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 date: **23 September 2025**

Chair: **Dr Andrew Catto, Non-Executive Director (NED) and Chair, Q&SC**

Paper Author: **Executive Assistant | Dr Andrew Catto**

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 – QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL (QEQM)	The Committee received the report and **NOTED** the following key updates:
	• There were 455 incidents reported, and the top three reporting categories were:
	  ○ Tissue Viability - 151
	  ○ Delay/Failure – 55
	  ○ Patient Falls – 49
	• Of the 151 Tissue Viability incidents reported, only 24 were deemed to be hospital acquired, which was a decrease on previous months.
	• At the time of reporting, there were 145 Datix reports open for over six weeks, of which 23 could not be completed within this timeframe as subject to a Patient Safety Incident Investigation (PSII), After Action Review (AAR) or Safeguarding investigation.
	• There were 193 overdue incident actions for the Care Group, (and a further 22 for historical specialties that moved to the QEQM Care Group during the restructuring). The Governance Team were actively working with staff to close these, starting with the historical actions.
	• In August 2025, compliance with verbal, written and final Duty of Candor was 100%.
	• In August 2025, the top subject of complaints was Clinical Management, followed by Staff Attitude.
	• **Risk 3743 – Procurement of respiratory lung function equipment**. The Risk score for this risk was increased from 12 (moderate) to high (15) as the procurement process for the new kit had been delayed.

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QUALITY GOVERNANCE REPORT (PATIENT EXPERIENCE, INQUESTS, CLAIMS, INCIDENTS AND CENTRAL ALERTING SYSTEM (CAS)).	The Committee received the report and **NOTED** the following key updates: • Targeted work was taking place in relation to overdue incidents. • Around 30% of Clinical Guidelines were currently overdue, the governance was now being reviewed to make it more streamlined and consistent across the Care Groups. • The Trust received its highest recorded number of complaints in July, and neighboring Trusts had also experienced a similar increase. No key themes had been identified from the additional complaints. **Legal** • There had been positive meetings with the Coroner. • A new Head of Legal joined the Trust on 29 September 2025. • Witness and inquest training was being developed for staff. • The Prevention of Future Deaths Notice (PFD) responses were submitted on time. **Audit** • National Institute for Health and Care Excellence (NICE) Guidance compliance remained in a good position at 96%. • Stroke audit - the Trust was among the top nationally regarding Stroke Audit Compliance. • **Epilepsy 12 audit** - it was confirmed that the Trust would be taking part in the audit going forward, following a review of the data collection. • **InPhase** – discussion was ongoing with InPhase. • Patients being unhappy with care and treatment was the most common reason for a complaint, when these complaints identified areas of clinical concern, these were investigated.
NON REFERRAL TO TREATMENT (RTT) UPDATE	The Committee received and **NOTED** the following key updates: • An oversight group had been established and each of the Care Groups were working on oversight trajectories. • Some work could be carried out with an algorithmic approach which would require quality oversight.

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QUARTERLY MENTAL HEALTH UPDATE	The Committee **NOTED** the following key updates: • There had been a re-structure in the mental health team that allowed for an increase in senior specialist practitioners. • The learning disabilities and autism liaison workforce were under recruited compared to peers, therefore, we were looking to increase the team, to provide greater specialist advice across all the sites. • The restructuring had enabled a new lead nurse for mental health to be appointed. • The risk of staff being exposed to aggression and violence was being addressed, funding had been sought to enable training of 136 staff. Training was prioritised for senior nurses from the Emergency Department (ED) and security staff. • A longer-term arrangement for specialist de-escalation and physical intervention training was required. The numbers of staff requiring the different levels of training were requested to determine the approximate annual cost. • Supplementary training was being scoped and offered to clinical staff. For example, the Trust commissioned a 1hr external e-learning course, “We Can Talk” for staff to give them confidence in talking about mental health issues to patients. • Kent & Medway (K&M) Integrated Care Board (ICB) commissioned training for all health and social care providers up until end February 2026. Dates and venues were being shared with operational teams to promote uptake. • A plan was yet to be developed for the funding and provision of training from March 2026 onwards. This was being discussed at a meeting of K&M ICB Chief People Officers (it was acknowledged that this would be difficult to provide on an ongoing basis for all providers, therefore, a system-wide approach was being advocated). • Enhanced Therapeutic Observations and Care (ETOC) was an NHS England (NHSE) national programme of work. The current Enhanced Support policy was being reviewed to become the ETOC policy. This would align Trust processes with the national programme and Safer Nursing Care Standards. The ETOC policy also aimed to standardise the process across the Care Groups and give more detail around working with patients with risk/challenging behaviours. • Self-harm and suicide reduction. There had been several near-miss situations involving ligatures. Appropriate levels of investigation were being undertaken and learning shared as per usual governance and process.

CANCER BOARD UPDATE	The Committee **NOTED** the following key updates: • The Cancer Delivery Group meet on a quarterly basis. A review of the Terms of Reference was planned for the December meeting, to ensure alignment with current strategic priorities and operational delivery. • The Group provided a structured forum for Trust Executives, Multi-Disciplinary Team (MDT) Clinical Leads, Nursing Leads, and Operational Leads to oversee service developments, performance against national cancer standards, and improvement planning across all tumour sites and palliative care. It also acted as a conduit for strategic and operational updates, including commissioning intentions, peer review outcomes, and national data submissions. • Further improvement could be made by increasing clinical representation. It would be preferable to have all MDT leads or their deputies in attendance as it was a valuable forum to share key themes.
BABIES, CHILDREN AND YOUNG PEOPLE BOARD	The Committee **NOTED** the following key updates: • The Board had recently had its third meeting, and it had been well attended by members. • It was planned there would be a patient partner representative at a future meeting. • A NED children's champion had been requested.
ASSOCIATION FOR PERIOPERATIVE PRACTICE (AFPP) PROGRESS UPDATE	The Committee received the report and **NOTED** the following key updates: • Kent and Canterbury Hospital (K&C) theatres had now been accredited and William Harvey Hospital (WHH) was being reviewed on 25 September 2025 and QEQM were due to be reviewed in October 2025.
PATIENT SAFETY INCIDENT INVESTIGATION (PSII) REPORT	The Committee received and **NOTED** the report. • The Trust transitioned to the Patient Safety Incident Response Framework (PSIRF) in June 2024. Since then, 23 patient safety incidents had been reported and identified as requiring PSII, nine of which were under national requirements. They could be broken down into six never events, two deaths and one antenatal screening, and for the for the remaining 14 incidents, a local PSII had taken place. • The Patient Safety Partner Policy has been approved, so patient representatives will be attending meetings soon. • Feedback from the Care Groups was that investigations were much more detailed and focused. From the patient's perspective they would not likely experience any change.
MONTHLY SIGNIFICANT RISK REGISTER REPORT	The Committee received and **NOTED** the report. • There were currently 24 quality risks, seven of which had overdue actions, (an increase of three since the last report).

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CARE QUALITY COMMISSION (CQC) UPDATE REPORT	The Committee received the report and **NOTED** the following key updates: • The third round of CQC Self-Assessment Check and Challenge meetings started with Children and Young People (CYP) and showed an increase in the quality standards being fully met. • The CQC made a short-notice announced one-day visit to the Spencer Wing located at the QEQM on 21 January 2025.The inspection report was published on 19 August 2025. The Spencer Wing had received a 'Good' rating from the CQC in all five domains, with an overall rating of 'Good'. • There were now only 4% of actions remaining open from the 2023 inspections. Multiple actions were associated with medical compliance with statutory and mandatory training (urgent and emergency care and medical care) which was still not at Trust target. Leadership was being provided by the Chief Medical Officer (CMO), and performance was monitored via Performance Review Meetings (PRMs). • The remaining Must Do action was around pharmacy staffing and there was one outstanding Should Do in relation to Allied Health Professional (AHP) staffing levels.

HUMAN TISSUE AUTHORITY (HTA) ANNUAL REPORT	The Committee received the report and **NOTED** the following key updates:
	• The annual report provided assurance that the Trust's mortuary services were compliant with the HTA codes of practice, which covered consent, governance, premises and tissue disposal.
	• The Trust operated mortuary services at WHH, QEQM and K&C with post-mortems licensed to take place at WHH and QEQM.
	• The HTA carried out an unannounced inspection in January 2024, the results of which were positive, and an action plan was submitted and completed in May 2024.
	• Key achievements included:
	  ○ Improved mortuary storage capacity, although winter pressures remained a challenge and we procured off site capacity to provide additional support during the winter season.
	  ○ Proactive incident reporting via the HTA portal and enhanced training provided to nursing and mortuary staff.
	• Staffing challenges persisted, as there was a relatively small team across the three sites.
	• Standard Operating Procures (SOPs) and risk assessments were regularly reviewed and audits were conducted to ensure compliance.
	• Tissue donation activity was carried out in accordance with the HTA guidance and teaching opportunities were provided to our trainee pathologists.
	• Incidents, such as unauthorised access to the mortuary had reduced significantly and were effectively managed, with no breaches confirmed with our licensed premises. Lessons were learned from any incidents which have informed training and access protocols.
	• In line with the Fuller Report, access controls had been enabled.

CLINICAL AUDIT ANNUAL REPORT UPDATE TO DEMONSTRATING LEARNING AND IMPROVING PATIENTS' OUTCOMES FROM CLINICAL AUDITS	The Committee received the report and **NOTED** the following key updates: • The portfolio of audits was a mix of national and local projects and learning from incidents. • There was good 'buy in' from the Care Groups, and the programme was well led by the Medical Director at K&C and the Clinical Audit Programme lead. • 43 medical students supporting audit projects which was commended as fantastic resource to move forward with several projects.
ASSURANCE REPORT ON COMPLIANCE AND DEMONSTRATING IMPROVEMENT LEARNING FROM DEATHS PROCESS AND LEAD MEDICAL EXAMINER REPORT	The Committee received the report and **NOTED** the following key updates: • Some clinical teams were behind with their Structured Judgement Reviews (SJRs) and compliance with the Morbidity and Mortality (M&M) agreed terms of reference. • Two consistent recurring themes were identified by SJRs: delays in identifying the deteriorating patient and delays or escalation in a patient being put onto a palliative care pathway. • There had been an increase in influenza deaths.

	• We were working to understand the impact of our care on community deaths and understanding pathways of care from a system perspective. • Increased mortality for patients experiencing long ED stays was an emergent theme. However, it appeared that patients with higher acuity experienced shorter stays in the ED.
TRUST RADIATION COMMITTEE (TRAC) UPDATE	The Committee received the report and **NOTED** the following key updates: • The relaunched TRAC meeting was well attended. • The quality of discussion was good; however, work was ongoing to reduce the risk score.
MATERNITY AND NEONATAL ASSURANCE BOARD (MNAB)	The Committee received and **NOTED** the report. • The Trust was part of the national maternity enquiry, as one of the criteria was Trusts who had previously been subject to an enquiry. • The MNAB had family member and Governor representation. • The main issue for escalation was the concerns over cover, raised by our anaesthetists. • There had been a slight increase in the number of still births and was subject to review. • The Trust had received the results of our NHSE Insight visit and there were few recommendations.
MIDWIFERY WORKFORCE REVIEW	The Committee received and **NOTED** the following key updates: • There was adequate staff for the current birth rate. It was confirmed the birth rate plus considered the changing demographic and the Trust planned accordingly. • All newly qualified midwives (NQM) were in post across the acute sites. • Vacancy rate at WHH remained at 15.14 and a robust recruitment plan was in place. • Over recent weeks the maternity units and units across Kent had been very busy and a divert unfortunately occurred on one occasion.
SAFE STAFFING/ ESTABLISHMENT REVIEW	The Committee received and **NOTED** the following key updates: • The Trust was not in the top or bottom 10% nationally and we had shown improvement. • Both positive and negative themes were highlighted within the report. The responses would be led by each Care Group and would feed into the Trust-wide response.
ANNUAL CQC INPATIENT SURVEY REPORT	The Committee received and **NOTED** the report.

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INTEGRATED PERFORMANCE REVIEW (IPR)	The Committee received and **NOTED** the IPR.
PATIENT EXPERIENCE COMMITTEE ASSURANCE REPORT	The Committee received and **NOTED** the Patient Experience Committee report.
SAFEGUARDING COMMITTEE ASSURANCE REPORT	The Committee received and **NOTED** the Safeguarding Committee report.
MORTALITY STEERING & SURVEILLANCE GROUP (MSSG) CHAIR'S REPORT	The Committee received and **NOTED** the MSSG report.
REGULATORY COMPLIANCE GROUP CHAIR'S REPORT	The Committee received and **NOTED** the Regulatory Compliance Group report.

Referrals from other Board Committees: None

The Committee asks the BoD to discuss and **NOTE** this Q&SC Chair Assurance Report.	Assurance	4 December 2025

Dr Andrew Catto
Chair Q&SC
25 November 2025