025
3725	Corporate Services **Accountable Executive: CNMO** **The legal portfolio has transferred to Corporate Nursing/ Quality Governance. Risk owner changed and risk to be refreshed.**	Risk of inadequate legal services support due to vacancies and resignations	High (16)	⟺	Moderate (12)	Agreement on structure of legal function for the new Head of Legal in place, for example numbers of staff, through agreement with the Trust, and to commence permanent recruitment. Due date extended as requires input from new Head of Legal who is starting post in Sept 2025 Person Responsible: Director of Quality Governance (DQG) Due: 31 Oct 2025
3743	Care Group – QEQM	There is a risk that the lung function equipment will stop working due to age and servicing history	High (15)	NEW (escalation) To be reviewed by Risk Review Group 21/10/25	Low (6)	Loan kit is in place with good engineering oversight and old kit is not longer in use. Procurement process and sign off for new kit still required Person Responsible: General Manager Due: 30 Sep 2025 New equipment, which will not require manual uploads of results, has been identified. The procurement process needs to be followed and where necessary expedited. September procurement not

						confirmed and still reliance on loan equipment which is not networked. Delay in procurement process will impact on Community Diagnostic Centre (CDC) change due to take place in 6 weeks so score increased as unlikely to be completed in 6 weeks Person Responsible: General Manager Due: 31 Oct 2025
3752	Corporate – Nursing **Accountable Executive: CNMO**	There is a risk that the Trust is non-compliance with HBN 04-01 2009 as additional beds have historically been put in permanently into four bedded bays to create six bedded bays	High (15)	⟺	Low (4)	Recommendation to Executive to pilot removing two additional beds on three wards – decision pending Paper presented to Trust Management Committee (TMC) but no decision reached thus far. Review in one month. Decision as to possibly removing additional beds not yet confirmed. Extension due to risk transfer between leads. Person Responsible: Sarah Hayes, CNMO Due: 30 Sep 2025 Undertake Trust-wide, a bed space measurement review (to be supported by Directors of Nursing on each site). Plan to be agreed as to the process for doing this Person Responsible: Deputy Chief Nurse (CN)

						Due: 30 Sep 2025
3764	Care Group - Women's Health **Accountable Executive: CNMO**	Lack of infrastructure to enable training provision to meet national requirements	High (16)	⟺	Low (4)	Pursue renewing the St Paul's House lease Lease agreement discussions underway Person Responsible: Head of Operations Due: 30 Sep 2025
3782	Corporate – Operations **Accountable Executive: COO** **Escalation for risk update and to be replicated for QEQM Care Group.**	Overdue Appointments for Patients on the Diabetes and Endocrine Outpatients Patient Tracking List (PTL)	Extreme (20)	⟺	Moderate (9)	Procure additional Administration to Validate PTL to make sure that data is correct and clear any duplicates. Decision with Executive. Admin vacancies on hold. Person Responsible: Head of Operations Due: 31 October 2025 Remove a consultant from the ward to support with a second line of Validation by a Clinician to understand if any harm has come to patients and identify patients to be focused on and if any patients would be suitable to be discharged. This has not been possible yet due to demands of service/sickness. Person Responsible: Head of Operations Due: 31 October 2025. Letter to long waiters to understand if they still need a follow up and if not discharge supported by the additional admin team member. Letter

						drafted – confirmation needed as to if this has been sent and if in line with Trust wide workstream. Person Responsible: Head of Operations Due: 31 October 2025
3799	Care Group – William Harvey **Accountable Executive: COO**	Insufficient capacity to deliver gastro OPA in a timely manner	High (15)	⟺	Very Low (2)	Continuation of ID Medical gastro clinics being held at the weekend until end of Mar 2025 Person Responsible: General Manager Due: 30 Sep 2025
3803	Care Group – Diagnostics, Cancer and Buckland **Accountable Executive: CSPO**	Risk of total failure of DartOCM	Extreme (20)	⟺	Moderate (8)	Project plan in place – Trust IT, Path IT and KMPN Programme Management Office (PMO) team supporting to deliver Tactical solution by 01.12.25 Person Responsible: General Manager - Pathology Due: 01 Dec 2025
3804	Care Group – Women, Children and Young People **Accountable Executive: CNMO**	There is a risk to babies that they will not receive mechanical ventilation when being nursed in the Special Care Baby Unit (SCBU) transport rig	High (16)	⟺	Low (6)	To purchase a transport rig that is up to date to allow spare parts to be purchased. To take to medical devices group. Person Responsible: Clinical Scientist Due: 30 Dec 2025
3810	Corporate – Nursing	Lack of capital funding to adequately	High (16)	⟺	Low (4)	Continue with Infection, Prevention and Control (IPC) surveillance,

	Accountable Executive: CNMO	maintain the estate it is not always possible to comply fully with Health Technical Memoranda (HTM) and Health Building Note (HBN) standards which enable prevention control measures including cleaning and ventilation				monitoring and implementation of clinical policies Audits commenced Person Responsible: Deputy Director IPC Due: 31 Oct 2025
3833	Care Group – QEQM **Accountable Executive: CSPO**	Lack of Health and Safety Oversight Impacting Safety Culture	High (16)	⟺	Low (6)	Review of departmental Health & Safety (H&S) leads and Ops and Nursing oversight Person Responsible: Managing Director Due: 31 October 2025 Pro-active review of Health and Safety Training and Assessment (HASTA) prep quarterly ahead of audits to ensure compliance Person Responsible: Nurse Due: 31 Dec 2025 Site wide H&S audit to determine investment plan for 2026. Working with 2gether to understand key areas of infrastructure and service challenges to be presented back to H&S Recovery meeting

						Person Responsible: Managing Director Due: 31 Dec 2025
3837	Corporate Finance and Performance Management **Accountable Executive: CFO**	25-26 System delivery of the Financial Position	Extreme (20)	⟺	Moderate (12)	Twice monthly Financial Improvement Programme Board. Person Responsible: Director of Finance Due: 31 March 2026 Monthly reporting into the Trusts Finance and Performance Committee and Trust Board. Person Responsible: Angela Van der Lem, CFO Due: 31 March 2026
3838	Corporate Finance and Performance Management **Accountable Executive: CFO**	Failure to deliver the Trust Financial Plan for 25/26	High (16)	⟺	Moderate (12)	Mitigating actions will need to be taken if the Trust moves away from plan mid-year. Person Responsible: Director of Finance Due: 31 March 2026 Delivery of workforce headcount reductions (25/26) Person Responsible: Norman Blissett, CPO Due: 31 Mar 2026
3849	Diagnostics, Cancer and Buckland Care Group **Accountable Executive: CSPO**	Delays in diagnostics and patient health outcomes for multiple care pathways	High (16)	NEW	Low (6)	Review and investigate lifting man hole drains Following completion of drainage works the lifting of drains should cease. Final drain clearance is planned 19/9/25 implementation

						date moved to allow review Person Responsible: Community Diagnostic Hub Operational and Site Manager Due: 30 Sep 2025 Aco drains to be cleared of debris and direct holes to be reperforated 15/9/25 Main ACO drains reperforated, ACO drains outside of Radiology fire exit and energy centre planned for replacement with scope of works agreed, no date yet confirmed for works Person Responsible: Community Diagnostic Hub Operational and Site Manager Due: 01 Oct 2025 Site Business Continuity plan to be developed to agree flood thresholds and consequences/impact for services across site. Templates from emergency planning for business continuity plans to be shared, meeting with emergency planning for requirements completed 9/9/25. Escalation communication tree to be completed for site Person Responsible: Community Diagnostic Hub Operational and Site Manager

						Due: 01 Oct 2025 Regular service and maintenance plan to be put in place by 2gether solutions and shared with Trust and site. To include frequency of maintenance for all drains across site. Estates have confirmed a regular 6 month PPM is being put in place for Buckland Hospital Dover (BHD) draining. Action to close once PPM is in place Person Responsible: Community Diagnostic Hub Operational and Site Manager Due: 01 Oct 2025 Completion of CCTV to review all drains before and after works completed Final phase of drain clearage planned for 19/9/25 for upper level of staff car park Person Responsible: Community Diagnostic Hub Operational and Site Manager Due: 01 Oct 2025
3874	Corporate – Operations **Accountable Executive: COO**	Risk of patient harm and poor patient experience due to non-RTT (Referral to Treatment) follow up backlog	High (15)	NEW	Low (6)	Data Algorithm Implementation Person Responsible: Deputy Director of Information Due: 30 Sep 2025 Risk stratification by clinical teams to identify

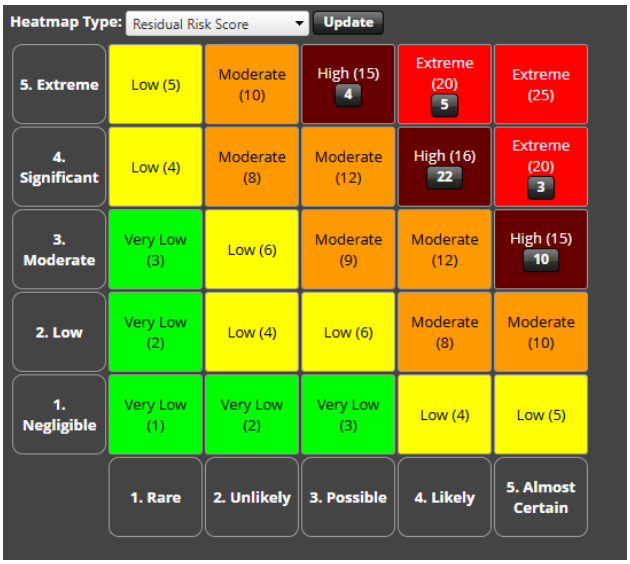
						high risk cohorts for escalation and review Person Responsible: Dan Gibbs, COO Due: 30 Sept 2025 Review and relaunch of all training materials and implementation of awareness and training sessions for operational and administrative staff Person Responsible: Interim Director of Planned Care Recovery Due: 30 Sep 2025 Utilisation of existing administrative staff for validation Person Responsible: Dan Gibbs, COO Due: 31 Dec 2025 Following Risk Stratification for each cohort (and after validation to establish volume of patients per cohort) consider cost option and draft business case if required Person Responsible: Interim Director of Planned Care Recovery Due: 31 Dec 2025 Receive quotes from external validation companies re temporary validation workforce and automated AI solutions to clear low risk backlog

						Person Responsible: Interim Director of Planned Care Recovery Due: 31 Dec 2025
3875	Critical Care, Anaesthetics and Specialist Surgery Care Group **Accountable Executive: CNMO** **Pending review by Deputy Chief Nurse**	Unable to safety staff theatres across the three sites due to high vacancy levels	High (16)	NEW	Low (6)	Posts to be approved on TRAC and recruited to Person Responsible: DoN Due: 30 Sep 2025
3867	Critical Care, Anaesthetics and Specialist Surgery Care Group **Accountable Executive: CNMO** **Pending review by Deputy Chief Nurse**	Inability to safely staff all three critical care units due to current vacancies within the nursing establishment	High (16)	NEW	Low (6)	Posts to be approved on TRAC and recruited to Post now out and advertised. Interviews to take place. Recruitment still to take place Person Responsible: Head of Nursing Due: 25 Sep 2025
3866	Corporate – People and Culture **Accountable Executive: CPO**	Risk of inability to deliver Cost Improvement Programme (CIP) due to not achieving planned workforce reductions	High (16)	NEW	Moderate (9)	Delivery of planned workforce headcount reductions 2526 Person Responsible: Norman Blisett, CPO Due: 31 Mar 2026

East Kent Hospitals University NHS Foundation Trust

3.5 The below table shows the risk register entries by clinical or corporate care group and residual risk score. All Significant Risks have been allocated an Accountable Executive.

	Residual Risk Score				
Care Group	**15**	**16**	**20**	**25**	**Total**
CCASS CG		4			4
DCB CG	4	4	2		10
K&C CG		1			1
QEQM CG	3	3			6
WHH CG	2	1	2		5
WCYP CG		3			3
Corporate Medical	1		1		2
Corporate Nursing	1	2			3
Corporate Operations	1	1	1		3
Corporate Strategic Development	1	1			2
Corporate Finance		1	2		3
Corporate Services					0
Corporate People and Culture	1	1			2
TOTAL	**14**	**22**	**8**	**0**	**44**
CHANGE SINCE LAST REPORT	**+2**	**-1**	**0**	**0**	**+2**



4. Changes since the last report

4.1 New risks approved for inclusion on the Significant Risk Report since last report

There are five significant risks approved by the Risk Review Group since the last Board of Directors report. These are listed below:

- Risk of flooding due to inadequate maintenance of drainage causing delays in diagnostics and patient health outcomes for multiple care pathway (risk ref: 3849) DCB Care Group. Residual risk rating 16 (high). Approved 16/09/25.
- Risk of patient harm and poor patient experience due to non RTT (referral to treatment) follow up backlog (risk ref 3874) Corporate Operations. Residual Risk Rating 15 (high). Approved 16/09/25.
- Inability to deliver CIP due to not achieving planned workforce reductions (risk ref 3866) Corporate People and Culture. Residual risk rating 16 (high) Approved 16/09/25.

- Inability to safely staff all three critical care units due to current vacancies within the nursing establishment (risk ref: 3867) CCASS Care Group. Residual risk rating 16 (high). Approved 16/09/25.
- Unable to safely staff theatres across the three sides due to high vacancy levels (risk ref: 3875) CCASS Care Group. Residual risk rating 16 (high). Approved 16/09/25. Risk currently being reviewed by Deputy Chief Nurse.

4.2 Escalations of existing risks to the Significant Risk Report

None.

4.3 Closure of risk or de-escalation from the Significant Risk Report

The following risk has been de-escalated since the last Board report. This will go to the next Risk Review Group for information:

- Staff may experience an increased risk of physical and psychological harm from patients and visitors exhibiting challenging behaviours due to an absence of personal safety and de-escalation training (risk ref: 3701) Corporate Nursing. Previous residual risk rating 16 (high). Residual risk rating reduced to 12 (moderate) on 25/09/25 due to mitigations in place for priority groups. To be kept under review.

5. Escalations from Risk Review Group

5.1 There were no escalations from the meeting but Care Group and Corporate leads were asked to ensure that all risks are up to date – with significant risks reviewed at a minimum monthly. Care Groups were also asked to ensure they are reviewing the monthly emerging risk report via their Care Group governance meetings

6. InPhase Developments

6.1 There have been delays in the rollout In Phase (Quality Management System) for Risk - due to issues with the supplier which have been escalated – but work continues – with Subject Matter Expert (SME) Testing and User Acceptance Testing (UAT) taking place in October 2025.

7. Conclusion

7.1 The Board is asked to receive the Significant Risk Report for assurance purposes and for visibility of the key risks facing the organisation.

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: **12 August 2025 and 9 September 2025**

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

Paper Author: **Michelle Cudjoe, 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	The Maternity Incentive Scheme (MIS) Year Seven data collection period commenced on 2 April 2025. At the August and September MNAB meetings the following papers were discussed and are presented to the Trust Board in compliance with CNST reporting: **Avoiding Term Admissions into Neonatal Units (ATAIN) Q1 Report – CNST Safety Action 3** The purpose of this report is to update the Maternity and Neonatal Assurance and Trust Board on East Kent Maternity's progress in implementing Safety Action 3 and provide an update on the Quality Improvement (QI) project required against the standard. Drawing on insights from themes identified from the reviews of term or late preterm admissions to the neonatal unit, the service is continuing the implementation of a quality improvement initiative to decrease admissions and/or length of infant/mother separation. Progress on this initiative is shared with the Safety Champions as a part of the MNAB and the Local Maternity and Neonatal System (LMNS).

The paper provides an update on progress in relation to the QI project which was registered within the Trust quality and improvement team.

- For the month of June, the ATAIN performance increased to **5.5%** against the static target of **4.5%.** This surge was specific to William Harvey Hospital (WHH) but no obvious themes were identified in relation to this surge in admissions.

- Overall ATAIN performance at EKHUFT for **Q1 was 4.7%** which was a slight increase compared to **Q4 2024-2025** at **4.5%.**

- The main reasons for term admissions were respiratory, infection and hypoglycaemia.

- There is evidence to demonstrate that data and learning is shared amongst the team in the form of a monthly poster and where appropriate, individual support for staff is provided.

- The QI working party meets weekly and the current focus is to improve infant feeding rates in 60 minutes of age and to effectively risk assess babies in line with Bobble hat risk assessment tool. Progress against the QI will be presented to the LMNS on 19 August 2025.

Medical Workforce Papers - CNST Safety Action 4

Anaesthetic Workforce Requirements

CNST Safety Action 4 requires the Board to have oversight of anaesthetic medical workforce in relation to two key outputs:

1) A Duty Anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising Anaesthetic Consultant at all times.

2) Where the Duty Anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients.

In relation to Standard 1 for both WHH + Queen Elizabeth the Queen Mother Hospital (QEQM): The paper confirms that there is a duty anaesthetist available to the obstetric units 24 hours a day at both WHH and QEQM and the Trust has clear escalation guidance for the duty anaesthetist to a supervising consultant - Appendix 1, 3 and 4.

The Board is alerted to the risk in relation to standard 2:

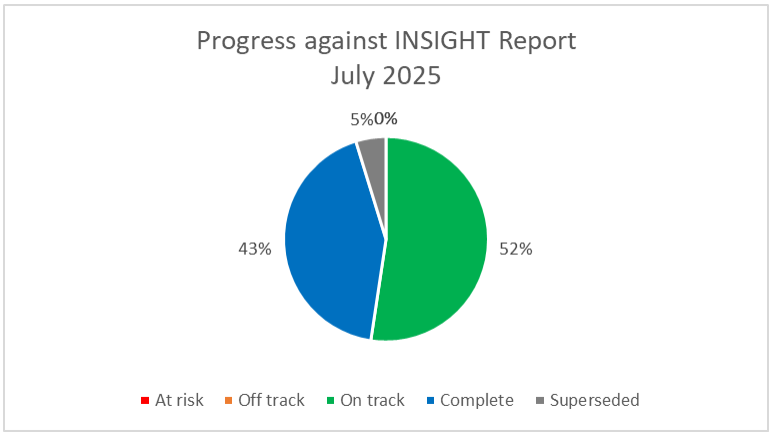
	• Where the Duty Anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. The paper demonstrated compliance for QEQM but notes partial compliance for WHH. This is purported to be linked to the inability to cover gaps with locums whilst recruitment is underway. **Action:** The evidence required by CNST is one month's representative rota demonstrating compliance with the above standard. There will be an ongoing review of the rota and monthly update to MNAB. **Saving Babies Lives (SBL) Report – CNST Safety Action 6** To provide the Trust Board with assurance of compliance or actions in place to reach compliance for the NHS Resolution (NHSR) CNST safety action. As part of the new SBLV3 care bundle each Trust is required to use the implementation tool within the Future NHS Workspace platform in order to share evidence with the LMNS and ensure compliance with each of the interventions in line with CNST Safety Action 6. • Self-assessment was submitted on 18/06/25 and the LMNS validated result is currently visible on the futures platform. Total compliance has been assessed as 97%. • This quarter was the first to be assessed using the updated tool to reflect version 3.2 of the bundle which included the removal of a number of manual audits. Seeing a change of focus from compliance metrics to embedded processes and trajectories. • Element 1: 80% implementation. There are two outstanding interventions; both relating to the expansion of an in-house smoking cessation service. • Element 2: 100% compliance. • Element 3: 100% compliance. • Element 4: 100% compliance. • Element 5: 100% compliance. • Element 6: 100% compliance. Weekly meetings with the LMNS are ongoing for support to meet outstanding actions and interventions. **Claims, complaints and Incidents Report - CNST Safety Action 9 (SA9)** This paper was brought in compliance with SA9 to demonstrate how learning is triangulated from reviewing claims, complaints and incidents. The paper demonstrates that in 2024/25 20 legal claims were logged. The scorecard review demonstrated that 86.61% of

	these claims were in the low value high volume quadrant and 13.39 in the high value high volume quadrant. The top three indications for high value claims was: 1. Delay in treatment 2. Inappropriate treatment 3. Failure to respond to an abnormal Cardiotocography (CTG) As it applies to clinical incidents in the period of January-June 2025 the top three categories of incidents reported included: 1. Staffing challenges. 2. Unexpected outcome (including admissions to Neonatal Unit (NNU)). 3. Obstetric complications. The top three categories within the complaints profile included: 1. Communication failure. 2. Concerns regarding the quality of treatment. 3. Care given by staff. The paper demonstrates how the review of the claims, incidents and complaints profile is used to both inform the Patient Safety Incident Response plan and prioritise QI projects being undertaken as a part of the Maternity and Neonatal Improvement Programme (MNIP).
Perinatal Quality Surveillance Tool (PQST) June and July	The PQST report is presented to the Board in keeping with the Ockenden recommendation. It contains the minimum dataset that the Board requires oversight of for the months of June and July 2025. • The total number of babies born in June was 491 and 536 in July. • Our supernumerary status compliance was reported at 100% on both sites in June. In July there was one occasion when supernumerary status was lost for a 30-minute period whilst the escalation policy was being triggered. The coordinator was supernumerary at the start of the shift as per CNST guidance. • Compliance of 1:1 in Labour was reported at 100% for both months. • Level 3 Adult Safeguarding compliance at the end of June remained above the 90% target at 93.3% in June but show a small decrease in July to 89.2% with a plan in place. • Three Moderate/severe harms were reported but one has since been downgraded. In June the service has: Four internal Patient Safety Incident Investigations (PSIIs) (some ongoing from previous months) in the process of investigation: • Neonatal death (extreme prematurity) • Maternal Intensive Therapy Unit (ITU) admission

	• Maternal death at 13.5 weeks postnatal • Maternal Enhanced Maternal Care (EMC) case and NICU admission Two Maternity and Newborn Safety Investigations (MNSI) cases in the process of investigation, both sadly related to maternal deaths that have been previously reported on. In July: The service has three internal PSIIs in the process of investigation and the fourth (Maternal ITU admission) has recently been completed. • Friends and Family Test (FFT) had an 9.5% response rate in June and further to a change in data collection within July this increased significantly to 39.3%. • Your Voice is Heard in June – Response rate Key Performance Indicator (KPI) - 70%. The service achieved a response rate of 65.8%. • 93.5% were positive about Antenatal care. • 92.7% were positive about Intrapartum care. • 86.6% were positive about Postnatal care. • 96.9% were positive about Neonatal care. Top positive themes include; care by staff and staff attitude, communication and explanations about care plans. • Themes for focused improvement included: Communication, delays, environment and facilities. **Training and Education** • Training remains on the Care Group risk register **(Risk Reference 3764)**, due to training space to enable the Maternity Training Programme to be delivered at full capacity. Progress has been made in relation to this and it is likely that the lease will be extended. The risk will then be closed. • PRactical Obstetric Multi-Professional Training (PROMPT) compliance is above 90% for all staff groups for June with the exception of obstetric which is a recurring theme for this staff group. • Training compliance for fetal monitoring is ≥ 90% for all staff groups in June. • Newborn Life Support (NLS) compliance remains on target with the exception of obstetric doctors. • The trajectory for Neonatal / Paediatric doctors falls below the 90% compliance target as of July and continues to have a downward trajectory into August where the trajectory for compliance will be 60%. The DSA and Clinical Director for Neonatal Services has been contacted to verify NLS training

	data (as there are some issues in relation to data quality) and formulate a plan to regain compliance. **Maternity and Neonatal Voices Partnership (MNVP) Funding escalation** The service remains unable to provide adequate MNVP Lead time to enable MNVP attendance as a quorate member at all of the required Trust assurance and Governance meetings as set out in year 7 CNST guidance. This has been escalated to the Integrated Care Board (ICB) awaiting a response. An action plan has been collated and presented to MNAB. The service has received confirmation that the MNVP contract has been secured by the ICB.
MNIP Update	The MNIP highlight report for the programme was presented. 74% of the overall programme of work has been completed. The year 2 engagement session took place on the 25 June 2025 to prioritise QI for the final year of the programme. There is an Executive Senior Responsible Owner (SRO) aligned to each of the six workstreams. Highlights: • 97% compliance with Saving Babies Lives Care bundle. • Sustained reduction in complaints regarding Midwives' attitudes. (Links to workstream 1 positive culture). • Completion of local review of stillbirths. Areas of focus/risk • Risk of non-compliance with MIS Year 7 owing to anaesthetic workforce. • Baby Friendly Initiative project. • Delayed commencement of the perinatal pelvic health project. All risks to programme delivery discussed at the MNIP programme board and reviewed trajectories in place
NHS England (NHSE) Insight Visit	The Maternity Service received an Insight Visit from the Regional Team and ICB on the 13 May 2025. As a part of this review evidence was submitted to the external team ahead of the visit. On the day key staff were interviewed and focus groups were held with the multi-disciplinary team. The service received extremely positive feedback on the day and no 'red' rate actions or recommendations were received. An INSIGHT report was received 8 July 2025 which acknowledged all of the achievements of EKHUFT Maternity Service and highlighted 21 recommendations across the four themes within the single delivery plan. The actions were mapped to the local MNIP workstreams and are monitored within the local compliance and assurance group. Progress against the actions is shown in chart below.

East Kent Hospitals University NHS Foundation Trust

	
Matters to escalate to Quality & Safety Committee (Q&SC) and Board	• Alert in relation to Anaesthetic Medical staffing and associated risk of non-compliance with CNST. • Completion of a review into stillbirths. • Positive consultant obstetrician recruitment – some posts have been vacant for nearly five years. • Positive improvement in FFT uptake from 9% to 39%. • Positive feedback from NHSE Insight visit and progress against recommendations.

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 BoD to discuss and **NOTE** this MNAB Chair Assurance Report.	Assurance	9 October 2025

We care

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Nurse Staffing Establishment Review for In-Patient Wards, Acute Medical Units (AMUs) and Emergency Departments (EDs) (January – March 2025)**

Meeting date: **9 October 2025**

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

Paper Authors: **Clare Herridge, Joint Lead Nurse for Workforce and Education**
Associate Director of Nursing (ADoN) for Workforce and Education for Nursing, Midwifery and Allied Health Professionals (AHP)
Deputy Chief Nurse

Appendices:

Appendix 1: National Quality Board Gap Analysis
Appendix 2: Bed capacity included in the establishment review
Appendix 3: Summary of Current and Proposed Nursing Establishments with Safer Nursing Care Tool (SNCT) Recommendations and Quality Metrics (for In-Patient Wards and AMUs)
Appendix 4: National Profile Change for Band 2/3 Health Care Support Workers (HCSWs) Skill Mix Review
Appendix 5: Setting evidence-based nursing Establishments
Appendix 6: Process for the establishment review for existing adult and children's In-Patient areas and ED January 2025
Appendix 7: Care Group Recommendations

Executive summary:

Action required:	**Approval**
Purpose of the Report:	The purpose of this report is to provide assurance to the Trust Board that the Trust biannual establishment review process complies with the Developing Workforce Safeguards (NHSI 2018) and the National Quality Board Guidance (2016) on Safe, Sustainable, and Productive Staffing. The report provides an overview of the methodology used to review the staffing establishments for adult and children's In-Patient ward areas, and EDs and presents the findings of the review. It also identifies where service changes have been made to areas (since the last review), and advises of the staffing requirements for these. It is noted this paper has been delayed in moving through the Trust's governance process owing to the National and regional focus on workforce and the internal reviews that have subsequently taken place. Alongside this further consideration was given to the recommendations owing to the reduced timeframe between this review and the implementation of the January 2024 review in healthroster during the same timeframe, therefore impact of changes would not yet have been experienced. Therefore, whilst it is important to note the recommendations made throughout this review for each area, they are not being requested to be

	approved for implementation. The next review process is underway and instead they will be used to inform decision making. From an assurance perspective staffing has been monitored twice daily and appropriate actions taken to maintain safety for patients and staff across this timeframe as part of regular processes.
Summary of key issues:	• The January 2024 establishment review was not implemented into healthroster until 27 January 2025, therefore, wards have not felt the full impact in all areas. • Changes from the same review are still being processed through Electronic Staff Record (ESR) and the financial ledger. • This paper provides the outcome of the review undertaken between January - March 2025. • Changes were recommended for several areas which needed careful consideration and for some a Quality and Equity Impact Assessment (QEIA) to be completed. • The paper includes the review undertaken for split for Band 2/3 in each area. • The June 2025 establishment review is currently going through process with check and confirm meetings taking place through September 2025.
Key recommendations:	The Board of Directors is invited to: 1. **NOTE** the content of the report and process and methodology behind the review. 2. Receive **ASSURANCE** that the safer staffing review has been undertaken in accordance with national guidance. 3. **APPROVE** the recommendations made at the end of the review.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Sustainability
Link to the Trust Risk Register:	**CRR 116** - Patient outcome, experience and safety may be compromised as a consequence of not having the appropriate nursing staffing levels and skill mix to meet patient's needs. **CRR 68** – Risk to the delivery of the operational constitutional standards and undertakings **CRR 76** - Care is potentially compromised as a consequence of staffing not meeting planned numbers per shift. **CRR 84** – Lack of timely recognition and response to the deteriorating patient.
Resource:	N/A
Legal and regulatory:	Yes - National Quality Board Guidance & Care Quality Commission (CQC)

Subsidiary:	N

Assurance route:

Previously considered by: Nursing & Midwifery Executive Committee (NMEC) 8 April 2025
Trust Management Committee (TMC) 3 September 2025
People & Culture Committee (P&CC) 16 September 2025
Quality and Safety Committee (Q&SC) 23 September 2025

1. Purpose

1.1 This paper demonstrates how the Trust complies with the National Quality Board (NQB) requirement for a bi-annual strategic review of nursing and midwifery establishments.

1.2 It provides Trust Board with assurance of the work in progress to assess, monitor and manage levels of nursing and midwifery staff in the Trust and highlights any areas of concern.

1.3 It evidences our current level of compliance with the NQB guidance as outlined within the Developing Workforce Safeguards (2018) paper.

1.4 It provides the findings of the data collection completed across January 2025 and the check and confirm meetings held in March 2025.

1.5 It outlines the recommendations, considered by the CNMO on safe staffing levels across adult and children in-patient wards and EDs following this review.

2. Background

2.1 In 2021, the Trust reviewed nursing workforce establishments and adjusted in-patient ward staffing levels to reflect national guidance and the Trust priorities. The business case at this time acknowledged the need to improve ward leadership, including nurse in charge status and 'right size' the workforce to enable safe patient care and sought investment of 369.32 Whole Time Equivalent (WTE) Registered Nurses (RNs) and 1.13 WTE HCSW for ward areas and AMUs only.

2.2 In January 2024, the Trust reviewed current staffing which involved a rigorous approach, using an updated version of SNCT© to capture changing patterns of patient acuity and dependency alongside more detailed professional judgement discussions with clinical staff. The staffing review also considered the staffing requirements of the EDs which did not form part of the 2021 review/business case. The review included the approval of additional investment to staff adult inpatient wards, paediatric inpatient wards, AMUs and EDs including a staffing approach for the escalation and overflow areas in ED; a phased introduction of Registered Nursing Associates (RNAs); and the aspiration to achieve a phased increase in uplift from 22% to 25% for in-patient ward areas and AMUs by 2027/28 and from 25% to 27% in EDs by 2026/27.

2.3 The September 2024 nursing workforce review recommended one change to the establishment for Kings C1 at William Harvey Hospital (WHH). This was to revert the establishment back to its pre-January 2024 WTE owing to the continued increased activity on the ward (an increase of 5.2 WTE).

2.4 It should be noted that it is recommended that SNCT© data collection is undertaken bi-annually, six months apart. The January data collection was only four months after the September data collection, as this was previously delayed.

2.5 The September 2024 nursing workforce review went through internal Trust governance process and was presented and approved at Board on 8 April 2025.

2.6 Future SNCT© data collections will be achieved in June and January, allowing for seasonal variation to be captured.

3. Care Hours Per Patient Day (CHPPD)

3.1 For in-patient areas, the CHPPD for EKHUFT is 8.9 compared to a peer median of 7.9 and a provider median of 8.5 (based on January 2025 data) on Model Health System as detailed in the graph (fig.1) below.

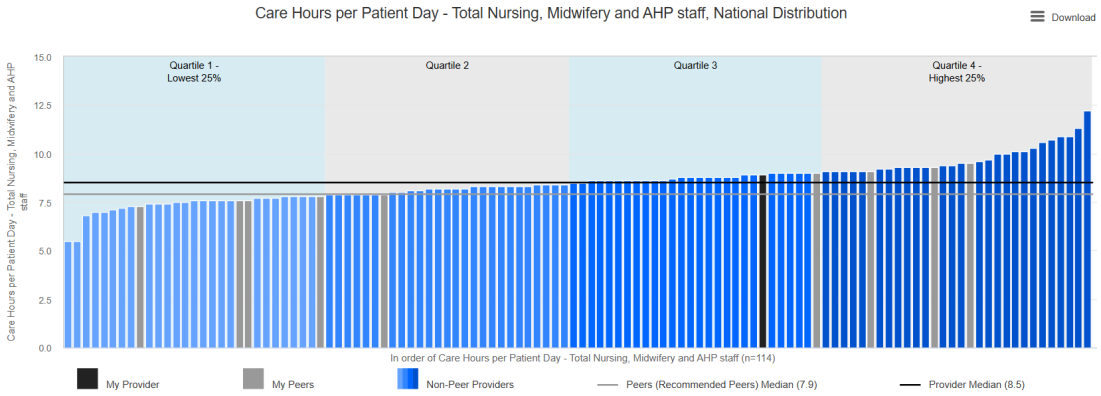


Figure 1 – Care Hours per Patient Day (Model Health System)

3.2 Continued improvement has been seen in the Trust's position for CHPPD but it is acknowledged there is further potential for improvement. Work is on-going to realign budgets and ESR to separate inpatient activity and clinic-based activity, which will provide increased accuracy and consistency to future CHPPD.

4.0 Overview by care group

4.1 For the majority of the in-patient wards there was minimal change proposed. In clinical areas whereby change is suggested, this information will be used as part of the process for the June 2025 establishment review to inform decision making.

4.2 SNCT data and quality indicators information shared at the check and confirm meetings is in Appendix 3 for the Inpatient areas.

4.3 WHH care group (excluding ED)

4.3.1 All areas were discussed over a two-day period chaired by the Deputy Chief Nurse and supported by the Director of Nursing.

4.3.2 Quality and safety concerns were identified across several of the wards and supported informed decisions regarding staffing as detailed further below.

4.3.3 For the following inpatient ward areas, the **recommendation was for staffing levels to remain the same**; AMU A, AMU B, Bartholomew, Cambridge J2, Cambridge M1, Coronary Care Unit (CCU) at WHH, Kennington, Kings B, Kings C2, Oxford and Richard Stevens.

4.3.4 AMU A and AMU B are proposed **to remain with the staffing level as recommended when the clinical areas were split in November 2024**, with close monitoring of the quality and safety indicators by the Care Group.

4.3.5 Owing to the continued patient dependency within Cambridge J1 it was **recommended to decrease the day shift by a registered nurse and increase the night shift by a HCSW**. The ward has seen consistent additional shifts booked at night to cover this need whilst not working to the registered nurses' numbers set within the day. Quality impact assessment to be completed by Care Group and to ensure close monitoring is put in place on impact on quality indicators.

4.3.6 A discussion was held regarding Registered Nursing Associates working within Cambridge J2 as previously they had not recommended the role was introduced. It was agreed within the skills required for the speciality there was no identified risk of introducing the role however as expected a QEIA would be completed by the care group. Therefore, **recommendation is for the establishment to remain the same however to introduce a registered nursing associate per day and night shift from the registered nurse funded establishment.**

4.3.7 Cambridge K quality indicators have previously been of concern with an action plan implemented to address. A substantive ward manager has been recruited and positive progress has been made to support quality and safety indicators. However, to maintains and support ongoing improvement with the high level of patient dependency and layout of the ward environment, it is **recommended to increase the establishment by one HCSW per night shift.**

4.3.8 Cambridge L previously trialled a change in skill mix, reducing one registered nurse per day shift and increasing by one HCSW per day shift. Following this successful trial, with stable quality indicators, **the recommendation is to permanently change the establishment to reflect this.** The care group will complete a QEIA for Chief Nurse approval.

4.3.9 Cambridge M2 **is recommended to increase to three HCSW on Saturday/Sunday** to rectify a previous error made in the financial establishment configuration within the January 2024 review. To maintain quality and safety of the ward, alongside patient complexity and clinical transfer of patients daily, three HCSWs are required per day shift. This has been allocated Monday to Friday but was reduced to one from Saturday to Sunday, there is no change in activity at the weekend.

4.3.10 **CCU at WHH is recommended to stay the same**. However, a full review of cardiac services is required as currently the nurse in charge of the ward can be called to support the primary service at night.

4.3.11 As indicated within the September 2024 review CCU at Queen Elizabeth the Queen Mother Hospital (QEQM) has had a continued change in pathways which has changed the acuity and dependency. Therefore, it is **recommended to decrease by an HCSW on the early shifts**. Owing to flexible working requirements within the ward early and late shifts will also be included

for registered staff. Quality indicators will continue to be monitored and they will also be included in the wider review of cardiac services.

4.3.12 There is significant concern across quality indicators for patients and staff within Bartholomew. Whilst **the recommendation for the ward establishment is to remain the same**, an action plan has been requested to address the concerns identified which will be monitored through the care group governance process.

4.3.13 There is an identified concern through quality indicators for patients and staff on Kings A2 owing to the night shift having half of the registered workforce compared to the day shift. Several options were discussed as to how this could be addressed with **the recommendation being to move one registered nurse per day shift to a night shift**. This does not alter the establishment.

4.3.14 Following the recommendation in September 2024, for Kings C1 to return to the establishment prior to the January 2024 review, a further **recommendation is being made to reduce the registered nurse staffing at night by one but increase the HCSW by the same amount** which will support higher patient dependency and enhanced care needs.

4.3.15 Kings C2 has seen a continued change in profile of its patients within the ward, with a significant amount requiring enhanced care on a 2:1 basis. The **recommendation is to remain the same,** with support to be provided within the care group to improve and closely monitor quality indicators with the Director of Nursing (DoN) discussing with the Chief Nurse further actions outside of the next review if required.

4.3.16 Following the ward split and the opportunity for the identified patient activity for each ward to become more defined it has identified both Kings D1 and Kings D2 are receiving a high number of dependant patients and there is a demonstrated effect on the quality indicators for patients. There it is **recommended that Kings D 1 & 2 both increase by one HCSW at night** to support this, with a clear expectation they will work across the whole floor to support enhanced care within their establishments unless significant risk is identified, resulting in escalation from DoN to the Chief Nurse.

4.3.17 Richard Stevens is **recommended to remain the same.** However, whilst the changes have been made to remove the Respiratory Assessment Day Unit (RADU) clinic from this budget, the hot clinic still needs to be addressed.

4.4 QEQM Care Group (Excluding ED)

4.4.1 All areas were discussed over a three-week period chaired by the Deputy Chief Nurse and supported by the DoN, aside from the following areas where this responsibility was delegated by the DoN to the Associate Director of Nursing (Deal, Fordwich, Quex, Sandwich Bay, St Augustine and St Margaret's. The decisions made were later discussed by the ADoN with the DoN with no further discussions requested.

4.4.2 Quality and safety concerns were identified across several of the wards and supported informed decisions regarding staffing as detailed further below.

4.4.3 Escalation beds for the following areas were closed following an outbreak of Norovirus on the site and clear associated identified risks; Deal, Fordwich, Sandwich Bay, Seabathing and St Margaret's. These beds are not routinely expected to be used however do remain as part of the Trusts full capacity protocol.

4.4.4 For the following inpatient areas, the recommendation is for staffing levels to remain the same; Bishopstone, Cheerful Sparrows Female, Cheerful Sparrows Male, Fordwich, Sandwich Bay and St Margarets.

4.4.5 Bishopstone is still receiving a mixture of different specialities within the ward and staff quality indicators are a concern. Proposals were made to increase the establishment by the Head of Nursing however this was not supported owing to limited triangulation of need. Therefore, the **recommendation is to remain the same** however there needs to be close monitoring of quality indicators by the senior leadership team.

4.4.6 Cheerful Sparrows Female is **recommended to remain the same**, however owing to the quality indicators being a concern an action plan has been requested which will be monitored through the care group governance process.

4.4.7 Whilst Cheerful Sparrows Male is **recommended to remain the same**, the impact of transferring patients is expected to be reducing over time, currently consuming on average 20 nursing hours per week, which will be considered at the next review.

4.4.8 Deal has continued to experience a significant number of patients requiring 2:1 care alongside having high acuity patients, including those on Bilevel Positive Aire Pressure Therapy (BiPaP). SNCT recommends the need for an increase which was supported by the ward manager and matron. Discussions were had around how to support the admissions to this area given the current limited beds on site for patients under 75 and it was agreed the ADoN would discuss with the care group triumvirate, including impact on quality indicators for patients and staff. The **recommendation of increasing by one HCSW at night** was supported with a request for the ongoing activity for mental health patients to be closely monitored, with support from the ADoN for Mental Health to ensure staffing provision meets demand.

4.4.9 Fordwich has seen some improvement within its quality indicators and therefore the **recommendation is to remain the same.** However, an action plan was requested to support a continued improvement in quality and safety indicators which will be monitored through the Care Group governance process.

4.4.10 Quex ward has seen a considerable change in the last year, with 12 trollies/chairs now being utilised within two bays for frailty assessment during the day and transferring to beds overnight. Plans are proposed to expand this service which are being worked through by the care group. **Recommendation is to increase** by 4.2 WTE to meet demand of service and to closely monitor quality and safety indicators, which require improvement. However, this will need to be urgently considered by the care group triumvirate as part of the delivery model with acknowledgement of the demonstrated impact on quality indicators.

4.4.11 Significant concern's identified with quality indicators for patients and staff on Seabathing which led to immediate actions being requested during the meeting. DoN to discuss with Chief Nurse option of proceeding through a quality summit approach to engage nursing, medical and

operations teams to support substantial improvement in quality and safety indicators. **Recommendation to increase by one HCSW at night** to support high dependency and ward layout.

4.4.12 St Augustine's is expected to remain as a ward dedicated to supporting patients, from a therapy perspective, to improve prior to discharge. Owing to this and therefore the increased need for therapeutic interventions it is recommended **to decrease by one registered nurse on a day shift and increase by one additional HCSW at night.** Aside from this an error has been noted in the financial establishment configuration for the registered nursing associate whole time equivalent required to meet the roster template and as approved from the January 2024 establishment review which needs to be rectified. A quality impact assessment to be completed by Care Group and shared with the Chief Nurse for approval.

4.5 K&C Care Group recommendations for In-patient Wards

4.5.1 For the following inpatient areas, the recommendation is to stay the same; Clarke, Invicta, Kent, Kingston, Mount McMaster, Harvey, Marlowe and St Lawrence.

4.5.2 Whilst the SNCT for Invicta ward recommends a decrease it is acknowledged there has been a decrease in elective activity. Owing to the wider work being undertaken across the Trust in relation to activity and theatre productivity **the recommendation is for the establishment to remain the same** until this is completed.

4.5.3 Kingston ward has trialled changing one RN to one HCSW at nights due to high patient dependency levels, with positive staff results and with no negative impact on quality indicators. Kingston is therefore **recommended to reduce by one RN at night and increase by one HCSW**. A QEIA will be completed by the care group for approval by the Chief Nurse.

4.5.4 St Lawrence ward has seen an increase in patient dependency and has been using bank staff to fill additional HCSW night shifts to maintain patient safety for enhanced care. Alongside this it has also seen an increase in oncology patients being allocated if Brabourne ward is over capacity, however these patients are not high acuity. Owing to these changes, the reduction of one RN day and increase by one HSCW at night to support quality of care for patients was discussed. However, **the recommendation was the establishment would remain the same** due to the planned fireworks programme.

4.5.5 Owing to the concerns identified for quality indicators on Kent ward and Marlowe ward action plans have been requested and will be monitored through the care groups governance process.

4.5.6 A full-service review is being undertaken on Harbledown ward, following partial external money being awarded, to provide assurance of compliance against standards for stroke services. This will be discussed further by DoN and DCN and presented to the Chief Nurse.

4.6 Women's Children & Young People (WC&YP) Care Group

4.6.1 Despite recommendations for it to be separated Birchington still has staff for inpatient and outpatient activity present within the budget. The now urgently requires separating and aligning to the recommendations approved in the January 2024 review. An increased dependency is noted at night owing to the number of outliers being placed within the ward. **The**

recommendation is to increase by one HCSW at night to support complexity of patient mix and quality of care.

4.6.2 The establishment for both Rainbow and Padua is **recommended to remain the same** overall. The budget urgently needs to be separated to enable rosters to accurately reflect establishment against inpatient and outpatient activity as outlined in the last review. Quality indicators to be monitored by Care Group as difficult to understand impact and risk currently owing to reporting.

5.0 Diagnostics, Cancer and Buckland (DCB) Care Group

5.1 Brabourne is a small inpatient ward with capacity for eight beds. It is recognised by Imperial College that SNCT© may not be accurate for a ward of this bed capacity so is to be relied upon with caution.

5.2 Brabourne is **recommended to remain the same** overall, and is to continue to trial having one HCSW per day and night shift, rather than two HSCW per day shift, with monitoring of impact on quality and safety indicators. Care Group to identify all clinical activity and required workforce demand to match.

6.0 Critical Care, Anaesthetics and Specialist Surgery (CCASS) Care Group

6.1 Despite only have 16 beds the layout of Rotary ward affects the ability of staff to be able to see multiple patients at one time indicating a high requirement of staff is required. Quality indicators remain within acceptable limits and therefore it **is recommended to remain the same.** Rotary ward also has staff on the establishment and rota which support inpatient and outpatient activity this urgently needs separating to enable key indicators to effectively be monitored.

7.0 ED Nurse Staffing

There are two EDs in the Trust, one at WHH and the other at QEQM.

7.1 There has been an increase in patient activity and high numbers of patients categorised as 'Decision to Admits' (DTAs) remaining in the department for more than 12 hours, resulting in patients still being cared for in identified escalation spaces and corridors.

7.2 Data was collected for the second time using the Safer Nursing Care Tool (SNCT©) for EDs.

7.3 It should be acknowledged that the ED SNCT© recommendation for staffing carries limitations as it only accounts for the real-time assessment of a patient once within the first 12 hours of being within the department. The ED SNCT© tool doesn't account for fluctuations in the patient's level of care during their time in ED and for patients who are within the department for longer than 12 hours and therefore does not reflect the overall number of patients who are in the ED at any one time. Therefore, it is recommended an information provided is used with extreme caution if the department is experiencing significant DTAs during collection, which both WHH and QEQM EDs were.

7.4 Data to show the live accumulative patient activity during the data collection period was obtained from the Trust Business Intelligence Team to support the SNCT© recommendations.

7.5 Current staffing includes the assumption that corridor and overflow areas will continue to be staffed with temporary staffing as these are not clinically appropriate areas. These areas are being reviewed through the Trust's productivity programme.

7.6 Detail of the check and confirm meetings is concluded in Appendix 3 for ED.

8.0 **Adult ED WHH**

10.1 The SNCT recommends a significant decrease in establishment, which as advised above was noted with caution. ED had eight medicine errors, 11 formal complaints and the initial assessment has improved to 81% completed within time. Staff turnover, statutory and mandatory training are within expected thresholds. Sickness absence at 9% is higher and is being managed. Corridor care remains challenging and to work towards capturing compliments across department. **The recommendation is for the budgeted establishment to remain the same.** Consideration is being given to including registered mental health nurses within the establishment**.**

11 Children's ED WHH

11.1 Some of the quality indicators for ED are currently unable to be separated however those that can are reflected. Paediatric ED had two medicine errors and one formal complaint. Vacancy, turnover and sickness remains high, but is being addressed and managed. Statutory and mandatory training are within expected thresholds. Streamer implemented to support patient care. To work towards capturing compliments across department. **The recommendation is for the budgeted establishment to remain the same.**

12 Adult ED QEQM

12.1 The SNCT recommends a significant decrease in establishment, which as advised above was noted with caution. ED had seven medicine errors, one hospital acquired pressure ulcer, 13 formal complaints, 98.6% compliance with sepsis screening and the initial assessment was recorded as 94.7% completed within time. Active recruitment to vacancies was progressing, and sickness management has seen a reduction to 6.3%. Statutory and mandatory training compliance are within expected thresholds. **The recommendation is for the budgeted establishment to remain the same.**

13 Children's ED QEQM

13.1 Some of the quality indicators for ED are currently unable to be separated, however, those that can are reflected. Children's ED had one medication error and zero formal complaints. Sickness is at 9.0%. Statutory and mandatory training compliance are within expected thresholds. **The recommendation is for the budgeted establishment to remain the same.** Consideration is being given to an annualised contract to support seasonal peak activity periods. Further education to support SNCT data collection is also required to improve accuracy of SNCT results.

14 Overall Recommended changes

14.1 Where there were recommended changes as an outcome of the check and confirm discussions these have been included in appendix 7.

14.2 Following further reviews and discussions these recommended changes will be considered as part of the check and confirm process in September 2025 and in line with potential planned ward changes at WHH and QEQM.

15 Conclusion

15.1 Trust Board is asked to acknowledge the bi-annual evidence-based nurse staffing review process undertaken in the Trust.

15.2 Trust Board is asked to acknowledge the original recommendations made throughout the review process and confirm agreement these will be considered as part of the process for the June 2025 review.

15.3 Work continues to align the ledger and ESR to the approved January 2024 establishment review.

15.4 Work is continuing to review outpatient activity and to work towards separating out all inpatient and outpatient activity within the budgets.

Appendix 1: National Quality Board Gap Analysis

Expectation 1	COMPLIANCE	EVIDENCE	ACTIONS
RIGHT STAFF			
1.1 Evidence based workforce planning	YES	Annual establishment reviews undertaken in line with Shelford Group Safer Nursing Care Tools (SNCT©) and compliant with the Developing Workforce Safeguards (2018) and National Quality Board guidance (2016) for safe, sustainable and productive staffing.	A full safe staffing review of in-patient wards, acute assessments units and ED's undertaken. 6 month bi-annual workforce establishment review to be undertaken in accordance with guidance – January and July SNCT data collection.
1.2 Professional Judgement	YES	Professional judgment applied alongside the evidence based SNCT©. This is particularly relevant when considering skill mix in areas and new roles in practice.	Professional judgement conversations held with nursing senior leadership teams to review SNCT© recommendations and consider patient and staff outcomes at the check and confirm meetings.
1.3 Compare staffing with peers	YES	Reporting and benchmarking monthly CHPPD against peers using Model Hospital. CHPPD being applied at granular level of the organisation through understanding and compliance of the system SafeCare.	Monthly unify data submitted to NHS England (NHSE) with narrative. CHPPD reported in monthly Board Integrated Performance Report (IPR). Monthly CHPPD data reviewed on Model Hospital to benchmark against peers and nationally. Monthly CHPPD data made accessible on Trust public facing webpage. To further embed knowledge of CHPPD across organisation.

Expectation 2	COMPLIANCE	EVIDENCE	ACTIONS
RIGHT SKILLS			
2.1 Mandatory training, development and education	Yes	Workforce establishments calculated within SNCT© at 22% for inpatient wards/AMU's and 25% for ED's in line with RCN guidance and National best practice. Mandatory training available and bookable via ESR system.	Compliance with mandatory training is monitored through the Nursing Scorecard and Trust Dashboard by Care Group DoNs and ADoNs. Compliance of mandatory and statutory training discussed at monthly Key Performance Indicator (KPI) meetings and in bi-annual check and confirm meetings.
2.2 Working as a multi-professional team	YES	Commitment to investing into the role of the Registered Nursing Associate role and supporting using Apprenticeship levy. Commitment to aligning all Enhanced, Specialist, Advanced and Consultant roles.	EKHUFT promotes multi-professional team working and innovation. Emergency Surgical Ambulatory Care (ESAC) review undertaken with policy implemented and alignment of level of practice applicable to roles and banding being achieved.
2.3 Recruitment and Retention	Yes	Recruitment and retention to be reviewed by new CNMO workforce team. To ensure Trust achieving equality and diversity, plus enhancing opportunities of recruitment and ensuring that support is available for all new staff.	Corporate Workforce Development, Education and Training (WDET) team has been reviewed and expanded to support Trustwide initiatives to enable successful recruitment and retention for our future workforce. Collaborative working with Equality Diversity and Inclusion (EDI) lead to ensure value-based recruitment and opportunities for career development. Restorative Clinical Supervision available to staff across workforce from a Professional Nurse Advocate. Pastoral Care team engaged in enabling retention across all roles within the workforce.

Expectation 3	COMPLIANCE	EVIDENCE	ACTIONS
RIGHT PLACE AND TIME			
3.1 Productive working and eliminating waste	Yes	Site Triumvirates review patient flow regularly and redeploy staff as required to mitigate risk and maintain safety.	Safe staffing policy includes escalation processes to guide staff. Red shift escalation process to be embedded. Nursing Scorecard developed with Business Intelligence (BI) to support senior leads to monitor workforce data, including use of temporary staffing, and triangulate with quality of care.
3.2 Efficient deployment and flexibility	Yes	Daily SitRep completed by each Care Group to support safe patient care across all clinical areas, with redeployment of staff actioned as necessary to mitigate staffing shortfalls. Use of SafeCare Live to support real-time decision making for care groups, site team and senior leaders in the organisation. All in-patient areas (non-critical care) have SafeCare in place.	Safe Care masterclasses including appropriate use of red flags are available and bookable via ESR. SafeCare “sunbursts” being used at morning site meetings to support appropriate deployment of staff based on acuity and dependency, and not just staffing numbers. Nursing and Midwifery Workforce KPI meetings held monthly by the CNMO/delegated to DCN to monitor clinical areas compliance, with consideration of impact of deployment of staff. BI powered Nursing Scorecard with key metrics available to triangulate staffing position and BI powered Nursing Planning Tool to support efficient senior leadership and oversight of rosters and staffing deployment.
3.3 Efficient employment and minimising agency	Yes	EKHUFT utilises NHS Professionals for Bank staff and ID Medical for agency staff. HSCW agency now stopped across all wards and expected to cease on 1 March (unless approval for short term by CNMO)	Actively recruiting to vacancies and monitoring progress across Trust following approval of January 2024 workforce establishment review. Monitoring temporary staffing usage with consideration of impact on continuity and quality of care. Clear plans in place for remaining areas using agency (ED, AMU and Maternity) for when this will be stopped based on recruitment activity,

		Agency nurse usage also reducing with a plan to stop from 1 April 2025 (unless approval for short term by CNMO)	

Appendix 2 Bed capacity included in the establishment review

Ward Name	Care Group	Beds - Funded	Additional beds	Total Bed included in establishment review
BRABOURNE WARD	DCB	8		8
CLARKE WARD	K&C	36	6	36
HARBLEDOWN WARD	K&C	24		24
INVICTA T&O WARD	K&C	24 (16 beds & 8 trolleys)		24
KENT WARD	K&C	28		28
KINGSTON WARD	K&C	26		26
MOUNT & MCMASTER WARD	K&C	22	4 (Clinic)	22
HARVEY WARD	K&C	19		19
MARLOWE WARD	K&C	27	4 (Day case)	27
ST LAWRENCE WARD	K&C	24		24
BIRCHINGTON WARD	WCYP	17	3	20
BISHOPSTONE WARD	QEQM	22	2	24
CHEERFUL SPARROWS WARD FEMALE	QEQM	32		32
CHEERFUL SPARROWS WARD MALE	QEQM	17		17
CORONARY CARE UNIT - QEQM	WHH	12	1	13
DEAL WARD	QEQM	28		28
FORDWICH WARD	QEQM	19		19
QUEX MEDICAL WARD	QEQM	16	12	28
SANDWICH BAY FRAILTY WARD	QEQM	6	15	21
SEABATHING WARD	QEQM	30		30
ST AUGUSTINE'S WARD	QEQM	28		28
ST MARGARET'S WARD	QEQM	24		24
BARTHOLOMEW UNIT	WHH	22		22
CAMBRIDGE J1 WARD	WHH	20		20
CAMBRIDGE J2 WARD	WHH	19		19
CAMBRIDGE K WARD	WHH	27		27
CAMBRIDGE L WARD	WHH	26		26
CAMBRIDGE M1 WARD	WHH	18		18
CAMBRIDGE M2 WARD	WHH	19		19
CORONARY CARE UNIT - WHH	WHH	10		10
KENNINGTON WARD	WHH	15		15
KINGS A2 WARD	WHH	20		20
KINGS B WARD	WHH	23	1	24
KINGS C1 WARD	WHH	27		27
KINGS C2 MEDICAL WARD	WHH	24		24
KINGS D1 MALE	WHH	25		25
KINGS D2 FEMALE	WHH	19		19

OXFORD WARD	WHH	14		14
RICHARD STEVENS WARD	WHH	24	4	28
ROTARY SUITE	CCASS	16		16
PADUA WARD	WCYP	28		28
RAINBOW WARD	WCYP	20	3	20
AMU A QEQM	QEQM	30		30
AMU B QEQM	QEQM	23		23
AMU A WHH	WHH	25 (17 beds + 8 AAU)		25
AMU B WHH	WHH	26		26
ED ADULTS QEQM	QEQM			
ED PAEDIATRIC QEQM	QEQM			
ED ADULTS WHH	WHH			
ED PAEDIATRIC WHH	WHH			

Total = 1047 beds

Appendix 5

Setting evidence-based nursing Establishments

In line with the National Quality Board (NQB) guidance, nursing establishments at EKHUFT adult and children inpatient areas will be reviewed bi-annually; the Chief Nurse and Midwifery Officer (CNMO) has also requested that ED is included. This enables seasonable variance to be captured and reviewed appropriately.

It recommends a 'triangulated approach' and requires the provider to use evidence-based tools, professional judgement and outcomes to ensure the "right staff with the right skills are in the right place at the right time".

EKHUFT has chosen to use the Shelford Group Safer Nursing Care Tools (SNCT©) as its evidence-based workforce tool. The Trust holds the licences for Adult inpatient wards, Acute Assessment Units, Children's and young people, and Emergency Department (ED); all were used in this review.

The Shelford Group SNCT© for adult In-Patient Wards and adult Acute Assessment Units in Acute Hospitals includes enhanced care needs in the acuity and dependency levels of patient care.

The SNCT© for Children and Young People is due to be updated and currently does not include any additional levels of care.

SNCT Masterclass training was provided through booking on ESR for all ward managers, matrons and nominated data collectors to attend as initial or refresher training to ensure adherence to the data collection process.

Furthermore, to comply with the NQB guidance, the following processes were adhered too:

- Staff were knowledgeable of the acuity and dependency levels through completion of the inter-rater reliability assessment.
- Only three data collectors were selected, the Ward Manager and two Band 6/senior Band 5 Registered Nurses (RNs).
- Data collection was undertaken for 30 days in adult in-patient wards, AMUs and children and young peoples' in-patient wards.
- Data collection was undertaken for 12 days in ED at the set twice daily times until the 24-hour period was captured. In line with the guidance the data collection was only for patients who had been in the department for less than 12 hours.
- External verification was completed by Matrons from different specialities within the care groups.

The Trust's current state of compliance with the National Quality Board guidance is outlined in Appendix 1, with details of actions currently being undertaken to achieve full compliance.

Appendix 6

Process for the establishment review for existing adult and children's Inpatient areas & ED January 2025

In-patient ward and AMU data collection began on 2 January 2025 and was completed on 31 January 2025.

ED data collection began on the 13 January 2025 and was completed on the 24 January 2025.

The results of the SNCT© were then analysed for each clinical area manually by the Joint Lead Nurse for Workforce and Education (Safe Staffing). The SNCT© data used in the review included a 22% uplift allowance for adult and paediatric inpatient wards and AMUs and a 25% uplift allowance for the EDs, as agreed in the January 2024 review.

The appropriate SNCT© tool was applied for areas with greater than 75% side rooms as indicated. This is applicable to three in-patient areas across the Trust; Brabourne ward, Oxford ward and Rotary ward.

SNCT© results were presented using a Power BI dashboard, accessible to each clinical area with inclusion of workforce and quality indicators. In addition, the senior leadership were provided with Roster templates for the relevant clinical areas.

Check and confirm meetings were held with each clinical area during March 2025.

All check and confirm meetings were led by the Deputy Chief Nurse, Workforce, Strategy and Professional Standards.

Directors of Nursing/Midwifery, Associate Directors of Nursing/Midwifery, Heads of Nursing, Matrons and Ward Managers were all invited to the meetings and attended for their relevant areas of responsibility.

During the check and confirm meetings, the current staffing rosters and funded establishment were considered alongside quality and safety metrics, current staffing utilisation, the SNCT© recommendations, changes to service and professional judgement.

The recommendations from the SNCT© data collection was reviewed and each Ward Manager was asked to verify that the patient acuity and dependency data over the SNCT© collection period was truly representative. The majority of areas agreed that it was, however where this was not the case this was recorded and explored in detail during the meeting.

National guidance on safe staffing for clinical specialties was considered, where relevant.

Individual ward environments and layouts were also considered during the meetings.

The quality metrics considered for each adult and child in-patient area as applicable were: statutory training; mandatory training; IPC compliance; inpatient falls with harm; medication errors; hospital acquired pressure ulcers; roster red flags; Care Hours Per Patient Day (CHPPD); compliments; formal and informal complaints; staff vacancies; staff sickness and staff turnover.

The quality metrics considered for each ED area were: statutory training; mandatory training; Infection Prevention and Control (IPC) compliance; initial assessment; sepsis screen; medicine errors; compliments; formal and informal complaints; staff vacancies; staff sickness and staff turnover.

The bed capacity included in the establishment review is detailed in Appendix 2.

In several of the ward areas there continues to be additional services in operation that are provided from within the clinical area's budget. The SNCT© tool does not consider additional services/clinic activity, so this was reviewed separately during the check and confirm discussions using professional judgement. (Details of the wards with clinics are recorded in Appendix 3).

Following these detailed discussions, agreement was reached on the proposed staffing rosters for each in-patient area. For clinical areas where this agreement was not made at the check and confirm meeting, conversations and outcomes were shared and included.

The review of the National Profile Change for Band 2/3 Health Care Support Workers (HCSWs) has been completed, revealing that 838.83 WTE positions were eligible for an upgrade to Band 3 status, effective March 1, 2025. Notably, only seven Band 2 HCSWs within the scope opted out of the automatic uplift, opting to remain at Band 2. In conjunction with this review, the Directors of Nursing/Midwifery and Care Groups have assessed the skill mix of Band 2/3 HCSWs. Given that the majority of HCSWs have chosen to accept the uplift, work is ongoing to evaluate the implications of this transition on the proposed HCSW skill mix (Appendix 4).

The review of outpatient activity (including those within inpatient areas) is on-going and once concluded will be presented in a separate paper.

APPENDIX 7: Care Group Recommendations

Care Group	Staff Group	Current	Proposed	Difference
W&CYP	Registered	106.19	106.19	No change
	HCSW	39.94	42.56	+2.62
	Total	146.13	148.75	+2.62
KCH	Registered	270.20	267.60	-2.6
	HCSW	140.20	142.80	+2.6
	Total	410.40	410.4	410.4
WHH	Registered	436.28	433.86	- 2.42
	HCSW	234.05	249.55	+ 15.5
	Total	670.41	684.08	+ 13.67
QEQM	Registered	267.67	263.89	- 3.78
	HCSW	160.21	172.83	+ 12.62
	Total	427.89	436.72	+8.83

ED Recommendations

Ward Name	Care Group	Budget code	Initial assessment within 15 mins	Sepsis screen *	Falls	Medication Errors	Compliments	Complaints	Turnover	Vacancies	Sickness	Current Establishment			SNCT Recommendation (25%)			Indicative of activity	Roster Detail		Check & Confirm	Skill Mix	Proposed Final 25%			Outcome	Narrative
												RN	HCSW	Total	RN	HCSW	Total		Day	Night			RN	HCSW	Total		
Emergency Department	QEQM	1606	94.70%	99%	3	7	0	14	6.60%	14.24%	6.27%	132.56	56.27	188.83	58.36	14.59	72.95	No	24 RN + 12 HCSW	24 RN + 12 HCSW	04/03/2025	70/30	132.57	56.27	188.83	Same	Explore tools.
Paediatric Emergency Department	QEQM	1656	98.60%		0	1		1	6.70%	9.00%	4.42%	21.78	8.05	29.83	13.74	3.44	17.18	No	4 RN + 2 HCSW	3 RN + 1 HCSW	04/03/2025	73/27	21.78	8.05	29.83	Same	Serena & Clare - data compliance revisit. Review resus activity & paediatric acuity.
Emergency Department	WHH	1605	80.80%	96%	2	8	18	11	9.20%	3.40%	9.01%	147.14	60.72	207.86	61.38	15.35	76.73	No	27 RN + 12 HCSW	27 RN + 12 HCSW	10/03/2025	71/29	147.14	60.72	207.86	Same	182.10 funded & 25.76 temp staff recruited at 0% = 207.86 wte
Paediatric Emergency Department	WHH	1655	91.50%		0	2		1	35.30%	29.20%	25.66%	18.78	8.05	26.83	18.32	4.35	22.67	No	4 RN + 1 HCSW	3 RN + 1 HSCW	10/03/2025	70/30	18.78	8.05	26.83	Same	
												320.26	**133.09**	**453.35**	**151.8**	**37.73**	**189.53**						**320.27**	**133.09**	**453.35**		

* Sepsis screen - Antibiotics within 1 hour of sepsis red %

AMU Recommendations

Ward Name	Care Group	Beds	Falls	Medication Errors	Pressure ulcers	Compliments	Complaints	Turnover	Vacancies	Sickness	Red flags	CHPPD	Current Establishment			SNCT Recommendation (22%)			Indicative of activity	Roster Detail		Check & Confirm	Skill Mix	N:P ratio	Proposed Final 22%			Outcome	Narrative
													RN	HCSW	Total	RN	HCSW	Total		Day	Night				RN	HCSW	Total		
ACUTE MEDICAL UNIT A - QEQM	QEQM	30	0	3	1	0	0	15.90%	14.30%	13.40%	10	8.6	52.10	19.08	71.18	40.50	21.80	62.30	Yes	1 NIC B6, 8 RN B5/4 M-F & 7 RN B5/4 S-S, 3 HCSW M-F & 4 HCSW S-S PDN B7 & CSLF B6	1 NIC B6, 7 RN B5/4, 4 HCSW B2	04/03/2025	67/33	1:3.75	52.1	19.08	71.18	Same	34% Level 1b & 12% Level 2. To consider development opportunities for HCSW to achieve 5.24 B4. To consider B6 allocations. ? LT consider Sat/Sun RN/HCSW allocation - moving towards 7 day AMU service.
ACUTE MEDICAL UNIT B - QEQM	QEQM	23	0	0	7	0	1	5.10%	8.20%	5.30%	8	9.3	35.13	18.33	53.47	32.18	17.32	49.50	Yes	1 NIC B6, 6 RN B5, 4 HCSW B2	1 NIC B6, 5 RN B5, 3 HCSW B2	04/03/2025	64/36	D 1:3.3, N 1:4.6	35.13	18.33	53.47	Same	41% Level 1b
ACUTE MEDICAL UNIT - AMU A	WHH UEAM	17 + 8 AAU	0	4	0	0	1	9%	-130.20%	5.80%	65	9.9	101.09	41.90	142.99	28.58	15.39	43.96	Yes	1 NIC B6, 6 Reg, 3 HCSW	1 NIC B6, 6 Reg, 3 HCSW	10/03/2025	66/34 + 2.0 PDN/CSLF	1:3.6	39.27	15.71	54.98	Same	AMU split in middle of collection period. To maintain quality & safety for Kim & Carly to take to Sarah - 101.41 funded & 62.97 unfunded (overall 165.38) AMU A: 52.38 roster + 0.6 WM + 2.0 PDN/CSLF = 54.98
ACUTE MEDICAL UNIT - AMU B	WHH UEAM	26	0	1	1											30.55	16.45	47.00		1 NIC B6, 6 Reg, 3 HCSW	1 NIC B6, 6 Reg, 3 HCSW	10/03/2025	70/30	1:3.7	37.27	15.71	52.98	Same	AMU B: 52.98 142.99 - 107.96 = 35.03 (unfunded) to support SDEC
													188.32	**79.31**	**267.64**	**131.80**	**70.96**	**202.76**							**163.77**	**68.83**	**232.61**		

K&C Recommendations

Ward Name	Care Group	Speciality	Beds	Clinics	Falls	Medication Errors	Pressure ulcers	Compliments	Complaints	Turnover	Vacancies	Sickness	Red flags	CHPPD	Current Establishment			SNCT Recommendation (22%)			Indicative of activity	Roster Detail		Check & Confirm	Skill Mix	N:P Ratio	Proposed Final 22%			Outcome	Narrative
															RN	HCSW	Total	RN	HCSW	Total		Day	Night				RN	HCSW	Total		
CLARKE WARD	KCH	Surgical	36 + 6	No	0	1	1	0	0	12.10%	12.60%	4.30%	3	6.3	32.03	18.33	50.36	33.57	18.08	51.65	Yes	1 NIC, 6 Reg, 4HCSW	6 Reg, 3 HCSW	06/03/2025	67/33	D 1:5.1 N 1:6	32.03	18.33	50.36	Same	
HARBLEDOWN WARD	KCH	Stroke	24	No	0	1	2	0	0	6.50%	11.5%	7.10%	2	9.5	46.12	15.71	61.48	27.12	14.60	41.72	Yes	1 NIC, 7 Reg, 3 HCSW	5 Reg, 3 HCSW	06/03/2025	69/32	D 1: 4.8 N 1:6	46.12	15.71	61.48	Same	To maintain quality.
INVICTA T&O WARD	KCH	T&O	24	Joint school & Telephone clinic	0	0	0	23	2	5.90%	16.4%	17.00%	0	0	21.83	13.09	34.92	19.68	10.59	30.27	Yes	1 NIC, 5 Reg, 3HCSW	3 Reg, 2 HCSW	06/03/2025	65/35	D 1:3.4 N 1:8	21.83	13.09	34.92	Same	Zilpah & Kim to speak to Sarah - activity risks/COO.
KENT WARD	KCH	Vascular	28	No	0	3	1	0	0	9.30%	11.0%	11.50%	1	6.5	27.79	15.71	43.5	30.05	16.18	46.22	Yes	1 NIC, 5 Reg, 4HCSW	4 Reg, 2 HCSW	06/03/2025	67/33	D 1:4.7 N 1:7	27.79	15.71	43.5	Same	To reduce beds to 28 beds to improve LOS programme & give area of 3 beds to therapies. To maintain skills mix but improvement to quality indicators must be seen. To monitor impact and support ward to recovery. Action plan needed to improve quality indicators with QIA completed.
KINGSTON WARD	KCH	Stoke	26	No	0	2	0	0	0	2.20%	11.0%	9.40%	8	7.8	32.83	18.33	51.16	33.98	18.30	52.28	Yes	1 NIC, 6 Reg, 4HCSW	4 Reg, 4 HCSW	06/03/2025	58/42	D 1:3.7 N 1:6.5	30.21	20.95	51.16	Same	Permanent change of 1 x RN to 1 x HCSW at night. Quality metrics are stable. Overall same establishment.
MOUNT & MCMASTER WARD	KCH	Medical	22+4	No	0	2	0	47	0	8.3%	11.8%	10.30%	11	8	29.41	15.71	45.12	26.29	14.16	40.44	Yes	1 NIC, 5 Reg, 4 HCSW	5 Reg, 2 HCSW	06/03/2025	62/38	D 1:4.40 N 1:5.2	29.41	15.71	45.12	Same	To review additional activities and staffing required. 1 x Telemetry bed to be incl in OPA.
HARVEY WARD	KCH	Neuro	19	No	0	1	1	83	0	8.5%	8.1%	9.70%	3	8.4	24.17	13.09	37.27	22.51	12.12	34.63	Yes	1 NIC, 4 Reg, 3HCSW	4 Reg, 2 HCSW	06/03/2025	65/35	D 1:3.8 N 1:4.8	24.17	13.09	37.27	Same	B2/3/4 scope and role.
MARLOWE WARD	KCH	Renal	27+4	Day case & Dialysis bay	0	2	2	0	0	7.50%	9.5%	8.40%	13	6.3	34.45	17.1	51.55	25.97	13.98	39.95	Yes	1 NIC, 5 Reg, 3 HCSW	1 NIC, 3 Reg, 2 HCSW	06/03/2025	66/34	D 1:4.9 N 1:6.8	34.45	17.1	51.55	Same	SNCT representative of 27 Inpt beds. Action plan needed to improve quality indicators with identification of support needed. To review workforce establishment all of renal services - pending April.
ST LAWRENCE WARD	KCH	MFFD	24	No	0	0	1	0	1	7.50%	5.6%	11.40%	19	7.1	21.55	13.09	34.65	26.88	14.47	41.35	Yes	1 NIC, 3 Reg, 3HCSW	3 Reg, 3 HCSW	06/03/2025	55/45	D 1:6 N 1: 8	21.55	13.09	34.65	Same	Maintain same establishment due to quality and Fire Works programme.
															270.18	**140.16**	**410.4**	**246.033**	**132.479**	**378.512**							**267.56**	**142.78**	**410.4**		

SNCT is indicative of inpatient ward bed activity and does not account for any clinic activities.
Professional judgement proposal at 22% includes clinic activity and services already identified within current establishment.

QEQM Recommendations

Ward Name	Care Group	Speciality	Beds	Clinics	Falls	Medication Errors	Pressure ulcers	Compliments	Complaints	Turnover	Vacancies	Sickness	Red flags	CHPPD	Current Establishment			SNCT Recommendation (22%)			Indicative of activity	Roster Detail		Check & Confirm	Skill Mix	N:P ratio	Proposed Final 22%			Outcome	Narrative
															RN	HCSW	Total	RN	HCSW	Total		Day	Night				RN	HCSW	Total		
BISHOPSTONE WARD	QEQM	Surgical	22+2	No	0	4	3	0	0	13.00%	10.0%	8.30%	4	6.6	23.26	13.09	36.35	26.89	14.48	41.37	Yes	1 NIC B6, 4 RN B5 (1xlate), 3 HCSW B2	4 RN B5, 2 HCSW B2	04/03/2025	69/31	D 1:4.8, N 1:6.0	23.26	13.09	36.35	Same	Keep shift diary of activity/outputs. Flex late shift to varying times of day 7 trial 10-6.
CHEERFUL SPARROWS WARD FEMALE (10/10 - 8/11)	QEQM	Surgical	32	No	0	0	5	31	0	9.40%	8.8%	8.60%	10	6.7	32.03	20.95	52.98	35.01	18.85	53.87	Yes	1 NIC B6, 6 Reg, 4 HSCW	5 Reg, 4 HCSW	25/03/2025	60/40	D 1:4.6, N 1:5.3	32.03	20.95	52.98	Same	To improve quality indicators and data narrative to support. Action plan required.
CHEERFUL SPARROWS WARD MALE	QEQM	Medical	17	No	0	0	2	8	1						18.93	10.48	29.41	18.23	9.82	28.05	Yes	1 NIC B6, 3 Reg, 2 HCSW	3 Reg, 2 HCSW	25/03/2025	62/38	D 1:4.3, N 1:5.7	18.93	10.48	29.41	Same	Transfers x 20 nursing hrs per week. Leadership challenging. Fluctuating A&D levels.
DEAL WARD	QEQM	Medical	28	No	0	1	1	26	1	5.70%	13.8%	5.30%	11	7.1	29.41	18.33	47.74	35.42	19.07	54.49	Yes	1 NIC B6, 5 Reg, 4 HCSW	5 Reg, 4 HCSW	10/03/2025	58/42	D 1:5.2, N 1:6.2	29.41	20.95	50.36	Increase	3 x escalation beds closed. Ward now at usual bed base of 28. Proposal to increase 1 x HCSW at night to support MH needs (2.62 wte). Challenge to be raised with MH lead/CCO to educate & upskill staff. To keep diary of activity for MH/1:1/2:1 pts. Kim & Sue to take to Sarah.
FORDWICH WARD	QEQM	Respiratory/NIV	19	No	0	1	5	0	2	25.50%	16.0%	7.20%	15	9.5	34.71	15.71	50.42	25.84	13.91	39.76	Yes	1 NIC B6, 5 Reg, 3 HCSW	6 Reg, 3 HCSW	10/03/2025	64/36	D & N 1:3.2	34.71	15.71	50.42	Same	4 x escalation beds closed. Ward now at usual bed base of 19. To stay the same but utilisation of 47.74 wte to manage roster needed. Improvement in quality needed - action plan required & to be monitored by Care Group.
QUEX MEDICAL WARD	QEQM	Frailty/HCOOP	16+12	Yes	0	2	4	0	2	3.40%	-34.0%	8.90%	2	6.3	22.11	16.19	38.30	28.67	15.44	44.11	Yes	1 NIC B6, 4 Reg, 4 HCSW	4 Reg, 3 HCSW	10/03/2025	57/43	D 1:5.6, N 1:7	24.17	18.33	42.5	Increase	95% Level 1b. Frequent opening of SDEC chair areas to beds throughout collection period. Quality to be improved. Increase establishment by 4.2 wte to manage roster needed/being utilised. Kim & Sue to take to Sarah.
SANDWICH BAY FRAILTY WARD	QEQM	Medical/Palliative	21	No	0	2	1	0	0	12.20%	-101.8%	2.70%	20	8.1	24.17	15.71	39.88	27.31	14.70	42.01	Yes	1 NIC B6, 4 Reg, 3 HCSW	4 Reg, 3 HCSW	10/03/2025	61/39	D 1:4.2, N 1:5.25	24.17	15.71	39.88	Same	2 x escalation beds closed. Ward now at usual bed base of 21. 5 beds palliative.
SEABATHING WARD	QEQM	Surgical	30	No	0	0	13	54	0	19.30%	22.2%	8.80%	9	5.9	32.03	18.33	50.36	44.10	23.75	67.85	Yes	1 NIC B6, 6 Reg, 4 HCSW	5 Reg, 4 HCSW	25/03/2025	59/41	D 1:4.3, N 1:6	31.43	20.95	52.38	Increase	85% Level 1b & 14% Level 1c. Quality summit required - Kim & Sue to take to Sarah - recommend Nursing, Ops, Ortho team, AHP. To increase by 1 HCSW at night. Review PDN support - Jill to work on SBU for next 12 weeks. Leadership required.
ST AUGUSTINE'S WARD	QEQM	Medical	28	No	0	2	0	0	0	7.50%	18.60%	2.70%	52	6.6	24.23	15.71	39.95	40.68	21.91	62.59	Yes	1 NIC B6, 5 Reg, 4 HCSW	4 Reg, 4 HCSW	10/03/2025	54/46	D 1:4.6, N 1:7	18.99	20.95	39.94	Increase	77% Level 1b & 16% Level 1c. Previous establishment - B4 RNA line not accurate. To move 1 x RN day/night to 1 x HCSW day/night. To find monies for additional Therapy HCSW to support ward (outside of this recommended increase). Kim & Sue to take to Sarah.
ST MARGARETS WARD	QEQM	Medical	24	No	0	0	1	58	1	10.00%	15.80%	3.60%	5	7.0	26.79	15.71	42.50	27.26	14.68	41.94	Yes	1 NIC B6, 5 Reg, 3 HCSW	4 Reg, 3 HCSW	10/03/2025	61/39	D 1:4.8, N 1:6.0	26.79	15.71	42.50	Same	3 x escalation beds closed. Ward now at usual bed base of 24. Potential change to function of ward due.
															267.67	**160.21**	**427.89**	**309.41**	**166.61**	**476.02**							**263.89**	**172.83**	**436.72**		

SNCT is indicative of inpatient ward bed activity and does not account for any clinic activities.
Professional judgement proposal at 22% includes clinic activity and services already identified within current establishment.

WHH Recommendations

Ward Name	Care Group	Speciality	Beds	Clinics	Falls	Medication Errors	Pressure ulcers	Compliments	Complaints	Turnover	Vacancies	Sickness	Red flags	CHPPD	Current Establishment RN	Current Establishment HCSW	Current Establishment Total	SNCT Recommendation (22%) RN	SNCT Recommendation (22%) HCSW	SNCT Recommendation (22%) Total	Indicative of activity	Roster Detail Day	Roster Detail Night	Check & Confirm	Skill Mix	N:P ratio	Proposed Final 22% RN	Proposed Final 22% HCSW	Proposed Final 22% Total	Outcome	Narrative
BARTHOLOMEW UNIT	WHH	Cardiology	22	No	0	2	1	0	0	10.70%	9.20%	3.20%	1	6.7	24.17	10.48	34.65	22.37	12.05	34.42	Yes	1 NIC B6, 4 Reg, 2 HCSW	4 Reg, 2 HCSW	14/03/2025	70/30	D 1:4.4, N 1:5.5	24.17	10.48	34.65	Same	
CAMBRIDGE J1 WARD	WHH	Medical	20	No	0	0	2	0	1	4.00%	14.30%	14.00%	3	7.5	26.79	13.09	39.88	23.88	12.86	36.75	Yes	1 NIC B6, 4 Reg, 3 HCSW	4 RN, 3 HCSW	14/03/2025	61/39	D 1:4, N 1:5	24.17	15.71	39.88	Same	High dependency of patients - Gen Med. Move 1 x RN day to 1 x HCSW night. QIA needed.
CAMBRIDGE J2 WARD	WHH	Respiratory/NIV	19	No	0	0	4	0	0	3.90%	11.10%	6.80%	7	10.3	29.41	18.33	47.74	25.32	13.64	38.96	No	1 NIC B6, 5 Reg, 4 HCSW	5 Reg, 3 HCSW	17/03/2025	62/38	D 1:3.2, N 1:3.8	29.41	18.33	47.74	Same	Reduced NIV/Altered airway pts during SNCT data collection period. Introduce RNA day & night shift - 5.24 wte.
CAMBRIDGE K WARD	WHH	Medical	27	No	0	1	2	0	1	11.60%	27.20%	9.10%	5	6.4	26.79	15.71	42.50	33.56	18.07	51.64	Yes	1 NIC B6, 5 Reg, 3 HCSW	4 Reg, 4 HCSW	14/03/2025	59/41	D 1:4.5, N 1:6.75	26.79	18.33	45.12	Increase	New manager appointed during collection period. High patient dependency. Additional 1 x HCSW at night - 2.62 wte. Carly & Kim to present to Sarah.
CAMBRIDGE L WARD	WHH	Medical	26	No	0	0	4	0	1	5.00%	9.80%	4.00%	0	7.8	32.03	15.71	47.74	36.92	19.88	56.80	Yes	1 NIC B6, 5 Reg, 4 HCSW	5 Reg, 3 HCSW	10/03/2025	62/38	D 1:4.3, N 1:5.2	29.41	18.33	47.74	Same	79% Level 1b. Same overall establishment but new skill mix - 1 x RN moved to 1 x HCSW on day shift following successful 6 month trial.
CAMBRIDGE M1 WARD	WHH	Medical	18	No	0	0	0	0	1	4.30%	8.30%	7.40%	3	7.4	18.93	13.09	32.03	22.99	12.38	35.37	Yes	1 NIC B6, 3 Reg, 3 HCSW	3 Reg, 2 HSCW	14/03/2025	60/40	D 1:4.5, N 1:6	18.93	13.09	32.03	Same	
CAMBRIDGE M2 WARD	WHH	Gastro	19	No	0	4	2	12	0	8.50%	2.60%	7.20%	12	7.0	18.93	11.60	30.53	18.14	9.77	27.91	Yes	1 NIC, 3 Reg, 3 HCSW	3 Reg, 2 HCSW	14/03/2025	60/40	D 1:4.75, N 1:6.3	18.33	13.09	32.03	Increase	As agreed move to 3 HCSW Sat/Sun day.
CCU WHH	WHH	Cardiology	10	PPCI/Tel	0	0	0	0	0	10.30%	10.40%	4.30%	2	16.6	26.79	5.24	32.03	11.90	6.41	18.31	Yes	M-F: 2 NIC B6, 3 Reg, 1 HCSW S-S: 1 NIC, 4 Reg, 1 HCSW	1 NIC B6, 4 Reg, 1 HCSW	14/03/2025	81/19	D 1:2, N 1:2	26.79	5.24	32.03	Same	Cardiology review needed.
CCU QEQM	WHH	Cardiology	12+1	No	0	0	1	0	0	9.10%	20.7%	12.10%	5	8.4	18.93	7.74	26.68	14.78	7.96	22.74	Yes	1 NIC B6, 1 Reg LD, 1 Reg E, 1 Reg L, 1 RNA, 1 HCSW E, 1 HCSW L	1 NIC B6, 1 Reg, 1 RNA, 1 HCSW	14/03/2025	77/23	D 1:3.3, N 1:4.3	19.73	6.03	25.76	Decrease	Increased accuracy of patient A&D scoring. To move some LD's to Early's & Lates to support staffing requirements. Reduce 1 HCSW on early shift
KENNINGTON WARD	WHH	Frailty	15	No	0	2	1	0	0	3.10%	8.20%	1.90%	6	8.1	18.93	10.48	29.41	19.71	10.61	30.32	Yes	1 NIC B6, 3 Reg, 2 HCSW	3 Reg, 2 HSCW	14/03/2025	64/36	D 1:3.75, N 1:5.0	18.93	10.48	29.41	Same	87% Level 1b & 8% Level 1c
KINGS A2 WARD	WHH	Surgical	20	No	0	0	3	0	0	5.30%	-5.90%	9.80%	13	6.5	21.55	13.09	34.65	19.71	10.61	30.32	Yes	1 NIC B6, 3 Reg (2RN, 1 RNA) , 3 HCSW	4 Reg, 2 HCSW	14/03/2025	68/32	D 1:4, N 1:6.6	21.55	13.09	34.65	Same	Move 1 Reg from day to night
KINGS B WARD	WHH	Surgical	23+1	No	0	0	2	0	0	7.90%	5.00%	3.20%	21	6.4	24.17	13.09	37.27	24.58	13.23	37.81	Yes	1 NIC B6, 4 Reg, 3 HCSW	4 Reg, 2 HCSW	14/03/2025	63/37	D 1:4.8, N 1:6	24.17	13.09	37.27	Same	
KINGS C1 WARD	WHH	T&O	27	No	0	0	3	0	0	5.00%	-0.60%	5.90%	24	7.4	26.79	18.33	45.12	37.47	20.17	57.64	Yes	1 NIC B6, 6 Reg, 4 HCSW	4 Reg, 4 HCSW	14/03/2025	59/41	D 1:3.9, N 1:6.75	29.41	20.95	50.36	Same as S24	Sept 24 paper recommended increase in staffing. Skill mix change needed - 1 RN to move to 1 HCSW at night to support enhanced care needs.
KINGS C2 MEDICAL WARD	WHH	Medical	24	No	0	3	1	0	0	4.40%	11.30%	11.70%	4	6.3	24.17	13.09	37.27	25.80	13.89	39.69	Yes	1 NIC B6, 4 Reg, 3 HCSW	4 Reg, 2 HCSW B2	14/03/2025	65/34	D 1:4.8, N 1:6.0	24.17	13.09	37.27	Same	To check 3.8% level 1d.
KINGS D1 MALE	WHH	Surgical	25	No	0	2	6	0	0	12.70%	15.10%		24	15.3	18.93	13.09	32.03	29.15	15.69	44.84	Yes	1 NIC B6, 4 Reg, 3 HCSW	4 Reg, 3 HCSW	14/03/2025	61/39	D 1:5, N 1:6.25	24.17	15.71	39.88	Increase	Increase by 1 HCSW at night.
KINGS D2 FEMALE	WHH	Surgical	19	No	0	0	4	0	0						24.17	13.09	37.27	22.50	12.12	34.62	Yes	1 NIC B6, 3 Reg, 3 HCSW	3 Reg, 3 HCSW	14/03/2025	55/45	D 1:4.75, N 1:6.3	18.93	15.71	34.65	Increase	Increase by 1 HCSW at night.
OXFORD WARD	WHH	Infection	14	No	0	2	2	0	0	5.80%	31.20%	4.60%	7	9.9	24.17	13.09	37.27	22.21	11.96	34.17	Yes	1 NIC B6, 4 Reg, 3 HCSW	4 Reg, 2 HCSW	14/03/2025	65/35	D 1:2.8, N 1:3.5	24.17	13.09	37.27	Same	SINGLE SIDE ROOM
RICHARD STEVENS WARD	WHH	Medical	24+4	Yes	0	3	2	0	1	9.00%	20.60%	10.90%	0	6.8	30.63	15.71	46.34	27.55	14.84	42.39	Yes	1 NIC B6, 5 Reg, 3 HCSW	5 Reg, 3 HCSW	14/03/2025	66/34	D 1:4.7, N 1:5.6	30.63	15.71	46.34	Same	To work towards seperating out hot clinic and wards budget.
															436.28	**234.05**	**670.41**	**438.55**	**236.14**	**674.70**							**433.86**	**249.55**	**684.08**		

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Professional judgement proposal at 22% includes clinic activity and services already identified within current establishment.

DCB Recommendations

Ward Name	Care Group	Speciality	Beds	Clinics	Falls	Medication Errors	Pressure ulcers	Compliments	Complaints	Turnover	Vacancies	Sickness	Red flags	CHPPD	Current Establishment			SNCT Recommendation (22%)			Indicative of activity	Roster Detail		Check & Confirm	Skill Mix	N:P Ratio	Proposed Final 22%			Outcome	Narrative
															RN	HCSW	Total	RN	HCSW	Total		Day	Night				RN	HCSW	Total		
BRABOURNE WARD	DCB	Haematology	8	No	0	0	1	21	0	0%	8.90%	2.90%	1	9.3	12.95	5.99	18.93	9.49	5.11	14.60	Yes	3RN WD, 2 RN WE 2 HCSW	2RN 1 HCSW	06/03/2025	73/27	D 1:3.2 N1:4	12.95	5.99	18.93	Same	SINGLE SIDE ROOM. To continue trial 1 x HCSW day/night & to identify all clinical ctivity & required workforce.

W&CYP Recommendations

Ward Name	Care Group	Speciality	Beds	Clinics	Falls	Medication Errors	Pressure ulcers	Compliments	Complaints	Turnover	Vacancies	Sickness	Red flags	CHPPD	Current Establishment			SNCT Recommendation (22%)			Indicative of activity	Roster Detail		Check & Confirm	Skill Mix	N:P ratio	Proposed Final 22%			Outcome	Narrative
															RN	HCSW	Total	RN	HCSW	Total		Day	Night				RN	HCSW	Total		
BIRCHINGTON WARD - QEQM	WC&YP	Womens	17+3	Yes	0	3	0	0	1	5.60%	3.30%	3.80%	10	8	22.59	13.09	35.68	16.59	8.93	25.52	No	1 NIC B6, 3 Reg, 3 HCSW B3	3 Reg, 2 HCSW	17/03/2025	66/34	D 1:4.75, N 1:6.3	22.59	15.71	38.3	Increase	To increase by 1 HCSW per night for inpatient bed base. 32.03 WTE needed for inpatient activity.
RAINBOW & DOPLHIN WARD - QEQM	WC&YP	Childrens	20+3	Yes	N/A	3	N/A	25	0	8.70%	16.10%	2.70%	0	6.7	38.88	16.05	54.93	14.31	7.70	22.01	No	M-F: 1 NIC B6, 1 B6 7.5hr, 4 Reg, 2 HCSW S-S: 1 NIC B6, 4 Reg, 1 HCSW	1 NIC, 4 Reg, 1 HCSW	13/03/2025	70/30	1:4	38.88	16.05	54.93	Same	16.32 beds/82% occupied of 20 beds. Under 2's 27% (5.4 beds) 1:3 & Over 2's 73% (14.6 beds) 1:4 = 6 Reg New configuration of staffing proposed - Chris & Kim to share with Sarah for decision & then for it to be cascaded to us
PADUA WARD - WHH	WC&YP	Childrens	28	Yes	N/A	6	N/A	14	0	3.90%	6.40%	1.20%	0	8.3	44.72	10.8	55.52	18.56	10.00	28.56	No	1 NIC B6, 7 Reg, 2 HCSW	1 NIC B6, 6 Reg, 1 HCSW	13/03/2025	79/21	1:4	44.72	10.8	55.52	Same	18.53 beds/66% occupied of 28 beds. Under 2's 46% (12.88 beds) 1:3 & Over 2's 54% (15.12 beds) 1:4 = 8 Reg
															106.19	**39.94**	**146.13**	**49.46**	**26.63**	**76.09**							**106.19**	**42.56**	**148.75**		

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Professional judgement proposal at 22% includes clinic activity and services already identified within current establishment.

CCASS Recommendations

Ward Name	Care Group	Speciality	Beds	Clinics	Falls	Medication Errors	Pressure ulcers	Compliments	Complaints	Turnover	Vacancies	Sickness	Red flags	CHPPD	Current Establishment			SNCT Recommendation (22%)			Indicative of activity	Roster Detail		Check & Confirm	Skill Mix	N:P ratio	Proposed Final 22%			Outcome	Narrative
															RN	HCSW	Total	RN	HCSW	Total		Day	Night				RN	HCSW	Total		
ROTARY SUITE	CCASS	ENT	16	Yes	0	1	1	57	0	4.90%	7.50%	4.80%	0	10.50	25.15	17.73	42.88	20.13	10.84	30.97	Yes	1 NIC B6, 4 RN B5, 3 HCSW	4 RN, 2 HCSW	13/03/2025	57/43	D 1:3.2, N 1:4	25.15	17.73	42.88	Same	SINGLE SIDE ROOM. 77% Level 1b. Complex ward layout and tracheotsomy patients. ENT clinic activity included - to work towards seperating out.

Location	Comment	Staff Type	Band	Payscale	Start	Break	Finish	Paid Hours per shift	Number of people	Leave Cover	WTE Incl Leave Cover)
BRABOURNE HAEMATOLOGY WARD - K&C	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	2	22%	5.24
BRABOURNE HAEMATOLOGY WARD - K&C	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	1	22%	2.62
		Clinical								22%	
CLARKE WARD - K&C	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	4	22%	10.48
CLARKE WARD - K&C	HCSW Band 2 - long day	Clinical	2	XR02/03	07:30	01:00	20:00	**11:30**	1	22%	2.62
CLARKE WARD - K&C	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	2	22%	5.24
CLARKE WARD - K&C	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	1	22%	2.62
HARBLEDOWN WARD - K&C	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	3	22%	7.86
HARBLEDOWN WARD - K&C	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	3	22%	7.86
										22%	
INVICTA T&O WARD K&C	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	3	22%	7.86
INVICTA T&O WARD K&C	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	3	22%	7.86
KENT WARD - K&C	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	3	22%	7.86
KENT WARD - K&C	HCSW Band 2 - long day	Clinical	2	XR02/03	07:30	01:00	20:00	**11:30**	1	22%	2.62
KENT WARD - K&C	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	1	22%	2.62
KENT WARD - K&C	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	1	22%	2.62
KINGSTON WARD - K&C	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	2	22%	5.24
KINGSTON WARD - K&C	HCSW Band 2 - long day	Clinical	2	XR02/03	07:30	01:00	20:00	**11:30**	2	22%	5.24
KINGSTON WARD - K&C	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	1	22%	2.62
KINGSTON WARD - K&C	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	2	22%	5.24
MOUNT & MCMASTER WARD - K&C	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	2	22%	5.24
MOUNT & MCMASTER WARD - K&C	HCSW Band 2 - long day	Clinical	2	XR02/03	07:30	01:00	20:00	**11:30**	2	22%	5.24
MOUNT & MCMASTER WARD - K&C	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	3	22%	7.86
MOUNT & MCMASTER WARD - K&C	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	0	22%	0
										22%	
NEUROREHAB NURSING (HARVEY) - K&C	HCSW Band 2 - long day	Clinical	2	XR02/03	07:30	01:00	20:00	**11:30**	3	22%	7.86
NEUROREHAB NURSING (HARVEY) - K&C	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	2	22%	7.86
RENAL MARLOWE WARD - K&C	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	3	22%	7.86
RENAL MARLOWE WARD - K&C	HCSW Band 2 - long day	Clinical	2	XR02/03	07:30	01:00	20:00	**11:30**	2	22%	5.24
RENAL MARLOWE WARD - K&C	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	2	22%	5.24
RENAL MARLOWE WARD - K&C	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	0	22%	0
ST LAWRENCE WARD - K&C	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	3	22%	7.86
ST LAWRENCE WARD - K&C	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	2	22%	5.24
Intensive Care - K&C	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	1	22%	2.62
Intensive Care - K&C	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	1	22%	2.62

	WTE at 22%
Band 3	7.86

Band 3	15.72
Band 2	5.24
Total	20.96

Band 3	15.72

Band 3	15.72

Band 3	10.48
Band 2	5.24
Total	15.72

Band 3	7.86
Band 2	10.48
Total	18.34

Band 3	13.1
Band 2	5.24
Total	18.34

Band 2	5.24
Total	13.09

Band 3	13.1
Band 2	5.24
Total	18.34

Band 3	13.1
Total	13.1

Band 3	5.24
Total	5.24

Location	Comment	Staff Type	Band	Payscale	Start	Break	Finish	Paid Hours	Number of people per shift	Leave Cover	WTE Incl Leave Cover)		
Emergency Department - QEQM	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	8	22%	20.96	Band 3	41.92
Emergency Department - QEQM	HCSW Band 2 - long day	Clinical	2	XR02/03	07:30	01:00	20:00	**11:30**	2	22%	5.24	Band 2	10.48
Emergency Department - QEQM	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	8	22%	20.96	Total	52.4
Emergency Department - QEQM	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	2	22%	5.24		
Paediatric Emergency Department - QEQM	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	2	22%	5.24	Band 3	7.86
Paediatric Emergency Department - QEQM	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	1	22%	2.62		
Acute Medical Unit A - QEQM	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	3	22%	7.86	Band 3	15.72
Acute Medical Unit A - QEQM	HCSW Band 2 - long day	Clinical	2	XR02/03	07:30	01:00	20:00	**11:30**	1	22%	2.62	Band 2	5.24
Acute Medical Unit A - QEQM	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	3	22%	7.86	Total	20.96
Acute Medical Unit A - QEQM	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	1	22%	2.62		
Acute Medical Unit B - QEQM	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	3	22%	7.86	Band 3	15.72
Acute Medical Unit B - QEQM	HCSW Band 2 - long day	Clinical	2	XR02/03	07:30	01:00	20:00	**11:30**	1	22%	2.62	Band 2	2.62
Acute Medical Unit B - QEQM	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	3	22%	7.86	Total	18.34
Acute Medical Unit B - QEQM	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	0	22%	0		
Medical Same Day Emergency Care - QEQM	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	5	22%	13.1	Band 3	13.1
BIRCHINGTON WARD - QEQM	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	2	22%	5.24	Band 3	10.48
BIRCHINGTON WARD - QEQM	HCSW Band 2 - long day	Clinical	2	XR02/03	07:30	01:00	20:00	**11:30**	0	22%		Band 2	0
BIRCHINGTON WARD - QEQM	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	2	22%	5.24	Total	10.48
BIRCHINGTON WARD - QEQM	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	0	22%			
BISHOPSTONE WARD - QEQM	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	1	22%	2.62	Band 3	2.62
BISHOPSTONE WARD - QEQM	HCSW Band 2 - long day	Clinical	2	XR02/03	07:30	01:00	20:00	**11:30**	2	22%	5.24	Band 2	10.48
BISHOPSTONE WARD - QEQM	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	0	22%	0	Total	13.1
BISHOPSTONE WARD - QEQM	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	2	22%	5.24		
CHEERFUL SPARROWS WARD FEMALE - QEQM	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	2	22%	5.24	Band 3	5.24
CHEERFUL SPARROWS WARD FEMALE - QEQM	HCSW Band 2 - long day	Clinical	2	XR02/03	07:30	01:00	20:00	**11:30**	2	22%	5.24	Band 2	15.72
CHEERFUL SPARROWS WARD FEMALE - QEQM	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	0	22%	0	Total	20.96
CHEERFUL SPARROWS WARD FEMALE - QEQM	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	4	22%	10.48		
CHEERFUL SPARROWS WARD MALE - QEQM	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	1	22%	2.62	Band 3	2.62
CHEERFUL SPARROWS WARD MALE - QEQM	HCSW Band 2 - long day	Clinical	2	XR02/03	07:30	01:00	20:00	**11:30**	1	22%	2.62	Band 2	7.86
CHEERFUL SPARROWS WARD MALE - QEQM	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	0	22%	0	Total	10.48
CHEERFUL SPARROWS WARD MALE - QEQM	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	2	22%	5.24		
CORONARY CARE UNIT - QEQM	HCSW Band 3 - long day	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	3	22%	7.86	Band 3	10.48
CORONARY CARE UNIT - QEQM	HCSW Band 3 - long night	Clinical	3	XR02/03	19:30	01:00	08:00	**11:30**	1	22%	2.62		
DEAL WARD - QEQM	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	3	22%	7.86	Band 3	13.1
DEAL WARD - QEQM	HCSW Band 2 - long day	Clinical	2	XR02/03	07:30	01:00	20:00	**11:30**	1	22%	2.62	Band 2	5.24
DEAL WARD - QEQM	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	2	22%	5.24	Total	18.34
DEAL WARD - QEQM	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	1	22%	2.62		
FORDWICH WARD - QEQM	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	2	22%	5.24	Band 3	10.48
FORDWICH WARD - QEQM	HCSW Band 2 - long day	Clinical	2	XR02/03	07:30	01:00	20:00	**11:30**	1	22%	2.62	Band 2	5.24
FORDWICH WARD - QEQM	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	2	22%	5.24	Total	15.72
FORDWICH WARD - QEQM	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	1	22%	2.62		
QUEX MEDICAL WARD - QEQM	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	3	22%	7.86	Band 3	13.1
QUEX MEDICAL WARD - QEQM	HCSW Band 2 - long day	Clinical	2	XR02/03	07:30	01:00	20:00	**11:30**	1	22%	2.62	Band 2	5.24
QUEX MEDICAL WARD - QEQM	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	2	22%	5.24	Total	18.34
QUEX MEDICAL WARD - QEQM	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	1	22%	2.62		
RAINBOW WARD - QEQM	HCSW Band 3 - long day	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	1	22%	2.62	Band 3	5.24
RAINBOW WARD - QEQM	HCSW Band 3 - long night	Clinical	3	XR02/03	19:30	01:00	08:00	**00:00**	1	22%	2.62		
RAINBOW WARD - QEQM	Dolphin Ward - HCSW Band 2 - 9.5hour shift M-F	Clinical	3	XR03/03	08:00	00:30	18:00	**11:30**	1	22%	1.55		
RAINBOW WARD - QEQM	Dolphin Ward - HCSW Band 2 Clinic - 9.5hour shift M-F	Clinical	3	XR03/03	08:00	00:30	18:00	**11:30**	1	22%	1.55		
RAINBOW WARD - QEQM	HCSW Band 2 - OPD QEQM Clinic	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	1	22%	2.16	(1 x Mon-Friand 2 X Sat)	
RAINBOW WARD - QEQM	HCSW Band 2 - OPD QEQM Needle Phobia Clinic	Clinical	3	XR03/03	08:00	00:30	18:00	**09:30**	1	22%	0.08	(0.25 on a Sat)	
RAINBOW WARD - QEQM	OPD @ K&C Blood clinic - HCSW Band 2 - 9.5 hours - Mon	Clinical	3	XR03/03	08:00	00:30	18:00	**09:30**	2	22%	0.6	(only on a Mon)	
RAINBOW WARD - QEQM	OPD @ BHD Clinic - HCSW Band 2 - Mon-Fri 7.5hours	Clinical	3	XR03/03	09:00	00:30	17:00	**07:30**	1	22%	1.22	(1 x Mon-Fri)	
SEABATHING WARD - QEQM	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	1	22%	2.62	Band 3	2.62
SEABATHING WARD - QEQM	HCSW Band 2 - long day	Clinical	2	XR02/03	07:30	01:00	20:00	**11:30**	3	22%	7.86	Band 2	15.72
SEABATHING WARD - QEQM	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	0	22%	0	Total	18.34
SEABATHING WARD - QEQM	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	3	22%	7.86		
ST AUGUSTINE'S WARD - QEQM	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	2	22%	5.24	Band 3	10.48
ST AUGUSTINE'S WARD - QEQM	HCSW Band 2 - long day	Clinical	2	XR02/03	07:30	01:00	20:00	**11:30**	2	22%	5.24	Band 2	10.48
ST AUGUSTINE'S WARD - QEQM	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	2	22%	5.24	Total	20.96
ST AUGUSTINE'S WARD - QEQM	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	2	22%	5.24		
Intensive Care - QEQM	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	1	22%	2.62	Band 3	5.24
Intensive Care - QEQM	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	1	22%	2.62		

Location	Comment	Staff Type	Band	Payscale	Start	Break	Finish	Paid Hours	Number of people per shift	Leave Cover	WTE Incl Leave Cover)
BARTHOLOMEW UNIT - WHH	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	2	22%	5.24
BARTHOLOMEW UNIT - WHH	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	2	22%	5.24
CAMBRIDGE J1 WARD - WHH	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	1	22%	2.62
CAMBRIDGE J1 WARD - WHH	HCSW Band 2 - long day	Clinical	2	XR02/03	07:30	01:00	20:00	**11:30**	2	22%	5.24
CAMBRIDGE J1 WARD - WHH	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	1	22%	2.62
CAMBRIDGE J1 WARD - WHH	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	2	22%	5.24
CAMBRIDGE J2 WARD - WHH	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	3	22%	7.86
CAMBRIDGE J2 WARD - WHH	HCSW Band 2 - long day	Clinical	2	XR02/03	07:30	01:00	20:00	**11:30**	1	22%	2.62
CAMBRIDGE J2 WARD - WHH	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	2	22%	5.24
CAMBRIDGE J2 WARD - WHH	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	1	22%	2.62
CAMBRIDGE K WARD - WHH	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	1	22%	2.62
CAMBRIDGE K WARD - WHH	HCSW Band 2 - long day	Clinical	2	XR02/03	07:30	01:00	20:00	**11:30**	2	22%	5.24
CAMBRIDGE K WARD - WHH	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	1	22%	2.62
CAMBRIDGE K WARD - WHH	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	2	22%	5.24
CAMBRIDGE L WARD- WHH	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	1	22%	2.62
CAMBRIDGE L WARD- WHH	HCSW Band 2 - long day	Clinical	2	XR02/03	07:30	01:00	20:00	**11:30**	2	22%	5.24
CAMBRIDGE L WARD- WHH	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	1	22%	2.62
CAMBRIDGE L WARD- WHH	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	1	22%	2.62
CAMBRIDGE M1 WARD - WHH	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	2	22%	5.24
CAMBRIDGE M1 WARD - WHH	HCSW Band 2 - long day	Clinical	2	XR02/03	07:30	01:00	20:00	**11:30**	1	22%	2.62
CAMBRIDGE M1 WARD - WHH	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	2	22%	5.24
CAMBRIDGE M1 WARD - WHH	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	0	22%	0
CAMBRIDGE M2 WARD - WHH	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	2	22%	5.24
CAMBRIDGE M2 WARD - WHH	HCSW Band 2 - long day	Clinical	2	XR02/03	07:30	01:00	20:00	**11:30**	1	22%	2.62
CAMBRIDGE M2 WARD - WHH	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	1	22%	2.62
CAMBRIDGE M2 WARD - WHH	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	1	22%	2.62
CORONARY CARE UNIT - WHH	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	1	22%	2.62
CORONARY CARE UNIT - WHH	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	1	22%	2.62
KENNINGTON FRAILTY WARD - WHH	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	2	22%	5.24
KENNINGTON FRAILTY WARD - WHH	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	2	22%	5.24
KINGS A2 WARD - WHH	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	2	22%	5.24
KINGS A2 WARD - WHH	HCSW Band 2 - long day	Clinical	2	XR02/03	07:30	01:00	20:00	**11:30**	1	22%	2.62
KINGS A2 WARD - WHH	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	1	22%	5.24
KINGS A2 WARD - WHH	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	1	22%	2.62
KINGS B WARD - WHH	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	2	22%	5.24
KINGS B WARD - WHH	HCSW Band 2 - long day	Clinical	2	XR02/03	07:30	01:00	20:00	**11:30**	1	22%	2.62
KINGS B WARD - WHH	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	2	22%	5.24
KINGS B WARD - WHH	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	0	22%	0
KINGS C1 WARD - WHH	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	2	22%	5.24
KINGS C1 WARD - WHH	HCSW Band 2 - long day	Clinical	2	XR02/03	07:30	01:00	20:00	**11:30**	2	22%	5.24
KINGS C1 WARD - WHH	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	0	22%	0
KINGS C1 WARD - WHH	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	3	22%	7.86
KINGS C2 WARD - WHH	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	2	22%	5.24
KINGS C2 WARD - WHH	HCSW Band 2 - long day	Clinical	2	XR02/03	07:30	01:00	20:00	**11:30**	1	22%	2.62
KINGS C2 WARD - WHH	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	2	22%	5.24
KINGS C2 WARD - WHH	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	0	22%	0
KINGS D WARD FEMALE - WHH	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	2	22%	5.24
KINGS D WARD FEMALE - WHH	HCSW Band 2 - long day	Clinical	2	XR02/03	07:30	01:00	20:00	**11:30**	1	22%	2.62
KINGS D WARD FEMALE - WHH	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	1	22%	2.62
KINGS D WARD FEMALE - WHH	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	1	22%	2.62
KINGS D WARD MALE - WHH	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	2	22%	5.24
KINGS D WARD MALE - WHH	HCSW Band 2 - long day	Clinical	2	XR02/03	07:30	01:00	20:00	**11:30**	1	22%	2.62
KINGS D WARD MALE - WHH	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	1	22%	2.62
KINGS D WARD MALE - WHH	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	1	22%	2.62
OXFORD WARD - WHH	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	2	22%	5.24
OXFORD WARD - WHH	HCSW Band 2 - long day	Clinical	2	XR02/03	07:30	01:00	20:00	**11:30**	1	22%	2.62
OXFORD WARD - WHH	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	2	22%	5.24
OXFORD WARD - WHH	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	0	22%	0
PADUA WARD - WHH	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	2	22%	5.24
PADUA WARD - WHH	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	1	22%	2.62
PADUA WARD Out Patient Clinic- WHH	HCSW Band 3 - Mon-Fri	Clinical	3	XR03/03	07:30	00:30	17:30	**09:30**	2	22%	2.1
RICHARD STEVENS WARD - WHH	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	2	22%	5.24
RICHARD STEVENS WARD - WHH	HCSW Band 2 - long day	Clinical	2	XR02/03	07:30	01:00	20:00	**11:30**	1	22%	2.62
RICHARD STEVENS WARD - WHH	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	2	22%	5.24
RICHARD STEVENS WARD - WHH	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	1	22%	2.62
ROTARY SUITE - WHH	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	4	22%	10.48
ROTARY SUITE - WHH	HCSW Band 2 - long day	Clinical	2	XR02/03	07:30	01:00	20:00	**11:30**	2	22%	5.24
ROTARY SUITE - WHH	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	2	22%	5.24
ROTARY SUITE - WHH	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	0	22%	0
CHANNEL DAY - WHH	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	2	22%	5.24
CHANNEL DAY - WHH	HCSW Band 2 - long day	Clinical	2	XR02/03	07:30	01:00	20:00	**11:30**	0	22%	0
CHANNEL DAY - WHH	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	1	22%	2.62
CHANNEL DAY - WHH	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	0	22%	0
Emergency Department - WHH	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	8	22%	20.96
Emergency Department - WHH	HCSW Band 2 - long day	Clinical	2	XR02/03	07:30	01:00	20:00	**11:30**	2	22%	5.24
Emergency Department - WHH	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	8	22%	20.96
Emergency Department - WHH	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	2	22%	5.24
Paediatric Emergency Department - WHH	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	1	22%	2.62
Paediatric Emergency Department - WHH	HCSW Band 2 - long day	Clinical	2	XR02/03	07:30	01:00	20:00	**11:30**	1	22%	2.62

	WTE at 22%
Band 3	7.86

Band 3	5.24
Band 2	10.48
Total	15.72

Band 3	13.1
Band 2	5.24
Total	18.34

Band 3	7.86
Band 2	7.86
Total	15.72

Band 3	5.24
Band 2	7.86
Total	13.1

Band 3	10.48
Band 2	2.62
Total	13.1

Band 3	7.86
Band 2	5.24
Total	13.1

Band 3	5.24

Band 3	10.48

Band 3	7.86
Band 2	5.24
Total	13.1

Band 3	10.48
Band 2	2.62
Total	13.1

Band 3	5.24
Band 2	13.1
Total	18.34

Band 3	10.48
Band 2	2.62
Total	13.1

Band 3	7.86
Band 2	5.24
Total	13.1

Band 3	7.86
Band 2	5.24
Total	13.1

Band 3	10.48
Band 2	2.62
Total	13.1

Band 3	9.96

Band 3	10.48
Band 2	5.24
Total	15.72

Band 3	15.72
Band 2	5.24
Total	20.96

Band 3	7.86
Band 2	0
Total	7.86

Band 3	41.92
Band 2	10.48
Total	52.4

Band 3	5.24

Acute Medical Unit - WHH	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	8	22%	20.96	Band 3	39.3
Acute Medical Unit - WHH	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	7	22%	18.34		
Intensive Care Unit - WHH	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	2	22%	5.24	Band 3	7.86
Intensive Care Unit - WHH	HCSW Band 2 - long day	Clinical	2	XR02/03	07:30	01:00	20:00	**11:30**	1	22%	2.62	Band 2	5.24
Intensive Care Unit - WHH	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	1	22%	2.62	Total	13.1
Intensive Care Unit - WHH	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	1	22%	2.62		
SEAU - WHH	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	3	22%	7.86	Band 3	7.86
Intensive Care Unit - WHH	HCSW Band 3 - long night	Clinical	3	XR03/03	19:30	01:00	08:00	**11:30**	1	22%	2.62	Band 2	5.24
Intensive Care Unit - WHH	HCSW Band 2 - long night	Clinical	2	XR02/03	19:30	01:00	08:00	**11:30**	1	22%	2.62	Total	13.1
SEAU - WHH	HCSW Band 3 - long day	Clinical	3	XR03/03	07:30	01:00	20:00	**11:30**	3	22%	7.86	Band 3	7.86

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Safeguarding Annual Report 2024/25**

Meeting date: **9 October 2025**

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

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

Appendices:

None

Executive summary:

Action required:	**Approval**
Purpose of the Report:	***The Annual Safeguarding Report is a Statutory Requirement*** The purpose of the annual report covering April 2024 – March 2025 is to inform the Board of the safeguarding structures, governance arrangements and activity undertaken to fulfil the responsibilities to safeguard both our patient's and EKHUFT's continued registration with the Care Quality Commission (CQC), it has to ensure the responsibilities under the Accountability and Assurance Framework (NHS England 2024) are fulfilled.
Summary of key issues:	Safeguarding accountability sits with the CNMO as Executive lead. During this period, she had delegated representation on the Kent Safeguarding Children Multi Agency Partnership (KSCMP) through, the Kent and Medway Chief Nurse from the Integrated Care Board, who is the local NHS System executive Safeguarding lead. The Kent and Medway Safeguarding Adults Board (KMSAB) she has attended herself or been represented by the Deputy Chief Nurse or Head of Safeguarding. The Associate Director of Safeguarding strategically leads Safeguarding across the trust and represents EKHUFT in the KMSAB and KSCMP at sub group level and leads operational safeguarding within the Trust.
Key recommendations:	The Board of Directors is asked to **APPROVE** and publish the report.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Trust Risk Register:	N/A

Resource:	N
Legal and regulatory:	**Y** - Statutory safeguarding duties as defined in the Care Act and Children's Act legislation and statutory guidance within Safeguarding Accountability and Assurance Framework (SAAF).
Subsidiary:	N

Assurance route:

Previously considered by: Safeguarding Assurance Committee, and Quality & Safety Committee

PROTECT EMPOWER SAFEGUARD

ANNUAL REPORT

NHS
East Kent Hospitals University NHS Foundation Trust

Safeguarding

APRIL 2024-2025

Associate Director of Safeguarding

Salli Alihodzic

Deputy Carol Tilling

Childrens-Claire Lapworth

Adults/ MCA- Martin Cripps

Maternity Danielle Micheal

Table of Contents

1. Purpose of the report

1.1 This Report describes the processes and systems in place across all trust sites to Safeguard adults, pregnant people, children and young people who are cared for at East Kent Hospitals University Foundation Trust (EKHUFT). It is the obligation of every NHS organisation and each individual working in the NHS to ensure that the principles and duties of safeguarding children, young people and adults identified as at risk are holistically, consistently and conscientiously applied, with the needs of children and adults at risk of abuse or neglect at the heart of all that we do.

1.2 The purpose of this Annual report, covering the period April 2024-March 2025 is to provide assurance to the Board that East Kent Hospitals University Foundation NHS Trust (EKHUFT) is fulfilling its statutory duties in relation to safeguarding children and adults defined within legislation (Children Act 1989 and 2004, Care Act 2014, Mental Capacity Act 2005 and 2019, Homelessness Reduction Act 2017, Domestic Abuse Act 2021) , following guidance from Working together to Safeguarding Children (2018) and CQC regulation 13.The report also highlights the outstanding risks and their current mitigations.

1.3 It is the obligation of every NHS organisation and each individual working in the NHS to ensure that the principles and duties of safeguarding children, young people and adults identified as at risk are holistically, consistently and conscientiously applied, with the needs of children and adults at risk of abuse or neglect at the heart of all that we do.

1.4 The report provides assurance EKHUFT is using data and feedback to drive improvements.

1.5 It will provide assurance of the effectiveness of the safeguarding assurance committee.

1.6 It will provide an overview of safeguarding activity over the 2024/25.

1.7 To safeguard EKHUFT's continued registration with the Care Quality Commission, it has to ensure the responsibilities under the Accountability and Assurance Framework (NHS England (NHSE) 2024) are fulfilled and the contractual requirements as laid out in Schedule 32 of the NHS Contract.

1.8 EKHUFT has been in National Oversight Framework at level 4 and 3 during the period of this report. Assurance monitoring has been completed throughout the year initially at national then from May at NHSE regional and Kent and Medway Integrated Care Board (ICB) local level. This has included:

- Monitoring Structure and capability to meet statutory functions
- Culture and Development of safeguarding within the Trust
- Key lines of enquiry responding to incidents, appropriateness of response and escalation
- Current risks within the Trust
- Benchmarking against SAAF

2. Introduction

2.1 Executive accountability for Safeguarding is held by the Chief Nursing and Midwifery Officer (CNMO) this has been held by one person within this period. The current CNMO has been in post since September 2023. This role is supported by the Safeguarding Team who provide both strategic, clinical and operational leadership for safeguarding within the Organisation. During this time period, the team have been led by a Substantive Associate director of Safeguarding appointed in January 2024.

2.2 During this reporting period, there has been a reduction in the level of oversight and assurance required by EKHUFT. Since May Safeguarding into level three of the National oversight framework. In relation to safeguarding, regular assurance was provided to NHSE at regional level in addition to the Kent and Medway ICB, it was determined that sufficient evidence around systems and processes primarily had been received at the time of writing this report.

2.3 The Safeguarding team has been recruiting to positions in the new configuration of services throughout 2024/25 this has been challenging and the +resilience of the team has been impacted by high sickness levels

2.4 A Safeguarding Strategy is in place covering 2023-26 this describes the core values, the priorities for the Trust and how they will be achieved.

2.5 The Safeguarding team support individuals and families throughout their lifespan when accessing services at the Trust. Within the Safeguarding Duty service there are specialists for Adults, 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. The team sit within the Corporate Care Group, Clinical Quality and Patient Safety.

2.6 The team have continued to carry a significant deficit in workforce during the year. It has proved challenging recruiting to key leadership and operational positions this has impacted the ability to deliver the safeguarding sustainability plan.

2.7 The safeguarding team enable the workforce to recognise their individual safeguarding responsibility, providing guidance and support to safeguard as a core part of the care we deliver.

2.8 All NHS Trusts must have a safeguarding culture embedded at every level within the organisation so that they can appropriately respond to the needs of their population

2.9 Safeguarding should be interwoven through all elements of care delivery and a key factor in strategic planning

3. Local Context

3.1 During this report period, EKHUFT sat within the area covered by one ICB. We are a large acute hospitals Trust, with five hospitals and a number of community clinics serving approximately 700,000 people in East Kent. We also provide some specialist services for a wider population, including renal services in Medway and Maidstone and a cardiac service for all of Kent based at William Harvey Hospital (WHH), Ashford.

3.2 Locally at EKHUFT, in the financial year 2024/25, there were 5,887 babies born, which is a 2% increase compared to 2023/24. Among the total, 27 were born to mothers aged under 18, which is five lower than last year.
9,652 babies, children and young people were inpatients in our Neonatal Intensive Care Unit (NICU)/Special Care Baby Unit (SCBU), inpatient children's wards, and day surgery units, a 16% rise compared to 2023/24.
762 children and young people attended the Children's Assessment Units, which is a significant decrease compared to last year. This occurred due to a change in recording to same day emergency care (SDEC) attendances rather than admissions, in accordance with NHSE requirements.
A total of 7,727 were inpatients on wards outside of Child Health (includes day surgery (283) and cots for babies born in maternity (6,576)).
Children and young people attended 97,429 initial and follow up outpatient appointments, a similar number to last 2023/24. This data is utilised to determine the level of training required by staff across the organisation (Appendix 1). Adults attended 747,463 outpatients' appointments, which rose 2.6% from last year's 728,494 appointments.
Across all sites, 73,156 under 18s were seen in the Emergency Departments (EDs) and Urgent Treatment Centres (UTCs), compared to last year's figures 70,525 – this increase is largely due to the change in recording to SDEC mentioned previously. There was a rise in adults attendances in EDs and UTCs this year to 231,096, compared to 224,469 attendances last year – a 3% increase.

3.3 In Kent there are approximately 370,000 children and young people 0-19 (Kent Public health observatory), with 14.8% of children under 16s living in poverty/absolute low-income households, this rises to 22.1% in Thanet, 19.5% in dover and 19.1 in Folkstone. (Kent analytics, 2025)

3.4 East Kent has a higher proportion of elderly residents compared to the national average.

3.5 A significant number of patients are accessing acute medical care instead of Primary Care, whilst there have been local initiatives to improve utilisation of community services it has remained the case that EKHUFT continue to see high volumes.

3.6 The need for safeguarding is increased due to continued social admissions due to the breakdown of care packages or families and informal carers struggling to cope with the needs and the numbers within the population who experience social exclusion

3.7 **Health Inclusion considerations**

3.7.1 East Kent 88.6% of the population are White, 4.7% are Asian, 3.1% are Black, 2.4% are Mixed and 1.3% are Other. The five most widely spoken languages are English, Nepalese, Polish, Romanian and Slovak(census,2021). The percentage of LGBTQIA+ people in Kent is 3.25% compared with 89.75% of people who identify as heterosexual or straight. 28.5% of the population in Kent and Medway have long-term conditions (so in East Kent that means over 180,000 people)

3.7.2 East Kent has a high percentage of its population living in coastal communities, it also has an aging population with poor employment opportunities. The highest areas of deprivation in East Kent are within Thanet and Romney Marsh

3.7.3 The rural nature of areas within East Kent impact access to healthcare due to poor transport links and digital dead zones impacting ability to access some health and social care resources

3.7.4 In Kent, in September 2024, the estimated number of rough sleepers was 139. This is up by 10.3% from the autumn 2023. Canterbury had the highest number of people who were rough sleeping on a single night in autumn 2024. 31 people were sleeping rough equating to a rate of 4.5 per 10,000 households, the highest rate in Kent, and accounting for 22.3% of all rough sleepers in Kent. Thanet (3.7) and Maidstone (3.0) also had high rates of rough sleepers per 10,000 households. Sevenoaks had the lowest number of people sleeping rough (one person). (Annual Rough Sleeping Snapshot 2025 DLUHC).

3.7.5 East Kent has a large transient population of asylum seekers and completed initial assessments for unaccompanied asylum-seeking children. In 2024 36,816 people were recorded as having enter the UK via small boats across the channel arriving in East Kent, these people can present with significant health complications, or injuries.

3.7.6 East Kent has a large number of military veterans, the largest number residing in Thanet (5,765 veterans). Dover had a higher-than-average proportion of veterans with 5.9% of the resident population aged 16 and above having served at some time in their life and Folkestone also has a higher-than-average number of veterans. A significant number of the veteran community are Nepalese (census2021)

4. Executive Summary

Statutory Responsibilities and Assurance

4.1 Safeguarding accountability sits with the Chief Nursing and Midwifery Officer as Executive lead. During this period, she had delegated representation on the Kent Safeguarding Children Multi Agency Partnership (KSCMP) through, the Kent and Medway Chief Nurse from the Integrated Care Board, who is the local NHS System executive Safeguarding lead. The Kent and Medway Safeguarding Adults Board she has attended herself or been represented by the Deputy Chief Nurse or Head of Safeguarding.

4.2 The Associate director of Safeguarding strategically leads Safeguarding across the trust and represents EKHUFT in the KMSAB and KSCMP at sub group level and leads operational safeguarding within the trust

4.3 Safeguarding, Learning Disabilities and Mental Health were moved into the portfolio of the Deputy Chief Nurse to provide strategic leadership and oversight alongside the associate director of Safeguarding.

4.4 Named Professionals were in place for Children, Maternity and Adults. Mental Capacity strategic lead was moved into the portfolio of the Named Nurse for Safeguarding adults in July following their appointment and an additional operational lead for Mental Capacity Act (MCA)/DoLs was created. Since September the Named Nurse for Safeguarding Children post became vacant, this was mitigated by the Deputy Head of Safeguarding and Named Midwife whilst recruitment to the role was prioritised

4.5 The Safeguarding Sustainability plan was used to ensure improvement was monitored. This considered safeguarding oversight and accountability at governance, executive, strategic, operational and frontline levels.

4.6 There is a clear governance structure for safeguarding including the Safeguarding Assurance Committee, which reported directly to the Quality and Safety Committee and then the Board, therefore, ensuring that all safeguarding activities and risks were cited through this process. There is also direct reporting into the board of safeguarding reviews and incidents.

4.7 The Safeguarding Assurance Committee met bi-monthly during the report period, chaired by the CMNO. The terms of reference were reviewed to ensure medical representation. The purpose of the meeting is to provide assurance and identify risks and mitigations of all age safeguarding issues across the Trust.

- Reports on the work of the Safeguarding operational group
- Summarises progress against the safeguarding strategy and sustainability plan
- Progress is reported on regional oversight meetings
- Reporting Self-assessment against the SAAF, Section 11 and KMSAB self-assessment tool
- Safeguarding operational workstreams report the work of the Named doctors, MCA, Mental health, Learning disabilities, safeguarding adults, safeguarding maternity and safeguarding children
- Safeguarding assurance is given through the joint business report including Prevent, FGM, domestic abuse
- Outstanding actions, Learning and participation in Safeguarding reviews including Child Safeguarding Practice Reviews (CSPR), RR, DHR, SAR and LeDeR
- Current safeguarding risks, Policies and Audit
- Partnership work

4.8 The designated professions assigned to EKHUFT by the local Integrated Care Board (ICB) are invited to the Safeguarding Assurance committee. They provide can provide guidance and challenge to governance processes.

4.9 A Safeguarding Operational Group takes place monthly is in place to provide regular assurance of care group and Safeguarding team activity.

- Key changes to internal, local or national safeguarding policy impacting care delivery
- Outcomes of Audits impacting safeguarding and reporting on actions
- Safeguarding activity through the business report and workstreams
- Safeguarding themes and information to be shared throughout the care groups to provide Safeguarding insight and evidence-based practice
- Reporting of care group safeguarding activity, good practice, lessons learnt and challenges to delivery of safeguarding duties
- Supervision levels
- Training compliance, actions and specific workshops delivered seeking feedback
- All local published safeguarding reviews, learns, recommendations for practice and monitoring embedded learning through case examples
- Current risks and safeguarding incident
- Any items for escalation to the safeguarding assurance committee

4.10 In relation to safeguarding, regular assurance was provided to NHSE at a regional and local level through the oversight group. Monthly meetings were moved to quarterly in May to reflect the transition to National oversight framework at level 3 the group determined if systems and processes for safeguarding had been effective by assurance received.

4.11 A number of task and finish groups have been led by the Named professionals and Deputy Head of Safeguarding to progress Safeguarding policies and workstreams

4.12 A Safeguarding training programme is in place supported by a training needs analysis with levels of training required indicated through the electronic staff record to ensure EKHUFT staff receive the level of training required by the intercollegiate documents

- Adult Safeguarding: roles and competencies for healthcare staff (2019)
- Safeguarding Children and Young people: roles and competencies for healthcare staff (2021)

4.13 Processes, procedures, protocols and policies are in place to support staff in safeguarding, prioritising needs and decision making when caring for individuals and families where there are high levels of social complexity and risk of abuse or neglect.

4.14 Safeguarding supervision is received and delivered by the safeguarding team through formal and informal mechanisms. A new policy is in place to address challenges in ability to engage parts of the workforce in supervision and additional Safeguarding supervisors have been trained to support this function.

4.15 EKHUFT complies with national standards set for safe recruitment including consideration of national requirements for modern slavery. A review of the process for pre-employment enhanced disclosure and barring checks (DBS) has been undertaken by the deputy head of safeguarding alongside the recruitment team. Processes are now in place, with pre-employment clearance at an appropriate level for all staff. An annual audit provides additional assurance around this.

4.16 Key achievements

- Movement through the national oversight framework, benchmarking improvements against all criteria in the Safeguarding accountability and assurance framework
- Creation of tools to support the delivery of effective safeguarding in the areas of Neglect, Mental capacity, complex maternity and continued development of the safeguarding duty system
- The allocation of site-based practitioners to improve access safeguarding advice and support
- Bespoke training workshops on MCA, Non -accidental injury, neglect, safer discharge and safeguarding in theatres
- Sustained achievement of training levels of over 85% improved supervision levels
- Improved responsiveness to emerging safeguarding incidents issues and concerns
- Improved collaborative working with care groups

4.17 Priorities for 2025/26

- Launch new Strategy
- Digital transformation of safeguarding processes
- Strengthen work around learning from incidents and feedback from service users
- Continue work with care groups to improve early identification and recording of abuse or neglect
- Continue to embed and think family and making safeguarding personal approach
- Ensure sufficient organisational safeguarding capacity to discharge our safeguarding duties
- Collaborate with multi-agency and multi-disciplinary colleagues, systems leads, and patient experience partners to drive improvement in support for patients experiencing social challenges who require safeguarding
- Implement an annual audit plan for which monitors and assesses safeguarding practices and outcomes

5. Governance and accountability arrangements

5.1 Roles and responsibilities

5.1.1 The safeguarding structure includes the required roles from both intercollegiate documents

5.1.2 the statutory lead roles identified in Working Together (2023), the Care Act (2014), sectotion11 of the Children's Act (2004), NAAF (2019) and The MCA Act (2005) includes the following designated roles

5.2 Statutory safeguarding responsibilities

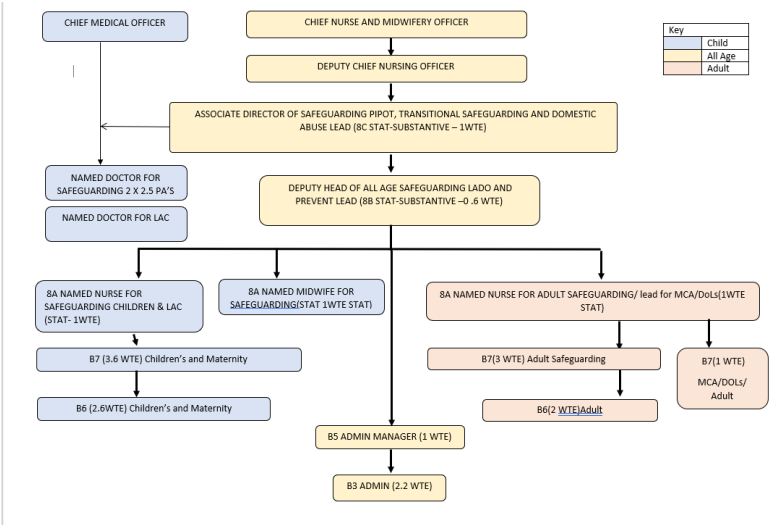
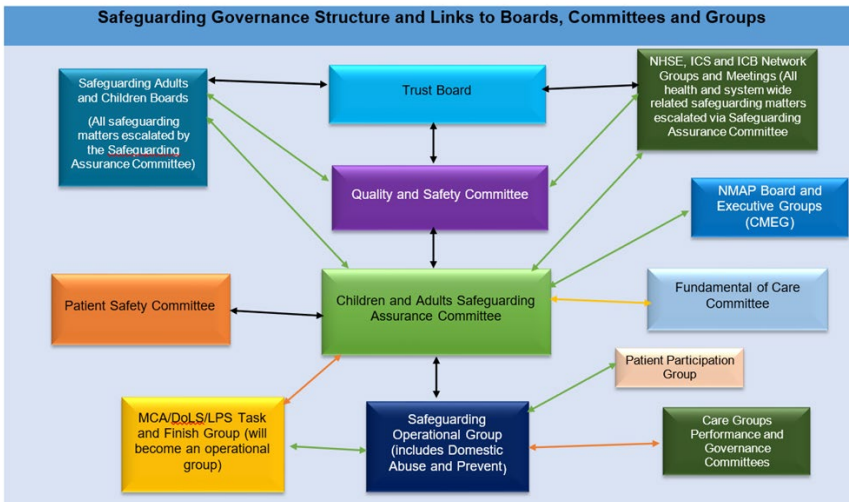


Figure 1: Safeguarding Team Structure

5.3 Safeguarding governance structure



6. Reporting Framework

6.1.1 All Care groups operational safeguarding issues are dealt with and mitigated by the Safeguarding Operational Group and the Task and Finish Groups, where all Care Groups are represented.

6.1.2 The Safeguarding Operational Group reports to the Safeguarding Assurance Committee.

6.1.3 The Safeguarding Assurance Committee reports to the Quality and Safety Committee.

6.1.4 The Quality and Safety Committee reports to the Trust Board.

6.1.5 The Safeguarding Operational Group escalates all safeguarding concerns to the Safeguarding Assurance Committee, who then escalate to the Quality and Safety Committee, and this Committee then escalates to the Trust Board who have overall accountability and responsibility for safeguarding. Therefore, there is oversight of safeguarding at every level from Board to clinical level.

6.1.6 The Safeguarding Assurance Committee also escalates patient safety concerns identified to the Patient Safety Committee and for any quality-of-care concerns to the

Fundamentals of Care Committee, and other Committees, Groups and Boards within the Trust.

6.1.7 All system wide safeguarding issues affecting patients are escalated to the though the Safeguarding Assurance Committee, with oversight from the Quality and Safety Committee and Trust Board. Depending on the nature of these and how they impact on the Trust they are escalated appropriately to Commissioners, Local Authority and NHSE.

6.2 Safeguarding Operational group

The Operational group is chaired by chaired by the Associate director of safeguarding. The purpose of the meeting is place to provide regular assurance of care group and Safeguarding team operational activity. There is a suite of key performance indicators for safeguarding workstreams reviewed and reported by the Safeguarding team, Associate directors of Nursing and Heads of service See the executive summary for further details.

6.3 Safeguarding Assurance Committee

The Safeguarding Assurance Committee met bi-monthly during the report period, chaired by the chief nursing and midwifery officer as the Executive board member with responsibility for safeguarding. See the executive summary for further details.

6.4 Safer recruitment

Assurance received from current services around competencies, safeguarding training, escalation and sanction placed on staff who are not compliant. An audit was completed on the level of DBS checks undertaken were in alignment with both the Trust Policy' Disclosure and Barring Checks Policy', guidance from the Disclosure and Barring Service and the NHS Employment Checks Standards. Overall, the audit showed that staff had the appropriate level of DBS for the level of regulated activity within their job role.

6.5 Participation in wider Trust governance meetings

The Associate director of Safeguarding attends or is represented at the Fundamentals of Care Committee and Nursing and Midwifery Executive Committee (NMEC) where information about themes / trends from a safeguarding perspective are shared with the leaders in the Care Groups. The Deputy Head of All Age Safeguarding attends the Children's and young people s Board and reports upon training compliance alongside the above issues. This Trust wide meeting provides the forum for improvement of services for children across EKHUFT and our membership ensures that safeguarding forms an explicit part of service development

6.6 Care group governance Participation

The Deputy Head of All Age Safeguarding is an active participant of the Clinical Governance process within the Children's care group. The Safeguarding Midwife also attends clinical governance meetings with the Women's health team. The site-based leads have begun attendance at care group governance meetings, they have also met with patient safety business partners

6.7 Patent Safety incident response framework

The Named Safeguarding professionals attend the weekly patient incident meetings to give expert safeguarding guidance. The Associate director of Safeguarding

participates in the weekly analysis and response decision making to patient safety incidents. In addition to this the safeguarding team join fundamentals of care decision making on pressure ulcers, falls and nutrition and have a weekly interface with the patient safety teams about incidents reported on the patient safety reporting system (DATIX)

6.8 Service user Participation

The team works closely with the Patient Advice and Liaison Service and Patient Experience Team regarding any complaints or concerns that come into the Trust where safeguarding may be a factor for consideration. At the same time, there is team representation at the Serious Incident Panel meetings and safeguarding SIs are discussed at the weekly team case management meetings.

6.9 Complaints

The Safeguarding team give a safeguarding perspective on complaint received by the trust participating in responses and local resolution meetings where appropriate

7. Safeguarding Sustainability

7.1 During this period, the Trust has made progress against all areas of the safeguarding sustainability plan. There are identified areas for improvement across a number of workstreams.

7.2 The progress of the All Age Safeguarding Sustainability plan is reviewed quarterly. This includes review of current safeguarding activity workstreams, progress against external oversight objectives, care group input and feedback from the Committee.

7.3 Throughout the year, the associate director of safeguarding has self-assessed safeguarding standards against the NHSE SAAF., This is an ongoing process which is monitored through the external oversight group where progress is reviewed and outstanding activity required by the Trust discussed. This was presented to the Safeguarding Assurance Committee and the Quality and Safety Committee. The self-audit tool focuses on the systems and processes in place to ensure effective safeguarding response and identified the gaps in the benchmark indicators in each of the 9 domains relating to this. A number of the areas have remained as amber as further work is required with regards to the quality of the evidence to ensure that this is robust and reflects the current systems and processes in place. This is under constant review and the Committee has ongoing oversight as evidence of the gaps identified is provided for assurance.

7.4 Externally, associate director safeguarding has been an active member of and participant in the KMSAB Board and sub-groups and Domestic Homicide Local Partnership Board, the annual report submit for this year's activity and progress will be submitted in June 2025.

7.5 The Safeguarding leadership team are active members of the ICB led Child, Adult and All Age health reference groups. The Deputy Head of All Age safeguarding is an active member of the Policies and Procedures group of KSCMP.

7.6 Safeguarding sustainability within the trust is supported by the champions programme, providing additional training and development to ward based champions in safeguarding throughout the trust

8. Statutory Safeguarding reviews

8.1 As part of a national system to learn from, respond to and enhance the protection of adults with care and support needs, children, individuals with learning disabilities who have died or seriously harmed through abuse or neglect and those experiencing domestic abuse which has resulted in a homicide, EKHUFT are mandated to share relevant information and evaluate the trust response to the individual need during any care episodes within the terms of reference.

8.2 EKHUFT have contributed to a number of learning reviews, including safeguarding adult reviews (SAR), Domestic homicide reviews (DHR), Children Safeguarding Practice reviews (CSPR) And Learning Disability (LEaDER).

8.3 Safeguarding Adult Reviews

The team participated in one SARs in this time period, compared to three last year. In addition, they completed a further 17 Rapid Reviews and an additional two summary of agency involvements were provided. The work required for SARs is allocated and monitored through case management. When Kent SARs are published, they are reviewed for thematic learning, if this is pertinent to EKHUFT it is added to our SAR workstreams and progress against these actions has been monitored by the Safeguarding Assurance Committee. The applied learning from SARs was presented by EKHUFT at the Adult Health reference group to support system learning and demonstrated progress on embedding learning

8.4 Domestic Abuse Related Death Reviews (DARDR formally DHR)

The Domestic Violence, Crime and Victims Act 2004, Section 9, requires that, following a domestic homicide, the local area must organise a multi-agency review. The lead responsibility for co-ordinating Domestic Abuse Related Death Reviews lies with the local Community Safety Partnership (Police). The multiple agencies that had contact with the perpetrator and/or victim reflect on the contact and interventions each organisation has had, in order to see if opportunities were missed that may have prevented the homicide. During this time frame, there was participation in three DHR cases, and one rapid review. After concerns were raised by charities and bereaved families that the previous definition did not fully reflect the range of domestic abuse related deaths. In May 2024 following changes brought into law via the amendment to the Victims and prisoners Act 2024 the domestic Homicide reviews have been renamed DARDR(domestic abuse related death reviews)and consider a wider range of domestic abuse related deaths

8.5 LeDeR reviews

As part of the statutory requirements the Learning Disability Team complete LeDeR (Learning from Death of People with Learning Disabilities) notifications when a person with learning disabilities and/or Autism dies in hospital, during this reporting period there were a number of referrals made, and the learning disabilities Nurses contributed to the local LeDeR Operational meetings.

8.6 Child safeguarding practice reviews

EKHUFT completed two Rapid reviews and one Safeguarding child practice review, compared to five last year. This included work of the safeguarding team to gather relevant information about staff involved in the care episode to attend practitioner events and the formulation, monitoring and execution of required actions. These actions are tracked through case management and the Safeguarding assurance group

8.7 Child Death reviews

The Local ICB lead the Child death process once reported. The Trust has a guideline that supports staff in the process to follow. All unexpected Child deaths trigger a joint agency response (JAR) to establish initial clinical interpretation of cause of death, any identified concerns and support for the family. A lead clinician is identified to attend with the safeguarding team if there are any identified safeguarding concerns. Following this the ICB co-ordinate review through the child death overview panel and are responsible for distributing learning across the health system. Learning from unexpected child deaths is incorporated into peer review. The Safeguarding team are awaiting a memorandum of understanding from the Kent coroner's office to develop a new policy to support staff

An external review was commissioned by Maternity following the rising in neonatal deaths – Learning was shared through the Maternity and Neonatal Assurance Group

9. Other statutory Reporting

9.1 Female Genital Mutilation (FGM)

This is classified as a form of child abuse in the country and those participating in it can be prosecuted under the FGM Act (2003) The serious crime act (2015) requires all regulated health professionals in England and Wales to report any known cases of FGM where there is a risk to a child and directly identified cased in individuals to the police. Data about risk for 34 people was reported to the Department of Health as per statutory reporting requirements, Compared to 33 the previous year. There was no mandatory reporting required for individuals under 18.

9.1.1 FGM-IS system alerts the practitioner to FGM being within females in the family. The system can be checked if pregnant people under the age of 18 years present. If baby girls are born at EKHUFT to a mother with FGM then their details are added to FGM-IS, as a further safeguarding measure information about familial FGM is put in the baby's red book as per national guidance.

9.1.2 The FGM policy has been updated to ensure it reflects national guidance

9.2 Child Protection Information System (CPIS)

The National CP-IS project was implemented at EKHUFT in early 2018. Staff in unscheduled settings such as ED, children's wards and maternity access the system using their smart card through an icon on the ZENworks desktop. This allows the staff member to see if the child is on a child protection plan or is 'looked after 'and sends a message back to the Local Authority informing them of the attendance to EKHUFT. The UTCs now have a fully automated system so this area is no longer audited.

9.2.1 Audits of the use of the system have been undertaken on the children's wards

9.2.2 The Deputy Head of Safeguarding was involved in work to implement phase 2 for scheduled care settings. Community child paediatric appointments have since December has phase 2 CPIS – which means they can view to gather information about a child's social care history.

9.2.3 A SOP is in place to support the new CPIS phase two process staff have access through a smart card enabled system

9.2.4 Children within the KCC Level 4 children's social care cohort continue to be flagged on Allscripts. All children with this flag continue to be alerted to the safeguarding team in real time. In addition, there are a small cohort of children who are additionally flagged at the request of our multi-agency partners or the safeguarding team. There are governance arrangements in place around the flagging.

9.2.5 The is CPI flagging for safeguarding concern follow up which alert the safeguarding team of a child's admission to any EKHUFT site.

10. PREVENT

10.1 As an NHS organisation the trust is required under the prevent duty (counter terrorism and security Act 2015) to provide training to ensure staff can recognise when a person is at risk of radicalisation and take steps to report **it.** The safeguarding team offer level 3 training, delivered face to face and level 2 online through ESR. The training materials were updated following input from the local Prevent team

10.2 One Prevent referral was made in relation to an adult

10.3 Multi- agency, local Authority led Channel panels, supported by Kent Police aim to discuss the risks posed by an identified individual who is thought to have been showing signs or involved in activity which would indicate they have been radicalised and could pose a risk to the local population. No referrals were made to the Channel panel for patients of any age.

10.4 The Safeguarding team received 49 requests for information, compared to 36 last year in relation to individuals who have identified through the PREVENT process

10.5 PREVENT data returns were completed and sent quarterly as per our statutory reporting requirements.

11. DOLS

11.1 The number of referrals for Deprivation of Liberty Safeguards (DoLS) remains proportionate to the size of the Trust. These figures are supplied by the DoLS office (Kent County Council (KCC)). The DoLs office share this information with the safeguarding team.

11.2 A DoLs checklist has been developed on the electronic patient record which linked to the Patient Tracking List (PTL) to support clinical staff with the administration of DoLs and site teams to understand where patients are who my require additional resource for clinical staff to deliver the care they need.

11.3 The Security arrangements are currently under review in response to incidents requiring increased levels support to reduce risk of harm to themselves or other patients or visitors to the site. The policy support restrains has been refreshed and review of the training programme for staff on clinical holding and restraint.

11.4 An Enhanced observations policy is in place to support staff in care of patients with complex needs.

11.5 The outcome of DoLS applications by EKHUFT notified to the CQC.

Site	2022-2023	2023-2024	2024-2025
K&C	202	222	202
WHH	563	589	607
QEQM	423	479	501
Total	1,188	1,290	1310

Table 1: DoLs figures comparison

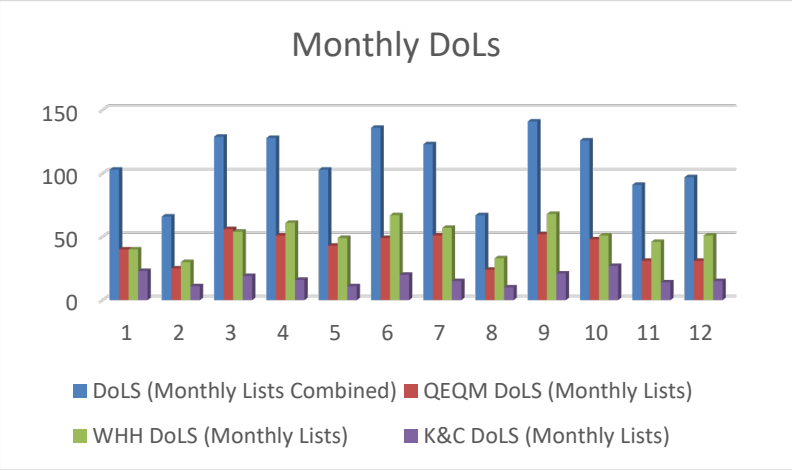


Figure 2: Number of DoLS at K&C, WHH & QEQM 2024-2025

12. Other Regulated Activity

12.1 Child protection medicals

There were 115 child protection medicals undertaken in the Community, compared to 119 last year.

12.2 Managing Allegations against Staff

All allegations against staff are managed as per the Managing Allegations Against Staff Policy and are Datix reported and investigated by the Police where appropriate.

12.3 Managing Allegations Against Staff- Requiring referral to the Local Authority Designated Officer (LADO)

When an allegation is made against a member of the children's workforce, the needs of the child and other children with whom the professional comes into contact are considered paramount as advocated by the Children Act 1989. Employers, however, have an additional duty of care towards their staff and thus the complexities involved in responding to such allegations require balance and careful judgement to ensure risk and support are measured at both levels. During the year 11 cases involving staff were referred to the Kent Local Authority Designated Officer. Two required a risk assessment to enable us to support staff in the workplace where there are safeguarding concerns, 3 were identified as a risk by association and plans put in

place. Six referrals were closed. There were no themes/departments overly identified, except most cases have been where staff 's own children have been subject to child protection investigations or plans.

12.4 Managing Allegations Against People in a Position of Trust (PiPoT)

The Allegations of Abuse Neglect or Harm Against People in a Position of Trust (PiPoT) policy was strengthened to include all staff, volunteers and contractors at the Trust. A formal process to support and manage the staff member to mimic the role of the LADO service has been devised. There were 31 cases raised, compared to 42 cases last year.

13. All age Safeguarding activity

13.1 Duty

The All-age Safeguarding team continues to be a significant number of contacts to the All-Age team which provides assurance evidence that staff at EKHUFT have good awareness of what to do if they have concerns about a patient. The team provide advice and expertise to other staff at EKHUFT through the operation of a duty system, Monday to Friday 9-5, this includes midwifery, learning disability, homeless specialists, domestic abuse advisors and mental capacity and DoLS. This means both staff and outside multi-agency partners receive a prompt response when they have a safeguarding concern.

13.2 Number of consultations

During the period of the report the team undertook **21.233** for children and maternity combined. **463** with urgent treatment centres. **2854** for adult safeguarding. **283** for domestic abuse and **490** for homelessness pathway. There continues to be year on year growth

13.3 Multi-Agency information sharing

13.4 Missing Persons

The Trust continue to be proactive working with our police partners to support the Missing Person agenda. The teams have undertaken reviews of people who went missing for the Police MCE Team to identify if any of these children have had engaged with the Trust at the point of the missing episodes. The adult team are also contacted daily for vulnerable missing adults (Table 2).

Activity	April 2022 – March 2023	April 2023 – March 2024	April 2024 – March 2025
Missing and Child Exploitation reviewed children	1788	1074	1068
Missing and Child Exploitation shared information	32	29	32
Missing Adults reviewed	549	660	463

Missing adults shared information	2	18	20

Table 2: Number of missing contacts from Kent Police

14. Supervision

14.1 It is essential that staff who are involved in safeguarding have access to supervision should they require it, the Intercollegiate document (2019) sets out the appropriate levels of supervision for specific roles. The two Trust supervision policies outline the ways different levels of supervision could be accessed. Improving engagement with supervision has been an all-age priority this year. The Trust is responsible for ensuring that its workforce is competent to carry out their responsibilities for safeguarding and promoting the welfare of children, to do this, it is key an environment is developed where they feel supported and able to raise concerns. Supervision is available in different formats and all staff are also able to access 'individual supervision' through the duty system.

14.2 The Safeguarding team have access to individual supervision during their monthly one to ones and through the leadership team if required throughout the day. There is weekly opportunity for group supervision during case management. The safeguarding leadership team have access to peer supervision through a provider network.

14.3 Group supervision separate delivered by external team.

14.4 For data purposes this is recorded as a 'Consultation' rather than a supervision episode. However, when consultation figures are included, the numbers provide assurance that many staff are accessing the Safeguarding team effectively for support on individual safeguarding cases.

14.5 Paediatric case-holding staff, are offered with four sessions, as per the policy, the expectation is that they will attend three of those sessions. The figure for attendance was **63%,** compared with **49%** the previous year.

14.6 As a result of poor compliance with supervision in Midwifery, more sessions have been offered in a variety of formats and more safeguarding supervisors have been trained. Midwifery staffing levels in the community teams has had an impact on attendance and work has been done around recruitment.

14.7 Safeguarding Children Supervision has hybrid model across all specialities.
In the ED figures the model of supervision has been reviewed 296 cases were discussed over the four sites, compared to 280 cases last year. In addition to these 63 cases were discussed in UTC supervision.

14.8 All staff are offered supervision following and during completion of section 42 investigating officer report for safeguarding adults.

14.9 The Named professionals deliver peer supervision for the safeguarding team as part of case management weekly and ad hoc on individual cases as required.

14.10 Paediatricians also attend 'Peer Review' where case discussion, learning and support are offered. This is run by the Designated and Named Doctors quarterly and is well supported by the Paediatric Medical teams from both the Acute and Community sector with 166 **people attending during the year**, compared to 195

people last year one less session was delivered. Members of the safeguarding team and health professionals from across child health attend these sessions.

14.11 EKHUFT have a cohort of Trauma Risk Management (TRiM) practitioners and managers, this is an initiative which is designed to provide psychological support to staff in the aftermath of potentially traumatic incidents. Trim practitioners are trained to help individuals who may be distressed and to facilitate onward referral for specialist support if this is deemed necessary. The Safeguarding team have 1 member of staff trained as a practitioner and they have been available to support teams across the Trust when incidents have occurred.

15. Safeguarding Pregnant people and new born babies

15.1 Maternity Safeguarding includes the assessment of social risk and provides a unique opportunity for the earliest intervention to minimise risk to the new born baby when they arrive**.** It requires a holistic picture of the whole family or support network to consider safety, current risk or health issues which could affect the outcomes for the unborn baby and any other siblings. Professionals must try to enable the right support to be put in place to maximise parenting capacity whilst maintaining a safe environment**.**

15.2 The named midwife provides support to the community midwifery teams in recognising those people within their caseload who may require further support. The maternity support form acts as a way of considering concerns about the family pre-birth and once the birth has occurred. In addition, it is used to share information with the wider health network including health visitor and GPs. The role is supported by the Safeguarding children's advisors and practitioners.

15.3 The team received 3810 Maternity Support forms from Midwifery and determined safeguarding action plans for these families, this was compared to 4304 last year. 174 women and their babies and families were given additional support via a multi-agency pre- birth plan at the time of delivery, compared to 201 last year. The threshold for pre-birth plan is determined by the local authority.

15.4 The named midwife alongside children's safeguarding advisors, the midwifery team, safeguarding adults and learning disability practitioners participated in a complex maternity task and finish group. This was developed in response to a CSPR to improve the Trust response to increasing complex maternity cases.

15.5 Reports were provided for 84 initial per birth child protection conferences.

15.6 A complex maternity toolkit has been launched and is currently being evaluated following a task and finish group in response to a child safeguarding practice review. This has received both local and regional recognition for best practice.

15.7 There has been work to increase the visibility of safeguarding within maternity, the Safeguarding team now attend a daily Sit rep to discuss maternity safeguarding risks. The safeguarding team also contributed to the recent CQC inspection of maternity services.

15.8 There has been improved collaborative working within maternity to identify gaps in service provision and possible solutions.

16. Safeguarding Children

16.1 EKHUFT general safeguarding children's activity was 10,430. 8138 admissions were considered in relation to children's safeguarding risks, information gathering for 856 strategy discussions, 1344 case conferences.

16.2 The safeguarding team 486 Referrals for Support (RFS) to the Local Authority, compared to 657 last year. Changes to social service front door processes have impacted ease of reporting for emergency care staff.

16.3 27 Case were assessed and managed under the Non-accidental injury protocol.

16.4 A process is in place to monitor the quality assurance of the referrals into Social Services. A Quality Assurance checklist has been devised, scoring referrals out of a possible 10 and this has been incorporated into the Safeguarding Children Policy since 2018.

16.5 As a result of recording, EKHUFT can provide assurance that all the written referrals undertaken by our staff scored over 5/10 with most scoring 8/10 or above. This demonstrates similarity in the quality of referrals from the previous year.

16.6 1757 Multi agency safeguarding reports we received by the team from children's social care, considered and added to child safeguarding records.

16.7 The team contributed to partnership work on Neglect in relation to children and developed an EKHUFT tool to assess Neglect in an acute environment.

16.8 A training workshop was delivered to support the new was not brought policy.

16.9 Several safeguarding children's workstreams were moved into a digital format.

16.10 There was a challenge in recruiting to the Named nurse for Safeguarding children roles which impacted safeguarding leadership in other areas as the Named midwife and the deputy head of safeguarding stepped in to manage children's safeguarding workstreams.

17. Looked after children

17.1 A separate Annual report is produced for Looked After Children Reporting. The safeguarding team recognise the unique challenges faced by children who are currently in the care of the local authority. Whilst their needs will be individually assessed it is important that the EKHUFT workforce understand through training and case discussion the risks and health inequalities these young people face. The Named nurse for Safeguarding children also holds responsibility for looked after children.

17.2 Adoption forms recording health information are completed by the maternity team to capture Maternal and neonatal health history for children who are taken into the care of the local authority.

18. Paediatric Liaison

As part of information sharing arrangements identified in the Children Act (2004), all ED attendances to EKHUFT are shared with our primary care partners, i.e. GPs, Health Visitors and School Nurses. These are primarily undertaken electronically with

the support of our IT team. However, for those children who do not have an identifiable Kent postcode, this is managed manually by the Safeguarding team.

19. Was not Brought (WNB)

Health exclusion is a significant factor for safeguarding particularly neglect. Early intervention can be hugely significant outcomes for individual children ensuring that there has been re-engagement with the health provision they require to achieve their own individual potentials outcomes This year, **1541** missed appointments were reviewed by the team. There has been a reduction in the volume of cases where children not being brought to their health appointments (Figure 3) were reviewed by safeguarding due to a policy change which encourages clinicians to work with families to enable attendance/access prior to referral.

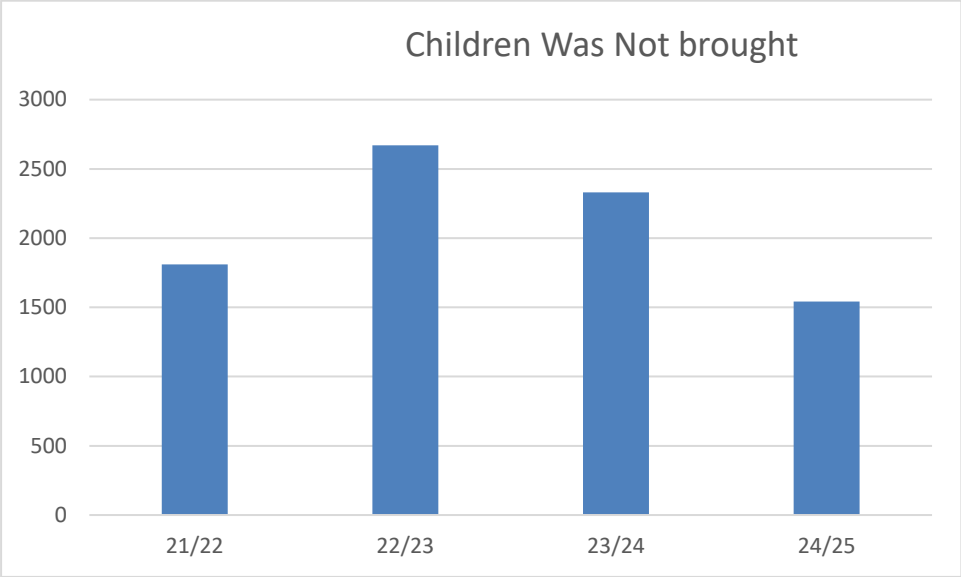


Figure 3: Decrease in WNB April 2023 – March 2024

20. Safeguarding Adults

20.1 Safeguarding Adults workstreams

20.1.1 In October EKHUFT welcomed 185 staff to a hybrid Safeguarding Conference focused on Safeguarding Adult and a think Family approach to safeguarding.

20.1.2 As part of the digital transformation of Safeguarding records a new Patient tracking List (PTL) was created to support the case management of safeguarding within the trust.

20.1.3 There have been challenges around sickness within safeguarding adults' specialist, measures have been introduced to support staff well being.

20.2 Safeguarding adult referrals

The care Act (2014) provides a definition of individuals with care and support needs who may be at risk of abuse, neglect or exploitation. The team also consider what further support might be required under the well-being principle of the care Act The adult specialist in the team receive initial referrals identifying risk through the all-age duty system, these come in a range of formats.

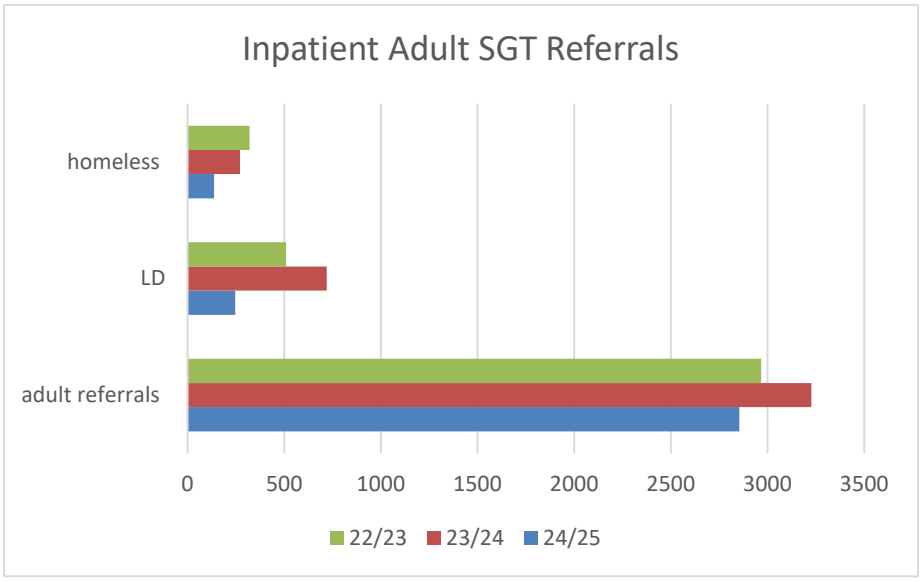


Figure 4: Number of Adult Referrals

20.3 Adult Social care Referrals

The EKHUFT workforce including the Safeguarding team raised 789 Kent Adult Safeguarding concerns forms. The safeguarding dataset monitors the site care was accessed and the main theme of the referral.

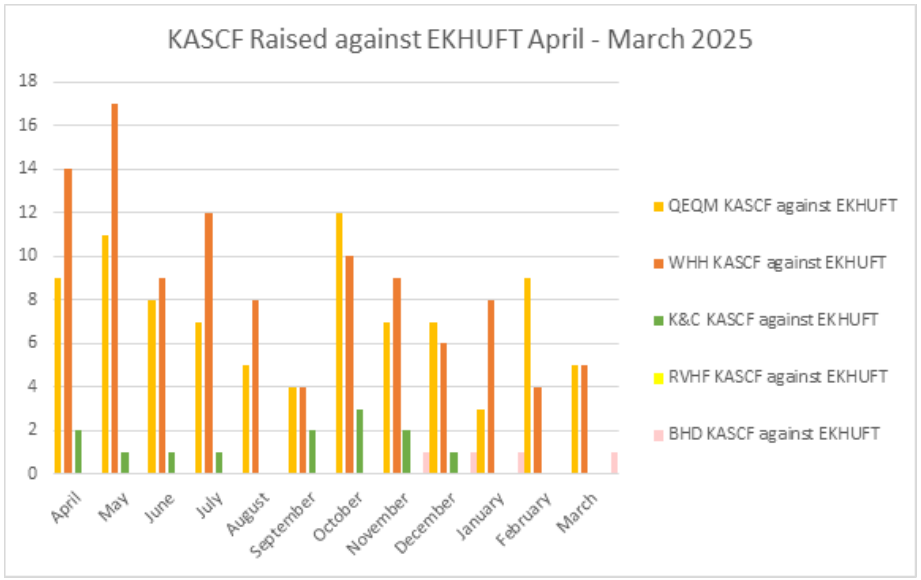


Figure 5: KASCFs raised against EKHUFT per site 2024-2025

20.4 Following receipt to the referral the local authority will decide if it meets threshold. All Section 42 Enquiries are notified to CQC by Social services. All cases raised as Care Act Section 42 Enquiries are logged on Datix and those meeting the criteria for a Serious Incident (STEIs) reported to the ICB. All allegations against staff are managed as per the Managing Allegations Against Staff Policy and are Datix reported and investigated by the Police where appropriate.

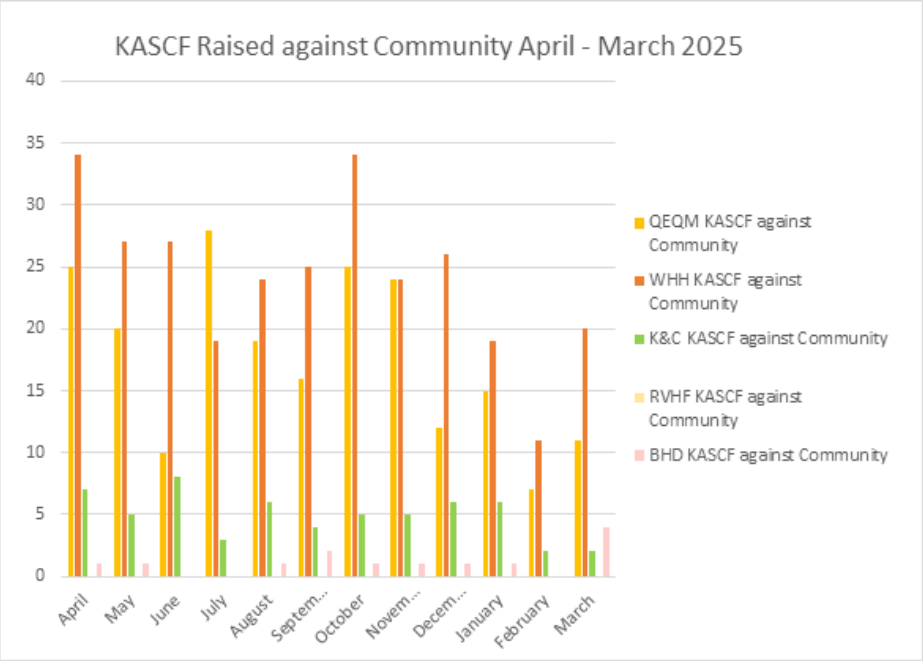


Figure 6: KASCFs raised by EKHUFT per site for community issues 2024-2025

20.5 The main themes for Community KASCFs were:

- Self- Neglect
- Neglect
- Financial abuse
- Domestic Abuse
- Physical abuse

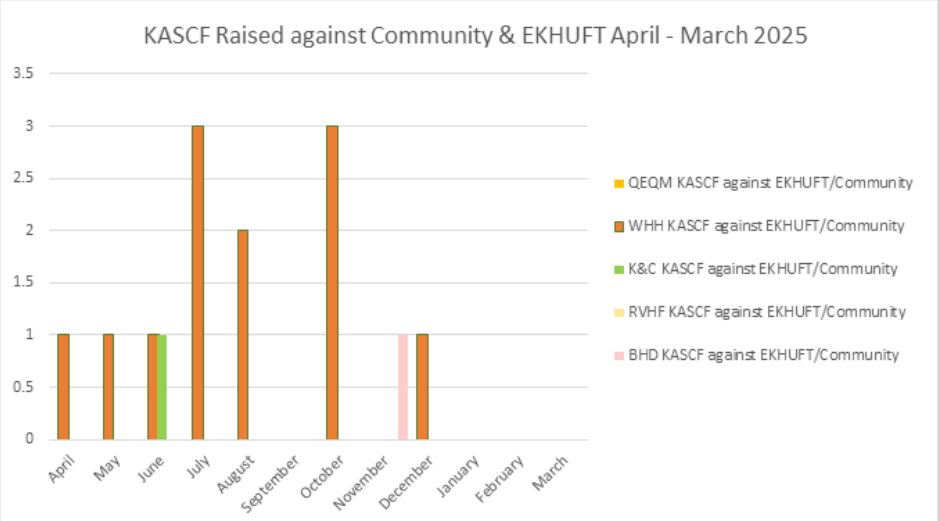


Figure 7: KASCFs raised for EKHUFT/Community 2024/25

20.6 The number of KASCFs raised by the Trust in relation to issues in the Community which is positive and shows that staff are recognising omissions of care for patients coming into hospital (Figure 5).

21. Delegation of Section 42 Inquiry Officer (IO) report writing to the Care groups

Since January 2024 delegate the completion of IO reports to the leads within the care groups. This is now supported by a standard operating procedure (SOP) for staff to follow and access to a training video and best practice guides/templates to aid high quality completion.

21.1 The operational group monitors themes emerging from individual care groups S42 investigations highlighting actions and discussing lessons learnt. A report from this group is then sent to Safeguarding Assurance committee for oversight of themes and areas for learning and improvement. Exceptions are shared with the Quality and Safety Committee and system wide issues shared with the Kent and Medway Safeguarding Adult Board.

21.2 Significant work has taken place with the care groups and Kent county council to improve the timeliness of receiving terms of reference to start section 42 investigations, their completion and confirmation of closure. The Safeguarding team continue to support quality assuring final reports. This has led to removal of s42 back log from risk register.

22. Mental Capacity

22.1 A Lead Nurse for MCA/DoLs was recruited to strengthen EKHUFTs understanding, application and Compliance with the Mental Capacity Act (MCA) & Deprivation of liberty Safeguards (DoLS). This post is supported by the Named Nurse for Safeguarding Adults with strategic lead for MCA.

22.2 A bespoke training package was delivered bi-monthly throughout the year this supports the application of a suite of support materials to aid assessing mental capacity, supporting best interest decision making and identifying any deprivation of liberty.

22.3 Bespoke sessions were delivered to meet the needs of particular staffing groups including the support of the Maxillofacial Surgical team to present a court of protection case study on Surgical Audit Day.

22.4 The MCA lead is part of the clinical ethics committee bringing specialist expertise to decision making.

22.5 An MCA steering group is in place to ensure best practice , learning from the local and national systems enabling best evidence based practice within the trust also monitoring progress on standards.

22.6 The team supported the complex maternity Task and finish group from an MCA perspective, this has aided understanding of capacity within the Maternity staffing groups.

22.7 An MCA /DoLS Policy is in place, and an audit to monitor adherence. Training is included in the wider Safeguarding training needs analysis. Level three safeguarding training around MCA/DoLs is included in the level 3 package.

23. Mental Health

23.1 In November the new Associate Director of Mental health, Learning Disability, Autism and Dementia came into post taking over from the interim Mental Health Lead who was appointed in October 2023.

23.2 The Mental health steering group has created more effective system working. The Mental Health Strategy was designed to be a joint 3-year strategy, and a new operational mental health group has also been created.

23.3 The Mental Health Lead has worked with the Health and Safety and Security leads to refresh ligature, missing persons and restraint policy.

23.4 The safe use of restraint across the trust has been an area of challenge. The primary need to use restraint has been patients presenting a risk of harm to themselves, followed by risk to staff and other patients. Consistent recording of restraint is an area for development. The training offer around safe practice has been reconsidered. There is a new supporting positive behaviours group led by the Deputy Chief Nurse.

23.5 Police have implemented Right Care Right Person as of April 2024 and multi-agency meetings continue to discuss cases and learning from incidents.

23.6 There has also been multi-agency work completed around 136 provision, a new sit and wait service is in place across Kent and Medway.

23.7 The Multi Agency Risk Framework and Tool for Adults and Transitions (MART) tool used within ED settings across Kent and Medway to aid decision making for staff when patients present with mental health challenges is being reviewed.

23.8 A Safe Haven is in place at the QEQM site. This is funded by the ICB for three years and there are steps underway to establish a further Safe Haven at the WHH Site. The aim of this service is to support the increasing number of patients with mental health challenges to have a more appropriate place where they can get support if they are not requiring acute mental health or physical treatment

23.9 A new triage system is in place to try and see patients requiring mental health support at the front door and direct them to appropriate mental health pathways

24. Learning disabilities

24.1 The Learning Disability Team continues to support patients aged 18 or over diagnosed with both learning disabilities and Autism or either condition needs who required additional support when attending the EDs, admitted in an emergency or planned way to a ward, or outpatients. The team offers advice and support during admission and identifying reasonable adjustments. The Team have been moved under the oversight of the Associate director of Nursing for mental health.

24.2 A Learning Disability steering group has been exploring how we meet the needs of services users.

24.3 Work is ongoing on Easy read leaflets and electronic flagging to improve accessibility and empower staff to consider appropriate communication of information.

24.4 System working to ensure safe discharge where needs are complex and standard care pathways are not appropriate is in progress, with the ICB.

24.5 An acute learning disability liaison pathway has been developed to promote joint working with community teams during hospital admission and aid early consideration of onward discharge referrals which may be necessary. It also increased community learning disability team's awareness of patient's health and enabled targeted support to patient and GP services to reduce attendance.

24.6 Online Tier 1 Oliver McGowen Training has compliance reached 91% in March 25 and the second phase has been launched provided by the ICB.

24.7 Work is ongoing with the Patient voice and IT team about the implementation of NHS reasonable adjustment flag.

25. Domestic abuse

25.1 The executive Lead for Domestic abuse was the CNMO.
25.2 The Trust has a Domestic abuse policy.
25.3 The Domestic Abuse Hospital Independent Violence Advocates (HIDVA) project continues across QEQM, WHH & K&C, providing support to families and staff who are the subject of physical or psychological abuse via the provision of a dedicated Hospital Domestic Abuse Advocate. They have continued to provide support to staff and patients. The numbers of referral remain consistent, these are reported via the care flow system (Table 3). During this timeframe all HIDVAs were in post and covered all sites.

Activity	April 2022 – March 2023	April 2023 – March 2024	April 2024-March2025
HIDVA Referrals	193	214	283

Table 3: HIDVA Referrals

25.4 The HIDVAs have also undertaken teaching sessions and participated in the Safeguarding team walkabouts and raising awareness across all sites.
25.5 Specific ED training was provided for Urgent and emergency care areas.
25.6 As part of the Domestic Abuse workstream devised to strengthen and deliver the Trust's statutory duties on domestic abuse, a new stand-alone domestic abuse policy for patients and staff is in place to reflect the Domestic Abuse Act 2021 and NICE guidance (ph50). Training requirements have been refreshed, strategies for staff to use with patients and information for people managers supporting staff including the Trust's well- being services for staff. The HIDVA service have made podcast training videos for EKHUFT staff in support of the policy with practical hints and tips for staff.
25.7 A domestic Abuse conference in March was hosted by EKHUFT delivered by our two community HIDVA providers, Oasis and rising sun.

26. MARAC

26.1 The Interim Head of Safeguarding and Deputy Head of Safeguarding continue to participate in health meetings led by the ICB regarding the proposed changes to the MARAC process this workstream has experienced delays interim arrangements remain the same, currently the Safeguarding team spend 1-4 hours a week supporting the process.
26.2 The following number of cases had data provided for the victim, perpetrator and any children for the family shared with the MARAC service around recent attendances to EKHUFT (Table 8), this helps support the safety planning for the victims. All victims and their children are flagged for one year from the start of their safety plan via the alert system on Allscripts, allowing practitioners to be aware of this information and to incorporate this into their assessment of the patient at their attendance.

Sites	April 2022 – March 2023	April 2023 – March 2024	April 2024-March 2025
Ashford	173	181	154
Canterbury	166	200	183

Dover	179	163	181
Folkestone	91	150	168
Thanet	220	222	263
Total	578	916	948

Table 4: MARAC enquiries

27. Homelessness

27.1 EKHUFT have a statutory legal duty (Homelessness reduction Act 2017) to assist that individual; with their consent, to make a homelessness approach to the local authority. There is close liaison with all relevant Local Housing Authorities including the 'Rough Sleeper Teams' that sit within those local authorities. Encouraging Multi agency working when an individual is admitted to hospital and requesting complex discharge planning meetings, has enabled staff to address the complex issues, that often-mean individuals have multiple attendances to the acute EKHUFT setting.

27.2 There is one homeless nurse (Band 7), who covers all sites across the Trust, offering advice support and guidance when an individual is identified as being homeless. Staff are supported and signposted if an individual is identified as having Adult Safeguarding/ Self neglect issues and assist with suggestions with regard to appropriate referrals interventions. Many individuals who are homeless, have been excluded from GP practice, or have difficult registering – the Nurse is in communication with Integrated Care System (ICS) special GP allocations scheme, if an individual is struggling to register it may be possible to assist.

27.3 The Safeguarding team work closely on this project with the Homelessness Pathway team to providing support on the interface between homelessness and safeguarding, this had resulted in work being strengthened around discharge and assess to support under the wellbeing principle of the Care act.

27.4 A significant proportion of individuals who are homeless have had significant past Trauma, EKHUFT staff are encouraged to adopt a trauma informed approach and to consider Adverse Childhood experiences. Awareness of this is included in level 3 training and is regularly highlighted in 'Safeguarding Matters' in Trust news.

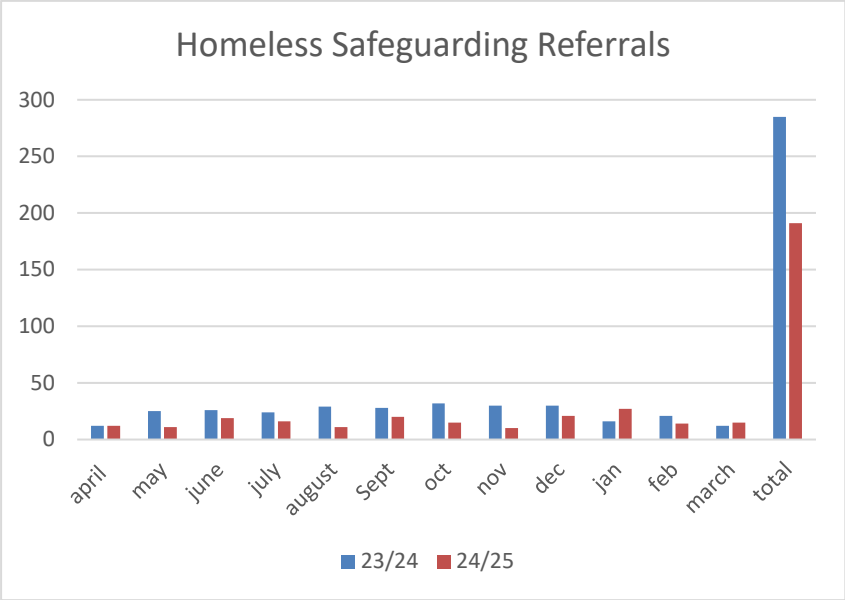


Figure 8: Homeless Safeguarding Referrals

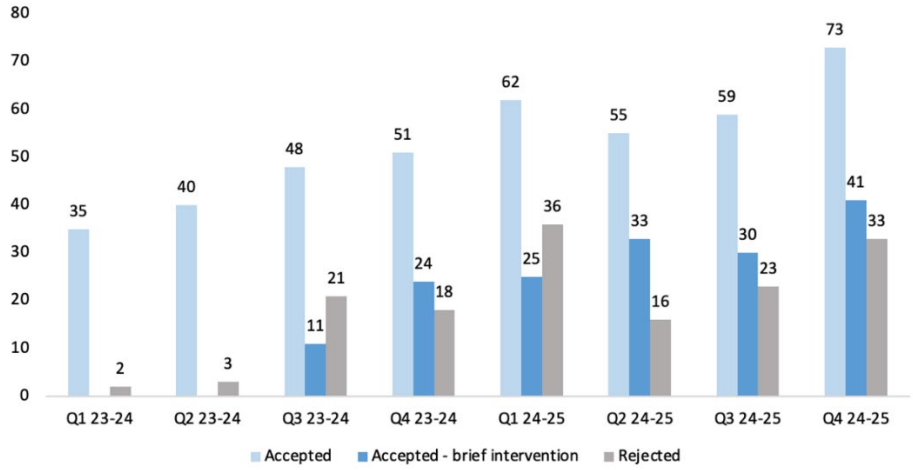


Figure 9: Homeless Pathway Activity

2024/25	Q1	Q2	Q3	Q4
Accepted (full support)	62	55	59	73
Accepted (brief)	25	33	30	41
Total accepted	87	88	89	114
% holistic assessment	87%	77%	94%	94%
% care plan	70%	90%	98%	90%
% GP registered	0%	100%	75%	88%
% rough sleeping reduction	-54%	-22%	-65%	-38%
% sofa surfing reduction	-14%	-29%	-26%	-53%
% self-discharge	8.6%	9.3%	16%	6%
% delayed discharge	21%	33.3%	25%	17.5%
% NRPF	3.4%	3.4%	2.2%	5%
% additional/practical support	98.6%	98%	100%	
% follow up by team	38%	37.5%	41%	31%

Table 5: Referrals to homeless pathway

28. Reachable moments

28.1 Reachable moments project supports young people attending hospital following suspected assaults ensuring they are offered support as part of a scheme launched by the Kent and Medway Violence Reduction Unit (VRU). As part of the 'Reachable Moments' project, youth workers were stationed at accident and emergency departments in Medway and Thanet to engage with those who may have been injured at the hands of others, including using weapons. Their role was to understand how they came to be hurt and what support they or their families may need to help them move away from criminal activity such as carrying knives or being involved in county lines or gang activity. The project is a partnership between the VRU, Kent County Council, Medway Council, NHS and the domestic abuse charity Oasis. Now up to 25 and more support out of hours.

	Q1	Q2	Q3	Q4
23/24	21	33	43	52
24/25	75	71	70	Awaiting data

Table 6: Reachable Moments per quarter

28.2 The safeguarding team interface with the community safety partnership to support disruption activity of county lines offending, with the aim to reduce the local exploitation risk. Offenders recruit, transport and exploit vulnerable individuals including children to carry out low level criminal activity essential to their operations victims can be harmed during high risk or gang related activity leading them to present in urgent and emergency care settings.

28.3 EKHUFT submit data to the Violence Reduction Unit around knife crime and injuries. There are challenges around this submission it is difficult for staff EKHUFT to record locations of incidents routinely. Data has been submitted and sent retrospectively for the year.

29. Risk Management

29.1 Care groups are responsible for reporting risk incidents the safeguarding team will report a risk when they become aware that a safeguarding risk has not been managed in an appropriate or timely way which has led to increased risk.

29.2 The Safeguarding team meet regularly with the Patient Safety team to consider any themes, delays and complex cases. The safeguarding team attend Pre IRP and IRP to provide safeguarding risk guidance.

29.3 Themes from incidents are explored at the Safeguarding operational group.

29.4 At the end of this period of report there remained two open risks on the corporate register.

- Safeguarding workforce
- Safeguarding Training compliance

30. Partnership working

30.1 Multi-agency partnership working is essential for effective safeguarding. The ICB represents Health as one of the three statutory partners on both the Kent and Medway Safeguarding adults Board (KMSAB) and at Both the Kent and Medway Safeguarding children's partnerships.

30.2 Associate Director of Safeguarding and Deputy Head of Safeguarding participate in the following subgroups of the Safeguarding Adult board:

- The Business Group
- The communications and engagement working group
- Quality assurance working group
- Policies, practices and procedures working group
- SAR working group health is represented by Kent and Medway NHS and Social Care Partnership Trust (KMPT)

30.3 The ICB represent the all the provider organisations at the children's partnerships and the Safeguarding team are involved in task and finish groups as required.

30.4 The Named Professionals participate in the Adults, Children's and All Age health reference groups.

30.5 The Named Midwife participates In the National Safeguarding Maternity Network, South East Regional maternity network.

30.6 The Interim Heads of Safeguarding have participated in the Safeguarding Adults National Network.

31. Training

31.1 The annual figures show there has been an increase in meeting the agreed local compliance standard of over 85% at both level 2 and 3 (Table 7). Training at level 2 was delivered online.

Employees compliance at required level by staff group	**Safeguarding Children**			**Safeguarding Adult**		
Staff Group	**Head Count Required**	**Head Count Gained**	**Compliance %**	**Head Count Required**	**Head Count Gained**	**Compliance %**
Add Prof Scientific and Technic	313	285	91	313	307	98
Additional Clinical Services	1786	1590	89	1786	1682	94
Administrative and Clerical	2161	2157	99	2161	2160	99
Allied Health Professionals	723	662	92	723	694	96
Estates and Ancillary	5	5	100	5	4	80
Healthcare Scientists	262	251	96	262	260	99
Medical and Dental	1327	976	74	1327	981	74
Nursing and Midwifery Registered	3326	3079	93	3326	3073	92
Students	26	24	92	26	25	96
Grand Total	**9929**	**9029**	**91**	**9929**	**9186**	**93**

Figure 10: Training Figures by staff group (March 25)

31.2 There remains constant drilling down into the data to ensure pockets of non-compliance in wards and departments are highlighted to care groups so action to improve and maintain compliance is undertaken. Support with data cleansing and bespoke training sessions has been provided by the Safeguarding team. During this timeframe progress for training compliance was monitored closely as part of the Safeguarding sustainability plan.

31.3 The training strategy and training needs analysis has been reviewed and updated against the current intercollegiate documents (The Royal College of Paediatrics and Child Health (RCPCH 2019) and Royal College of Nursing (RCN 2018)).

31.4 There has been an increase of training sessions offered by the team, in addition staff who require only level 2 training are now able to achieve this through online training. There are more spaces available for the following year than those requiring level 3 training. All courses are overbooked.

2023-2024	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
L1 C	100	100	100	100	100	100	100	100	100	100	100	100
L4 C	100	100	100	100	100	100	100	100	100	100	100	100
L1 A	100	100	100	100	100	100	100	100	100	100	100	100
L4A	100	100	100	100	100	100	100	100	100	100	100	100

Table 7: Training Compliance levels 2024-25

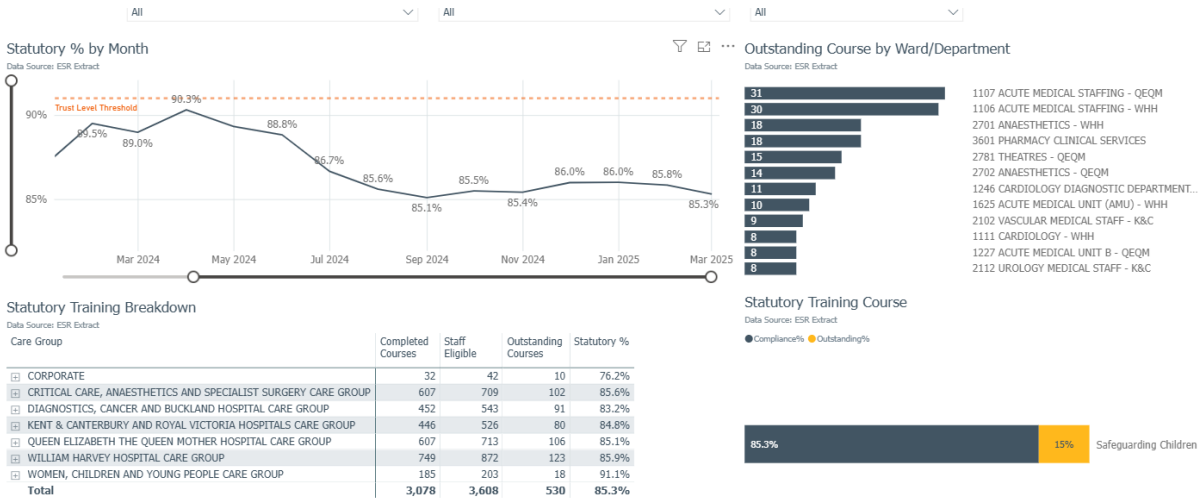
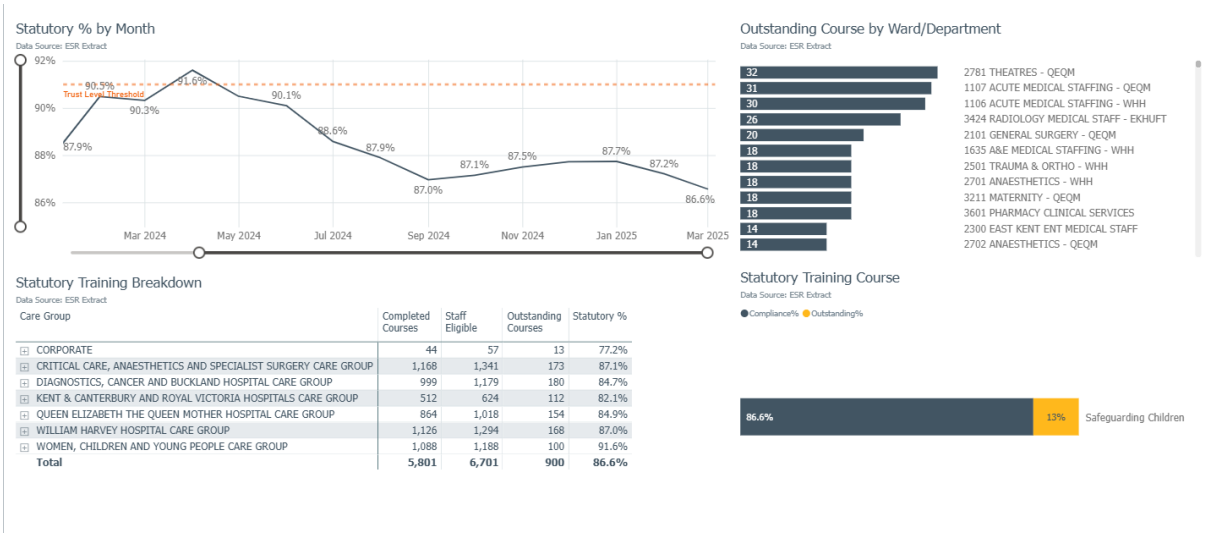
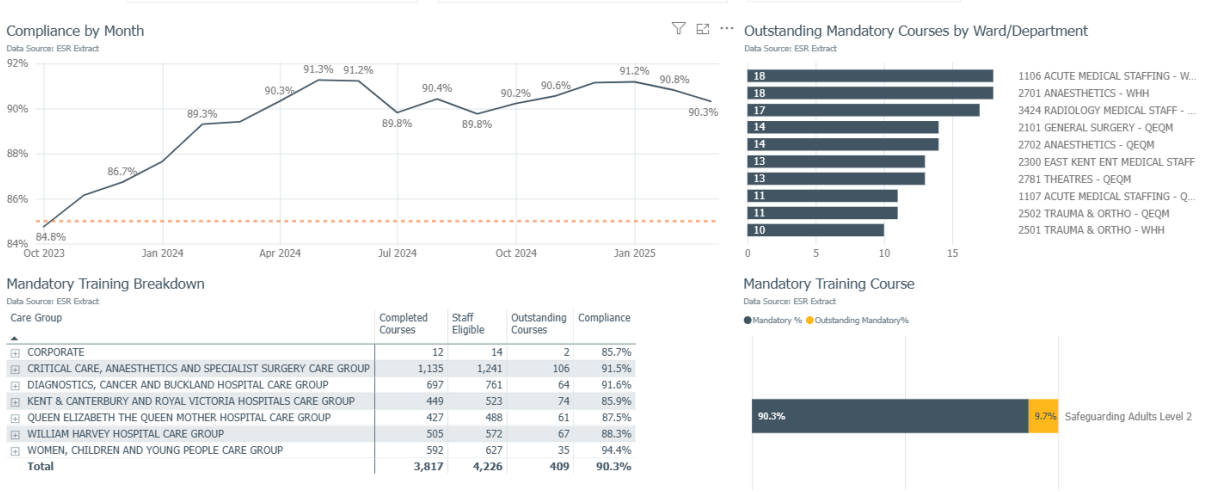


Figure 11: Safeguarding children's level 2 Training



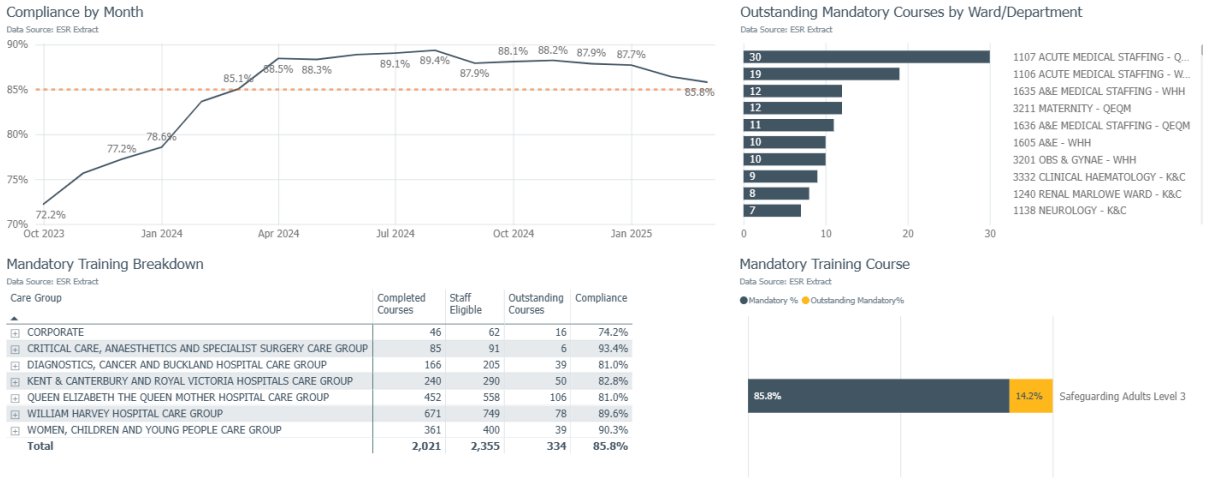
Care Group	Completed Courses	Staff Eligible	Outstanding Courses	Statutory %
CORPORATE	44	57	13	77.2%
CRITICAL CARE, ANAESTHETICS AND SPECIALIST SURGERY CARE GROUP	1,168	1,341	173	87.1%
DIAGNOSTICS, CANCER AND BUCKLAND HOSPITAL CARE GROUP	999	1,179	180	84.7%
KENT & CANTERBURY AND ROYAL VICTORIA HOSPITALS CARE GROUP	512	624	112	82.1%
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL CARE GROUP	864	1,018	154	84.9%
WILLIAM HARVEY HOSPITAL CARE GROUP	1,126	1,294	168	87.0%
WOMEN, CHILDREN AND YOUNG PEOPLE CARE GROUP	1,088	1,188	100	91.6%
Total	**5,801**	**6,701**	**900**	**86.6%**

Figure 12: Safeguarding children's level 3 Training



Care Group	Completed Courses	Staff Eligible	Outstanding Courses	Compliance
CORPORATE	12	14	2	85.7%
CRITICAL CARE, ANAESTHETICS AND SPECIALIST SURGERY CARE GROUP	1,135	1,241	106	91.5%
DIAGNOSTICS, CANCER AND BUCKLAND HOSPITAL CARE GROUP	697	761	64	91.6%
KENT & CANTERBURY AND ROYAL VICTORIA HOSPITALS CARE GROUP	449	523	74	85.9%
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL CARE GROUP	427	488	61	87.5%
WILLIAM HARVEY HOSPITAL CARE GROUP	505	572	67	88.3%
WOMEN, CHILDREN AND YOUNG PEOPLE CARE GROUP	592	627	35	94.4%
Total	**3,817**	**4,226**	**409**	**90.3%**

Figure 13: Safeguarding Adults level 2 Training



Care Group	Completed Courses	Staff Eligible	Outstanding Courses	Compliance
CORPORATE	46	62	16	74.2%
CRITICAL CARE, ANAESTHETICS AND SPECIALIST SURGERY CARE GROUP	85	91	6	93.4%
DIAGNOSTICS, CANCER AND BUCKLAND HOSPITAL CARE GROUP	166	205	39	81.0%
KENT & CANTERBURY AND ROYAL VICTORIA HOSPITALS CARE GROUP	240	290	50	82.8%
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL CARE GROUP	452	558	106	81.0%
WILLIAM HARVEY HOSPITAL CARE GROUP	671	749	78	89.6%
WOMEN, CHILDREN AND YOUNG PEOPLE CARE GROUP	361	400	39	90.3%
Total	**2,021**	**2,355**	**334**	**85.8%**

Figure 14: Safeguarding Adults level 3 Training

32. External Audit/Reporting

32.1 KMSAB Safeguarding adult's Self-assessment framework

32.1.1 The Kent and Medway Safeguarding Adults Board self-assessment was submitted and we began with 12 Amber actions to complete and 1 red which is to create an Adults Was Not Brought policy.

32.1.2 A new Was not brought policy was created to compliment the access policy in place to support vulnerable adults or those with complex needs to be supported in their access to healthcare.

32.1.3 At the time of witting this report there is one open amber action to provide assurance around the safeguarding in estates and hospitality.

32.2 Section 11

32.2.1. EKHUFT Section 11 self-assessment was submitted to the Kent and Medway children's safeguarding Partnership.

32.2.2. EKHUFT undertook the self- assessment Section 11 audit from the Kent Safeguarding Multi Agency Partnership in September 22, a small plan of three actions was identified to ensure our full compliance with this. Delivery on these actions has been monitored by the Safeguarding Assurance Committee. There remains one outstanding action around levels of supervision.

32.2.3. The Learning Disability Team completes the statutory LeDER and an annual NHSI Learning Disability Improvement Standards Benchmarking audits.

32.2.4. A system wide Discharge Audit was completed.

33. Internal Audit

33.1. A formal audit programme has been in place this year, with planned activity for quality assurance of safeguarding processes, guidance and policy, as well as assurance that recommendations undertaken for Serious Case Reviews and Rapid Reviews. In addition, audit results have been able to provide tangible assurance for the ICB metrics and will provide ongoing evidence for the S11 and SAF submissions. The team were fully supported by the audit team

33.2. An MCA/DoLS Audit has been established with overarching training strategy.

33.3. CP-IS audits children's wards were undertaken during the year. Overall, the data showed that the staff on the wards consistently accessed CP-IS during the admission process, a 'message of the week' has been undertaken to re-enforce this practice. There is a plan around record CPIS recording in Maternity as the audit showed that new maternity patient records did not have the space for recording.

33.4. RAG tool audit has been completed for Safeguarding children.

33.5. Discharge proforma audit has been completed for safeguarding children and participation in a multi-agency discharge audit across the system has been completed for safeguarding adults.

33.6. The quality of the completion of the maternity support form and safeguarding action plan has been audited quarterly. The results have been fed back to the women's health audit meetings and all actions from the identified recommendations have been delivered. This QIP will continue.

33.7. Determining the efficacy of the Was Not Brought Policy for infants, children and young people. A regular undertaken, and the results shared in within the Child health audit meeting and then the subsequent Children and Young Person's Committee.

33.8. A regular audit is in place for the delivery of ICON at three agreed touchpoints during the maternity period to all pregnancies recorded on E3 (except where they opted out of data collection).

33.9. An audit of the level of DBS checks undertaken were in alignment with both the Trust's Policy Disclosure and Barring Checks Policy', guidance from the Disclosure and Barring Service and the NHS Employment Checks Standards.

33.10. Quality Assurance has taken place for adults and children's safeguarding trainers for delivery of safeguarding training.

34. Policies and guidelines

34.1 All trust polices which were renewed this year have been reviewed by the Safeguarding team as a member of the policy Approval group.

Safeguarding Policy Title	Date for review	Lead
Was Not Brought to Outpatient Appointments (Infants, Children and Young People	27/07/2027	Safeguarding
Was Not Brought to Outpatient Appointments (Adults)	11/01/2028	Safeguarding
Safeguarding Children Policy	26/03/2027	Safeguarding
Child protection Medical Policy	27/03/2027	Safeguarding
All Age Safeguarding Supervision Policy	11/01/2028	Safeguarding
Covert Administration of Medicines Policy	31/07/2025	Drugs and therapeutics committee
All Age Clinical Restraint, Restrictive and Safe Holding Practices Policy	27/05/2027	Mental health
All age Mental health	27/03/2027	Mental health
Domestic Abuse Policy (Patients and Staff)	09/02/2026	Safeguarding
Mental Capacity and Deprivation of Liberty Safeguards Policy	28/02/2026	Safeguarding
Missing Patient/Person Policy for Children, Young People and Adults (including Staff)	28/12/2025	Mental health
Safeguarding Adult Policy	30/04/2026	Safeguarding
Prevent Policy	30/04/2026	Safeguarding
Safeguarding strategy and training needs analysis	2026	Safeguarding
? enhanced observation policy		Child health

Safeguarding Guidelines	Date for review	Lead
Perplexing Presentation and Fabricated/induced illness Guideline	24/05/2025	Safeguarding
Child Death Guideline	Request change to policy	Safeguarding

Table 8: Safeguarding policies and Guidelines 2024-25

References:

National Crime Agency (2021) National Strategic Assessment of Serious and Organised Crime

Royal College of Nursing (2024) Adult Safeguarding: Roles and Competencies for Health Care Staff Inter-Collegiate Document

Royal College of Paediatrics and Child Health (2019) Safeguarding children and young people roles and competences for health care staff Intercollegiate Document

Safeguarding Accountability and assurance framework 3rd ed (NHSE 2019)

Working together to Safeguard Children: Statutory Guidance (DfE 2023)

Kent Analytics,Kent County council (2025) Children in Poverty https://www.kent.gov.uk/__data/assets/pdf_file/0009/7956/Children-in-poverty.pdf

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Patient Safety Incident Investigations (PSIIs)**

Meeting date: **9 October 2025**

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

Paper Author: **Mel Brewer, Head of Patient Safety and Improvement**

Appendices:

None

Executive summary:

Action required:	Information
Purpose of the Report:	This report provides information regarding the PSIIs commenced since June 2024 when the Trust transitioned to the Patient Safety Incident Response Framework (PSIRF). It outlines the number and type of patient safety incidents that were identified as being appropriate for a PSII response. These incidents were determined to require a comprehensive system based learning response.
Summary of key issues:	Twenty-three (23) patient safety incidents were identified as requiring a Patient Safety Incident Investigation (PSII): nine (9) meeting national requirements (six Never Events, one death of a patient detained under the mental health act, one death of a patient identified via the Learning from Deaths review process and a screening incident). The remaining were identified as appropriate for a local PSII. Eleven (11) PSIIs have been completed and received oversight approval or are awaiting oversight approval. These reports demonstrate: • Engagement with patients or their representatives and with staff; • A systems based review and analysis; • The PSII methodology was appropriate to the learning potential. The timeframes for investigations have been adjusted to ensure the analysis and development of safety actions is focused on improvements required. • The oversight process internally of reports and follow up of actions is embedded. The learning and safety actions cover all elements of the work system. Issues to highlight specifically include: • That patients with protected characteristics or affected by health inequalities are represented. • Communication regarding consent.

East Kent Hospitals University NHS Foundation Trust

	• Use of IT systems to minimise the potential for human error. • Ensuring recognised safety standards are incorporated into work processes. • Strengthening oversight of processes reliant on human actions. • Awareness of the impact of the environment on procedural safety. • Trust responsibilities in relation to safety standard procedures and development of policies and procedures which consider protected characteristics. During the first year of PSIRF, the PSII methodology has been successfully adopted. The application of the PSII methodology has identified system based, rather than people focused, learning and associated safety actions which are being implemented within the Trust. Further work is planned to strengthen the patient and family involvement and the effectiveness of resultant improvement plans.
Key recommendations:	The Board of Directors are asked to **NOTE** the systems based approach to improvements as a result of PSIIs completed.

Implications:

Links to Strategic Theme:	Quality and Safety
Link to the Trust Risk Register:	Care Quality Commission (CQC) oversight. Assess systems' and organisations' ability to respond effectively to patient safety incidents, including whether change and improvement follow its response to patient safety incidents. NHS Standard Contract 2025/2026. Requirement for at least two patient safety partners for NHS Trusts.
Resource:	N
Legal and regulatory:	Y
Subsidiary:	N

Assurance route:

Previously considered by: Operational Quality Governance Committee, Quality and Safety Committee

East Kent Hospitals University NHS Foundation Trust

Patient Safety Incident Investigations (PSIIs)

1. Purpose of the report

1.1 This report provides information regarding the Patient Safety Incident Investigations (PSIIs) commenced since June 2024 when the Trust transitioned to the Patient Safety Incident Response Framework (PSIRF).

1.2 It outlines the number and type of patient safety incidents that were identified as being appropriate for a PSII response. These incidents are complex and were determined to require a comprehensive system based learning response.

1.3 The report does not detail patient safety incidents meeting the Each Baby Counts criteria. These are investigated by the Maternity and Neonatal Safety Investigations (MNSI) and reported through the Trust's maternity oversight process.

2. Background

2.1 The Trust transitioned to the Patient Safety Incident Response Framework (PSIRF) in June 2024; this replaced the previous Serious Incident Framework.

2.2 PSIRF transforms the approach to developing and maintaining systems and processes for responding to patient safety events for the purpose of learning and improvement in patient safety. It focuses on how patient safety events, including incidents, happen, including the factors which contribute to them.

2.3 The PSIRF integrates four key aims:

2.3.1 Compassionate engagement and involvement of those affected by patient safety incidents.

2.3.2 Application of a range of system-based approached to learning from patient safety incidents.

2.3.3 Considered and proportionate responses to patient safety incidents.

2.3.4 Supportive oversight focused on strengthening response system functioning and improvement.

2.4 The Trust PSIRF Policy and Plan outline how the Trust takes a proportionate approach to responding to patient safety incidents, the governance mechanisms and the detail of how different types of patient safety incidents are reviewed. The Plan describes the national requirements for PSIIs (e.g. Never Events) and the Trust's local requirements.

2.5 The Trust has recently reviewed and updated the PSIRF policy.

2.6 The review of the Trust PSIRF plan is underway and planned for review at the Operational Quality Governance Committee in August 2025. There are no plans to change the criteria for initiating a PSII. The PSIRF plan will be aligned with the annual cycle for the Trust Quality Report.

3. Patient Safety Incident Investigations (PSIIs) initiated

3.1 At the time of compiling this report, twenty-three (23) patient safety incidents were identified as requiring a PSII.

3.2 Nine (9) under national requirements including:

3.2.1 Six (6) Never Events: wrong site block, wrong site oral lesion biopsy, wrong route medication, wrong implant (radiology), retained pack post procedure, fall from a poorly restricted window.

3.2.2 Two patient deaths, one of which involves multiple providers and is being led by the Kent and Medway Integrated Care Board (KM ICB) as the patient was under the care of the Mental Health Act, and the death of a patient identified via the Learning from Deaths review process.

3.2.3 A pre-natal screening incident.

3.3 Fourteen (14) reported as local requirements:

3.3.1 Three (3) related to the care of women which do not meet MNSI criteria.

3.3.2 Three (3) regarding the recognition and management of deterioration.

3.3.3 Three (3) delays in providing treatment.

3.3.4 Four (4) concerning vulnerable patients, one of which involves multiple providers and is being led by Kent and Medway NHS and Social Care Partnership Trust (KMPT).

3.3.5 One incorrect procedure which does not meet Never Event criteria.

3.4 At the time of compiling this report, eight (8) of the PSIIs had been completed and a further three (3) were awaiting final oversight approval. These are listed below and the learning is detailed in the next section.

3.4.1 Wrong implant (cancer treatment) (Never Event).

3.4.2 Wrong route medication (Never Event).

3.4.3 Wrong site block (Never Event).

3.4.4 Wrong site biopsy (Never Event).

3.4.5 Retained throat pack (Never Event) (oversight approval pending).

3.4.6 Intrauterine death.

3.4.7 Antenatal screening.

3.4.8 Wrong tooth extraction (not a Never Event).

3.4.9 Delayed administration of critical medications.

3.4.10 Restraint involving police (oversight approval pending).

3.4.11 Management of a miscarriage (oversight approval pending).

4. PSII approach

4.1 Engagement

4.1.1 Patient and staff engagement is pivotal to PSIRF. The PSII methodology ensures that patients or their representatives are invited to be involved in the investigation process through sharing their experience and commenting on the draft investigation reports. Ten of the 11 reports demonstrate the involvement of the patient or their representative. In one instance patient involvement was, in liaison with safeguarding, deemed not to be in the patient's best interest.

4.1.2 All the investigation reports and initial stakeholder analysis demonstrate relevant staff stakeholder involvement, including external partner providers.

4.2 Systems

4.2.1 All the reports demonstrate consideration of systems factors. The Trust has adopted the Systems Engineering Initiative in Patient Safety (SEIPS) framework. This is based on a human factors and system based approach to understanding care systems, processes and outcomes to inform improvement. SEIPS is one tool used within PSIIs to explore the interactions in the work system and how these influence processes and thus outcomes. The purpose is to focus on systems, and not people, to enable the design of improvements and increase the awareness of risks in practice.

4.2.2 The analysis of the learning identified demonstrates consideration of all aspects of the work system (see section 5).

4.3 Proportionate

4.3.1 The incidents identified as local PSIIs were all complex involving more than one process and/or multiple stakeholders, therefore the PSII process was proportionate to the potential for learning.

4.3.2 The PSII methodology application for the Never Events, has strengthened the case for review of procedures and how staff are enabled to apply procedures in practice. How the learning will be addressed has developed a greater systems focus than previously.

4.3.3 Originally, the timeframe set for PSIIs was 16 weeks including the oversight approval process, however frequent extensions were requested. None of the PSIIs have been completed within 16 weeks. Initially this was due to unfamiliarity with the investigation processes such as stakeholder analysis, observations of practice, interviews, and the time required to ensuring draft reports had been reviewed by patients and families. Latterly, delays have occurred due to difficulties scheduling meetings to work on system based solutions. The PSIRF is clear that responses should be managed within the available resource. Thus, in the revised PSIRF Policy and Plan, the timeframe has been adjusted to 16 to 26 weeks with two weeks for oversight approval. The aim is to ensure the quality of investigations and improvements are maintained and continue to be strengthened. At the point of initiating the PSII, a discussion regarding a realistic timeframe, based on the complexity of the incident is now routine and is discussed with the patient and/or representative. There are plans to implement a structured approach to working with patients and families in the next year and to recruit two volunteer Patient Safety Partner roles.

4.4 Oversight

4.4.1 The PSII improvement plans are approved via the Learning Response Approval Panel (LRAP), and the Chief Nursing and Midwifery Officer and Chief Medical Officer.

4.4.2 LRAP monitors completion of the patient safety actions or confirms oversight of these actions via an alternate governance route e.g. Maternity and Neonatal Improvement Plan (MNIP).

4.4.3 An evaluation of the impact of PSII improvement plans and safety actions has not yet been completed.

5. Learning

5.1 **The completed investigations** were themed using SEIPS. The learning is presented under the work system element headings of SEIPS.

5.1.1 People

5.1.1.1 Representation of patients with protected characteristics or potentially affected by health inequalities including maternity, vulnerable adults, children, advanced age and cancer diagnosis.

5.1.1.2 Perception that the use of checklists (Local Safety Standards for Invasive Procedures (LocSSIPs)) does not add value to safety.

5.1.1.3 Communication between staff and patient in relation to consent.

5.1.1.4 Improvement of written and verbal communication.

5.1.2 Tools and Technology

5.1.2.1 Upload of clinic outcomes directly to the patient record system (removing human element).

5.1.2.2 Flags on the pharmacy system for vulnerable patients.

5.1.2.3 Linking access to electronic systems (e.g. direct link from patient record system to system storing images).

5.1.2.4 Digitised system for recording induction of labour.

5.1.2.5 Patient tracking system for antenatal screening.

5.1.2.6 White board availability to record procedural checks in outpatients.

5.1.3 Tasks

5.1.3.1 Coloured tray and dedicated trolley for blocks performed in the emergency department.

5.1.3.2 Updating LocSSIPs in accordance with National Safety Standards for Invasive Procedures (NatSSIPs2).

5.1.3.3 Re-enforce requirement to record plans on patient record system and nursing handover document.

5.1.3.4 Discontinue the routine use of throat packs (unless clinically indicated).

5.1.3.5 Introduce audits of tasks to monitor compliance / deviation from expected standards e.g. throat pack use, radiology vetting process.

5.1.4 Organisation of work

5.1.4.1 Explore how to increase the capacity for radiology vetting.

5.1.4.2 Ensure pharmacy provision to areas is fully risk assessed.

5.1.4.3 Discuss potential delayed induction at daily SitRep (Situation Report) meeting.

5.1.4.4 Introduce one stop clinic for antenatal scans and blood tests.

5.1.4.5 Additional posts with specific function in relation to ensuring relevant patient tasks undertaken e.g. Maternal Medicine Midwife, Failsafe Clerk for antenatal screening.

5.1.4.6 Training frequency increased in relation to: Block procedures, medication administration.

5.1.4.7 Simulation training incorporating human factors and SEIPS based debrief.

5.1.5 Internal environment (Team)

5.1.5.1 Awareness of the impact of environment on procedural safety and patient dignity e.g. space, activity, availability of staff.

5.1.6 External environment (Trust)

5.1.6.1 Working group to update safety standards for procedures (LocSSIPs) in accordance with NatSSIPs2 requirements.

5.1.6.2 Recognition that understanding the impact of policies and procedures in relation to patients (and staff) with protected characteristics has the potential to strengthen improvements and thus safety.

6. Conclusion

6.1 During the first year of PSIRF, the PSII methodology has been successfully adopted.

6.2 The application of the PSII methodology has identified system based, rather than people focused, learning and associated safety actions which are being implemented within the Trust.

6.3 Further work is planned to further strengthen the patient and family involvement and the effectiveness of resultant improvement plans.

East Kent Hospitals University NHS Foundation Trust

REPORT TO THE BOARD OF DIRECTORS (BoD)

Report title: **Chief Medical Officer's (CMO's) Report: Medical Appraisal and Revalidation**

Meeting date: **9 October 2025**

Board sponsor: **Dr Des Holden, Chief Medical Officer (CMO)**

Paper Author: **Tynita Patterson, Senior Business and Operations Manager to the CMO**

Appendices:

Appendix 1: Statement of Compliance

Executive summary:

Action required:	**Approval**
Purpose of the Report:	As part of the Trust's duty as a Designated Body, the Trust is required to ensure it is able to execute the responsibilities of the Medical Profession (Responsible Officers) Regulations 2010 (and its amendments). The purpose of the report is to provide updates and assurance that the responsibilities are being met and improvements are being delivered as agreed by the Statement of Compliance (SoC) report submitted to the Board of Directors in November 2023.
Summary of key issues:	• Appraisal compliance is on average 88.5% across a 12 month period. • The rate of positive revalidation recommendations continues to improve.
Key recommendations:	The Board of Directors is asked to **NOTE** this report and: • Review and **AGREE** the Statement of Compliance linked to this report. • Recommendations are to review this report and provide any comments or feedback that will help continue to realise the improvements being sought.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People
Link to the Trust Risk Register:	CRR 123 - Patient outcome, experience and safety may be compromised as a consequence of not having the appropriate medical staffing levels and skill mix to meet patients' needs.
Resource:	N

East Kent Hospitals University NHS Foundation Trust

Legal and regulatory:	Y: Impacts our functions regulated by the Higher-Level Responsible Officer (NHS England).
Subsidiary:	N

Assurance route:

Previously considered by: The contents of this paper have been subject to ongoing review and monitoring by the Responsible Officers Advisory Group (ROAG).

East Kent Hospitals University NHS Foundation Trust

Medical Appraisal and Revalidation

1. Purpose of the report

1.1 To provide assurance that the Trust is meeting its requirements to deliver the Medical Profession (Responsible Officers) Regulations (2010).

2. Background

2.1 Revalidation and appraisal are carried out in the NHS to ensure doctors are licensed to practice medicine and supported to develop so care continuously improves. This report summarises the Trust's position in respect to its performance as a Designated Body.

3. Appraisal Compliance

3.1 The Trust currently has 1007 connected doctors, with 907 (90%) with appraisal completed/within guidelines at August 2025. This has increased from 966 within the previous appraisal reporting year (1 April 2024 – 31 March 2025).

3.2 The appraisal compliance rate has remained at a steady rate across the year with an average of 88.5% over the past 12 months.

3.3 Actions agreed by the Board of Directors following the previous Statement of Compliance report (October 2024) were updated and presented to the Board of Directors through the Annual Organisational Audit (AOA) report in May 2025. The latest Statement of Compliance has been updated and is attached to this report.

4. Revalidation

4.1 All recommendations for revalidation are discussed at the monthly Responsible Officers Advisory Group (ROAG).

4.2 Since January 2025, 71 doctors have required revalidation recommendations. 58 (82%) have received a positive recommendation; 12 (17%) have had recommendations deferred due to insufficient evidence; and one (1%) had recommendations deferred as they are subject to an ongoing process. The most common cause for deferring a recommendation due to insufficient evidence continues to be lack of 360 Multi-Source Feedback. However, the number of positive recommendations has continued to improve from a position of 72% of all revalidations due since the last report to the current 82%.

4.3 Portfolios are now as standard reviewed three months prior to the revalidation due date at ROAG for example those due in November are reviewed in August. Depending upon when the revalidation due date falls in the month this provides ten to twelve weeks to complete any outstanding recommendations. This has helped to maintain positive revalidation recommendations.

5. Maintaining Accurate Records

5.1 Connection check is performed twice a month to maintain an accurate list of our prescribed connections with medical practitioners.

6. Job Planning

6.1 As of the end of August 2025, there are 753 doctors contractually required to have a current job plan. Of which 430 have completed for this year's job planning round. A job planning compliance to date of 57%.

6.2 In regards to the status of all other job plans as of the end of August 2025; 18% are in progress and 25% have been completed and signed off by the doctor and are in the sign off stage.

6.3 In April 2025 job planning was migrated from the Allocate system to the L2P system. This meant a six week down time to allow data to be migrated across to L2P which had an impact on doctor's ability to job plan in that period. To mitigate for the down time an extended deadline for job plan completion for this year's round, was moved forward to the end of June 2025, with a target of 90% compliance. However, completion in this time frame has not been realised for 43% of job planning doctors.

6.4 This year's job planning round was due to complete on 31 March 2025 and extended to 30 June 2025 due to the implementation of L2P job planning. A new deadline of 90% compliance by 30 September 2025. With proactive action being taken to ensure doctors compliance with job planning and the completion of the current cycle. The aim is to achieve 90% job planning compliance and meet the requirements of level 1 of the Levels of Attainment and Meaningful Use Standards.

7. Levels of Attainment and Meaningful Use Standards

7.1 There are 17 standards to meet across five levels (level 0 – level 4), each standard/level is sequential and must fully met before the next level can be obtained.

7.2 Our current position against these standards are as follows: 5/17 standards met, 6/17 partially met, 5/17 not met.

7.3 Level 0 (e-job planning): 1/1 standards met.

7.4 Level 1 (basic individual job planning): 3/4 standards met (remaining standard: achieve 90% job planning compliance).

7.5 Level 2 (advanced individual job planning): 1/3 standards met.

7.6 Level 3 (team job planning): 0/5 standards met.

7.7 Level 4 (organisational job planning): 1/4 standards met.

8. Conclusion

8.1 The Trust's medical appraisal position has maintained an average of 88.5% over the past 12 months.

8.2 Revalidation recommendations continue to be reviewed and provided by the Responsible Officers Advisory Group (ROAG) and the group continue to review and improve processes in response to data and feedback from the General Medical Council (GMC).

8.3 The governance around maintaining accurate data relating to medical practitioners continues to meet the expectations of the Higher-Level Responsible Officer and the Trust is continually seeking ways to improve and respond to local and national changes.

8.4 Actions developed to improve appraisal and revalidation are impacting other workstreams within the Chief Medical Officer portfolio, such as job planning and the Levels of Attainment.

25/80 – APPENDIX 1

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses.

Reporting period 1 April 2024 – 31 March 2025

1A – General

The board/executive management team of: East Kent Hospitals University NHS Foundation Trust

can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Yes
Action from last year:	None

Comments:	Dr Helen Mackie took responsibility for the Responsible Officer (RO) duties in March 2025 following Dr Jonathan Purday stepping back from the role.
Action for next year:	None

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes
Action from last year:	Continue to review resources and ensure RO services are being met in response to workforce changes
Comments:	Ongoing resource being provided by Chief Medical Officer (CMO) team including CMO, DCMO and support staff to help with the RO functions
Action for next year:	Continue to review resources and ensure RO services are being met in response to workforce changes

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Yes
Action from last year:	Continue to maintain accurate records
Comments:	Connection checks performed twice a month to ensure both incoming and outgoing connections are accurate.
Action for next year:	Continue to maintain accurate records

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Yes

Action from last year:	Confirm publication of updated policy
Comments:	Policy confirmed by Policy Advisory Group on 20 May 2025. Uploaded to Trust Policy Centre in June 2025 and circulated to all doctors on 1st September 2025.
Action for next year	Work to embed policy into workforce with increased training for appraisers and revised minimum/maximum allocation of appraisees.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	Yes
Action from last year:	Continue to undertake regular reviews on quality appraisals.
Comments:	No peer review within the last 12 months, however new appraisal policy performed by peer review on 28th February 2025 and implementing several of those recommendations this year with a focus on improving quality of appraisals.
Action for next year:	Establish internal appraiser network to provide peer to peer support, training and feedback

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Yes
Action from last year:	Continue to undertake reviews of temporary workforce compliance
Comments:	Support is offered to temporary workforce through monthly inductions and on-site clinics allow for doctors to attend for

	further advice. Fortnightly connection checks ensure that the records are accurate for temporary workforce.
Action for next year	Continue to undertake reviews of temporary workforce compliance.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Yes
Action from last year:	Continue to monitor delayed appraisals and improve governance around revalidation recommendations.
Comments:	An escalation process has been established and circulated to all doctors to notify them of the process. Where needed, the use of the Rev6 process to notify the GMC of doctors with perceived non-engagement has been utilised, with agreement from the RO. Any doctor under the Rev6 process are reviewed monthly and then stood down once suitable engagement has been seen. The Trust have not had to escalate further beyond this process.
Action for next year:	Continue to monitor delayed appraisals and improve governance around revalidation recommendations

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Yes
Action from last year:	Continue to monitor delayed appraisals and improve governance around revalidation recommendations
Comments:	The actions taken in question 1B(i) have sufficiently worked to improve appraisal governance.
Action for next year:	Continue to monitor delayed appraisals and improve governance around revalidation recommendations

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Yes
Action from last year:	Re-write and publish new appraisal policy, including consultation with joint Local Negotiating Committee
Comments:	The appraisal and revalidation policy was approved by the Policy Approval Group on 20 May 2025. During
Action for next year:	Embed the medical appraisal and revalidation policy into the workforce and implement changes.

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	Yes

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Action from last year:	Continue to review appraisers completion rates and establish a pool of senior appraisers
Comments:	Our new policy has defined the optimal appraiser to appraisee ratio of 1:8. We anticipate that we need around 130 appraisers within the Trust. We currently have over that number; however, some only perform a small number of appraisals. We are running a process of re-appointment of all our appraisers and appointing new appraisers.
Action for next year:	Implement quarterly medical appraiser update sessions and organise new appraiser training/refresher updates.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	Yes
Action from last year:	Continue to review QA process and establish a team to champion QA
Comments:	ASPAT scores are not automatically generated from our currently medical appraisal software provider. We are working through how to re-establish a robust reporting mechanism. There is functionality with our current provider to obtain user feedback which is reviewed. Our appraisal lead reviews all appraisals and leads on training/feedback.
Action for next year:	Continue to review QA process and establish the appraiser quarterly update sessions.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Yes
Action from last year:	None
Comments:	QA report continues to be generated every 6 months and presented to the Board.
Action for next year:	None

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	Continue to work with the ROAG members to provide challenge and strengthen the governance process of providing recommendations.
Comments:	ROAG continues monthly and is part of our business as usual. The membership meets monthly and reviews doctors three months prior to revalidation due dates to help improve revalidation rates. Regular meetings with the GMC Employee Liaison Officer and Practitioners Performance Service also ensure we are making good decisions.
Action for next year:	Continue to work with the ROAG members to provide challenge and strengthen the governance process of providing recommendations. Continue frequent meetings with GMC ELO and PPS.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	Continue to monitor and uphold this practice.

Comments:	The year prior to revalidation doctors are informed of the ROAG process and the requirements to be ready for revalidation. A further update is provided to doctors confirming the date that their portfolio will be reviewed by ROAG the month before review. Once the decisions have been made by ROAG, the outcomes are recorded and communicated to the doctors. If information is missing, or requested by the RO, the doctor is informed of the requirements and have 3 months to provide the information. They are then re-reviewed by the RO and/or ROAG before a final decision.
Action for next year:	Continue to monitor and uphold this practice.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Yes
Action from last year:	Complete the remaining outstanding actions from the HLRO visit in 2022. Some of these actions were put on hold due to implementation of new system
Comments:	Information about our doctors is triangulated from appraisal records, clinical governance systems (incidents and complaints) and Employee Relations.
Action for next year:	Re-review the HLRO recommendations and implement those

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Yes

Action from last year:	Continue to embed the reporting of complaints/incidents governance following the implementation of the new system.
Comments:	The implementation for the new complaints/incidents governance system has been further delayed. Monthly reviews of Datix continue with notification to doctors of any incident/complaint.
Action for next year:	Continue to complete monthly review of Datix for reporting. Establish a new process once the new governance system is implemented.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Yes
Action from last year:	Continue to embed the reporting of complaints/incidents governance following the implementation of the new system.
Comments:	Reports are provided to doctors the month prior to appraisal due date with any incident/complaint. If there is no incident/complaint recorded on Datix, then a notification is also provided.
Action for next year:	Continue to provide monthly reports to doctors on their governance for the year.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Yes
Action from last year:	Continue to develop skills of new medical leaders to support the process.

Comments:	In 2024 a clinical leads development programme was established to cover a range of topics including staff governance and managing concerns. A number of senior consultants completed MHPS training in November 2024.
Action for next year:	Continue to embed good practice.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Yes
Action from last year:	None
Comments:	Reports to the Board to continue to be submitted in line with the reporting timescales
Action for next year:	None

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Yes
Action from last year:	None
Comments:	MPIT process is standard within the team. For each new connection an MPIT review is undertaken and requested where appropriate.

Action for next year:	Continue to share relevant information via MPIT requests.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Y/N	Yes
Action from last year:	As per question 1
Comments:	As per question 1
Action for next year:	As per question 1

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Yes
Action from last year:	Not reported in previous year
Comments:	All policies are reviewed in line with policy renewal date with reference to the most up to date guidance, examples of policies which have been amended in past 2 years include consent (GMC Guidance from 2020), LOCSIPs with reference to guidance at NATSIPS 2023. A comprehensive review of all local clinical guidance has been undertaken to ensure compliance with NICE guidance. The annual Staff Survey had a focus on improving engagement in 2024 with an increase number of responses

	including the number from medical staff. This information is used as part of triangulating data from other sources to inform organisational culture.
Action for next year:	Continue to work to improve quality and staff experience.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	Not reported in previous year
Comments:	We are currently reviewing our local professional standards in emergency and urgent care as a focus area. Including development of automated reports, of time to consultant assessment within 14 hours of admission.
Action for next year:	To continue to develop and embed work on promoting professional standards.

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Yes
Action from last year:	Continue to reduce reliance on long-term temporary workers
Comments:	For all doctors employed by the Trust, we use the TRAC applicant tracking system to ensure full compliance with NHS Employers' guidance. As part of this process, we verify GMC registration, obtain a copy of the individual's medical degree certificate, and request references from previous employers that specifically address the candidate's

	competence and suitability for the role. These checks are audited by resourcing team leaders before arranging a start date in post.
Action for next year:	To move to a managed clinical service with MTW moving staff, agency workers to be directly employed to provide a more robust oversight of employment checks.

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Yes
Action from last year:	Not reported in previous year
Comments:	The NHS Staff Survey identified three organisational culture actions for the year; making East Kent a place staff choose, building confidence around raising and resolving concerns, and ensuring greater consistency in compassionate leadership. A Key focus has been around sexual safety, namely implementing the sexual safety charter. Active bystander training has been rolled out in conjunction with the 'stop, talk, change' resolution framework, and an associated policy sub-group is developing the sexual misconduct policy.
Action for next year:	Establish and embed a sexual safety charter within Trust

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Yes

Action from last year:	Not reported in previous year
Comments:	The Trust has developed a new People Strategy, with five key focus areas. These focus around compassion in the workplace – specifically improving levels of compassionate leadership. Leadership development programmes have been refreshed to reflect this focus. There is also specific attention on diversity and inclusion, with a focus on fairer recruitment processes and ensuring more representative leadership, with debiasing recruitment training and targeted leadership development planned.
Action for next year:	Continue to embed the new People Strategy.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	
Action from last year:	Not previously reported
Comments:	The Trust have FTSU Guardians employed for all staff members to be able to approach with any concerns, alongside our whistleblowing policy. Doctors Voice provides support to both Trainees and SAS doctors with support.
Action for next year:	Continue to promote and embed all channels for doctors to be able to speak up.

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	
Action from last year:	Not previously reported
Comments:	Maintaining High Professional Standards policy has been updated and circulated to all doctors following approval by the Policy Advisory Group.
Action for next year:	Embed new MHPS policy into the workforce.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Y/N	Yes
Action from last year:	None
Comments:	We collect data on protected characteristics via the ER record system on doctors that undergo disciplinary process to identify themes.
Action for next year:	Continue to collect information in line with Trust process.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Yes

Action from last year:	Not reported previously
Comments:	Attendance at the SE RO networking meetings continues to be undertaken by the RO, Appraisal Lead and Revalidation Project Manager. The Revalidation Project Manager links with other Trusts teams to discuss and compare processes.
Action for next year:	Continue to attend networking meetings

Section 2 – metrics

Year covered by this report and statement: 1 April 2024 – 31 March 2025 .

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	966
Total number of appraisals completed	711
Total number of appraisals approved missed	202
Total number of unapproved missed	68
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	258
Total number of late recommendations	4
Total number of positive recommendations	228
Total number of deferrals made	30
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	4
Total number of trained case managers	8
Total number of concerns received by the Responsible Officer[2]	4
Total number of concerns processes completed	3
Longest duration of concerns process of those open on 31 March (working days)	Not recorded
Median duration of concerns processes closed (working days)[3]	Not recorded
Total number of doctors excluded/suspended during the period	2
Total number of doctors referred to GMC	2

[2] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

[3] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	142
Total number of new employment checks completed before commencement of employment	11
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld[4]	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
The last statement of compliance was completed in 2024. Since the last report the Trust have focussed on appraisal compliance rates which have increased to 90% in March 2025. This has been helped by the implementation of the new e-portfolio system to complete appraisals. The implementation of the new e-portfolio system commenced on 1st April 2024 with a 4 month transition period to 31st July 2024. During this period, appraisals could be completed on either system with a number of doctors choosing to complete their appraisal early to complete prior to switchover. The metrics above refer only to completed appraisals within the period 1st April 2025 to 31st March 2025. There are specific parameters for an appraisal to be marked as completed. It must be that i. the appraisal meeting has taken place in the three months preceding the agreed appraisal due date, ii. the outputs of the appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting, iii. the entire process occurred between 1 April 2024 and 31 March 2025. Otherwise the appraisal is marked as missing. There are a variety of factors for a doctors appraisal to be marked as approved missed such as a late appraisal (over 3 months), a new starter, or on prolongued leave. A number of doctors have completed their appraisal but not under the parameters above and these are recorded as 'missing' appraisals. There are 66 doctors within the 202 doctors listed as missing that have completed their appraisal but outside of the above parameters. The 82 new starters to the Trust within this period are also included amongst missing appraisals as they are prescribed connections but their appraisals are due from 1st April 2025 which comes after this reporting period. Other reasons to have

[4] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

missed an appraisal include long term sickness, approved leave e.g. maternity, adoption leave, and sabbaticals.

Within the Trust there has been a focus on key areas, including sexual safety, following the annual Staff Survey has also worked to enhance the organisational culture. Key themes from the Staff Survey have been used to shape training and leadership with a key focus on embedding these into daily practice.

Key reports have been approved by the Policy Advisory Group which have created opportunity to introduce outstanding changes and improvements. Such as establishing an appraiser networking group, amending the remuneration rate for appraisers and setting core standards.

Actions still outstanding

The key actions that remain outstanding from the previous report are that the Trust need to embed the newly updated policies including Medical Appraisal and Revalidation and MHPS. Further engagement is required following this to ensure that any changes are both actioned and standardised in business as usual.

The Trust need to re-focus on the actions following the HLRO visit that were placed on hold due to system implementation and policy updates. Actions to include engaging relevant stakeholders in People and Culture with the appraisal and revalidation process, creating appraiser networking sessions, and to encourage engagement from GDC registered practitioners.

Furthermore, the Trust need to focus on establishing a new QA process both within the Trust and potentially utilising neighbouring Trusts for peer review.

Current issues

The trust is facing financial challenges and has plans to reduce the reliance on temporary staffing and reduction of agency and bank workers.

Medical appraisal compliance rates, whilst improved since the last report, continue to require focus to ensure non-compliance is reduced further.

A focus on job plan sessions is critical to ensure that there is enough resource within available time that all doctors are able to fulfil their personal requirements for revalidation as well as other supporting professional activities to help support high professional standards.

Actions for next year (replicate list of ‘Actions for next year’ identified in Section 1):

Continue to review resources and ensure RO services are being met in response to workforce changes

Continue to maintain accurate records

Work to embed policy into workforce with increased training for appraisers and revised minimum/maximum allocation of appraisees.

No external peer review planned but internal appraiser network being established to provide peer to peer support and training.

Establish internal appraiser network to provide peer to peer support, training and feedback

Continue to undertake reviews of temporary workforce compliance.

Continue to monitor delayed appraisals and improve governance around revalidation recommendations

Embed the medical appraisal and revalidation policy into the workforce and implement changes.

Implement quarterly medical appraiser update sessions and organise new appraiser training/refresher updates.

Continue to review QA process and establish the appraiser quarterly update sessions.

Continue to work with the ROAG members to provide challenge and strengthen the governance process of providing recommendations. Continue frequent meetings with GMC ELO and PPS.

Re-review the HLRO recommendations and implement those

Continue to complete monthly review of Datix for reporting. Establish a new process once the new governance system is implemented.

Continue to provide monthly reports to doctors on their governance for the year.

Continue to embed good practice.

Continue to share relevant information via MPIT requests.

Continue to work to improve quality and staff experience.

To continue to develop and embed work on promoting professional standards.

To move to a managed clinical service with MTW moving staff, agency workers to be directly employed to provide a more robust oversight of employment checks.

Establish and embed a sexual safety charter within Trust

Continue to embed the new People Strategy.

Continue to promote and embed all channels for doctors to be able to speak up.

Embed new MHPS policy into the workforce.

Continue to attend networking meetings

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

Our Responsible Officer has changed this year and has embedded a number of changes to the appraisal and revalidation process alongside job planning. The Trust have focussed on establishing a new e-portfolio system for appraisal and revalidation within the Trust which in turn has helped to strengthen a number of key areas in the process. including greater transparency, compliance and reporting.

The Trusts Responsible Officer Advisor Group (ROAG) continues to strengthen decision making by early review of portfolios. Communication surrounding revalidation decisions has helped to increase our revalidation recommendations.

The annual Staff Survey in 2024 has helped to shape a number of initiatives including a new People Charter, increased awareness/training on sexual safety and an emphasis on compassionate working.

Next year the Trust will focus on strengthening governance, embedding updated policies and supporting the workforce/leadership to ensure high standards of professional practice.

Governance processes will be enhanced through regular reviews of temporary workforce compliance, monitoring of overdue appraisals and the ongoing management of revalidation recommendations. Peer support will be strengthened by establishing an internal network for appraisers with quarterly update sessions and regular appraiser refresher training.

Quality Assurance will remain a priority with a continued review of QA process and appraiser refresher training. Monthly reporting process will be maintained with continued monthly ROAG meetings to ensure robust decisions.

Efforts will also focus on improving staff experience, embedding the new People Strategy and establishing the Sexual Safety Charter within the Trust. Promoting professional standards and ensuring all doctors have access to safe channels to raise concerns will be a key priority.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	East Kent Hospitals University NHS Foundation Trust

Name:	
Role:	
Signed:	
Date:	

Name of the person completing this form:	Louise Hall
Email address:	Louise.hall26@nhs.net

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Winter Planning and Board Assurance Statement (BAS) 2025/26**

Meeting date: **9 October 2025**

Board sponsor: **Dan Gibbs, Chief Operating Officer (COO)**

Paper Author: **Alison Pirfo, Deputy COO**

Appendices:4

Appendix 1: Winter Plan 2025/26
Appendix 2: BAS 2025/26

Executive summary:

Action required:	Assurance
Purpose of the Report:	The Winter Plan for 2025/26 alongside the requisite Board Assurance Statement (BAS) was considered at an extra-ordinary Board meeting on 29 September 2025 to meet the 30 September submission deadline. The BAS and the Winter Plan is included with the open board papers for broader, public awareness.
Summary of key issues:	East Kent Hospitals University NHS Foundation Trust (EKHUFT) has developed a 'live' Winter Plan for 2025/26 in line with national requirements set out in the Urgent and Emergency Care (UEC) Plan in June 2025. Following a request received in mid-July, a draft plan was completed and stress tested at an NHS England (NHSE)-hosted exercise on 8 September. Following which the plan has been updated and submitted for sign off utilising a BAS to the Trust Management Committee (TMC) on 17 September, to the Board on 29 September, and submitted to the National UEC team on 30 September. Performance and Modelling has been undertaken to review the Trust and Acute hospital sites potential January 2026 position of a negative bed capacity of 109 Trust-wide. To date no additional winter incentive monies have been made available for schemes. Therefore mitigations have been sought from opportunities in improving our Length of Stay (LOS), turnover and productivity in Acute Medical Unit's (AMU's) and reduction in Complex and Delayed Discharges due to opportunities in our benchmark position presented. These opportunities could reduce the Trust-wide bed capacity gap from -109 beds to -12 if delivered from productivity and efficiency gains and our improvement week programme. Within the Integrated Urgent and Emergency Care (iUEC) Programme Board schemes will be developed around the agreed themes and to achieve the objectives published by NHSE in the UEC Plan. To note, projections generated as part of the bed modelling are based on performance from the last 12 months, and the impact of historic winter schemes are reflected in this

	position. These projections therefore include the ongoing effect of any Health and Care Partnership (HCP) ACF schemes that were in place over the last year, of which there are pending discussions around the continuation of all of the funding for 2025/26. Plans are in place to monitor and report real-time pressures utilising the Operational Pressures Escalation Levels (OPEL) framework through emergency planning, site management and leadership in on-call arrangements. The sites, Care Groups and Support Services have been engaged in the development of the plans. Further planning from Infection, Prevention and Control (IPC) for 2025/26 is on-going with the Winter Plan checklist. Workforce and Communications conclude the Winter Plan. The on-call rotas for the period of November to March will be included as they are released. Quality and equality impact assessments have also been completed in preparation for the Board meeting and required national submission. The Winter Plan has been shared and discussed with system partners and colleagues across a number of forums for updates, comments or changes prior to the live exercise on the 8 September. The Winter Plan concludes with an outline timetable for the Improvement Weeks, which will continue through to the end of the financial year and include the themes within our submission.
Key recommendations:	The Board of Directors is asked to take the opportunity of the Open Board to **NOTE** the Winter Plan for 2025/26 and the BAS.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Trust Risk Register:	Risk Reference:1891 Misalignment between Demand and Capacity across the Trust's urgent and emergency care pathway.
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: TMC 17/09/25 and BoD 29/09/25

East Kent Hospitals University NHS Foundation Trust

Winter Plan 2025/26

Executive Sponsor: Dan Gibbs - Chief Operating Officer (COO)
Winter Lead: Alison Pirfo – Deputy COO
Emergency Preparedness, Resilience and Response (EPPR): Hayley Lingham – Head of Emergency Planning

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Executive Summary

East Kent Hospitals University NHS Foundation Trust

East Kent Hospitals University NHS Foundation Trust (EKHUFT) has developed a 'live' winter plan for 2025/26 in line with national requirements set out in the Urgent and Emergency Care (UEC) Plan in June 2025. Following a request received in mid-July, a draft plan was completed and stress tested at an NHS England (NHSE)-hosted exercise on 8 September. Following which the plan has been updated and submitted for sign off utilising a Board Assurance Statement (BAS) to Trust Management Committee (TMC) on 17 September, and subsequently to the Board on 29 September for submission to the National UEC team on 30 September.

Performance & Modelling has been undertaken to review the Trust and Acute hospital sites potential January 2026 position of a negative bed capacity of 109 Trust-wide. To date no additional winter incentive monies have been made available for schemes. Therefore mitigations have been sought from opportunities in improving our Length of Stay (LOS), turnover and productivity in Acute Medical Unit's (AMU's) and reduction in Complex and Delayed Discharges due to opportunities in our benchmark position presented. These opportunities could reduce the trust wide bed capacity gap from -109 beds to -12 if delivered from productivity and efficiency gains and our improvement week programme.

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Plans are in place to monitor and report real-time pressures utilising the Operational Pressures Escalation Levels (OPEL) framework through emergency planning, site management and leadership in on-call arrangements.

The sites, Care Groups and Support Services have been engaged in the development of the plans. Further planning from Infection, Prevention and Control (IPC) for 2025/26 is on-going with the winter plan checklist. Workforce and Communications conclude the winter plan. The on-call rotas for the period of November to March will be included as they are released. Quality and equality impact assessments have also been completed in preparation for the Board meeting and required national submission.

The Winter Plan has been shared and discussed with system partners and colleagues across a number of forums for updates, comments or changes prior to the live exercise on the 8 September.

The Winter Plan concludes with an outline timetable for the Improvement Weeks, which will continue through to the end of the financial year and include the themes within our submission.

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Urgent & Emergency Care Activity

EKHUFT Headlines (12 month period)

East Kent Hospitals University NHS Foundation Trust

20,784
Walk ins (per month)

4,561
Ambulance Arrivals (per month)

75.5%
4 Hour Compliance

19.9%
12 Hour Breach Rate

36.4%
Medical Admissions discharged within 72 Hours

977
Adult General and Acute beds

172
Patients with No Criteria to Reside (avg occupancy)

5.0 Days
From Discharge Ready Date to Discharge for Complex Patients

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Purpose

The EKHUFT Winter Plan has considered the Urgent and emergency care plan 2025/26 summary of priority actions required in it's development to:

- Meet the maximum 45-minute ambulance handover time standard
- Ensure a minimum of 78% performance is achieved of patients who attend Accident & Emergency (A&E)
- Reduce the number of patients waiting over 12 hours, so this occurs less than 10% of the time
- Reduce the number of patients in Emergency Department (ED) for over 24 hours for a Mental Health admission
- Tackle the delays in patients waiting to be discharged (No Criteria to Reside (nCTR))
- Improve vaccination rates for frontline staff
- Increase the number of patients receiving urgent care outside of an acute setting, including Urgent Community Response teams and cared for in virtual wards
- Reduce length of stay for patients who need an overnight emergency admission

To focus as a whole system on achieving improvements that will have the biggest impact on urgent and emergency care services this winter.

East Kent Hospitals University NHS Foundation Trust

Performance & Modelling

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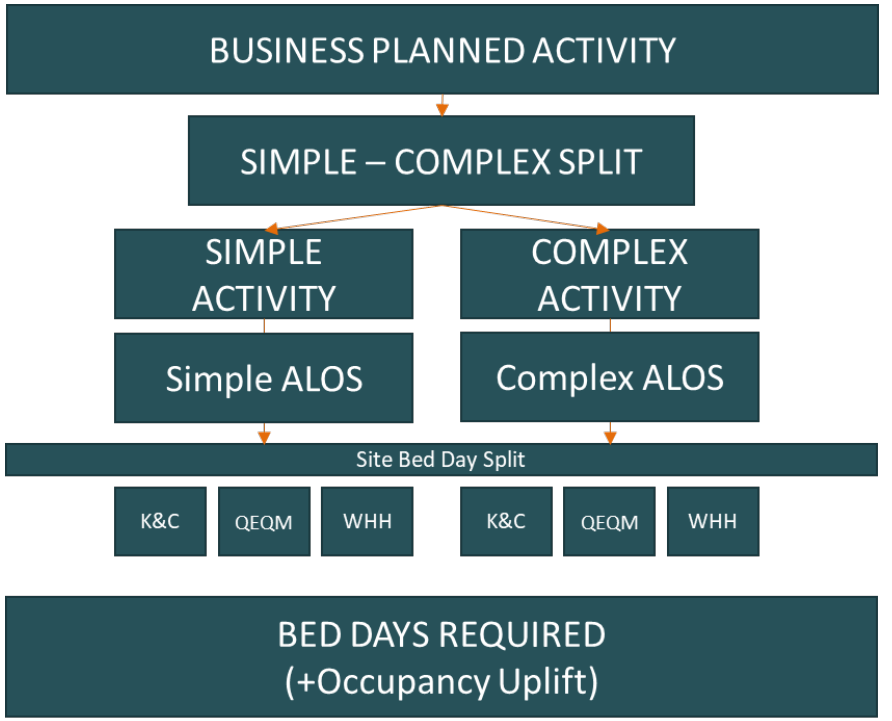
Performance & Modelling

East Kent Hospitals University NHS Foundation Trust

- The Bed Model was developed during business planning to account for expected levels of non-elective growth and business planned elective activity levels.
- Bed projections were built at Care Group and Specialty level, in order to provide granularity of bed demand by service, and factoring in recent LOS data.
- Includes unmet demand within NEL (required to support ED flow).
- Occupancy levels calibrated to 96% for non elective activity, following analysis of daily variation from trust average – daily variation +- 2% of bed occupancy from the month average level.
- The following slides show the initial summary at trust wide & site level for the outline bed modelling outputs for the year, showing the gap from estimated bed demand levels and physical capacity for adult acute beds across the Trust.
- Note the underlying model integrates recent historic length of stay in the projections, which will reflect the ongoing effect of any HCP ACF schemes that were in place over the last year. HCP estimates the ongoing impact of these schemes to be equivalent to a bed capacity saving of 132 beds. There are risks around the continuation of these ACF schemes, pending further discussions.



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Performance & Modelling
Trust wide Forecast

East Kent Hospitals University NHS Foundation Trust

ADJUSTED DEMAND MODEL (BEDS) – TRUSTWIDE												
Base output summary												
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
NEL DEMAND (AT OCCUPANCY LEVEL)	1,005	1,006	1,005	1,004	998	1,005	1,008	1,012	1,017	1,018	1,015	1,011
ELECTIVE DEMAND (AT OCCUPANCY LEVEL)	69	64	69	74	64	72	73	66	65	67	70	70
BED REQUIREMENT	1,074	1,070	1,074	1,078	1,062	1,077	1,081	1,079	1,083	1,086	1,085	1,081
GAP*	-97	-93	-97	-101	-85	-100	-104	-102	-106	-109	-108	-104
Beds Available	977	977	977	977	977	977	977	977	977	977	977	977
Available Escalation Beds	49	49	49	49	49	49	49	49	49	49	49	49
GAP after escalation capacity	-48	-44	-48	-52	-36	-51	-55	-53	-57	-60	-59	-55

Bed Model has been updated using data from Q1, to reforecast bed demand and gaps based on Year to Date (YTD) volumes of admission growth, and extended ED waits.

This projection shows a significant gap between the demand projection and available adult beds. Capacity has been taken from a recent review and is flat for the year for the purposes of this model*

Initial modelling shows a gap in January of 109 beds trust wide. Note this position includes a surplus of beds at the Kent & Canterbury (K&C) site, and the gaps across Queen Elizabeth the Queen Mother (QEQM) and William Harvey Hospital (WHH) will exceed this level. The individual site gaps are detailed on the following slide.

*Bed capacity aligned to BAU Adult beds submitted in ICB return dated 14/08/2025

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Performance & Modelling
Trust wide Forecast

East Kent Hospitals University NHS Foundation Trust

WHH	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
BED REQUIREMENT	498	497	499	500	497	502	503	508	510	513	512	510
GAP*	-78	-77	-79	-80	-77	-82	-83	-88	-90	-93	-92	-90
Beds Available	420	420	420	420	420	420	420	420	420	420	420	420
Available Escalation Beds	29	29	29	29	29	29	29	29	29	29	29	29
GAP after escalation capacity	-49	-48	-50	-51	-48	-53	-54	-59	-61	-64	-63	-61

QEQM	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
BED REQUIREMENT	369	370	370	369	362	368	371	373	374	375	374	372
GAP*	-53	-54	-54	-53	-46	-52	-55	-57	-58	-59	-58	-56
Beds Available	316	316	316	316	316	316	316	316	316	316	316	316
Available Escalation Beds	14	14	14	14	14	14	14	14	14	14	14	14
GAP after escalation capacity	-39	-40	-40	-39	-32	-38	-41	-43	-44	-45	-44	-42

K&C	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
BED REQUIREMENT	207	203	206	208	204	207	208	197	198	198	199	199
GAP*	34	38	35	33	37	34	33	44	43	43	42	42
Beds Available	241	241	241	241	241	241	241	241	241	241	241	241
Available Escalation Beds	6	6	6	6	6	6	6	6	6	6	6	6
GAP after escalation capacity	40	44	41	39	43	40	39	50	49	49	48	48

Summary output at site level.

Gaps (prior to escalation bed capacity), are WHH:-93 beds and QEQM:-59 beds, a total of 152 beds across the two sites

24 beds at K&C (St Lawrence ward) are for the relocation of QEQM patients during works on St Augustine's at Margate over winter 2025-26

Under this current operating model, QEQM's revised gap would be -35 in January, with a surplus at K&C reduced to 19 beds.

Note that the majority of the remaining surplus beds at K&C are elective ringfenced beds at the site.

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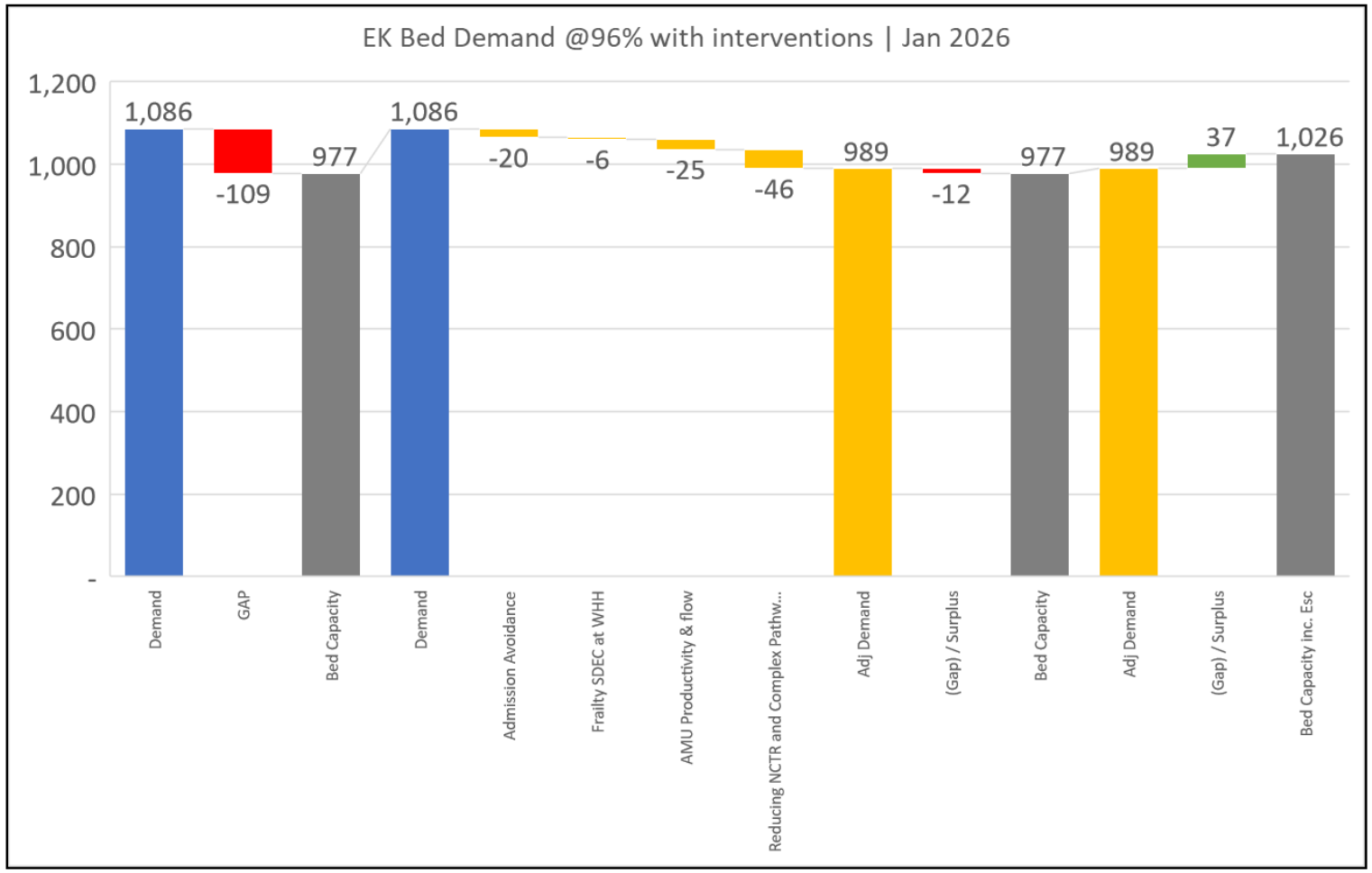
Performance & Modelling Improvement Potential

East Kent Hospitals University NHS Foundation Trust



- Waterfall is as at January 2026, where the largest overall monthly gap is forecast
- Updated trust wide waterfall with outline schemes to bridge the gap, these have been discussed with HCP partners to triangulate against their workings
- Shows a trust wide gap remains after potential opportunities have been explored. Additional escalation beds are shown which would create a surplus position trust wide of 37 beds.

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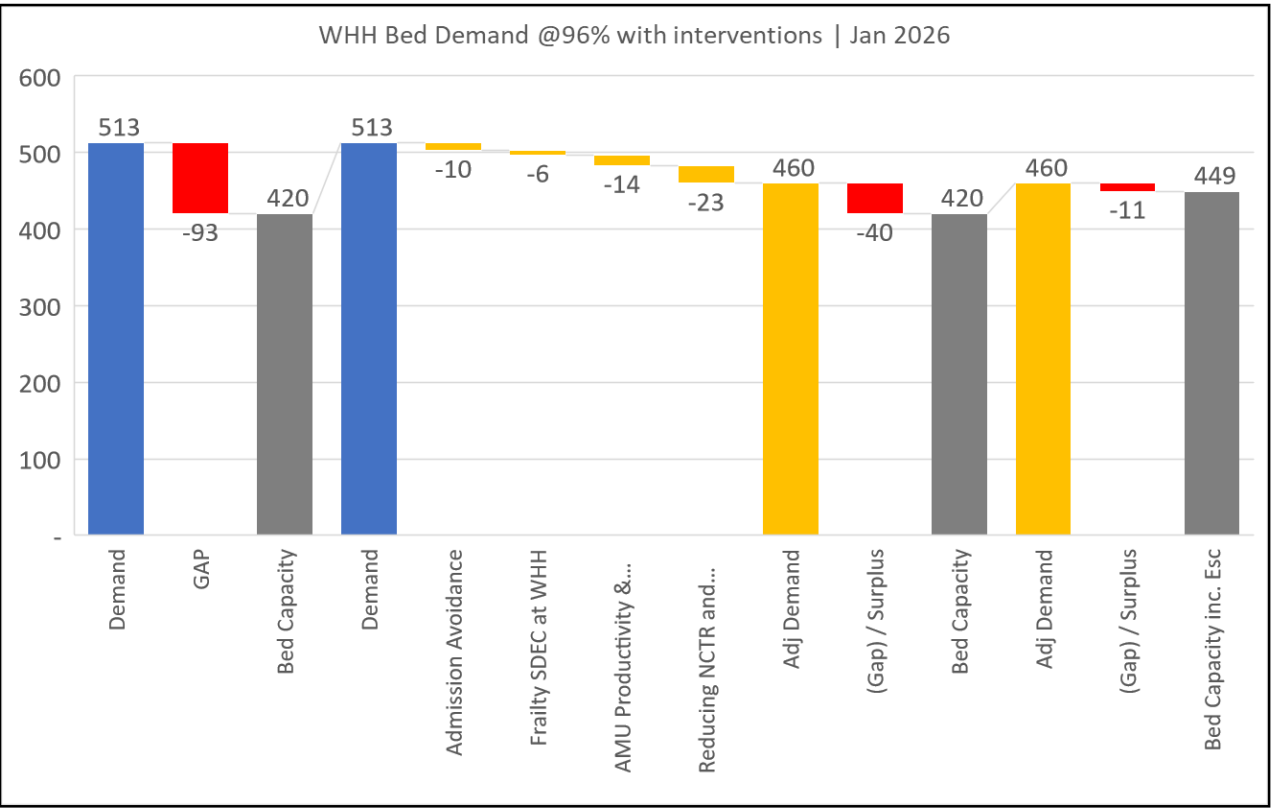
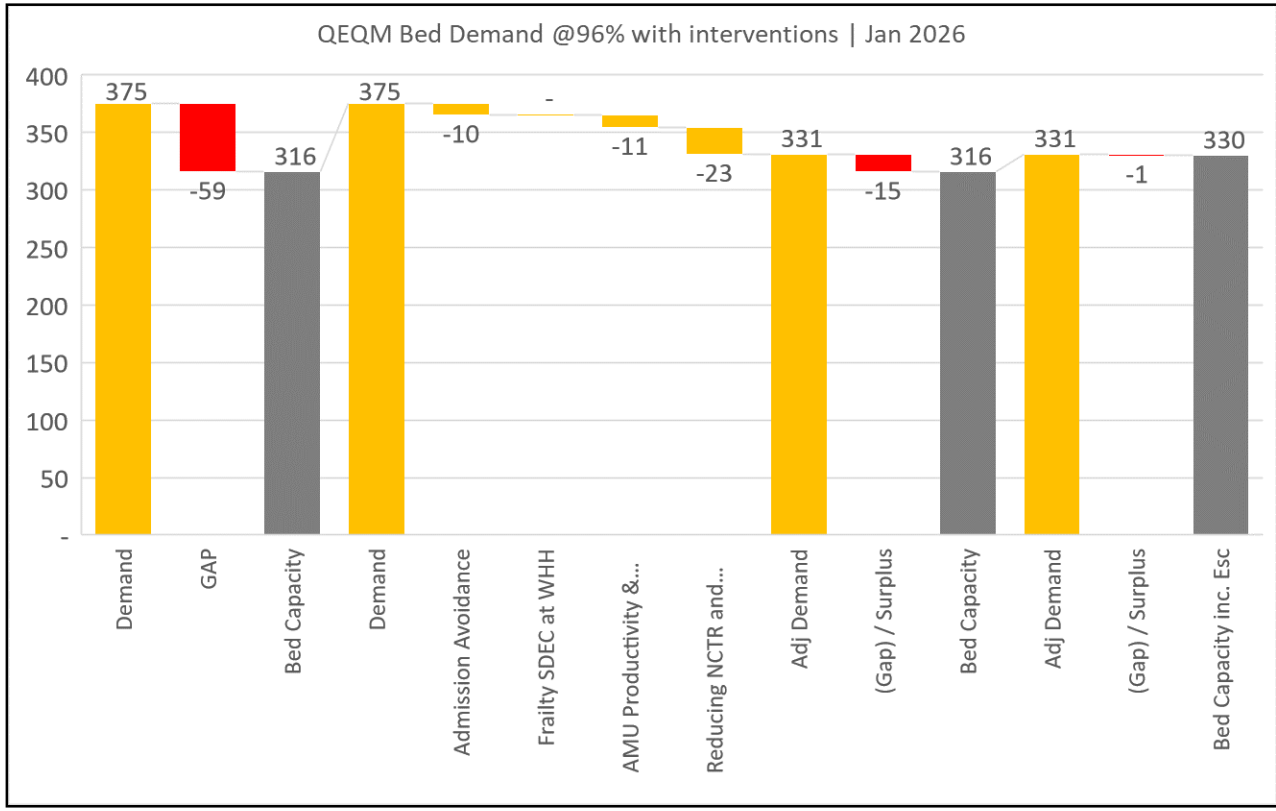
Performance & Modelling
Site Level Outputs

East Kent Hospitals University NHS Foundation Trust





WHH and QEQM waterfalls are shown above:

Initial gap at these sites totals -152. After mitigations this is -55 beds.

K&C has a surplus of 43 beds. Historically the site has been used to decant NCTR patients to increase acute flow at the other sites. Under current plans, QEQM will have access to 24 beds at K&C to mitigate works impacting on St Augustine's ward at Margate over winter 2025-26. Accounting for this transfer, QEQM could achieve a surplus bed position against their core bed base of +9)

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Performance & Modelling
LOS Benchmarking

East Kent Hospitals University NHS Foundation Trust

Headline data & benchmarking illustrates the LOS opportunity at EKHUFT

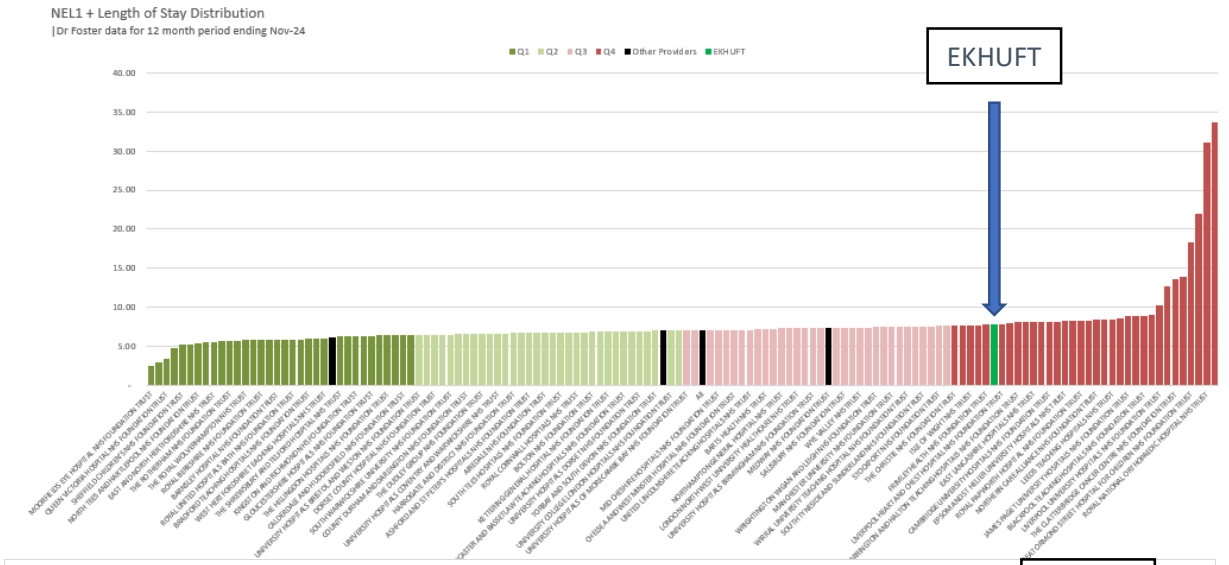
Benchmarking data has been used to understand EKHUFT's current Elective & non-elective LOS.

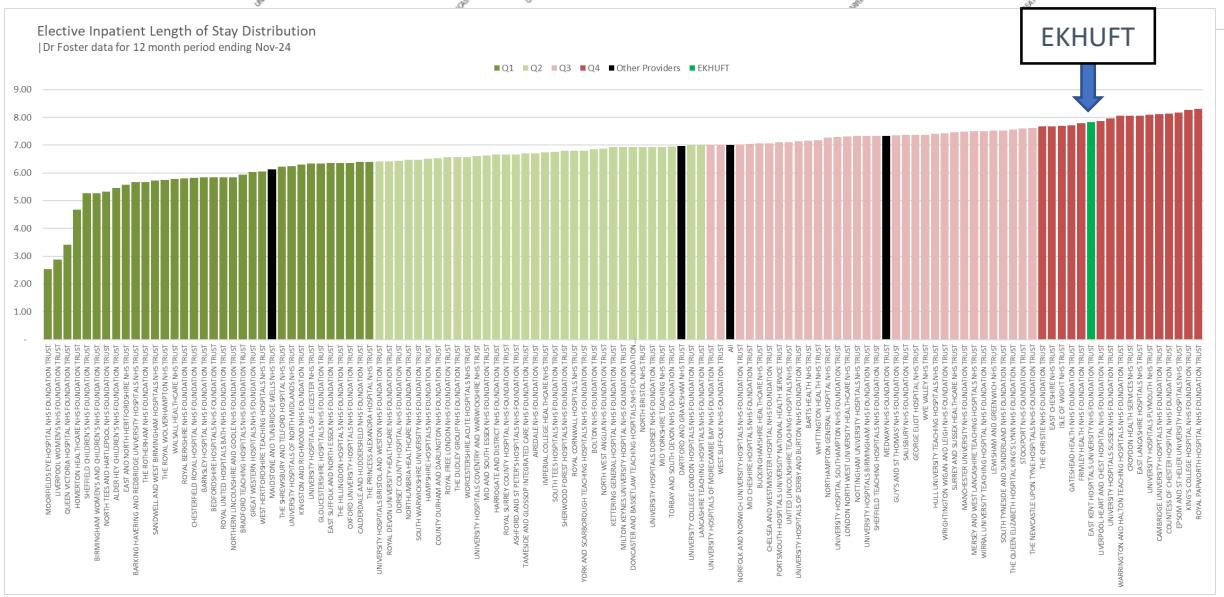
This data shows EKHUFT has a Non elective LOS in the 4th Quartile, using national submitted data, there is a notable opportunity across a number of specialties for reduced LOS.

Position of the Trust means there is potential for significant LOS reduction across the sites for non-elective spells.

Underscores that there are clear opportunities around LOS, which would reduce if inpatient flow were unlocked.

The following slide demonstrates a review of the potential improvement potential





Performance & Modelling Improvement Potential

East Kent Hospitals University NHS Foundation Trust

Admission Avoidance, SDEC Streaming and Frailty SDEC

- Implementing a Clinical Decision Unit (CDU) with a clear policy and increasing redirection to Same Day Emergency Care (SDEC) can reduce Emergency Department (ED) volumes, shorten patient waits, and avoid unnecessary admissions by enabling assessments and short treatments without formal hospital admission.
- An enhancement to frailty SDEC at WHH, based on the model implemented at QEQM is also planned

AMU Productivity & Flow

- Reviewing the proportion of <72 hour admissions can identify opportunities to improve turnover and productivity in AMUs.
- Benchmarking shows EKHUFT is in the lowest-performing quartile for such discharges, highlighting potential gains for medical admissions if AMU flow can be unlocked

Complex & Delayed Discharges

- Improvement in this area noted in 2024-25, further potential exists to delivery a greater volume of efficiencies
- Review of longer length of stay patients, and potential to reduce time spent in hospital by patients who have No Criteria to Reside (NCTR)
- Triangulated with data from HCP partners
- Envisaged being delivered by through system working across the discharge processes
- Enabled by Improvement Week (Sept-25)

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Performance & Modelling Improvement Potential

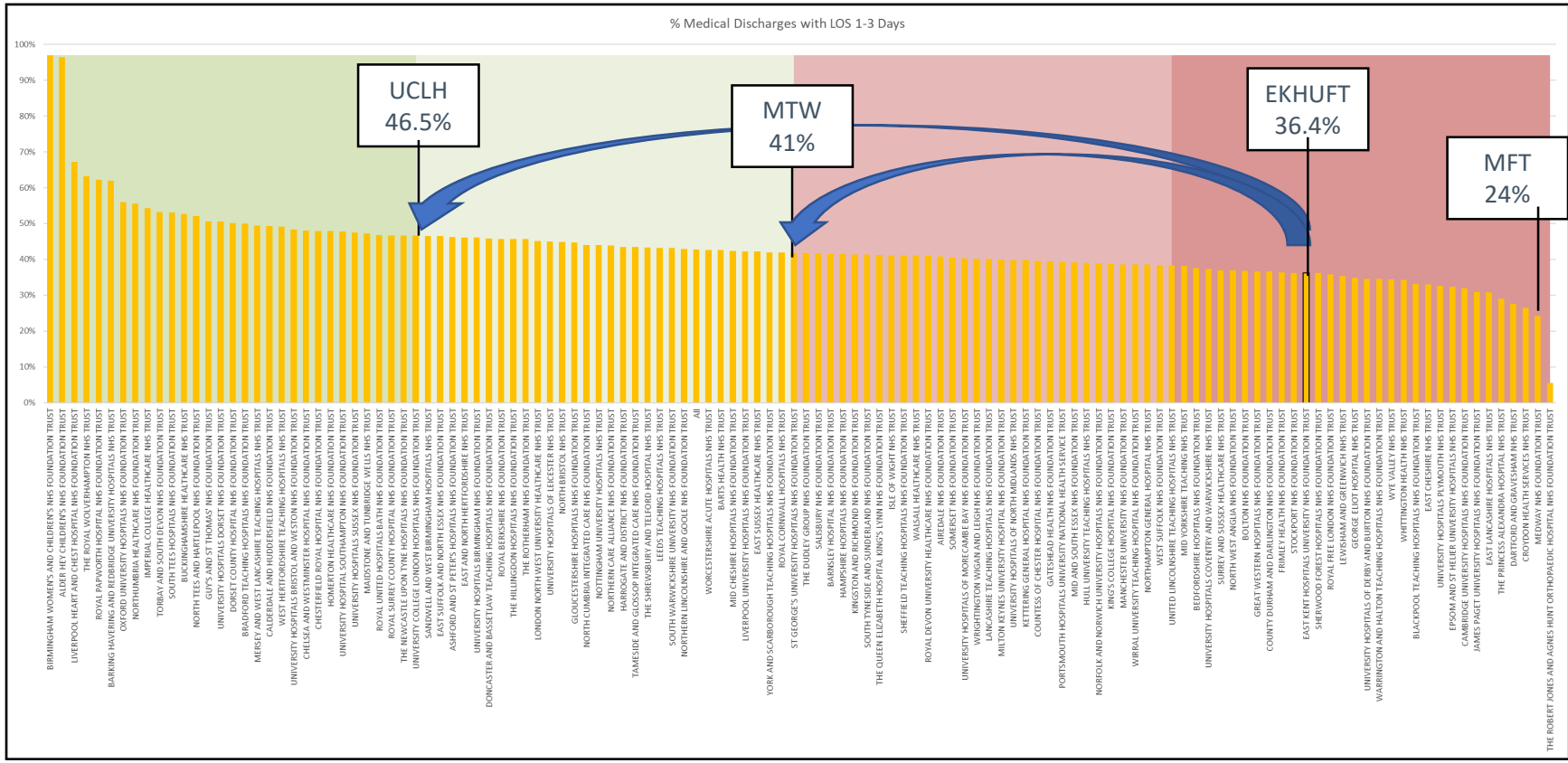
East Kent Hospitals University NHS Foundation Trust

AMU Productivity & Flow

Data demonstrating position - extracted from Telstra Health platform, July 2025

This data shows that there is large potential to reduce the LOS if the proportion of medical discharges within the first 72hours were to increase

ECIST have commenced support to the trust from the 12 August, which will continue over the coming months



Performance & Modelling Improvement Potential

East Kent Hospitals University NHS Foundation Trust

AMU Productivity & Flow

Potential bed savings

		If median of 41.8% achieved			If upper quartile of 46.5% achieved		
	Current % 1-3 Days	Daily discharges brought fwd	Bed potential (left shift of LOS 4-5)	Bed potential (left shift of aLOS 4+)	Daily discharges brought fwd	Bed potential (left shift of LOS 4-5)	Bed potential (left shift of aLOS 4+)
QEQM	34.4%	1.3	3.3	11	2.4	6.1	20
WHH	38.0%	1.6	4.2	14	2.9	7.9	26
Trust wide		2.9	7.5	25	5.3	13.9	46

Potential Bed savings are calculated using 2 methodologies, giving a range of impact

If EKHUFT achieved a similar proportion of medical discharges within 72 hours as the median trust, potential is 7.5-25 beds

If EKKHUFT were to achieve upper quartile performance, potential is calculated as 13.9-46 beds

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Performance & Modelling Improvement Potential

East Kent Hospitals University NHS Foundation Trust

Complex Discharges show a historic reduction in NCTR over 2024-25

- Complex patients occupancy an average of 448 beds across EKHUFT, with an average LOS of 23 days.
- In 2024-25, there has been a reduction in the total beds used by *complex discharges*, with a year on year reduction in the volume of beds utilised by No Criteria to Reside patients by 27 on average
- Over 2024-25, days spent from Discharge Ready Date to Discharge was an average of 5 days.
- Projections generated as part of the bed modelling are based on performance from the last 12 months, and the impact of historic winter schemes are reflected in this position

2023-24

Pathway_Type	Avg LOS	Total Bed Days	Equiv. Daily beds (LOS Days)	Total Beds NCTR (cumulative)
PATHWAY 1	20.56	96,837	265	67.9
PATHWAY 2	23.07	39,976	109	32.8
PATHWAY 3	33.79	62,686	171	70.8
Total	**24.04**	**199,499**	**545**	**171.5**

2024-25

Pathway_Type	Avg LOS	Total Bed Days	Equiv. Daily beds (LOS Days)	Total Beds NCTR (cumulative)
PATHWAY 1	20.93	69,513	190	55.7
PATHWAY 2	24.32	51,446	141	48.4
PATHWAY 3	27.25	42,480	116	40.5
Total	**23.36**	**163,439**	**448**	**144.6**

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Performance & Modelling
NCTR - Current Position

East Kent Hospitals University NHS Foundation Trust

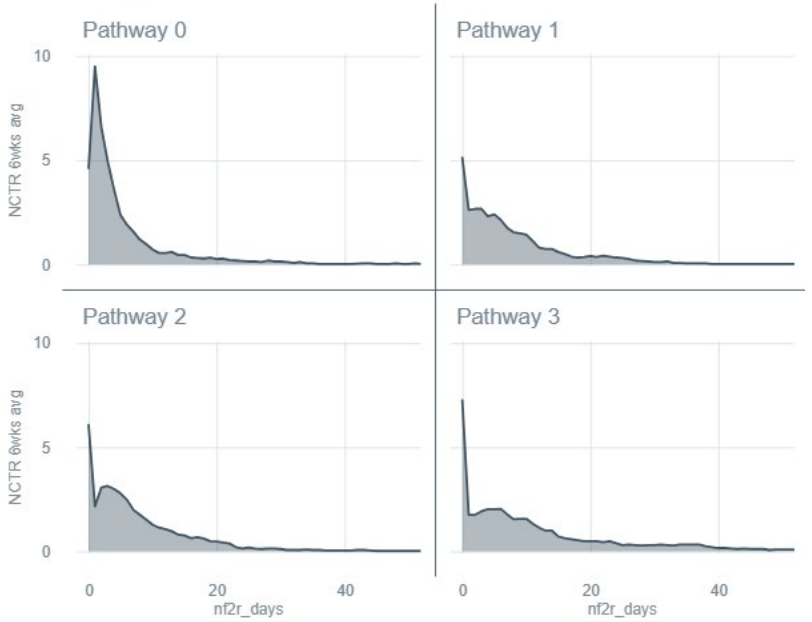
NCTR Occupancy remaining at midnight | By Site and Pathway

week_start	Pathway 0	Pathway 1	Pathway 2	Pathway 3	Total
21/07/2025	50	31	43	51	**174**
28/07/2025	42	32	44	50	**167**
04/08/2025	47	33	49	46	**175**
11/08/2025	41	48	34	35	**158**
18/08/2025	41	39	37	33	**150**
25/08/2025	50	34	35	39	**159**
Total	**45**	**36**	**40**	**42**	**164**

Daily Discharges | By Site and Pathway

week_start	Pathway 0	Pathway 1	Pathway 2	Pathway 3	Total
21/07/2025	84.0	8.6	4.9	3.9	**101.3**
28/07/2025	80.0	6.9	3.7	2.9	**93.4**
04/08/2025	81.4	5.7	3.0	4.3	**94.4**
11/08/2025	80.1	5.7	3.6	3.4	**92.9**
18/08/2025	78.9	10.6	5.4	2.9	**97.7**
25/08/2025	71.0	6.0	3.0	2.4	**82.4**
Total	**79.2**	**7.2**	**3.9**	**3.3**	**93.7**

Distribution by NCTR Days Delay



Examining the current position of NCTR patients and their respective daily discharge rate, we can see:

- The remaining occupancy of NCTR patients is significantly above the volume of daily discharges, implying a large delay from NCTR to discharge for these patients (5-12 times the daily discharge volumes for complex pathways)

- The distribution profile of each pathway occupancy is shown to the right
  - Pathway 0s show a steep fall after 1 delayed NCTR day
  - Pathway 1 shows a shallow decline, with a long tail
  - Pathway 2 patient volumes typically do not start to decline until around 7 delayed days are accumulated
  - Pathway 3 – Large initial volume at 0 days which disappears (Potentially returns to original CH, or immediately rejected?) . Followed by a flat period with a gradual tail beginning after 6 days

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Performance & Modelling Improvement Potential

East Kent Hospitals University NHS Foundation Trust

Discharges

- Community review of the complex patients triangulates opportunities around delays to discharges.
- Opportunity over 2025-26 to further reduce the waits and overall days spent by patients who are NCTR, which would reduce the volume of NCTR patients remaining in hospital.
- Through reducing LOS and increasing daily complex discharges by ~4 per day, it would be possible to halve the time these patients are spending awaiting discharge (Discharge Ready Date to Discharge), which would be equivalent to saving 46 beds.
- This would require the reduction of the volume of NCTR patients within the acute bed base from phased initiatives prior to the period of expected peak demand (w.c. 24 Nov 2025 though Jan 2026)
- To achieve this, we envision a period of an additional complex discharges per day to reduce the population of delayed patients in hospital by 40-50 patients. Followed by a sustained increase in daily Mon-Fri discharges from 21 to 26 per day.
- This could be enabled by plans and changes implemented from Improvement Week 2's focus on discharges, and alternatives to hospital.

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Performance & Modelling
NCTR – Current and Proposed

East Kent Hospitals University NHS Foundation Trust

Discharges

- Discharge profiles show an average of 18 complex discharges per day, with a weekday average of 21.
- The proposed sustainable discharge targets are a significant uplift on current positions, increasing discharges on average by 4 a day.
- Further discussions are scheduled with partners to develop joint plans around our capability and capacity to deliver this.

Avg Complex Ward Discharges (Last 12 months)

	Avg Daily Discharges by Weekday			*Total complex discharges*	*Variance from overall Daily avg*			
	PATHWAY 1	**PATHWAY 2**	**PATHWAY 3**		**PATHWAY 1**	**PATHWAY 2**	**PATHWAY 3**	*Variance*
Monday	8	5	5	18	0	-1	0	0
Tuesday	9	6	5	20	1	0	1	2
Wednesday	9	7	5	21	1	1	1	3
Thursday	10	7	6	22	2	1	1	4
Friday	10	7	5	21	2	1	1	3
Saturday	6	5	2	13	-2	-1	-2	-5
Sunday	4	4	1	9	-4	-2	-3	-8
Daily Avg	8	6	4	18				

Proposed (sustainable) of discharge target

	Avg Daily Discharges by Weekday			*Total complex discharges*	Increase per day
	PATHWAY 1	**PATHWAY 2**	**PATHWAY 3**		
Monday	10	7	6	23	5
Tuesday	11	8	6	25	5
Wednesday	11	9	7	26	5
Thursday	13	8	7	28	6
Friday	12	9	6	27	5
Saturday	8	6	3	17	3
Sunday	5	5	2	12	2
Daily Avg	10	7	5	22	4

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Performance & Modelling
Improvement Potential

East Kent Hospitals University NHS Foundation Trust

EKHUFT 2025/26

Total G&A Beds - August 2025	BAU	Surge	Total Max Surge	Total Crisis Surge
WH	420	29	48	**497**
QEQM	316	14	12	**342**
K&C	241	6	20	**267**

The above table shows the volume of adult G&A beds, surge, and max-surge beds by site.

This position was submitted to the ICB on 14 August 2025

Note that St Augustine's at QEQM is closed until May 2026, and has been removed from the bed base. Bed capacity is being re-provisioned at the K&C site

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EKHUFT Additional Mitigation Options

Additional mitigations not yet added to waterfalls

Additional Mitigation Options

Potential reduction of elective inpatient activity

East Kent Hospitals University NHS Foundation Trust

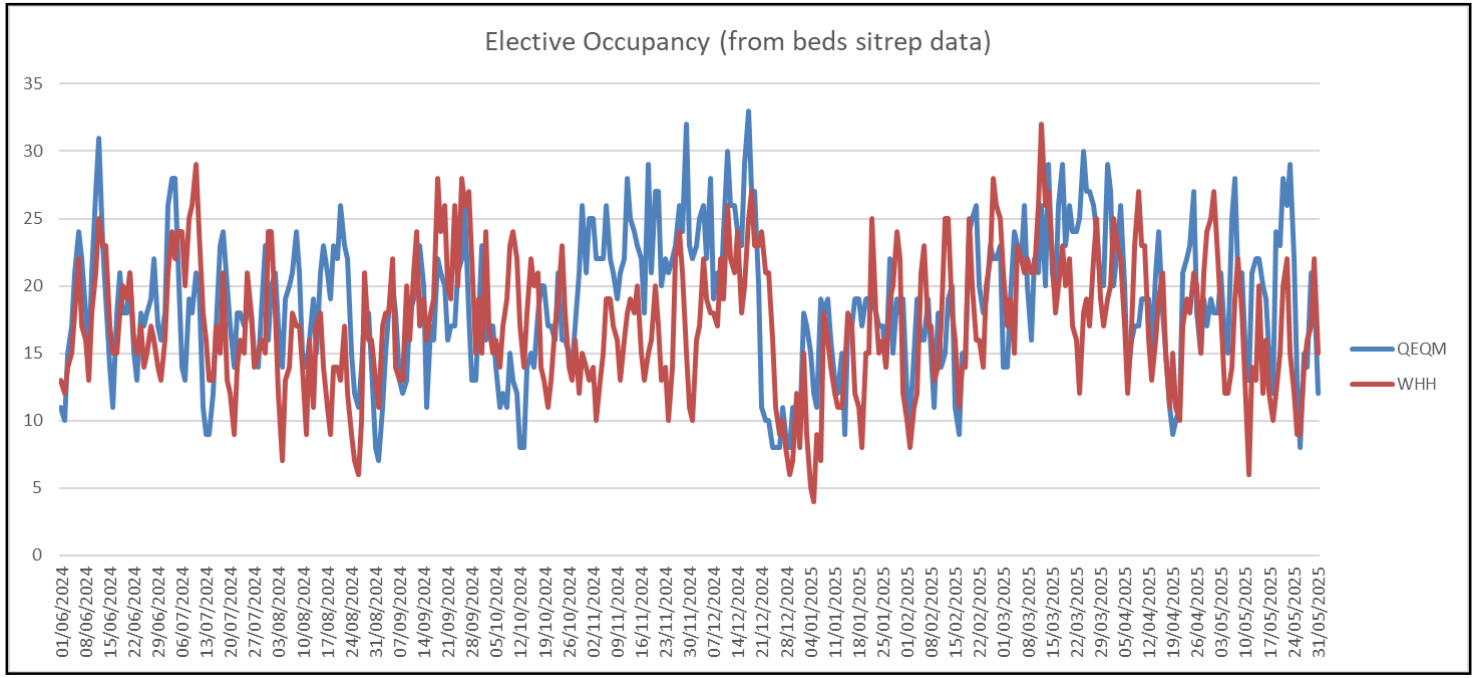
Over the last 12 months, overall occupancy by elective patients is a historic average of ~36 beds across both QEQM and WHH, with ~19 at QEQM, and 17 at WHH.

Note the historic reduction in occupancy in the days around Christmas

We can identify the priority of our elective inpatient activity from waiting list data.

This enables us to split the historic activity on the basis of procedure urgency.

This intervention proposes examining the volume of beds in use by lower priority admissions, and preserving the higher priority admissions (for example, maintaining surgical admissions for cancer treatment)



Additional Mitigation Options

Potential reduction of elective inpatient activity

East Kent Hospitals University NHS Foundation Trust

Table to the right shows the average volumes of occupied acute beds over the year with a split between higher (P1/P2) and lower (P3/P4) priority admissions

This shows that across QEQM and WHH there are an average of 11.5 beds occupied by lower priority elective admissions at any one time

Potentially, it may be possible to reduce the volume of elective admissions over a short period of time during the peak of winter demand to provide additional resilience

	Beds in Use		
	Higher Priority admissions	Lower Priority admissions	Total
QEQM	12.2	6.6	18.8
WHH	12.3	4.9	17.2
QEQM + WHH	**24.5**	**11.5**	**36**

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Additional Mitigation Options
Potential reduction of elective inpatient activity

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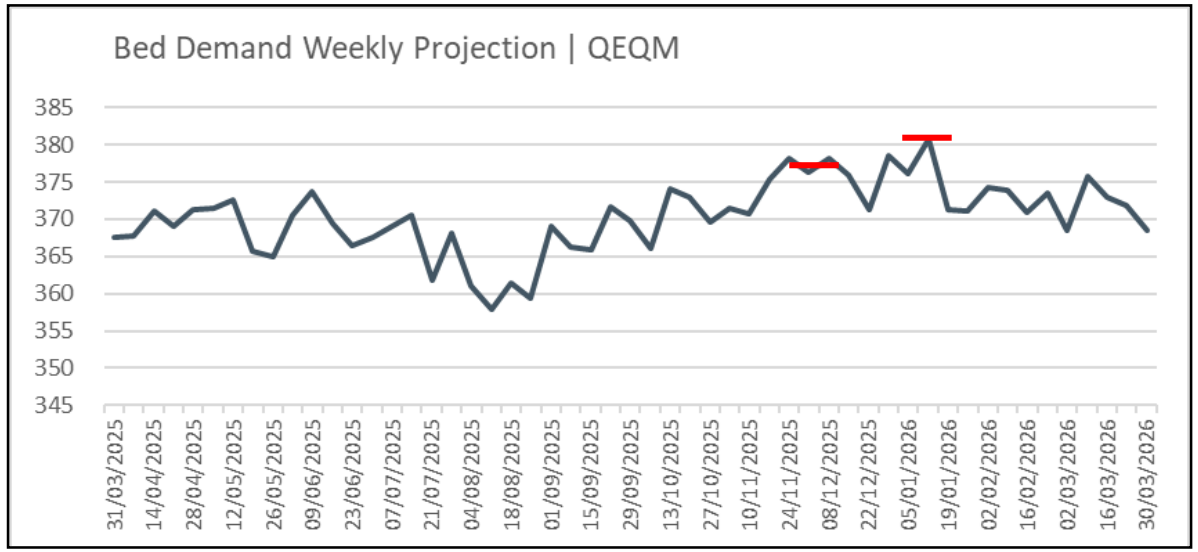

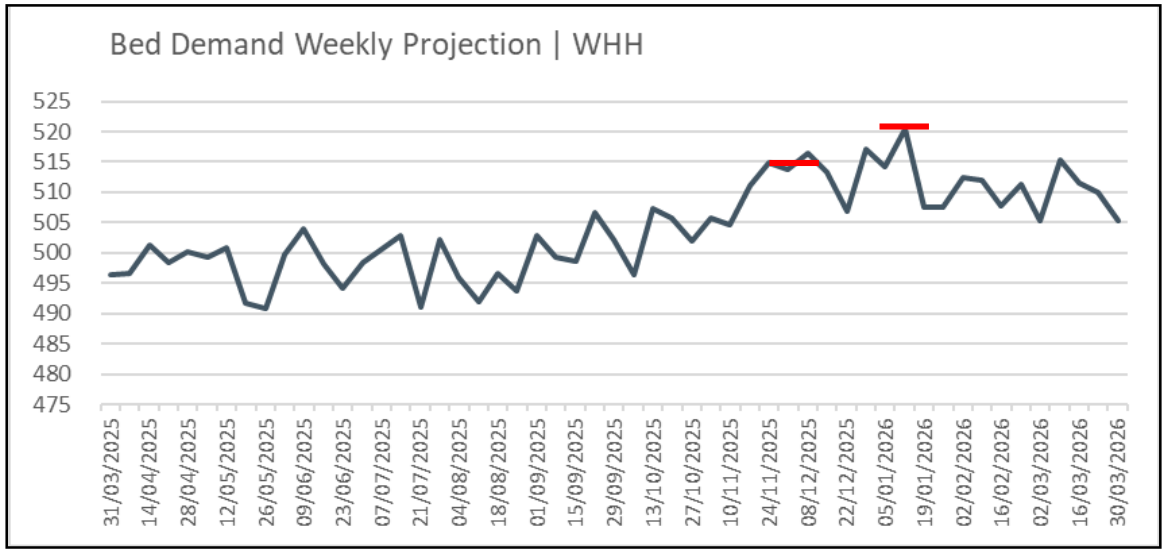

A review of the weekly bed demand projections at the sites shows:

- A relative peak in bed demand over a 4 week period from the last week of November (w.c 24th) through to 21st December
- A projected peak in bed demand in early January (w.c 5 January) of 381 beds at QEQM and 521 at WHH.
    - After mitigations are considered, this would represent a gap at the sites of 7 beds at QEQM and 19 at WHH

Given these forecasts, it may be possible to engage in a planned 'industrial action type' approach to reduce the volume of elective inpatient admissions over these periods of time, with the option to redeploy clinical staff to outpatients, ward areas or the Emergency Department.

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Performance Trajectories

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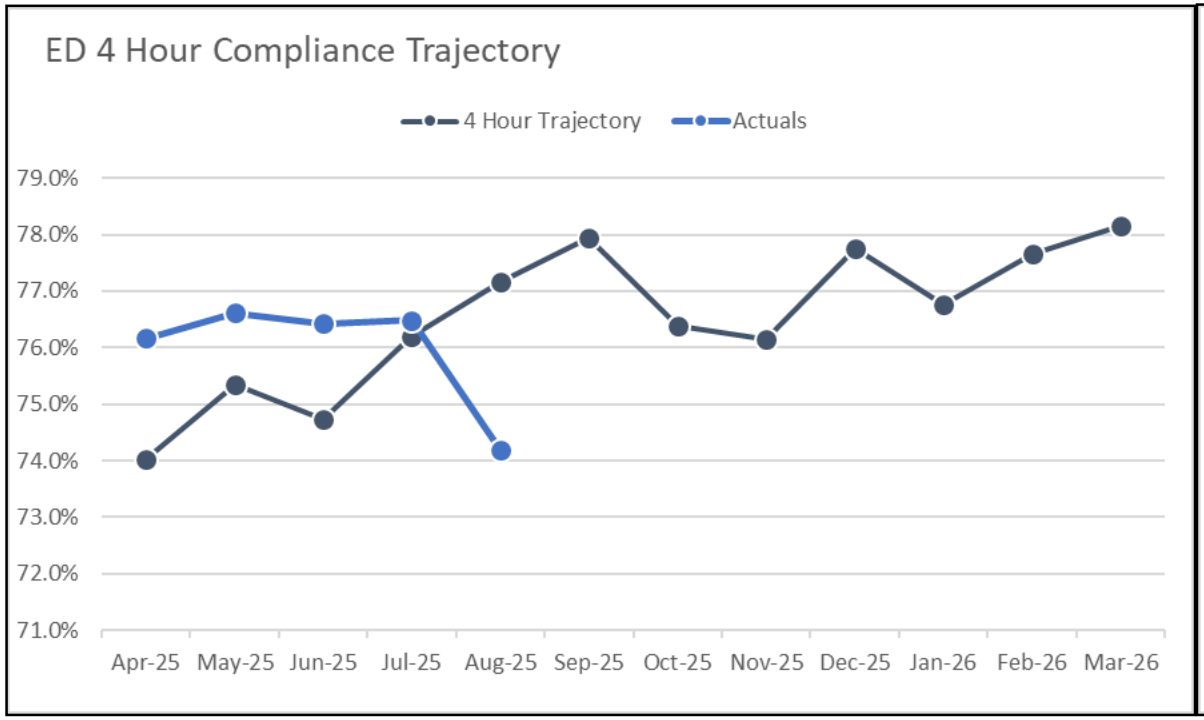
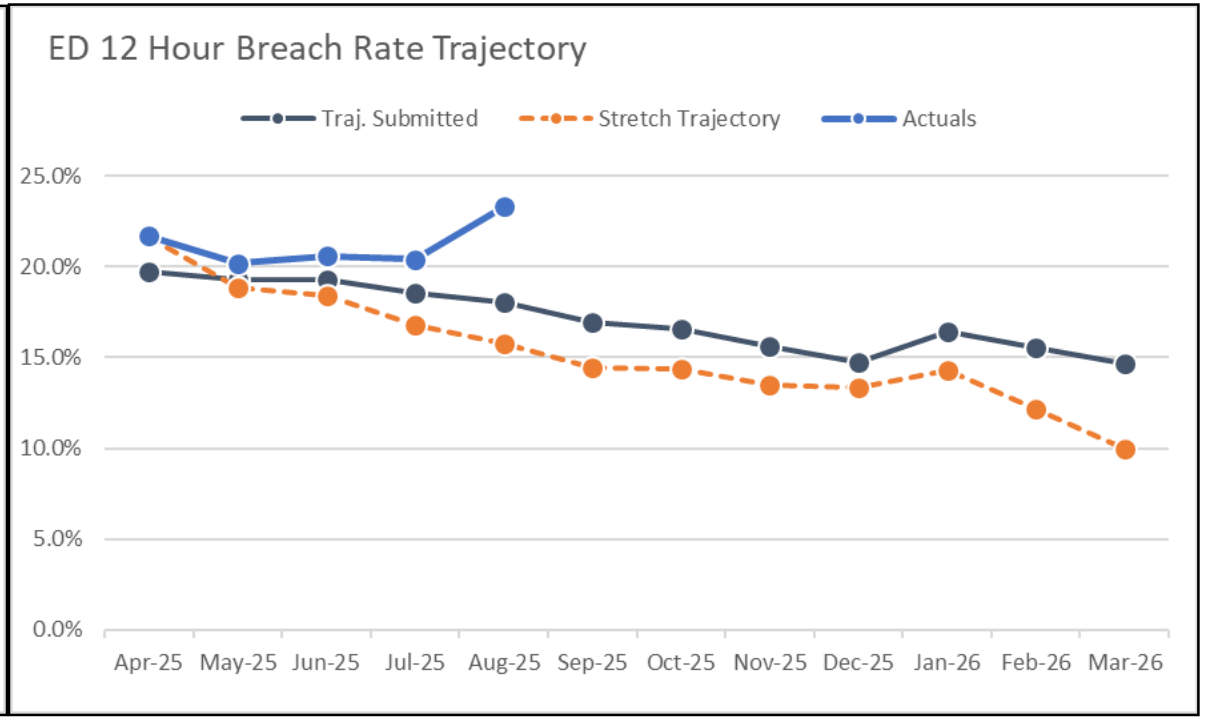
Urgent & Emergency Care Trajectories

East Kent Hospitals University NHS Foundation Trust





UEC Trajectories for 4 Hour compliance and 12 Hour Breach rate are shown above.
The trust has developed a 12 hour “stretch” trajectory, with a more ambitious improvement target than the previously submission.

The Integrated Urgent & Emergency Care Improvement programme is being delivered by operational teams, with governance via internal monthly Operational Board, and reporting to the HCP Urgent Care Delivery Board

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Planned Care Trajectories

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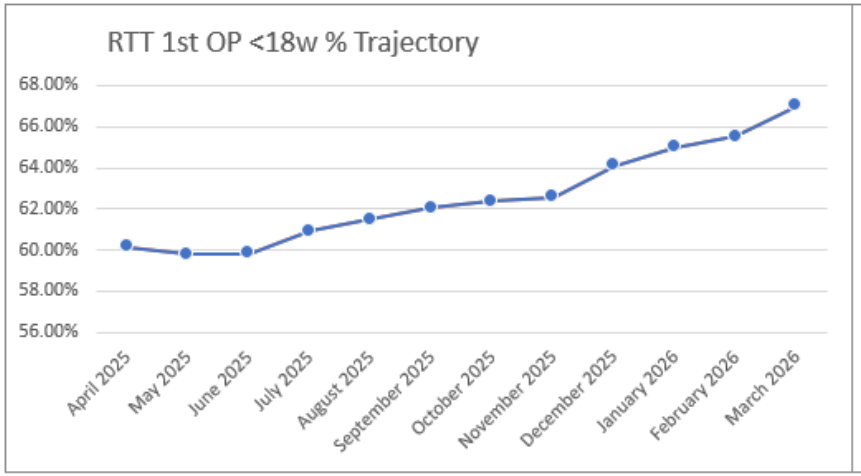

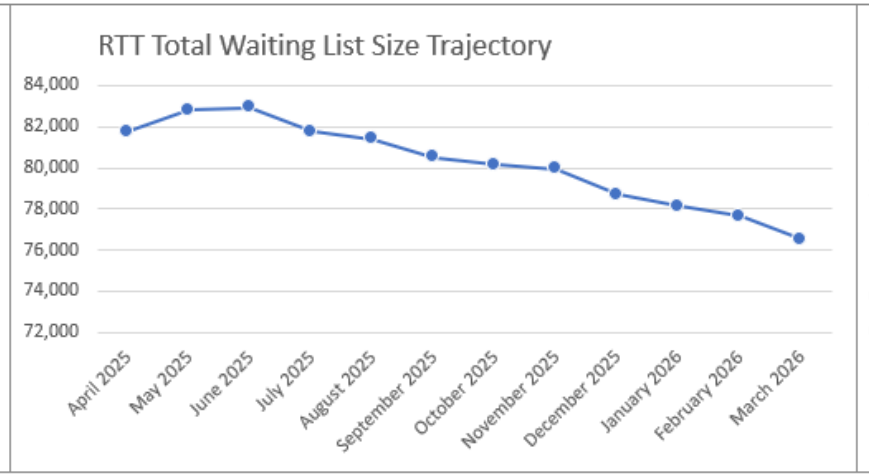

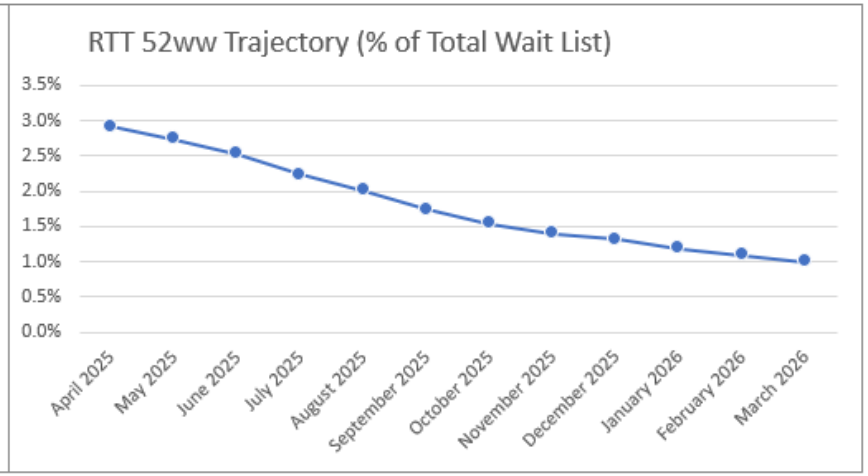

The operational plan is profiled to maintain sufficient capacity to provide resilience during anticipated winter demand. Elective & Cancer Activity plans for quarters 2 and 3 aim to provide mitigation to the impacts of likely winter demand – including on diagnostic services.

The Kent & Canterbury Hospital site hosts the trust's elective orthopaedic centre, and does not have a Type 1 Majors department on site, only taking direct admissions for specific centralised services like urology, vascular and stroke.
As such the levels of elective inpatient admissions at the site is likely to be well insulated from specific winter pressures, allowing a ~430 elective inpatient admissions per month to continue throughout winter (approx. half of the Trust's elective inpatient admissions)

Internal data shows that non clinical cancellations on the day at EKHUFT due to lack of bed availability are minimal

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EKHUFT Escalation & Surge Planning

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EKHUFT Adult Patient Flow & Escalation

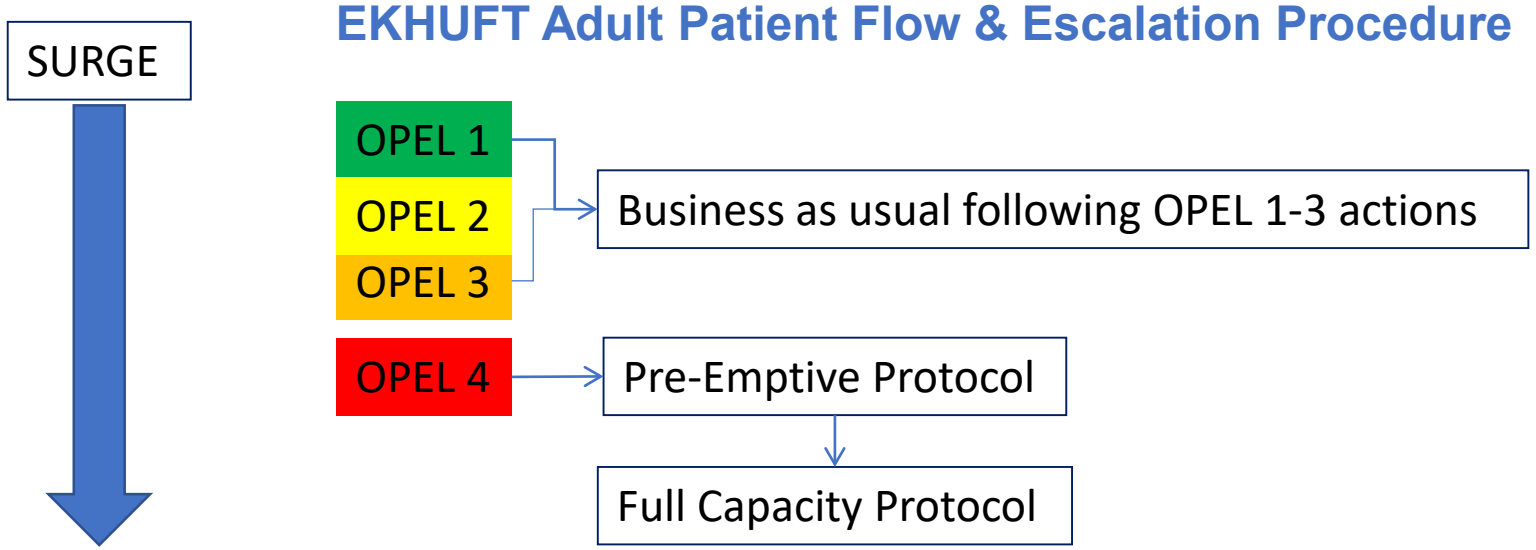
East Kent Hospitals University NHS Foundation Trust

As the Emergency Department (ED) attendances and non-elective patient admissions to the Trust can be affected by seasonality and surges into the hospital, this can pose as a challenge to the Trust daily. ***The proactive response to surge in non-elective activity is fundamental to ensure patient safety.***

The Adult Patient Flow & Escalation Procedure provides a consistent and standardised approach to managing a surge in demand, a reduction in bed capacity – e.g. due to infection outbreaks, or lack of sufficient discharges and an increase in operational pressure.

The procedure details the activities required for ensuring safe and effective utilisation of non-elective patient pathways and in-patient beds to ensure those, who require admission, are admitted on the right pathway.

Patient safety and experience are our priority. The procedure is intended to support clinical decision making not to replace it.



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EKHUFT Adult Patient Flow & Escalation

East Kent Hospitals University NHS Foundation Trust

Pre-Emptive Protocol

The 'Pre-emptive' protocol is a de-escalation action which will be enacted when areas of the emergency pathway require urgent decompression to reduce the risk of overcrowding, support patient safety and improve patient flow.

'Pre-emptive' is defined as moving a patient from an emergency assessment area to their designated base ward prior to the patient who has been identified as being ready for discharge having left the receiving ward area. Promptly moving the identified patient to the discharge lounge or booking transport (and making ready) reduces the time the ward is 'pre-emptive'. The discharge lounge will give priority to areas where they have gone 'pre-emptive'.

A risk assessment supports the utilisation of 'pre-emptive' and not 'boarding' or 'plus one' which is when there is no patient identified as being discharged on the ward.

Full Capacity Policy

This Full Capacity Policy (FCP) is based on an end state escalation when there is failure to deliver sufficient patient flow to meet demand through daily business as usual. There will be times when the Emergency Department (ED) is deemed to be at full capacity as defined by the triggers, and the Trust has more patients than it can potentially safely care for. This is usually demonstrated by long waits in ED for speciality or Assessment Unit beds.

The FCP will be activated when the Care Group/Trust is operating at its highest escalation levels where demand significantly outweighs capacity and actions taken at OPEL 4 have failed to improve service pressures.

The FPC is a top-level escalation process; the documents below will have been used prior to its enactment in an attempt to improve the position.

The FCP will be activated by the Chief Operating Officer (or their deputy) in hours following discussion with the CNMO/CMO, and out of hours following careful consideration of the efficacy of actions carried out at OPEL 4. When the FCP is declared, the Trust will adapt a Command and Control leadership model through which management and coordination of next steps will commence.

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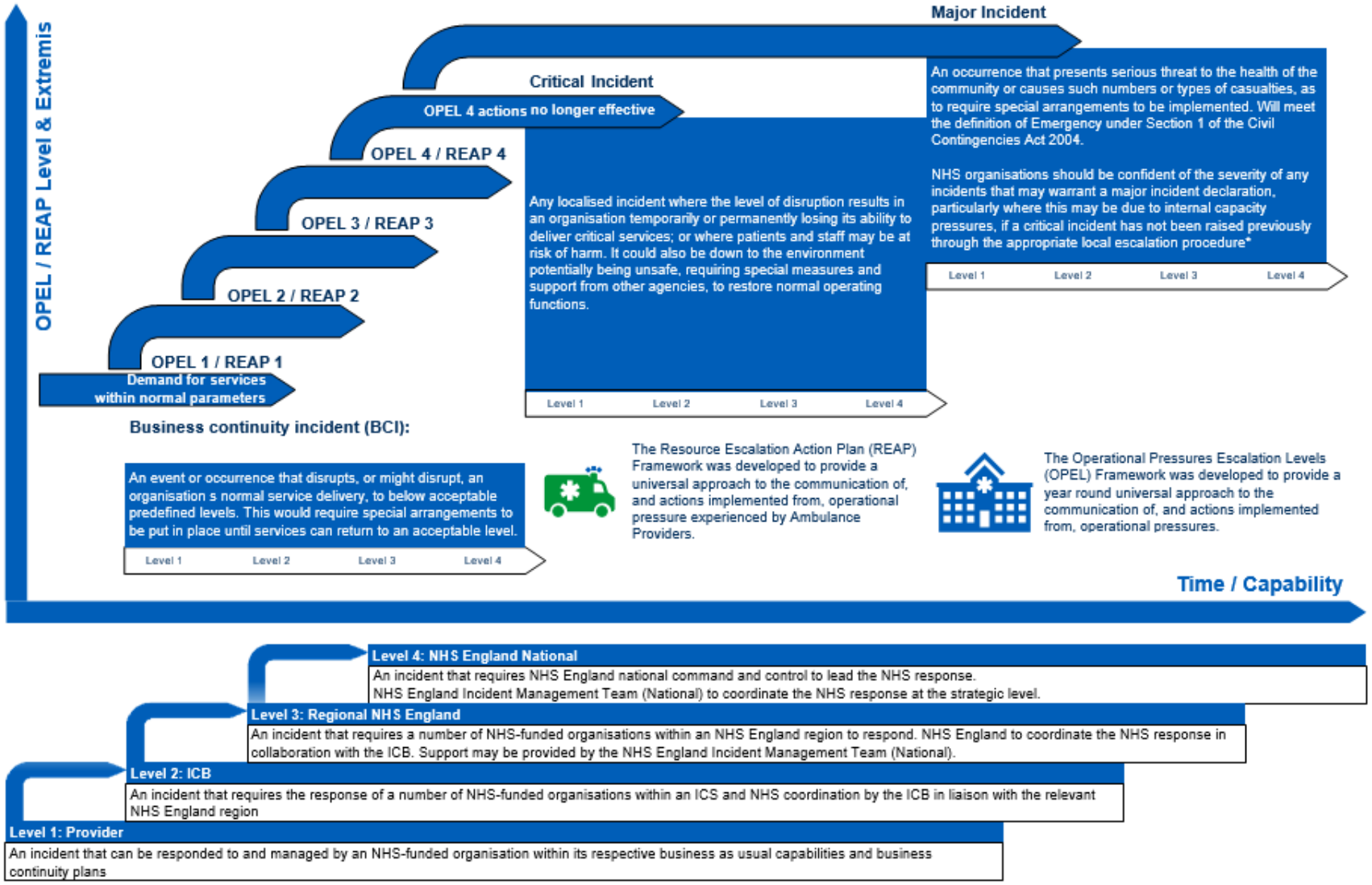
OPEL to EPRR Escalation

East Kent Hospitals University NHS Foundation Trust



Level 4: NHS England National
An incident that requires NHS England national command and control to lead the NHS response.
NHS England Incident Management Team (National) to coordinate the NHS response at the strategic level.

Level 3: Regional NHS England
An incident that requires a number of NHS-funded organisations within an NHS England region to respond. NHS England to coordinate the NHS response in collaboration with the ICB. Support may be provided by the NHS England Incident Management Team (National).

Level 2: ICB
An incident that requires the response of a number of NHS-funded organisations within an ICS and NHS coordination by the ICB in liaison with the relevant NHS England region

Level 1: Provider
An incident that can be responded to and managed by an NHS-funded organisation within its respective business as usual capabilities and business continuity plans

There is no continuum of definitions between the OPEL and EPRR Frameworks. It is therefore possible for an organisation to be at OPEL 1 and to have declared an (EPRR) incident. Similarly, the declaration of a critical incident due to 'operational pressures' is not an automatic expectation where OPEL 4 is sustained as the OPEL 4 actions have not achieved de-escalation. The declaration of an incident is a decision for the NHS provider based on the EPRR Framework and trust incident response policies and procedures.

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William Harvey Hospital

East Kent Hospitals University NHS Foundation Trust

Winter Plans	Detail
Escalation capacity	(also see next slide) Now: ED – 8 spaces, DTA 15 spaces Planned: ED – 14 – 34 spaces, DTA 15 to 65 (extreme end)spaces
Risks and Mitigations	Decrease in appropriate staff skill set – only mitigation is use of potential high cost agency. Isolated areas for bedding patients – increase in staffing to maintain appropriate staff ratio's Stopping diagnostic and surgical flow by using capacity – impacts on ED flow and urgent elective care – prioritise p1 and p2 patients
Capital Works/Estates improvements	SDEC development, Cath Lab installation, UTC expansion, Fire safety installation works
Flow improvement initiatives	Quarterly improvement weeks, UEC Improvement plan, ECIST review of hospital flow,
Staffing	Increase in staff needed to support escalation (unfunded) areas
[Add if needed]	

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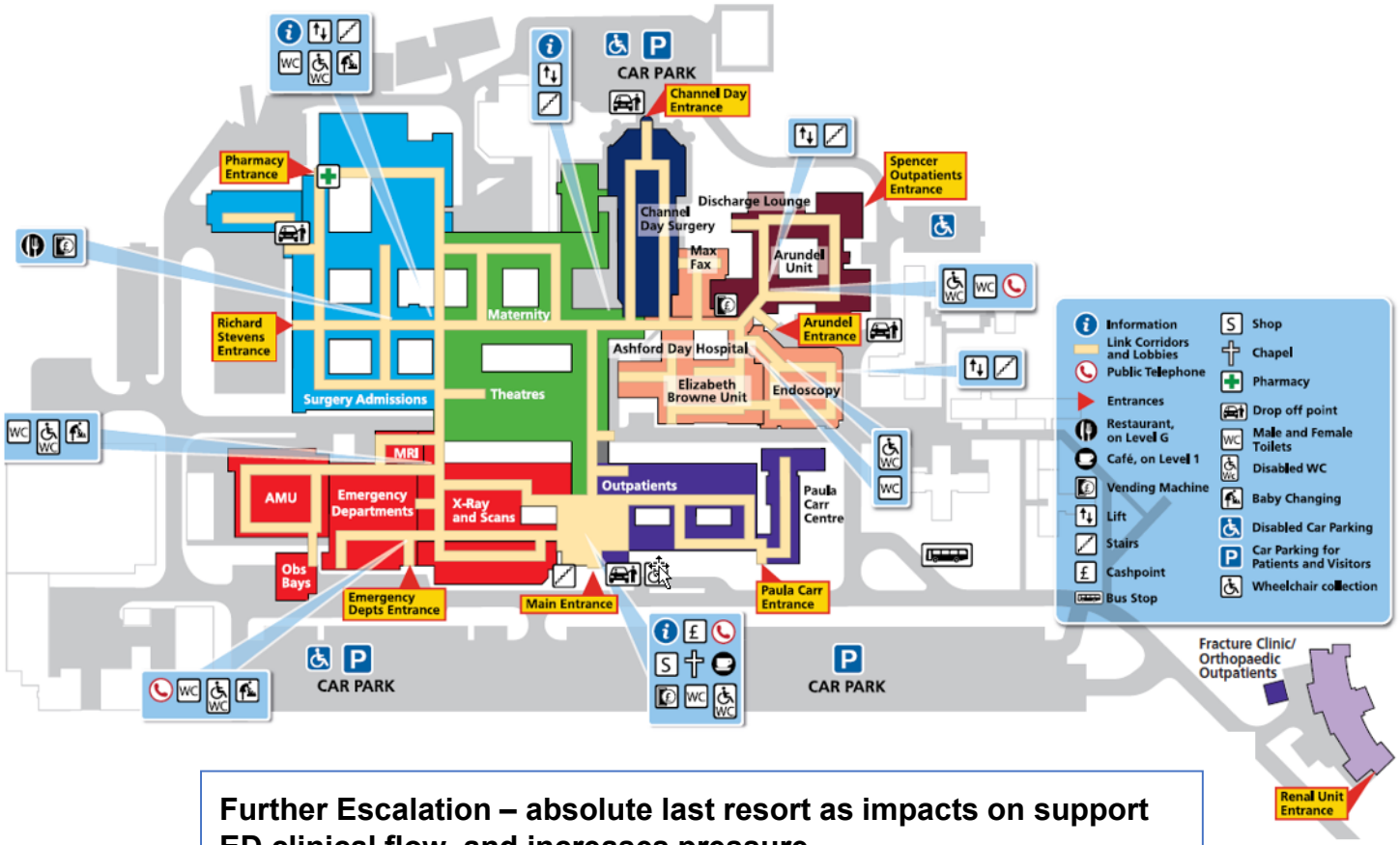
EKHUFT Escalation Planning
Winter Site Escalation – WHH

East Kent Hospitals University NHS Foundation Trust

ED Escalation

- Phase 1 - Corridor B x 8 spaces
- Phase 2 - Corridor A x 6 spaces (exec approval only)
- Phase 4 – Radiology x 6 spaces



Escalation Beds for DTAs

Escalation Beds:

- Richard Stevens x2
- Cambridge M2 x 1
- AMU A & B x 2
- Discharge Lounge bedded area x 10
- Discharge Lounge trolley area x 2
- Cambridge K trolleys x 12

Further Escalation – absolute last resort as impacts on support ED clinical flow, and increases pressure

Closing SDEC can potentially place 16 patients

Closing RADU **or** CADU (SEACOLE) would provide c.10 places for patients

Closing Endoscopy would provide a place for 8 patients

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Kent & Canterbury Hospital

East Kent Hospitals University NHS Foundation Trust

Escalation capacity	(also see next slide) Now: 8 Mount McMaster, 7 Renal day unit (suitable bedded areas). Endoscopy and Day Surgery in extremis, not staffed and not existing overnight bed spaces. Planned: St Lawrence ward could be available for escalation once no longer providing decant for fire works at QEQM.
Risks and Mitigations	Medical staffing cover at K&C- the existing model is no Gen Med consultant cover, only SHO and RMO. Work is currently underway to review mitigations with exec for approval in August to create better senior cover and continuity.
Capital Works/Estates improvements	Recurrent lift breakdowns, recently both lifts at once. Remedial works undertaken but some issues have persisted. Business continuity plans in place.
Flow improvement initiatives	Improvement week planned for October Deep dive into vascular LoS and potential to repat- beginning now
Staffing	Some escalation areas could utilise existing staffing but others would be dependent on availability of NHSP or agency nursing (see next slide for details).

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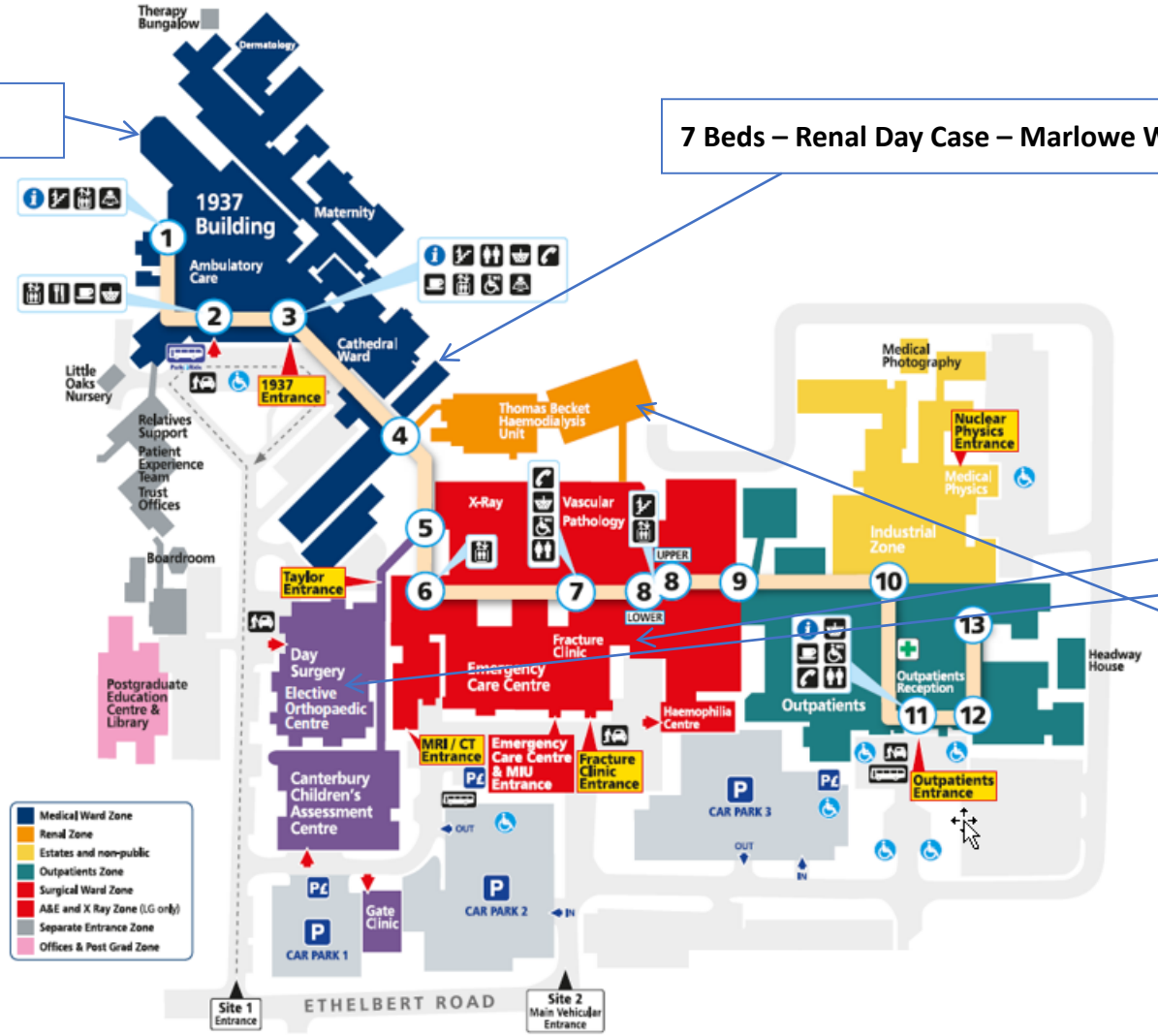
EKHUFT Escalation Planning
Winter Site Escalation – K&CH

East Kent Hospitals University NHS Foundation Trust

8 beds Mt McMaster

7 Beds – Renal Day Case – Marlowe Ward



Unstaffed areas

- Endoscopy – displace activity
- Day Surgery ward- displace activity

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QEQM Hospital

East Kent Hospitals University NHS Foundation Trust

Escalation capacity	See slide No. 3
Risks and Mitigations	Due to SDEC expansion – bed capacity is listed. Risk mitigation is the iUEC Plan, community capacity and the Full Capacity Protocol.
Flow improvement initiatives	QEQM Improvement Project Plan 25-26
Capital Works	As per SDEC expansion.
Staffing	All wards maintained above Amber

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EKHUFT Escalation planning winter 25/26
Site Escalation – QEQM

East Kent Hospitals University NHS Foundation Trust

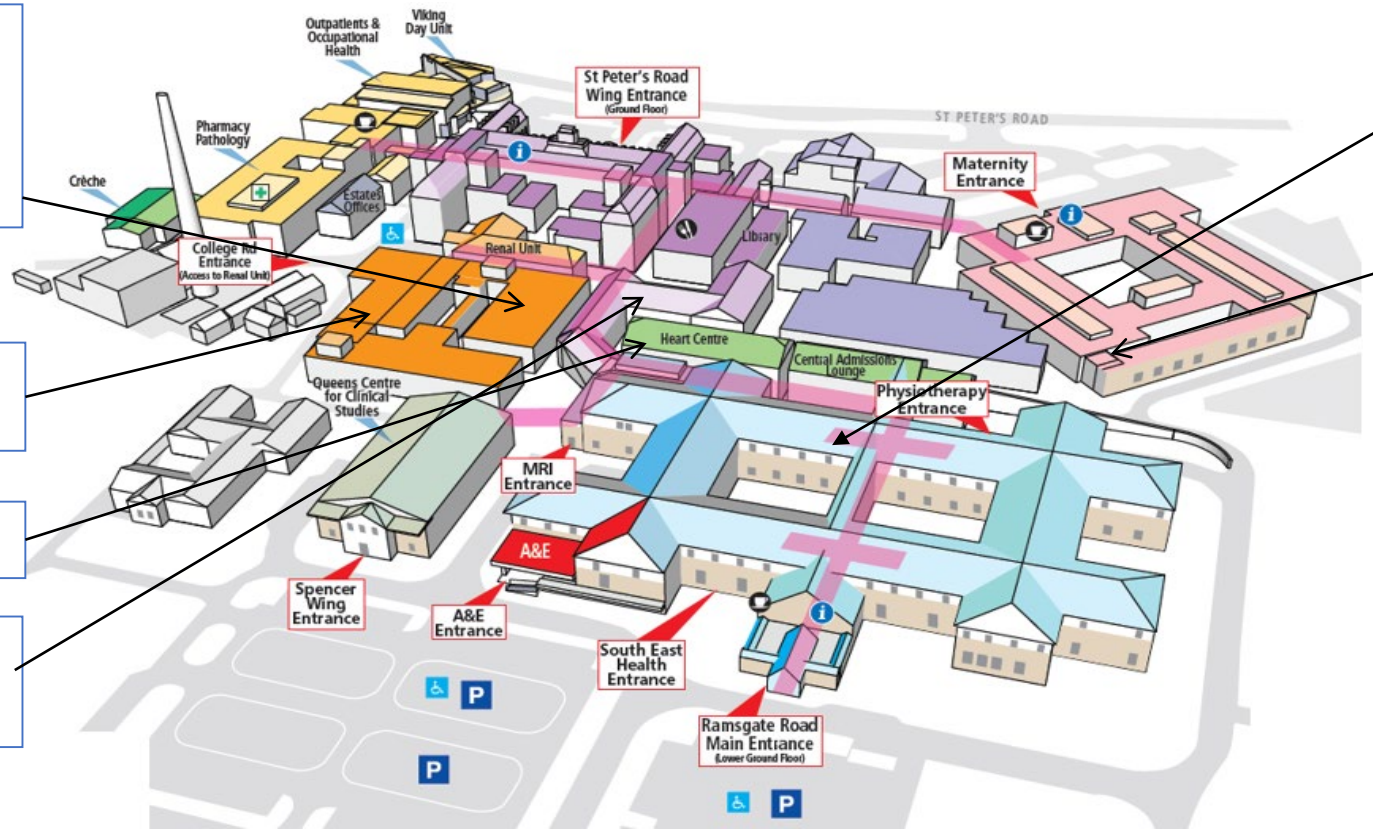
1. **Discharge Lounge**

- Phase 1 – Existing Escalation bedded area
- Phase 2 – entire lounge - 12 Beds

2. **Frailty SDEC**
12 beds

3. **Cath Lab**
4 beds

4. **SEAU / SDEC (on Quex)**
6 beds



5. **CCU**
1 bed

6. **Birchington**
1 Bed

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Winter Weather Preparedness

East Kent Hospitals University NHS Foundation Trust

Robust comms plans and Switchboard messaging in place.

Snow and Ice Clearance. Areas of High Risk across sites to be reviewed with 2gether's Facilities and EPRR.
Portable Heaters – Review and assurance of the process for issuing seasonal equipment

Risk - Transportation in snow and icy weather. MoU with voluntary sector cannot be relied upon as business continuity arrangements for stranded staff. No viable alternative arrangement in place.

Emergency accommodation process in place.

Risk –BHD flooding during episodes of high volumes of surface with a wet winter forecast

EPRR to review Severe Winter Weather Plan in line with revised National Adverse Weather alerts.

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Care Groups & Support Services

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Critical Care

NHS
East Kent Hospitals University Trust

Escalation capacity	**Critical Care Surge Tiers:** **Pre-surge:** Maintain normal bed base (i.e. WHH 18 beds, QEQM 9 beds, K&C 8 beds) **Surge:** WHH can flex to 24 beds; QEQM uses theatre recovery beds for lower-acuity patients; K&C can flex by 2 unfunded beds **Escalation:** Additional 8 beds at WHH (doubling ITU spaces), 8 beds at QEQM (Cheerful Sparrows Male), and trust-wide redeployment of ex-ITU staff **Critical care footprint may be maximised** by using recovery areas and temporary expansion zones **Bed escalation decisions** will be made by clinical leads and matrons based on staffing availability **System-wide decompression/mutual aid** may be considered only if EKHUFT capacity is not at risk
Risks and Mitigations	**Staffing shortages** during prolonged surge phases may limit ability to open additional beds - *Mitigation:* Use NHSP and agency workers, redeploy staff from non-critical services, and prioritise reduced services if surge lasts >48 hours. **Avoidable patient transfers** if capacity thresholds are exceeded on any site - *Mitigation:* Exhaust internal escalation pathways (recovery areas, surge beds) before considering transfers **Maintaining clinical standards** of GPICS nurse-to-patient ratios during peak periods - *Mitigation:* Adjust nurse-to-patient ratios as a last resort, with trust-wide support for redistribution of experienced staff. **Infrastructure constraints** (e.g., limited physical bed spaces) - Mitigation: Pre-identification of recovery and ward step-down spaces
Capital Works/Estates improvements	There are no works planned Uninterrupted Power supply business continuity plan will be activated.
Flow improvement initiatives	**We-Care discharge project** working with site teams to improve discharge times **Expedited step-down protocols** from ITU to ward-level care to free up Level 2/3 beds **Use of theatre recovery** as overflow for lower-acuity or ward-ready critical care patients **Daily operational reviews** to match capacity with real-time demand across the three hospital sites **Collaborative discharge planning** with site teams to minimise bottlenecks
Staffing	**Critical care nursing ratios:** 1:1 for Level 3 patients and 1:2 for Level 2 patients (per GPICS guidance) **Contingency staffing pool:** Use of NHSP, agency staff, and ex-ITU personnel from other departments. Trust-wide redeployment plan for sustained surge **Leadership oversight:** Escalation requests above normal capacity will be reviewed clinical leads and site matrons
Critical Care Surge Plans	There are escalation plans for each site to transfer patients across site if required

Elective Surgery

East Kent Hospitals University NHS Foundation Trust

Escalation capacity	**Strategic release of inpatient** (IP) beds across WHH, KCH, and QEQM through elective activity adjustments **Suspension of elective activity** on Bank holidays (24–26 Dec, 31 Dec–1 Jan) **Reduce inpatient elective** theatre activity during 2-week festive period **WHH and QEQM (Hot Sites)** prepared to absorb additional trauma and CEPOD demand
Risks and Mitigations	**Impact of reduced inpatient** activity on RTT waits and backlog reduction due to reduced elective IP activity **Mitigation through prioritisation of cancer cases**, urgent IP needs, and RTT long waiters (78wk, 65wk) **Risk of staffing constraints** over holiday period addressed through advanced rota optimisation **Potential IP bed pressures reduced** by maximising same-day discharge pathways and day case throughput
Capital Works/Estates improvements	**Challenges with estates** issues may impact operating theatres
Flow improvement initiatives	**Surgeons to review lists for conversion of eligible inpatient procedures** to day case wherever clinically safe **Implementation of fast-track day case admission** and discharge protocols to increase list capacity Early planning of patient discharges and ensuring outpatient post-ops / follow-ups are booked appropriately to prevent readmissions
Staffing	**Anaesthetics and theatre teams rotas** pre planned to support uninterrupted emergency and elective coverage **Daily review of elective theatre lists** to balance Inpatient and Day case activity to support flow through all sites **The 8-6-4-2 theatre session review process** will be used to assess and approve extra sessions **Theatres 3-2-1 staff planning** will be aligned to theatre scheduling to ensure sufficient cover for all planned lists
Critical Care Surge Plans	**Expand theatre use for day case surgery**, particularly at WHH and QEQM **Maximise flexibility in scheduling** to respond to emergency care demands **Daily review of site level theatre** utilisation data to inform real-time adjustments in staffing

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Women's Services - Maternity

East Kent Hospitals University NHS Foundation Trust

Escalation capacity	Maternity have a total of 78 beds across the Trust – 44 at WHH and 38 at QEQM. These include delivery rooms, AN &PN capacity and our MLU beds. Surge capacity is limited by safe staffing which currently meet bed capacity in line with Birth-rate +. Vacancy levels remain high, but are currently mitigated by agency usage. A further cohort of Newly Qualifies Midwives (NQM) are due to join in July and September. Daily sitreps are held and if MOPEL levels reach 3 on either site an internal divert will be arranged to our other Trust site, or if affecting both sites, mutual aid is requested via the LMNS escalation route.
Risks and Mitigations	Acuity, staffing and capacity levels have been high but robust plans for escalation are in place for 24/7
Capital Works/Estates improvements	No major build work occurring during this period – design planning and minor works only
Flow improvement initiatives	NIPE clinics; work with discharge coordinators to reduce LOS and increase capacity. Bed and c-section capacity / demand modelling has been completed
Staffing	Remains at Amber risk levels for reasons stated above.

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Children & Young People

East Kent Hospitals University NHS Foundation Trust

Escalation capacity	NICU (L3) at WHH have 28 cots in total and can be flexed between ITU, HDU and SCBU depending on demand and staffing levels: SCBU (L1) at QEQM have a max of 12 cots. Paediatrics have a total of 48 beds across the Trust – 28 at WHH and 20 at QEQM. Safer staffing levels are based on these beds and surge beds are only available in small numbers (4 and 3 beds respectively) if additional staff are available via NHSP. Care group sit-reps occur daily to ensure oversight of issues and mitigation can be made.
Risks and Mitigations	Cubicle capacity is always a challenge if RSV/ bronchiolitis / infections are prevalent during winter months. Cohorting is possible and respiratory support for children is available. CAHMS admissions remain a concern as these can impact on bed capacity on the ward. Safe staffing levels are always paramount.
Capital Works/Estates improvements	Some potential for disruption of CAU's on both sites due to expansion of the SDEC otherwise nil anticipated.
Flow improvement initiatives	Ops teams on ward rounds to expedite discharge; earlier discharge of CYP from wards into correct OPD pathway; golden child identified.
Staffing	Safe staffing has got to remain in place at all times

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Diagnostics, Cancer & Buckland Hospital

East Kent Hospitals University NHS Foundation Trust

Oxygen	WHH - 5000l/min capacity on an oxygen ring main with duplex VIE apparatus, with auto-changeover facilities on the evaporators. The flow into the system monitored by Ultrasonic flow meter as well as via the Trust Covid App that draws information recorded on VitalPAC about oxygen use that gives the Trust awareness to ward level on the system draw. QEQMH - 3000l/min capacity (Ramsgate road) and 917L/min St peters road. No auto-changeover facilities on the evaporators manual de-icing process in place. The flow into the system monitored by Ultrasonic flow meter as well as via the Trust Covid App that draws information recorded on VitalPAC about oxygen use that gives the Trust awareness to ward level on the system draw. System can be joined so that Ramsgate road supports the site with support from St Peter's road. Main Covid areas currently fed off Ramsgate Road. The site will be benefit from an Oxygen Ring Main which is a work in progress. K&CH - 917L/min capacity via a single VIE apparatus with no auto-changeover facilities on the evaporators (manual de-icing process in place.) Back up to the VIE is provided by ERM . The ERM is a UHF (ultra-high flow) manifold capable of a 3500L/m output. Connected down stream of the VIE on site. The manifold is fed from 2x10 banks of ''W'' size bottles. At an average demand of 200L/m, the ERM will provide the site with approx. 18.5Hrs of continuous Oxygen, in the event of a primary and secondary VIE failure. The flow into the system monitored by Ultrasonic flow meter as well as via the Trust Covid App that draws information recorded on VitalPAC about oxygen use that gives the Trust awareness to ward level on the system draw.
Risks and Mitigations	BHD Flooding – robust flood defence systems in place, ongoing works to drainage system Microbiology capacity pressure from increased demand resulting from Norovirus, CDiff, Infectious Respiratory Virus testing – use of NHSP to support, cost pressure
Flow improvement initiatives	Provision of 7 day inpatient and TADs service utilising NHSP
Staffing	Therapy inpatient staffing levels to support 5 day services remain challenged with 16.2wte vacancies across sites. Have been approved and part of therapy establishment review and recruitment ongoing
Mortuary	Primary focus for pathology is to assess the need for additional cold storage for mortuary. Each year the Trust has needed additional 'surge' capacity to cope with winter demand with this typically increasing Mid December to end of April. The Trust will hire an additional 40 spaces for 6 months with an associated cost of approximately £60k. Jackson Hub are the agreed supplier for body store in Kent and provide transport arrangements as part of the agreed contract.

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Infectious Respiratory Viruses –

IP&C/ quick guide testing & isolation- Version 6 –to be updated Oct 25 for Winter 25/26

East Kent Hospitals University NHS Foundation Trust

Patient group	Immediate action	Testing	Infection prevention and control action and information* *For treatment and prophylaxis – please see Eolas
All adult emergency admissions with respiratory symptoms (e.g. ED/ECC/MAU/maternity Use clinical judgement if viral respiratory illness suspected	Triaged to specific waiting area	**Lateral flow device (LFD) point of care test for:** **COVID-19** **INFLUENZA A** **INFLUENZA B** *Patients who test negative by lateral flow are **non-infectious** but do PCR if underlying risk factors affecting immune or respiratory function, cancer, renal or liver disease or neurological disorders and who have no new oxygen requirement or a low flow oxygen requirement (as they may be eligible for treatment)*	• **Influenza positive by lateral flow** – isolate for 5 days (or 48 hours symptom free) • **COVID -19 positive by lateral flow** isolate for 5 days (see below) **IPC precautions:** • Staff entering isolation rooms or cohorts must follow droplet precaution PPE – fluid repellent surgical masks MUST be worn – aprons if in close contact, and gloves if exposed to blood or body fluids. Airborne precautions should be followed if AGP (aerosol generating procedure) takes place. • If positive patients need to be transported around hospital – they should be provided with a fluid repellent surgical mask, to be worn if tolerated
Paediatric patients with respiratory symptoms as clinically indicated Use clinical judgement if viral respiratory illness suspected	Triaged to specific waiting area	**Liat (PCR) point of care test for:** **COVID-19** **INFLUENZA A** **INFLUENZA B** **RSV**	• **Influenza positive** – isolate for 5 days (or 48 hours symptom free) • **COVID-19 positive** isolate for 5 days (see below) • **RSV positive** – isolate in a cubicle
Inpatients who develop new respiratory symptoms including: Fever (over 37.8° C) Shortness of breath New or worsening cough Use clinical judgement if viral respiratory illness suspected	1) Pull curtains round/barrier 2) Droplet precautions; airborne precautions if doing AGPs 3) Amber clean 4) Test	Throat swab in viral transport media Select COVID PCR or respiratory screen on sunrise (all these requests will be tested for COVID, flu and RSV during winter)	• Isolate in single room (cohort bay if no single rooms available) • Refer to Eolas to check eligibility for treatment • Refer to Eolas to check eligibility for influenza prophylaxis for contacts • Ensure any symptomatic contacts are tested • Inform IP&C IPC precautions as above
Contacts of positive COVID-19/Influenza	Isolate/cohort (review patients in contact cohorts – if any	ONLY test if become symptomatic	• Contact of COVID-19: Isolate/cohort for 4 full days post last exposure to COVID • Contact of Influenza: Isolate/Cohort for 3 days post last exposure to Influenza

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Infectious Respiratory Viruses

IP&C/ quick guide testing & isolation- Version 6 –to be updated Oct 25 for Winter 25/26

East Kent Hospitals University NHS Foundation Trust

	clinically immunocompromised – suggest clinician review for potential single room isolation)		• **IN EXTREME BED /SITE PRESSURES** – there may be a situation whereby non COVID contacts may be placed in contact cohort bays – using clinical judgement e.g. not immunocompromised patients – or confused wandering patients. THESE DECISIONS TO BE DOCUMENTED IN HOSPITAL OCC DECISION LOGS IPC precautions as above
Known COVID-19 positive patients (immunocompetent)	Isolate/cohort Refer to Eolas for treatment eligibility criteria	No routine testing for de- isolation	• Release after 5 days if free of fever for 48 hours IPC precautions as above
Known COVID-19 positive patients (severely immunosuppressed – see below)	Isolate/cohort Refer to Eolas for treatment eligibility criteria	LFD after 5 days for de- isolation	• a single negative LFD after minimum 5 days isolation IPC precautions as above
Asymptomatic inpatients awaiting discharge to residential or other care facility	**ONLY test IF known to have been in an outbreak ward/ exposed to COVID within previous 5 days OR symptomatic on day of discharge**	LFD	• Inform onward care facility of result

1. Covid – 19: Definition of immune-compromised when considering LFD test to release from isolation

- patients undergoing chemotherapy or radical radiotherapy leading to immunosuppression
- solid organ transplant recipients, bone marrow or stem cell transplant recipients
- HIV infection at all stages
- multiple myeloma or genetic disorders affecting the immune system (e.g. IRAK-4, NEMO, complement disorder, SCID)
- Individuals who are receiving immunosuppressive or immunomodulating biological therapy including, but not limited to, anti-TNF, alemtuzumab, ofatumumab, rituximab
- Patients receiving protein kinase inhibitors or PARP inhibitors, and
- Individuals treated with steroid sparing agents such as cyclophosphamide and mycophenolate mofetil
- Individuals treated with or likely to be treated with systemic steroids for more than a month at a dose equivalent to prednisolone at 20mg or more per day for adults
- Anyone with a history of haematological malignancy, including leukaemia, lymphoma, and myeloma and those with systemic lupus erythematosus and rheumatoid arthritis, and psoriasis who may require long term immunosuppressive treatments

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Workforce

East Kent Hospitals University NHS Foundation Trust

Staff Vaccinations

There is a plan to achieve a 5% increase in the vaccination rate for frontline healthcare workers, through an enhanced peer vaccinator programme.

All frontline healthcare workers, including both clinical and non-clinical staff who have contact with patients, should be offered the flu vaccine from the start of October. This is a vital element of the organisation's strategy to prevent the transmission of flu. Employers should ensure the vaccine is easily accessible to all frontline staff, actively encourage vaccination uptake, and monitor the delivery of their vaccination programmes.

Seasonal illness

The adult flu vaccination programme for 2025–2026 will begin in early October (exact date to be confirmed), with the aim of completing most vaccinations by the end of November. This later start follows advice from the JCVI, which highlights that the effectiveness of the flu vaccine in adults can wane over time. Vaccinating closer to the period when flu typically circulates—usually peaking in December or January—will ensure better protection during the highest-risk months**. Staff Well Being programmes**

Staff Wellbeing support and training continues throughout winter, with Wellbeing Champions, Wellbeing Conversations, and Leading for Wellbeing training available on a monthly basis, with the exception of December. Additionally, thanks to new funding, Mental Health First Aid Training will be re-launched in October, to increase local expert peer support available to our colleagues.

The Wellbeing Advent Calendar returns for its fourth consecutive year from the 1st-25th of December to uplift staff morale during a challenging month, and to serve as a reminder of the multiple avenues of support available to staff through the Wellbeing Team.

Rotas

Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.

Staff Preparedness

Staff are provided with FFP3 fit testing where appropriate and procurement hold stocks of PPE in case of increased demand.

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Communications

East Kent Hospitals University NHS Foundation Trust

Objective of the Winter 25/26 communications plan; ensure the public is informed & prepared through; • **Prevention of seasonal illness** • **Reducing NHS pressure** • **Promotion of self-care and resilience** • **Wellbeing support for our staff**	
Key Messages	• Know where to go: using NHS services wisely and at the right time • Be Prepared: Stock up, stay warm, get vaccinated, healthy living • Support for NHS staff: signposting resources and wellbeing information for EKHUFT staff
Target Audiences	• General public • Vulnerable Groups; elderly, pregnant women, those with pre-existing conditions, young children. • Internal communication for NHS staff to keep morale high, provide support, update on changes • Local communities; provide information on NHS services available in area
Communication Channels	• Social media: Use Twitter, Facebook, Instagram to share dedicated EKHUFT winter campaign assets providing information on tips and advice, and signposting to EKHUFT website. • Staff social media: use staff specific social media channels to continue with wellbeing support and positive stories from Trust • Internal news channels: both to support internal flu vaccination campaign and wider winter messaging • Website: Update EKHUFT website with dedicated winter wellbeing pages for public • Public health: Work with national public health to support targeted public health campaigns when appropriate
Key Activities & Timeline	• Sep-Oct: vaccine programme launched, prep winter campaign assets • Oct – Nov : Launch winter social media campaign, dedicated public webpages • Dec–Feb: reactive comms management and continuing with proactive campaign/support • Mar: Evaluate & plan ahead
Reactive communications	• ED pressures: If NHS services face exceptional demand issue clear info on service availability and alternatives • Severe weather warnings; prepare for sudden winter-related weather issues with dedicated assets signposting to official guidance

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Improvement Weeks

East Kent Hospitals University NHS Foundation Trust

Improvement Week	Week commencing	Care Group	Theme
One	5th May	WHH	Processes in Hospital
	2nd June	QEQM	
Two	1st September	WHH	Alternatives to Hospital and Hospital Discharge
	15th September	QEQM	
Joint working	6th October	W&CYP & DCB	TBC
	27th October	CCASS & K&C	
Three	1st December	WHH	Going home for Christmas and comms to be developed
	8th December	QEQM	
Review in January 2026 to determine schedule for week 4			
Four	9th March	WHH	TBC
	23rd March	QEQM	

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Winter Planning 25/26

Board Assurance Statement (BAS)

NHS Trust

Introduction

1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the CEO and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please double-click on the template header and add the Trust's name.

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 25/26 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 25/26 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2025.**

Provider:	East Kent Hospitals University NHS Foundation Trust

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the Trust Winter Plan for 2025/26.	Yes	Trust Management Committee – 17th September Board of Directors – 29th September
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	Appendices included for EHIA and QIA
The Trust's plan was developed with appropriate input from and engagement with all system partners.	Yes	A draft plan was completed and stress tested at an NHS England-hosted exercise on 8th September
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	Board representatives attended the event on 8th September
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Yes	Dan Gibbs, Chief Operating Officer
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.	Yes	
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	Yes	Bed gap of a negative 109 beds following mitigations from efficiency and productivity (additional winter incentive funding is not available.
The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off and returned to NHS England in April 2025.	Yes	Dependent upon delivery of mitigations through opportunities highlighted. Risk 1891 on register.

Provider CEO name	Date	Provider Chair name	Date
Tracey Fletcher	29/09/2025	Dr Annette Doherty	29/09/2025

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1. There is a plan in place to achieve at least a 5-percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.	Yes	Confirmed in workforce slide 46.
Capacity		
2. The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.	YES Partially	Modelling is understood Plan shows a deficit of 109 beds at peak demand
3. Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.	Yes	As released
4. Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.	Yes	Agreed, dependent upon release of opportunities through improvements
5. Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes	Slide 26 for trajectories
Infection Prevention and Control (IPC)		
6. IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.	Yes	Slide 44 and 45
7. Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.	Yes	Workforce, slide 46, staff preparedness
8. A patient cohorting plan including risk-based escalation is in place and	Yes	Slide 44 and 45

	understood by site management teams, ready to be activated as needed.		
Leadership			
9.	On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Yes	
10.	Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Yes	Slides 27 to 37
Specific actions for Mental Health Trusts			
11.	A plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	N/A	
12.	Any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	N/A	

East Kent Hospitals University NHS Foundation Trust

BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)

Committee: **Nominations and Remuneration Committee (NRC)**

Meeting date: **22 September 2025**

Chair: **Dr Annette Doherty, Trust Chair**

Paper Author: **Board Support Secretary**

Quorate: **Yes**

Appendices:

None

Declarations of interest made:

The Chief Executive, Chief People Officer and Director of Corporate Governance declared interests in respect of the Very Senior Manager (VSM) reports presented to the Committee.

Assurances received at the Committee meeting:

Agenda item	Summary

NRC Decisions Outside Committee	• The Committee ratified the following decisions taken outside the NRC business cycle:
	  • Approved the salary range for the Director of Financial Sustainability role;
	  • Approved the salary range for the Deputy Chief Operating Officer (COO) role;
	  • Approved the appointment of Jo Hills as 2gether Support Solutions (2gether's) Chair for a period of three years;
	  • Approved for 2gether to conduct an executive search for two Non-Executive Directors (NEDs).

VSM Pay Framework	• The Committee received **Assurance** on the NHS VSM pay framework for all Integrated Care Boards (ICBs) and NHS Provider Trusts from 1 April 2025 (published in May 2025). • The Committee discussed the VSM pay framework and the applicable ranges pursuant to the Trust turnover . • The strengthened framework was welcomed and the alignment of future appointments within this framework and at the mandated pay band ranges. • The Committee approved to apply and implement the VSM pay framework, and approved to apply the 'D' pay band based on the annual turnover. • The Trust's VSM Pay Policy will be revised reflecting this VSM pay framework and presented to a future NRC meeting for approval.

VSM Pay Benchmarking	• The Committee received **Assurance** on VSM pay benchmarking analysis against the VSM pay framework bands and in comparison with other trusts. This also included benchmarking the number of VSMs against Kent & Medway provider trusts. • The Committee highlighted the proportionately higher VSMs in post in the Trust compared to other K&M provider trusts. A proposal on how these numbers will be reduced in the future will be monitored by the NRC The Committee re-emphasised the need to ensure VSM salaries, like all salaries, were comparable and equitable across similar roles in the Trust . The NRC will keep this under review.
2025/26 VSM Pay Uplift	• The Committee authorised the 3.25% nationally recommended VSM pay uplift that remained within their operational maximum range for their role after applying the uplift. For those VSM role-holders who were above the operational maximum range would receive the 3.25% VSM pay uplift as a non-consolidated discretionary increase payment. • However, the Committee made clear no pay increase, substantive or non-consolidated, should be paid to any VSM role-holder who was subject to any formal or informal performance or conduct investigation until the outcome of such a process was concluded to the Trust's satisfaction. • The Committee will be presented with a proposed process for applying pay uplifts for those appointed in-year and backdated uplift for consideration at a future NRC meeting.
Spencer Private Hospitals (SPH) Bonus Scheme	• The Committee received **Assurance** and approved to reinstate the SPH bonus scheme for 2025/26 against agreed terms and conditions.
SPH Managing Director	• The Committee noted the current gap and risk with only one Executive Director of SPH and on its Board. • The Committee approved the recommendation to formally appoint SPH's Managing Director as an Executive Director of SPH and to join SPH's Board.
Board Composition Review: Skills and Diversity	• The Committee received **Assurance** and noted the Composition of the Board and self-assessment by the Board of its skills, capabilities and diversity. It agreed the gaps in diversity needed to be prioritised. • The Committee agreed the action of a new non-statutory short-term Associate Developmental Board member role be prioritised to ensure the Board remained fully competent and representative. • The Committee noted the Trust will also explore the opportunity to host an Empowering People of Colour (EPOC) Fellow. • The Committee noted these additional roles will support increasing diversity and skills on the Board as well as succession planning.
Board Developmental Review	• The Committee received **Assurance** and noted the expression of interest submission jointly with Maidstone and Tunbridge Wells NHS Trust (MTW) for NHS England's (NHSE's) new Board Development Programme.

	• The Committee agreed to move forward with commissioning a Well-Led review for the Trust.
Board NED Term Renewals	• The Committee received **Assurance** and noted the proposal to seek Council of Governors' approval for the renewal of appointment of the NED, Dr Andrew Catto.
Fit and Proper Person Test (FPPT) Annual Audit Submission 2024/25	• The Committee received **Assurance** and noted submission by the Trust Chair within the timeline of the 2024/25 annual FPPT submission. • The Committee noted the 2025/26 appraisals will be aligned with the current framework.
Annual Review of 2gether Managing Director Objectives for 2025/26	• The Committee noted 2gether's Managing Director's 2025/26 objectives were being agreed with the new Chair of 2gether and these will be shared with the Committee at its next meeting.
Board Performance Annual Review 2024/25 and Objectives for 2025/26: Executives SPH Chief Executive	• The Committee noted and received **Assurance** from the 2024/25 performance review and the 2025/26 objectives for SPH's Chief Executive.
Annual Review Executive Directors Objectives for 2025/26	• The Committee noted and received **Assurance** from the appraisal summary for the Executive Team for 2025/26 objectives. • The Committee requested going forward objectives were set using Specific, Measurable, Achievable, Relevant, and Time-bound (SMART) criteria, enabling these to be effectively performance monitored. • NRC members agreed to provide any comments and feedback on the objectives direct to the Chief Executive.
Annual Review Chief Executive Objectives for 2025/26	• The Committee noted and received **Assurance** from 2025/26 Chief Executive's objectives. • The Committee requested going forward objectives were set using SMART criteria, enabling these to be effectively performance monitored. • NRC members agreed to provide any comments and feedback on the objectives direct to the Trust Chair.
Board Performance NEDs and Appraisal Timetable	• The Committee noted and received **Assurance** from the NED objectives and timetable for the NED appraisal process assessment for 2025/26. • The Committee requested going forward objectives were set using SMART criteria, enabling these to be effectively performance monitored. • NRC members agreed to provide any comments and feedback on the objectives direct to the Trust Chair.

Other items of business

- The Committee noted the 2025/26 Annual NRC Work Programme.

- The Committee noted the Board Register of Interests.

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

Item	Purpose	Date
The NRC asks the BoD to receive and **NOTE** this assurance report.	Assurance	To Board on 9 October 2025

East Kent Hospitals University NHS Foundation Trust

BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)

Committee: Quality and Safety Committee (Q&SC)

Meeting dates: 15 July 2025

Chair: Dr Andrew Catto, Non-Executive Director (NED)

Paper Author: Dr Andrew Catto, NED/Executive Assistant

Quorate: Yes

Appendices:
None

Declarations of interest made:
None

Assurances received at the Committee meeting - *focus on learning and improvement*:

Agenda item	Summary

CARE GROUP DEEP DIVE/PRESENTATION – KENT & CANTERBURY HOSPITAL (K&C) AND ROYAL VICTORIA HOSPITAL (RVH) CARE GROUP	The Committee received the report and **NOTED** the following key updates:
	• The Care Group has two significant risks on the significant risk register, both of which related Renal.
	  ○ **2796**: There was a risk of delay in dialysis treatment due to the high number of Renal Dialysis machines that were over 15 years old.
	  ○ **2853:** There was insufficient haemodialysis capacity to meet the demand to provide all dialysis patients with conventional three times a week dialysis.
	• **Missed/delayed capacity. Thematic review**: following three Datix incidents, a theme regarding the breakdown of communication for such patients was identified and discussed at the Incident Review Panel. The decision was made to undertake an 'end-to-end' Thematic Review to investigate the issues related to the use of various pathways which could have caused patients delays in their treatment, diagnosis, referrals and care.
	• **Abdominal aortic aneurysm (AAA) screening not meeting national standard of 65% in eight weeks** - after a AAA diagnosis, patients had to wait longer, and any future appointment maybe impacted by theatre capacity and clinician availability.
	• **Statutory/Mandatory training compliance** - overall compliance for statutory and mandatory training for K&C and RVH was above 85%. The Care Group, however, continued to be challenged in two areas of statutory and mandatory training, namely Safeguarding Adult Level 3 and Resuscitation training.
	• **Structure Judgement Review (SJR) Completion rates for Trauma and Orthopaedic (T&O**) - all specialties except T&O had been fully compliant with learning through SJRs in the past two years. Historic backlogs notwithstanding, the Care Group had the highest compliance rates compared to others.

	• **Good National Institute for Health and Care Excellence (NICE) compliance for the Care Group** - for K&C/RVH 95% of the relevant NICE guidelines had been implemented, 3% were in the process of being implemented and 2% required further resources to be implemented. • **Virtual wards occupancy** was in the lower half regionally, and further improvement was required. There was currently one virtual ward which had been operational for a few years, the second virtual ward was in Cardiology, and a third virtual ward was currently in its pilot phase. A business case was being developed, looking at the plan for virtual wards going forward, which would be going to a future Trust Management Committee (TMC) for review.
QUALITY GOVERNANCE REPORT (PATIENT EXPERIENCE, INQUESTS, CLAIMS, INCIDENTS AND CENTRAL ALERTING SYSTEM (CAS)).	The Committee received the report and **NOTED** the following key updates. • The number of overdue incidents decreased to 756. The number of incidents becoming overdue each day had also reduced from 22 to 19 per day. The Standard Operating Procedure (SOP) for incident management was being embedded within the care groups to standardise the process. Therefore, performance was now moving in the right direction. • There had been an error related to the Learning from Patient Safety Events (LFPSE), due to the mis-categorisation of incidents and this was now being addressed.
LEGAL SERVICES UPDATE	The Committee received and **NOTED** the following key updates. • The last six months have been extremely challenging for the Legal Team. • The Trust had now recruited permanently to the Head of Legal role and would take up the role permanently in September 2025.

PROFESSIONAL STANDARDS UPDATE	The Committee **NOTED** the following key updates.
	• Professional standards related to the timed expectations for various stages of a patient's journey.
	• The four key standards to be measured were:
	  ○ Initial review
	  ○ Referral
	  ○ Ability to get investigations
	  ○ Ability to get the results of investigations
	• The Information Team were currently working on data for the time of referral and time of patient review.

PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK POLICY AND PLAN	The Committee received and noted the Patient Safety Incident Response Framework Policy and Plan It was noted that the health inequalities and engagement section had been updated and strengthened.
NON-REFERRAL TO TREATMENT (RTT) UPDATE	The Committee **NOTED** the following key updates. • Most of the backlog were likely to be data quality errors. • It was estimated that around 10% of the patients on the backlog would require further intervention. • The non-RTT plan would continue to be monitored by Q&SC.

ORGAN DONATION ANNUAL REPORT	The Committee received the report and **NOTED** the following key updates: • The Trust was a level 1 organ donation centre. The Trust referred 43 potential organ donors during 2024/25. There were four occasions where potential organ donors where not referred. • When compared with UK performance, the Trust was average for referral of potential organ donors to the NHS Blood and Transplant Team. • A Specialist Nurse Organ Donation (SNOD) was present for 28 organ donation discussions with families during 2024/25. There were three instances where a SNOD was not present. • There were 22 consented donors which resulted in the Trust facilitating 13 solid organ donors and 24 patients receiving a life-saving transplant. (The other nine consented did not proceed). There were an additional 36 corneas donated. • There was a drive across the UK to improve tissue donation rates. • NHS Blood and Transplant (NHSBT) Sustainability and Certainty in Organ Retrieval (SCORE) project was moving towards a more sustainable system for the donation pathway. This would mean moving towards planned retrievals usually overnight. • The Team was working on raising the profile of Organ and Tissue Donation across the Trust, with both staff and public and reinvigorating the Organ and Tissue Donation Committee. The key challenge was maintaining engagement from stakeholders. • A memorial mural was being painted on the wall of Intensive Therapy Unit (ITU), in recognition of the relatives who had donated.
ALFENTANIL THEMATIC REVIEW REPORT	The Committee received and **NOTED** the report. The Chair noted this was very thorough and detailed.
ARMED FORCES COVENANT AND VETERAN AWARE WORKING GROUP TERMS OF REFERENCE	The Committee received and **NOTED** the report. The Chief Medical Officer (CMO) and the Chief People Officer (CPO) had discussed the actions required to make the Trust an anchor institution for armed forces.
MONTHLY SIGNIFICANT RISK REGISTER REPORT	The Committee received the report and **NOTED** the following key updates: • There were currently 21 quality risks, five of which had overdue actions. Three risks had been added since the last report and one risk was recommended for closure. • Risk 3367: Lack of timely review of diagnostic test results had an increased risk score.
CARE QUALITY COMMISSION (CQC) UPDATE REPORT	The Committee received and **NOTED** the report. The Improvement in medical statutory and mandatory training compliance was noted. The CQC well led development review was currently being scoped.

COST IMPROVEMENT SCHEME QUALITY IMPACT ASSESSMENTS (QIA)	The Committee received and **NOTED** the report. The QIA process has been developed over the last year, and now weekly QIA panels took place.
CLINICAL AUDIT ANNUAL REPORT UPDATE TO DEMONSTRATING LEARNING AND IMPROVING PATIENTS' OUTCOMES FROM CLINICAL AUDITS	The Committee received and **NOTED** the report. The Trust was not an outlier for any of the national audit reports, apart from the Epilepsy 12 audit, where a derogation had been previously approved. The CMO was now discussing the Trust's participation in the audit with the national audit lead.
SINGLE POINT OF ACCESS (SPoA) UPDATE	The Committee received and **NOTED** the report and the positive impact on ambulance arrivals.
PATIENT DOCUMENTATION AUDIT UPDATE	The Committee received and **NOTED** the report. Further work was planned to educate staff on the risks of possible 'cutting and pasting' records. This would be audited more regularly, to gauge the effectiveness of staff training. The Consent Policy had been rewritten and was in the process of being ratified.
VALPROATE: ORGANISATIONS TO PREPARE FOR NEW REGULATORY MEASURES FOR OVERSIGHT OF PRESCRIBING TO NEW PATIENTS AND EXISTING FEMALE PATIENTS	The Committee received and **NOTED** the report. The Committee agreed that it was safe to close the national valproate alert, however, it would be continuously audited, to assure that standards remained. The Kent and Medway (K&M) Integrated Care Board (ICB) quality representative agreed to provide an update on the system-wide response to the valproate alert.
MATERNITY & NEONATAL BOARD	The Committee received and **NOTED** the report. The Maternity and Newborn Safety Investigations (MNSI) pathway had been formally stepped down and the Trust continued to make progress. Funding had been removed for the Maternity and Neonatal Crisis Partnership, and additional work was being carried to assess the risk and endeavour to secure ongoing funding.
ANNUAL COMPLAINTS REPORT AND COMPLAINTS DEEP DIVE	The Committee received and **NOTED** the following key updates: • The team had been working to meet the NHS complaints standards issued by the Parliamentary and Health Service Ombudsman (PHSO).

	• The complaints team had been centralised, staff had moved from the care groups to the central complaints team, and a gap analysis had taken place to identify what further staff training was required. • The complaints process had been re-engineered. • There had been a 15.2% increase in the number of complaints received. A deep dive identified no specific areas for concerns, and the additional complaints were not linked to any specific areas. • The key themes had remained the same for the past five years. • The number of compliments had also increased.
INTEGRATED PERFORMANCE REVIEW (IPR)	The Committee received and **NOTED** the IPR.
PATIENT EXPERIENCE COMMITTEE ASSURANCE REPORT	The Committee received and **NOTED** the Patient Experience report.
OPERATIONAL QUALITY GOVERNANCE UPDATE (OQG) CHAIR'S REPORT	The Committee received and **NOTED** the Operational Quality Governance report.
SAFEGUARDING COMMITTEE ASSURANCE REPORT	The Committee received and **NOTED** the Safeguarding Committee report.

Referrals to other Board Committees:

The Q&SC Chair to raise virtual wards with the Chair of the Finance and Performance Committee (FPC)

Item	Purpose	Date
The Committee asks the BoD to discuss and **NOTE** this Q&SC Chair Assurance Report.	Assurance	9 October 2025

Dr Andrew Catto
Chair, Q&SC 29 September 2025

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BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)

Committee: **Finance and Performance Committee (FPC)**

Meeting date: **2 September 2025**

Chair: **Richard Oirschot, Non-Executive Director (NED)**

Quorate: **Yes**

Appendices: **None**

Declarations of interest made:

No declaration of interest was made outside the current Board Register of Interest.

Assurances received at the Committee meeting:

Agenda item	Summary
Significant Risk Register (SRR)	The Committee received and **NOTED** the updated SRR relevant to its remit. The Chair sought assurance that the risk around workforce reduction had been factored in the SRR. The Chief People Officer (CPO) and Chief Nursing and Midwifery Officer (CNMO) agreed to add workforce reduction to the SRR as a separate risk.
Review of FPC Board Assurance Framework (BAF) Risks	The Committee received and **NOTED** its BAF risks.
Month 4 Finance Report	The Committee received the Month 4 Finance Report and **NOTED** its content. The Committee heard that the Deficit Support Funding (DSF) may be withdrawn in Q3 and Q4, and the Chair requested an update on the risks for the Trust if the DSF is withdrawn. In addition, it was suggested to revisit the Financial Sustainability Plan (FSP) assumptions and compare them with the actual data now available as if the assumptions were no longer valid, this could have implications for current modelling and projections. A concern regarding the bank expenditure was raised and the Chief Finance Officer (CFO) shared that the Care Groups would be asked to present a clear and detailed understanding of what is required to achieve its planned activity target by the end of September 2025. The Chair sought assurance that the Care Groups had their Cost Improvement Programme (CIP) targets agreed with them and reiterated the importance of launching the 2026/27 CIP programme as soon as possible so that actions could be taken swiftly when required.

Cost Improvement Programme (CIP) Oversight and Assurance **Workforce Plan – update on progress against targets**	The Committee received and **NOTED** the CIP progress report. The Committee had a robust discussion around the Thanet Community Diagnostic Centre (CDC) underspend on planned investment as Thanet CDC was designed as revenue neutral undertaking because the Trust was meant to be funded for this. The Trust Chair sought assurance that clinical leadership was actively engaged with the CIP process. In addition, the Trust Chair emphasised the importance of engagement from both subsidiaries in supporting the delivery of CIP objectives. The Committee made a recommendation to assess what interim resources may be needed within Care Groups to support the CIP programme and ensure delivery. The CPO presented the workforce reduction update and highlighted that in August 2025, the number of contracted substantive staff had begun to decline for the first time. The Committee heard that the data was somewhat complex due to the staggered arrival of new doctors. The CPO highlighted the need for consistent and tight workforce controls across all areas of the organisation, adding a key priority is to understand what workforce numbers are actually needed, based on activity levels and service demand. The Committee revisited the issue of redundancy costs, and whether the previously estimated £5m remained accurate given the profile of staff leaving the Trust (e.g. longer service staff potentially increasing costs).
Update on medical agency staff reduction including challenges associated with this	The Committee received the update on medical agency staff reduction noting the following: – July 2025 showed a significant reduction in medical agency spend, aligning closely with the 40% reduction target. – Bank spend was £0.9m above the 10% reduction trajectory as of July 2025, a deterioration from the £0.6m variance in June 2025. Care Groups are increasingly replacing agency staff with bank staff to reduce costs. While this does save money, it is not as cost-effective as hiring substantive NHS staff at basic rates. – Establishment reviews are taking place to assess whether the current medical staffing levels are aligned to service demands ensuring the workforce is appropriately structure to deliver safe care and sustainable savings. The Committee sought assurance around the medical establishment review governance and agreed that that there was the need for a clear, consistent and fair method for conducting establishment reviews across all specialties. This process should be documented and repeated annually.

We Care Integrated Performance Report (IPR) (M4): National Constitutional Standards for Emergency Access, Referral to Treatment (RTT), Cancer and Diagnostics	The Committee received the July 2025 IPR operational metrics and noted that the majority of the IPR metrics were satisfactory. The Chair highlighted that the deterioration in the super stranded and no longer fit to reside position was of concern. The Committee heard that that the Emergency Care Intensive Support Team (ECIST) had been engaged to support EKHUF, particularly at William Harvey Hospital (WHH). The diagnostic visit from ECIST revealed no unexpected findings and a formal feedback session with the Executive team is scheduled. The Chief Operating Officer (COO) reminded the Committee that previous ECIST recommendations (from 2019–2020) were not implemented, highlighting the need for accountability and follow-through.
Business cases: over £1.75m Requiring Investment £2.5m for Self-Funding. Capital Business Cases Over £1m	The Committee received and **APPROVED** the Thanet CDC Business Case and the Reconfiguration of Acute Stroke Services Business Case.
Capital Investment Group (CIG) Assurance Report	The Committee received and **NOTED** Capital Investment Group (CIG) Assurance Report.
Update on solar panels and Pharmacy robot capital schemes	The Committee discussed the bid for additional capital funding for solar panels at Kent & Canterbury Hospital (K&C). The Committee was informed of ongoing challenges with the existing Pharmacy robot. A new business case regarding a replacement robot is being prepared by the Pharmacy team. Initial concerns about space limitations for a modern robot have been reassessed, and the updated proposal will be reviewed once cost estimates are available.
Procurement to Payment Policy	The Committee received the Procurement to Payment Policy and noted that it was updated following the introduction of the Procurement Act 2023, which replaces the Contract Regulations 2015. The revised policy incorporates internal audit recommendations, particularly around counter fraud and data protection impact assessments, and is part of broader efforts to enhance procurement processes and improve operational effectiveness. The Committee **APPROVED** the Procurement to Payment Policy.
System Partnership Working Update	The Committee received a verbal update on system partnership working and agreed to receive a formal report in November 2025 due to ongoing mapping and alignment work to understand how system partnership fits with existing structures.

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Feedback to Board of Directors	There was no specific feedback to Board of Directors.
Referrals to Other Board Committees	The Committee noted no referrals to Board Members.

Item	Purpose	Date
FPC asks the BoD to discuss and **NOTE** this FPC Chair Assurance Report.	Assurance	9 October 2025

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Reconfiguration of Stroke Services Full Business Case (FBC)**

Meeting date: **9 October 2025**

Board sponsor: **Ben Stevens, Chief Strategy and Partnerships Officer (CSPO)**

Paper author: **Michelle Fleming, Stroke Programme Manager**

Appendices:

None

Executive summary:

Action required:	**Approval**
Purpose of the Report:	Approval is sought to enable the reconfiguration of stroke services incorporating a new build, stand-alone unit at the William Harvey Hospital (WHH).
Summary of key issues:	Reconfiguration of stroke services will see a move from Kent & Canterbury Hospital (K&C) to a Hyper-acute Stroke Unit (HASU) / Acute Stroke Unit (ASU) stroke unit at the WHH aligning with the national and regional strategies for transforming stroke care. This will improve clinical pathways by rapid admission, imaging access, improved thrombolysis / thrombectomy workflow and increase in the stroke workforce. Currently, we are expecting a net bottom line impact to the Trust of around adverse £3.1M.
Key recommendations:	The Board of Directors is asked to **APPROVE** the reconfiguration of stroke services incorporating a new build, stand-alone unit at the WHH.

Implications:

Links to Strategic Theme:	This report aims to support: • Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Trust Risk Register:	Ref: 2761 / 1448

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Resource:	Y - Relocation of current staff groups to WHH – with protected travel costs.
Legal and regulatory:	Y - This business case forms part of the Kent & Medway stroke review. Meets legal requirements of a judicial review in February 2020 and subsequent Secretary of State for Health & Social Care confirmed support in November 2021 for the reconfiguration.
Subsidiary:	N

Assurance route:

Previously considered by:

- Business Case Scrutiny Group (BCSG) – 7th
- Capital Investment Group (CIG) – 12th
- Trust Management Committee (TMC) – 20th
- Finance and Performance Committee (FPC) – 2nd

Parallel governance process with Integrated Care Board (ICB):

- BCRG – 28th
- SSG – 8th

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BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)

Committee: **Finance and Performance Committee (FPC)**

Meeting date: **30 September 2025**

Chair: **Dr Annette Doherty, Trust Chair (standing in for Richard Oirschot, Non-Executive Director (NED))**

Quorate: **Yes**

Appendices: **None**

Declarations of interest made:

No declaration of interest was made outside the current Board Register of Interest.

Assurances received at the Committee meeting:

Agenda item	Summary
Significant Risk Register (SRR)	The Committee received and **NOTED** the updated SRR relevant to its remit. The Committee requested ongoing diligence and follow-up from the Executive on overdue or soon to be overdue actions and the need for timely updates. The Committee requested a standing item for tracking overdue actions and explanations as to the reasons they were overdue.
Review of FPC Board Assurance Framework (BAF) Risks	The Committee received and **NOTED** its BAF risks. The Committee agreed that the BAF risks assigned to it are still pertinent, they will benefit from further review following the work being done on producing the Trust Strategy.
Month 5 Finance Report	The Committee received the Month 5 Finance Report and **NOTED** its content. The Committee noted the Trust's Month 5 position remains on plan with a marginal surplus of £0.5m to plan Year to Date (YTD); however, there is a system-wide in-year deficit. This has implications for Deficit Support Funding (DSF): £23m of this is at risk for Q3 and Q4; no decision has been taken, however. Therefore, the Committee requested close monitoring and management of this as decisions are made. The Chair enquired of the Trust's Month 6 position and the Chief Finance Officer (CFO) indicated the figures were not yet available but an indicative position would be provided to the Board on 9 October.

	The CFO also highlighted that Month 7 is the month in which the Cost Improvement Programme (CIP) challenge significantly increases for the Trust and multiple interventions are being pursued to respond to this. The Committee made a request to the Executive team to identify more radical measures to ensure that Q3 and Q4 targets were delivered and present these at the October 2025 meeting. The Committee were also assured that work to launch implementation of the Financial Sustainability Plan (FSP) interventions was in train to mitigate risks to next year's financial plan delivery.
Cost Improvement Programme (CIP) Oversight and Assurance **Workforce Plan – update on progress against targets**	The Committee received and **NOTED** the CIP progress report. The Committee noted at the end of M5 the Trust remains on plan with savings delivery. YTD the Trust has delivered £16.54m against a plan of £16.51m. The Committee recognised this good progress. It also noted the ongoing and considerable risks associated with the delivery of the remainder of the savings plan for the second half of the financial year. The current risk adjusted cost improvement delivery forecast when considering the schemes in delivery and the remaining schemes in the pipeline is £49.1m. This is compared to an unadjusted cost improvement delivery forecast is £78.9m. The Trust is projecting to deliver the full £80m and mitigate the delivery risk through additional interventions which are currently not within the cost improvement programme. The Chief People Officer (CPO) presented the workforce reduction update and the additional controls across all areas of the organisation on pay; and the need for further, more stringent measures. The Committee endorsed a robust approach and consideration of all options to stem the increasing costs. The Committee agreed to hearing directly from Managing Directors (MDs) of its subsidiaries: 2gether Support Solutions Limited and Spencer Private Hospitals on their saving schemes at the next meeting.
We Care Integrated Performance Report (IPR) (M5): National Constitutional Standards for Emergency Access, Referral to Treatment (RTT), Cancer and Diagnostics	The Committee received and **NOTED** the August (M5) 2025 IPR. The Committee discussed the operational metrics and noted that August performance – particularly in Emergency Departments (EDs) – was challenging. The number of patients waiting in our EDs for over 12 hours in August has increased. This remains a significant challenge and key operational focus for the Trust and system partners at 23.3%. The Trust's RTT and diagnostics were impacted by staffing and infrastructure issues but outpatient Did Not Attend (DNA) rates were improving due to targeted interventions.

	The Chief Operating Officer (COO) agreed to share with the Committee the Emergency Care Intensive Support Team (ECIST) report and the support being received.
Managing Delayed Discharges	The Committee received **ASSURANCE** into the Trust's approach to increase productivity and efficiencies across the hospital sites for 2025/26 in managing delayed discharges. The Committee noted the proportion of patients experiencing a delay at EKHUFT is above the national average, with 22.6% of discharges having experienced a delayed discharge. For delayed patients, the average delayed days is slightly below the England average of 6.07 days, with EKHUFT performance being close the median provider (56th of 117 providers) The Committee noted there was a Focus on "No Longer Fit to Reside" (NCTR) patients, with 44% of delays due to internal process issues. The Committee invited executives to consider further opportunities for voluntary sector involvement and upstream discharge planning, including engagement with care home providers.
Winter Planning	The Committee received **ASSURANCE** on the Trust's Winter Planning. The Committee noted the Trust has developed a 'live' winter plan for 2025/26 in line with national requirements set out in the Urgent and Emergency Care (UEC) Plan in June 2025. This is based on a draft plan which stress tested at an NHS England-hosted exercise on 8 September. The Committee asked the COO about the potential financial impact if the Trust would need to open all escalation areas and the preliminary estimate was £1.5m. The Committee noted the Board had signed off the Board Assurance Statement (BAS) accompanying the Winter Plan and submitted it to NHS England (NHSE) as required by the deadline of 30 September. This will be included in the Board papers of 9 October.
Business Planning 2026/2027	The Committee **NOTED** the arrangements for the 2026/27 and medium-term national planning process. The Trust is working to deliver the requirements to the timescales with the Committee noting a truncated timeline to submission of final 2026/27 plans to NHSE in December 2025, 3-4 months earlier than in prior years, which means the planning window is effectively 10 weeks. The Committee asked to continue to receive reports recognising the role the Board must play in this process. The Committee also advised scenario planning in light of uncertainty on DSF.
National Oversight Framework (NOF)	The Committee **NOTED** the paper on the National Oversight Framework (NOF) Segmentation Process and the Trust's allocation in Segment 3.

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Segmentation Process	The Committee recognised the Trust is at the very bottom end of Segment 3 and work needs to continue in all areas to improve.
HM Treasury VAT – Contracted Out Services Guidance	The Committee **NOTED** the potential risk to the Trust of any mooted changes to the Contracted-Out Services Direction (COSD), included in Section 41 of the UK VAT ACT 1994. In particular, there is a risk that any change to the definition of "Healthcare Facility" applied to pre-existing contracts could impact the Trust's ability to continue to recover c.£8m of VAT, via the 2gether contract. The Committee noted that the risk and the indication that any changes are not expected to be backdated and will not come into effect this financial year. The Committee asked to be kept updated.
Business cases: over £1.75m Requiring Investment £2.5m for Self-Funding. Capital Business Cases Over £1m	The Committee received and **APPROVED** a business case in relation to Altera Sunrise (Electronic Patient Record (EPR)) relating to concurrent user amounting to a capital solution (£1.25m plus £100k per annum revenue).
Capital Investment Group (CIG) Assurance Report	The Committee received and **NOTED** Capital Investment Group (CIG) Assurance Report.
Feedback to Board of Directors	There was no specific feedback to Board of Directors.
Referrals to Other Board Committees	The Committee noted no referrals to Board Members.

Item	Purpose	Date
FPC asks the BoD to discuss and **NOTE** this FPC Chair Assurance Report.	Assurance	9 October 2025

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BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)

Committee: People & Culture Committee (P&CC)

Meeting date: 16 September 2025

Chair: Claudia Sykes, Non-Executive Director (NED)

Paper Author: Claudia Sykes, NED

Quorate: Yes

Appendices: None

Declarations of interest made: None

Assurances received at the Committee meeting: see below

Agenda item	Summary
Board Assurance Framework (BAF) risk: recruitment and retention	The Committee reviewed the report from the Chief People Officer (CPO). Key areas discussed were: Appraisals – completion had dropped to 74% at the end of August, which was concerning. The CPO noted that the lowest rate was in the corporate department which was affected by consultations currently. The Committee acknowledged this but also reflected that it was important to maintain appraisals and supervisions with staff as normal, especially as many staff would not be affected by consultations. Staff turnover was at 7.4%, the lowest for some years. This would now limit the Trust's ability to make cost savings though natural staff turnover. Medical job planning – this has been below the target rate of 90% for several years. The Chief Medical Officer (CMO) reported that the rate was 57% at the end of August and he expected it to be at 80% at the end of September as there were a lot just awaiting sign off from managers after annual leave. He reflected that this had taken a concerted effort to achieve, and it was still not embedded in the Trust culture. Continued efforts from the executive and senior leaders would be needed to change this and ensure job plans were completed on a timely basis.
BAF risk: culture and values **Staff voice**	The Committee heard from the Staff Congress Chair, Gillian Hart, and member Emma Bryan. They were extremely committed to the success of the Congress. They highlighted some initial concerns around engagement, and how to escalate actions. It was noted that some of the issues which had been raised at the Congress had also been raised through other forums, and action was being taken by the executive team on these. The CPO and Director of Corporate Governance (DCG) have been attending the Congress meetings, and there have also been meetings with the Chief Executive Officer (CEO).

	The CPO said he would meet more monthly with the Congress Chair to ensure they had a clear escalation route to the executive team, and action taken could also then be shared. The Congress Chair also commented that many staff did not have the time to read Trust News, or attend staff forums. The Committee Chair requested a paper at a future meeting to review the methods the Trust used to communicate with staff and how effective these were deemed to be, and ideas for improvement.
BAF risk: culture and values **Sexual safety**	The Committee reviewed the action plan for implementing the Sexual Safety charter. The aim was to train all Band 7+ staff (c 3000 staff) in sexual safety training, including the Board, and to give this much greater visibility at the Trust, with leadership and commitment from the executive team that action will be taken for behaviours which did not meet Trust standards and values.
BAF risk: organisational development and resilience **Workforce reductions**	The CPO gave a detailed update on the £43m workforce reductions included as part of the Trust's Cost Improvement Plans (CIP). As at August, there was a gap of £11m in the savings expected for workforce. Whilst progress was being made on agency costs, bank costs were significantly above plan. Lower staff turnover also reduced potential savings in substantive staffing. The Committee noted the concerns around the workforce programme, and discussed options to get back on track. The Trust was limited in offering any further redundancies as the actual redundancy costs would outweigh any salary savings made in the financial year. Further restrictions on recruitment would be looked at, but this might lead to ongoing use of higher cost bank and agency staff. Patient safety remained the key priority and services needed to remain safely staffed, especially approaching winter. There were opportunities from improved digital services, but this was not progressing quickly enough to give confidence over financial savings this year, and the Trust was still very analog. The CMO noted that 50% of the medical agency costs was at the Queen Elizabeth the Queen Mother Hospital (QEQM) care group and he would be looking at this. The Committee was NOT ASSURED around the workforce reduction targets.
BAF risk: organisational development and resilience **Staff Survey**	The Committee reviewed the action plan for the 2025/26 staff survey. The CPO commented that the workforce reductions and consultations would likely impact on the results of the survey, although this was an issue for all NHS bodies. The NEDs noted that the 2024/25 survey had shown considerable variation across teams, and asked if the 20 areas which had performed the worst in the survey were likely to show any improvement. The CPO commented that these areas had some long standing issues and this was likely to be two to three years to turn around the culture and fully tackle the issues driving the poor results.

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Other items of business: None

Actions taken by the Committee within its Terms of Reference: None

Items to come back to the Committee outside its routine business cycle: None

Items referred to the BoD or another Committee for approval, decision or action: None

Item	Purpose	Date
P&CC asks the BoD to discuss and **NOTE** this P&CC Chair Assurance Report.	Assurance	9 October 2025

East Kent Hospitals University NHS Foundation Trust

BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)

Committee: **Integrated Audit and Governance Committee (IAGC)**

Meeting date: **1 August 2025**

Chair: **Dr Olu Olasode, Non-Executive Director (NED)**

Paper Author: **Board Support Secretary**

Quorate: **Yes**

Appendices:

None

Declarations of interest made:

No additional declarations of interest were made

The Purpose of the Committee Terms of Reference (ToR) extracts:

The IAGC is the high-level committee with overarching responsibility for risk. The role of the IAGC is to scrutinise and review the Trust's systems of governance, risk management, and internal control. It reports to the Board of Directors (herein shown as the Board) on its work in support of the Annual Report, Quality Report, Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness of risk management arrangements, and the robustness of the self-assessment against CQC regulations.

Assurances received at the Committee meeting:

Internal Audit

Assurances received on the effectiveness of the Trust's internal audit function and counter-fraud arrangements:

Internal Audit – Progress Report	• The Committee received **Assurance** and noted the Internal Audit progress report.
	
	• Two final audit reports issued since last IAGC including the following:
	  • **Complaints Management** - Reasonable Assurance;
	  • **Cyber Assessment Framework and Data Security and Protection Toolkit (DSPT) Independent Assessment** - Low risk rated and High confidence in the Trust's self-assessment.
	
	• The Committee noted 13 **management actions** implemented, and five actions remained overdue but in progress, in respect of Legal Services, Discharge Planning, and Business Continuity. It was emphasised the need for continued focus in these areas.
	
	• The Committee recognised the benefits of Executive Director leads attending IAGC meetings to provide updates and assurance on the work to progress outstanding actions, as well as ensuring prompt closure of these.

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Counter Fraud

Assurances received on the adequacy of the Trust's arrangements for counter fraud and as required by NHS Counter Fraud Authority.

Local Counter Fraud Specialist (LCFS) RSM Risk Assurance Services LLP • **Progress Report**	• The Committee received **Assurance** and noted the LCFS Progress Report with updates on proactive and reactive counter fraud activities. It also noted a national reactive benchmarking report and procurement exercise analysis. • The Committee acknowledged delivery of staff awareness sessions, including cyber fraud awareness, bribery and identity document verification, along with two bespoke sessions to urology and vascular and bowel cancer clinicians. • Referrals continued indicating a positive and strong organisational engagement with counter fraud and awareness. • Successful prevention of a significantly costly mandate fraud attempt due to the prompt action by the Finance team. • The Committee raised concern about the outdated status of previously agreed management actions relating to declarations of interest, gifts, and hospitality. Recognition of new proactive exercise launched in 2025/26 to address ongoing compliance concerns, and the Trust's improved return rate. It was emphasised the need for timely sharing of data provision to LCFS to support testing. • The Committee raised concerns with risks of staff working whilst on sick leave and private practice during NHS hours, noting plans to scope a proactive exercise, an update to be presented to IAGC at its next meeting.

External Audit

Assurance received on the effectiveness of the external audit process and the work of external auditors.

External Audit Grant Thornton (GT): External Audit Progress Report and Sector Update	• The Committee received **Assurance** from the External Audit Progress Report and Sector Update. • 2024/25 audit process proceeded more smoothly than in previous years. A lessons learnt exercise to be undertaken with the Finance team, and outcomes from this will be reported to IAGC at its next meeting. • The Committee queried the timing of the audit plan presentation, and for this to be brought forward to the January 2026 IAGC meeting. It was noted due to other commitments planning will commence in January, and plan will be presented to the IAGC after this date once completed. Assurance received of ongoing engagement with the Trust's Finance leadership team and review of Board papers that will ensure early identification of any emerging risks, which will be escalated and raised at January IAGC meeting.

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	• Assurance received of sufficient resources within External Audit team to deliver the NHS audit work.

Financial Reporting

Assurances received on the integrity of the financial statements of the Trust and formal announcements relating to the Trust's financial performance.

Single Tender Waiver (STW) Report	• The Committee received **Assurance** from the STW Report for the 2024/25 Financial Year (FY). • Total number of approved STWs of 136 (value of £9.9m); A 53% (47) increase in number of STWs compared to FY 2023/24, although total value decreased by 19% (£2.3m); Retrospective STWs accounted for 26.5% (36) by volume and 21.8% (£2.2m) by value of total STWs requested and approved within FY 2024/25. It was emphasised the importance of process improvement, training, and Executive level involvement to address the high volume of retrospective and urgent STWs. 60 STWs rejected. • The Committee noted the ongoing review of the Trust's procurement process.
Losses and Special Payments Report	• The Committee received **Assurance** from the report covering the period from 1 April 2025 to 30 June 2025. • Total losses and special payments for this quarter totalled £80k (49 cases), compared to £49k (52 cases) in previous FY, representing a year-on-year increase of £31k. • Overseas visitor debt write-offs accounted for £59k (10 cases), rise from £28k (8 cases) in same period the previous year. • Staff debt write-offs decreased to £7k (9 cases), down from £15k (20 cases) previous year. • Accommodation debt rise to £5k (12 cases), compared to £422 (8 cases) previous year. The Committee agreed an action to check and confirm the reasons for the outstanding rent payments. • Other losses include loss of personal effects totalling £4.5k (8 cases), with dentures comprising the majority of this amount.
Financial Position, Financial Risk and Cost Improvement Programme (CIP) (Any Other Business)	• The Committee received **Assurance** from a verbal update report on the Trust's financial position, confirming as at Month 3, the organisation remained on plan, with deficit support funding for Q2 confirmed by the Integrated Care Board (ICB). • This was positive, emphasising the financial plan will become more challenging in the second half of the year. Trust's £80m CIP savings schemes, with £27m still requiring further development, particularly around workforce initiatives, and review of medical

	agency costs. FPC will continue to closely monitor the CIP, and savings that were recurrent, need for additional schemes to mitigate delivery risks. • Trust's appointment substantively to the role of Director of Financial Sustainability starting on 1 September. • A deep dive report will be presented to the next IAGC meeting, to monitor ensuring delivery of the Trust's annual financial plan, review of financial risk and mitigating actions, and progress to meet the CIP year-end target.

Governance

Assurances received on the effectiveness of the Trust's system of integrated governance, risk management, and internal control (clinical and non-clinical) across the whole of the organisation's activities that support the achievement of the Trust's objectives.

Governance Structure 2gether Support Solutions (2gether)	• The Committee received **Assurance** on the revised structure to strengthen governance around oversight and operational performance. This includes multiple engagement levels, bi-annual Board to Board meetings, and weekly operational huddles. • The Committee raised concern regarding financial oversight and risk escalation, and confirmation received financial performance monitored through the Trust's Finance and Performance Committee (FPC), including CIP monitoring. • The Committee requested an action to identify an effective and robust Executive and Non-Executive Director monitoring and reporting process of 2gether's risk and governance assurance and escalation as needed to IAGC and the BoD (outside the Board to Board meetings).
Well-Led Review	• The Committee received **Assurance** on the Trust exploring alternative options to conduct this review, noting best practice for this to be undertaken every three years, of which the Trust was significantly outside of this period. A proposal will be presented to the next IAGC meeting. • Good progress with internal developmental activities, including rollout of Care Quality Commission (CQC) self-assessments and 'check and challenge' sessions across Care Groups, leadership training delivered to triumvirates and service leads. These will support the organisation's preparation for future inspections and embed the principles of the new CQC Well-Led framework, that included eight quality statements assessed at Trust level.
Senior Manager's Training Compliance – Board Level Compliance	• The Committee received **Reassurance** of the overall training compliance progressing well, with some remaining areas of non-compliance. The Director of Corporate Governance will follow-up with individual Board members who are not up to date with their training.

	• The Committee sought clarification to be confirmed on the required training to be undertaken by NEDs and Executive Directors as Board members and those not relevant taking into consideration these roles as non-clinical.
Update Report on Declarations of Interest, Gifts and Hospitality	• The Committee received **Assurance** noting historically low compliance ranging between 20–30%, representing a significant counter fraud risk. • The Committee was assured following targeted campaign involving direct communications and support from HR and senior leaders, the Trust achievement of a marked improvement of 79% compliance as of 15 July 2025. • RSM commissioned to undertake a third-line assessment of the declarations process, review will include cross-referencing internal records with external data sources such as Companies House and the National Fraud Initiative to identify any undeclared interests. Findings of this review will be reported to IAGC at its Q3 meeting. • The Committee noted the importance of an electronic automated alerts system to support future compliance.

Risk Management and Internal Control

Assurances received on the adequacy of the Trust's internal controls (clinical and financial) and risk management systems, and all risk and control related disclosure statements (in particular the Annual Governance Statement, regular reports on the activities of the Executive Risk Assurance Group, self-certification statements to the Regulator, and Care Quality Commission declarations), together with any accompanying Head of Internal Audit statement, External Auditor opinion or other appropriate independent assurances.

Significant Risk Register (SRR) Report	• The Committee received **Assurance** and noted the SRR report and visibility of the key risks facing the organisation. • Legal services was now under the portfolio of the Director of Quality Governance (DQG). Efforts to stabilise this service was ongoing, noting the appointment to the substantive role of Head of Legal who will join the Trust in September. Completion of actions arising from the legal audit are a key priority. • Good progress in complaints handling, with consistent Key Performance Indicator (KPI) performance over past six months, with focus towards embedding learning from complaints. • The Committee discussed the growing importance of cyber fraud risk and a review of internal controls.

Board Assurance

Assurances received on the Trust's underlying assurance processes that underpin the achievement of corporate objectives, and compliance with relevant regulatory, legal and code of conduct requirements, any related reporting, and self-certifications.

2025 Board Risk Appetite Review and Board Assurance Framework (BAF)	• The Committee received **Reassurance** and noted the review and statement of the Trust's Risk Appetite. Proposed appetite levels: Low for Quality & Safety, Moderate for People and also Sustainability, and High for Patients and also Partnerships. It was felt there had been insufficient discussion at the 3 July BoD Strategic Session and a further discussion needed to revisit these appetite levels. • The Committee received **Assurance** and noted the July BAF.

Other Assurance Functions and Regulatory Compliance

Other significant assurance received, both internal and external to the Trust, that may affect governance of the organisation. These will include, but not be limited to, any review by Department of Health arms-length bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Resolution, NHS England/NHS Improvement etc.), and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies etc.), and arrangements by which staff within the Trust may raise confidentially concerns over financial control, reporting, clinical quality and patient safety and other matters.

2025/26 Priorities and Operational Planning Guidance – Board Assurance Submission	• The Committee received **Assurance** from the updated submission on 12 May to ICB.
	
	• The Committee acknowledged progress and Trust's improved position, from a majority 'not assured' to a majority 'assured' status following significant developments in operational, financial, and workforce planning. The Following two areas remained partially assured:
	  • Completion and Board review of the Quality and Equality Impact Assessment (QEIA);
	  • Full assurance on the deliverability of the operational, workforce, and financial plans;
	  • These partial assurance areas will be monitored throughout the year against delivery.

Relationships With Other Committees

Assurances from the Committee's review of Chair reports from the Quality and Safety Committee, Finance and Performance Committee and People and Culture Committee to consider findings of significant assurance and the implications on the Trust's governance.

Other items of business

The Committee noted the 2025/26 IAGC Annual Work Programme.

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

Item	Purpose	Date
The Committee asks the BoD to discuss and **NOTE** this assurance report from IAGC.	Assurance	To Board on 9 October 2025.