East Kent Hospitals University NHS Foundation Trust

EKHUFT Board Chair's Report, January 2026

Winter is once again having a dramatic impact across the NHS as a whole and our Trust is no exception. NHS England's concerns over the virulence of flu this season were positively managed by the Trust's hugely successful flu vaccination drive: 54% of the Trust's workforce agreed to be vaccinated, which is credit to the approach of the Trust's Occupational Health team. It has undoubtedly helped keep our patients and colleagues safe.

The severe winter weather has nonetheless put significant pressure on all of our sites. On 12 January, the Queen Elizabeth the Queen Mother Hospital (QEQM) declared a critical incident following significant bed pressures and an increase in norovirus cases. Although this was de-escalated ten days later, our acute sites continue to experience huge pressures. The Trust remains at critical incident standby, given continued high activity and reduced bed availability.

January has also seen the Trust visited by our regulator, the Care Quality Commission (CQC), which the Board welcomes. Inspectors undertook an unannounced inspection of the Urgent and Emergency Care core service at QEQM Hospital in early January and returned to that site to inspect our medical pathway last week. The Board have been kept updated and will await their formal assessment and discuss their findings at a future meeting.

I want to recognise and thank all of our staff for their resilience and hard work in what are very demanding circumstances. I also recognise the experience of patients can be very challenging in times of such heightened activity. Thank you for your patience and understanding.

In this period, I have joined each of the Trust Board's sub-committees: this includes the monthly Finance & Performance Committee; the December Charitable Funds Committee; the January People & Culture Committee and Quality & Safety Committee. I have also chaired the Trust's Nomination and Remuneration Committees in this period. I am grateful to our Non-Executive Directors (NEDs) for the rigour and thoroughness of their management of those committees. These committees play a fundamental part in supporting the Board with its assurance and decision making outside of our Board discussions. You will see from the Chair's reports in the Board Pack how much is being covered in our Committees.

There also continues to be the vitally important Kent & Medway and National NHS meetings. I participated in the Kent & Medway System Chairs meeting in December 2025; and the Kent & Medway Joint Committee away day on 13 January. You will hear more about this in the meeting but it is a formal meeting of Chairs and Chief Executive Officers (CEOs) across our System. These continue to be productive meetings to break through any shared challenges and make decisions promptly and collectively.

The NEDs and I also had the first of our now regular informal NED-Governor catch-ups. These are informal meetings in-between Council of Governor Meetings. I put these in place to have more regular contact with our Governors and learn from what they are hearing from our Members and for the NEDs to share the work of their Committees. By the date of this Board meeting we will also have had our formal Council of Governor meeting, taking place on 3 February. It will be another energised and constructive meeting and I am grateful to Bernie as

Lead Governor and others who have worked on creating a new approach to those meetings which allow for more discussion and sharing of views.

I mentioned in my last report that I welcomed Baroness Amos, the Maternity Inquiry Chair, and her Team to the Trust on 11 November. I was subsequently invited to be interviewed by her Team as Trust Chair. It was a very wide-ranging and considered interview. It was clear to me that the Inquiry is a learning exercise for everyone and I, on behalf of the Trust, made our cooperation and unconditional support very clear.

I also want to celebrate our East Kent Stroke Services, which topped the national stroke audit in January, reflecting the outstanding work of our stroke teams. A huge congratulations.

Finally, January has been marked by extraordinary operational pressure combined with sustained regulatory and governance activity. My thanks go to every colleague supporting safe and effective services.

Chair
Dr Annette Doherty

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

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

Meeting date: **5 February 2026**

Board sponsor: **Des Holden, Acting Chief Executive**

Paper Author: **Des Holden, Acting Chief Executive**

Appendices:

N/A

Executive summary:

Action required:	**Discussion**
Purpose of the Report:	The Acting 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 Acting 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

We care

East Kent Hospitals University NHS Foundation Trust

CHIEF EXECUTIVE'S REPORT

1. PURPOSE OF THE REPORT

The Acting 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. INTERNAL UPDATE

2.1 Performance update

Our Emergency Department (ED) performance deteriorated in December with 73.0% of patients across all ED types being admitted, transferred, or discharged within the four-hour standard. Our EDs remain challenged, with the proportion of attendees staying longer than 12 hours deteriorating from 18.5% in November to 20.23% in December, driven in part by winter pressures alongside earlier than usual norovirus at the Queen Elizabeth the Queen Mother Hospital (QEQM).

The Trust's 'Home for Christmas' plan was successful in improving occupancy, however the aforementioned pressures contributed to significant delays in our EDs and a declaration of an internal critical incident at the QEQM on 12 January, which lasted for seven days. Our teams responded well, and that site subsequently de-escalated to Operational Pressures Escalation Levels (OPEL 3). Numbers of patients no longer meeting criteria to reside in our hospitals remain high and we are working with partners to improve this.

By the end of December 2025, despite improvements in productivity, the Trust was behind trajectory for our elective referral to treatment (RTT) and long waiters pathways: 51.8% of patients waiting for treatment on our Elective RTT Pathways have a wait time of under 18 weeks, with 2.6% waiting over one year for treatment. Work is ongoing to recover the position through Q4. The Trust's DM01 (diagnostic six week wait) position has also deteriorated. Recovery plans are in place to improve the position in the main challenged areas by June 2026.

2.2 Finance update

As at month 9 (December) the Group's Financial position is £9.0m adverse to plan with an actual of -£67.4m pre-deficit support funding. Deficit Support Funding (DSF) has currently been withdrawn for the Kent and Medway system for quarters three and four, which has an additional impact of £23.0m; £11.5m to Month 9.

Our year-to-date financial performance has been adversely impacted by under-delivery against our cost improvement plan. This efficiency target includes a significant stepped increase in the second half of the year and work is ongoing to reduce pay and non-pay expenditure and to maximise delivery of these planned savings.

Detailed finance information is available in the finance report.

3. EXTERNAL UPDATE

3.1 Care Quality Commission (CQC) Inspection update – Urgent and Emergency Care (UEC) and Medicines pathway

The CQC completed an unannounced inspection of the UEC core service at QEQM on 6 – 7 January 2026. Verbal feedback from their visit was provided each day with immediate actions implemented to strengthen the oversight of quality and safety.

A letter was received on 9 January 2026 with some immediate CQC concerns and was responded to ahead of the deadline with an action plan shared detailing the steps that have been taken to address areas of concern that had been outlined.

Sarah Hayes, the Trust's Chief Nursing and Midwifery Officer (CNMO), continues to meet with lead inspectors supporting ongoing dialogue, while interviews with the QEQM Care Group Triumvirate, safeguarding leads, and the Patient Safety Specialist took place between 23 – 26 January 2026.

The CQC undertook a further unannounced inspection of the specialties within the medicine pathway at the QEQM on 27 and 28 January, reviewing all aspects of the pathway. We received some positive feedback but we will wait the outcome letter. We have an extensive Information Request to complete by 13 February.

The CQC undertook a further unannounced inspection of ED at William Harvey Hospital (WHH) on 2 and 3 February. We received some positive feedback and will wait for the outcome letter and the Information Request.

We will ensure continued Board updates.

3.2 National Investigation into Maternity and Neonatal Services

Following site visits by Baroness Valerie Amos and the National Maternity Investigation Team in November 2025, it has been confirmed that repeat visits to both the William Harvey and QEQM hospitals will be arranged and staff focus groups reconvened.

We await further information on the scope and timing of this work and will provide an update to the Board once further information and details are available.

4. OTHER AREAS TO NOTE

4.1 Norovirus outbreak

Norovirus continues to dominate winter infection prevention and control challenges, with the QEQM declaring and managing a hospital wide outbreak from early January 2026, which has now significantly improved, and with a number of wards also impacted at the WHH.

Across East Kent, there has also been an increase in community cases of norovirus, with both schools and care homes impacted.

At the QEQM a total of 77 patients tested positive for Norovirus between 1 December 2025 and 21 January 2026. It is important to note that in this time patients were not moved between wards (unless under Infection Prevention and Control (IPC) guidance to single rooms) and therefore the outbreaks across the wards were not related, but constituted individual bays and ward exposures.

During December the Trust managed to contain the norovirus cases in single rooms or bays, however by early January cases increased significantly, and by 14 January 2026 at QEQM there were 23 Bays with either positive or exposed patients across the hospital – and within those bays 35 empty beds.

The QEQM has only 43 single rooms this winter season, and norovirus is an extremely infectious virus, with millions of virions in minute aerosolised droplets of vomitus. It is estimated that 70% of people exposed to vomitus of an infected patient will become symptomatic. The QEQM site management team opened escalation areas to admit patients not previously exposed to norovirus, allowing the outbreaks to be managed until a time that case numbers dropped, unfortunately, due to the ongoing community spread of norovirus, patients started presenting with symptoms within these escalation areas in early January.

In this season it is noted that the Trust's case numbers are reflective of a national five year high peak in week two of 2026, and both EKHUFT and Maidstone and Tunbridge Wells NHS Trust (MTW) have seen significant outbreaks that have resulted in ward closures.

Whilst it is not possible to compare the number of affected patients to 2024/25 due to a change in testing protocols - the number of wards impacted in this current season remains the same, but the cases in this season have spread over a significantly longer timeframe (Mid December to late January) which has caused significantly more challenges to the flow of patients through the Trust.

At the time of writing (28 January 2026) there are currently seven individual bays on four wards affected at the WHH and one individual bay at the QEQM hospital, with a further four suspected cases awaiting test results.

4.2 Robotic Assisted Surgery Business Case

The Trust has been successful in securing £4.7m of capital funding for two additional surgical robots taking the total across the Trust to five. This investment will enable the Trust to expand minimally invasive surgical capacity across multiple specialities, supporting safer, more efficient and high-quality surgical care that improves the experience of our patients.

As the robotic service matures, productivity will increase by reducing post-operative complications, reducing length of stay, reduced re-admission rates and in some cases, reduced operating time.

In addition to purchasing two robots, over the coming months enabling works will be taking place in theatres to upgrade the power systems to finalise installation, with completion expected in April 2026.

4.3 Flu and Vaccination campaign update

The Trust's annual flu vaccination campaign launched on Wednesday 1 October 2025, with staff continuing to be offered vaccinations through the Occupational Health Department until 31 March 2026.

I am pleased to share that we have exceeded last year's figures and passed the target set by the Integrated Care Board (ICB) of vaccinating 44% of front-line staff through the six-month flu season, with to date more than 54% (6,416) of the Trust's workforce now vaccinated, helping to keep our patients and colleagues safe from the seasonal flu.

4.4 NHS Excellence Awards

The new NHS Excellence Awards are now open; marking the first year of a national programme designed to recognise, celebrate and share innovative work across health and care services.

The awards provide a regional and national platform to highlight projects and teams that are already, contributing to the ambitions of the 10 Year Health Plan, sharing the best of the NHS with the rest of the NHS.

There are ten award categories, each focusing on transformational and impactful local innovation, with regional judging panels selecting regional champions, who will progress to national judging in advance of an awards ceremony on 10 June 2026 at the NHS ConfedExpo.

These awards provide an important opportunity to showcase our services/ people and to promote shared learning across the NHS; I would like to encourage and support teams across the Trust to consider submitting an entry for their team, another team or their colleagues.

4.5 Stroke services

The Trust's stroke service has been rated the top service nationally, achieving the only Grade A in the latest Sentinel Stroke National Audit Programme (SSNAP) audit (July–September 2025). This reflects outstanding performance across the stroke pathway, supported by major innovation, including AI-enabled CT decision-support, the UK's first 24/7 pre-hospital video triage, and round-the-clock access to advanced imaging.

Stroke mortality rates within the Trust are statistically lower, with strong seven-day multidisciplinary care and a bridging rehabilitation service supporting early discharge and seamless transition into community services.

Long-term plans remain in place to expand and relocate the service to the WHH.

4.6 New Satellite Maternal Medicine Clinic

I am please to share that a new monthly maternal medicine satellite clinic has been launched at the Kent and Canterbury Hospital, improving access for women with medically complex pregnancies who previously had to travel to Medway.

The first patients have already benefitted from personalised care plans, and the clinic reflects significant work by the Trust's maternal medicine lead obstetricians, Dr Rishu Goel and Dr Aylur Rajasri, to ensure more equitable specialist provision across east Kent**.**

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

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

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

Meeting date: **5 February 2026**

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

Paper Author: **Ben Stevens, Chief Strategy & Partnerships Officer**

Appendices:

APPENDIX 1: December 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 Integrated Performance Report 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 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 (December Reported Month): **Patients** • The 62-Day performance remains below target at 70.2% (year-end target - 75%). Recovering the Breast screening

capacity issues, and continuing recovery from the early-pathway challenges within Dermatology, will be critical to improving overall 62-Day performance.

- The end of December position was that there were 46 patients waiting greater than 65 weeks including 3 x 78 week waits. No patients were waiting over two years.
- Overall four-hour compliance has decreased and performance across all types of department at 73% and Type 1 departments also decreased at 51.6%.
- The number of patients waiting in our emergency departments (EDs) for over 12 hours in December has increased to 1,276.
- Diagnostics performance has deteriorated from 71.9% in November to 64.8% in December.

Quality & Safety

- There was one never event reported in December.
- The Trust at the end of December had:
  - Two nationally reportable Patient Safety Incident Investigations (PSII)s ongoing & Two never events
  - 12 Local PSIIs
  - Two externally led investigations requiring Trust support
- The number of overdue incidents increased to 950 at the end of December.
- There were 50 occurrences of mixed sex accommodation breaches in December.
- Blood stream infections in December 2025 are lower than previous months for all reportable organisms, but C-dif cases have increased – in part due to norovirus outbreaks and increased stool testing.
- Norovirus outbreaks impacted wards predominantly in Queen Elizabeth the Queen Mother Hospital (QEQM) in December, but both William Harvey Hospital (WHH) and Kent & Canterbury Hospital (K&C) saw single ward outbreaks in December. In WHH and K&C these were locally managed and resolved. In QEQM the outbreaks increased and continued through January – but with no evidence of cross ward transmission. Local communities were also seeing high rates of norovirus circulating.

People

- Sickness absence has risen to 5.67% (from 5.13%), reflecting the intense seasonal pressures linked to high levels of respiratory illness and norovirus, which have contributed to the critical incident declared in January.
- Appraisal compliance remains static at 75.6%, increasing by only 0.1% this month and remaining around 5% below target.
- Statutory training compliance remains stable at 93.9%, with 72,964 courses completed over the last 12 months and 4,754 currently outstanding.

	Finance • The month 9 Year to Date (YTD) position achieved by the Group (Pre deficit support funding) was a £67.4m deficit; £9.0m adverse to plan. • As at month 9, the Trust is £9.0m adverse to plan (Pre-deficit support funding). • The Trust's income from patient care is £11.4m higher than plan YTD. **Maternity** • The extended perinatal rate remains below the threshold of 5.44 per 1,000 births, with the 12-month perinatal rate performance at 4.39 in December 2025. This rate includes both stillbirths and neonatal deaths. • In December, the neonatal death 12 month remained below the MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK target of 1.84 for the 8th time in the 12 month rolling reporting period, at 1.02. The service reported 0 neonatal death >24 weeks in month, and a total of 6 in the past 12 months. • 11 moderate /severe patient safety incidents were reported in December.
Summary recommendations:	The Board of Directors is asked to **CONSIDER** and **DISCUSS** the metrics reported in the Integrated Performance Report

Implications:

Links to Strategic Theme:	• 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

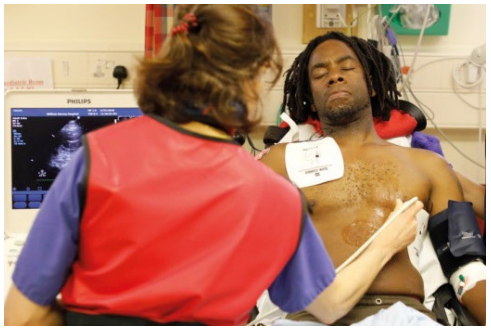
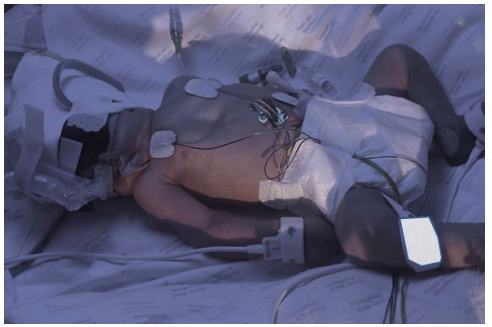
Integrated Performance Report

DECEMBER 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.

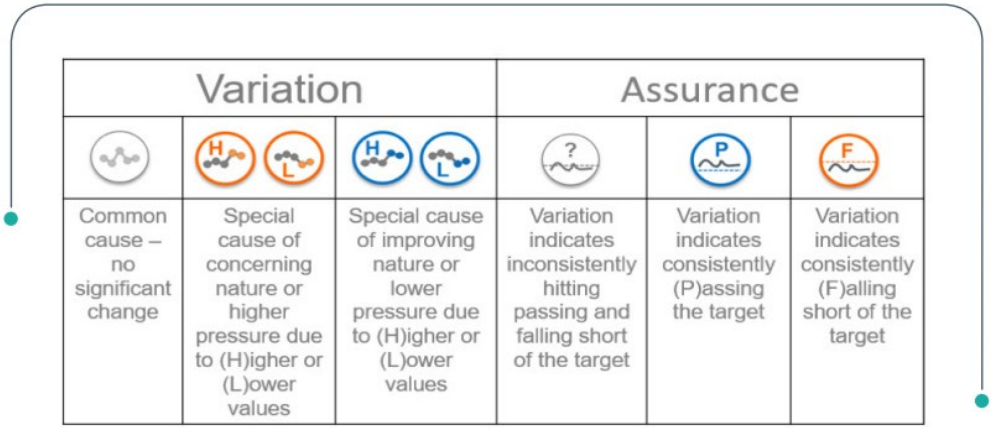
The main aims of using statistical process control charts is to understand what is different and what is normal, to be able to determine where work needs to be concentrated to make a change. The charts also allow us to monitor whether metrics are improving.

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 Rapid Access Perf Outpatient DNA Rate RTT Total Incomplete Pathways	Ambulance Handovers within 30m RTT 52w Breaches RTT 52w Performance Theatre Uncapped Utilisation
No Significant Change		% Beds Occupied 14+ Cancer 31d Combined Performance Cancer 62d Combined Performance Cancer Over 62d on PTL RTT 104w Breaches RTT 78w Breaches Theatre Session Opp. Type 1 Compliance 4hrs	12 Hr Total Time in Department 12Hr Trolley Waits Cancer 28d Combined Performance Cancer Over 104d on PTL Not Fit to Reside (pats/day) RTT 1st OPA Performance RTT 65w Breaches Super Stranded >21D
H / L — Concerning Variation (High or Low)		DM01 Compliance ED Compliance	RTT Incomplete Performance

Patients

Scorecard View

Urgent & Emergency Care Metrics & Cancer Waiting Times

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Patients	NAT		ED Compliance			73.0%	73.4%	73.2%	74.6%	76.2%	76.6%	76.4%	76.5%	74.2%	75.2%	74.3%	77.2%	73.0%
	IIP		Type 1 Compliance 4hrs			57.0%	51.0%	50.1%	51.4%	54.2%	54.6%	54.0%	55.2%	48.8%	52.2%	51.6%	57.9%	51.6%
	IIP		12 Hr Total Time in Department			16.8%	21.3%	20.7%	20.8%	21.7%	20.2%	20.6%	20.4%	23.3%	21.0%	21.2%	18.5%	20.2%
	NAT		12Hr Trolley Waits			0	1,385	1,177	1,327	1,256	1,210	1,150	1,195	1,311	1,172	1,238	1,105	1,276
	NAT		Ambulance Handovers within 30m			95.0%	88.2%	87.7%	90.5%	92.7%	93.9%	94.7%	94.9%	93.7%	93.1%	92.3%	94.7%	94.0%
	IIP		% Beds Occupied 14+			30.0%	33.9%	34.9%	35.4%	34.1%	33.2%	29.4%	30.8%	31.2%	31.4%	32.7%	33.6%	29.6%
	KEY		Super Stranded >21D			107	224	239	236	232	219	191	203	209	216	219	238	198
	NAT		Not Fit to Reside (pats/day)			100.0	165.7	171.0	172.9	173.0	161.8	154.5	173.7	160.5	165.9	174.1	187.5	168.6
	IIP		Cancer 28d Combined Performance			80.0%	66.5%	78.5%	76.4%	75.0%	74.9%	76.8%	76.9%	74.8%	71.6%	71.2%	75.1%	71.7%
	NAT		Cancer 31d Combined Performance			96.0%	92.9%	96.2%	97.2%	96.8%	95.7%	95.7%	97.5%	96.7%	97.6%	97.3%	96.1%	97.1%
	IIP		Cancer 62d Combined Performance			80.0%	69.1%	70.8%	77.3%	76.4%	75.6%	72.4%	78.7%	77.3%	69.0%	73.0%	67.6%	70.7%
	IIP		Cancer Over 62d on PTL			200	197	183	167	192	222	170	150	166	185	202	182	197
	KEY		Cancer Over 104d on PTL			0	40	44	46	34	42	38	40	33	29	35	42	43
	KEY		Cancer Rapid Access Perf			93.0%	96.7%	97.7%	94.0%	96.1%	96.5%	92.7%	79.1%	74.6%	67.4%	72.4%	76.7%	95.3%

Patients

Scorecard View

Referral to Treatment Waiting Times, Diagnostics & Productivity Measures

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
	NAT		RTT Incomplete Performance			57.5%	52.5%	52.8%	53.3%	54.0%	54.7%	55.0%	54.9%	54.7%	54.3%	53.9%	53.6%	51.8%
	NAT		RTT 1st OPA Performance			64.1%	58.3%	58.8%	60.4%	61.9%	63.0%	63.5%	64.0%	63.6%	63.0%	62.5%	62.0%	59.7%
	NAT		RTT 52w Performance			1.3%	3.5%	3.2%	2.8%	3.2%	3.0%	2.8%	2.6%	2.9%	3.1%	3.0%	2.7%	2.6%
	NAT		RTT Total Incomplete Pathways			78.7K	81.2K	81.3K	81.0K	83.1K	82.1K	80.7K	80.0K	80.1K	78.9K	78.4K	76.9K	76.0K
	NAT		RTT 52w Breaches			1,035	2,861	2,621	2,272	2,648	2,466	2,221	2,087	2,320	2,435	2,327	2,078	1,977
	IIP		RTT 65w Breaches			0	164	148	33	45	69	67	59	94	127	112	87	46
	IIP		RTT 78w Breaches			0	4	17	6	12	17	8	13	24	29	8	7	3
	IIP		RTT 104w Breaches			0	0	9	1	3	3	4	5	10	10	3	1	0
	IIP		Endoscopy Backlog				247	258	206	255	268	314	258	247	257	250	374	618
	IIP		DM01 Compliance			78.0%	83.9%	86.2%	87.0%	82.8%	83.2%	81.5%	79.3%	73.5%	76.0%	71.2%	71.9%	64.8%
	KEY		Theatre Session Opp.			25	36	39	29	31	26	25	30	36	34	39	31	46
	NAT		Outpatient DNA Rate			7.0%	6.6%	6.4%	6.5%	6.6%	6.5%	6.2%	6.0%	5.6%	5.8%	5.6%	5.4%	6.2%
	NAT		Theatre Uncapped Utilisation			85.0%	77.5%	76.6%	78.0%	80.3%	80.1%	80.2%	80.2%	79.0%	81.6%	80.2%	81.7%	79.7%

Patients

Executive Summary

Urgent and Emergency Care & Planned Care

Urgent and Emergency Care

- Overall four-hour compliance has decreased and performance across all types of department at 73% and Type 1 departments also decreased at 51.6%. 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.
- The number of patients waiting in our emergency departments for over 12 hours in December has increased to 1,276. This remains a significant challenge and key operational focus for the Trust and system partners at 20.2% to a trajectory of 16.8%. 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 improved to 94% 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 decreased in December following a successful 'home for Xmas campaign'. Patients recorded as having No Criteria to Reside (NCTR) and remaining in hospital at midnight was an average occupancy of 168 patients for December. Delayed discharges continues to contribute to the increased LOS observed and challenges in flow through the three main sites.

Planned Care

- Performance has deteriorated to 51.8% from a peak of 55% at the end of Quarter 1 of patients waiting less than 18 weeks for treatment. This is against a target of 60% by March 2026. This is linked to reduced activity against plan.
- At the end of December, the Trust saw a further reduction in the number of patients waiting greater than 52 weeks for treatment, falling from 2,078 in November to 1,977 in December. This represents 2.6% of the PTL with a target of no greater than 1.3% in December. There was also an improvement in the number of patients waiting greater than 65 weeks from 87 in November to 46 at the end of December. NHSE had set a target to reduce this to zero by the 21st December. EKHUFT achieved 58. Currently, the Trust is working to reduce the number of 65 week breaches to no greater than 38 by the end of January with further risks identified for 10 patients. The aim is to reduce this to zero by the end of February. Cardiology remains the bigesst risk to achieving this due to delays in securing Locum consultants as well as insufficient capacity for Cardiac CT.
- The Trust have been invited to participate in a Q4 'First Outpatient Sprint' where activity above plan will be paid at National Tariff rates. This is presenting a challenge due to a reduction in outpatient clinic capacity due to vacancies and controls for consultant extra contractual payments that had previously been used to meet core activity requirements. The Trust has also joined Cohort 2 of the GIRFT 'Further Faster' Programme focusing on follow up pathways with support provided to reduce unnecessary follow up appointments in Cardiology, Dermatology, General Surgery, Colorectal, Ophthalmology and Oral and Maxillofacial Surgery. Launch meetings are taking pace from January.
- The Trust has been allocated £500k from the bid to generate capacity to ensure 52 week wait targets are met at the end of Q4. A plan is being enacted to utilise the Independent Sector subject to capacity.
- Diagnostics performance has deteriorated from 71.9% in November to 64.8% in December. CT and Non-Obstetric Ultrasound are key areas of concern. There have been challenges related to booking processes that have been exacerbated by vacancies and increased sickness within the team. Additionally, a focus on the additional capacity required to meet RTT challenges has had an impact on DM01 performance. An improvement plan is underway with a focus on driving bookings to make best use of capacity.
- FDS performance was not able to sustain the improvement seen in November (75.1%), with December reporting at 71.7%. Urology Haematuria pathway has experienced extended booking times for CT and Cystoscopy. Longer wait times for scopes are affecting Upper and Lower GI pathways. Extended vetting and reporting time for imaging continues to impact a number of specialty pathways. Histology reporting timeframes remain extended.
- The 62-Day performance remains below target at 70.2% (year end target - 75%). Recovering the Breast screening capacity issues, and continuing recovery from the early-pathway challenges within Dermatology, will be critical to improving overall 62-Day performance.

Patients

Urgent & Emergency Care

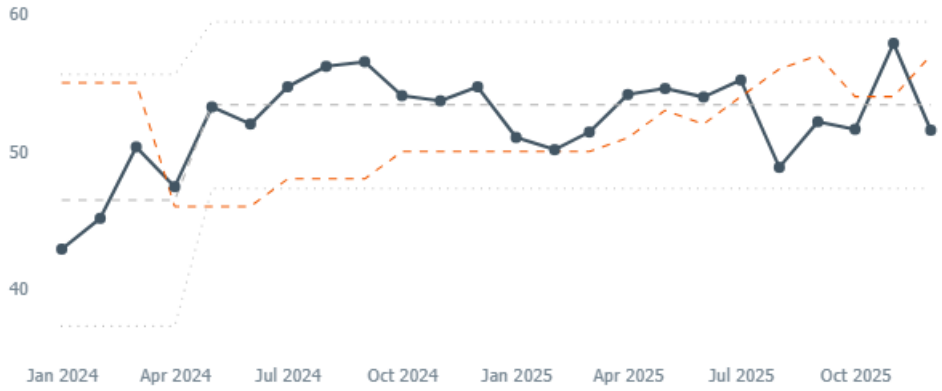
Type 1 Emergency Department; Four Hour Compliance

Type 1 Compliance 4hrs

Timescale	Value	SPC
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%	
Sep-25	52.2%	
Oct-25	51.6%	
Nov-25	57.9%	
Dec-25	51.6%	

XMR Run Chart

No Special Cause Flags



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/12/2025 the latest Type 1 Compliance 4hrs performance is 51.6% against a Trajectory target of 57.0% (higher is better).

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

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 51.6% decreased in December below the previous levels for the year to date. Clinically lead Improvement Weeks for WHH and QEQM are scheduled across 25/26. Week 3 on both hot sites had a positive impact in December with a 'going home for Xmas' theme with partners. • As part of the SDEC steering group for the new capital builds on both sites, all direct access pathways will be reviewed. 111 pts on the DOS being reviewed with the ICB and alliance UTC colleagues for direct attendances.
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 Site Tri's and GIRFT in Q3 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 October. Proof of concept changes trialled in November. CDU in place at WHH with a positive impact.
Admission Avoidance	Front door alternatives to ED: • SDEC capital plans being developed for WHH and QEQM with a steering group and workstream MDT approach, decants achieved. • 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, completed successfully October 2025, streaming to be further developed to enable full utilisation of the emergency footprint for patient pathways .

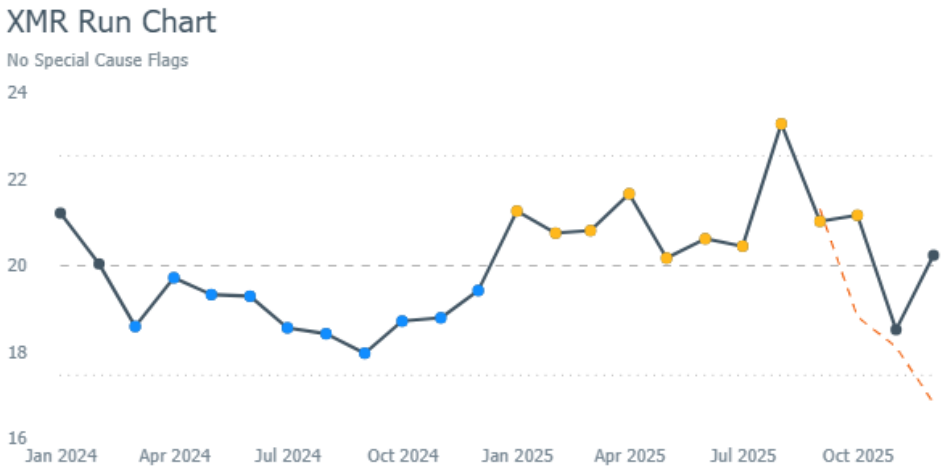
Patients

Urgent & Emergency Care

12 Hour Total Time in Emergency Department

12 Hr Total Time in Department

Timescale	Value	SPC
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%	
Sep-25	21.0%	
Oct-25	21.2%	
Nov-25	18.5%	
Dec-25	20.2%	



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/12/2025 the latest 12 Hr Total Time in Department performance is 20.2% against a Trajectory target of 16.8% (lower is better).

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

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 Q2 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, approved by the Board September 2025, 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 GIRFT report and support for opportunities outlined. • Position for 12hrs is starting to show the required improvements following an Amber SDEC model introduced at WHH, 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 GIRFT 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. GIRFT red lines and programme plan approach taken from the end of October.
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 and increased in November. • Nurse led RAT introduced at WHH.

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. • MH action cards taken forward via UEC Programme Board in October. • All long waits reported daily through system calls to ICB as key point of contact now. • New framework implementation from January 2026.

Patients

Urgent & Emergency Care

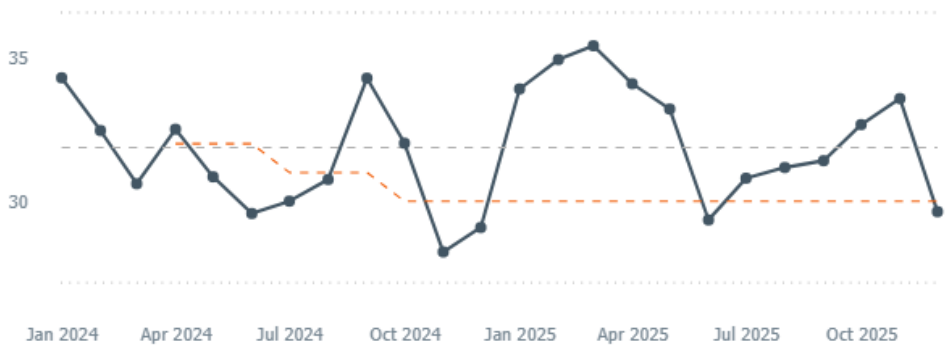
In-Hospital Spells with a Length of Stay over 14 Days

% Beds Occupied 14+

Timescale	Value	SPC
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%	
Sep-25	31.4%	
Oct-25	32.7%	
Nov-25	33.6%	
Dec-25	29.6%	

XMR Run Chart

No Special Cause Flags



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/12/2025 the latest % Beds Occupied 14+ performance is 29.6% 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 3 focus in December on both of the acute sites, pre planning scheduled with MDT approach and the improvement team in support. Positive impact with nctr's to 136 and positive 12 hour waits until last week in December. • Implementation of the SOP's across the wards. • Joint discharge staffing review agreed with partners, option of an integrated team to be take forward. • Range of alternative services and therapy in a community setting to be discussed. • nCTR patient numbers in total to be monitored and reported upon. P0 report set up.
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 and updated • 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	• 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

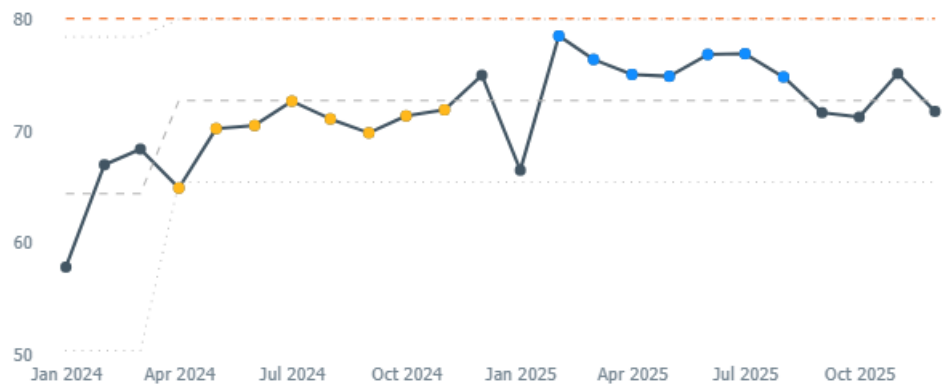
Cancer 28 Day Performance

Cancer 28d Combined Performance

Timescale	Value	SPC
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	74.8%	
Sep-25	71.6%	
Oct-25	71.2%	
Nov-25	75.1%	
Dec-25	71.7%	

XMR Run Chart

No Special Cause Flags



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/12/2025 the latest Cancer 28d Combined Performance performance is 71.7% against a static target of 80.0% (higher is better).

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

The biggest contributing factors are: 07 - Lower GI (57.2% , 293*), 11 - Urological (55.7% , 204*), 09 - Gynaecological (63.8% , 166*). *Breaches

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Access to timely diagnostic	• Reduce wait times for CT and US Biopsy, US • Endoscopy booking times • Breast US booking times	• Radiology • Endoscopy	• Ongoing	• Increase in reporting wait times observed for Histopathology with staffing challenges, particularly centred around the laboratory staff. Escalation processes remain in place and patients are being monitored. • Access to CT Guided Biopsy challenged due to lack of recovery at WHH. No activity was able to be supported from early November however, recovery space was secured in CAU and activity recommence mid December. This recovery solution has since been impacted by ED pressures as ED have needed to bed the CAU. Kennington ward now also supporting recovery. • Extended booking out times for MRI and CT were observed in December – all escalations raised with Radiology (for vetting) and PSC (for booking).
Benign Letter Backlog	• Timely consultant dictation of cancer letters to patients • Timely admin support to process dictated letters	• Cancer compliance • Admin • Consultant	• 25/26	• The trust regularly achieved it's threshold target of having fewer than 250 benign letters in the backlog in the month of December. Typically post Christmas letter wait times extend due to high levels of annual leave. This anticipated deterioration in the letter backlog needs to be address by the end of January. • Process changes across key specialties have driven this supported by weekly escalation processes.
FDS – Drive to achieve year end target	• To achieve year end target of 80%	• Specialties	• Q4	• Lower GI – Results review inbox to launch in January (aligned with MTW model). Clinical engagement and team buy-in are complete. Job plan adjustments are required to allow specialist doctors to support consultant results review and admin. • Breast – Screening patients must be compliant by February 2026 for Breast FDS, and 62D to achieve overall improvement before year end. Insourcing set to commence end of January to support screening pathway. • Reduced timeframes required across key diagnostics to improve the FDS – Early view in January is that CT wait times have improved, histology report times are coming down and endo capacity is set to increase by the end of January.

Patients

Cancer Care

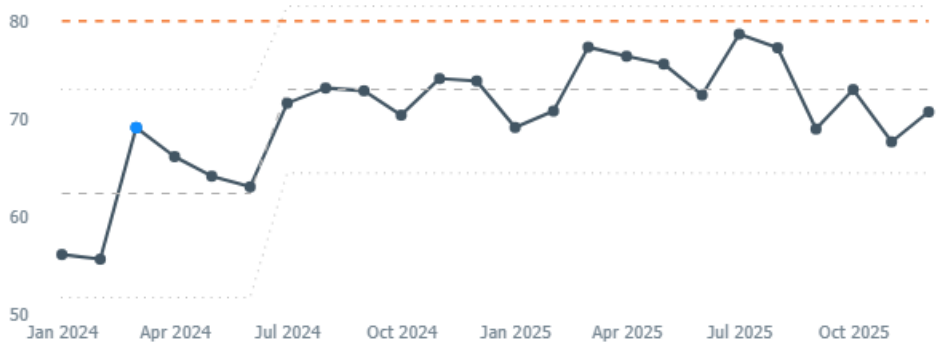
Cancer 62 Day Performance

Cancer 62d Combined Performance

Timescale	Value	SPC
Jan-25	69.1%	
Feb-25	70.8%	
Mar-25	77.3%	
Apr-25	76.4%	
May-25	75.6%	
Jun-25	72.4%	
Jul-25	78.7%	
Aug-25	77.3%	
Sep-25	69.0%	
Oct-25	73.0%	
Nov-25	67.6%	
Dec-25	70.7%	

XMR Run Chart

No Special Cause Flags



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/12/2025 the latest Cancer 62d Combined Performance performance is 70.7% against a static target of 80.0% (higher is better).

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

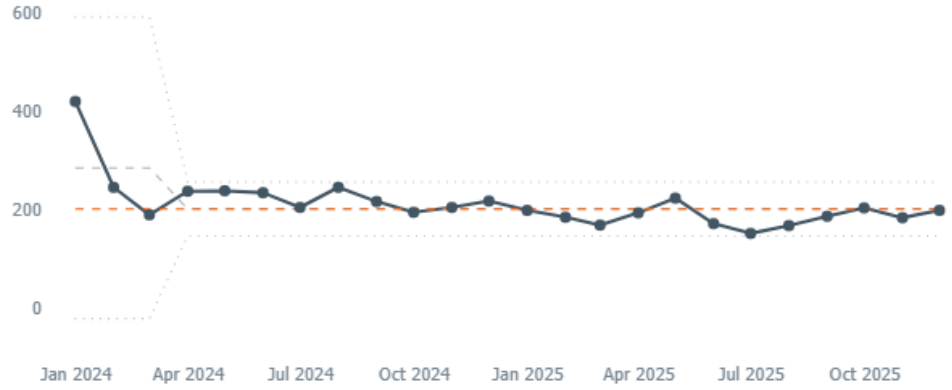
The biggest contributing factors are: 01 - Breast (57.3% , 25*), 11 - Urological (72.5% , 22*), 03 - Lung (56.6% , 18*). *Breaches

Cancer Over 62d on PTL

Timescale	Value	SPC
Jan-25	197	
Feb-25	183	
Mar-25	167	
Apr-25	192	
May-25	222	
Jun-25	170	
Jul-25	150	
Aug-25	166	
Sep-25	185	
Oct-25	202	
Nov-25	182	
Dec-25	197	

XMR Run Chart

No Special Cause Flags



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/12/2025 the latest Cancer Over 62d on PTL performance is 197 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: 07 - Lower GI (58*), 11 - Urological (50*), 08 - Skin (21*). *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	• Urology demand and capacity exercise in progress to ensure capacity is right sized for the years ahead. • Current wait times for clinic appointments exceed 4 weeks post MDM. • Insufficient surgical capacity for Urology, particularly prostate. Options for three RALP lists with the lead consultant are being explored; however, this is dependent on theatre staff availability and financial sign off. The teams are working to timetable joint oncology/surgical clinics however, aligning job plans is challenging.
Chemotherapy provision	• Ensuring capacity to meet demand • Project planning Aseptic shutdown	• Cancer Services/ Oncology/ Pharmacy	• Q3	• The Trust has received the Kent & Medway Cancer Alliance Chemotherapy Demand and Capacity Report, which is now informing business planning for 2025/26. Key findings and actions include: • Non-SACT Activity Pressure: Chemotherapy units are currently supporting a degree of non-Systemic Anti-Cancer Therapy (non-SACT) activity due to limited alternative ambulatory day care capacity. This issue is being linked to ongoing discussions with KCH regarding access to medical day unit space. • Equitable Patient Distribution: A re-zoning exercise is required to ensure balanced patient allocation across the main three chemotherapy units, improving operational efficiency and patient experience. • Subcutaneous Chemotherapy Options: Opportunities are being explored to relocate subcutaneous chemotherapy (injections) to Saturday clinics or community settings, aiming to relieve pressure on core unit capacity. Business case now approved. • Future Capacity Planning: Based on current demand projections, existing unit capacity is expected to be fully utilised within two years. Strategic planning is now required to scope and deliver necessary service expansion. • Pharmacy capacity also being reviewed as part of business planning to ensure pharmacy provision can meet demand. • Chemotherapy scheduling team impacted by long term sickness – backlog of rebooking and rescheduling requirements for patients reached an all time high. Mutual aid requested from neighbouring trusts to support the team.
Breast screening	• Breast screening performance the primary driver to the Breast 62D decline			• Breast screening performance, now a national outlier – Insourcing will commence in the last week of January supported by the NHS Q4 Sprint funding that was bid for. There is a currently an 8 week wait for a first appointment for our breast screening patients. Expected that the recovery will take two months.

Patients

Planned Care

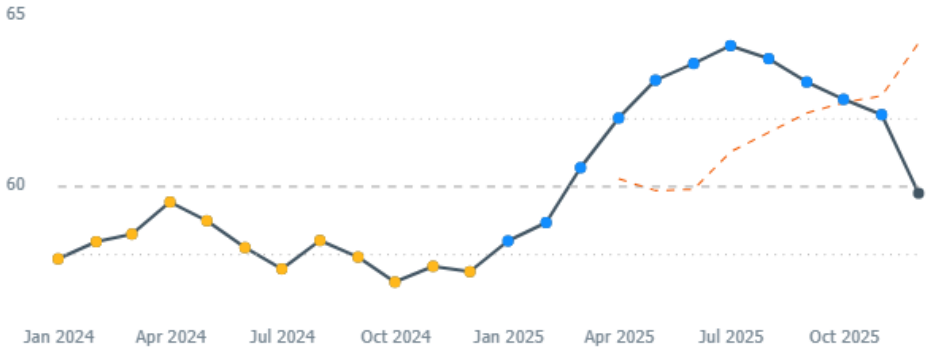
Referral to Treatment Waiting Times; 1st OPA and 52ww Performance

RTT 1st OPA Performance

Timescale	Value	SPC
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%	
Sep-25	63.0%	
Oct-25	62.5%	
Nov-25	62.0%	
Dec-25	59.7%	

XMR Run Chart

No Special Cause Flags



Understanding the Latest Performance

ALERT: Variation flag has changed from Improvement to Commo...

For the month beginning 01/12/2025 the latest RTT 1st OPA Performance performance is 59.7% against a Trajectory target of 64.1% (higher is better).

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

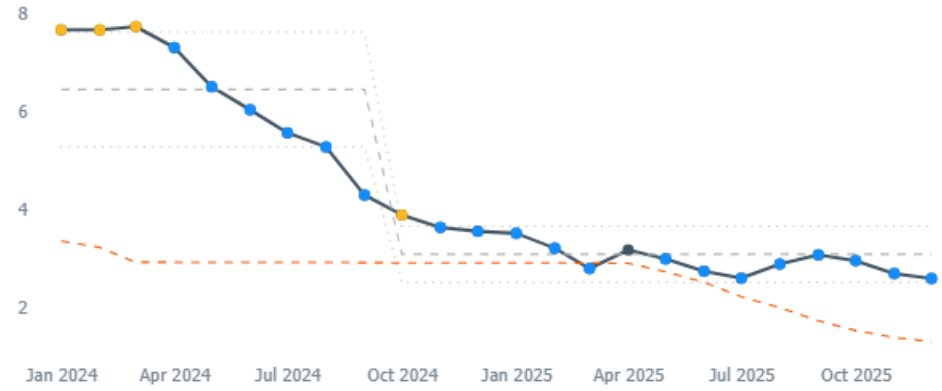
The biggest contributing factors are: 145 - ORAL AND MAXILLOFACIAL SURGERY (45.1% , 2,231*), 410 - RHEUMATOLOGY (37.6% , 1,979*), 320 - CARDIOLOGY (45.5% , 1,729*). *Breaches

RTT 52w Performance

Timescale	Value	SPC
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%	
Sep-25	3.1%	
Oct-25	3.0%	
Nov-25	2.7%	
Dec-25	2.6%	

XMR Run Chart

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



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/12/2025 the latest RTT 52w Performance performance is 2.6% against a Trajectory target of 1.3% (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 (1.6% , 7,088*), 120 - EAR NOSE AND THROAT (2.1% , 6,409*), 145 - ORAL AND MAXILLOFACIAL SURGERY (6.0% , 5,635*). *Breaches

Patients

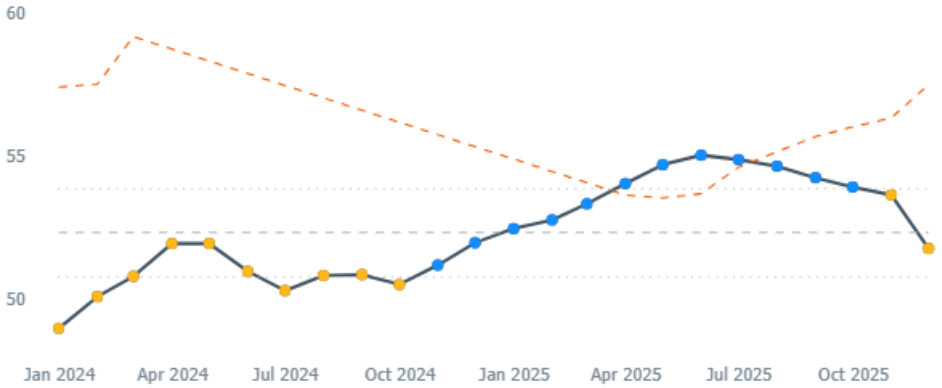
Planned Care

Referral to Treatment Waiting Times; Incomplete Pathways Performance

RTT Incomplete Performance

Timescale	Value	SPC
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%	
Sep-25	54.3%	
Oct-25	53.9%	
Nov-25	53.6%	
Dec-25	51.8%	

XMR Run Chart



Understanding the Latest Performance

Concern flag alerting for 2 periods

For the month beginning 01/12/2025 the latest RTT Incomplete Performance performance is 51.8% against a Trajectory target of 57.5% (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).

The biggest contributing factors are: 110 - ORTHOPAEDICS (44.1% , 4,023*), 145 - ORAL AND MAXILLOFACIAL SURGERY (39.3% , 3,636*), 120 - EAR NOSE AND THROAT (47.7% , 3,424*). *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%. Additional targets introduced by NHSE – no greater than 100 x 65 week waits to be reported at the end of October 2025 and eradicate all 65 week waits by the 21st December as well as recover 52 week trajectory to meet March target of no greater than 1% of PTL	• Submit Q4 First Outpatient Sprint. Complete. • Submit Q4 52 Week Recovery Plan. Complete. • Devise further plan to address shortfall in activity forecast against plan for Q4 sprints. • Theatre programme to improve utilisation to 85% and drive clearance of backlog. Expectation set for booking to 100% of Planned capacity using Expected Theatre Time. Waiting list Initiative controls to incorporate actions to improve core utilisation. Ongoing.	• Dir Planned Care Recovery • All Care Groups • Dir Planned Care Recovery	• 21st December- complete • 31st December - complete • January 31st	• The Trust achieved x 58 (revised down following validation) on the 21st December and achieved 46 against our aim for no greater than 51 on the 31st December. Cardiology remain the main challenge. Delays are ongoing in recruiting locum consultants although we have been offered some support for Cardiac CT from Dartford and Gravesham. • The Trust has submitted a trajectory for the Q4 First Outpatient Sprint where activity above plan will be paid at National Tariff rates. Ther forecast is that capacity for circa 4,000 additional first outpatients will need to be found in Q4 before the trust can earn additional income. • The Trust has also submitted the bid to generate capacity to ensure 52 week targets are met at the end of Q4 and received notification that £500k was to be allocated out of the £2m that was bid for. Again, subject to first meeting the Q4 plan. • Ongoing clinical engagement, strengthened weekly theatre scheduling and specialty action group meetings. • Perioperative Improvement Programme Oversight Group continues to meet monthly to track progress. • Progress tracked through Perioperative Improvement Group and Operations Board • Further WLI controls will be agreed in January 2026

Patients

Planned Care

Referral to Treatment Waiting Times; Incomplete Pathways Performance

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%. Additional targets introduced by NHSE – no greater than 100 x 65 week waits to be reported at the end of October 2025 and eradicate all 65 week waits by the 21st December as well as recover 52 week trajectory to meet March target of no greater than 1% of PTL Two specialties are most at risk of not meeting and sustaining the December 21 target – General Surgery and Cardiology	General Surgery • Administrative validation has been undertaken on those patients without a date - complete • Identification of patients who meet Independent sector criteria (180 patients) • Review of theatre lists and maintain current utilisation (continued improvement to 88.7% in December exceeding the 85% target) • Sample audit of patients against RATC policy to ensure patients meet criteria • Patients identified to transfer to QEQM for treatment but theatre lists need to be identified • Workforce required to close this gap identified and awaiting approval for temporary workforce Cardiology • Two locum consultants being sourced to support backlog reduction and reduce wait time to first OPA. • Close working with radiology to support additional CTCA capacity where possible, as well as increasing throughput on lists. • Continued close working with Independent Sector to support elective waits • Recovery of DM01 to support RTT pathways • Reduction in wait times for cardiac monitors to support RTT pathway • Additional clinics to be provided internally to support reduction in wait to first appointment. • Close monitoring of pathways and daily validation. • Additional admin staff required to book additional clinics and diagnostic lists.	• William Harvey Hospital Care Group • William Harvey Hospital Care Group	• December 31st • March 31st • December 31st complete and ongoing • December 31st • December 31st • March 31st	• Further cohorts of General Surgery patients has been sent to the Independent Sector to mitigate 65 week breaches in Q4 following approval to utilise Inter Provider Patient Transfer allocation. • Contributing to the plan for the First Outpatient Sprint and 52 week IP/DC recovery following submission of bid on the 30th December. • Complete - Minimal RaTC Opportunity identified • Continuing to identify further patients suitable for transfer to QE • Locums agreed • End of December 65 week risk reduced from 125 to 28 patients. • Awaiting January start date for 2 x fixed term Consultant posts to continue to reduce waits for first Outpatients. • Ongoing clinical engagement, led by clinical lead. • Ongoing weekly Catheter lab utilisation meeting to ensure maximum Cath lab lists are running. • Progress tracked through weekly access meetings. • Additional clinics to reduce wait provided by existing workforce (~80 slots in November/Dec) completed • Daily tracking of patients at risk of breaching 65 weeks in place. • Further funding bid to mitigate 65 week breaches in Q4 submitted to Execs in December. Awaiting confirmation. • Awaiting confirmation of further funding for the First Outpatient Sprint and 52 week IP/DC recovery following submission of bid on the 30th December.

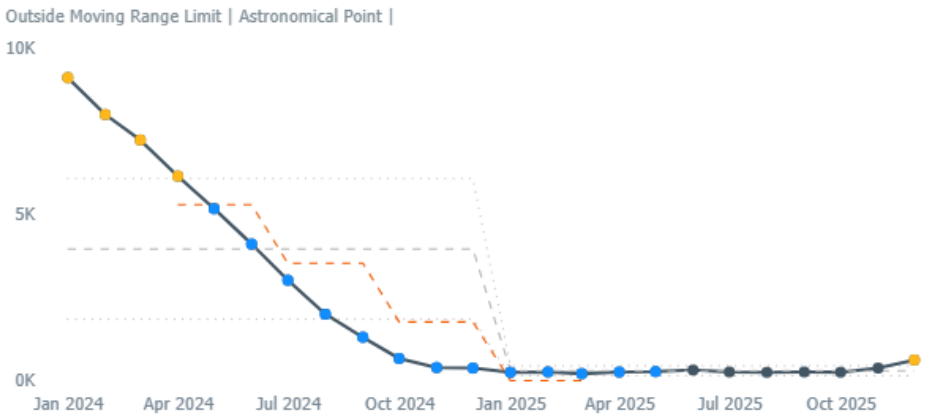
Patients

Planned Care

Endoscopy Backlog; Overdue Surveillance and Routine Waits

Endoscopy Backlog

Timescale	Value	SPC
Jan-25	247	
Feb-25	258	
Mar-25	206	
Apr-25	255	
May-25	268	
Jun-25	314	
Jul-25	258	
Aug-25	247	
Sep-25	257	
Oct-25	250	
Nov-25	374	
Dec-25	618	



Understanding the Latest Performance

ALERT: Variation flag has changed from Common Cause to Concern

There is no target for this measure, and performance is statisticaly declining.

The biggest contributing factors are: OGD (214*), Colon (188*), Dual (144*). *Overdue Waiters

Proposal to remove action plan for Endsocopy backlog action log following sustained improvement of position for 9+ months. Metric will still be monitored via the domain scorecard (slide 5).

Patients

Planned Care

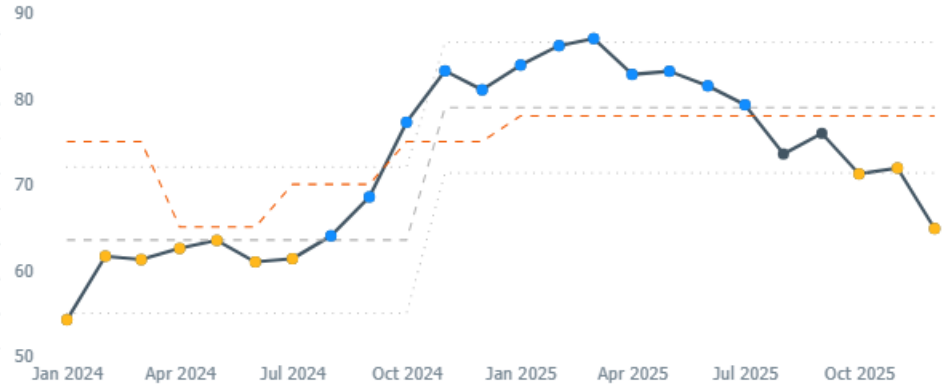
Diagnostics; DM01 Compliance % Patients Waiting less then 6 Weeks

DM01 Compliance

Timescale	Value	SPC
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%	
Sep-25	76.0%	
Oct-25	71.2%	
Nov-25	71.9%	
Dec-25	64.8%	

XMR Run Chart

Astronomical Point | Two Out Of Three Beyond Two Sigma Group



Understanding the Latest Performance

Concern flag alerting for 3 periods

For the month beginning 01/12/2025 the latest DM01 Compliance performance is 64.8% 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: Non Obstetric Ultrasound (48.3% , 4,232*), MRI (76.3% , 2,343*), CT (67.8% , 1,925*). *Breaches

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Cardiac MRI Backlog	• Recruitment to vacant consultant posts.	• Cardiology GM	• March 2026	• New consultant starts in May • 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 (exc. Cardiac) Booking Capacity Consultant Vetting; delays extending wait times & restricting patient flow Insufficient capacity for sedation & GA patients Current vacancy levels High Cancellation Rates @ Buckland & Deal Sites	Current Month performance 76.3% • Training required to increase the pool of staff with the knowledge and skills to book MRI • Review consultant job plans to ensure sufficient vetting time within job plans and explore options for radiographer led vetting. • Full demand capacity modelling to be undertaken to consider option for increased capacity • Establishment review requested to understand requirement. • Training for booking teams to manage messaging with patients.			• Training ongoing. Booking utilisation has significantly improved and booking utilisation through to the end of January exceeds 100% • A dashboard has been created to monitor vetting performance which is monitored by the operational team and escalated to site leads as necessary and a pilot implemented to implement a new vetting model. • Backfill with NHSP as available • Forecast trajectory to achieve 96% DM01 performance by April 2026 by improving booking utilisation and reducing cancellation rates. • Deep dive underway into DNA and cancellations
CT (exc. Cardiac) Booking Capacity Consultant Vetting; delays extending wait times & restricting patient flow High Cancellation Rates @ Buckland & downtime CT Biopsy capacity	Current Month performance 67.8% • Training required to increase the pool of staff with the knowledge and skills to book CT • Review consultant job plans to ensure sufficient vetting time within job plans and explore options for radiographer led vetting. • The downtime of CT's have contributed to a number of cancellations. Two CTs were due for replacement this year due to age but this has been delayed and both CTs have had downtime due to faults. • CT Biopsy is an ongoing challenge due to consultant capacity. This is further impacted currently by the lack of recovery space at WHH following the SDEC moves. An urgent solution has been identified.			• Training Underway. Booking utilisation has declined in month due to high volumes of staff sickness • A dashboard has been created to monitor vetting performance which is monitored by the operational team and escalated to site leads as necessary. • Recovery space for CT Biopsy identified at WHH and increased capacity in place to manage backlog • Training underway • CT replacement programme due to commence March 2026

Patients

Planned Care

Diagnostics; DM01 Compliance % Patients Waiting less then 6 Weeks

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
CT Cardiac Underlying capacity deficit	Current Month performance 13.2% • Demand & Capacity Analysis required • Full review of Cardiac Pathways to be undertaken to understand capacity required to in-house all EK demand			• Demand capacity exercise has been undertaken which clearly demonstrates in house capacity is insufficient to meet the current demand. The service receives an average of 250 referrals per month. In house capacity is 140. We currently send 60 patients per month to the Chaucer leaving a monthly shortfall 50 slots. In 23/24 we sent 120 patients per month to the Chaucer but funding was reduced for 25/26 resulting in the worsening position. • In order to maintain current performance and prevent a worsening DM01 position additional funding is required of £380k for26/27 to increase Chaucer capacity back to 120 slots per month. This will maintain current performance. To clear the backlog and achieve DM01 compliance a further £500k would be required. • Deep dive underway into long term capacity requirements • Chaucer contacted regarding increasing capacity

NB The CT replacement programme is due to commence in January 2026. This presents a significant risk to cardiac CT capacity at both QEQM and WHH. A working group is currently meeting regularly to discuss mitigations. One option currently being reviewed is to move staff from QEQM/WHH to Buckland. The implications of this are being explored.

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Non-Obstetric Ultrasound Booking Capacity Consultant Rotas (delay to production) High Cancellation Rates Recruitment	Current Month performance 47.0% • Training required to increase the pool of staff with the knowledge and skills to book NOUS • Significant delays in the production of consultant rotas impacting on the ability of booking staff to book ahead eg December rotas published 29th November, January rotas not available as at 19th December • Training for booking teams to manage messaging with patients. • Current vacancies for RDAs not recruited to due to delays with approvals. A high number of NOUS lists require a chaperone. Backfill with NHSP as available. • Current vacancies for booking staff not recruited to due to internal vacancy approvals processes			• Training Underway. Booking utilisation and performance has significantly declined in moth due to staff vacancies and high sickness absence. Plan in place to support staffing gaps and deliver improvement. • Internal approval for external advertisement to fill band 2 booking staff vacancies • Implementation of Patchwork will support with addressing this issue. • Training underway. • Forecast trajectory to achieve 96% DM01 performance by June 2026 by improving booking utilisation, increasing establishment of RDAs and reducing cancellation rates.

Patients

Planned Care

Diagnostics; DM01 Compliance % Patients Waiting less then 6 Weeks

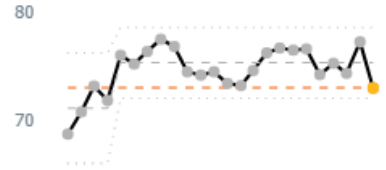
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
DEXA Field safety notice	Current Month performance 88.5% The field safety notice that was in place for several months has been lifted for the KCH scanner and long waiting patients are being booked throughout December and January. Awaiting confirmation of part replacement at Buckland but likely to be February 2026. Booking utilisation of all scanners is consistently above 100% so no issues with booking and utilisation. DM01 performance has improved since the field safety notice has been lifted and current trajectory aims to deliver compliance by March 2026.			

Patients

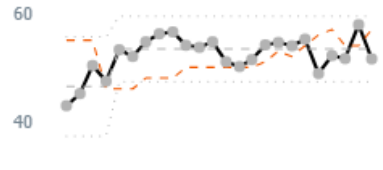
Trend Analysis

Patient Domain Metrics

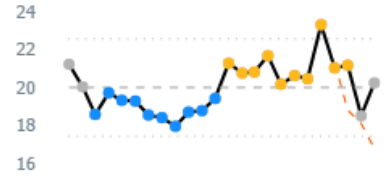
ED Compliance



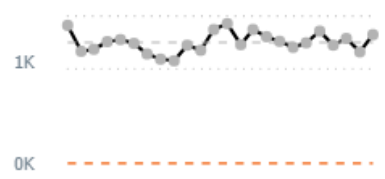
Type 1 Compliance 4hrs



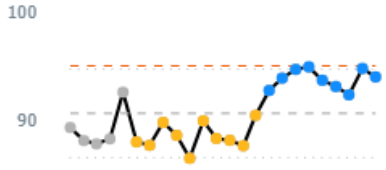
12 Hr Total Time in Department



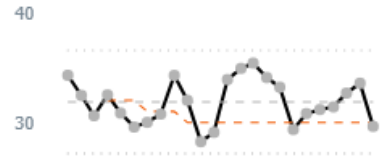
12Hr Trolley Waits



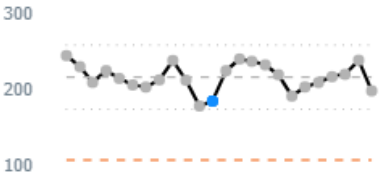
Ambulance Handovers within 30m



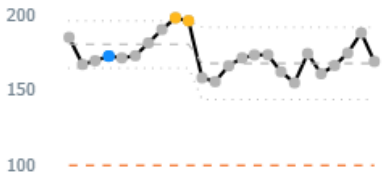
% Beds Occupied 14+



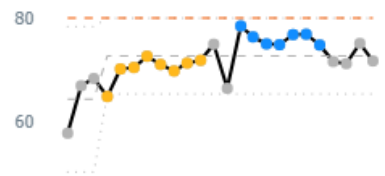
Super Stranded >21D



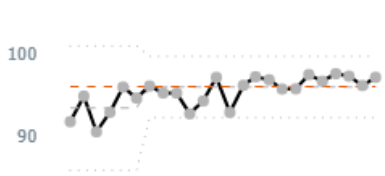
Not Fit to Reside (pats/day)



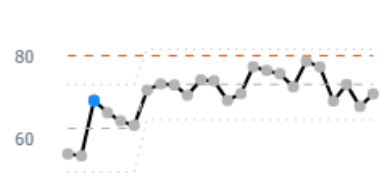
Cancer 28d Combined Performance



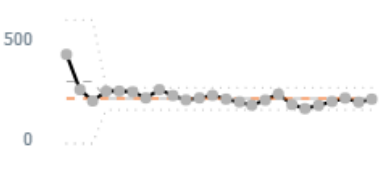
Cancer 31d Combined Performance



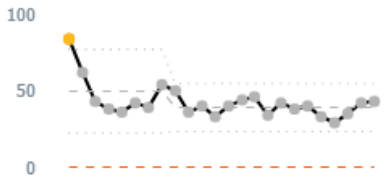
Cancer 62d Combined Performance



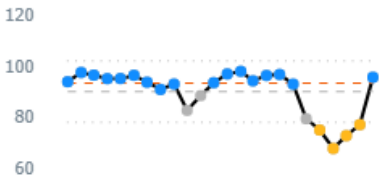
Cancer Over 62d on PTL



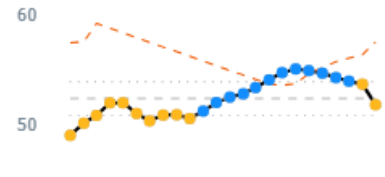
Cancer Over 104d on PTL



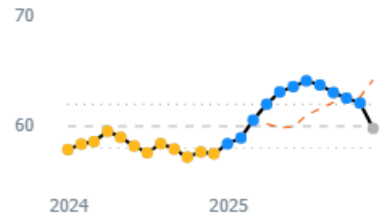
Cancer Rapid Access Perf



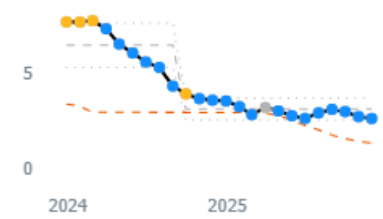
RTT Incomplete Performance



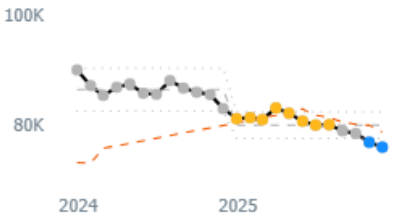
RTT 1st OPA Performance



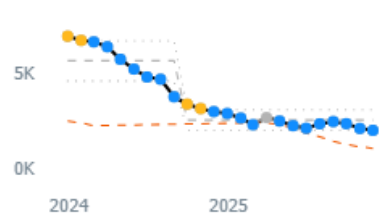
RTT 52w Performance



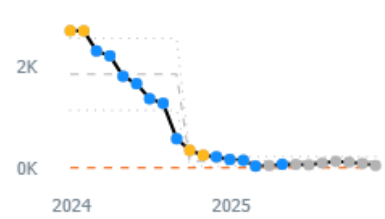
RTT Total Incomplete Pathways



RTT 52w Breaches



RTT 65w Breaches

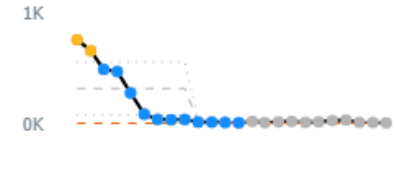


Patients

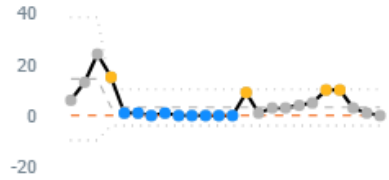
Trend Analysis

Patient Domain Metrics

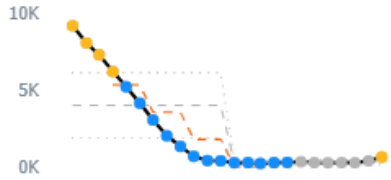
RTT 78w Breaches



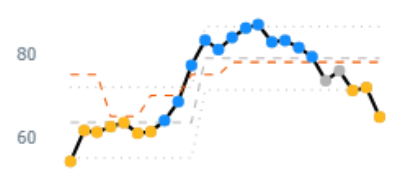
RTT 104w Breaches



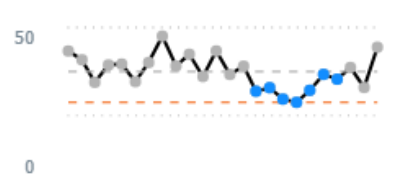
Endoscopy Backlog



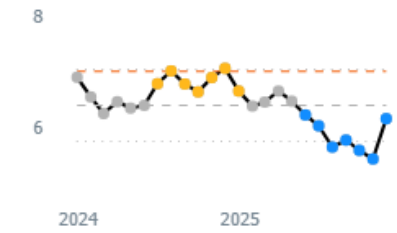
DM01 Compliance



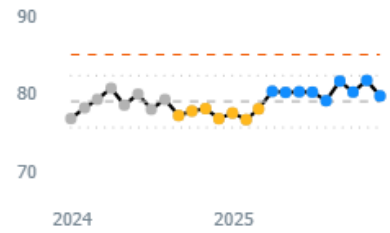
Theatre Session Opp.



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)		Never Events Pressure Ulcers PSII - Local PSII - National	AARs Overdue
No Significant Change	FFT Satisfaction Level - Outpatient NICE Compliance	After Action Reviews (AARs) Complaint Response Complaints Number Duty of Candour - Findings Duty of Candour - Verbal 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	FFT Satisfaction Level - ED HSMR Overdue Incidents
H / L — Concerning Variation (High or Low)	Safeguarding Adults Training Safeguarding Children Training	Patient Safety Incidents - Mod/Sev	SHMI

Quality and safety

Scorecard View

Incident Reporting, Compliments/Complaints & Safeguarding

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Quality	NAT		Patient Safety Incidents			2,406	2,181	1,974	1,982	2,176	2,013	2,072	2,300	1,875	1,951	2,209	1,981	2,084
	NAT		Patient Safety Incidents - Mod/Sev			68	40	63	49	50	35	44	49	54	57	49	46	74
	KEY		Overdue Incidents			0	974	1,202	1,160	965	756	728	813	994	1,142	1,112	908	950
	NAT		PSII - Local			0	2	2	2	2	1	1	1	1	2	0	0	0
	NAT		PSII - National			0	0	0	1	1	1	0	0	0	0	1	0	0
	NAT		After Action Reviews (AARs)			0	8	11	13	9	4	8	11	6	4	3	1	3
	NAT		AARs Overdue			0	35	37	42	39	35	25	31	24	30	34	32	27
	NAT		Never Events			0	0	0	0	0	1	0	0	0	0	1	0	1
	NAT		Duty of Candour - Findings			100%	100%	100%	100%	90.9%	100%	96.7%	100%	100%	95.5%	93.3%	95.0%	84.2%
	NAT		Duty of Candour - Written 15wd			100%	100%	96.0%	100%	96.2%	100%	95.5%	87.5%	100%	89.5%	100%	90.5%	91.7%
	NAT		Duty of Candour - Verbal			100%	100%	96.3%	100%	100%	100%	100%	94.4%	100%	94.1%	100%	89.5%	92.9%
	KEY		Complaints Number			150	117	99	97	117	130	129	160	98	139	129	100	79
	KEY		Complaint Response			85.0%	86.1%	87.3%	86.0%	87.5%	85.3%	86.3%	85.4%	89.9%	85.3%	85.4%	85.0%	85.1%
	NAT		FFT Satisfaction Level - ED			90.0%	82.7%	81.8%	84.7%	87.2%	86.7%	86.3%	86.2%	86.2%	85.3%	80.4%	83.2%	82.4%
	NAT		FFT Satisfaction Level - Outpatient			90.0%	96.0%	95.7%	95.4%	95.6%	95.2%	95.5%	95.4%	96.1%	95.4%	95.5%	95.9%	95.9%
	NAT		FFT Satisfaction Level - Inpatient			90.0%	89.2%	88.5%	91.4%	92.1%	92.8%	90.5%	90.3%	89.3%	91.0%	91.1%	91.7%	90.8%
			SJRs Outstanding									777	732	665	594	568	567	532

Quality and safety

Scorecard View

IPC, Patient Safety & Mortality

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Quality	NAT		Safeguarding Incidents			54	16	21	32	24	31	35	35	23	19	28	17	32
	NAT		Safeguarding Children Training			90.0%	91.7%	91.4%	90.9%	91.1%	90.9%	90.7%	90.5%	91.1%	90.5%	90.4%	89.9%	90.3%
	NAT		Safeguarding Adults Training			90.0%	93.3%	92.9%	92.5%	92.4%	92.4%	91.9%	91.7%	92.4%	91.7%	91.7%	91.2%	91.8%
	NAT		IPC: EColi Infections			12	14	12	10	13	11	17	12	12	14	17	16	8
	NAT		IPC: CDiff Infections			8	11	8	11	7	8	9	5	13	13	8	6	10
	NAT		IPC: Klebsiella Infections			6	6	5	9	5	1	1	5	7	7	10	3	1
	NAT		IPC: Pseudomonas Infections			2	5	1	2	0	2	2	1	2	3	9	4	3
	NAT		IPC: MRSA Infections			0	0	0	0	1	1	0	0	0	1	0	0	0
	NAT		IPC: MSSA Infections			6	9	11	13	5	6	9	4	5	7	1	7	5
	IIP		Falls with Harm			15	1	7	11	2	2	7	1	6	4	3	5	5
	IIP		Pressure Ulcers			111	119	101	101	111	79	76	70	69	67	77	83	74
	NAT		Mixed Sex Breaches			139	92	33	49	118	133	109	86	50	68	53	46	50
			Theatre recovery Mixed Sex Breaches			3	0	0	0	0	7	0	0	1	0	2	0	0
	KEY		HSMR			96.0	98.6	99.9	99.5	100.4	101.1	102.0	100.8	102.0				
	KEY		SHMI			1.070	1.114	1.126	1.126	1.119	1.115	1.125	1.120	1.122				
	NAT		VTE Assessment Compliance			95.0%	94.0%	94.7%	94.2%	94.9%	94.9%	95.7%	94.8%	95.1%	95.0%	95.4%	94.5%	94.1%
			NICE Compliance			90.0%	83.1%	91.9%	98.5%	98.5%	98.5%	96.4%	96.5%	93.2%	91.9%	94.0%	94.0%	96.1%

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 analysis 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 December, had:

- Two (2) nationally reportable PSIIs ongoing: 2 Never Events (a retained swab incident and an incorrect insertion of a guidewire)
- Two (2) Maternity and Neonatal Safety Investigations (MNSI).
- Seven (7)other local response investigations (2 MDT reviews, 2 thematic reviews, 1 safeguarding review, 1 AAR and 1 table-top review exercise). Approval will be via LRAP with Executive oversight.
- Twelve (12) Local PSIIs (four of which were overdue – Two (2) being updated after Safeguarding reviews, one with the CNMO for sign off, one awaiting triumvirate sign off, booked for LRAP in February)
- Two (2) externally led investigations which require Trust support.

There are currently thirty-eight (38) open AARs, with eight (8) closed in December and three (3) new AARs commenced.
Twenty-seven (27) AARs are overdue for completion., of which seven (7) are booked for LRAP by end of February.
Quality Governance staff continue to support handlers responsible for completion of the AARs. Progress with AARs is included in the weekly report to executives.

The increase in moderate to severe incidents is thought to be due to a small lag in the review process of incidents that is likely to result in some being downgraded. This will be monitored but is not of concern.

Overdue Incidents:

The number of overdue incidents increased to 950 at the end of December. A total of 644 incidents became overdue in December, which is an increase from 534 in November. The weekly overdue and anomalies report to QGBPs which is shared with the Care Group Leadership teams 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 the aim is to see a month-on-month reduction for incident closure to reduce to 300 unjustifiable overdue incidents by the end of March 2026. It is reasonable for an organisation with a high volume of incident reporting to always have some open incidents and the teams are clear that this is an agreed expectation.

Quality and safety

Executive Summary

Systems Update, Safeguarding & Patient Privacy

Duty of Candour:

In December Duty of Candour compliance was below the KPI of 100% for all three components:

- Verbal compliance was 92.9% due to one QEQM conversation being carried out after day 10 (completed prior to day 15)
- Written compliance was 91.7% due to once obstetric letter being sent after day 15.
- Findings compliance was 84.2% due to two letters being sent after day 10 (but completed prior to day 15) and one obstetrics letter which is still awaiting completion. All breached cases were escalated to triumvirates prior to due dates as per the escalation process.

Weekly reports on the DoC due and current compliance is sent out to QGBPs and Director of Quality Governance to maintain oversight. Monitoring of compliance continues to be shared in the weekly report to executives to provide assurance.

Following updates to the Trust Duty of Candour Policy, a review of fields on Datix and data quality is underway.

Never Events:

There was one (1) reported never event on December.

A patient was identified as having the wrong type of breast wire inserted in Radiology. This was immediately recognised and with the patients consent removed and the correct coil inserted. No harm came to the patient. The case was discussed at Incident Review Panel (IRP) and an AAR investigation commenced led by DCB care group.

Safeguarding :

The Trust benchmarks safeguarding training compliance against the national standard of **85%**. Current compliance for **Adult and Child Safeguarding Levels 1, 2, and 4** exceeds this benchmark. However, compliance for **Safeguarding Level 3** is **82.8%** for Children and **82.1%** for Adults

- **Training** Capacity**:** Adequate capacity exists for all staff to complete required courses
- Monthly List and booking shared with Triumvirates reporting at Care Group Performance Review Meetings(PRMs)

The professional group with the highest level of non-compliance is the **medical and dental workforce**. This risk is recorded on the **Corporate Risk Register (CR3733)**

- **Supervision:** Levels of safeguarding supervision have increased to support compliance and practice improvement.
- **Digital transformation of safeguarding consultations**, delayed which is impacting efficiency and accessibility of safeguarding information. New Safeguarding additions On Datix

Backlog of transfer of safeguarding information onto records, national alerts ,conference minutes, DoLs list due to sickness / absence and recruitment of safeguarding administrators

Mixed Sex Breaches

50 breaches occurred in the month of December.

- There has been an 8% increase in the number of patients sharing the same sex accommodation, with all occurring within the critical care units. The Mixed Sex breach distribution in the critical care units according to site, KCH Intensive Care Uniti, WHH critical care unit and QEQM Intensive Care unit, were; 1, 34 and 15 respectively.
- Breaches in critical care units are predominantly related to patients waiting more than 4 hours for transfer to a ward bed after being stepped down.

Executive Summary

Infection Prevention Control

Infection Prevention and Control:
Blood stream infections in December 2025 are lower than previous months for all reportable organisms, but C-dif cases have increased – in part due to norovirus outbreaks and increased stool testing.
Norovirus outbreaks impacted wards predominantly in QEQM in December, but both WHH and K&C saw single ward outbreaks in december. In WHH and K&C these were locally managed and resolved. In QEQM the outbreaks increased and continued through January – but with no evidence of cross ward transmission. Local communities were also seeing high rates of norovirus circulating.

There were 10 Clostridium difficile cases, with no identified cross infection - but some cases were incidental findings of norovirus testing, 8 cases of E.coli with no obvious linked cases. Klebsiella, had lowest month, with just 1 case reported and pseudomonas 3, suggesting that the environmental focus may be having an impact.

As well as norovrisu the Trust saw some Flu and COVID in December, but not at the levels of 2025 , nor the levels predcited, again, small localised outbreaks were managed and closed.

The IPC team are focussing on working collaboratively with the 'CLEAN Together' campaign focussing on decluttering and management and cleanliness of the environment and equipment, with specific focus on UEC pathways.

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

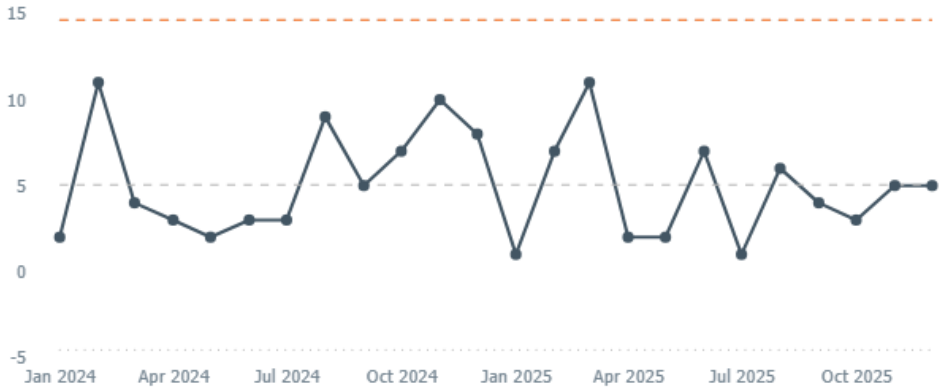
Patient Falls with Moderate or Above Harm Recorded

Falls with Harm

Timescale	Value	SPC
Jan-25	1	
Feb-25	7	
Mar-25	11	
Apr-25	2	
May-25	2	
Jun-25	7	
Jul-25	1	
Aug-25	6	
Sep-25	4	
Oct-25	3	
Nov-25	5	
Dec-25	5	

XMR Run Chart

No Special Cause Flags



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/12/2025 the latest Falls with Harm performance is 5 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 – 5 falls in December resulting in moderate harm.	• Focussed work in areas with highest number of falls, using MDT approach.	Falls lead/ Care groups	March 2026	• Falls Steering Group will continue to discuss falls and analyse data from incidents noting themes. Real time training provided by the Falls service within areas of concern. MDT Environmental walk arounds in hot spot areas. Incidents resulting in harm discussed at the Fundamentals of Care Incident Panel, lessons learned and actions agreed monitored and aligned to Trust Wide Improvement Plan.
	• Supporting clinical areas with actions within the Trust Wide Improvement Plan.	Falls Lead	March 2026	• Specialised review with advice for patients who repeatedly fall. • Development of a Dynamic Risk Management Tool to support staff in real time practice in continuous assessment. Feedback sought, review of current audit tools where overlap highlighted required. Tool to be digitalised meeting held with ADON IT plan for stand alone document to be developed. In que with IT.
	• Themes to be discussed at Falls Stakeholder event, January 2026	Falls lead	Jan 2026	• Planned stake holder event with a multidisciplinary invitation list, co creative working to align new Trust Wide Improvement Plan (TWIP) actions, review current actions and trust wide data.

Quality and safety

Safe Care

Falls with Harm; Actions Table

Falls with Harm (con't)

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Increase in falls resulting in low and no harm in ward areas where the focus is to encourage patients to sit out of bed and get moving.	• Co creation of a newly constituted 'patient care and deconditioning' working group. • Increase awareness of the risk of deconditioning- related falls	AHP Lead Therapy Leads Trust Wide/ Falls Lead/ Manual Handling Lead	April 2026	• Patient Care and Deconditioning working group four meetings held. Objectives to be established. • Campaign to address deconditioning to be agreed, meeting to be held to plan stake holder event for early 2026, supported by the 'We Care' team. • Enablement bays across care groups having positive impact, we care projects improving functional movement post operative, plan to triangulate projects within the patient care and deconditioning model. • Break out group formed to review functional competency for mobility aids. Plan to incorporate into manual handling mandatory training for train the trainer model. Link workers to attend BHD. • Manual Handling team to revisit staff competencies in real time ward environment to support confidence with patient mobility assistance eg, sit to stand.
MASA risk assessments are not always fully completed in a timely manner.	• Falls dashboard to be created to include MASA completion, including time of medical reviews, radiology reports and status of clinician completing review. • Simplify the risk assessment process through triangulation of FOC services within one document to enable fluid streamline documentation into the risk assessment. • Review white boards to create live boards for information and updated assessment information to be pulled through to the white board.	Falls Lead FOC lead nurses/IT sunrise IT transformation team/Falls lead WDET	March 2026 January 2026 May 2026	• IT agreed and in queue for Sunrise amendments, latest update regarding care plans delayed until April 2026. • Meeting took place on the 2nd October 2025 between Sunrise team and FOC lead nurses. Sunrise advise a 6-month timeline due to other workstreams. Plan to discuss the relevant information being pulled into Drs notes. • Meeting held with head of information and development and WDET agreed stake holder meeting for 27th January, plan to co create white boards trust wide with live information.
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 • DRMT to be accessed and completed digitally	Falls Lead/ADoN FoC/ADON WDET Falls Lead/ADoN FoC/ADON WDET	December 2025 March 2026	• Partial overlap of assessment tools and audits in place noted as a key issue. Plan to build on previous review undertaken by Associate Chief Nurse of nursing audit tool. • Nursing audit work to be agreed/confirmed prior to implementation. • DRMT to be taken back to NMEC to agree timeline of a proposed role out now overdue. • DRMT currently in paper format discussed with IT for Sunrise launch, IT report waiting times for work streams, document will present as a standalone document for IT with priority. Meeting held December document agreed.

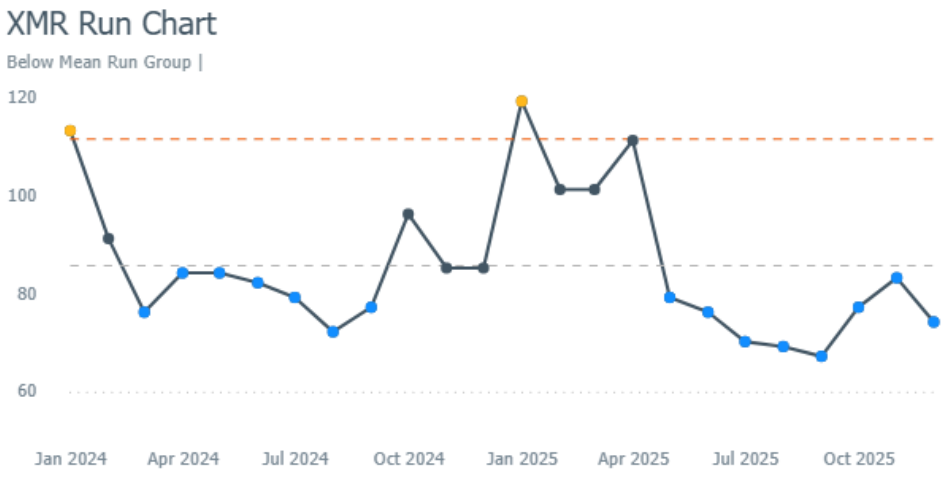
Quality and safety

Safe Care

Pressure Ulcers; Hospital Associated

Pressure Ulcers

Timescale	Value	SPC
Jan-25	119	
Feb-25	101	
Mar-25	101	
Apr-25	111	
May-25	79	
Jun-25	76	
Jul-25	70	
Aug-25	69	
Sep-25	67	
Oct-25	77	
Nov-25	83	
Dec-25	74	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/12/2025 the latest Pressure Ulcers performance is 74 against a (6 Sigma Threshold) target of 111 (lower 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).

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Known seasonal risk of increase in tissue viability incidents across winter months in hospital owing to increasing occupancy.	• ED working group to review initial skin inspection in Emergency Departments	ED Matrons	January 2026	• Due to pressures in the ED, Tissue Viability Team meeting with ED senior nurses in person.
	• Increased TVN presence in ED across winter months to support	Tissue Viability Lead	March 2026	• ED to send representation to Tissue Viability Stakeholder event in January 2026. • Lead working with TVN on each site to ensure cover
	• Restructure of TV team to allow more site-based working, to include timely reviews in ED.	Tissue Viability Lead	April 2026	•Vacancies approved at VCP.
The accuracy, completeness & dynamic nature of risk assessments remain critical challenges with a consistent theme in audits & incidence data demonstrating that risk assessments are incomplete or inaccurate leading to delayed pressure ulcer prevention strategies.	• A full documentation review is taking place with the Sunrise team to simplify & streamline the documentation process for all clinical staff.	TV lead/Chief Nursing Information Officer	March 2026	• Sunrise team advised work will take 6-months due to other workstreams. Also discussed the relevant information being pulled into Drs notes. • Met with Sunrise team to amalgamate PURPOSE T risk assessment into SKINS bundle, to reduce duplication, inconsistencies with risk assessment and to easily identify when review is required.
	• Review the Risk assessment process on Sunrise to simplify & reduce duplication.	FOC Lead Nurse/Sunrise team	April 2026	• Ongoing discussions are being had with Sunrise teams, latest update regarding care plans delayed until April 2026.
	• Simplify the risk assessment process through triangulation of FOC services within one document to enable fluid streamline documentation into the risk assessment.	Maternity Unit Managers/ TV Team	January 2026	• Icon for PTL boards has been added to review list at part of rebuild of whiteboards by IT team. First whiteboard working group to be held on 27/1/26. • There is an increased focus on a multi-disciplinary risk assessment with increased discussion at huddles and handovers.
	• To improve the compliance with risk assessment & SKINS bundle completion within Maternity.		February 2026	• Maternity to transfer documents to Sunrise. • To arrange study sessions to update on the changes & support on the completion of the documents.

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.	Manual Handling & TV Leads	January 2026	• Delay due to changes needed to material used on straps due to fire safety regulations, company aiming to have this rectified before next foam mattress order.
	• To review equipment to assist staff in repositioning complex patients, meaning fewer staff are required to reposition these patients appropriately .	Manual Handling Team	March 2026	• Manual Handling lead has liaised with company who have agreed to fund tubular slide sheets for 2 wards to trial at WHH. Wards to trial will be Kings C1 and Cambridge K. Trial will commence in January 2026. Training and evaluating under way.
		Manual Handling Lead	April 2026	• Trial of patient chairs is progressing, and phase 1 will be completed by December 2025. Meeting to be held in February 2026 to discuss final results & to award contract to a supplier.
	• Repositioning as a theme to be discussed at TV Stakeholder event, January 2026. Multidisciplinary invitation list, to align new Trust Wide Improvement Plan (TWIP) actions, review current actions and trust wide data.	Tissue Viability Team	January 2026	• Stakeholder planned for 14th January 2026.
Ineffective heel offloading continues to be a recurrent theme in the development of hospital acquired pressure ulcers.	• 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.	Tissue Viability Team	February 2026 January 2026	• Heel offloading compliance and technique audit to be repeated in 6 months. • Joint TV & MH ward-based scenario training has commenced, assisting staff with patients and providing real time teaching & support simultaneously.
	• To continue to raise awareness of the appropriate techniques for offloading heels	Tissue Viability Steering Group	March 2026 April 2026	• Stakeholder event planned for January 14th. Heel offloading to be discussed as part of the ongoing issues. • Reviewing new guidance from EPUAP & NPIAP to align trust wide policy and best practice. • PAG asked to review current pillow supplier to provide a more effective product.
Medical device related pressure ulcers continue to be a recurrent theme trust wide.	• Provide a targeted approach based on learning from incidents involving face to face training in the appropriate clinical areas	Matron for ICUs	January 2026	• Analysis of causative factors to be presented at Tissue Viability Stakeholder event in January to allow for more targeted actions to be delivered.
	• In response to an increased in facial damage due to NIV masks, current mask to be reviewed.	Procurement Assurance Group	December 2025	• Masks reviewed by respiratory ward & aim is for them to trial. Alternative NIV masks now in use on Respiratory ward. Monitoring for reduction in MDRPU.

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 Falls Lead/ADoN FoC/ADON WDET	March 2026 January 2026 March 2026	• Newly updated TWIP includes action for matrons/ward managers to role model categorising of 1 & 2 pressure ulcers. • Virtual awareness workshops on Decision Tool completion & skin inspection to commence. • ED now have pressure ulcer risk assessment icon on tracker board to evidence early identification of risk. • Due to pressures in the ED Tissue Viability Team meeting with ED senior nurses in person. ED to send representation to Tissue Viability Stakeholder event in January. • Tool to be digitalised meeting held with ADON IT plan for standalone document to be developed. In queue with IT.

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 approved and updated on Policy Centre completed • Patient safety training programme in place: PSIRF, Swarm, AAR, Incident Investigation, Engagement/Duty of Candour, Human Factors. • The Patient Safety Partners policy has been approved and is available on Policy Centre. Interviews for the two (2) PSP posts are scheduled for January and February • Training compliance with level 1 of the patient safety syllabus is 93.6% Trust wide, which is above the 85% KPI. Specialties that are non-compliant have been escalated to Care Group Triumvirates and QGBPs.	• Head of Patient Safety and Improvement .	30/01/2026	• 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. Annual patient safety training content review due in April 2026. • Incident Investigation, Swarm, DoC and AAR training dates are available on to book on ESR • PSIRF Plan updated and has been published on the external Trust website along with the policy. • Duty of Candour (DoC) updated policy has been approved at the Regulatory Oversight Committee and at PAG pending CNMO final sign off. The policy will be available on Policy Centre in January.
Investigations commenced in December	PSII Local: 39+2 arrived in triage with 2nd episode of reduced fetal movements. No fetal heart heard on auscultation. IUD confirmed on USS. AAR: Never event- The patient attended radiology for insertion of a breast marker coil . A localisation hook wire was inserted into the breast lesion after ultrasound guided biopsy instead of a marker coil. MNSI: IUD at 37+3 weeks gestation. EMCS performed – suspected placental abruption. AAR: Cardiac arrest in corridor C in WHH ED. Resuscitation commenced but unsuccessful. AAR: In hospital cardiac arrest. Unexpected death.	• Head of Patient Safety and Improvement	15/05/2026	• To be presented through PMRT to identify learning • Further review of clinical documentation with Fetal Wellbeing focus • Update outcome of IUD Diagnosis meeting to learning/actions • MOSOS to be added to 'Stop the Clock' for audit and oversight • To consider the controls in place to support the operator • Reflect on how the LocSSIP is used in practice. • AAR for LRAP presentation and approval upon completion • Presented at IRP: referred to MNSI for investigation and accepted. • Case to be presented at PMRT • DoC completed • Bereavement support in place • Links with ED overcrowding MDT review • Deteriorating patient TWIP- education regarding acute confusion. • AAR to look at SDEC first attendance. • LRAP oversight • AAR to look at remote prescribing of sodium (review policy). • Review of medical outlier on a surgical ward. • Referred to Coroner

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	• Tissue viability (including pressure ulcer) remains the highest reported incident type., with admitted with category 2 PU (184), hospital acquired moisture related skin damage (60), and Hospital acquired other ulcers (not pressure related such as blisters, skin tears and bruising) (48). These are all within normal variance and type when compared to previous months. • The top subcategories for Care/Treatment were Delay in providing treatment (128) of which 11 related to delays in Parkinsons treatment. A review of the Parkinsons service is underway with provider and commissioning partners. • The top subcategories for Delay/Failure in December were Discharge planning failure/delay (50), Breach of 104-day cancer target (49) and Failure to follow up arrangements (43). • Patient safety incidents of concern or interest, including incidents resulting in significant harm, continue to be reviewed via the PSIRF process and plan.	• Head of Patient Safety and Improvement	31/01/2026	• 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.
There has been an increase in the number of moderate harm incidents in December with 74 being reported	• Seven (7) were downgraded following outcomes of clinical reviews. • There was an increase in patients admitted with pressure ulcers (26) • There were nine (9) reported incidents relating to complications associated with operations and procedure. • There were seven (7) care/treatment issues which was within the normal variation for this category and • There was an increase in medications incidents with seven (7) reported in December. No clear themes from these identified. Four (4) of these were escalated to Pre-IRP discussion and one (1) to be management via the LfD process. One (1) aligns with the ongoing PSIRF missed medication theme, led by the Medication Safety Officer.	• Head of Patient Safety and Improvement	28/02/2026	• All moderate harm patient safety incidents are reviewed by Deputy Head of Patient Safety monthly to identify any themes and to ensure the PSIRF plan and process has been followed to ensure learning takes place. • Any emerging themes are escalated to the Head of Patient Safety and relevant clinical leads for review.
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. • Focus on governance of water systems and safety	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 and line insertion and care - Focus on governance , roles and responsibilities around water
Mixed sex breaches	• Work is continuing at QEQM and WHH to improve step down from critical care	• QEQM & WHH triumvirate	• March 2026	• System wide conversations are ongoing regarding removing 'exit block'

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 met	• All ED, AMU, SDEC and UTC staff to undertake the AIS e-learning • All ED, AMU, SDEC and UTC staff to learn to use the BSL video on demand service.	• Associate Directors of Nursing for UEAM at QEQM and WHH / Operational Managers	• By September 2026	**Benchmark data:** • UEAM staff who have completed AIS e-learning between 2021 and 2025: **8 (eight).** • Data on use of BSL video on demand in UEAM: No BSL video on demand used between April 2025 and end of December 2025.
Patients' communication needs are not always shared by ED staff with the receiving ward / SDEC or when they are sent for a diagnostic test	• ED must add the patient's communication needs to Sunrise when the patient books in.	• Associate Directors of Nursing for UEAM at QEQM and WHH / Operational Managers	• By end of June 2026	**Benchmark:** Number of patients whose communication needs are recorded on Sunrise – 10,392 as of 1st December 2025
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. Patients' family / friends must not be used unless the issue the patient presents with is clinically urgent or life threatening.	• ED Managers with support from Trust interpreting lead	• By September 2026	**Benchmark data:** • Current level of use of interpreting in ED and UTC – from April 2025 to end of December 2025: WHH 279, QEQM 247, K&CH 115, Buckland 71. TOTAL: 698 interpreting sessions (spoken languages)
Care of patients in escalation areas increases the risk to patient safety and leads to a poor patient and carer/family experience	• Patients in escalation areas receive adequate food and drink, including having their dietary needs met.	• ED Matrons and senior nurses	• By June 2026	**Benchmark data:** • FFT comments related to food and drink (data awaited) • Complaints related to food and drink whilst in ED (data awaited)
	• Carers / family say they were sign-posted to the Carers Support Hospital Service. • Carers were offered the Carers Leaflet.	• Assoc Directors of Nursing for UEAM / Heads of Nursing, plus, ED teams to signpost to support for carers	• July 2026	**Benchmark data:** • Carers survey question related food and drink (question to be added) **– update: Questions still to be added.**

Quality and safety

Safe Care

Patient Experience; Friends & Family Test (FFT)

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Inpatient care: Patients are able to get meals that meet their dietary and cultural needs.	• Patient feedback via our in-house inpatient survey shows an improvement in patients saying their dietary and cultural needs are being met. From 77% (CQC inpatient survey 2024) to 85% by March 2027.	• Directors of Nursing / Associate Directors of Nursing	• By end of March 2027	**In progress**
	• Improved score in next CQC adult inpatient survey	• Directors of Nursing / Associate Directors of Nursing	• September 2026	Results of 2024 survey shared with site senior nursing teams, along with areas requiring improvement.
Patients say they were involved in decisions about their care and treatment	• Improve the use of shared decision-making tools (e.g. BRAN) – evidence of use in five specialisms (clinical audit)	• Care Group Medical Directors • Audit team	• December 2026	**Not started yet**
	• Develop a training package for doctors on shared decision making and pilot	• Medical Education team / Patient Voice and Involvement	• End of June 2026	**Not started yet**
Patients / carers say the carer / family were involved in the discharge of their loved one	**Implement the NHSE Carers and Hospital Discharge toolkit:** • Establish a task and finish group	• Deputy COO / Associate Director of Patient Experience / Heads of Nursing / Ward staff	• February 2026	Initial discussion with Deputy COO and ADofPE taken place and DoNs asked for information on any checklists currently in use.
	• FFT additional question	• Lead for Patient Voice and Involvement	• April 2026	**Not started yet**
	• Carers survey promoted by ward staff and through social media / posters	• Matrons / Ward Managers / Communications team	• From April to November 2026	**Not started yet**
Patients say that their communication needs were met whist in hospital	• Roll out 'What Matters to me' communication posters behind patient beds on each site.	• Associate Directors of Nursing across the three sites / Lead for Patient Voice and Involvement	• February to April 2026	**Not started yet**
Patients say their spiritual needs were met whilst they are an inpatient	• Ward Accreditation audits • CQC inpatient survey 2025 / inhouse inpatient survey • Chaplaincy service profile and data on patient contacts	• QIWA team • Patient Voice and Involvement team • Chaplaincy team	• September 2026 • Six-month report to Patient Exp Cttee	**Not started yet** **Due in May and November 2026**

Quality and safety

Safe Care

Safe Staffing

Staff Type	Vacancy Rate Dec-25 (Target 10%)	Sickness Rate Dec-25 (Target 5%)	Safe Care Red Flags Dec-25

Staff Type	Care Hours Per Patient Day (CHPPD) Dec-25	Avg Fill Rate Day Dec-25	Avg Fill Rate Night Dec-25
Registered Nursing & Midwifery	6.4	86%	92%
Registered Nursing Associate	0.1	100%	100%
Health Care Support Worker	2.9	80%	100%

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 December 2025 are still at an acceptable level overall. Staff are redeployed across the sites daily to mitigate staffing based on dynamic risk assessment of patient acuity and dependency levels, with ward managers working clinically as required. Operational meetings are held throughout the day to support safe staffing levels. St Augustine's QEQM remained closed with staff being redeployed to other areas to provide support and mitigate staffing shortfalls. Invicta continues to see fluctuating activity and Mount McMaster continues to see fluctuating bed occupancy and patient acuity. Cambridge K has seen a change in function to a short stay frailty ward, with the frailty assessment unit also relocated to this area.

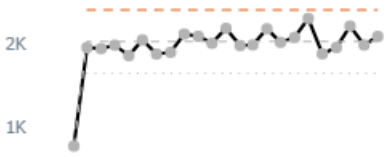
Several areas did work on amber shifts, as defined within our organisation. There was one red shift; Critical Care WHH (5 hours day shift). A shift review meeting was completed to recognise real time escalation and to support ongoing learning.

Quality and safety

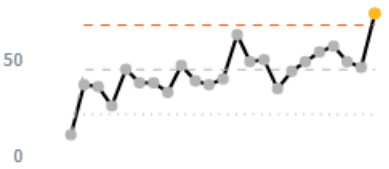
Trend Analysis

Quality Domain Metrics

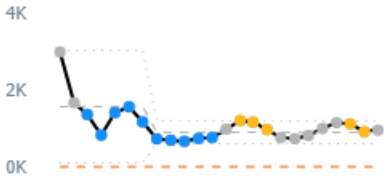
Patient Safety Incidents



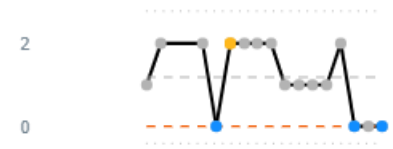
Patient Safety Incidents - Mod/Sev



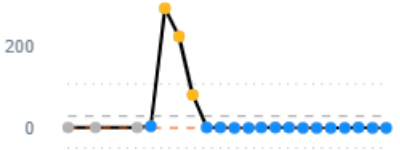
Overdue Incidents



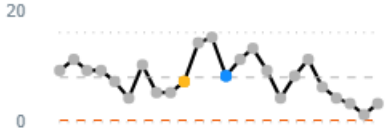
PSII - Local



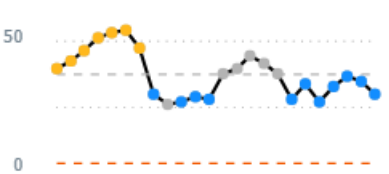
PSII - National



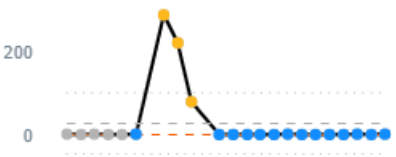
After Action Reviews (AARs)



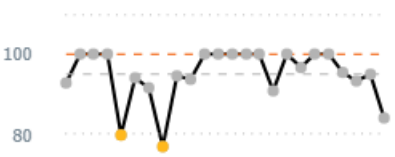
AARs Overdue



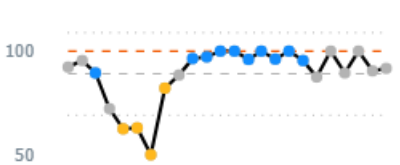
Never Events



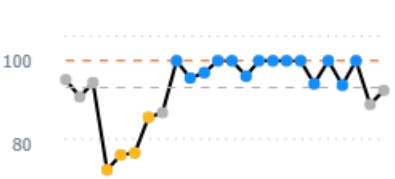
Duty of Candour - Findings



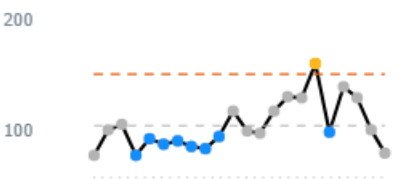
Duty of Candour - Written 15wd



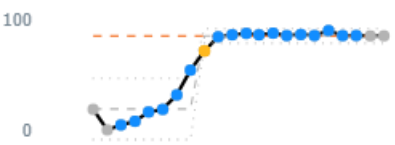
Duty of Candour - Verbal



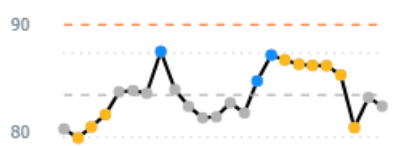
Complaints Number



Complaint Response

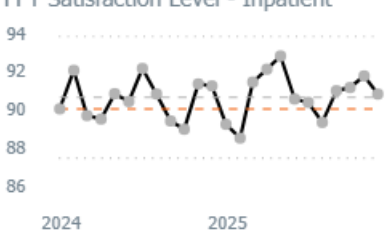


FFT Satisfaction Level - ED



FFT Satisfaction Level - Outpatient

FFT Satisfaction Level - Inpatient

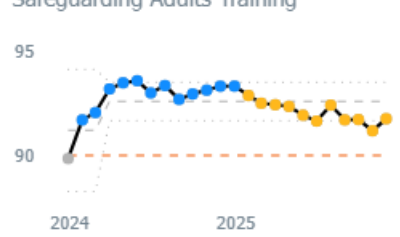


SJRs Outstanding

Safeguarding Incidents

Safeguarding Children Training

Safeguarding Adults Training

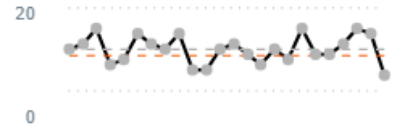


Quality and safety

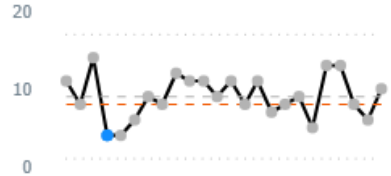
Trend Analysis

Quality Domain Metrics

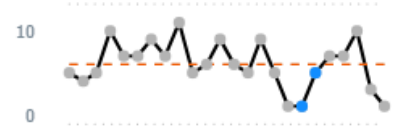
IPC: EColi Infections



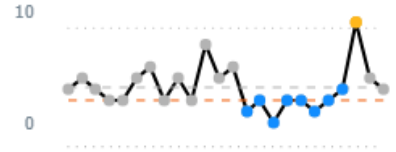
IPC: CDiff Infections



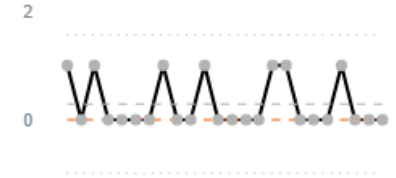
IPC: Klebsiella Infections



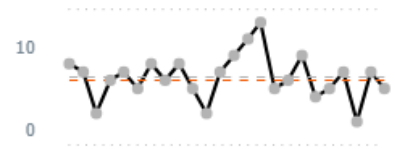
IPC: Pseudomonas Infections



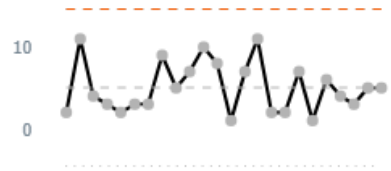
IPC: MRSA Infections



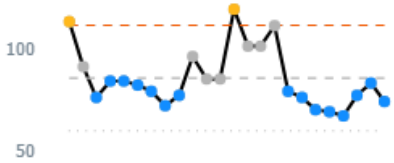
IPC: MSSA Infections



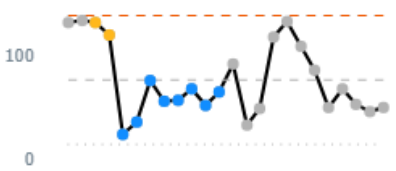
Falls with Harm



Pressure Ulcers

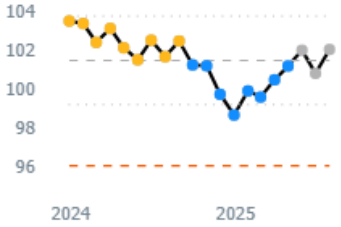


Mixed Sex Breaches

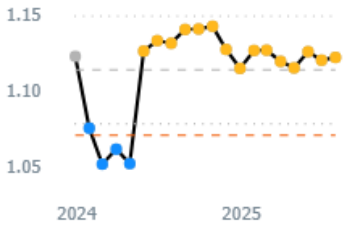


Theatre recovery Mixed Sex Breaches

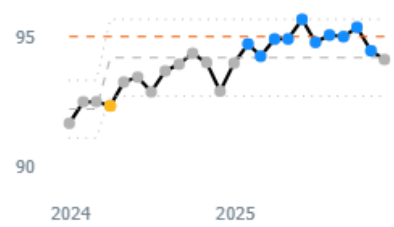
HSMR



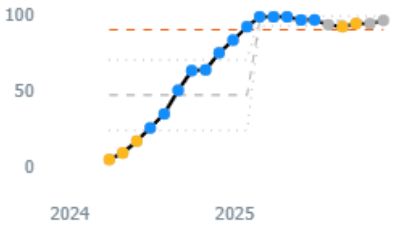
SHMI



VTE Assessment Compliance



NICE Compliance



People

Assurance

Variation

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)	Infection Control Training Premature Turnover Rate Staff Turnover Rate Statutory Training	Hand Hygiene Training	
No Significant Change		Vacancy Rate	Staff Advocacy Score
H / L — Concerning Variation (High or Low)		Appraisals Compliance Sickness	Medical Job Planning Rate Staff Engagement Score

People Scorecard View

Workforce Metrics

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
People	NAT		Sickness			5.0%	5.5%	5.0%	4.4%	4.6%	4.5%	4.5%	4.7%	4.8%	5.3%	5.3%	5.1%	5.7%
	NAT		Vacancy Rate			10.0%	9.0%	10.1%	8.9%	9.2%	9.3%	9.0%	8.6%	9.0%	8.3%	8.6%	9.1%	9.4%
	NAT		Staff Turnover Rate			10.0%	8.3%	8.2%	7.8%	7.8%	7.6%	7.6%	7.5%	7.4%	7.1%	7.1%	6.7%	6.6%
	NAT		Premature Turnover Rate			25.0%	13.5%	12.7%	12.1%	12.5%	12.6%	12.9%	13.1%	13.3%	13.2%	13.4%	12.5%	12.9%
	KEY		Appraisals Compliance			80.0%	81.4%	80.8%	80.5%	81.1%	74.8%	72.9%	75.0%	74.4%	74.9%	75.2%	75.5%	75.6%
	IIP		Staff Engagement Score			6.80	6.04	6.04	6.04	5.97	5.97	5.97	5.85	5.85	5.85			
	KEY		Staff Advocacy Score			6.70	5.55	5.55	5.55	5.49	5.49	5.49	5.29	5.29	5.29			
	NAT		Statutory Training			91.0%	92.5%	92.3%	92.4%	92.8%	93.4%	93.3%	93.4%	93.6%	93.6%	93.8%	93.9%	93.9%
	KEY		Infection Control Training			90.0%	93.1%	92.9%	92.8%	93.1%	93.3%	93.1%	93.1%	93.1%	93.1%	93.4%	94.3%	94.9%
	KEY		Hand Hygiene Training			85.0%	92.7%	91.7%	91.4%	91.7%	91.8%	91.0%	90.8%	90.5%	89.7%	89.9%	91.0%	91.0%
	KEY		Medical Job Planning Rate			90.0%	27.9%	32.1%	31.1%	30.5%	18.0%	36.4%	46.6%	50.1%	62.9%	65.8%	78.4%	0.1%

People Executive Summary

Workforce Metrics & Statutory Training

Sickness absence has risen to **5.67%** (from 5.13%), reflecting the intense seasonal pressures linked to high levels of respiratory illness and norovirus, which have contributed to the critical incident declared in January. There were 2,775 episodes of sickness in December, affecting 2,436 colleagues, an increase of 637 episodes month-on-month. Sickness rates range from 6.55% in DCB (the highest, with 645 episodes) to 4.09% in Strategy & Partnerships, the lowest across all care groups. Seasonal illness continues to dominate the profile. Coughs, cold and flu accounted for 1,063 episodes, an 81% increase from 588 the previous month. Gastrointestinal problems rose to 419 episodes, up 41% from 298. In contrast, stress, anxiety and depression fell slightly to 272 episodes, down from 284, indicating a small, real-terms improvement. Overall, 59% of absence was long term and 41% short-term, consistent with Winter patterns but amplified by the current system pressures.

The vacancy rate has increased slightly to **9.4%** (from 9.1%) but remains below the 10% threshold and broadly consistent with the pattern seen over the past 12 months. The rise continues to reflect the impact of the Vacancy Control Panel (VCP) and the deliberate holding of posts to support financial recovery. There are currently 953 vacancies, with rates ranging from 12.8% in KCRVH (the highest) to 5.5% in Strategy & Partnerships (the lowest). The largest concentrations remain in DCB (220 vacancies) and WHH (184 vacancies). The profile continues to be dominated by entry-level roles: 865 vacancies are at Band 2, representing 95% of all vacancies. There are also 228 Band 4 vacancies and 60 medical and dental vacancies, reinforcing that the primary challenge remains recruitment into the lowest bands, not retention.

Turnover has fallen again to **6.6%** (from 6.7%), reaching an historic low. Over the past 12 months 568 colleagues have left the organisation, with the highest number from DCB (151). The highest turnover rate remains in Corporate Services at 9.0%, reflecting the impact of consultation and restructure. Notably, the most frequently cited reason for leaving in this area is 'lack of opportunity', suggesting that the climate created by organisational change is proving challenging and may be influencing retention. While the headline reduction appears positive, such unusually low turnover presents a latent risk. It is driven by the current economic climate and limited external opportunities, rather than an improved staff experience. As the economy recovers, the organisation may face a sharper rise in turnover unless the underlying cultural and experiential issues are addressed. The latest staff survey results have now been presented to EMT and TMC. Work is underway to learn from high-performing areas such as the Rotary Suite at WHH, and to align survey-driven actions with the People Strategy.

Appraisal compliance remains static at **75.6%**, increasing by only 0.1% this month and remaining around 5% below target. There are 1,829 outstanding appraisals, with a further 288 due next month, indicating continued pressure on capacity and time. Compliance ranges from 77.8% at QEQM (the highest) to 66.1% in Corporate Services, where operational disruption and structural change continue to affect completion rates. The backlog remains concentrated in Nursing and Midwifery (688 outstanding) and Admin and Clerical (551 outstanding), together accounting for over two-thirds of all overdue appraisals. At a ward/ departmental level, the largest volumes of outstanding appraisals are in; Theatres QEQM (58), Maternity WHH (40) and the Patient Service Centre KCH (39), highlighting the operational hotspots where targeted support may have the greatest impact. A new appraisal policy has now been approved, shifting the Trust from an annualised cycle to an anniversary-based system. This is expected to support a more even distribution of workload across the year and reduce the peaks that currently contribute to persistent backlogs.

Statutory training compliance remains stable at **93.9%**, with 72,964 courses completed over the last 12 months and 4,754 currently outstanding. The highest volumes of overdue training are in; Acute Medical Staff at QEQM (123), Theatres QEQM (112) and Maternity WHH (109). Two of these areas appear in the appraisal hotspot list and are under significant operational pressure. Targeted intervention or intensive support here would have the most pronounced impact on overall compliance and risk reduction.

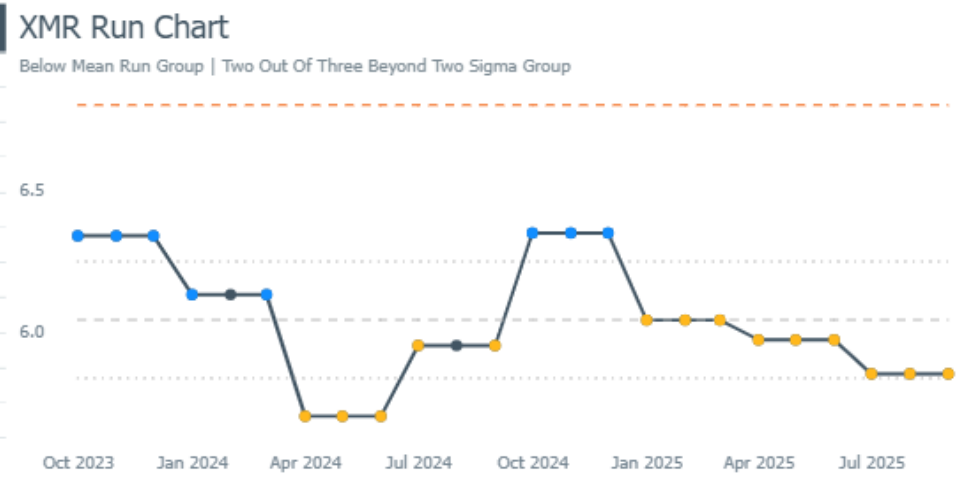
People

Integrated Improvement Plan (IIP)

Staff Engagement Score

Staff Engagement Score

Timescale	Value	SPC
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	
Sep-25	5.85	



Understanding the Latest Performance

Concern flag alerting for more than 4 periods

For the month beginning 01/09/2025 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 Culture & Inclusion	End Mar 26	• The overall picture on staff engagement remains challenging, with colleagues being clear and honest about the pressures they face. The results reflect a demanding year, marked by significant operational and financial strain and the ongoing impact of organisational change. These findings reinforce the central importance of the People Strategy and the need to accelerate work to rebuild confidence across the organisation. Despite the difficult headline position, there are reasons to be positive. Improvements are evident in themes such as team working, line management, behaviours and local wellbeing, highlighting the strength of immediate teams and the commitment of local leaders. The clearest message from the survey is the contrast between how people experience their own team and how they experience the organisation as a whole, signalling where cultural and leadership focus is most needed.
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 Culture & Inclusion	End Mar 26	• A comprehensive response is underway. Results have been shared with EMT and TMC. Care Groups now have full access, and the dashboard has been built to support local insight. Papers have been authored, and insight sessions are being run to deepen understanding of the themes. Actions are being developed at three levels – corporate, service and ward/ department – ensuring alignment with the People Strategy and enabling targeted, meaningful improvement. The overall approach is being taken to TMC in February for sign-off.
2025 NHS Staff Survey	• Driving response rates across the 2025 NSS is key to improving engagement and the credibility of results	Head of Culture & Inclusion	End Nov 25	• **Action Closed.** The action is now closed, with the survey achieving a majority response rate and the second-highest participation in the Trust's history. While the exact figure remains under national embargo, we are confident the sample is representative and credible, reflecting strong engagement from staff across all care groups, staff groups and areas. The focus now shifts to distilling what almost 5,500 colleagues told us, and developing the associated plans and actions that will underpin our organisational response.

People Integrated Improvement Plan (IIP)

Workforce Metrics

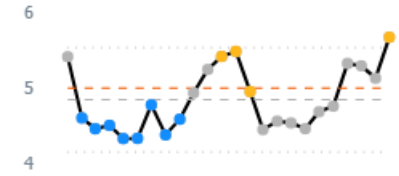
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Ensuring vacancy rate remains below the Trust threshold of 10%.	• Monthly monitoring of vacancies across Care Groups, ensuring that active recruitment is taking place. • Focus on hard to recruit areas and supporting new ways of working to reduce 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 **9.0%** 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	• **3,895** face to face counselling sessions have been delivered to-date to 885 individual. 85% of staff demonstrated clinically reliable improvement, improving CORE-OM scores by 4.19 points – from 16.40 (moderate clinical distress) to 12.21 (mild non-clinical). The counselling service will continue, albeit in a reduced capacity following reduced funding from Charitable Funds Committee.
Maintaining **Staff Turnover** against a gold standard of 10%	• Improving HCSW, Nurse & Premature retention which are the main contributors to overall turnover	Head of Culture & Inclusion	• Ongoing	• Staff Turnover remains below 8% (**6.6%**) 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. While the overall trend is encouraging, we remain mindful that the current economic climate may be artificially suppressing movement – and that if conditions shift, turnover could rise more sharply.
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 Culture & Inclusion	• Complete	• Premature turnover (**12.9%**) remains stable, inflecting upwards slightly month-on-month, though this is more a result of reduced overall turnover than any material change in new starter turnover.
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 Culture & Inclusion	• Dec 26	• Staff survey results have now been received. Plans are being developed across three levels – corporate, service, and ward/department – to respond to the findings and align actions with the People Strategy.
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 25	• Compliance for medical staff has reached **88.3%** - the highest levels 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 (77.2%).

People

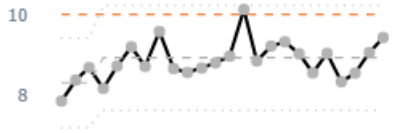
Trend Analysis

People Domain Metrics

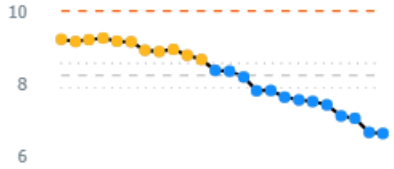
Sickness



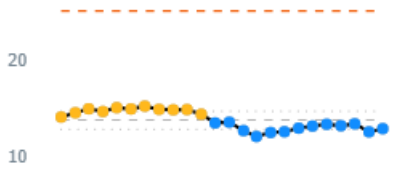
Vacancy Rate



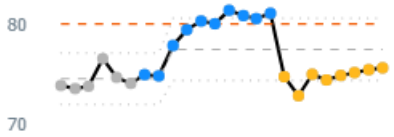
Staff Turnover Rate



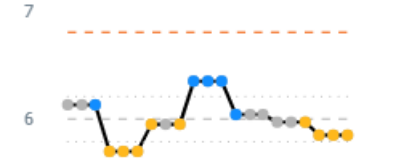
Premature Turnover Rate



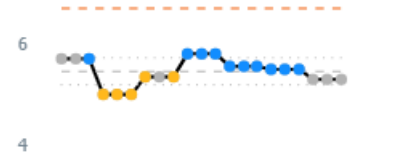
Appraisals Compliance



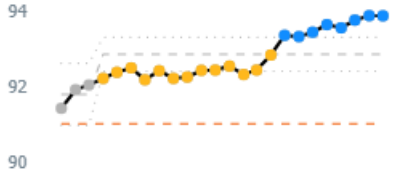
Staff Engagement Score



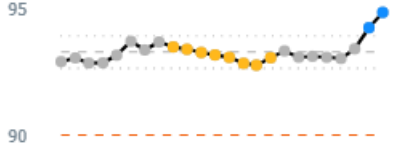
Staff Advocacy Score



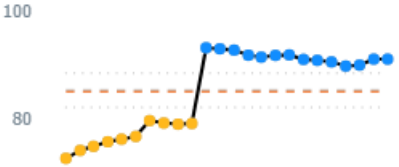
Statutory Training



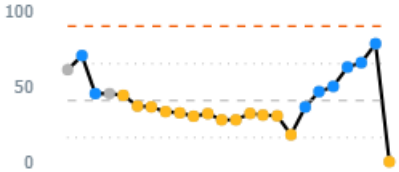
Infection Control Training



Hand Hygiene Training



Medical Job Planning Rate



Sustainability

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

Sustainability

Scorecard View

Financial Metrics

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Sustainability	IIP		Deficit In Month Group (£)			2.3M	6.5M	4.9M	5.2M	9.7M	8.8M	8.8M	8.4M	7.9M	8.0M	3.2M	5.9M	6.6M
	KEY		Variance to Plan (£)			0K	3,990K	-2K	240K	23K	10K	-35K	6K	1K	215K	-1,309K	-3,595K	-4,271K
	KEY		Premium Pay			9.6M	7.6M	8.3M	9.1M	8.7M	8.7M	7.9M	7.8M	7.9M	7.1M	7.2M	7.1M	6.4M
	KEY		WTE worked (Premium Pay)			1,105	964	1,072	1,108	1,041	971	864	880	890	794	812	779	694
	KEY		Total Pay Spend In Month			63M	53M	55M	49M	57M	56M	56M	57M	57M	56M	55M	55M	55M
	KEY		WTE worked (All Pay Spend)			10,308	10,110	10,237	10,309	10,292	10,208	10,111	10,162	10,159	10,073	10,111	9,923	9,761
	KEY		Efficiencies Green Schemes (£M)			40	35	40	45	0	6	9	12	17	21	45	50	51
	IIP		Efficiencies YTD Variance (£M)			0.0	0.4	0.4	0.5	-1.5	0.0	0.0	0.0	0.0	0.2	-2.9	-4.7	-9.0

Sustainability

Executive Summary

Financial Position

The month 9 YTD position achieved by the Group (Pre deficit support funding) was a £67.4m deficit; £9.0m adverse to plan. This is predominantly due to CIP under-delivery (which includes the reversal of the car parking VAT reclaim following the recent Supreme Court ruling in favour of HMRC (£1.7m YTD), following the step up in the CIP target in the second half of the year.

As at month 9, the Trust is £9.0m adverse to plan (Pre deficit support funding).

The Trust's income from patient care is £11.4m higher than plan YTD. This is predominantly driven by additional Specialised Commissioning income for Elective Recovery Fund (ERF) performance (£2.8m), prior year ERF (£2.0m), prior year high cost drugs (£1.9m) and over performance on rechargeable high cost drugs and devices (£4.0m).

Trust other operating income is £0.4m favourable to plan YTD. Above plan income for education and training of £1.4m is offset by below plan income for car parking, and non-patient care services totalling £1.0m.

Trust employee expenses are £11.8m adverse to plan YTD. Substantive staffing is £5.3m adverse YTD, and temporary staffing costs £6.5m adverse YTD. There is a stepped increase in the CIP target in the second half of the year, which is not currently being delivered.

Other operating expenses are £9.1m adverse to plan YTD, predominantly driven by overspends in general supplies, premises and drugs, partly offset by underspends in clinical supplies and services, purchase of healthcare, clinical negligence, consultancy and depreciation.

To note Post deficit support funding, the Group is £20.5m adverse to plan YTD. DSF has been withdrawn from K&M ICS for Quarters 3 and 4 (£23.0m impact for the Trust). This had an adverse impact of £3.8m in month and £11.5m YTD.

The year end forecast, as submitted to NHS England on 08/01/26, is a £47.4m year end deficit; £40.8m deficit to plan. The 2 key drivers being CIP under-delivery and loss of DSF (excluding DSF, £17.8m deficit to plan).

Sustainability

Financial Measures

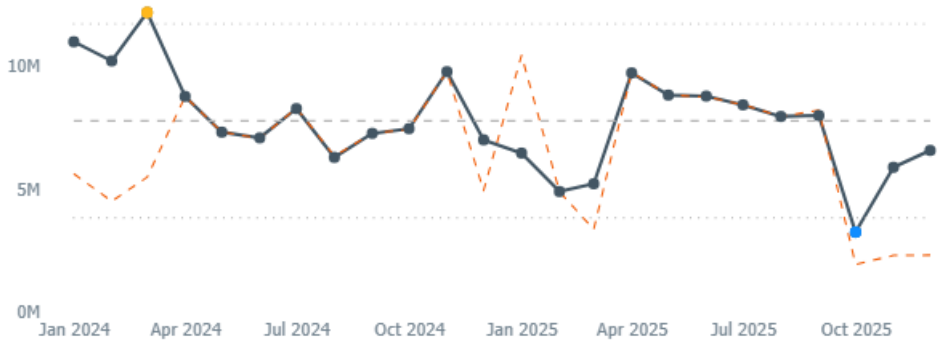
Income & Expenditure Monthly Deficit (Group)

Deficit In Month Group (£)

Timescale	Value	SPC
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	7.9M	
Sep-25	8.0M	
Oct-25	3.2M	
Nov-25	5.9M	
Dec-25	6.6M	

XMR Run Chart

No Special Cause Flags



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/12/2025 the latest Deficit In Month Group (£) performance is 6.6M against a Trajectory target of 2.3M (lower is better).

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

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 9 the Groups financial position (excluding DSF) is adverse to plan by £4.3m, with a YTD deficit of £9.0m. • The year end forecast, as submitted to NHS England 08/01/26, is a £47.4m year end deficit; £40.8m deficit to plan. The 2 key drivers being CIP under-delivery and loss of DSF (excluding DSF, £17.8m deficit to plan). • Work is continuing with the Care Groups and Corporate areas to deliver the reforecast • Regular COO and CFO led meetings with Care Groups on financial delivery are in place since November, focusing on specific areas of delivery to reduce our run-rate expenditure, identifying variances to plan and implementing mitigations, and maintaining close alignment between operational and financial performance requirements. Each meeting reviews bank spend (to achieve a 60% reduction), Agency spend (to have clear exit plans, with exceptions being agreed by the CMO) non-pay opportunities, and CIP Scheme delivery. • Trust-wide communications on Grip and Control requirements was circulated mid-November. • EKHUFT continues to engage with the system wide savings schemes. • 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

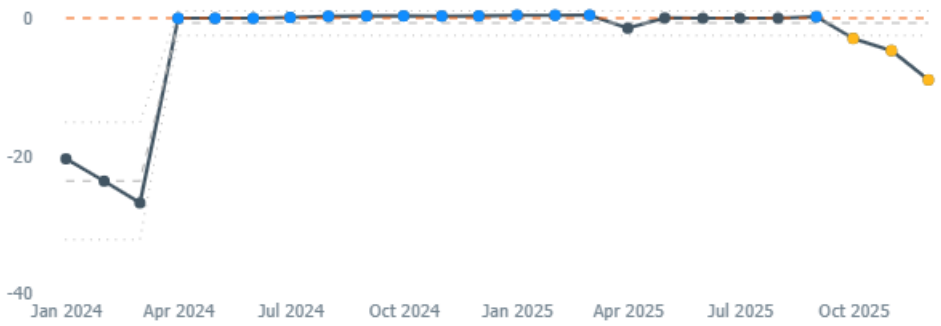
Financial Efficiencies; YTD Variance

Efficiencies YTD Variance (£M)

Timescale	Value	SPC
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	
Sep-25	0.2	
Oct-25	-2.9	
Nov-25	-4.7	
Dec-25	-9.0	

XMR Run Chart

Outside Moving Range Limit | Astronomical Point | Two Out Of Three Beyond Two Sigma Group



Understanding the Latest Performance

Concern flag alerting for 3 periods

For the month beginning 01/12/2025 the latest Efficiencies YTD Variance (£M) performance is -9.0 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. • Resourcing to support in-year delivery identified	Financial Sustainability Director	• On-going	• YTD the Trust has delivered £41.2m against a plan of £50.1m, of which YTD is 48% recurrent (the target is 75%) • The month 9 underperformance is largely driven by the Care Group-led schemes, 2gether, and Medical Workforce • The revised CIP forecast for FY2526 is £60m to deliver the revised I&E forecast, as submitted to NHS England 08/01/26.
Ensuring robust CIP reporting of achievement	• Streamlined reporting process • Robust CIP Methodology	Financial Sustainability Director	• On-going	• CIP Methodology defined • CIP reporting process streamlined • Internal audit on Efficiencies commenced Sept'25 and recommendations shared • PMO has transitioned to the Finance team as of the 1st Dec'25 to strengthen alignment of financial management and project delivery • Further infrastructure to support CIP delivery has been agreed.

Sustainability

Financial Measures

Agency & Temporary Workforce Spend

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
The Temporary Workforce team are 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.	•The Temporary Workforce/MTW team are meeting with each Care Group following the change to the agency managed service in December 2025. Working with the CMO, Managing Directors and Medical Directors to highlight the issues and gain support to reduce premium pay workers. •Need to increase DE workers, making the savings on VAT payments.	CPO	Ongoing	• Agency spend continues to reduce across all staff groups, with the largest decrease in AfC, down 29% in December 2025. •Joint sessions held with the MTW team and NHSP, CG MDs, Temp Workforce and PMO to review agency usage, agree exit plans and discuss recruitment plans following the transition to Patchwork agency manager in December 2025. The number of active agency locums has increased to 58. All agency locums to be reviewed with exit plans to be agreed. • Monthly meetings are now scheduled with all Care Groups. The MTW team and currently undertaking a review of current rates paid against the rate caps and discuss plans to reduce these to improve our compliance. • Our DE throughput decreased in December 2025 to 89%. This was partly due to the transition away from the ID Medical managed service and it is expected that this will return to 95% once all bookings have fully migrated. Plans are now in place to remove/replace the long-term standard placement locums. We now have four standard placement locums remaining with exit plans agreed. • Notice was served for 7x long-term agency locums in December who are looking to migrate to the bank. This is due to be completed in January, taking the total to 40 for the financial year to date. • New agreed processes are now in place following the transition to Patchwork agency manager. • Bank and Agency trackers tools shared with CG's; to be monitored weekly and monthly via PMO and CG finance meetings.
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 Temp Staffing & 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 December 2025, down 68% when compared to April 2025. Overall medical agency hours also continue to reduce in line with exit plans (down 67% compared to April 2025). • A new AfC rate card (agency) was 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, with a further 4 joining in December 2025. • The South East Temporary Staffing Programme has published their next step down rates for both agencies and bank. These have now been approved and were implemented in October 2025. • On the 1st March 2025, the Trust implemented a restriction on the use of agency staff for bands 2 and 3. Agency hours (AfC bands 2-3) has reduced 100% since this was implemented. • Working with the ICB, a number of new controls/processes have been implemented to support 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. • The Next stage of AFC rate card step down was applied in October 2025.

Sustainability Financial Measures

Agency & Temporary Workforce Spend

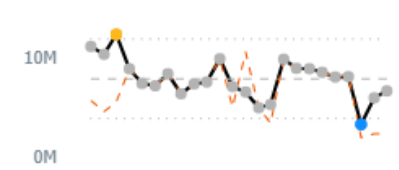
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Agency management across the South East NHS Region means disparity across Kent and Medway Trusts for Medical rates.	•Sign up to the Kent and Medway Collaborative Medical Rate Card •Areas above cap to work with the Temp Staffing team & South East 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	•Temp Staffing, PMO & South East Collaboration; monthly meetings scheduled, to progress and implement actions against CIPs. •To date, we have successfully reduced the hourly rates of 30 long-term agency locums. Plans are now being established ahead of the transition to the new service. • As a result of tighter controls, a number of agency locums are now considering migrating to the bank or joining the Trust substantively. 7x agency locums and 4x AfC agency staff served notice in December with their transition to the bank to be completed in January. A further 6x agency locums and 5x AfC agency staff are currently starting the application process. • Agreed exit plans discussed and in place for the majority of the remaining agency locums. Regular meetings are continuing, now being led by the MTW team following their implementation in December 2025. • A regional meeting was held with the South East Collaborative to review the current bank position with the intention of aligning our rate cards. When reviewing our medical rate card, only the Consultant rate was above the new cap. Analysis has now been completed and should the consultant rate be reduced to the new cap, this would save the Trust approximately £33k per month. •Plans are also now being established to reduce our bank rates (medical), which contributes an additional spend of approximately £130k per month.

Sustainability

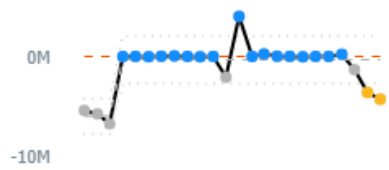
Trend Analysis

Sustainability Domain Metrics

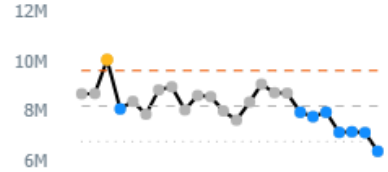
Deficit In Month Group (£)



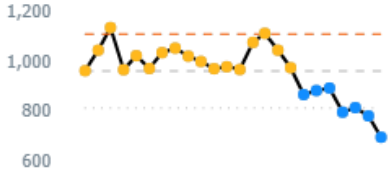
Variance to Plan (£)



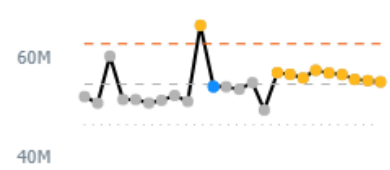
Premium Pay



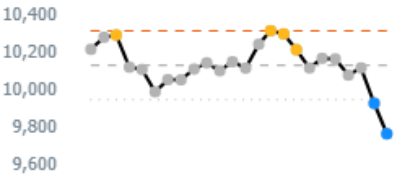
WTE worked (Premium Pay)



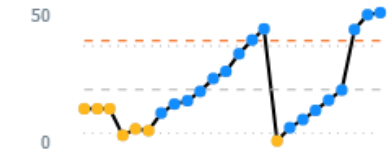
Total Pay Spend In Month



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 PSII - National (Maternity)	
No Significant Change	Extended Perinatal Mortality	FFT Maternity (IP) Recommended Maternity Complaint Response Maternity Complaints PSII - Local (Maternity)	
Concerning Variation (High or Low)		FFT Maternity Recommended Mat Patient Safety Incidents Mod/Sev	WH Engagement Score

Maternity: Scorecard View

Maternity Metrics

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Maternity	KEY		Mat Patient Safety Incidents Mod/Sev			9	4	6	7	3	4	2	7	3	5	2	2	11
	NAT		PSII - National (Maternity)			0	0	0	1	1	0	0	0	0	0	0	0	0
	NAT		PSII - Local (Maternity)			0	1	0	0	0	1	1	0	0	1	0	0	0
	KEY		Maternity Complaints			16	8	6	7	7	4	5	6	3	16	10	7	7
	KEY		Maternity Complaint Response			85.0%	100%	60.0%	80.0%	100%	75.0%	100%	100%	66.7%	100%	25.0%	88.9%	100%
	KEY		Extended Perinatal Mortality			5.44	3.73	4.43	4.44	3.93	3.76	3.73	4.06	3.39	3.55	4.07	4.58	4.39
	NAT		FFT Maternity Response Rate			15.0%	10.0%	10.3%	11.9%	8.2%	10.6%	9.1%	39.3%	41.0%	42.8%	27.0%	33.2%	30.4%
	NAT		FFT Maternity Recommended			90.0%	92.5%	91.2%	90.5%	90.9%	89.9%	86.2%	89.4%	86.5%	84.9%	85.4%	87.9%	88.7%
	NAT		FFT Maternity (IP) Recommended			90.0%	91.5%	95.3%	94.3%	97.6%	96.0%	95.8%	90.4%	83.9%	86.5%	91.3%	89.1%	90.6%
	KEY		WH Engagement Score			6.90	6.19	6.19	6.19	6.03	6.03	6.03	5.78	5.78	5.78			

Maternity: Executive Summary

Maternity Mortality Measures

The extended perinatal rate remains below the threshold of 5.44 per 1,000 births, with the 12 month perinatal rate performance at 4.39 in December 2025. This rate includes both stillbirths and neonatal deaths.

In December, the neonatal death 12 month remained below the MBRRACE target of 1.84 for the 8th time in the 12 month rolling reporting period, at 1.02. The service reported 0 neonatal death >24 weeks in month, and a total of 6 in the past 12 months.

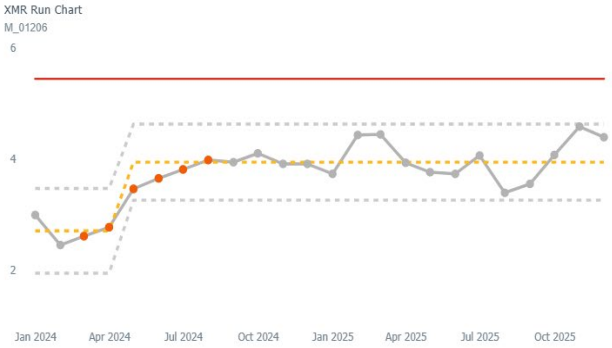
The stillbirth rate decreased slightly in month, from 3.57 in November to 3.38 in December. The service reported 2 stillbirths in month and a total of 20 in the past 12 months.

MBRRACE Ext Perinatal Rate 12m

FILTER: TOTAL | RP05230 | M_01206 | Updated: 15/01/2026 09:52

M | Dec 25
4.39
Num: 26
Denom: 6K

Timescale	Value	Target	Num	Denom
M | Jan-25	3.73	5.44	22	5,901
M | Feb-25	4.43	5.44	26	5,864
M | Mar-25	4.44	5.44	26	5,861
M | Apr-25	3.93	5.44	23	5,847
M | May-25	3.76	5.44	22	5,855
M | Jun-25	3.73	5.44	22	5,891
M | Jul-25	4.06	5.44	24	5,916
M | Aug-25	3.39	5.44	20	5,899
M | Sep-25	3.55	5.44	21	5,923
M | Oct-25	4.07	5.44	24	5,895
M | Nov-25	4.58	5.44	27	5,890
M | Dec-25	4.39	5.44	26	5,924

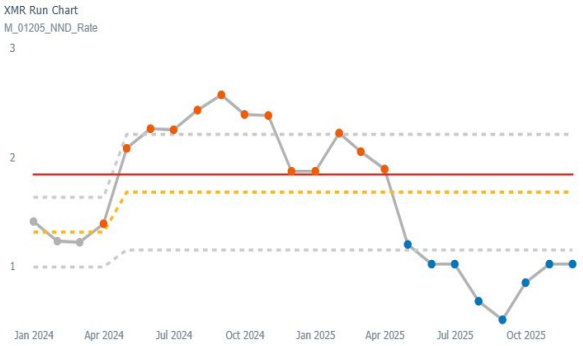


MBRRACE NND Rate 12m

FILTER: TOTAL | RP05230 | M_01205_NND_Rate | Updated: 15/01/2026 10:05

M | Dec 25
1.02
Num: 6
Denom: 6K

Timescale	Value	Target	Num	Denom
M | Jan-25	1.87	1.84	11	5,890
M | Feb-25	2.22	1.84	13	5,851
M | Mar-25	2.05	1.84	12	5,847
M | Apr-25	1.89	1.84	11	5,835
M | May-25	1.20	1.84	7	5,840
M | Jun-25	1.02	1.84	6	5,875
M | Jul-25	1.02	1.84	6	5,898
M | Aug-25	0.68	1.84	4	5,883
M | Sep-25	0.51	1.84	3	5,905
M | Oct-25	0.85	1.84	5	5,876
M | Nov-25	1.02	1.84	6	5,869
M | Dec-25	1.02	1.84	6	5,904



MBRRACE Stillbirth 12m Rate

FILTER: TOTAL | RP05230 | M_01204_SB_Rate | Updated: 15/01/2026 09:17

M | Dec 25
3.38
Num: 20
Denom: 6K

Timescale	Value	Target	Num	Denom
M | Jan-25	1.86	3.60	11	5,901
M | Feb-25	2.22	3.60	13	5,864
M | Mar-25	2.39	3.60	14	5,861
M | Apr-25	2.05	3.60	12	5,847
M | May-25	2.56	3.60	15	5,855
M | Jun-25	2.72	3.60	16	5,891
M | Jul-25	3.04	3.60	18	5,916
M | Aug-25	2.71	3.60	16	5,899
M | Sep-25	3.04	3.60	18	5,923
M | Oct-25	3.22	3.60	19	5,895
M | Nov-25	3.57	3.60	21	5,890
M | Dec-25	3.38	3.60	20	5,924

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

Maternity: Executive Summary

Maternity Investigations

Datix	MNSI	Current open MNSI investigations	Progress
WEB315829	MI-049910	Neonatal Therapeutic cooling	Investigation commenced following consent from parents
WEB322689	MI-050962	Intrauterine Death	Investigation commenced
WEB324577	MI-051407	Neonatal Therapeutic cooling	Investigation commenced

	Current open local PSSI's	Progress
WEB313295	Twin birth – 31/40 – Twin 1 admission to NICU	Investigation in progress
WEB320567	Term IUD	Investigation commenced
WEB306840	Maternal bladder injury and unexpected neonatal admission to NICU	Investigation in progress
WEB312352	Management of pre-term labour and maternal DVT	Previously a PMRT case. Declared a PSII in Sept for additional investigation – investigation in progress
WEB313471	Joint neonatal/maternity case. Medical gases availability	Investigation in progress

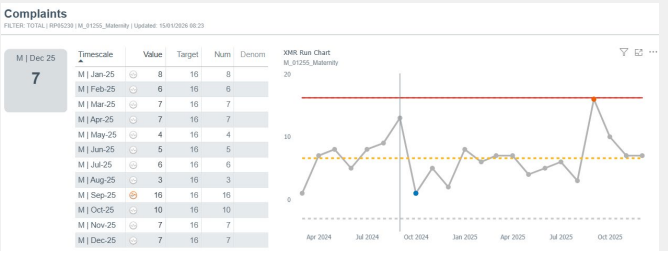
11 moderate /severe patient safety incidents were reported in December under the following categories:

- X3 PPH >1500ml
- X1 Return to theatre (laparotomy)
- X1 Unplanned Hysterectomy
- X1 Unexpected NNU admission
- X2 Intrauterine deaths (QEQM)
- X1 Eclamptic seizure – ITU admission
- X1 Neonatal thermoregulation
- X1 Collapse due to medical condition

This position is subject to change following review of reported incidents and detailed consideration given to grading of harm.

Maternity: Maternity Care

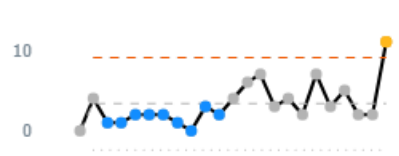
Patient Experience, Incident Reporting & Complaints

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
				FFT response rate remains higher than average However, the recommended rates have been decreasing, with total maternity recommended score at 88.7% against a threshold of 90%. This is the 6th month below average and is a significant change. AN spells have the lowest satisfaction, with small numbers responding (<10) 
	• 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.			• The number of maternity overdue incidents in December was 180– an increase of 27 from previous month • 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 • NHSP provided for staff able to support the incident investigation process with a particular focus on overdue and soon to be overdue incidents. • Incident data sheets emailed to incident handlers to support them to target their overdue incidents when they are time constrained 
		• Head of Governance		• Total of 7 maternity complaints received in December 2025 • Complaint response rate was 100% in December for Obstetrics against a threshold of 85%. 

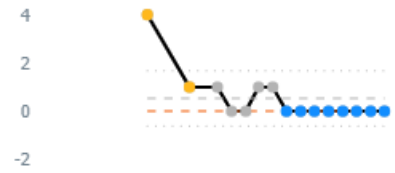
Maternity: Trend Analysis

Maternity Domain Metrics

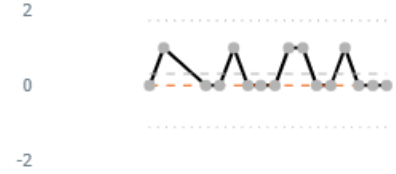
Mat Patient Safety Incidents Mod/Sev



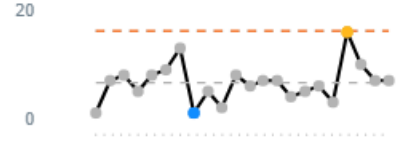
PSII - National (Maternity)



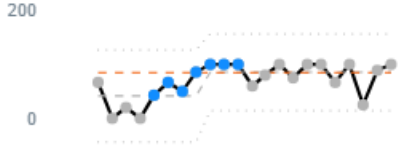
PSII - Local (Maternity)



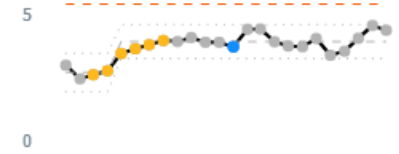
Maternity Complaints



Maternity Complaint Response

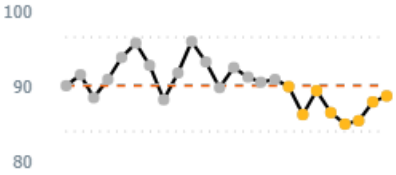


Extended Perinatal Mortality

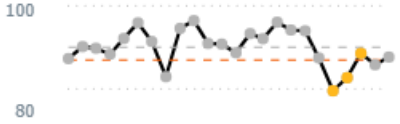


FFT Maternity Response Rate

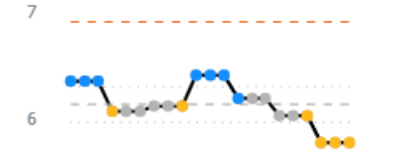
FFT Maternity Recommended



FFT Maternity (IP) Recommended



WH Engagement Score



25/114.2

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Month 9 (M9) Finance Report**

Meeting date: **5 February 2026**

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

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

Appendices:

Appendix 1: Month 9 Finance report

Executive summary:

Action required:	**Information**
Purpose of the Report:	The report is to update the BoD on the financial performance for December 2025 (Month 9).
Summary of key issues:	**The Finance Report** The Month 9 Year to Date (YTD) position achieved by the Group (Pre-Deficit Support Funding (DSF)) was a deficit of £67.4m, £9.0m adverse to plan, as illustrated below.

£000	**YTD Plan**	**YTD Actual**	**YTD Variance**
Patient care income	£708,685	£721,468	£12,783
Other income	£56,969	£47,342	(£9,627)
Employee Expenses	(£534,204)	(£546,799)	(£12,595)
Other operating expenses	(£284,260)	(£284,198)	£62
Non-operating expenses	(£6,124)	(£5,659)	£465
Operating Surplus / (Deficit)	**(£58,934)**	**(£67,846)**	**(£8,912)**
Technical Adjustments	£530	£486	(£44)
TECHNICALLY ADJUSTED SURPLUS / (DEFICIT) EXCL DEFICIT SUPPORT	**(£58,404)**	**(£67,360)**	**(£8,956)**

The Trust's Month 9 YTD position was a deficit of £70.2m, £9.0m adverse to plan, as illustrated below.

£000	**YTD Plan**	**YTD Actual**	**YTD Variance**
Patient care income	£695,242	£706,629	£11,387
Other income	£49,659	£50,017	£358
Employee Expenses	(£493,201)	(£504,960)	(£11,759)
Other operating expenses	(£307,529)	(£316,640)	(£9,111)
Non-operating expenses	(£5,897)	(£5,752)	£145
Operating Surplus / (Deficit)	**(£61,726)**	**(£70,706)**	**(£8,980)**
Technical Adjustments	£530	£486	(£44)

25/114.2

	TECHNICALLY ADJUSTED SURPLUS / (DEFICIT) EXCL DEFICIT SUPPORT	**(£61,196)**	**(£70,220)**	**(£9,024)**

The Trust's income from patient care is £11.4m higher than plan YTD. This is predominantly driven by additional Specialised Commissioning income for Elective Recovery Fund (ERF) performance (£2.8m), prior year ERF (£2.0m), prior year high cost drugs (£1.9m) and over performance on rechargeable high cost drugs and devices (£4.0m).

Trust other operating income is £0.4m favourable to plan YTD. Above plan income for education and training of £1.4m is offset by below plan income for car parking, and non-patient care services totalling £1.0m.

Trust employee expenses are £11.8m adverse to plan YTD. Substantive staffing is £5.3m adverse YTD, and temporary staffing costs £6.5m adverse YTD. There is a stepped increase in the Cost Improvement Programme (CIP) target in the second half of the year, which is not currently being delivered.

Other operating expenses are £9.1m adverse to plan YTD, predominantly driven by overspends in general supplies, premises and drugs, partly offset by underspends in clinical supplies and services, purchase of healthcare, clinical negligence, consultancy and depreciation.

2gether Support Solutions (2gether) reported a YTD surplus of £2.8m, £0.3m ahead of plan. This is primarily due to the contract price uplift required to meet group transfer pricing rules being approved by the Trust and subsequently invoiced. In addition, there has been a YTD improvement in retail catering profit and higher bank interest received.

Spencer Private Hospitals (SPH) reported a YTD surplus of £0.02m, £0.3m below plan. This is mainly due to higher pay and operating costs partially offset by increased patient care income. Measures are in place to reduce agency spend going forward.

The Trust cash balance (excluding subsidiaries) at the end of December was £15.6m.

Key recommendations:	The Board of Directors is asked to review and **NOTE** the financial performance of Month 9.

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.

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Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: Finance and Performance Committee – 27 January 2026

East Kent Hospitals University NHS Foundation Trust

Finance Performance Report 2025/26

December 2025

Chief Finance Officer
Angela van der Lem

We care

Group Summary
Month 09 (December) 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	645.475	652.809	7.334	0.000	0.000	0.000	15.597	16.608	1.011	(0.771)	(1.769)	(0.998)	660.301	667.648	7.347
NHS Income From Commissioners - Drugs	44.060	46.720	2.659	0.000	0.000	0.000	0.000	0.000	0.000	(1.382)	0.000	1.382	42.678	46.720	4.042
NHS Income From Commissioners - Devices	5.707	7.100	1.393	0.000	0.000	0.000	0.000	0.000	0.000	(0.001)	0.000	0.001	5.706	7.100	1.394
Other Income	49.659	50.017	0.358	126.092	137.676	11.584	0.044	0.034	(0.010)	(118.826)	(140.385)	(21.559)	56.969	47.342	(9.627)
Total Income	**744.901**	**756.646**	**11.745**	**126.092**	**137.676**	**11.584**	**15.641**	**16.642**	**1.001**	**(120.980)**	**(142.154)**	**(21.174)**	**765.654**	**768.810**	**3.156**
Substantive Staff (inc. Apprenticeship Levy)	(444.780)	(450.070)	(5.290)	(33.511)	(34.496)	(0.985)	(5.811)	(7.598)	(1.787)	0.543	1.463	0.920	(483.559)	(490.701)	(7.142)
Bank Staff	(33.621)	(39.456)	(5.835)	0.000	0.000	0.000	0.000	(0.108)	(0.108)	0.002	0.107	0.105	(33.619)	(39.457)	(5.838)
Agency/Contract	(14.800)	(15.434)	(0.634)	(1.614)	(0.913)	0.701	(0.612)	(0.295)	0.317	0.000	0.001	0.001	(17.026)	(16.641)	0.385
Total Employee Expenses	**(493.201)**	**(504.960)**	**(11.759)**	**(35.125)**	**(35.409)**	**(0.284)**	**(6.423)**	**(8.001)**	**(1.578)**	**0.545**	**1.571**	**1.026**	**(534.204)**	**(546.799)**	**(12.595)**
Drugs	(78.179)	(78.991)	(0.812)	0.000	(0.009)	(0.009)	(1.985)	(1.929)	0.056	1.834	1.571	(0.263)	(78.330)	(79.358)	(1.028)
Rechargeable Devices	(5.707)	(7.100)	(1.393)	0.000	0.000	0.000	0.000	0.000	0.000	0.001	0.000	(0.001)	(5.706)	(7.100)	(1.394)
Supplies and Services - Clinical	(40.204)	(36.774)	3.430	(43.203)	(49.950)	(6.747)	(1.671)	(1.086)	0.585	1.585	7.762	6.177	(83.493)	(80.048)	3.445
Supplies and Services - General	(101.458)	(117.389)	(15.931)	(24.978)	(27.350)	(2.372)	(0.186)	(0.203)	(0.017)	112.717	127.642	14.925	(13.905)	(17.300)	(3.395)
Clinical negligence	(28.326)	(27.196)	1.130	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	(28.326)	(27.196)	1.130
Depreciation and Amortisation	(20.040)	(18.466)	1.574	(0.387)	(0.813)	(0.426)	(0.172)	(0.256)	(0.084)	0.000	0.000	0.000	(20.599)	(19.535)	1.064
Other non pay	(33.615)	(30.723)	2.892	(19.747)	(21.441)	(1.694)	(4.816)	(5.117)	(0.301)	4.277	3.620	(0.657)	(53.901)	(53.661)	0.240
Total Other Operating Expenses	**(307.529)**	**(316.640)**	**(9.111)**	**(88.315)**	**(99.563)**	**(11.248)**	**(8.830)**	**(8.591)**	**0.239**	**120.414**	**140.596**	**20.182**	**(284.260)**	**(284.198)**	**0.062**
Non Operating Expenses	(5.897)	(5.752)	0.145	(0.141)	0.124	0.265	(0.094)	(0.030)	0.064	0.008	(0.001)	(0.009)	(6.124)	(5.659)	0.465
Profit/Loss	**(61.726)**	**(70.706)**	**(8.980)**	**2.511**	**2.828**	**0.317**	**0.294**	**0.020**	**(0.274)**	**(0.013)**	**0.012**	**0.025**	**(58.934)**	**(67.846)**	**(8.912)**
Less Technical Adjustments	0.530	0.486	(0.044)	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.530	0.486	(0.044)
Technically Adjusted Profit/Loss	**(61.196)**	**(70.220)**	**(9.024)** 1	**2.511**	**2.828**	**0.317** 2	**0.294**	**0.020**	**(0.274)** 3	**(0.013)**	**0.012**	**0.025** 4	**(58.404)**	**(67.360)**	**(8.956)** 5
Non Recurrent Deficit Support Revenue Allocation	46.089	34.567	(11.522)	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	46.089	34.567	(11.522)
Deficit Support Adjusted Profit/Loss	**(15.107)**	**(35.653)**	**(20.546)**	**2.511**	**2.828**	**0.317**	**0.294**	**0.020**	**(0.274)**	**(0.013)**	**0.012**	**0.025**	**(12.315)**	**(32.793)**	**(20.478)**

1. Trust

It was agreed in the planning process, at the outset of this financial year, that non-recurrent Deficit Support Funding (DSF) totalling £57.6m would be received in 2025/26. This non-recurrent allocation reduced 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, with DSF shown below the line to maintain emphasis on the recurrent position. However, it should be noted that due to the System being off plan in their Month 6 reporting, DSF has currently been withdrawn from K&M ICS for Quarters 3 and 4 (£23.0m impact for the Trust).

The Trust's YTD position as at month 9 is £20.5m adverse, primarily driven by the aforementioned loss of DSF income in October to December (£11.5m), the reversal of the car parking VAT reclaim following the recent Supreme Court ruling in favour of HMRC (£1.7m YTD) and other CIP under-performance, following the stepped increase in CIP targets from October. Excluding the impact of DSF, the Trust is £9.0m adverse to plan YTD.

- Income from patient care is £11.4m higher than planned YTD. This includes additional income for delegated Specialised Commissioning ERF performance of £2.8m, prior year ERF £2.0m, prior year high cost drugs £1.9m and overperformance of £4.0m in rechargeable high cost Drugs and Devices. Furthermore there is overperformance in Chemotherapy of £0.4m as well as overperformance from the Compensation Recovery Unit of £0.5m and GUM Pathology of £0.4m.
- Other operating income is £0.4m ahead of the YTD plan, mainly due to higher than expected education and training income.
- Employee expenses are £11.8m over plan year-to-date, reflecting overspends across substantive staff groups excluding administrative and clerical, alongside adverse bank staff costs. This position is predominantly attributable to under-delivery of CIP.
- Other operating expenses are £9.1m worse than plan YTD, with overspends in non-clinical supplies, premises, other costs and drugs partly offset by underspends in clinical supplies, purchased healthcare, clinical negligence and consultancy.

2. 2gether Support Solutions

2gether Support Solutions delivered a £2.8m year-to-date surplus, £0.3m above plan. This is primarily due to the contract price uplift required to meet group transfer pricing rules being approved by the Trust and subsequently invoiced. In addition, there has been a year-to-date improvement in retail catering profit and higher bank interest received.

3. Spencer Private Hospitals

Spencer Private Hospitals reported a YTD surplus of £0.02m, £0.3m below plan. This is mainly due to higher pay and operating costs partially offset by increased patient care income. Measures are in place to reduce agency spend going forward.

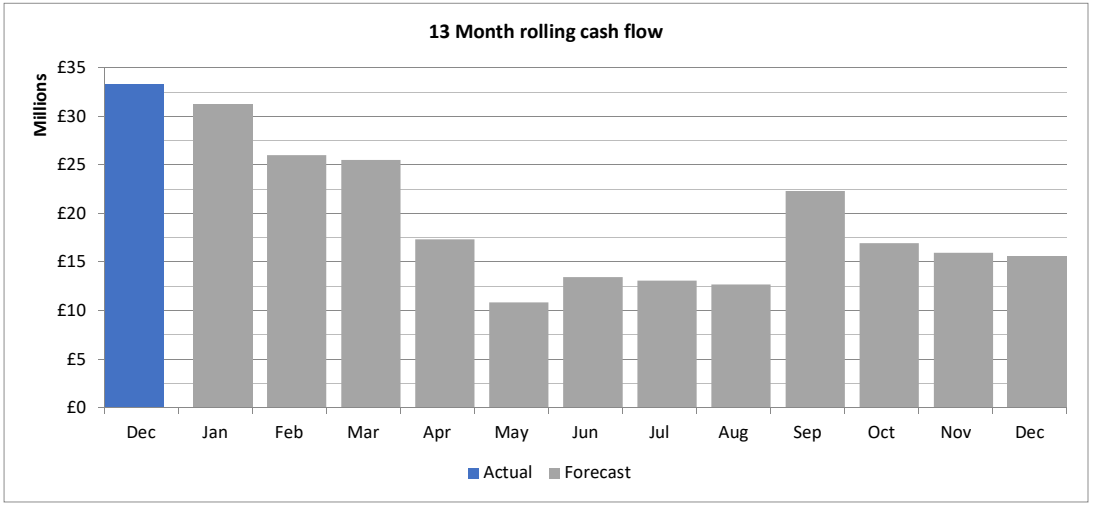
4. Consolidation Adjustments

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

5. Group

The YTD deficit for the Group as at Month 9 stands at £67.4m (excluding the non-recurrent DSF allocation), which is adverse to plan by £9.0m.

Cash Flow
Month 09 (December) 2025/26



Unconsolidated Cash balance was £15.6m at the end of December 2025, £16.0m below plan.

Cash receipts in month totalled £96.6m (£6.6m above plan)

- K&M ICB paid £69.3m in December (below plan by £4.0m. M09 £3.8m DSF was not received per plan)
- NHS England paid £7.2m in December, £0.4m above plan
- The November VAT reclaim was received in month, £4.0m, and the December reclaim expected has been reforecast for receipt in M10.
- No Capital PDC was received in month, £3.2m below plan
- Other receipts totalled £4.7m (this includes £1.9m from other NHS organisations and £2.8m from Non NHS debtors)

Cash payments in month totalled £97.8m (£8.7m above plan)

- Creditor payment runs were £27.3m (£3.0m above plan)
- £19.1m payments to 2gether (£1.8m above plan)
- Total payroll was £51.4m (£3.9m above plan in month 9)

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

Deficit Support Funding - DSF is dependant upon the ICS delivery of the system plan. Funding was received in Quarters 1 and 2. Notification that DSF will not be received in H2 has been received. Q3 and Q4 DSF has thereforebeen removed from the cashflow forecast and cash will be managed on this basis unless advised otherwise at a later date. The impact of this will be seen in reduced payments to creditors and a decline in the Better Payment Practice Code (BPPC) compliance.

PDC Revenue Support - The Trust received £11.5m support in December 2025**.** The Trust has also received confirmation from NHS England that the application to draw £10.2m PDC Revenue Support in January 2026 has also been successful (and has been received by the Trust on the 19th January). A further application has been submitted for February support of £5.0m. The region has supported this request and a final decision from NHSE on this application is not expected until early February.

The efficiency delivery - 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 further decline in the Better Payment Practice Code (BPPC) compliance.

PDC capital programme - 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 50 day creditor terms for suppliers in month 9. At the end of December 2025, the Trust was recording 41 creditor days (Calculated as invoiced creditors at 31st December/Forecast non-pay expenditure x 365).

Statement of Financial Position

Month 09 (December) 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**	**366.968**	**6.195**	**64.913**	**63.421**	**(1.492)**	**4.349**	**4.132**	**(0.217)**	**(141.301)**	**(138.988)**	**2.313**	**288.734**	**295.533**	**6.799**
Inventories	7.546	8.270	0.724	6.022	6.022	0.000	0.060	(0.109)	(0.169)	0.000	0.000	0.000	13.628	14.183	0.555
Trade Receivables	34.729	45.842	11.113	17.299	17.196	(0.103)	4.056	5.935	1.879	(21.540)	(23.132)	(1.592)	34.544	45.841	11.297
Accrued Income and Other Receivables	(3.870)	(3.710)	0.160	(0.115)	(0.172)	(0.057)	(0.083)	(0.082)	0.001	0.000	0.000	0.000	(4.068)	(3.964)	0.104
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	15.636	(32.059)	24.189	32.101	7.912	3.048	2.368	(0.680)	0.000	0.000	0.000	74.932	50.105	(24.827)
Current Assets	**86.100**	**66.038**	**(20.062)**	**47.395**	**55.147**	**7.752**	**7.081**	**8.112**	**1.031**	**(21.540)**	**(23.132)**	**(1.592)**	**119.036**	**106.165**	**(12.871)**
Payables and Accruals	85.542	89.879	4.337	23.409	27.738	4.329	4.421	5.303	0.882	(17.889)	(19.425)	(1.536)	95.483	103.495	8.012
Deferred Income and Other Liabilities	6.262	19.084	12.822	0.000	0.000	0.000	0.000	0.000	0.000	0.000	(0.015)	(0.015)	6.262	19.069	12.807
Provisions	10.424	4.367	(6.057)	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	10.424	4.367	(6.057)
Borrowing	4.244	4.688	0.444	2.468	2.158	(0.310)	0.079	0.026	(0.053)	(4.485)	(4.603)	(0.118)	2.306	2.269	(0.037)
Current Liabilities	**106.472**	**118.018**	**11.546**	**25.877**	**29.896**	**4.019**	**4.500**	**5.329**	**0.829**	**(22.374)**	**(24.043)**	**(1.669)**	**114.475**	**129.200**	**14.725**
Provisions	3.724	3.634	(0.090)	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	3.724	3.634	(0.090)
Borrowing	67.533	65.132	(2.401)	48.231	46.629	(1.602)	1.887	1.869	(0.018)	(111.229)	(107.762)	3.467	6.422	5.868	(0.554)
Non Current Liabilities	**71.257**	**68.766**	**(2.491)**	**48.231**	**46.629**	**(1.602)**	**1.887**	**1.869**	**(0.018)**	**(111.229)**	**(107.762)**	**3.467**	**10.146**	**9.502**	**(0.644)**
Net Assets	**269.144**	**246.222**	**(22.922)**	**38.200**	**42.043**	**3.843**	**5.043**	**5.046**	**0.004**	**(29.238)**	**(30.315)**	**(1.077)**	**283.149**	**262.996**	**(20.153)**
Public Dividend Capital	609.877	623.091	13.214	30.267	30.267	0.000	0.048	0.048	(0.000)	(30.315)	(30.315)	0.000	609.877	623.091	13.214
Retained Earnings	(394.090)	(430.228)	(36.138)	9.008	11.766	2.758	2.185	2.185	0.000	0.000	0.012	0.012	(382.897)	(416.265)	(33.368)
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**	**246.218**	**(22.924) 1**	**39.275**	**42.033**	**2.758 2**	**5.045**	**5.045**	**0.000 3**	**(30.315)**	**(30.303)**	**0.012 4**	**283.147**	**262.993**	**(20.154)**

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 £20m compared to 2024/25, primarily due to reductions of £32m in cash and recievable increased by £12m. Further details provided on the cash and working capital pages.

Current Liabilities - Current liabilities increased by £11.5m, mainly due to a £13m increase in deferred income from education-related revenue,and £4m increase in payables partly offset by £6m lower provisions (see Working Capital sheet).

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

Public Dividend Capital - In month and YTD movement in Public Dividend Capital (PDC) was £13.2m of which £11.5m relates to revenue support and £1.7m was capital PDC.

2. 2gether Support Solutions:

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

Current Assets - Current assets have increased by £7.8m mainly due to increase in cash.

Current Liabilities - Current liabilities decreased by £4.0m, mainly due to increase in payables.

3. Spencer Private Hospitals:

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

Current assets increased by £1.0m, driven by higher trade receivables offset by slight reduction in cash and inventories**.**

Current Liabilities: Increased by £0.8m, primarily due to a increase in invoice payables.

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

Capital Expenditure
Month 09 (December) 2025/26

2025/26 Capital Programme	Annual	Actual	FOT	FOT	FOT	FOT
£000	Plan	M9 YTD	M10	M11	M12	Year-end
PEIC (Critical Estates Priorities)	4,000	2,091	985	1,009	776	4,861
MDG (Medical Devices Replacement)	3,000	1,327	398	607	1,288	3,620
ERP (Equipment Replacement Programme)	3,800	430	0	0	2,845	3,275
IDG (IT Hardware and Systems Replacement)	2,300	1,350	1,250	1,485	1,660	5,745
Fire Compartmentation Strategy	4,930	3,051	175	250	301	3,777
Subsidiaries - 2Gether Suport Solutions (2SS)	450	84	0	66	300	450
Subsidiaries - Spencer Private Hospitals (SPH)	64	39	0	0	25	64
Thanet CDC	4,340	338	0	146	10	494
Hyper Acute Stroke Unit (HASU)	3,580	1,087	24	24	147	1,282
Diagnostics Imaging (QEQM MRI) - 2025/26 (Year 2)	2,050	1,786	0	0	0	1,786
WHH Cardiac Catheter Lab	1,190	114	96	250	540	1,000
Aseptic Suite Remedial Works	750	595	0	0	0	595
Block and Beam replacement - WHH - 2025/26 (Year 2)	350	350	40	60	50	500
Nursery Major Refurbishment Works	300	0	0	0	0	0
Maternity Information System (MIS)	125	0	125	0	0	125
Pathology Pneumatic Tubes - System Replacement	100	0	0	0	0	0
Procurement of 2x Mobile CT Scanners - 2025/26 (Year 2) - Enabling Wc	60	0	0	0	0	0
NHSE Maternity Scheme (Early Release Fees) - 2025/26 (Year 2)	800	257	150	193	200	800
2025/26 National Diagnostics Programme	1,218	0	0	0	522	522
2025/26 National UEC Programme	23,765	6,062	1,230	3,435	8,473	19,200
2025/26 National CIR Programme	12,637	4,077	2,197	3,113	3,845	13,232
2025/26 National CIR Programme - Phase 2	0	0	676	952	1,127	2,755
2025/26 Critical Estates Infrastructure - Design Works	0	0	5	35	110	150
Endoscopy Lease Equipment purchase	0	943	0	0	0	943
Maternity (CQC) Urgent Works	0	1	0	0	0	1
Digital Pathology Projects	0	1,104	149	541	352	2,147
Patients Experience Portal (PEP) integration with NHS App	0	0	17	17	217	250
Robotic Assisted Surgery	0	14	0	0	4,402	4,416
GB Energy NHS Solar	0	28	1,200	800	172	2,200
CDC Liver Surveillance Pathway	0	0	99	0	0	99
Pharmacy Automation Replacement at KCH	0	0	0	0	796	796
Donated Assets	600	548	0	0	52	600
Right of Use Assets (RoUA) - IFRS16 Leases	758	611	0	0	47	658
All Other	0	(148)	0	0	60	(89)
	71,167	**26,137**	**8,816**	**12,981**	**28,319**	**76,254**
Expenditure as a percentage of Year-End Forecast		**34%**	**12%**	**17%**	**37%**	**100%**
Funding						
Operational Capital	29,175					29,698
Donations	600					600
PDC	38,420					45,956
Total Funding	**68,195**					**76,254**
Funding Under/(Over) utilisation	**(2,972)**					-

At Month 9, the **year-end forecast of £76.254m is fully compliant with the available capital funding** envelope. The position includes the following adjustments to the previously-reported forecast (of £75.854m):
- Digital Histopathology scanner to support TATs reduction **(£0.25m additional** external PDC funding) and CDC Pathway Development **(£0.15m additional** external PDC funding), both following BCSG approval of business cases in December 2025.
- Re-distribution of circa £6.5m of identified capital slippage and VFM underspends against a corresponding level of mitigations that were endorsed and approved at the Capital Investment Group (CIG) in December 2025.

The Group's gross capital **YTD spend to the end of Month 9 was £26.14m**, representing 34% of the total year-end forecast. The remaining 66% is expected to be delivered in Q4, so there is an **inherent degree of risk**, however this is being monitored by the the Capital Working Group that is now meeting on a weekly basis to recieve regular assurance from all scheme leads on the delivery of the 2025/26 capital programme schemes and to provide a forum where any risks can be swiftly escalated to Execs and/ or dealt with immediately. The **£28.3m profiled for delivery in Month 12** is broken down into two main areas:

• **£20.2m (circa 71%) relates to externally funded schemes**, some of which are yet to have approval to proceed. Whilst assurance on delivery of all the strategic capital schemes has been received from the capital leads, this is **contingent upon a timely approval by the National Team** of the associated business cases that have been or are due to be submitted imminently.

• £8.1m profiled into M12 are internally funded schemes that have been approved by CIG as part of the 2025/26 slippage mitigation process. All reasonable steps have been taken (particularly for those schemes involving equipment purchasing) by the Procurement team to ensure delivery within the agreed timelines, though there remains significant reliance on suppliers' ability to do so.

• One piece of equipment will be vested (i.e. transfer of ownership completed but delivery delayed to align with installation date) which is a replacement CT Scanner at QEQM. This will be delivered to site in the 3rd week of April and go live by the end of May 2026.

Further PDC funding expected in Month 10 (subject to recieving MOU's):

• **£1.72m PDC Funding for Critical Estates Infrastructure (CIR) works** following submission of a bid for additional CIR funding submitted to the K&M ICB. The intention is to link a corresponding level of internally funded Fire Safety works to this external funding, in order to release the internal operational capital to fund the lease of a Vanguard Mobile Theatre unit for a period of 3 years (an enabling scheme for the Theatre Fire Safety works in 2026/27).

• **£1.55m PDC Funding for Maternity and Neonatal (M&N)** following submission of an expression of interest for capital to fund additional Maternity and Neonatal estates works and equipment totalling £1.55m across WHH, QEQM and K&C in December 2025. Confirmation expected from the National Team at the end of January 2026.

Cost Improvement Summary
Month 09 (December) 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
01. Estate Utilisation & Rationalisation	147	120	(27)	2,044	736	(1,308)
02. Procurement	593	483	(111)	3,114	2,947	(167)
03. Digital Utilisation & Rationalisation	104	36	(68)	405	121	(284)
05. Medical Workforce	744	129	(615)	3,445	843	(2,602)
06. AHP | Nursing | Midwifery Workforce	187	29	(158)	913	227	(686)
07. Non-Clinical Workforce	313	265	(48)	1,383	2,643	1,260
08. Diagnostics	90	144	54	461	740	279
09. Integrated Urgent and Emergency Care	257	97	(160)	1,225	746	(479)
10. Theatre Utilisation	163	39	(124)	770	90	(680)
11. Outpatients	44	46	2	211	150	(61)
12. Medicines Management and Devices	58	203	145	526	1,289	763
13. Subsidiaries - 2gether	417	13	(404)	3,750	44	(3,706)
14. Subsidiaries - Spencer	44	-	(44)	168	-	(168)
15. Service Efficiency Review	-	-	-	-	-	-
16 to 23 Care Group Led Schemes	6,684	1,073	(5,611)	31,713	10,153	(21,560)
25. Central	-	2,897	2,897	-	20,420	20,420
26. Miscellaneous	-	-	-	-	-	-
27. System	-	-	-	-	-	-
Grand Total	**9,845**	**5,575**	**(4,270)**	**50,128**	**41,150**	**(8,978)**

Delivered £000

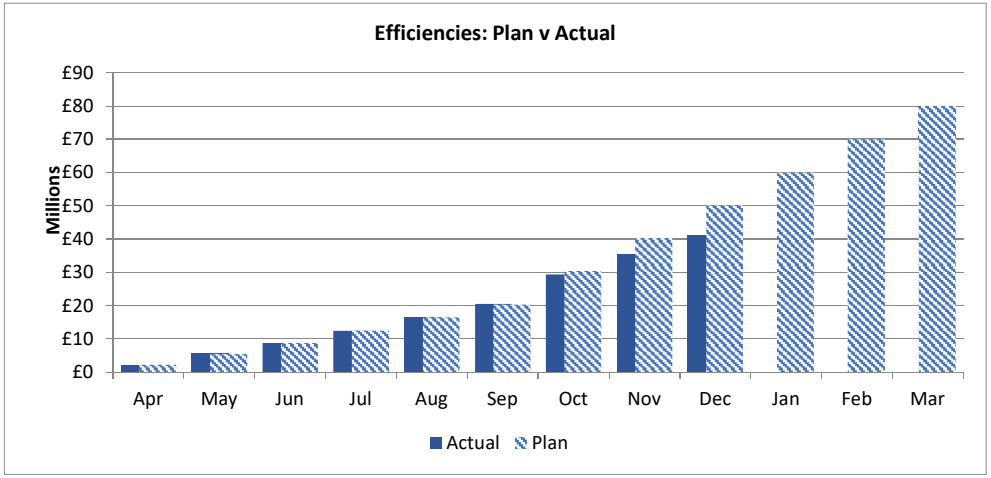
Month	Target	Actual
April	2,290	2,040
May	3,252	3,549
June	3,308	3,263
July	3,594	3,608
August	4,074	4,082
September	3,803	4,000
October	10,152	8,839
November	9,810	6,193
December	9,845	5,575
January	9,909	
February	9,941	
March	10,022	
	80,000	**41,150**
		51.4%

The agreed Efficiencies plan for 2025/26 is £80.0m. CIP delivery is adverse of plan in Month 9 by £4.3m and £9.0m YTD.

Total savings of £41.2m have been delivered to month 9; £14.9m from Pay schemes, £20.6m from Non-pay schemes and £5.7m from income schemes. The recurrent/non-recurrent delivery YTD is 48% Recurrent, 52% non-recurren

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.

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.



East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Significant Risk Register Report**

Meeting date: **5 February 2026**

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:

Appendix 1: Significant Risk Register by residual risk rating 27 January 2026

Executive summary:

Action required:	Assurance
Purpose of the Report:	This paper presents the current Significant Risk Report 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 27 January 2026, when the Significant Risk Register was extracted there were 43 risks on the Significant Risk Register. There are seven risks with associated overdue actions. This is an improved position on the last report. These have been escalated with risk owners and delegates via the Risk Review Group and Accountable Executives informed. There has been one new risk. One approved since the last report to the Board. One risk has been de-escalated and one risk has closed. Full details are within Section 4. 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 last Risk Review Group meeting was held on 20 January 2026. A deep dive was received from Queen Elizabeth the Queen Mother Hospital (QEQM) Care Group and Corporate Medical.

East Kent Hospitals University NHS Foundation Trust

	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.
Key recommendations:	The Board of Directors is asked to receive and **NOTE** the Significant Risk Report for assurance purposes and for visibility of key risks facing the organisation.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Partnerships • Sustainability
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. At present there is reduced corporate support for risk although some temporary support (two days per week) is due to commence on 26 November 2025.
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 (20 January 2026). A report will be received by Trust Management Committee on Wednesday 4 February 2026.

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 27 January 2026.

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 20 January 2026. A deep dive presentation was provided by QEQM Care Group and Corporate Medical. No new risks were approved at the meeting.

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 43 risks in total on the Significant Risk Report. This is one less risk than when the last report was received by the Board.

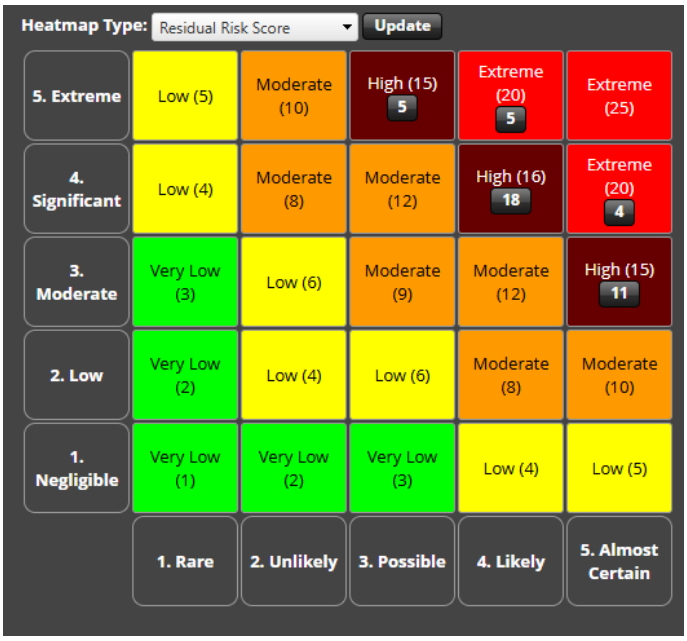
3.2 There has been one existing risk escalated to the Significant Risk Register since the last report. One further risk has been closed and one risk has been de-escalated. The remainder of the residual risk ratings remain the same. The details are at Section 4.

3.3 There are overdue actions associated with seven of the risks (marked in bold for clarity on the attached Appendix). This is an improved position on the last Board report. These have been escalated for immediate attention with the Risk Owners and Delegates and Accountable Executives informed.

3.4 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.

East Kent Hospitals University NHS Foundation Trust

	Residual Risk Score				
Care Group	**15**	**16**	**20**	**25**	**Total**
CCASS CG		4			4
DCB CG	6	2	2		10
K&C CG	1	1			2
QEQM CG	2	2			4
WHH CG	1	2			3
WCYP CG		2	1		3
Corporate Medical	1	1	1		3
Corporate Nursing	2	2			4
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	**16**	**20**	**7**	**0**	**43**
CHANGE SINCE LAST REPORT	**0**	**-1**	**-1**	**0**	**-1**



4. Changes since the last report

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

The below risk was approved at the Risk Review Group on 11 December 25:

- There is a quality and financial risk that due to the gaps in the QEQM medical grade rota there will be clinical and financial implications for the Trust (risk ref: 3836) Women, Children & Young People (WCYP) Care Group. Residual risk rating 20 (extreme) – but pending further review of rating following discussion at Risk Review Group.

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

The following risk has been closed since the last Board report:

- 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 (risk ref: 3804). WCYP

Care Group. Previous residual risk reference 16 (high). Closed 27 November 2025. New rig now in use.

The following risk has been de-escalated since the last Board report:

- Lack of infrastructure to enable training provision to meet national requirements (risk ref: 3764). WCYP Care Group. Previous residual risk rating 16 (high). Reduced to 9 (moderate) on 20 January 2026.

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. Conclusion

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

End.

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
3836	11/07/2025	Care Group - Children and Young People		There is a quality and financial risk that due to the gaps in the QEQM medical grade rota, there will be clinical and financial implication to the Trust. Risk Owner: Desmond Holden Delegated Risk Owner: Karen Costelloe Last Updated: 16 Dec 2025 Latest Review Date: 02 Jan 2026 Latest Review By: Karen Costelloe Latest Review Comments: some recruitment has been facilitated by use of BDI and Patchwork assisting with further CV's for consideration	Cause: Thanet is significantly difficult area to recruit doctors. Doctors need experience in Paediatrics and Neonates as they cover SCBU as well as Paediatrics. Generally doctors recruited at QEQM are overseas and require being on the SHO rota while they gain their competencies, this can take 3-6 months (while this process takes place there is a financial cost to use locums to cover the Middle grade gaps). There has been 4 gaps for the last few months. Leading to a risk the BCYP will not get a timely review or treatment plan. Effect: Core clinical shifts are difficult to cover with Middle grade Doctors, no substantive Doctors offering to cover as a locum. There are restrictions of using agency doctors sue to special measures There is disparity across the Trust of locum rates. Substantive doctors working for other Care groups increasing fatigue/ill health and potential safety risk. This is causing difficulty approving annual leave and supporting ongoing training and development	Financial	I 4 L = 5 Extreme (20)	Utilise NHSP. Continue to explore the use of agency/recruitment finders to provide competent doctors with experience in their grade, this will reduce the ongoing cost pressures to safely cover the rota. Control Owner: Sue Swailes	Limited	I 4 L = 5 Extreme (20)	To continue to explore the company BDI to provide UK trained Middle grades. Person Responsible: Sue Swailes To be implemented by: 31 Mar 2026	**25 Sep 2025** **Sue Swailes** Still awaiting VCP sign off for 3 WTE spec doctors concerns escalated to MD due to impact and financial implication for using more agency and NSHP. We have also escalated that we are awaiting sign off of 2 spec docs in Neonates one of whom has a a Visa Expiring in one weeks time, and both of whom are awaiting permanent contracts with us. Due to the recruitments challenges for doctors with Neonatal experience that is also require for our QEQM rota we are concerned that if we lose these doctors due to the delays and uncertainty they are experiencing we will not be able to find alternative doctors to replace them.	I = 2 L = 2 Low (4)
3700	25/07/2024	Corporate - Finance & Performance Management		Failure to agree a Medium-term Financial Recovery Plan with System / Region and National Partners Risk Owner: Angela Van der Lem Delegated Risk Owner: Michelle Stevens Last Updated: 10 Jun 2025 Latest Review Date: 08 Dec 2025 Latest Review By: Emma Kelly Latest Review Comments: Reviewed with Director of FInance, 08/12/25	Cause: Inability to reach strategic alignment with the ICB/ICS on vision and purpose. Inability to develop a plan that aligns with agreed vision and purpose that is affordable to the system. Inability to reach agreement with system over the pace of change towards an agreed vision and purpose. Trust does not have capacity and capability to develop Financial Recovery Plan. System does not have capacity and capability to develop Financial Sustainability Plan Effect: Inability to reach strategic alignment with the ICB/ICS on vision and purpose leading to a divergence in expectations and consequential failure to maximise healthy life expectancy for the population of Kent, and East Kent. Inability to deliver the expectation of the population of Kent within the resources required leading to an expectation gap and/or an inability to reach a sustainable financial position. Failure to transform services quick enough to enable patient and commissioner expectations to be met within the funding available.	Financial	I 4 L = 5 Extreme (20)	Additional support to strengthen the support and capacity for the development of the Trusts Financial Sustainability Plan Control Owner: Angela Van der Lem	Adequate	I 4 L = 5 Extreme (20)	Agreement of the MTFP with Board, ICB & NHSE Person Responsible: Angela Van der Lem To be implemented by: 31 Mar 2026	**08 Dec 2025** **Emma Kelly** Due dates extended to end of March 26 as relates to delivery of plan this year 2526	I = 4 L = 3 Moderate (12)
								CFO supporting CEO SRO with the design and implementation of the programme Control Owner: Angela Van der Lem	Adequate				
								Financial Sustainability Plan approved by the Trust Board, the ICB, Regional NHSE and National NHSE Control Owner: Angela Van der Lem	Adequate				
								Monthly CFO meeting with ICS partners and also the South East Regional Team Control Owner: Angela Van der Lem	Adequate				
								Timeline review with Executive team and the ICB partners Control Owner: Angela Van der Lem	Adequate				
								Twice monthly CFO review meetings with Southeast Region NHSE and ICB CFO Control Owner: Angela Van der Lem	Adequate				

3803	17/04/2025	Care Group - Diagnostics, Cancer and Buckland		Risk of total failure of DartOCM Risk Owner: Benjamin Stevens Delegated Risk Owner: Marcus Coales Last Updated: 15 May 2025 Latest Review Date: 09 Jan 2026 Latest Review By: Naomi Rogers Latest Review Comments: A six month extension to our DartOCM support has been secured. Tactical ICE and WebViewer expected to be live by this time.	Cause: DartOCM is an electronic ordering and viewing communication system, which has been used in the Trust for over ten years. It enables General Practitioners to make electronic requests for pathology tests. All primary and secondary care users are able to view all pathology results via DartOCM, some users rely on DartOCM as their only electronic route to view results i.e. Benenden, community trust, GUM, virtual ward, acute response team and other Kent and Medway pathology services. Users within EKHUFT rely on DartOCM to view cellular pathology reports. As a result of implementing DartOCM, the majority of paper reports have now been switched off. There is a risk of the software failing and not being recoverable. Ideagen have put a hard stop on supporting the software at the end of 2025. The risk exists already as we know Ideagen are not actively supporting the product, and do not have a team with product knowledge The risk grows substantively from 31 December 2025 as they would no longer even attempt to support or fix the system, and would not be under contract to do so. Effect: In the event of a total DartOCM failure, business continuity processes would be implemented, the impact will be as follows: •DartOCM is used in approximately 118 GP and community locations for requesting tests and viewing results. EKHUFT outpatients will use the system to view results •DartOCM is used within EKHUFT and by Private Hospitals (including One Health and Benenden) as the sole electronic mechanism to view cellular pathology reports. •If DartOCM was not available, pathology would have to revert to printing paper reports. •If DartOCM was not available, GPs and community locations would have to request all tests using paper request forms. •There would be no ability to view non-NHS results or Cellular Pathology reports electronically increasing the need for	People and Quality	I 5 L = 4 Extreme (20)	BCP for significant DartOCM downtime will be paper requests and paper/telephoned results BUT we will have to provide a reduced service to primary care as the workforce we have now would not be able to cope with the significant volumes. We would have to adopt and adapt the communication we sent out during blood tube crisis requesting that only urgent requests will be accepted and processed until system fixed or replaced. Control Owner: Marcus Coales		I 5 L = 4 Extreme (20)	**Project plan in place - Trust IT, Path IT and KMPN PMO team supporting to deliver Tactical solution by 1st Dec 2025** **Person Responsible: Marcus Coales** **To be implemented by: 01 Dec 2025**		I = 4 L = 2 Moderate (8)
3782	24/03/2025	Care Group - William Harvey		Overdue Appointments for Patients on the Diabetes and Endocrine Outpatients PTL Risk Owner: Dan Gibbs Delegated Risk Owner: Komal Whittaker-Axon Last Updated: 17 Sep 2025	Cause: There are currently 10,771 patients on the Diabetes and Endocrine outpatients PTL who are due a follow up appointment within the next year, or in most cases are overdue for a follow up which currently relates to 7,972 patients.	People and Quality	I 5 L = 5 Extreme (25)	Daily reviews, weekly meeting with Head of Operations, weekly updates to the COO and Managing Directors/Care Group Tri.	Adequate	I 5 L = 4 Extreme (20)	Letter to long waiters to understand if they still need a follow up and if not discharge supported by the additional admin team member Person Responsible: Kathryn Toase To be implemented by: 30 Apr 2026	**31 Oct 2025** **Kathryn Toase** This is on hold while we wait for the trusts approach to the non-RTT FU PTL.	I = 3 L = 3 Moderate (9)

				Latest Review Date: 07 Apr 2025 Latest Review By: Emma Kelly Latest Review Comments: COO monthly risk review, 07/04/25	It is recognised that patients waiting on the list for either a follow up review or are overdue may come to harm due to the need to complete regular monitoring and adaptation of medication. This service has been impacted by Covid which resulted in cancelled clinics, it has also been impacted due to a lack of admin staff to manage the follow up PTL. We've also cancelled clinics due to locum and substantive consultants leaving. Due to continued demand on the service to provide increased ward cover as well as manage the demand of new patients we have been unable to pull this back in line. Effect: Patient harm such as a delay in diagnosis, delay in treatment and progression of disease.			Control Owner: Kathryn Toase			Procure additional Administration to Validate PTL to make sure that data is correct and clear any duplicates. Person Responsible: Kathryn Toase To be implemented by: 30 Apr 2026	**31 Oct 2025** **Kathryn Toase** Additional admin staff have not been approved. This has been put on hold as there was a trust wide plan to work through this. No update yet. Also the Admin team in D&E have been depleted due to vacancies being put on hold and then held for redeployment.	
													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. Person Responsible: Kathryn Toase To be implemented by: 30 Apr 2026	**31 Oct 2025** **Kathryn Toase** We have not been able to progress with this due to waiting for the trusts decision on how we deal with the non-RTT PTL as a whole. We also are unable to pull a doctor off the ward due to financial constraints.	
1891	14/01/2020	Corporate - Operations		Misalignment between Demand and Capacity across the Trust's urgent and emergency care pathway Risk Owner: Dan Gibbs Delegated Risk Owner: Alison Pirfo Last Updated: 14 Oct 2025 Latest Review Date: 14 Oct 2025 Latest Review By: Alison Pirfo Latest Review Comments: Actions, ECIST review and New SDEC builds all in progress.	Cause: Increased urgent and emergency care demand from the community, combined with high numbers of patients without criteria to reside and internal processes that do not support good flow create the risk of extended length of stay (>12hrs) for patients attending our emergency departments. Effect: Adverse outcome (including harm) or experience for patients due to extended length of stay in EDs. Increased expenditure on temporary staff to care for patients in corridors and other areas not specifically designed to deliver care. Ability of staff to deliver the expected standard of care. Strain on staff leading to burnout and decreased morale. Inability to offload ambulances into a recognised clinical area. Increase in care provided outside of recognised clinical areas (and impact of this on patient safety and outcomes) Risk to CQC non compliance (the service	Quality	I 4 L = 5 Extreme (20)	Daily board rounds at ward level to release beds Control Owner: Dan Gibbs	Limited	I 4 L = 5 Extreme (20)	Conduct a comprehensive review of current 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 CDU model as part of SDEC capital build process as a enabler. Colocation of 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. Person Responsible: Alison Pirfo To be implemented by: 27 Feb 2026	**05 Dec 2025** **Alison Pirfo** UTC successfully relocated, CDU realigned and commenced. SDEC decant complete and building works on both sites has commenced	I = 3 L = 2 Low (6)
									Daily sitrep calls with EK HCP and Kent and Medway OCC Control Owner: Dan Gibbs	Adequate				
									ED Corridor Care SOP and review of ED escalation flow chart (within SOP) Control Owner: Alison Pirfo	Limited				
									Full Capacity Protocol refreshed and in use. Monitoring as part of business as usual processes. Control Owner: Alison Pirfo	Adequate				
									Kent and Medway UEC Delivery Board provides system wide strategic direction attended by the COO Control Owner: Dan Gibbs	Adequate				
									Newly established UEC Board (internal to EKHUFT) has been	Adequate				

					must ensure that all staff maintain effective oversight of patients for the duration of their care within ED. For example patients are regularly assessed and reassessed clinically. Regulation 12. Risk to CQC non compliance (the service must ensure all patients are treated with dignity and respect, including during medical and clinical assessments in overcrowded areas) Regulation 10. Risk to CQC non compliance ('the service must ensure fire safety risks associated with an overcrowded department are assessed and mitigated') Regulation 12.			established with all Care Group Tri's in attendance. Monthly Emergency Care Delivery Group focusing on improvements required to improve flow & performance. Re-lauch of professional Standards in July 2024 Control Owner: Dan Gibbs						
								Trust Access Standards monitored 'ED 12 Hour Total Time in Department' Control Owner: Dan Gibbs	Limited					
								Updated Trust Full Capacity Protocol Control Owner: Alison Pirfo	Limited					
3837	15/07/2025	Corporate - Finance & Performance Management		25-26 System delivery of the Financial Position Risk Owner: Michelle Stevens Delegated Risk Owner: Last Updated: 15 Jul 2025 Latest Review Date: 08 Dec 2025 Latest Review By: Emma Kelly Latest Review Comments: Reviewed with Director of FInance, 08/12/25	Cause: The South East Region has provided guidance that there will be an assessment to confirm whether systems as a whole are on track to deliver plans. This will apply to a collective system position, rather than individual organisations, irrespective of whether a provider is assuming receipt of Deficit Support Funding (DSF) in plans. Effect: If the System does not achieve its financial plan the deficit support funding could potentially be clawed back from the K&M ICS.	Financial	I 5 L = 5 Extreme (25)	Submission of the Final Groups Annual plan 30th April 25. This included an activity, workforce and financial plan. Control Owner: Michelle Stevens	Adequate	I 5 L = 4 Extreme (20)	Monthly reporting into the Trusts Finance and Performance Committee & Trust Board. Person Responsible: Angela Van der Lem To be implemented by: 31 Mar 2026		I = 4 L = 3 Moderate (12)
								The K&M ICS has developed a System wide cost improvement plan to support the delivery of patient care and quality and delivery. Control Owner: Michelle Stevens	Limited		Twice monthly Financial Improvement Programme Board. Person Responsible: Michelle Stevens To be implemented by: 31 Mar 2026		
								The Trust is continuing to develop cost improvement plans to support the financial position of the Trust whilst also deepening the productivity and efficiency gains the Trust needs to deliver. Control Owner: Michelle Stevens	Limited		Trust unlikely to receive DSF for Q3 and 4 from ICB. Trust is submitting a cash support return (to value of outstanding DSF and residual deficit) and will await feedback. Person Responsible: Julie Wells To be implemented by: 31 Mar 2026	**08 Dec 2025** **Emma Kelly** Notification that PDC support for £11.5 million.	
3553	31/10/2023	Care Group - William Harvey		Failure of Cardiac Catheter Suite equipment (Lab 1, 2 & 3) WHH Risk Owner: Benjamin Stevens Delegated Risk Owner: Komal Whittaker-Axon Last Updated: 31 Aug 2025 Latest Review Date: 14 Nov 2025 Latest Review By: Alexandra Mcvey Latest Review Comments: updated	Cause: All 3 cardiac catheter labs at WHH require replacement due to the fact they are over 10 years old. This has led to an increasing frequency of breakdowns and also deterioration in image quality. Currently, lab 1 at WHH is out of use due to a mechanical failure and is unable to be fixed until mid October at the earliest. Effect: Potential inability to provide the regional PPCI service - divert to other sites may be required. Cancellation of electives leading to long wait time for cardiac angiography/PCI (approx 48 weeks) and clinical risk. Potential harm to patients Loss of clinical income. QE inpatients have lengthy transfer times to the WHH waiting an average of 3 days longer than patients at WHH for NSTEMI Delays to patient flow Under utilisation of lab 3 due to poor image quality. Detrimental effect on reputation Deterioration in RTT position. Impact on staff morale Impact on recruitment and retention of clinical staff.	Quality	I 5 L = 5 Extreme (25)	all PCI electives cancelled to allow for IP and pPCI to be undertaken in the remaining lab. Control Owner: Alexandra Mcvey		I 5 L = 4 Extreme (20)	Working on solution for a new lab that will act as a decant lab initially, to be implemented by end of financial year. Further lab replacements will then be reviewed once this is completed. Person Responsible: Alexandra Mcvey To be implemented by: 30 Apr 2026		I = 5 L = 2 Moderate (10)
								All procedures conducted in lab 3 to use LOW DOSE setting on the C-arm Control Owner: Merrill Schofield	Limited		Capital across 2526 and 2627 capital programmes with expected completion of scheme August 26 Person Responsible: Nicky Bentley To be implemented by: 31 Aug 2026	**17 Nov 2025** **Nicky Bentley** On track	
								Cardiology matron now in post and actively monitoring lab PTL and pulling/swapping patients across sites/ensuring better flow through the cath labs. Control Owner: Rebecca Enright	Adequate				
								Datix completed for electives cancelled due to lack of capacity/lab break down etc Control Owner: Shirley Wilson	Adequate				
								electives booked as agreed with lab lead around the PPCI's to try and minimise cancellations and avoid delays with PPCI Control Owner: Shirley Wilson	Adequate				
								Equipment moved between labs and between sites where	Limited				

								possible. Control Owner: Alexandra Mcvey						
								Issues fixed as they occur in the labs. Electives cancelled as necessary to allow the PPCI service to run as priority Control Owner: Alexandra Mcvey	Limited					
								maintenance carried out as per specification for equipment Control Owner: Alexandra Mcvey	Adequate					
								Monitoring will be on-going re radiation levels via medical physics Control Owner: Merrill Schofield	Adequate					
								Staff members are monitored by their dose badges for occupational exposure Control Owner: Merrill Schofield	Adequate					
								Utilisation of the second lab through job planning has increased use of both labs Control Owner: Alexandra Mcvey	Adequate					
								Vacant lab sessions offered out as additional shifts to consultants on admin/SPA to increase capacity. Control Owner: Alexandra Mcvey	Limited					
679	31/08/2016	Care Group - Diagnostics, Cancer and Buckland		Failure to supply, from Pharmacy, scheduled chemotherapy treatments to patients Risk Owner: Desmond Holden Delegated Risk Owner: Will Willson Last Updated: 15 Jan 2026 Latest Review Date: 15 Jan 2026 Latest Review By: Will Willson Latest Review Comments: Risk updated following Unit failure 10/01/2026	Cause: Aseptic unit failure driven by Air handling unit failure Age & location of Estate Inability to recruit and retain staffs Capacity issues internally restricting ability to meet demand Capacity issues in commercial sector for supply of ready to use chemotherapy Isolator failure within the Aseptic unit Failure to obtain consumables due to non payment of invoices Unsuitable storage conditions of consumables and starting materials Failure of cold store Delays in recruitment with key posts posts being held in the Vacancy Control Process Unable to recruit suitably qualified staff to the accountable pharmacist role Effect: 1. Patient harm from delayed chemotherapy/interrupted regimens 2. Failure to supply scheduled chemotherapy (as at 23.10.23 2500 treatments dispensed per month) 4. Cancellation of patients treatments 5. Rescheduling of patients treatments 6. Outsourcing of chemotherapy from a	Quality	I 5 L = 5 Extreme (25)	2 manufacturing rooms each with 2 isolators so as to mitigate risk of failure Control Owner: Jenny Clements	Adequate	I 5 L = 4 Extreme (20)	replace HEPA filters following unit failure 10/1/2026 Person Responsible: Will Willson To be implemented by: 01 Feb 2026	**15 Jan 2026** **Will Willson** WEB325711	I = 5 L = 2 Moderate (10)
								Accountable pharmacist in place Control Owner: Will Willson	Substantial					
								Business continuity plan in place Control Owner: Jenny Clements	Limited					
								Capacity plan in place, monitored and reviewed on a daily basis, (takes into account activity demand, staffing and isolator capacity). Breaches of capacity risk assessed. Activity demand reviewed monthly and reported through Governance structure. Control Owner: Jenny Clements	Limited					
								Control of consumable stock management and ordering - highlight supplier list in order of priority Control Owner: Jenny Clements	Adequate					
								Daily review and inspection of clean rooms Control Owner: Jenny Clements	Adequate					
								Embedded Quality Management System inclusive of:	Adequate					

					commercial market - excessive increase in costs that may not be met by NHS Specialised commissioning 7. Commercial market may not have capacity to support volume of work from EKHUFT especially at short notice 8. Risk of waste from outsourcing 9. Some treatments cannot be outsourced due to short expiries impacting on patient care 10. Increased risk of error as the unit is not designed as a 'dispensing' facility 11. Support for clinical trials would stop 12. Adverse publicity for the Trust 13. The effect of the unsuitable storage conditions of consumables and starting materials would affect the production process and ultimately the quality of the medicinal products 14. If Trust does not rectify the 3 critical deficiencies highlighted in regional QA report (12.3.24), the unit is extremely likely to be shut down, causing all of the above effects to occur. 15. Regional QA audit review (12.3.24) highlight 3 critical deficiencies which move the unit from medium to high risk unit 16. Failure of clinical trials where product required to be aseptically dispensed			Weekly quality meetings Internal and External Inspections Error reporting and review Risk assessment on days where capacity exceeded Pharmacy QA resource to refer to Control Owner: Maria Blanco-Criado					
									Estates PPM of building, AHU and clean room Control Owner: Maria Blanco-Criado	Limited					
									for the unsuitable storage conditions of stock and starting materials , storage boxes and and plastic pallets are being used to store starting materials and stock to minimize the transfer of microbiological organisms into the production unit Control Owner: Jenny Clements	Limited					
									Patient tracking list to support allocation of treatments to appts scheduled - Control Owner: Jenny Clements	Adequate					
									Quarterly PPM reports for all five isolators with supplier Control Owner: Jenny Clements	Limited					
									Reduction in length of maximum expiry date of all manufactured products to 24 hours from time of manufacture. Control Owner: Jenny Clements	Adequate					
									Risk assessment for manufactured items which have visible particulate within. Update of processes to ensure medical staff aware when situation arises.- SOP to be updated - to be worked on with Lead Oncology Pharmacist and Accountable Pharmacist Currently any treatments with visible particles that are identified as not drug particulate are being remade. Control Owner: Jenny Clements	Limited					
									SLA in place with all suppliers for servicing and support Control Owner: Jenny Clements	Adequate					
									SLA with commercial companies supported by SOP for outsourcing Control Owner: Jade Winthrop	Limited					
									Team to work with seconded Accountable pharmacist to follow action plan generated for regional QA by next regional inspection. Escalation of issues to Rebecca Morgan / Des Holden with any barriers to completion of timelines. Control Owner: Jenny Clements	Limited					
3367	03/07/2	Corporate -		Lack of timely review of diagnostic test	Cause:	Quality	I 4 L = 5	A copy of the radiology results		I 4 L = 5	**Developing the Compass technology for the Inbox**	**29 May 2025**	I = 3 L = 2			

	023	Medical		results Risk Owner: Desmond Holden Delegated Risk Owner: Helen Mackie Last Updated: 29 May 2025 Latest Review Date: 09 Dec 2025 Latest Review By: Emma Kelly Latest Review Comments: Risk reviewed with interim CEO 09/12/25 in absence of CMO. DH has asked for an urgent meeting with leads to review in light of a recent incident related to missed results.	1. Sunrise system does not currently have functionality whereby a consultant is able to review on one page all test results that sit under them for all patients. What they are required to do is to review the test results within each patients records. The challenge is that as a result of difficulty within the Sunrise system or PACS system staff are not always able select the correct consultants because of the way the system is designed therefore regularly they have to select an incorrect consultant 2. For imaging, there is inadequate safety netting for abnormal findings that may indicate a previously undiagnosed cancer. 3. For endoscopy, all patient sit on waiting lists under an endoscopist, who will not (usually) have seen or known the patient. They will not necessarily conduct the procedure and there is a lack of clarity on which professional is responsible for the ongoing care (the operating endoscopist, the person named on the waiting list or the clinician originally referring the patient). 4. Clarity on the destination of the blood test results for histo pathology and other tests. Effect: Consultants are overwhelmed with test results that do not relate to the patients that are under them and that these test results are then sent on to another consultant providing they are reviewed in a timely manner Patients will have a delay in medical and nursing response to abnormal test results. We are aware that these issues relate to radiology, pathology including histology and haemotology.		Extreme (20)	are sent to the requesting clinician. Every week, a spreadsheet is generated based on specific SNOMED codes. This spreadsheet is sent to all of the MDM co-ordinators who will look for any new cases relevant to their speciality. The MDM co-ordinators will add it to the MDM list for discussion. Regular audits (weekly) will take place to ensure that the MDM co-ordinators workload is acceptable in identifying new cases relevant to their speciality. Control Owner: Nicola Chaston		Extreme (20)	**on Sunrise for consultants to review 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: Michael Bedford** **To be implemented by: 30 Jun 2025**	**Angela Callaghan** Mike's team has held workshops for Compass and will be trialling the software.	Low (6)
									An end to end pathway in cancer standard operating procedure has been approved and is being rolled out. Control Owner: Nicola Chaston			**Audit to take place of below process:** **The radiology process should mirror the Pathology process already in place - the fail safe is sent to the MDM co-ordinator. A copy of the results are sent to the requesting clinician. Every week, a spreadsheet is generated based on specific SNOMED codes. This spreadsheet is sent to all of the MDM co-ordinators who will look for any new cases relevant to their speciality. The MDM co-ordinators will add it to the MDM list for discussion.** **Person Responsible: Beverley Saunders** **To be implemented by: 31 Dec 2025**		
									Radiology fail safe is sent to the MDM coordinator. A copy of the results are sent to the requesting clinician. Every week, a spreadsheet is generated based on specific SNOMED codes. This is sent to all the 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. This mirrors the process in Pathology. Control Owner: Gemma Matthews			**Endoscopy PTL does not readily allow tracking, or feedback results, to the original referring clinician. A task and finish group concluded the management system needs to change to mirror imaging. This has been costed and the case will be brought by the Care Group** **Person Responsible: Katherine Hills** **To be implemented by: 01 Jan 2026**		
									Radiology have implemented a number of fail safe processes. including spreadsheets of all query cancer results to the Cancer Nurse Specialists weekly. Control Owner: Gemma Matthews	Limited				
3702	25/07/2024	Care Group - Critical Care, Anaesthetics and Specialist Surgery	Critical Care - Intensive Care	Delayed discharge of patients from Critical Care when medically fit to be transferred to the ward Risk Owner: Dan Gibbs Delegated Risk Owner: Gemma Oliver Last Updated: 23 Jan 2026 Latest Review Date: 23 Jan 2026 Latest Review By: Julia Cristall Latest Review Comments: Risk reviewed. To participate in the South of England Discharge from Critical Care Quality Improvement Project.	Cause: •Risk that a bed cannot be allocated to a patient requiring elective surgery on the day due to the delayed discharges from critical care and when at capacity. This is resulting in cancelations in surgery. •The potential that emergency admissions to critical care are delayed. •Reputational damage as EKHUFT is identified as a significant national outlier with discharge data reported externally. •All delayed patients are mixed sex policy breaches •Inappropriate/potentially distressing care environment for awake recovering patients Lack of flow of patients who are made ward ready from critical care to an appropriate ward. Currently 73% of patients who are made ward ready are delayed by over 4 hours. Effect: Potential delayed start / cancellation of patients who require critical care post operatively. The potential that emergency admissions to critical care are delayed. Reputational damage as EKHUFT is identified as a significant national outlier	Quality	I 4 L = 4 High (16)	Flag up electives 24 hours before surgery due to site team Control Owner: Gemma Oliver	Limited	I 4 L = 4 High (16)	Work with site triumvirate on priority for critical care wardables to be discharged from Critical care Person Responsible: Gemma Oliver To be implemented by: 30 Jan 2026	**31 Mar 2025** **Gemma Oliver** Implementation date changed. We care project now underway, process mapping exercise commenced to understand site responsibilities.	I = 4 L = 2 Moderate (8)
									Flag up to operational team where there is a risk of no bed being available Control Owner: Gemma Oliver	Limited				
									Monthly audit reporting . Participation in South of England Safe Discharge from Critical Care Quality Improvement project Control Owner: Gemma Oliver	Limited				
									No bed to be allocated to an elective when at capacity without an identified bed being given for a ward fit patient Control Owner: Gemma Oliver	Limited				
									Request priority for discharges from critical care	Limited				

					identified as a significant national outlier with discharge data reported externally. All delayed patients are mixed sex policy breaches Inappropriate/potentially distressing care environment for awake recovering patients			Control Owner: Gemma Oliver						
3449	11/08/2023	Corporate - Medical		There is a risk that patients who stay in ED for over 24 hours may not receive appropriate assessment and review Risk Owner: Desmond Holden Delegated Risk Owner: Helen Mackie Last Updated: 09 Dec 2025 Latest Review Date: 09 Dec 2025 Latest Review By: Emma Kelly Latest Review Comments: Risk reviewed and accountable leads amended. Contact to be made with Medical Directors for respective sites for actions to be populated. 09/12/25	Cause: Due to a lack of flow and delays in beds becoming available on the wards, many patients are remaining in ED for periods exceeding 24 hours while awaiting admission to a bed on a ward. This was highlighted during the 2023 CQC inspection (and subsequent Section 29A). Speciality cover (HCOP) is not being provided and patients are being reviewed by Acute Consultants Effect: Patients who remain in ED for over 24 hours are not always receiving Consultant reviews by a sub specialty consultant in a timely way. In addition, access to support services such as therapies is limited. The ED environment is not an inappropriate space to keep patients for an extended period, impacting on patient experience, treatment and in some instances outcomes. A review with the new site medical director is planned to review how we can improve the pathway for these patients in ED. The number of patients waiting in ED for more than 24 hours is in direct correlations to DTAs as the flow within the site has contracted as the winter progresses. Delays occur in reviews of speciality patients due to Acute Consultant capacity - this delays investigations and discharges as often late in the day before reviews take place.	Quality	I 4 L = 5 Extreme (20)	A designated Consultant is allocated to review all plus 24 hours patients and there are 2 junior doctors allocated to care for this patient group. Control Owner: David Bogard	Adequate	I 4 L = 4 High (16)	Plus 24 SoP in place and action to develop an audit tool and audit compliance with this , including quality of and documentation of plans of care and time patient reviewed Person Responsible: David Bogard To be implemented by: 31 Mar 2026		I = 3 L = 2 Low (6)
								A harm review audit is undertaken by the HoN and the Clinical Director and findings acted upon Control Owner: Wayne Kissoon	Adequate				
								A junior Doctor team is allocated to the +24 hour ED patients. The number of Drs is adjusted commensurate with the number of patients Control Owner: Jonathan Purday	Adequate				
3354	27/06/2023	Care Group - Queen Elizabeth, The Queen Mother		Inability to Delivery Adequate Care in Clinical Environment due to Infrastructure Deficiencies Risk Owner: Benjamin Stevens Delegated Risk Owner: Sunny Chada Last Updated: 06 Oct 2025 Latest Review Date: 20 Jan 2026 Latest Review By: Sunny Chada Latest Review Comments: Detailed review completed.	Cause: Old estate poorly maintained means a range of areas are often unable to be utilised to provide safe patient care. Over time areas have lost their MDT spaces meaning staff lose office/access to quiet areas and toilet spaces removed for staff. Issues with ability to push Bariatric patients up ramp from Discharge Lounge/Deal Ward impacting ability to place patients in correct place. Limited bed storage results in clutter/falls risk/fire risk Repairs are not addressed in a timely manner once reported to the Estates Team due to lack of system oversight. Lack of oversight on 2GSS cleaning standards results in infection control risks and wasted money. A number of entry points to site do not have security access control. Effect: Impact on patient pathways and access to care IPT risk health & safety issues Staff morale particularly around lack of assurance that estates issues are being addressed. staff conflict due to having to work in space limited areas Fire risk due to access/clutter	Quality	I 4 L = 4 High (16)	All changes to environment now only signed off by hospital triumvirate to ensure staff and MDT spaces are protected. Control Owner: Sunny Chada	Limited	I 4 L = 4 High (16)	Review of all Fire Risks fed back from WHH Fire and Rescue visit. Sub-group to be formed to ensure immediate actions are delivered. Person Responsible: Sunny Chada To be implemented by: 30 Jan 2026		I = 3 L = 3 Moderate (9)
								Creation of CLEAN campaign launched with all staff and cleanliness a regular item on quality improvement meetings and site team agenda. Control Owner: Catherine Maskell	Limited		Site Security review completed and to be presented to corporate Security Group to secure 5 year improvement plan for funding deficiencies. Immediate doors for security breaches locked e.g. by Spencer Person Responsible: Sunny Chada To be implemented by: 02 Feb 2026		
								Regular audits of environment completed. Control Owner: Susan Brassington	Limited		Working with 2GSS to create a clear targeted investment list of areas required to improve environment. Currently focussed on ventilation in core areas and awaiting proposal. Managed through H&S committee Person Responsible: Darren Weeks To be implemented by: 26 Feb 2026		
								Staff are aware of the need to report estates issues promptly having taken appropriate remedial action and to record and follow up on requests to estates, escalating as necessary Control Owner: Susan Brassington	Limited		Creation of a transparent system to see open estates requests and to be prioritised by triumvirate with 2GSS. Reporting to be created and submitted through H&S		

					staff unhappy/low morale Staff and patients at risk due to lack of security in core areas of site.						Reporting to be created and submitted through H&S committee into Board once produced. Person Responsible: Darren Weeks To be implemented by: 26 Feb 2026		
											Pilot of handyman role approved by 2GSS to focus on patient and staff environment improvements. Handyman now in place with weekly sign off of jobs. Review effectiveness in Q4 2025/26. Person Responsible: Sunny Chada To be implemented by: 06 Mar 2026	**30 Sep 2025** **Emma Kelly** Action owner changed to Sunny Chada as 2SS employees cannot be action owners on EKHUFT 4Risk system	
											Consider external review of 2GSS cleaning service to enhance standards and gain best value for money. Person Responsible: Benjamin Stevens To be implemented by: 31 Mar 2026		
											Issues with transfer of bariatric patients to and from Deal/Fordwych due to ramp. Currently utilising multiple porters but stronger bed mover options being reviewed. Person Responsible: Darren Weeks To be implemented by: 30 Apr 2026		
3386	17/07/2023	Care Group - Women's Health	Maternity	Potential risk of inaccurate records due to Euroking backcopying Risk Owner: Sarah Hayes Delegated Risk Owner: Michelle Cudjoe Last Updated: 19 Jan 2026 Latest Review Date: 19 Jan 2026 Latest Review By: Leisa Foad Latest Review Comments: Risk reviewed at monthly risk register meeting 09/01/2026	Cause: Notified by digital midwife from another trust about some of their records showing inaccurate information. Known issue to EKHUFT from 2020 when this was reported to E3. Further attempts to upgrade to v 1.74 attempted with E3. Example of issue where a potential safeguarding risks declared at 28 weeks appearing as though reported at booking but not actioned or sweep given at term backcopying to appear it was given at 18 weeks. Parity uploading incorrectly has been raised in other trusts. National patient safety alert released July 2024 for all Maternity services to progress upgrades urgently. Effect: Information logging incorrectly, data and reporting on inaccurate records	Quality	I 4 L = 5 Extreme (20)	CIS team log ticket for all patient and pregnancy level questions to be immediately changed to contact only by Magentus Control Owner: Sharon Gough	Limited	I 4 L = 4 High (16)	**Work continues to implement MSR 2.1.2 into the Euroking Test environment to then be tested with dummy patients but able to use the load of the live environment (SSRS). 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.** **Person Responsible: Sharon Gough** **To be implemented by: 25 Dec 2025**	**09 Jan 2026** **Leisa Foad** CK has requested update from SG	I = 2 L = 3 Low (6)
								Daily "incomplete workflow" reports run trustwide, and clinicians contacted immediately to complete Control Owner: Sharon Gough	Adequate				
								Daily meetings in place with Trust IT and Magnetus to review the queries and provide regular updates on progress Control Owner: Joanne Petcher	Limited				
								EKHUFT staff can help to mitigate: Workflows are designed to be completed to the end, answering all questions. (Leaving workflows incomplete doesn't trigger all the	Adequate				
											Procurement of a new Maternity IT system to ensure adequate reporting integration with current systems and patient accessibility Person Responsible: Cherrie Knight To be implemented by: 15 Sep 2026		

									incomplete doesn't trigger all the questions correctly, and puts users at risk of not having all the information. By completing a workflow, this allows the event to be "printed" to capture the information entered at the time. If a workflow is saved as incomplete, this will not trigger the print) NEVER re-open a completed workflow – By doing this, if a branching question has been answered since in another workflow that shares with the completed workflow, or a new question has been added, this will trigger the new questions to be inserted, when they were not appropriate to be answered at the time. Always review past data in MSR or "previously printed reports". If you need to "edit" or correct a question answer in a completed workflow, please either email ekhuft.e3team@nhs.net or log a call on the IT Service desk 723 6161 . We will then log a call with the supplier to remove the incorrect data , and the workflow will be reset to "incomplete". The correct data can then re-entered into the workflow safely by scrolling down the workflow and ONLY clicking on the question needing the answer populating and saving. Once saved, please then scroll to the bottom of the workflow and save the very last question which will then complete the workflow again and give the option to print – DO NOT save other questions in the workflow that are already completed. Understand which data you can correct yourself, and which you need to report						
								Following internal BCP meeting, the CPU space has been increased 19.04.24 to allow further usage space for E3 on the server. Outcomes of this increase are positive with the system not taking as long to process Control Owner: Jon McKinlay	Substantial					
								Issue is known and being investigated by the LMNS and the regional digital group. Control Owner: Claire Bayat	Adequate					
								On-going communications to midwifery and medical staff highlighting risks related to the NPSA Control Owner: Sharon Gough	Adequate					
								This is an open CAS Alert (ref: NatPSA/2023/014/NHSPS and overseen by Patient Safety Team. Control Owner: Melinda Brewer	Adequate					
								Workflow Dictionary Changes are now in place in Production Control Owner: Sharon Gough	Adequate					
3830	01/07/2025	Care Group - Women's Health	Maternity	Demand for maternity services will exceed the current environmental and community capacity required Risk Owner: Michelle Cudjoe Delegated Risk Owner: Cherrie Knight Last Updated: 28 Oct 2025 Latest Review Date: 09 Jan 2026 Latest Review By: Leisa Foad	Cause: There is a risk that the demand for acute site maternity services will exceed the current capacity required to provide care for everyone who needs it in a safe and timely manner. In addition the community teams of EKHUFT cover approximately 800 square	People and Quality	I 5 L = 4 Extreme (20)	Consultant midwife to birth plan any out of guidance cases and ensure community staff awareness Control Owner: Katie Christie		I 4 L = 4 High (16)	Review of community staffing roles Person Responsible: Hannah Horne To be implemented by: 31 Mar 2026		I = 2 L = 2 Low (4)
												Rotation of midwifery staff into community settings Person Responsible: Hannah Horne To be implemented by: 31 Mar 2026		
								Daily cross-site sit-rep reviews of capacity and planned admissions occur across the Trust.	Adequate					

				Latest Review Comments: Risk reviewed at monthly risk meeting	meters geographically. Due to staffing challenges there are minimal community midwives to undertake on calls on a daily basis and the community teams' location and size of the geographical area that they cover, there might be a delayed response in attending a woman's home due to the travel time incurred from midwives working across the whole site. This could mean that a baby is birthed before the midwives' arrival. The volume of people indicated for admission to the acute maternity units or provided with a homebirth service across East Kent exceeds the current space allocated for this purpose Effect: There is a potential risk that during periods of high activity the maternity service is unable to accept any further admissions. This poses a significant safety risk for mothers and babies utilising maternity services within East Kent. With a negative impact on patient experience when women are required to travel to an alternative site/provider to receive their maternity care. An impact of community staff shortages is that there are occasions when there are no staff available to provide a homebirth service. This will further impact upon the acute site capacity.		Control Owner: Joanne Shayler					
							Discharge co-ordinators are employed to support flow and timely discharge of patients. Control Owner: Joanne Shayler	Adequate				
							Escalation process in place for staff to raise concerns to matrons and MOC out of hours Control Owner: Sharon Hortal					
							Homebirth huddles daily – to ensure midwives are aware of who they are on call with, phone numbers exchanged and awareness of where they are travelling from Control Owner: Sharon Hortal					
							In-situ and cross-site safety huddles are called when concerns are raised regarding capacity. Consideration is given to diverting activity to the alternate EKHUFT site. Control Owner: Joanne Shayler	Adequate				
							In-situ and cross-site safety huddles are called when concerns are raised regarding capacity. Consideration is given to diverting activity to the alternate EKHUFT site. Control Owner: Joanne Shayler	Adequate				
							Matrons and HOMs/DOMs work in clinical areas to support the monitoring and mitigation of increasing activity when required Control Owner: Joanne Shayler	Adequate				
							On call midwives are rostered to support teams overnight and weekends. During working hours, ward managers, matrons and specialist midwives can be pulled to support teams working at capacity to support activity and flow. Control Owner: Joanne Shayler	Adequate				
							Operational B7 managers are employed across all shifts on both of the acute sites to monitor activity, re-allocate staff to meet clinical need and to monitor flow. Operational managers will escalate concerns regarding capacity to matrons/Homs/DOMs Control Owner: Joanne Shayler	Adequate				
							SECAMB to provide support in an emergency capacity when required. Control Owner: Katie Christie					
							Staffing challenges reported at Sitrep daily					

								Control Owner: Sharon Hortal					
								The Birthrate Plus tool is used to review and monitor activity in the acute sites. Control Owner: Joanne Shayler	Adequate				
								When capacity concerns are anticipated, a review of planned activity is held with the intention of moving cases to the alternate EKHUFT site, staggering or deferring admissions dependent on clinical priority. Control Owner: Joanne Shayler	Adequate				
								When there are capacity concerns on both sites, mutual aid is requested from local out of Trust sites with the consideration of moving planned activity to a different accepting site Control Owner: Joanne Shayler	Adequate				
								When there are capacity concerns on both sites, mutual aid is requested from local out of Trust sites with the consideration of moving planned activity to a different accepting site. Control Owner: Joanne Shayler	Adequate				
								When there are capacity concerns on both sites, mutual aid is requested from local out of Trust sites with the consideration of moving planned activity to a different accepting site. Control Owner: Joanne Shayler					
3838	15/07/2025	Corporate - Finance & Performance Management		Failure to deliver the Trust Financial Plan for 25/26 Risk Owner: Michelle Stevens Delegated Risk Owner: Last Updated: 11 Aug 2025 Latest Review Date: 08 Dec 2025 Latest Review By: Emma Kelly Latest Review Comments: Risk reviewed Director of Finance, 08/12/25	Cause: 1)Failure to deliver £80m of cash out CIP in 2025/26 2)Failure to continue to deliver grip and control actions. Inability to manage our cost base in a more robust way than we have over the last 3 years . 3)Failure to agree a settlement with our commissioners that allows for reasonable levels of income growth including the required 5% productivity ask (National Ask). 4)Failure to identify appropriate channels for engaging staff on financial governance 5)Financial Sustainability Plan (FSP) – Inability to reach agreement with system over the shape of the FSP 6)Financial Sustainability Plan (FSP) – Unable to develop a plan that transforms services at a pace that enables breakeven within a reasonable timeframe. 7) Failure to deliver workforce head count reductions (25/26). 8) Impact of industrial strike action (junior doctors and potential nursing action) on delivery of activity and financial impact Effect: Insufficient funds to continue adequate operations of the organisation which will results in impacts on quality of care, delivery of services, reputational damage and non compliance with regulators.	Financial	I 5 L = 4 Extreme (20)	Development of Internal and External CIP schemes to deliver the required £80m savings plan. Control Owner: Michelle Stevens	Limited	I 4 L = 4 High (16)	Delivery of workforce headcount reductions (25/26) Person Responsible: Norman Blissett To be implemented by: 31 Mar 2026		I = 3 L = 4 Moderate (12)
								Monthly local and Trust level governance in place to ensure oversight or the delivery of the approved financial plan - £64.2m deficit. Control Owner: Michelle Stevens	Adequate		Mitigating actions will need to be taken if the Trust moves away from plan mid year Person Responsible: Michelle Stevens To be implemented by: 31 Mar 2026		

3833	07/07/2025	Care Group - Queen Elizabeth, The Queen Mother		Lack of Health & Safety Oversight Impacting Safety Culture Risk Owner: Benjamin Stevens Delegated Risk Owner: Sunny Chada Last Updated: 20 Jan 2026 Latest Review Date: 20 Jan 2026 Latest Review By: Sunny Chada Latest Review Comments: Updated and reviewed.	Cause: Lack of local H&S Triumvirate meetings to ensure oversight. Poor compliance on H&S mandatory training. No specific funding dedicated to enhance health and safety standards Lack of clear escalation committees means that key issues are not understood at Executive level. Effect: Annual HASTA audits evidence poor compliance. Staff morale impacted. Lethargy amongst staff around health and safety issues.	People and Quality	I 5 L = 4 Extreme (20)	H&S audits are completed. Control Owner: Stuart Hammerton	Limited	I 4 L = 4 High (16)	Site wide H&S audit to determine investment plan for 2026. Person Responsible: Sunny Chada To be implemented by: 27 Feb 2026	**08 Jul 2025** **Angela Callaghan** Working with 2together partners to understand key areas of infrastructure and service challenges to be presented back to Health and Safety Recovery Meeting.	I = 3 L = 2 Low (6)
								Key H&S risks are escalated via quality improvement group for resolution Control Owner: Sunny Chada	Adequate		Bed store proposal completed and reviewed at Capital Investment Committee on 18th November and supported for BCSG presentation in 2026. Person Responsible: Darren Weeks To be implemented by: 31 Mar 2026		
								Monthly Health & Safety Meeting now established with core agenda and ToR. Classified as BAU. Control Owner: Sunny Chada	Limited		Site security walkaround completed and investment plan to be submitted to Trust Security Group for discussion/agreement. Delayed due to winter pressures so aiming for end of Q4. Person Responsible: Sunny Chada To be implemented by: 31 Mar 2026		
								Pro-active review of HASTA prep quarterly ahead of audits to ensure full compliance now BAU through H&S commitee. Control Owner: Sunny Chada					
3384	13/07/2023	Corporate - Strategic Development & Capital Planning		The ability to deliver safe and effective services & implement improvements across Trust estate is compromised due to financial constraints for capital funding and assets replacement Risk Owner: Benjamin Stevens Delegated Risk Owner: Last Updated: 08 Apr 2025 Latest Review Date: 23 May 2024 Latest Review By: Emma Kelly Latest Review Comments: Exec led review with Ben Stevens, 23 May 24	Cause: Aged estate Limited capital investment over a number of years Limited access to capital above the Trust allocation to address all issues Effect: - Resulting in poor patient and staff experience - Loss of activity due to service interruption - Adverse effects during extreme weather conditions (e.g. leaking roofs; burst pipes leading to water supply shortage; injury to staff/patients) - Potential breaches to health & safety standards and legislation - Inefficiencies and difficulties in moving forward with providing services of the future such as the Clinical Strategy	Regulatory	I 4 L = 5 Extreme (20)	A 6 facet estates survey has been undertaken which will be used as a benchmark to prioritise backlog maintenance requirements. Control Owner: Benjamin Stevens	Adequate	I 4 L = 4 High (16)	Progress to full business case for the replacement of maternity facilities at QEQM Person Responsible: Nicky Bentley To be implemented by: 31 Jan 2026	**17 Nov 2025** **Nicky Bentley** On track	I = 4 L = 3 Moderate (12)
								Prioritisation exercise for capital spend has been completed to ensure resources are used in the most effective / efficient way Control Owner: Benjamin Stevens	Adequate				
								Prioritised Patients Environment Investment Committee (PEIC) action plan in place for 2023/24. Control Owner: Benjamin Stevens	Adequate				
3105	09/02/2023	Care Group - Critical Care, Anaesthetics and Specialist Surgery		Patient harm to Head and Neck cancer operations delayed or aborted due to aged Leica microvascular microscope breakdown. Risk Owner: Anita Vincent Delegated Risk Owner: Sara Lawson Last Updated: 16 Jul 2025 Latest Review Date: 04 Dec 2025 Latest Review By: Gemma Oliver Latest Review Comments: Microscope trails continue with procurement	Cause: The current microscope is past it's expected life time, and cannot be repaired as spare parts are unavailable due to the age of the equipment. Effect: Major head and neck cancer surgery would have to be aborted during surgery if the microscope was to break down. All other operations would have to be delayed while a replacement were to be procured. This would cause significant harm and potential worsening of prognosis for cancer patients.	Our patients	I 4 L = 4 High (16)	23/11/2024 Consultants only trialed Zeiss not Leica microscope. 03/01/2025 Due to equipment cost, HF checking with procurement if we can trial Leica microscope. Existing Leica microscope in use, however, cannot be repaired as spare parts are unavailable due to the age of the equipment. 23/04/25 HF: Microscope has sustained damage to assistant viewpiece. This is unlikely to be repaired. Working with Procurement to arrange trial devices to be on site for 28/04 to cover booked cancer pathway surgeries. Potential loan to be arranged. 28/04/2025 Bbraun microscope on site for 2wk trial supported by company Rep.		I 4 L = 4 High (16)	A new microscope procured and installed to operation with training included as required. 1/9 - not resolved - advised still obtaining quotes 11/04/25 - Second trial device requested. Supplier has re-submitted bid. Trial to be actioned to Mid June when consultants are available to trial. Previously raised Datix WEB285679 WEB303655 WEB303334 24/07/25 - Trial Leica Exoscope to arrive 28/07/25 with a Zeiss exoscope to follow. Device replacement has been prioritised by Procurement. 10/10/25 HF: Meeting set for Monday 13th of October to progress procurement process and discuss next steps for replacement. Implementation date extended to reflect ongoing trials process. Person Responsible: Howard Ford To be implemented by: 31 Mar 2026	**16 Jul 2025** **Emma Kelly** Leica Microscope trial running until 4 July 25. Outcome to be finalised and submitted to MDG. Due date amended to reflect this.	I = 4 L = 1 Low (4)

									02/05/2025 Bbraun microscope trial extended through to 14 June 2025. Leica microscope trial in place from 17 June - 04 July 2025 supported by company Rep 30/09/2025 HF - Microscope trials have completed, with two remaining exoscopes to be evaluated. Clinician feedback forms still required. Meeting to be set to discuss next steps with stakeholders. Control Owner: Sara Lawson					
3557	02/11/2023	Corporate - Operations		Risk that mental health patients who present at our EDs will be in the Department for long periods (12 hours >) Risk Owner: Dan Gibbs Delegated Risk Owner: Alison Pirfo Last Updated: 14 Oct 2025 Latest Review Date: 14 Oct 2025 Latest Review By: Alison Pirfo Latest Review Comments: Framework reviewed, cascaded to wider stakeholders for comments September 25. New Safe Haven and pathways under development as part of new SDEC capital build to schedule.	Cause: *Lack of acute inpatient mental health beds external to the Trust causing long waits in ED, as the ED is not a mental health environment or secure area. *Knowledge gap of general nursing and medical staff to manage significant mental health appropriately *There is a lack of assessment space and therapeutic intervention. *At QEQMH a temporary MH room due to building works and there is insufficient assessment space *Length of stay has doubled since this time last year Effect: *Potential poor service to and environment for patients *Potential unsafe service to patients * Patient behaviour can escalate/ deteriorate and become challenging whilst waiting for mental health assessment which is a risk to staff and patients *Increased violence and aggression with assaults on staff	Quality	I 4 L = 5 Extreme (20)	*Direct referral pathways to psychiatry and single point of access team at both WHH and QEQM. *Review of frequent attendees, meetings monthly with good representation from external partners. *Enhanced observation support worked employed by the Emergency Department to support the care for patients experiencing mental health illness. *Head of Nursing meets to review patients being brought into ED under 136 *Supportive visits from ICB - welcomed. *Length of stay of mental health patients is reported by the Fundamentals of Care Committee. Control Owner: Benjamin Hearnden	Limited	I 4 L = 4 High (16)	Senior ED leads to review a good practice DTA framework with Dep 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 a MH inpatient bed. There are some circumstances where this might be appropriate , therefore having a best practice framework would be helpful. Person Responsible: Alison Pirfo To be implemented by: 31 Mar 2026		I = 3 L = 3 Moderate (9)
									A Frequent Attender review process is embedded with regular meetings and development of care plans and strategies to support patients to help them reduce attendance. Control Owner: Benjamin Hearnden	Limited				
									Agency Registered Mental Health nurses utilised to support staff when delays in psychiatric assessment occur and delays are reported on DATIX and escalated to Site Triumvirate. Control Owner: Benjamin Hearnden	Limited				
									An increase in DATIX incident reports relating to issues with MH patients exhibiting aggressive behaviour has resulted in Security staff being in place in the Observation bay at QEQMH. In addition, 4 EOSW have been appointed. Weekly Security meetings are utilised to align with Datix Control Owner: Benjamin Hearnden	Limited				
									Immediate work is being undertaken on the relatives room at WH which is currently being used as a Mental Health Assessment Room (relocated here due to Covid streams) is being undertaken to make it compliant with requirements for mental health areas. Control Owner: Benjamin Hearnden	Limited				
									The risk relating to the Trust not having a Ligature Policy in place	Limited				

								has been raised at the Risk and CQC Assurance meetings. Ligature Risk Assessments have been undertaken for all areas and are reported and reviewed weekly by the Care Group Triumvirate Control Owner: Benjamin Hearnden							
								There are delays in mental health assessments being undertaken and, where appropriate, patients with mental health conditions are cared for in the Observation Bays to ensure their comfort and safety. Both EDs now have 24 hour MH Liaison contact teams Control Owner: Hitendra Tanwar	Limited						
								We have an enhanced observation support worker 24/7 and use agency registered mental health nurses to match the demands, alongside agency CSW's. Control Owner: Benjamin Hearnden	Limited						
3691	10/07/2024	Care Group - Kent and Canterbury and Royal Victoria		There is a risk to deteriorating patients at KCH due to the lack of appropriate medical cover Risk Owner: Desmond Holden Delegated Risk Owner: Syed Mehdi Last Updated: 01 Oct 2025 Latest Review Date: 09 Dec 2025 Latest Review By: Emma Kelly Latest Review Comments: Risk reviewed with interim CEO 09/12/25 in absence of CMO. AM back on 16 December 25 and update required. Proposal to add enhance CCOT model to controls section, 09/12/25	Cause: Withdrawal of acute medical and HCOOP cover on KCH site in 2018 Medical emergencies of 231 patient beds being managed by agency employed 2 person junior doctor team that also covers acute stroke presentations out of hours. Inconsistent availability of acute medical, HCOOP or specialist medical advice from acute sites. Effect: Prolonged length of stays due to inadequate medical cover are accompanied by episodes of deterioration in patients deemed medical fit for discharge transferred from acute sites to KCH. There is a trend in care group reporting demonstrating common themes in terms of response timeliness and prompt transfer Medical consultant cover even for remote consultations not available at KCH	Quality	I 4 L = 4 High (16)	Adhoc remote support for patients from consultants from other sites for patients still admitted under them at KCH continuity of care when there is a deterioration Control Owner: Syed Mehdi		I 4 L = 4 High (16)	**The SOP currently being reviewed to be finalised and implemented asap** **Person Responsible: Syed Mehdi** **To be implemented by: 31 Aug 2024**	**02 Sep 2024** **Syed Mehdi** Discussion with HCOOP leads to explore remote cover to support Hot Medical Registrars at KCH. Hot Reg attends thrice weekly Site Meeting and if required bed meeting to identify medically unwell patients.	I = 2 L = 3 Low (6)
								Agreed acute cardiology pathway of patients with cardiac problems Control Owner: Syed Mehdi							
3867	11/09/2025	Care Group - Critical Care, Anaesthetics and Specialist Surgery	Critical Care - Intensive Care	Inability to safely staff all three critical care units due to current vacancies within the nursing establishment Risk Owner: Sarah Hayes Delegated Risk Owner: Gemma Oliver Last Updated: 17 Sep 2025 Latest Review Date: 04 Dec 2025 Latest Review By: Gemma Oliver Latest Review Comments: Recruitment plan continues, increase in staffing numbers expected end Dec/ Early Jan	Cause: Vacancies awaiting executive approval on TRAC. Effect: Unable to ensure safe staffing on all shifts.	People and Quality	I 4 L = 5 Extreme (20)	Move staff in-between units in response to staffing pressures. Use of NHSP. Utilise audit, education, research nurses. Cancel down training to release nurses. Control Owner: Julia Cristall		I 4 L = 4 High (16)	Person Responsible: To be implemented by:		I = 3 L = 2 Low (6)
2234	11/11/2020	Care Group - Diagnostics, Cancer and Buckland		Significant delays to cancer and non-cancer reporting due to lack of sustainable staffing. Risk Owner: Desmond Holden Delegated Risk Owner: Nicola Chaston Last Updated: 01 Dec 2025 Latest Review Date: 08 Jan 2026	Cause: Workforce: •EKHUFT financial position and vacancy restrictions have prevented timely recruitment into post. An admin position is awaiting external advert following a 6 month wait for internal advert. Current vacancies: 2x Band 2 in	People	I 4 L = 5 Extreme (20)	Cancer pathway patients prioritised from within the workload. Control Owner: Marcus Coales	Limited	I 4 L = 4 High (16)	Trust involved in discussions regarding a Kent & Medway Joint Venture. Trust to ensure areas of pressure are highlighted and worked up. Person Responsible: Desmond Holden To be implemented by: 31 Jan 2026	**02 Jul 2025** **Angela Callaghan** Feedback from Nicola Chawston: We have rolled out the workload points across all specialities and are working on an analysis of consultant DCC reporting availability (according to our JPs	I = 4 L = 2 Moderate (8)
								Locum support when available and position numbers available	Adequate						

				Latest Review By: Naomi Rogers Latest Review Comments: Histology performance – Overall turnaround time KPI for November for all histology cases reported in 10 days is 48%, a drop on last months which was 57%. Urgent biopsy case performance has also dropped to 75% from 64%. Overall backlog position has increased further in month to >1000 cases between 10 and 65 days. (target <500 cases <45 days). Overtime being offered to both laboratory staff and consultant (WLI payment) to support backlog.	laboratory, 1x Band 3 in admin team, 2x maternity posts. •Insufficient staff resource available: •Medical –there has been a significant increase in workload volume since 2019-20 and department is notably under-established according to the workload points system as specified by the Royal College of Pathologists, necessitating the use of both locum pathologists and outsourced reporting (using Source –LDPath) •Laboratory – 4.0 WTE staff have left the department in the last 6 months without replacement. Attempts at recruitment to x2 of these posts are being held at VCP •Admin – 1.0 WTE band 3 medical secretary left department in April of 2025 and attempts to recruit-to-turnover held by VCP. 1.0 WTE has been on maternity leave since Aug 2025. 2.0 WTE equates to 25% of available typists. Any additional absences (annual leave, sickness absence etc) lead almost immediately to typing backlogs, delaying work leaving the laboratory and progressing to reporting. Impact on turn-around-times significant. Remaining staff under stress, leading to increased sickness absence. •Sickness levels in the whole cell path team sits at 3.6%, but amongst the 7.8 WTE remaining typists, there has been 148 working days lost to sickness absence, significantly higher than in the wider department, with stress related symptoms cited as a common contributory factor. Activity: •Significant increase in workload volume and workload complexity comparative to previous pre-covid years. •The number of cases seen has increased by 32% over the last 3 years. •The number of cases being outsources to Source LDPath in 2024/25 increased by 160% relative to 2023-24 – a total 23% of the total workload. This came at considerable cost to the Trust. Processes: •Reports returned from outsourced reporting work require proof reading and formatting on receipt before data entry into local LIMS therefore rely on admin support, •Each sample received for dissection and histological review is subject to a macroscopic description that needs transcribing onto the written histology report to aid diagnosis. Voice recognition software has failed to be able to replace audio transcription, but lack of admin staff is impacting turn-around times. •Implementation of digital pathology required additional resource and the implementation has removed laboratory staff from business as usual duties, creating need from overtime to maintain laboratory output to minimise impact on turn-around times. Staff not always			and outsourcing non-complex histology cases to LD Path Control Owner: Stuart Turner				– we are >80 % done in cell path) versus workload coming in to give us an accurate position of where we are now. On a wider scale, we are also discussing demand management, including at PRM.	
								The short term mitigation is to put in place additional NHSP. Control Owner: Stuart Turner	Limited					
								We have recruited x3 FT proto-consultants in addition to the x1 FT consultant. In a year at least x2 of them will be consultant level. These are x2 specialist and x1 specialty grade doctors. Control Owner: Marcus Coales	Limited			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. Person Responsible: Stuart Turner To be implemented by: 31 Dec 2026	**14 May 2025** **Naomi Rogers** The digital pathology project is on hold at MTW, but validation of reporting by digital image (as opposed to microscope 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.	
3875	19/09/2025	Care Group - Critical Care, Anaesthetics and Specialist Surgery		Unable to safely staff Theatres across the three sites due to high vacancy levels Risk Owner: Gemma Oliver Delegated Risk Owner: Roxanne Vlachos Last Updated: 02 Jan 2026 Latest Review Date: 02 Jan 2026 Latest Review By: Roxanne Vlachos Latest Review Comments: Continue to review staffing levels weekly. Cross site support where possible. Continue active recruitment Band 7's and CE undertaking required	Cause: Vacancies awaiting executive approval on TRAC Effect: Unable to maintain safe staffing levels Inability to deliver activity levels Inability to deliver trust strategic objectives; reduce waiting list and increase activity Inability to deliver all emergency capacity resulting in increased length of stay and flow issues	Regulatory and Quality	I 4 L = 4 High (16)	Move staff in-between units in response to staffing pressures. Use of NHSP. Utilise coordinators, education teams. Cancel training to release staff Control Owner: Gemma Oliver		I 4 L = 4 High (16)	Person Responsible: To be implemented by:		I = 3 L = 2 Low (6)
								Weekly staffing review with Matrons, HoN and general						

				clinical hours NHSP usage in line with Trust financial controls.	flow issues Increase absenteeism, low morale and retention			manager. Increase as required. Attendance to site meetings with staffing information. Timely upload to TRAC for all vacancies with escalation to Care Group. Control Owner: Gemma Oliver						
3866	09/09/2025	Corporate - People and Culture		Risk of inability to deliver CIP due to not achieving planned workforce reductions Risk Owner: Norman Blissett Delegated Risk Owner: Louise Goldup Last Updated: 17 Sep 2025 Latest Review Date: 05 Jan 2026 Latest Review By: Louise Goldup Latest Review Comments: Workforce reductions continue to be monitored for current year - focus has turned to 26/27 and enabling savings through a zero based review that is due to start in Jan 26	Cause: -Not able to use redundancy as the means for reduction due to financial impact. -Turnover reduction so not able to release head count via natural wastage Effect: -Lack of delivery of financial plan 25/26 and workforce reduction plans -Consequences for other aspects of financial plan -Reputational and regulatory impact	People	I 4 L = 4 High (16)	Monitoring of existing plans, identifying mitigating plans where there are shortfalls in original plans Control Owner: Louise Goldup	Adequate	I 4 L = 4 High (16)	Delivery of planned workforce headcount reductions 2526 Person Responsible: Norman Blissett To be implemented by: 31 Mar 2026		I = 3 L = 3 Moderate (9)
								Vacancy Control Panel process in place Control Owner: Twyla Mart	Adequate					
3810	23/05/2025	Corporate - Nursing		Lack of capital funding to adequately maintain the estate it is not always possible to comply fully with HTM and HBN standards which enable prevention control measures including cleaning and ventilation. Risk Owner: Sarah Hayes Delegated Risk Owner: Lisa White Last Updated: 11 Jun 2025 Latest Review Date: 03 Dec 2025 Latest Review By: Janet Murat Latest Review Comments: Risk reviewed and action added with LW, DPO.	Cause: Limited capital investment over a number of years Limited access to capital above the Trust allocation to address issues Reduced revenue (impacting on replacement of non-capital items- and maintenance of sinks/replacement of chairs etc) Aged estates Effect: 1.Increased likelihood of hospital acquired infections as areas are hard to keep clean due to the condition of the building. 2.Poor ventilation in key areas which increases likelihood of health care associated infection. 3.Increased likelihood of hospital acquired infections as limited bed spacing does not allow for adequate daily cleaning behind patient beds (linked risk – ref: 3752). Also links to risk 3384 (Strategic Development and Capital Planning 'The ability to deliver safe and effective services & implement improvements across Trust estate is compromised due to financial constraints for capital funding and assets replacement') Residual risk rating high (16).	Regulatory and Quality	I 4 L = 4 High (16)	Implementation of National Cleaning Standards and audit (with 2Gether Support Solutions) Control Owner: Lisa White		I 4 L = 4 High (16)	Report through the Quality & Safety Committee to Board to ensure oversight of existing controls and gaps in assurance- quarterly and annually Person Responsible: Sarah Hayes To be implemented by: 31 Jul 2026		I = 2 L = 2 Low (4)
								Internal prioritisation process in place via the Patient Environment Investment Committee (PEIC). DDIPC is Co-Chair. Control Owner: Lisa White						
								IPC governance, surveillance and monitoring processes Control Owner: Lisa White						
								IPC surveillance, oversight and monitoring and implementation of clinical policies Control Owner: Lisa White						
								IPC Team involved in signing off designs that relate to planning new facilities or renovating older facilities. Control Owner: Lisa White						
								Prioritisation exercise for capital spend has been completed to ensure resources are used in the most effective / efficient way Control Owner: Lisa White						
3725	17/09/2024	Corporate - Nursing	Quality Governance	Risk of inadequate legal services support due to vacancies and resignations Risk Owner: Hannah Smith1 Delegated Risk Owner: Last Updated: 16 Jul 2025 Latest Review Date: 06 Nov 2025 Latest Review By: Emma Kelly Latest Review Comments: Risk reviewed. New Head of Legal to be added to 4Risk and action owner. AD QG, 06/11/25	Cause: All permanent, substantive members of the legal team left in September/November of 2024. This has resulted in a period of instability; under-resourcing; lack of corporate memory and challenges in maintaining a full service legal function. Audit of the function had already raised a number of structural issues needing to be addressed. Cause when raised: By the end of November 2024 there will only be one permanent member of staff in the legal team (Band 3). This is due to the resignation of 3x members of staff (Head of Legal Services, Legal Services Manager and Assistant Legal Services Manager)	Regulatory	I 5 L = 5 Extreme (25)	Additional temp staff recruited through NHSP Control Owner: Hannah Smith1	Limited	I 4 L = 4 High (16)	Legal structure agreed and approved. Recruitment in progress. Awaiting approval for deputy post. Person Responsible: Hannah Smith1 To be implemented by: 31 Mar 2026	**05 Jan 2026** **Emma Kelly** Recruitment progressing. Awaiting approval for deputy post ahead of advertising.	I = 4 L = 3 Moderate (12)
								Making more use of external solicitors on a needs basis. Control Owner: Hannah Smith1	Limited					
								Recruited Senior Lawyer on a temporary basis who has been in place since October 2024. Control Owner: Hannah Smith1	Limited					

					Manager). Effect: Lack of capacity for legal service provision for our employees and patients. Potential delay to investigation and management of claims and inquests. Regulatory, legal and reputational implications. Delay and distress to staff, patients and their families.			Recruited to the Head of Legal, and an appointment been in place since October 2024. Control Owner: Hannah Smith1	Limited				
								Secured external support for interim solution through secondments. Control Owner: Hannah Smith1	Adequate				
3889	17/10/2025	Care Group - Diagnostics, Cancer and Buckland		Risks to patient safety and service delivery, due to significant workforce shortages in Microbiology. Risk Owner: Samuel Moses Delegated Risk Owner: Last Updated: 26 Nov 2025 Latest Review Date: 02 Jan 2026 Latest Review By: Naomi Rogers Latest Review Comments: Risk review meeting held on 17/12/25. Actions updated accordingly. Trust recruitment restrictions prevent progress of actions requiring increased run rate. Staff consultation began 09/12/25 with planned go-live 24/01/26.	Cause: Workforce •EKHUFT financial position and holding posts has meant we have not had vacancies approved. 1.25 BMS and 2.0 support staff vacancies since June 2025. Further band 7 resignation, leaves end of October. •No backfill for maternity leave approved, 1.0 band 6 BMS since October 2024 and 1.0 Band 3 AHCS since March 2025. •Business plan submitted (Nov 24) and not approved for additional staff to deliver East Sussex sexual health contractual obligations. •No additional staff to manage increased activity and organisational demands associated with winter pressures. •TOIL accumulation from weekend and extended day impacts staff availability and productivity. •AFC compliant 7-day working was introduced in July 2012 with inadequate increases in staffing to manage and sustain this service safely. •High levels of sickness (2024/25-year average 4.1%). •High training and supervision burden, consistently >50% staff in training, due to being unable to recruit already trained or experienced staff. Do not have supernumerary trainers. Activity increases •Staffing has not increased proportionally with the increase in baseline activity, 6.5% above 2019 levels, 20% from 2012/13. This has been driven by an increase in complexity of infectious disease and their investigations, local outbreaks, national epidemics and increased needs & access by clinical services e.g. genito-urinary medicine (GUM) clinics. •The WTE workforce 2012/13 excluding medical/clinical staff was 45.59 WTE and now in 25/26 it is 41.69 WTE •No workforce backfills since March 2025 to manage Kent and Medway Pathology Network (KMPN) IT projects, to design and test protocols for harmonised new LIMS, tactical and strategic GP Order comms systems or to support additional activity from East Sussex GUM. Equipment and processes •Ineffective and time-consuming workflows caused by non-interfaced analysers, frequent equipment downtime, unable to replace or negotiate better contracts as new MES contract has not been approved. •No engineering support at the weekend for equipment downtime. •No IT connectivity between KMPN organisations and external reference labs which prevents effective mutual aid to circumvent staffing pressures. Effect: Patient safety and clinical outcomes •Ineffective management of the workload compromises sample integrity and increases turnaround times (TaTs). •Delays in specimen processing leads to samples deterioration, poor quality of sample generates a poor result. •Increased TaT leads to delays in diagnostics and treatment •Increased risk to organisational reputation due to samples being discarded or delayed results, errors and complaints. (WEB315875 and WEB291680) •Further reputational damage if there are delays to the antenatal and new-born screening service. •Decline in antimicrobial stewardship and	Regulatory and Quality	I 4 L = 4 High (16)	Escalated to KMPN for support, they approved funding of 3.0 WTE band 2 staff, 1-year FTC for project backfill. They will primarily undertake reception and data entry duties. Control Owner: Marcus Coales		I 4 L = 4 High (16)	Implement action plan of tasks or tests to stop which will include demand management/vetting for duplicate serology tests, reducing meetings and reports, preparing blood culture collection kits. Refer antifungal susceptibility testing and galactomannan tests externally. Person Responsible: Rachael Arkley To be implemented by: 30 Jan 2026	**08 Jan 2026** **Naomi Rogers** Blood culture packs now being compiled at QEQM by Brighter Future organisation.	I = 4 L = 2 Moderate (8)
								Escalation and risk assessment of situation, asking for overtime or part time staff having extra hours, if critical and when staff will support. Control Owner: Marcus Coales			Locum BMS workforce, to fill vacancies until filled substantively. Person Responsible: Marcus Coales To be implemented by: 30 Jan 2026	**08 Jan 2026** **Naomi Rogers** Band 7 post still in advertising/interviewing stage. Band 7 is now in the 3rd time of interviewing, and had no further CV's to review for Locum BMS since Mid-December.	
								Held staff engagement sessions to listen to their claims, concerns and issues and focus groups on 7-day working, workflow and processes. Undertaken an options appraisal of arrangements for 7-day working and have feasible options costed. Control Owner: Rachael Arkley			Business case approval for staffing positions (1.0 band 5, 1.0 band 3) to continue with East Sussex Sexual Health contract, maintain income. Person Responsible: Marcus Coales To be implemented by: 27 Feb 2026	**02 Jan 2026** **Naomi Rogers** Trust restrictions on increasing run rate.	
								Initiating and documenting business continuity plans when required. Control Owner: Rachael Arkley			Staff consultation and approval of final option to stop AFC compliant 7-day working temporarily, to significantly reduce TOIL. Pay protection may be needed. Person Responsible: Marcus Coales To be implemented by: 31 Mar 2026	**02 Jan 2026** **Naomi Rogers** Staff consultation began 9/12/25. Planned go-live 24/01/26	
								Prepared a list of tasks or tests which add no value or can be streamlined/done differently. Categorised these into High/low impact/easy/difficult and prepared action plan to implement them. Control Owner: Rachael Arkley			Prepare a business case for approval of additional staffing to run a safe AFC compliant 7-day service. Person Responsible: Rachael Arkley To be implemented by: 31 Dec 2026	**02 Jan 2026** **Naomi Rogers** Current recruitment restrictions within the Trust.	
								Rotating staff between sub-disciplines to improve resilience and facilitate training. Control Owner: Rachael Arkley					
								Signposted staff to wellbeing resources, preparing individual risk assessments, stress risk assessments and referral to occupational health where required. Have wellbeing and mental health first aiders in place. Control Owner: Rachael Arkley					
								Use NHSP as maternity leave backfill until March 2026, 1.0 WTE Band 3. Control Owner: Marcus Coales					
								Using mutual aid from KMPN network partners, e.g. we are					

					infection control Accreditation and regulatory compliance •ISO 15189 non-compliance with inability to maintain quality systems therefore unable to maintain UKAS accreditation at next reassessment in Feb 2026. •Risk to HSE compliance. Staff wellbeing and retention •Unable to sustain AFC-compliant 7-day working safely, with excessive TOIL accumulation. •Staff burnout, sickness, and morale issues are escalating, with increasing external job applications and inability to manage leave or swap weekends. •Training of staff and competency compliance is severely impacted. It is frequently inconsistent, fragmented and takes much longer. •Mandatory CPD and keeping up to date to maintain HCPC registration is significantly compromised. Financial performance •Unable to deliver CIPs and continue to maintain current levels of demand management processes. Potential loss of £80k-£100k per annum based on savings made in 2024/25. •Loss of income and profit from organisations we provide a service for e.g. East Sussex sexual health. Total GUM income was £1.1M 24/25. East Sussex GUM income represents 23% of this value and is over plan in Q1 25/26 i.e. £73k. (£223k YTD). •Increased frequency of referral to external laboratories, increasing test costs and run-rate.			currently referring mycology 6-week work backlog to MTW. Control Owner: Rachael Arkley					
2599	13/10/2021	Corporate - Medical		There is a risk of inadequate medical staffing levels and skills mix to meet patients needs Risk Owner: Desmond Holden Delegated Risk Owner: Helen Mackie Last Updated: 14 Apr 2025 Latest Review Date: 09 Dec 2025 Latest Review By: Emma Kelly Latest Review Comments: Risk reviewed with interim CEO 09/12/25 in absence of CMO.	Cause: An inability to recruit in key specialties and to key grades. Insufficient substantive consultant staff requiring long term locums to cover vacancies Lack of central medical function Effect: Patient outcomes Experience and safety Financial impact due to cover with high cost locums	People	I 3 L = 5 High (15)	Associate Medical Director in post to innovate in medical recruitment Control Owner: Desmond Holden	Adequate	I 3 L = 5 High (15)	Conversion of full time agency and full time bank into fixed term locally employed contracts whilst we complete an establishment review for all medical teams Person Responsible: Desmond Holden To be implemented by: 31 Jan 2026		I = 3 L = 3 Moderate (9)
								Locum policy describing induction for locum doctors Control Owner: Daniel Contla-Robertson	Limited				
								Medical recruitment team have process in place to check and challenge requests to extend locums beyond two years	Adequate		The trust is currently undertaking a medical establishment review for Acute and General Medicine. This is being led by the Deputy CMO and supported by internal PMO,1 WTE of consultant resource (4 consultants) and an external expert workforce consultancy team. Person Responsible: Helen Mackie To be implemented by: 31 Jan 2026		
								Programmes to support career progression and attraction of consultant posts for long term locums becoming substantive (i.e. CESR). Control Owner: Helen Mackie					
								Task and finish group established around medical recruitment including consultants	Limited				

2123	03/07/2020	Care Group - Diagnostics, Cancer and Buckland		Lack of storage space for Medical Records causing risks to staff and risk of notes being unavailable Risk Owner: Benjamin Stevens Delegated Risk Owner: Alison Mitchell-Hall Last Updated: 09 Sep 2025 Latest Review Date: 09 Sep 2025 Latest Review By: Emma Kelly Latest Review Comments: Risk record reviewed by Alison Mitchell-Hall, MD DCB Care Group and Emma Kelly, AD Quality Governance. This included review of inherent and residual risk rating, review of cause and effect, controls and population of actions. Additional risk owners informed. 09/09/25	Cause: The NHSx Records Management code of practice changed in 2021 and to cover all retention and disposal (R&D) criteria. Following a review, the EKHUFT Management Board instructed the department to keep all records for 30 years for live records and 10 years for RIP except those records that are required for open enquires IE Haemophilia and COVID 19 which must be kept until the end of the enquiry is finalised. Having to keep records for 30 years has caused critical storage issues with no storage space left. The impact has had further consequences on the mobile racking system with is unreliable and is in need of modernisation. The Team were scanning archived records but the system in use is unreliable and inefficient which is causing delays with clearing the records for additional space. Effect: -H&S risk to staff due to injuries pulling notes from compacted shelves. Staff have sustained injuries including RIDDOR reportable injuries. -H&S risk as storage crates are being used which are then stored within already crammed office areas. -Impact on staff morale and experience (no space to take breaks or kitchen area available) and stress and anxiety about working conditions. -Risk of notes being unavailable due to inability to access them which could lead to cancellation of patient activity.	Quality	I 3 L = 5 High (15)	Email sent to all staff regarding safe working and mitigations (08/24) by General Manager Control Owner: Angela Hills	Limited	I 3 L = 5 High (15)	**Intention to move Health Records under Digital team (Corporate SD - Director of Information) pending consultation. This will enable alignment with digital strategy** **Person Responsible: Alison Mitchell-Hall** **To be implemented by: 30 Nov 2025**		I = 2 L = 2 Low (4)
									Ensuring staff are complaint with Manual Handling mandatory training and understand their responsibilities regarding reporting adverse incidents Control Owner: Angela Hills	Adequate		**Agreement of new Retention Policy which will reduce the number of physical notes needed to store** **Person Responsible: Desmond Holden** **To be implemented by: 30 Nov 2025**	**06 Nov 2025** **Emma Kelly** Extended to enable discussion	
									Filing notes wherever possible in Health records on all sites Control Owner: Cathy Brett	Limited		**Creation of Health Records Digital Strategy** **Person Responsible: Peter Davies** **To be implemented by: 30 Nov 2025**	**06 Nov 2025** **Emma Kelly** Extended to enable discussion	
									Management team are rostering the staff to do shorter bursts in the filing areas where it is the hottest Control Owner: Angela Hills	Adequate		**Strategy to be developed and agreed regarding the creation of new health records** **Person Responsible: Desmond Holden** **To be implemented by: 30 Nov 2025**	**06 Nov 2025** **Emma Kelly** Extended to enable discussion	
									Risk discussed at DDAT meeting with a view to looking at digital solutions to support the storage concerns. Control Owner: Benjamin Stevens	Limited				
									We have asked all staff to be vigilant and to speak to supervisors, management team to highlight concerns regarding space and amounts of prefile returning with no space to file. to be mindful of boxes in the filing rooms and to Datix any injuries. Control Owner: Angela Hills	Limited				
3799	15/04/2025	Care Group - William Harvey	WH General Surgery and Gastroenterology	Insufficient capacity to deliver gastro OPA in a timely manner Risk Owner: Dan Gibbs Delegated Risk Owner: Komal Whittaker-Axon Last Updated: 29 Jul 2025 Latest Review Date: 29 Jul 2025 Latest Review By: Bridget Creighton Latest Review Comments: 29/7/2025 - waiting an update as to whether we can extend ID medical beyond August 2025	Cause: Insufficient capacity to deliver gastro OPA in a timely manner, therefore a risk to RTT access standards and potential patient harm due to delays Effect: Insufficient outpatient capacity to meet the demand. Patient harm such as a delay in diagnosis, delay in treatment.	Regulatory and Quality	I 3 L = 5 High (15)	Escalation through weekly access meetings with the COO Control Owner: Stella Grey		I 3 L = 5 High (15)	Continuation of ID Medical gastro clinics being held at the weekend until December 2025 Person Responsible: Stella Grey To be implemented by: 31 Mar 2026	**02 Dec 2025** **Susan Travis** 2/12/2025 -Awaiting decision from Exec team regarding clinic	I = 1 L = 2 Very Low (2)
									Insourcing with ID Medical to provide additional clinics. Control Owner: Stella Grey					
									Monitoring activity though					

								Monitoring activity though weekday daily RTT PTL reviews, ensuring that our longest waiters have an appointment Control Owner: Stella Gray						
1350	19/03/2018	Care Group - Diagnostics, Cancer and Buckland		Failure to provide ward stock medicines in a timely fashion due to obsolescence of Pharmacy TWS Distribution robot Risk Owner: Will Willson Delegated Risk Owner: Emily Hunnisett Last Updated: 04 Aug 2025 Latest Review Date: 04 Nov 2025 Latest Review By: Emily Hunnisett Latest Review Comments: Robot business case approved at BCSG on 17/10/25. Due to capital required, business case still needs to be signed off at FPC which is yet to be arranged. Need to confirm if tender process can be started as alluded to during scrutiny group. Outstanding action implemented. Added action for next stage.	Cause: The current picking robot for Pharmacy distribution was installed in 2005, and has had regular service visits but no upgrades. Company brought out by SSI Schafer, however due to age of robot no viable upgrades available, and support contact withdrawn. Robot no-longer serviced or supported externally. Single point of Failure: PC 1.Running Windows XP operating system 2.Can-not install robot software onto new PC, due to no install files 3.Cable Connections outdated 4.Computer at least 10 years old. Most likely point of Failure is Hard Disk. 5.No supplier support for software/configuration issues Updated on 11.09.2024 - Space committee are not meeting and have not reviewed our case for space to provide business continuity. Effect: No support of aging robot if it breaks is in place, and parts availability becoming low. Non-functioning robot will result in slower / less accurate picking, leading to missed doses and wards running out of stock. Delays in providing medications, leading to: 1. Missed doses 2. Delays in discharge 3. Wards and Clinics running out of stocks. 4. Ability to provide emergency care. 5. Delays to Dispensary workload as stocks delayed getting to them. Requirement for an additional 4 staff members Requirement to work longer hours / Additional Overtime, due to space constraints and not able to fit an additional 4 staff members working alongside current team quota. Therefore requirement for additional team leaders as well. Space requirements for storage of medications, on longer being able to be placed into robot, leading to: 1. Health and Safety issues 2. Stock being placed directly on the floor, IPC / Insurance 3. Ability to find stocks will be hampered. 4. Manual handling for staff will be difficult to maintain. Possible increase in staff sickness due to injury. 5. Increase in damage to stock, and finical impact of writing off damaged stocks 37% of stockholding currently stored and picked by Robot IT not able to build new PC, therefore if PC stops working robot is obsolete In the first 6 months of 2024, we have had 4 breakdowns, and one multiply daily intermittent fault (wifi). Each breakdown the robot has been offline for a minimum of 4 hours, with one breakdown lasting over 24hours whilst we awaited parts. These have caused delays with getting stocks to wards / Clinics / Dispensary's and Pilgrims Hospices. 07/07/2024: Robot out of action unable to use until new motors sourced and fitted. Manual picking implemented. 12/07/2024: Robot back up and working, however another motor has develop an intermittent fault. Awaiting 2nd motor to arrive, but coming from German. All breakdowns have been diagnosed and fixed by the Pharmacy Stores and Distribution Lead. If Distribution Lead off there is nobody else to diagnose and fix this	Quality		Due to break down of robot for 24hrs, a temporary solution to the fault has been done. We have cable tied some rods to the cage. Control Owner: Richard Prout	Limited		Start discussions around the tendering process with 2SS procurement team and manufacturers. Person Responsible: Richard Prout To be implemented by: 31 Jan 2026		
								Hoover filters once per month Control Owner: Richard Prout	Limited		Discuss finances with DCB finance lead again to ensure we are clear on costs, cost benefits and savings. Person Responsible: Emily Hunnisett To be implemented by: 31 Jan 2026		
								Manual picking, in event robot stops working. 4 additional staffs needed per day, that the robot is down. Control Owner: Richard Prout	Limited		Attendance at FPC for final business case approval Person Responsible: Emily Hunnisett To be implemented by: 31 Mar 2026		
2808	06/05/2022	Care Group - Queen Elizabeth, The Queen Mother	QEQM Urgent and Emergency and Acute Medicine	There is a risk of patient harm occurring due to delays in recognising and escalating deteriorating patients in ED due to capacity Risk Owner: Sarah Hayes Delegated Risk Owner: Susan Brassington Last Updated: 19 Dec 2025 Latest Review Date: 15 Jan 2026 Latest Review By: Janet Webber Latest Review Comments: Risk reviewed	Cause: The increase in patient attendances and in corridor care mean that monitoring of patient's and that the recognition of patient deterioration is not always identified in a timely manner. Staffing levels are impacted on by acuity and overcrowding and do not always support documentation and timely sepsis screening Recruitment of large volumes of new nurses without ED experience has diluted	Quality	I 5 L = 5 Extreme (25)	Adverse incidents resulting from lack of timely recognition and deterioration are recorded on Datix and investigated. Findings and identified actions are implemented and shared with staff at team and governance meetings Control Owner: Janet Webber	Limited	I 3 L = 5 High (15)	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. 15/8/2024. Confirmed with ADN that the audit process is ongoing February 2025 - audits are ongoing Audits - sepsis and deteriorating patient ongoing Person Responsible: Catherine Miller To be implemented by: 31 Jan 2026	**26 Jun 2024** **Emma Kelly** To mitigate this gap in data (repeat obs) the Matron for ED is auditing 10x patients per day (initial and repeat observations). This will help inform ongoing actions needed. Agreed with Deputy Head of Nursing that due date would be changed to mid July 25 and risk record amended to reflect improvement actions	I = 3 L = 2 Low (6)
								Audit data is collected manually	Adequate				

					the skill mix and proven to have impacted on recognition of deteriorating patients. The introduction of Eobs has impacted on the ability to pull data on secondary observations as it doesn't link across to the dashboard and the IT infrastructure is not in place December 2025 - senior approval process for NHSP for gaps in rota causes delays which can result in unfilled shifts. Effect: *Patient deterioration is not always promptly identified and escalated, potentially resulting in a poor patient outcome. *Observations not always taken in a timely manner or repeated within recommended timeframe. * Audit data has to be pulled manually *Delay in critical medications being administered.			Control Owner: Catherine Miller				to reflect improvement actions needed on conclusion of audit. Proposed that participation in audits should be a control and actions added to reflect work needed to reduce risk score (26/06/24)	
								Dedicated education teams to support the junior workforce and upskill the ED and AMU teams. Control Owner: Catherine Miller	Adequate		Agenda item and next UEAM Meeting and ongoing review of incidents and monthly update to Triumvirate Person Responsible: Catherine Miller To be implemented by: 31 Mar 2026		
								February 2025 - an Ambulance queue nurse is now allocated Control Owner: Catherine Miller	Limited		Focus on ensuring full compliance with resus training (paediatric and adult) for all remaining staff that require it within department - in particular medical staff. ILS and PILS compliance will be complete by end of March 2026 so date extended. Person Responsible: Hitendra Tanwar To be implemented by: 30 Apr 2026		
								HCA allocated to the waiting room to repeat observations and observe patients for changes in condition Control Owner: Catherine Miller	Limited				
								Improving access to resuscitation training Control Owner: Catherine Miller	Limited				
								New starters all complete the ALERT course Control Owner: Claire Sims	Adequate				
								Ongoing recruitment. Safer Nursing Care Tool completed	Substantial				

								and business plan drafted Control Owner: Catherine Miller						
								Participation in Trust Deteriorating Patient Workstream Control Owner: Catherine Miller	Limited					
								The Sunrise system flags a NEWS2 of 5 or more or 2 in 1 parameter on the PTL Control Owner: Catherine Miller	Adequate					
1814	29/10/2019	Corporate - Strategic Development & Capital Planning	Information Technology (IT)	Loss of access to key operational/clinical systems from threats (cyber, air con, break of external circuits, fire, floods etc) for a protracted period Risk Owner: Benjamin Stevens Delegated Risk Owner: Peter Davies Last Updated: 03 Jul 2025 Latest Review Date: 16 Dec 2025 Latest Review By: Elisa Steele Latest Review Comments: risks reviewed and updated, closed action - cyber teams roles and responsibilities and new action opened to reflect further work following the review. Action review and update incident response plan - extended time frame to complete this. this will them move to ongoing assurance section as needs yearly review in line with DSPT/CAF	Cause: a wide range of threats (cyber, air con, break of external circuits, fire, floods, human error etc) Effect: Loss to Trust's systems confidentiality and availability Reputational damage Potential financial and legislative penalties Financial loss Information loss Inappropriate access to information Operational impact relating to flow both UEC and elective	Regulatory and Quality	I 5 L = 4 Extreme (20)	annual servicing of air con in data centre Control Owner: John Kelly		I 5 L = 3 High (15)	**Training needs analysis to be undertaken for IT staff in relation to cyber.** **Person Responsible: Rob Brown** **To be implemented by: 31 Dec 2025**	**17 Sep 2025** **Elisa Steele** date extended to align with cyber action	I = 5 L = 2 Moderate (10)
						Biannual testing of network WAN resilience for mitigation of external circuit failure Control Owner: Rob Brown								
						EPRR and incident management in place	Limited		Review and update current IT incident and cyber response plans Person Responsible: Rob Brown To be implemented by: 28 Feb 2026	**17 Sep 2025** extended date to ensure CAF recommendations are included	
						Information Sharing Agreements (ISAs) in place with some third parties for access to Trust information Control Owner: Louise Boulden	Adequate		Review of external facing systems that currently do not support MFA Person Responsible: Jon McKinlay To be implemented by: 31 Mar 2026		
						Mitigations include DSPT measures and staff training, Cyber Essentials Plus, cybersecurity team in place, support from NCSC, testing of the Disaster Recovery processes in place/complete, Regular audits of electronic access to systems Control Owner: Rob Brown	Adequate		Review privileged access rights to key infrastructure systems (as per DocIT) Person Responsible: Rob Brown		
						Run regular (at least yearly) internal exercises to test plan and response with the IT team Control Owner: Rob Brown			Following the review of the role of cyber responsibilities within the IT team a further action is to review and update Job Descriptions to ensure the post holders role reflects their responsibilities. Person Responsible: Rob Brown To be implemented by: 30 Apr 2026		
						servicing of UPS in the data centre Control Owner: John Kelly					
678	31/08/2016	Care Group - Diagnostics, Cancer and Buckland		Insufficient Pharmacy support for the safe (and secure) use of medicines on wards Risk Owner: Desmond Holden Delegated Risk Owner: Rebecca Morgan Last Updated: 08 Jan 2026 Latest Review Date: 06 Jan 2026 Latest Review By: Rebecca Morgan Latest Review Comments: Requested updates from EB & ED on their workstreams / actions linked to this risk	Cause: 1. Regulators and Benchmark: Must do from CQC in Dec 2023 states clinical pharmacy must be present on each medical ward at WHH / QEQM which reduces the impact of the risk assessed clinical service. There is also an open Should Do (2020) related to inability to reconcile medicines in a timely manner in ED (WHH and QEQM). This is due to long lengths of stay in ED and lack of pharmacy support at the front door (reconciliation would usually be undertaken on admission but due to LOS in ED the risk increases) New national standards which have been released which state pharmacist / bed ratios are not met at EKHUFT e.g. ED	Quality	I 3 L = 5 High (15)	Health Building Note 14-02 – Medicines storage in clinical areas. Monthly storage and CD audits in place. Control Owner: Will Willson	Limited	I 3 L = 5 High (15)	**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 ToiL based which reduces clinical capacity)** **Person Responsible: Emma Dodridge** **To be implemented by: 01 Oct 2025**		I = 2 L = 2 Low (4)
						Risk assessment for clinical service and prioritisation of services delivered to high risk	Adequate				

					(see RCEM statement in documents) NICU (2023, ITU at QEQM and K&C (longstanding GPIC) Paediatrics (2023) Cases rejected in Summer 2025 for CQC medical wards and NICU/ Paeds to meet benchmarking. 2. Trust Clinical practice Increased activity for pharmacy generated by care groups ; Wards expanded or services developed within the Trust without consultation with pharmacy. This includes escalation areas and changes in pathway including from one site to another. Pharmacy is then expected to provide an operational / Clinical service to these areas without additional funding. Extra, multiple escalation areas opened up with current issues with demand/flow has created a context in which many of the standard approaches to pharmaceutical care are less effective as well as increasing the bed to pharmacist ratio 3. Trust Clinical Systems: New EPMA system introduced in April 2023 has added to the pressure by increasing processes time by up to 50% and reduced the impact of the team to monitor performance 4. Current Financial processes-Fully established clinical pharmacy service would provide cover to 60% of clinical areas but delays due to VCP holding vacancies is impacting R&R and therefore reducing this further. (VCP re-introduced April 2024) Vacancy rates are starting to increase again in June 2025 as a result of delays. In addition this R&R is impacted by the recruitment by many other organisations which isn't in line with AFC banding. Effect: 1. Patient Safety Wards only covered on a risk associated basis Medicines reconciliation rate is low eDN screening rate is low Clinical screening focused on supply only rather than regular review of patients delayed discharges missed doses of medicines 2. Medicines Governance			clinical areas first mitigates some of this risk but CQC have reduced the impact on this control. Control Owner: Rebecca Morgan			**Review impact of new workflow procedures and identify how to reduce workload for clinical team further in the dispensary** **Person Responsible: Emma Dodridge** **To be implemented by: 01 Oct 2025**		
									Staff have been recruited into new posts and trained to increase the number of staff available to cover. This lessens the impact but does not reduce the likelihood of this occurring again. Control Owner: Rebecca Morgan	Adequate		**Propose a new model of working to support review of most at risk patients. Proposal to include impact on other patients for CQC and Trust to review (following CQC case being turned down by Trust)** **Person Responsible: Erden Batkhisig** **To be implemented by: 01 Jan 2026**	**06 Jan 2026** **Erden Batkhisig** New model of working has been rolled out and being reviewed for effectiveness through auditing and peer review. A full review will
									Use of Locums and NHSP to limit the impact of the emerging issue around vacancies as a result of			Request purchase of Sunrise medicines management app for the 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) Person Responsible: Rebecca Morgan To be implemented by: 31 Jan 2026	**06 Jan 2026** **Rebecca Morgan** This has been added to Buisness
												Generate & Complete an action plan linked to the recommendations generated from the weekend review by Alice Lo. Person Responsible: Emma Dodridge To be implemented by: 31 Mar 2026	
												Use external review of pharmacy service to review risk 678 and add actions if relevant or close etc depending on outcome. (review scope in draft and timeline not confirmed yet) Person Responsible: Rebecca Morgan To be implemented by: 30 Jun 2026	
												Following action closures and external review-request Trust to record that they accept this risk in service and allow closure Person Responsible: Rebecca Morgan To be implemented by: 30 Jun 2026	
2982	08/10/2022	Care Group - Diagnostics, Cancer and Buckland		Inappropriate medicines use within Surgical Specialities (includes variety of care groups) and insufficient supervision and support to junior pharmacy staff Risk Owner: Desmond Holden Delegated Risk Owner: Rebecca Tarrant Last Updated: 13 Jan 2026 Latest Review Date: 12 Jan 2026 Latest Review By: Rebecca Tarrant Latest Review Comments: Awaiting advanced pharmacists to start in Feb 2026 and impact on risk	Cause: Multiple vacancies in clinical pharmacy team for surgery Posts held in recruitment management process - 8a Advanced pharmacist ITU - 8a Advanced pharmacist - surgery (urology, vascular & orthopaedics) - released Oct-25 - 6 junior posts held including rotational surgical pharmacists - Turnover in Junior staff such that vacancy position will deteriorate further	Quality	I 3 L = 5 High (15)	Plan for urgent work circulated and agreed with the team. Governance and MVT work on hold Control Owner: Rebecca Morgan		I 3 L = 5 High (15)	Rotational posts to be filled at when band 6 and 7 pharmacists next rotate – ED to coordinate Person Responsible: Emma Dodridge To be implemented by: 31 Jan 2026		I = 3 L = 4 Moderate (12)

					- Turnover further impacted by having to cover late nights and on call from vacancies Senior pharmacists acting down to provide cover Recent resignation of two Advanced Pharmacists and clinical technicians Effect: Insufficient senior support for Medicines which could lead to 1. Regulatory/Quality/Reputational - poor patient Safety e.g. - Lack of clinical service to some usually covered surgical wards Guidelines - Incident Review / RCA input - Formulary applications - Audits on use of medicines including AMS, CDs and Ward Storage - No education and training to clinical staff - Shortage management - Patient care in clinics e.g. pre-admission 2. Financial - impact - costs from poor shortages management - costs arising from cessation of Horizon scanning - costs arising from poor HCD Review - costs from no CIP support - costs from no review of FP10 prescribing 3. Quality/Regulatory/People - lack of supervision to junior pharmacist will impact patient safety, morale and R&R. Lack of effective line management to pharmacists 4. People - Lead surgical services pharmacist acting down impacting wider team and wellbeing 5. Quality - Unable provide pharmacist support to pre assessment clinics , impacting medicine prescribing on admission including those not currently on Sunrise			Wards covered in line with risk assessment so wards with higher risk receive the limited resource Control Owner: Rebecca Tarrant			External review Person Responsible: Desmond Holden To be implemented by: 31 Mar 2026		
													Recruit to 8a Vacancies (tweaked to include all of them). Person Responsible: Rebecca Tarrant To be implemented by: 01 Apr 2026	**12 Jan 2026** **Rebecca Tarrant** posts recruited to - advanced	
1679	10/06/2019	Corporate - People and Culture		There is a risk of failure to address poor organisational culture Risk Owner: Norman Blissett Delegated Risk Owner: Abigail Blake Last Updated: 06 Oct 2025 Latest Review Date: 09 Dec 2025 Latest Review By: Abigail Blake	Cause: Specifically, there is a requirement for urgent and significant improvement in relation to staff attitudes and behaviours. Effect: Negative patient outcomes Reputational damage	People	I 5 L = 4 Extreme (20)	Agreed HR KPIs (Inc. vacancy rate, turnover and engagement scores) Control Owner: Norman Blissett	Adequate	I 5 L = 3 High (15)	Implementation of new People and Culture Strategy and Delivery Plan which will address the organisation's culture as a core component. Person Responsible: Norman Blissett To be implemented by: 31 Jan 2026		I = 2 L = 2 Low (4)

				Latest Review Comments: This risk should be closed with the implementation of the new strategy and a new risk related to failure to implement the new P&C strategy.	Ability to deliver services Financial Patient harm Regulatory impact Staff wellbeing			Alignment of leadership framework with the behavioural framework and competencies within We Care Control Owner: Norman Blissett					
								Clinical and non-clinical leadership programmes in place Control Owner: Sam Bessant					
								EDI strategy in place Control Owner: Parveen Kumi	Limited				
								Freedom to Speak Up policy and dedicated Freedom to Speak Up guardians meet monthly with Chief People Officer Control Owner: Norman Blissett	Adequate				
								Guidance and toolkits for managers Control Owner: Norman Blissett	Adequate				
								Leadership Development Plans and targeted development plans for individuals in place Control Owner: Norman Blissett	Adequate				
								Leadership diagnostics Control Owner: Norman Blissett	Adequate				
								Revised Disciplinary Policy to include Just and learning culture practices Control Owner: Norman Blissett					
								Staff Survey action plan progress reports standing agenda item for PCC	Adequate				

									Control Owner: Norman Blissett Staff webinars monthly Control Owner: Norman Blissett						
3752	27/11/2024	Corporate - Nursing		There is a risk to patient and staff safety as additional beds have historically been put in permanently into four bedded bays to create six bedded bays on a number of wards across the Trust Risk Owner: Sarah Hayes Delegated Risk Owner: Kim Perry Last Updated: 01 Sep 2025 Latest Review Date: 21 Jan 2026 Latest Review By: Janet Murat Latest Review Comments: Action marked as implemented following information received from QEQM DoN via DRO. JM	Cause: Additional beds have historically been put in permanently into four bedded bays, resulting in multiple six-bedded bays in all hospitals across the Trust. This has led to congested and overcrowded patient bays and main corridors on wards. Whilst HBN04-01 does not strictly apply in the context of this risk, the principles contained therein have been considered. Effect: This may result in patient harm and staff injury. 1.Potential delay in evacuating a ward should a fire occur 2.Potential delay in accessing life-saving equipment such as Resus trolleys, emergency call bells, oxygen and suction 3.Increased likelihood of hospital acquired infections as limited bed spacing does not allow for adequate daily cleaning behind patient beds. 4.Likelihood of staff injury due to having to work in cramped spaces around patients and beds 5.Compromised privacy and dignity for patients	Quality	I 4 L = 5 Extreme (20)	A programme of decluttering of wards has commenced by corporate senior nursing team Control Owner: Kim Perry	Limited	I 3 L = 5 High (15)	Escalation to the Q&S committee on 03/02/2026 to seek advice regarding further actions required to mitigate this risk in current operational climate. Person Responsible: Kim Perry To be implemented by: 16 Feb 2026		I = 2 L = 2 Low (4)
									Regular de-cluttering of ward areas to be maintained by matrons and ward managers Control Owner: Kim Perry	Limited		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 the above Person Responsible: Kim Perry To be implemented by: 28 Feb 2026	**22 Oct 2025** **Emma Kelly** Risk owner changed - due date amended accordingly	
3556	02/11/2023	Corporate - Nursing		Risk to patient safety, privacy and dignity and experience due to overcrowding and delivery of care in non care spaces in the Emergency Departments Risk Owner: Sarah Hayes Delegated Risk Owner: Susan Brassington Last Updated: 20 Jan 2026 Latest Review Date: 27 May 2025 Latest Review By: Carly Sheehan Latest Review Comments: Risk continues with overcrowding but remains a focus	Cause: Due to overcrowding and demand not all patients are able to be cared for in an identified designated care space. Inability to provide appropriate care spaces for the number of patients in the department. Inability to provide beds with pressure relieving mattresses in designated escalation areas. Occupancy within ED for patients with a Decision to Admit is extended. Staffing ratios not optimal for nurse to patient due to additional escalation areas being utilised Effect: *Overcrowding in ED Departments *Patients being cared for and treated outside of a designated area within the department *Inability to safely observe, monitor and care for patients due to excessive demand and /or low staffing *Reduced flow through the ED departments, and hot floor due to low numbers of discharges in wards In addition there are times when patients remain in ambulance queues as there is no space for them to be moved into the ED.	Quality	I 5 L = 5	Corridor dashboard in place to facilitate monitoring and incident reporting Control Owner: Janet Webber	Limited	I 3 L = 5	Ongoing work at Care Group Care Group Board level and UEC Improvement Board to support flow through alternative pathways of care Person Responsible: Alison Pirfo To be implemented by: 31 Jan 2026		I = 3 L = 2
									Corridor SOP in place (updated Oct 25) Control Owner: Susan Brassington	Adequate				
									Corridor SOP in place and incident reporting where corridor exceeds set numbers/case mix Control Owner: Claire Sims	Adequate		Assess progress of clinical harm reviews and associated learning. Remains ongoing Person Responsible: Jonathan Purday To be implemented by: 31 Jan 2026		
												Reverse boarding in place to identify patients who need		

Designated areas on both WHH and QEQM sites for personal care for patients being cared for in non care spaces Control Owner: Susan Brassington	Adequate	resus and those who are well enough to be cared for in a non-care space. Ongoing monitoring against corridor care SOP Person Responsible: Charles Steadman To be implemented by: 31 Jan 2026
Funded GP service running out of ED Control Owner: Diwakar Sharma	Adequate	Fundamentals of care training to be completed by staff re privacy and dignity. Training remains ongoing. - new starters planned Person Responsible: Charles Steadman To be implemented by: 31 Jan 2026
Harm Review process in place and reporting via Quality and Safety Committee. This includes patients cared for in non care spaces.	Adequate	
Matron Daily Round (QEQM) Control Owner: Susan Brassington	Adequate	
Monthly Fundamentals of Care report (which relates to corridor care) is completed and reported monthly to the Fundamentals of Care Steering Group Control Owner: Tomislav Canzek		
NIC/EPIC 4 hourly safety round (visual review of all patients) Control Owner: Susan Brassington	Adequate	
Patient pathway review/retraining of triage and ENP staff Urgent Treatment Centre being planned Control Owner: Benjamin Hearnden	Adequate	
Power sources and call bells added to corridor for pumps and beds etc. Identified room in place for personal care etc. Screens also used. Control Owner: Charles Steadman	Limited	
Regular audits in place of ED Care Plan, Corridor SOP and Risk Assessments (PU, Falls and Nutrition) . These are all reported monthly to Fundamentals of Care Committee. Control Owner: Tomislav Canzek	Adequate	
The Site Management Team report captures the use of non-clinical spaces Control Owner: David Bogard	Adequate	
Two hourly huddles to review and prioritise patients on both sites (WHH and QEQM). To help with flow, at these board round patients are identified for alternative pathways to reduce the overcrowding Control Owner: Tomislav Canzek	Adequate	

								Working with external partners to explore alternative pathways and provision of services Control Owner: Diwakar Sharma	Limited					
								Working with patients to improve knowledge/health education and use of alternative pathways Control Owner: Benjamin Hearnden	Limited					
								Working with SECAmb to reduce conveyances to ED Control Owner: Benjamin Hearnden	Limited					
3743	06/11/2024	Care Group - Queen Elizabeth, The Queen Mother	QEQM General Medicine	There is a risk that the lung function equipment will stop working due to age and servicing history Risk Owner: Jonathan Purday Delegated Risk Owner: David Boyson Last Updated: 01 Sep 2025 Latest Review Date: 15 Jan 2026 Latest Review By: Janet Webber Latest Review Comments: Risk reviewed	Cause: There is a risk that all the lung function equipment will stop working. The servicing for the equipment has been poor. With a promise of service engineers to visit and no attendance occurring. The initial company Inspire went into receivership in 2020, they were taken over by Kokopft, who have not managed to support the service to the standard required. All of the equipment is 7-8 years old. IS slow running and costly to run. Poor servicing, old equipment which requires the inflation and deflation of a balloon assembly for every attempt at every test, which is on average 13 times per patient, or 104 times per day. Results from the current Lung function machine have to be manually uploaded to Sunrise which creates a risk of results being missed for moving across and also involves additional staff time to complete manual uploads and not all staff have access to Sunrise. Incorrect uploads (to the wrong patient records) can and have occurred. Effect: One lung function machine being out of action will result in 40 patients per week losing their appointments, some who are cancer patients. As some of these will be urgent and cancer patients, we will have to move routine patients out of the other two site diaries to ensure they will be seen in the expected time frames. Resulting in our waiting list growing with no potential to bring this down or clear it. If the Buckland site is lost, as a Trust we lose the CIP money form the Monday – Friday activity and then the additional activity that we have secured in September 2024 amounting to approximately £57K for 6 months. If we lose all three machines, which is a possibility then we would have no service. There would be no cancer patients seen, no surgical patients for pre-CABG or AAA seen and the waiting list which sits at around 9 months would increase exponentially with no long-term solution to resolve. The patient experience would be very poor, with many of those on our current waiting list waiting over 2 years for a test. This potentially means that these patients will be experiencing a worsening condition whilst they wait for a diagnosis. Patients. We have identified that one component of the equipment is reading inaccurately. This part is used in the calculation of gas transfer. Gas transfer is how easily oxygen travels across the alveolar capillary membrane to the blood. If the Va is inaccurate then we will be basing diagnosis and treatment on wrong measurements. As this is a diagnostic test it falls within the 42 -ay diagnostic pathway, which we are not monitored on, however, it does fall within the RTT for some of our patients. Many of the patients do not see their consultant until approximately 40 days and the diagnostics are required by 52 days. With the equipment as it stands we will not be able to meet this requirement. All of the lung cancer and other cancer patients will not be able to be tested, all the pre-cardiac surgery patients will not be able to be tested within the Trust making transfer to tertiary centres impossible. AS this is a diagnostic service that supports all disciplines failure to	Quality	I 5 L = 5 Extreme (25)	External support for lung function scoped Control Owner: David Boyson	Limited	I 3 L = 5 High (15)	Loan kit is in place with good engineering oversight and old kit is no longer in use. Procurement process and sign off for new kit still required. Update 15/10/25: The procurement process for the 3 pieces of kit are still with MDG to be signed off and procured. The 2 kits for Thanet CDC have been ordered by does not mitigate this in house risk November 2025 - kit due to CDC in December 2025 so date extended for this action Person Responsible: David Boyson To be implemented by: 31 Jan 2026		I = 3 L = 2 Low (6)
								Staff without Sunrise access email the Team Lead or Deputy with results that need to be uploaded ro Sunrise. Control Owner: Emma Ince	Limited					
								The equipment undergoes daily internal quality control checks and higher levels of balloon stock are ordered. Control Owner: David Boyson	Limited		New equipment, which will not require manual uploads of results, has been identified. The procurement process needs to be followed and where necessary expedited. November 2025 - kit due to CDC in December 2025 so date extended for this action September procurement not confirmed and still reliance on loan equipment which is not networked. Person Responsible: David Boyson To be implemented by: 31 Jan 2026	**01 Sep 2025** **Janet Webber** Delay in procurement process will impact on CDC change due to take place in 6 weeks so score increased as unlikely to be completed in 6 weeks,	

					diagnostic service that supports all disciplines failure to have such a service will prevent those utilising, respiratory, cardiology, neurology, rheumatology, form making their differential diagnosis confirmed and treatment plans formalised. Staff experience will be impacted. Staff within both the admin team and clinical team are feeling the pressure of the waiting list and the clinical team are concerned about the equipment and results they are generating, despite using all quality control processes to ensure reliability. Poor performing equipment will result in our trainee staff having a poor training experience and thus potentially lead to high attrition rates within lung diagnostics. Patients. We have identified that one component of the equipment is reading inaccurately. This part is used in the calculation of gas transfer. Gas transfer is how easily oxygen travels across the alveolar capillary membrane to the blood. If the Va is inaccurate then we will be basing diagnosis and treatment on wrong measurements. Financial – there will be fines placed for not meeting the RTT, the loss of income via the CDC will impact CIP and development of the service. SLA's will be required which would cost anywhere from £653,700 not including MFF, or CDC additional capacity or higher tariffs for CDC.								
3874	19/09/2025	Corporate - Operations		Risk of patient harm and poor patient experience due to non-RTT (Referral to Treatment) follow up backlog Risk Owner: Dan Gibbs Delegated Risk Owner: Titus Burwell Last Updated: 16 Dec 2025 Latest Review Date: 22 Sep 2025 Latest Review By: Emma Kelly Latest Review Comments: Approved by Risk Review Group on 16 September 25	Cause: Since the Covid-19 pandemic, the number of non-RTT follow up pathways has surged significantly, growing from 320,870 in May 2020 to 510,500 in June 2025. This rise reflects increased demand for care but also underscores issues with data quality and administrative processes and administrative capacity. A substantial proportion of the pathways contains potential data errors, complicating the identification of genuine patient records from erroneous data, which in turn hinders effective risk assessments and prioritisation of care. In some speciality's workforce gaps have led to cancelled clinics and prioritisation of RTT workload. Effect:	Regulatory and Quality	I 5 L = 3 High (15)	Conduct a full evaluation of the validation process and implement continuous improvement based feedback Control Owner: Dan Gibbs	Adequate	I 5 L = 3 High (15)	Review and relaunch of all training materials and implementation of awareness and training sessions for operational and administrative staff Person Responsible: Titus Burwell To be implemented by: 31 Jan 2026		I = 2 L = 3 Low (6)

					Patient harm such as delay in diagnosis, delay in treatment and progression of disease. Poor patient experience. Reputational impact. Regulatory impact (no national standards around Non RTT) but impact on delivery of quality safe care			Establish monitoring mechanisms including a reporting system to track validation progress and monitor KPIs Control Owner: Dan Gibbs	Adequate		Risk stratification by clinical teams to identify high risk cohorts for escalation and review Person Responsible: Dan Gibbs To be implemented by: 31 Jan 2026		
								Oversight Group to be chaired by Director of Planned Care Recovery (which Clinical Lead co-chair)	Adequate		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: Titus Burwell		
								Regular reporting to TMC and Quality and Safety Committee Control Owner: Dan Gibbs	Adequate		Utilisation of existing administrative staff for validation Person Responsible: Dan Gibbs To be implemented by: 31 Jan 2026		
											Receive quotes from external validation companies re temporary validation workforce and automated AI solutions to clear low risk backlog Person Responsible: Titus Burwell To be implemented by: 31 Jan 2026		
											Data Algorithm Implementation Person Responsible: Louise Pallas To be implemented by: 31 Jan 2026		
3840	17/07/2025	Care Group - Kent and Canterbury and Royal Victoria	Urology	There is a risk that patients are coming to harm, dying and having cancer treatment delayed or not commenced due to a breakdown in the surveillance, monitoring and escalation through the urology cancer pathways. Risk Owner: Dan Gibbs Delegated Risk Owner: Naomi Webb Last Updated: 09 Dec 2025 Latest Review Date: 06 Oct 2025 Latest Review By: Anthony Maskell Latest Review Comments: Reviewed	Cause: A number of causes have been identified highlighting lack of compliance on the 4 pathways including; •Prostate Pathway – delays in biopsy results and clinic decisions reaching MDM, delays and/or no follow ups post treatment, tracking stops after follow ups. Breakdown in communication requiring oncology follow ups. GP not continuing treatment recommended. Patients lost to follow up. •Renal/Upper Pathway - Track pathway delays with communicating and planning	Reputational	I 5 L = 3 High (15)	Discussed if one of the two Cancer trackers could be released to dual approach with surveillance. Control Owner: Naomi Webb	Limited	I 5 L = 3 High (15)	**Patients on a non RTT pathway, working group, ? AI solution** **Person Responsible: Naomi Webb** **To be implemented by: 20 Nov 2025**		I = 5 L = 1 Low (5)
								Radiology monitoring system in place with secretaries, generic email available and results sent to appropriate clinician.	Adequate		**Business case/ bid for Urology pathway coordinator 3 x band 3s, 2x CNS and 1 x pathway navigator.** **Person Responsible: Naomi Webb**		

					delays with communicating and planning decisions made in MDM, long wait due to lack of specialist robotic surgeon and surveillance post treatment. Oncology not being included/referred to in decisions being made so unable to offer radiotherapy. Results of diagnostics not being relayed to patients. Delays in 31 and 62 day cancer pathways due to capacity issues. •Bladder Cancer Pathway – Delay/or no referring into MDM following TURBT and delay or no follow ups once tracking stops. Not referring to other specialities once decision made for speciality input. OPAs not being made once decision made that consultation with patient was needed.•Testicular Pathway- Referrals not made to oncology post radical orchidectomy-OPA with urology team not made – discharges from teams without correct forward onward referrals-patients listed under incorrect consultants. Effect: A number of patients have come to harm due to the causes outlined above.			Control Owner: Naomi Webb			To be implemented by: 20 Nov 2025		
												Development of oncology tracker identified to assist with staging and follow up, **Person Responsible: Naomi Webb** **To be implemented by: 20 Nov 2025**		
												Recruitment of urology secretaries to meet the demands of the service. May need to be taken to VCP **Person Responsible: Naomi Webb** **To be implemented by: 20 Dec 2025**		
2844	26/05/2022	Care Group - Diagnostics, Cancer and Buckland		Inability to take on new patients for homecare for medicines due to the service exceeding its capacity to support patients and the processes involved Risk Owner: Desmond Holden Delegated Risk Owner: Alice Lo Last Updated: 13 Jan 2026 Latest Review Date: 16 Dec 2025 Latest Review By: Emma Kelly Latest Review Comments: As this has been escalated to significant risk record CMO added as accountable exec	Cause: Service funded for 3000 patients, currently supporting >6000 Increasing numbers of patients receiving homecare medicines 4050 patients (Apr 22) , 5897 April 2025, October 2025 6050 - Spend 24/24 £23M Inability to maintain headcount; Delays to VCP approval of 2 homecare posts: specialist pharmacist homecare (band 7) and homecare pharmacy technician (band 5-6) Delays at post approval - Specialist pharmacist due Nov-25 Lead technician released October 2025 - due ? Jan-26 No maternity cover for A&C. Maternity for 1 A&C in the team from Sept-25. Lead Pharmacist planned sick leave Dec-25 8-12 weeks Care grp approval for NHS-P on hold in VCP Finance paying invoices at 60 days Sciensus requesting settlement of invoices for their year end by 31.12.25. Risk of daily interest. Effect: •No new patients for homecare for medicines starting with oral chemotherapy patients •Delays in processing invoices > 5 weeks •Risk of homecare companies stopping services due to non-payment of invoices – currently being actively chase for > £1M •Financial. With the prescriptions being maintained in house leading to loss of potentially £300k in VAT efficiencies (based on 23/24 figures for 24/25 spend) •People - Increase workload to dispensary-based teams with patients needing to come into hospital to collect medicines reducing patient experience and convenience	Our quality and safety	I 3 L = 5 High (15)	Annual audit against professional standards overseen by SPS Regional medicines procurement team Control Owner: Folake Idowu		I 3 L = 5 High (15)	halt new oral oncology patients progressing to homecare. route via dispensary. Base on assessment of ability to attend the hospital regularly to collect prescription. Person Responsible: Miguel Capo-Mir To be implemented by: 31 Mar 2026	**21 Oct 2025** **Will Willson** Long implementation time because of time to accrue impact	I = 3 L = 1 Very Low (3)
								Cap on no. of patients the team can support Control Owner: Emily Hunnisett					
											Review income and team size in line with NMHC guidance Person Responsible: Emily Hunnisett To be implemented by: 31 Mar 2026		
								Divert prescriptions to dispensary for screening and dispensing Control Owner: Emily Hunnisett			To repatriate some homecare services in house Person Responsible: Alice Lo To be implemented by: 31 Mar 2026	**21 Oct 2025** **Will Willson** lead time extended because repatriation of patients is a	
								Full implementation of the CMM homecare system Control Owner: Christie Head			Consider moving staffs from dispensary telemeds to homecare to support patients onto homecare and bring capacity into balance as well as assess impact of so going in dispensary Person Responsible: Emily Hunnisett To be implemented by: 30 Jun 2026		
											NHS-P to supporting outsourced screening Person Responsible: Emily Hunnisett	**14 Aug 2025**	

					convenience. •Quality - Unable to handle shortages resulting in short term switches (ensuring continuity of patient treatment) •Financial - No biosimilar switch programs undertaken; leading to reduced CIP savings in biosimilar switches that has been forecasted as part of Trust CIP. Risk of daily interest from homecare providers due to unresolved backlog of invoices •Reputational - Negative Patient feedback/surveys (patient care) •Regulatory - Reduced contract management (audit and compliance) •Quality - Reduced support for current patients						To be implemented by: 31 Jul 2026 Outsource screening Person Responsible: Alice Lo To be implemented by: 31 Aug 2026	**Emily Hunnisett** NHSP applied for but on hold with VCP panel. NHSP form	
3719	09/09/2024	Care Group - Diagnostics, Cancer and Buckland		There is a risk of patient harm from availability, delays and errors in SACT prescribing for adults due to system failures with the ARIA medonc system being out of date at KMCC. Risk Owner: Desmond Holden Delegated Risk Owner: Alexis Warman Last Updated: 18 Dec 2025 Latest Review Date: 18 Dec 2025 Latest Review By: Janet Murat Latest Review Comments: Linked to risk 3662 post discussion with CMO and AD C&QG. JM	Cause: ARIA e-prescribing system has not been updated by KMCC in line with the releases from the company. The K&M version is very out of date which impacts support and functionality. KMCC version is 11 and the latest version of ARIA is 17 SACT 4.0 (due 2025) is not implementable with Version 11 The system is due to transfer to a cloud based system (?2025), given the current version the KMCC Aria cannot transition easily to this and the non-cloud based system will have highly limited support IT infrastructure challenges running a client server based system for the county. Insufficient licenses for user base Effect: Safety: People who require SACT will be delayed, or missed without a robust adequate system. Financial: Failure to support the commissioned service from NHS Specialised commissioning.	People and Quality	I 5 L = 3 High (15) =	This requires £1.5m capital this financial year and system-wide funding is available to be bid for as part of this. There are conversations at present across the ICS around converged ePRs and an options paper will need to be formulated. MTW to lead on baseline work regarding the form, function and scope of e-prescribing with support from the Cancer Alliance. Cancer Alliance governance meetings to discuss progress of procurement of new system. Control Owner: Pippa Enticknap	Limited	I 5 L = 3 High (15) =	New E-prescribing system to be procured and implemented across the Cancer Alliance. Person Responsible: Alexis Warman To be implemented by: 30 Apr 2026	**16 Dec 2025** **Michelle Burrough** Matter raised at Cancer Delivery Group meeting 10/12/2025 -	I = 5 L = 1 Low (5) =

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Assessing the impact of appointment scheduling on inequalities in deprived areas**

Meeting date: **5 February 2026**

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

Paper Author: **Marc Farr, Chief Analytical Officer**

Appendices:

Appendices 1 and 2
Paper with examples of dashboarding and analysis of inequalities.
Paper with a case study of the Data Science team demonstrating an improvement in the Did Not Attend (DNA) rate after the development of a risk strategy approach.

Executive summary:

Action required:	Discussion
Purpose of the Report:	This paper is coming to the Board to provide analysis of how EKHUFT's services are delivered across patients of different socio-economic, demographic and ethnic backgrounds. Clearly it is important that the Trust aims to deliver services fairly to all patients irrespective of any characteristics that they might have in terms of access, experience and outcome. The paper also provides examples of where the Trust has identified differences in access and attempted to correct these through the adoption of different strategies for different patients (akin to a private company marketing differently to different people).
Summary of key issues:	EKHUFT runs an Inequalities and Unwarranted Variation Committee, chaired by the Chief Operating Officer (COO) and Chief Medical Officer (CMO), and administered by the Chief Data and Analytical Officer (CDAO). This Committee meets every two months and receives data across different services and patterns that exist in access to their services. Through our analysis so far there do seem to be differences in access to our services across the four axis of inequality that we have measured so far (age/sex/ethnicity/deprivation), examples are presented below. In the first example the chart here shows how the most deprived decile of patients are seen fastest in the Emergency Department (ED):

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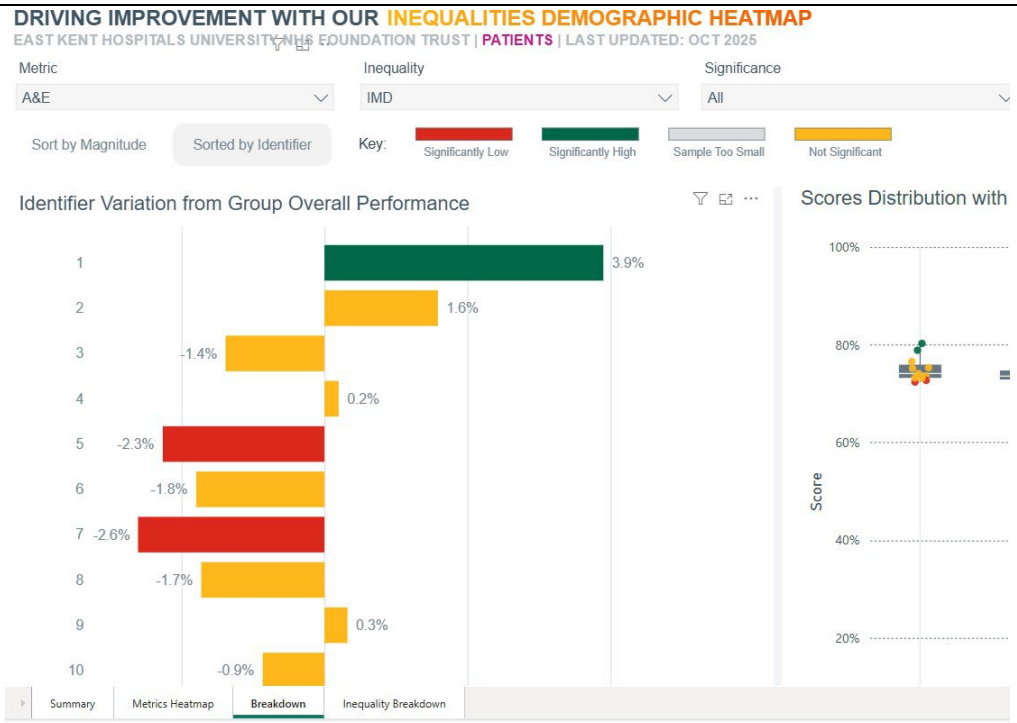
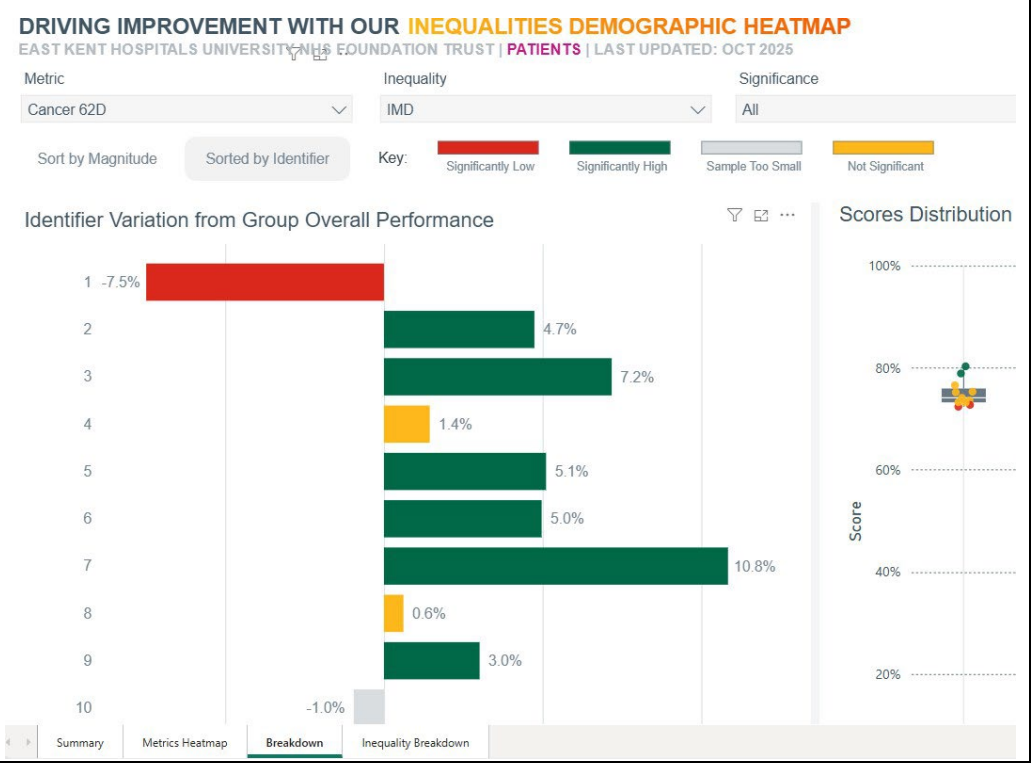
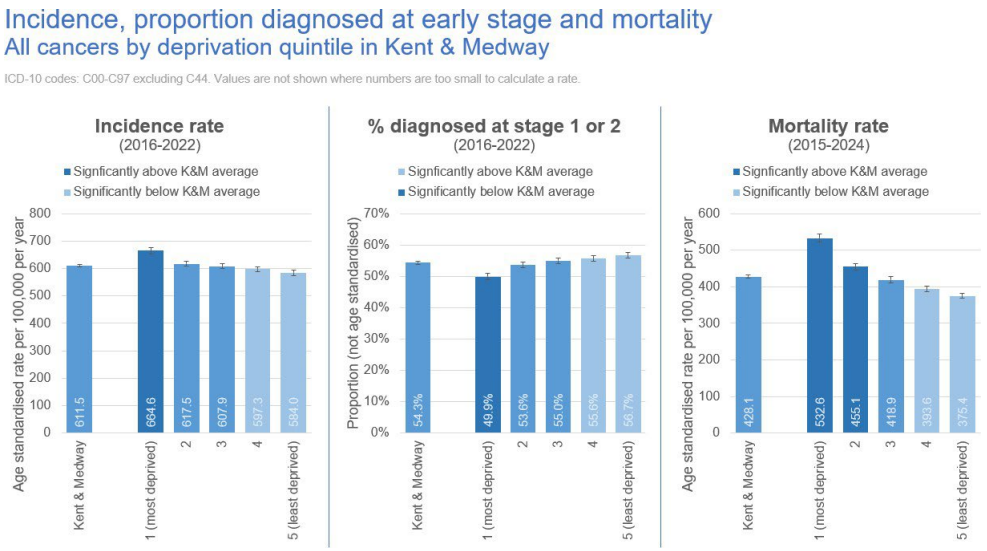


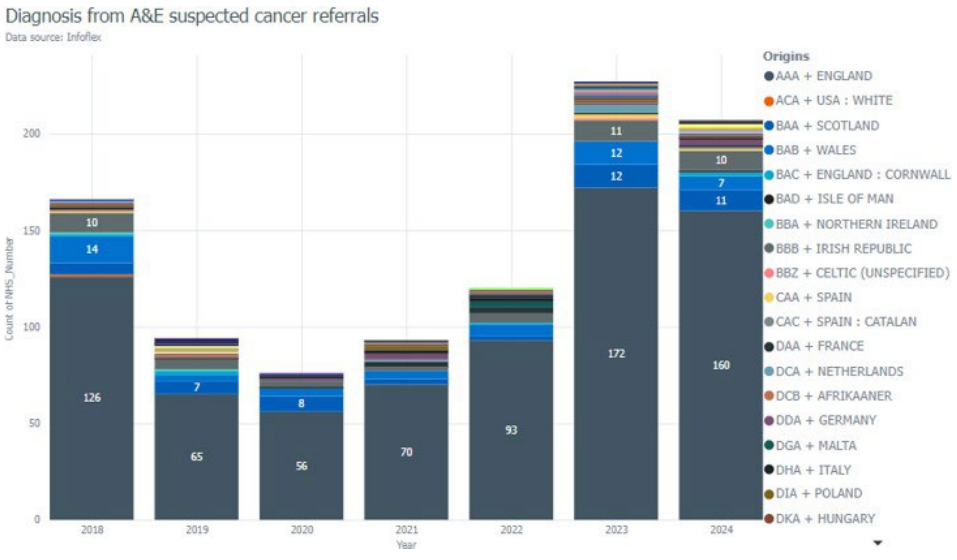
However, the next chart shows that this group are the slowest to begin their cancer treatment (the national 62 day standard):



This data is concerning as it may be an influence on the worse outcomes for the poorest parts of the county, see the chart below which shows outcomes by deprivation (quintile this time).



Linking ED and Cancer together, just illustratively, the graph below shows that more people are getting diagnosed with Cancer in ED, a resurgence after the pandemic. The graph also shows that we are able to analyse these patients according to their ethnicity – this type of analysis has been very illuminating.



Where these differences are material it is possible for the Trust, through our Data Science team (within our Business Intelligence team) to build algorithms to predict those that are likely to DNA or cancel their outpatient appointment

East Kent Hospitals University NHS Foundation Trust

	and then to use these to develop different strategies for different populations. See the attached paper but the findings are repeated here showing the reduction in DNA rate that is possible to achieve: As further findings become available this analysis can be extended into other strategies.
Key recommendations:	The Board of Directors is: • Recommended to **SEEK** regular assurance that EKHUFT's patients have the same access, experience and outcome irrespective of their background and demographics. • Asked to **NOTE** the analytical skills available at the Trust and to consider the highest priority areas that they could be deployed within.

	January 2024			February 2024				March 2024			
Appointment Type	Appts	DNA	(%)	Appts	DNA	(%)	Reduction	Appts	DNA	(%)	Reduction
• Follow-Up	601	29	(4.8)	429	19	(4.4)	8%	527	20	(3.8)	21%
• New	319	27	(8.5)	222	6	(2.7)	68%	228	7	(3.1)	64%
Booking Type	Appts	DNA	(%)	Appts	DNA	(%)	Reduction	Appts	DNA	(%)	Reduction
• Partially	837	53	(6.3)	621	24	(3.9)	39%	681	26	(3.8)	40%
• Fully	83	3	(3.6)	64	1	(1.6)	57%	74	1	(1.4)	63%
Consultation Method	Appts	DNA	(%)	Appts	DNA	(%)	Reduction	Appts	DNA	(%)	Reduction
• Face-to-Face	860	53	(6.2)	619	25	(4.0)	34%	714	24	(3.4)	45%
• Telephone	60	3	(5.0)	32	0	(0.0)	100%	41	3	(7.3)	-46%
PSC to Book	Appts	DNA	(%)	Appts	DNA	(%)	Reduction	Appts	DNA	(%)	Reduction
• No	598	29	(4.8)	422	19	(4.5)	7%	537	20	(3.7)	23%
• Yes	322	27	(8.4)	229	6	(2.6)	69%	218	7	(3.2)	62%
Total	920	56	(6.1)	651	25	(3.8)	37%	755	27	(3.6)	41%

Implications:

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

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Assurance route:

Previously considered by: Finance and Performance Committee (FPC) – 25 November 2025
This work summarises work done at the Inequalities and Unwarranted Variation Committee and has been to FPC.

Re-imagining Health Equity

Dr Marc Farr
Chief Analytical Officer,

East Kent Hospitals NHSFT
Kent and Medway ICB

NHS
East Kent
Hospitals University
NHS Foundation Trust

Re-imagining Health Equity

- The background to analysis of inequalities
- Analysis techniques that are now available
- Imagining the future – the opportunity and the challenge

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Marc

Chief Analytical Officer

Ask me:

Are we providing fair and equitable care at our hospital?

What are the regional plans for Population Health Management to address inequalities?

How are we collaborating with the local universities on recruitment and research?

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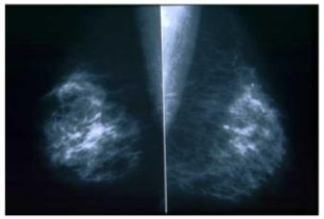
It was 20 years ago today…

Did you know?

…for every tube stop east of Westminster, life expectancy drops by a year…

Did you know?

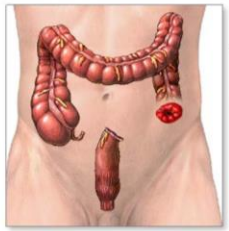
…women diagnosed with breast cancer in their 40s from an affluent background are more likely to have a lumpectomy than a mastectomy …



Did you know?

…there are as many unplanned pregnancies among the over 40s as there are for the under 20s…

Did you know?



…men diagnosed with bowel cancer in their 50s from a poor background are more likely to have a colostomy bag than a bowel reconstruction…

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- There are now opportunities to use data and analysis to provide assurance around equitable access, patient experience and outcomes for services delivered at acute hospitals and the importance of putting in place a governance framework for monitoring and tackling any health inequalities that might exist.

- Key points:

  - For the first time, there is national guidance that NHS organisations must be able to disaggregate their board reports by ethnicity and deprivation, in response to national concerns around differences in risk and vaccination uptake for Covid, and waiting times in the elective backlog. Guidance also requires executive leadership in this area.

  - Initial exploratory analysis conducted internally at EKHUFT, including maternity outcomes and likelihood of breaching 18 weeks on elective waiting lists, suggests some inequalities exist between different demographic groups.

  - An informal working group has been established between the Information team and two of our clinicians, seeking to ensure clinical input in understanding causes of health inequalities.

  - A more formal approach to governance is recommended. Information team plan to consider patient access, patient experience and patient outcomes - given that access is currently a key topic, we recommend that inequalities assurance is the responsibility of the COO.

Today…

EKHUFT: Approach to Inequalities analysis

Phase 1 – Q 1 22/23
Bronze

- Counts and Rates
- Crude data
- Examples include:
  - Staffing sexual orientation analysis
- Maturity level:
  - Pie Chart

Phase 2 – Q2 22/23
Silver

- Benchmarking versus all activity including statistical tests.
- Crude data
- Examples include:
  - Paediatric DNA rates
  - Continuity of Care for Maternity
  - Elective waiting list breakdown
  - Rates of falls
- Maturity level:
  - SPC

Phase 3 – Q4 22/23
Gold

- Regression and data mining
- Crude data
- Examples will include:
  - Factor analysis for DNA rates
- Maturity level:
  - Regression/Forecast

Phase 4 – Q2 23/24
Platinum

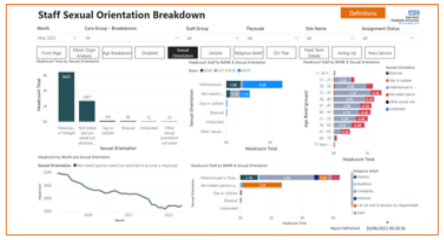
- Standardised rates
- Adjusted data
- Examples will include:
  - Overall equality and variation measure
- Maturity level:
  - HSMR

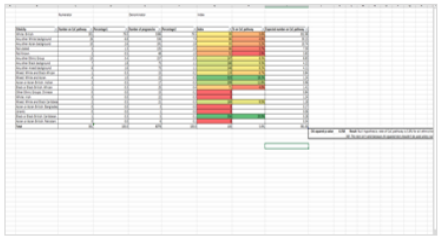
Statistical Tools

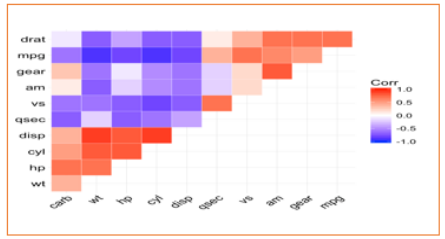
Segmentation Tools

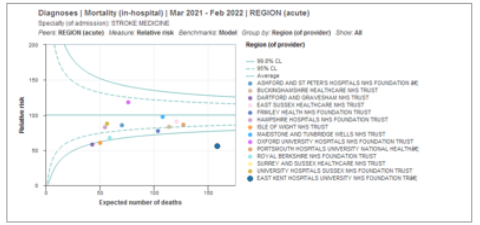
r/Python

Acorn or Mosaic, Look Ups and Stratification Tools









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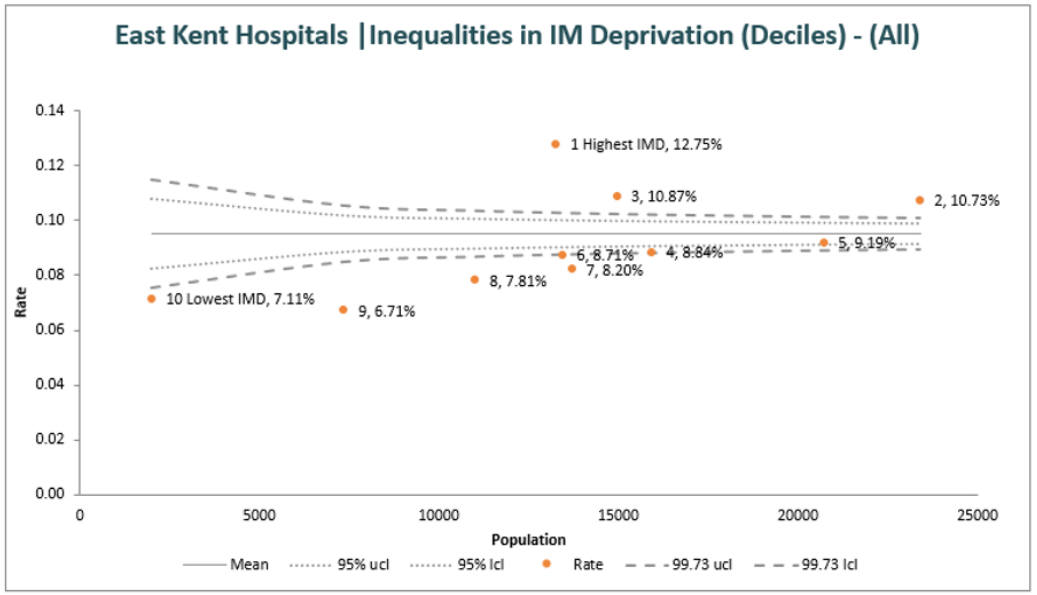
Paediatric DNA rates

The higher the level of deprivation the more likely families with children are to DNA.

Unknown is removed

Row Labels	Sum of Num	Sum of Denom	Index	Expected	Rate
1 Highest IMD	1,692	13,273	134	1263.7	12.7%
2	2,512	23,401	113	2228.0	10.7%
3	1,626	14,962	114	1424.5	10.9%
4	1,408	15,936	93	1517.2	8.8%
5	1,904	20,728	96	1973.5	9.2%
6	1,171	13,446	91	1280.2	8.7%
7	1,124	13,710	86	1305.3	8.2%
8	860	11,018	82	1049.0	7.8%
9	494	7,366	70	701.3	6.7%
10 Lowest IMD	143	2,010	75	191.4	7.1%



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Implementing Data Science

	likelihood to DNA	letter	text	phone call	likelihood to cancel	letter	text	phone call
sadia	90	1	1	1	50	1	1	
tim	70	1	1		50	1	1	
marc	30	1			30	1	1	

Model Training and Evaluation

East Kent Hospitals University NHS Foundation Trust

- Type of problem is Classification

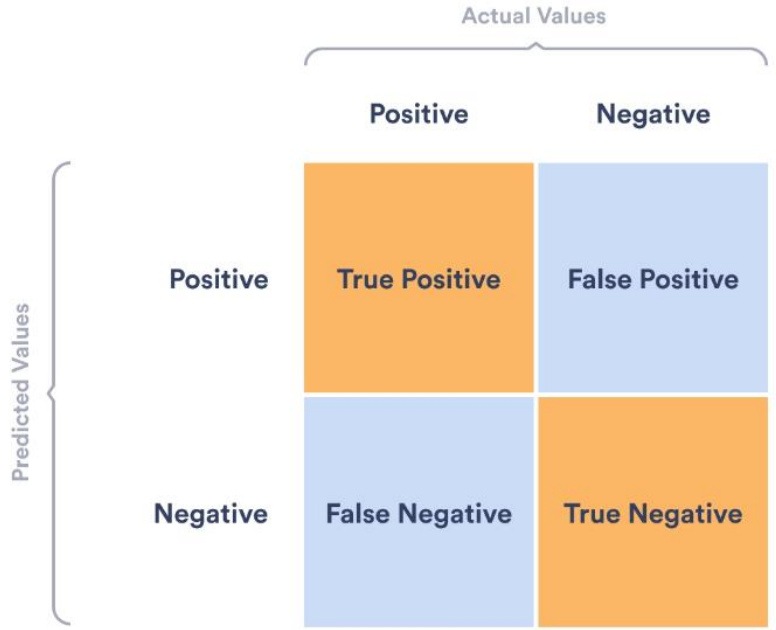
Model	Example Use Cases	Concept in Detail That Produces the Output
Logistic Regression	Predicting the likelihood of an event (e.g., churn prediction, spam detection).	It uses the logistic function to model a binary dependent variable. The model learns weights for the features that maximize the likelihood of reproducing the observed outcomes.
Decision Tree	Decisions that require a clear interpretation and understanding of the model (e.g., medical diagnosis).	It uses a tree-like model of decisions based on the features. Each node in the tree splits the data based on a feature value, and the final decision is based on the leaf nodes.
Random Forest	General classification and regression tasks that require robustness to noise and outliers (e.g., predicting customer satisfaction).	It uses an ensemble of decision trees, each trained on a different subset of the data. The final output is the mode (for classification) or mean (for regression) of the outputs of all trees.
Gradient Boosting	When high predictive accuracy is desired (e.g., predicting house prices).	It uses an ensemble of weak prediction models, typically decision trees. The model is built in a stage-wise fashion, and each new model helps to correct the errors made by the existing ensemble.
Bagging Classifier	Similar to Random Forest but for use with any base estimator (e.g., anomaly detection, classification tasks).	It creates an ensemble of base estimators, each trained on a different randomly sampled subset of the data. The final output is decided by majority voting (for classification) or averaging (for regression).
AdaBoost Classifier	Used in conjunction with many types of learning algorithms to improve performance (e.g., face detection).	It adjusts the weights of the training instances: instances that were misclassified by the previous model are given more weight. Each model in the ensemble focuses more on difficult instances, leading to a robust final model.

Model Training and Evaluation

East Kent Hospitals University NHS Foundation Trust

- How do we evaluate models?

Metric	Example Use Cases	Why is it Important to Consider this Metric?
Accuracy	General classification problems	Accuracy tells us about the overall performance of the model, giving us a basic idea of how well the model performs across all classes.
Precision **Precision measures how many of the predicted positive instances were actually correct.**	When false positives are costly (e.g., spam detection)	Precision is crucial when the cost of false positives is high. It tells us about the model's performance with respect to false positives.
Recall **Recall measures how well the model identifies the positive instances out of all the actual positive instances.**	When false negatives are costly (e.g., cancer diagnosis)	Recall is crucial when the cost of false negatives is high. It tells us about the model's performance with respect to false negatives.
F1 Score **The F1 score is the harmonic mean of precision and recall**	When an equal emphasis is given to both precision and recall (e.g., information retrieval)	F1 Score is the harmonic mean of precision and recall, and gives a balanced measure of the model's performance when both false positives and false negatives are equally important.
ROC AUC	When we want to measure the model's ability to distinguish between classes	ROC-AUC gives an aggregate measure of performance across all possible classification thresholds, providing a measure of how well the model can distinguish between classes.



$$\text{Precision} = \frac{\text{True Positive}}{\text{Actual Results}} \quad \text{or} \quad \frac{\text{True Positive}}{\text{True Positive + False Positive}}$$

$$\text{Recall} = \frac{\text{True Positive}}{\text{Predicted Results}} \quad \text{or} \quad \frac{\text{True Positive}}{\text{True Positive + False Negative}}$$

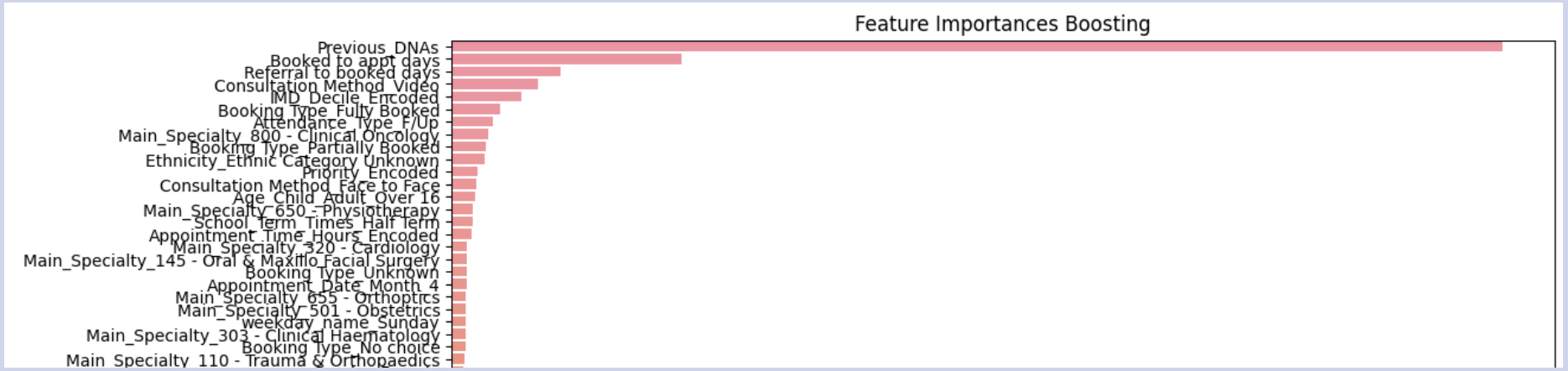
$$\text{Accuracy} = \frac{\text{True Positive + True Negative}}{\text{Total}}$$

$$F1\ score = 2 * \frac{Precision\ * Recall}{Precision + Recall}$$

Model Training and Evaluation

East Kent Hospitals University NHS Foundation Trust

- Important Features

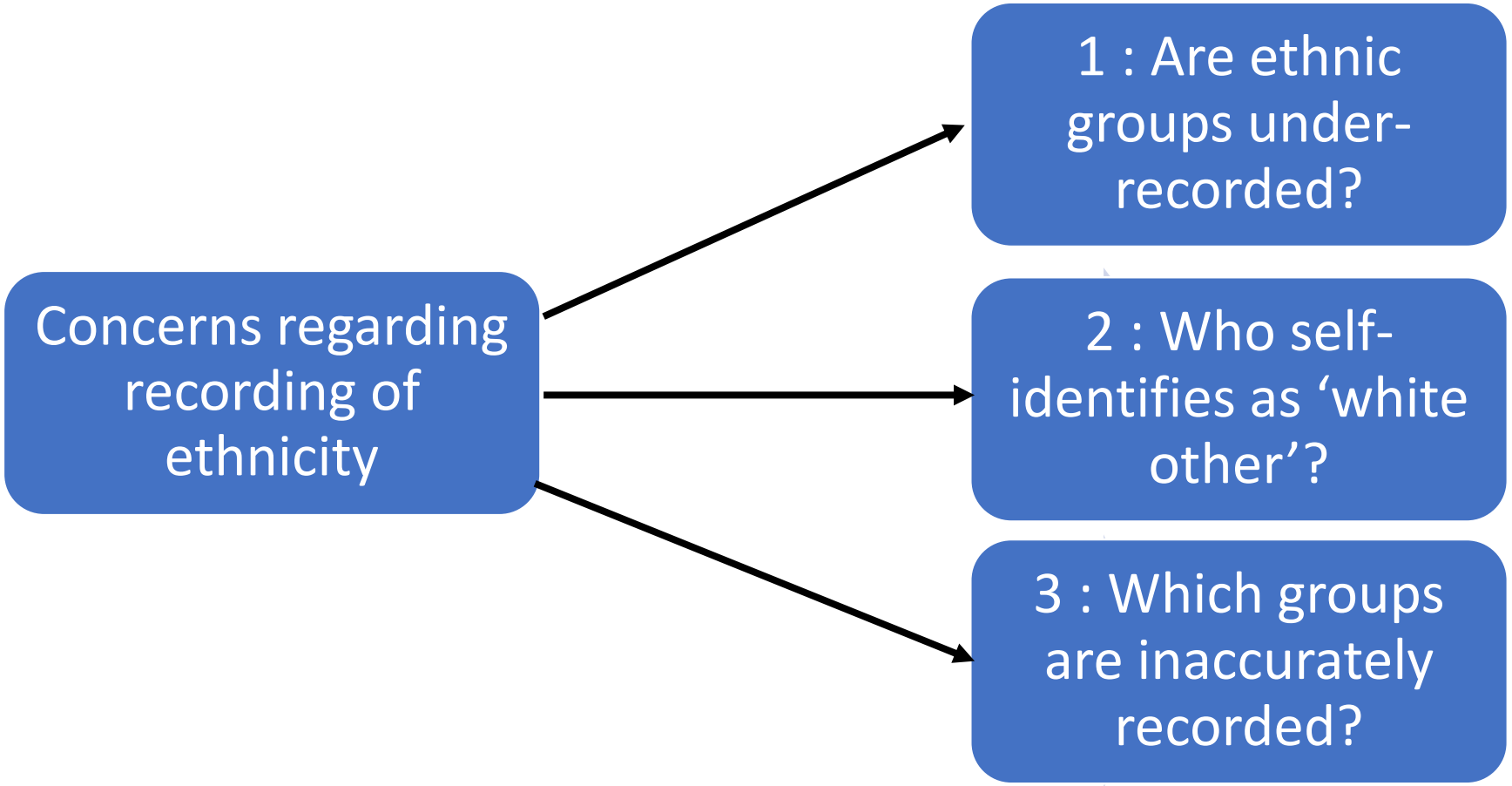
Model	Metrics
AdaBoost Classifier	

- Best Model selection

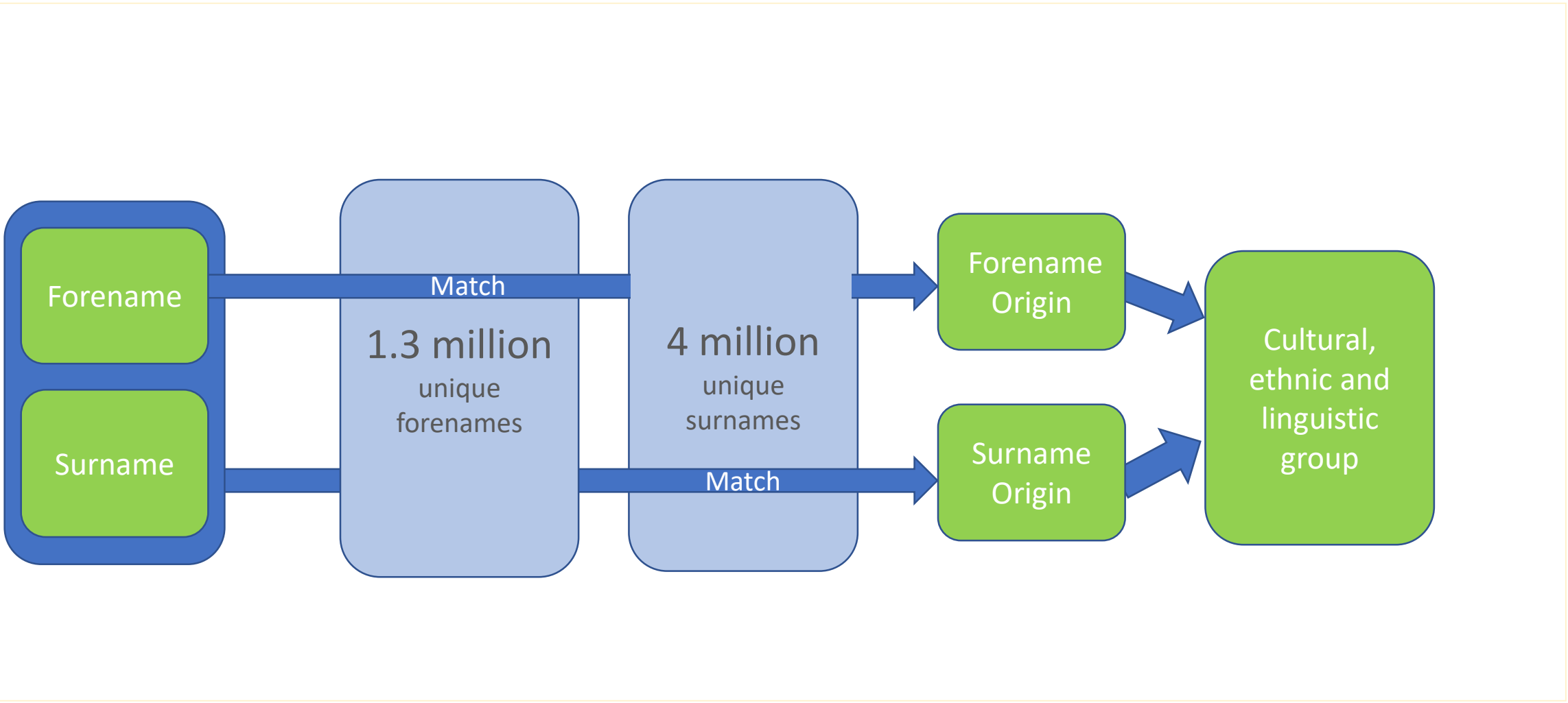
```
# Accuracies Dictionary
accuracies = {
    "Logistic Regression": lr_accuracy,
    "Decision Tree": dt_accuracy,
    "Random Forest": rf_accuracy,
    "Gradient Boosting": gb_accuracy,
    "Bagging": bagging_accuracy,
    "AdaBoost": boosting_accuracy
}

# Choose the model with the highest accuracy
best_model_name = max(accuracies, key=accuracies.get)
best_model = models[best_model_name]
print(best_model)
```

```
RandomForestClassifier(random_state=42)
```

Concerns of East Kent Hospital Trust



Origins software



1 : Are ethnic groups under-recorded?

Origin of name	% patients ethnicity not known or patients declined to answer
Britain and Ireland	5.38
Baltic States	15.35
Nigeria	16.51
Romania or Moldova	18.02
Bangladesh	18.04

2 : Who self- identifies as ‘white other’?

Origins Sub Groups	patients	% describing themselves as British	% describing themselves as any other white background
EIA : POLISH	7,273	30.06	50.05
EJZ : CZECH OR SLOVAK	3,994	17.88	50.15
EKA : HUNGARIAN	1,850	34.22	34.92
ELZ : BALTIC STATES	1,824	16.50	57.95
EMF : ALBANIAN	966	33.75	41.61
EMZ : FORMERLY YUGOSLAV	1,404	39.60	33.97
ENA : BULGARIAN	1,024	17.68	53.42
EOA : ROMANIAN	4,279	10.56	56.65
EPZ : RUSSIAN OR UKRAINIAN	4,313	18.76	51.05

Maternity Patients

NHS East Kent Hospitals University NHS Foundation Trust

Origins Group Profile of Maternity Patients vs East Kent Hospital Trust

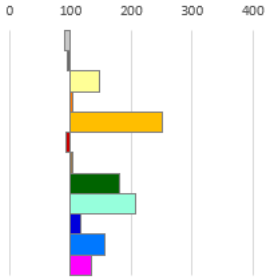
File: Maternity Patients
Base: East Kent Hospital Trust
Date of report: 19/01/2024

WEBBER PHILLIPS

Origins is a segmentation system which classifies consumers according to the part of the world from which their forebears are most likely to have originated.

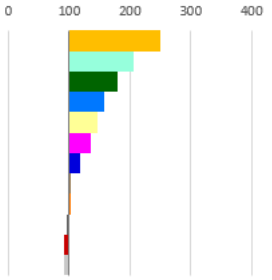
Origins Group Level Profile

Origins Group	File (Adults)	%	Base (Adults)	%
A : Anglo-Saxon	30,787	65.2%	265,776	71.9%
B : Celtic	7,290	15.4%	59,971	16.2%
C : Hispanic	530	1.1%	2,820	0.8%
D : Western European	1,843	3.9%	14,002	3.8%
E : Eastern European	2,997	6.3%	9,382	2.5%
F : Greek/Greek Cypriot	126	0.3%	1,071	0.3%
G : Jewish/Armenian	83	0.2%	629	0.2%
H : Black African & Caribbean	807	1.7%	3,497	0.9%
I : Muslim	1,398	3.0%	5,293	1.4%
J : Sikh	69	0.1%	458	0.1%
K : Hindu South Asian	948	2.0%	4,712	1.3%
L : East Asian	375	0.8%	2,167	0.6%
Total	**47,253**		**369,778**	



Ranked Origins Group Level Profile

Origins Group	File (Adults)	%	Base (Adults)	%
E : Eastern European	2,997	6.3%	9,382	2.5%
I : Muslim	1,398	3.0%	5,293	1.4%
H : Black African & Caribbean	807	1.7%	3,497	0.9%
K : Hindu South Asian	948	2.0%	4,712	1.3%
C : Hispanic	530	1.1%	2,820	0.8%
L : East Asian	375	0.8%	2,167	0.6%
J : Sikh	69	0.1%	458	0.1%
G : Jewish/Armenian	83	0.2%	629	0.2%
D : Western European	1,843	3.9%	14,002	3.8%
B : Celtic	7,290	15.4%	59,971	16.2%
F : Greek/Greek Cypriot	126	0.3%	1,071	0.3%
A : Anglo-Saxon	30,787	65.2%	265,776	71.9%
Total	**47,253**		**369,778**	



Ranked Origins Sub-Group Profile of Maternity Patients vs East Kent Hospital Trust

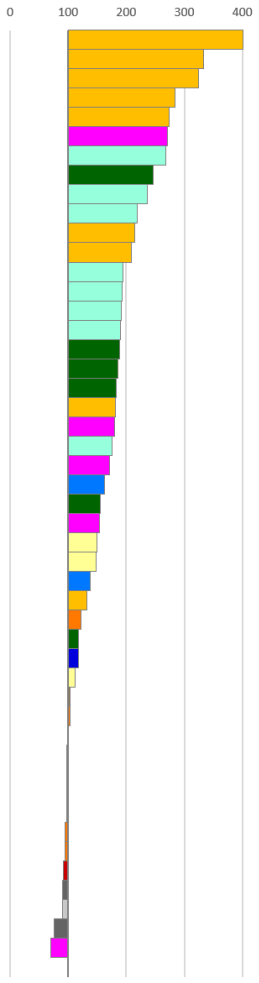
File: Maternity Patients
Base: East Kent Hospital Trust
Date of report: 19/01/2024

WEBBER PHILLIPS

Origins is a segmentation system which classifies consumers according to the part of the world from which their forebears are most likely to have originated.

Ranked Origins Sub-Group Level Profile

Origins Sub-Group	File (Adults)	%	Base (Adults)	%	Index
EMF : Albanian	171	0.4%	334	0.1%	401
EJZ : Czech Or Slovak	451	1.0%	1,058	0.3%	334
EOA : Romanian	569	1.2%	1,375	0.4%	324
ENA : Bulgarian	81	0.2%	223	0.1%	284
EPZ : Russian Or Ukrainian	510	1.1%	1,456	0.4%	274
LCA : Vietnamese	67	0.1%	194	0.1%	270
ICA: Turkish	348	0.7%	1,017	0.3%	268
HBA : Nigerian	306	0.6%	971	0.3%	247
IBZ : Somali	53	0.1%	176	0.0%	236
IAZ : North African Muslim	96	0.2%	344	0.1%	218
EIA : Polish	697	1.5%	2,545	0.7%	214
EMZ : Formerly Yugoslav	151	0.3%	565	0.2%	209
IIZ : Kashmiri and Afghan	233	0.5%	936	0.3%	195
IFA : Iranian	110	0.2%	445	0.1%	193
IHZ : Pakistani	159	0.3%	649	0.2%	192
IKA : Bangladeshi	140	0.3%	575	0.2%	191
HAA : Black Caribbean	144	0.3%	600	0.2%	188
HCA : Ghanaian	93	0.2%	391	0.1%	186
HED : Ethiopian	18	0.0%	77	0.0%	183
ELZ : Baltic States	216	0.5%	932	0.3%	181
LAA : Japanese	30	0.1%	131	0.0%	179
IZZ : Other Muslim	259	0.5%	1,151	0.3%	176
LZZ : Other East Asian	76	0.2%	348	0.1%	171
KAA : Hindu Indian	805	1.7%	3,890	1.1%	162
HZZ : Other Black African	109	0.2%	550	0.1%	155
LBA : Mandarin Chinese	78	0.2%	395	0.1%	155
CCA : Portugese or Brazilian	186	0.4%	973	0.3%	150
CAA : Spanish	319	0.7%	1,683	0.5%	148
KBA : Tamil Or Sri Lankan	142	0.3%	805	0.2%	138
EKA : Hungarian	151	0.3%	894	0.2%	132
DHA : Italian or Maltese	478	1.0%	3,063	0.8%	122
HDZ : Black South African	137	0.3%	908	0.2%	118
JAA : Sikh	69	0.1%	458	0.1%	118
CBA : Filipino	20	0.0%	139	0.0%	113
GAA : Jewish	74	0.2%	557	0.2%	104
DAA : French or Walloon	434	0.9%	3,278	0.9%	104
BBB : Irish	2,180	4.6%	17,203	4.7%	99
DZZ : Scandinavian	160	0.3%	1,279	0.3%	98
GBA : Armenian	9	0.0%	72	0.0%	98
BAB : Welsh	2,266	4.8%	18,130	4.9%	98
LBB : Cantonese Chinese	92	0.2%	738	0.2%	98
DDA : German	455	1.0%	3,744	1.0%	95
DCA : Dutch or Flemish	321	0.7%	2,663	0.7%	94
FAZ : Greek Or Greek Cypriot	126	0.3%	1,071	0.3%	92
BAA : Scottish	2,627	5.6%	22,634	6.1%	91
AAA : English	30,891	65.4%	266,614	72.1%	91
BBA : Northern Irish	113	0.2%	1,166	0.3%	76
LAB : Korean	32	0.1%	361	0.1%	69
KCA : Bangladeshi Hindu	1	0.0%	17	0.0%	Not Robust
Total	**47,253**		**369,778**		



Maternity Consultants & Doctors

East Kent Hospitals University NHS Foundation Trust

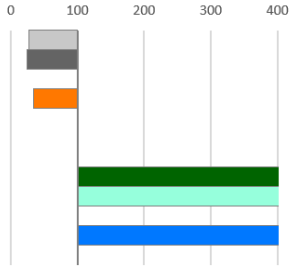
Origins Group Profile of Maternity Cons_Doctor vs East Kent Hospital Trust

File: Maternity Cons_Doctor
Base: East Kent Hospital Trust
Date of report: 18/01/2024

Origins is a segmentation system which classifies consumers according to the part of the world from which their forebears are most likely to have originated.

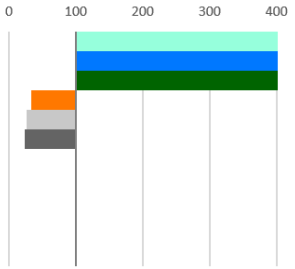
Origins Group Level Profile

Origins Group	File (Adults)	%	Base (Adults)	%	Index
A : Anglo-Saxon	15	19.2%	265,776	71.9%	27
B : Celtic	3	3.8%	59,971	16.2%	24
C : Hispanic	0	0.0%	2,820	0.8%	Not Robust
D : Western European	1	1.3%	14,002	3.8%	34
E : Eastern European	1	1.3%	9,382	2.5%	Not Robust
F : Greek/Greek Cypriot	4	5.1%	1,071	0.3%	Not Robust
G : Jewish/Armenian	0	0.0%	629	0.2%	Not Robust
H : Black African & Caribbean	11	14.1%	3,497	0.9%	1,491
I : Muslim	23	29.5%	5,293	1.4%	2,060
J : Sikh	2	2.6%	458	0.1%	Not Robust
K : Hindu South Asian	16	20.5%	4,712	1.3%	1,610
L : East Asian	2	2.6%	2,167	0.6%	Not Robust
Total	**78**		**369,778**		



Ranked Origins Group Level Profile

Origins Group	File (Adults)	%	Base (Adults)	%	Index
I : Muslim	23	29.5%	5,293	1.4%	2,060
K : Hindu South Asian	16	20.5%	4,712	1.3%	1,610
H : Black African & Caribbean	11	14.1%	3,497	0.9%	1,491
D : Western European	1	1.3%	14,002	3.8%	34
A : Anglo-Saxon	15	19.2%	265,776	71.9%	27
B : Celtic	3	3.8%	59,971	16.2%	24
C : Hispanic	0	0.0%	2,820	0.8%	Not Robust
E : Eastern European	1	1.3%	9,382	2.5%	Not Robust
F : Greek/Greek Cypriot	4	5.1%	1,071	0.3%	Not Robust
G : Jewish/Armenian	0	0.0%	629	0.2%	Not Robust
J : Sikh	2	2.6%	458	0.1%	Not Robust
L : East Asian	2	2.6%	2,167	0.6%	Not Robust
Total	**78**		**369,778**		



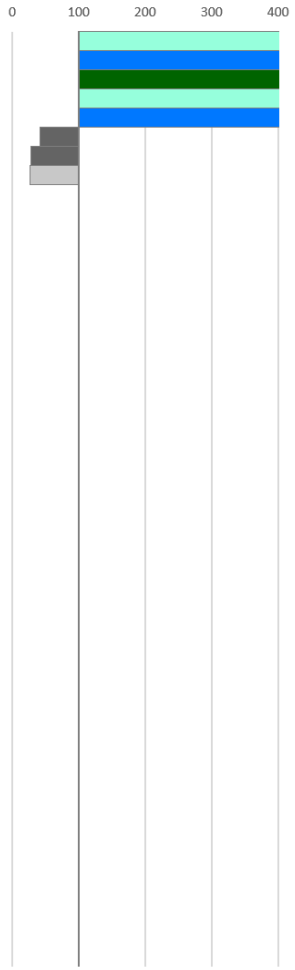
Ranked Origins Sub-Group Profile of Maternity Cons_Doctor vs East Kent Hospital Trust

File: Maternity Cons_Doctor
Base: East Kent Hospital Trust
Date of report: 18/01/2024

Origins is a segmentation system which classifies consumers according to the part of the world from which their forebears are most likely to have originated.

Ranked Origins Sub-Group Level Profile

Origins Sub-Group	File (Adults)	%	Base (Adults)	%	Index
IAZ : North African Muslim	6	7.7%	344	0.1%	8,269
KBA : Tamil Or Sri Lankan	5	6.4%	805	0.2%	2,945
HBA : Nigerian	6	7.7%	971	0.3%	2,929
IZZ : Other Muslim	7	9.0%	1,151	0.3%	2,883
KAA : Hindu Indian	11	14.1%	3,890	1.1%	1,341
BAA : Scottish	2	2.6%	22,634	6.1%	42
BBB : Irish	1	1.3%	17,203	4.7%	28
AAA : English	15	19.2%	266,614	72.1%	27
BAB : Welsh	0	0.0%	18,130	4.9%	Not Robust
BBA : Northern Irish	0	0.0%	1,166	0.3%	Not Robust
CAA : Spanish	0	0.0%	1,683	0.5%	Not Robust
CBA : Filipino	0	0.0%	139	0.0%	Not Robust
CCA : Portugese or Brazilian	0	0.0%	973	0.3%	Not Robust
DAA : French or Walloon	0	0.0%	3,278	0.9%	Not Robust
DCA : Dutch or Flemish	0	0.0%	2,663	0.7%	Not Robust
DDA : German	0	0.0%	3,744	1.0%	Not Robust
DHA : Italian or Maltese	1	1.3%	3,063	0.8%	Not Robust
DZZ : Scandinavian	0	0.0%	1,279	0.3%	Not Robust
EIA : Polish	0	0.0%	2,545	0.7%	Not Robust
EJZ : Czech Or Slovak	1	1.3%	1,058	0.3%	Not Robust
EKA : Hungarian	0	0.0%	894	0.2%	Not Robust
ELZ : Baltic States	0	0.0%	932	0.3%	Not Robust
EMF : Albanian	0	0.0%	334	0.1%	Not Robust
EMZ : Formerly Yugoslav	0	0.0%	565	0.2%	Not Robust
ENA : Bulgarian	0	0.0%	223	0.1%	Not Robust
EOA : Romanian	0	0.0%	1,375	0.4%	Not Robust
EPZ : Russian Or Ukrainian	0	0.0%	1,456	0.4%	Not Robust
FAZ : Greek Or Greek Cypriot	4	5.1%	1,071	0.3%	Not Robust
GAA : Jewish	0	0.0%	557	0.2%	Not Robust
GBA : Armenian	0	0.0%	72	0.0%	Not Robust
HAA : Black Caribbean	0	0.0%	600	0.2%	Not Robust
HCA : Ghanaian	2	2.6%	391	0.1%	Not Robust
HDZ : Black South African	1	1.3%	908	0.2%	Not Robust
HED : Ethiopian	0	0.0%	77	0.0%	Not Robust
HZZ : Other Black African	2	2.6%	550	0.1%	Not Robust
IBZ : Somali	1	1.3%	176	0.0%	Not Robust
ICA: Turkish	0	0.0%	1,017	0.3%	Not Robust
IFA : Iranian	2	2.6%	445	0.1%	Not Robust
IHZ : Pakistani	4	5.1%	649	0.2%	Not Robust
IIZ : Kashmiri and Afghan	3	3.8%	936	0.3%	Not Robust
IKA : Bangladeshi	0	0.0%	575	0.2%	Not Robust
JAA : Sikh	2	2.6%	458	0.1%	Not Robust
KCA : Bangladeshi Hindu	0	0.0%	17	0.0%	Not Robust
LAA : Japanese	0	0.0%	131	0.0%	Not Robust
LAB : Korean	0	0.0%	361	0.1%	Not Robust
LBA : Mandarin Chinese	0	0.0%	395	0.1%	Not Robust
LBB : Cantonese Chinese	1	1.3%	738	0.2%	Not Robust
LCA : Vietnamese	0	0.0%	194	0.1%	Not Robust
LZZ : Other East Asian	1	1.3%	348	0.1%	Not Robust
Total	**78**		**369,778**		



Elective Caesarean

East Kent Hospitals University NHS Foundation Trust

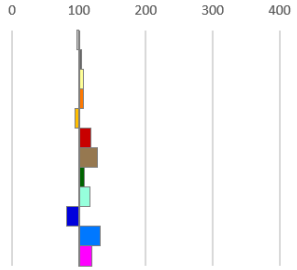
Origins Group Profile of Elective Caesarean vs All Births

File: Elective Caesarean
Base: All Births
Date of report: 21/01/2024

Origins is a segmentation system which classifies consumers according to the part of the world from which their forebears are most likely to have originated.

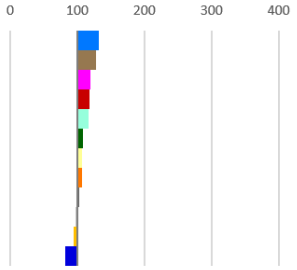
Origins Group Level Profile

Origins Group	File (Adults)	%	Base (Adults)	%	Index
A : Anglo-Saxon	4,215	63.2%	30,787	65.2%	97
B : Celtic	1,062	15.9%	7,290	15.4%	103
C : Hispanic	80	1.2%	530	1.1%	107
D : Western European	277	4.2%	1,843	3.9%	107
E : Eastern European	399	6.0%	2,997	6.3%	94
F : Greek/Greek Cypriot	21	0.3%	126	0.3%	118
G : Jewish/Armenian	15	0.2%	83	0.2%	128
H : Black African & Caribbean	123	1.8%	807	1.7%	108
I : Muslim	229	3.4%	1,398	3.0%	116
J : Sikh	8	0.1%	69	0.1%	82
K : Hindu South Asian	176	2.6%	948	2.0%	132
L : East Asian	63	0.9%	375	0.8%	119
Total	**6,668**		**47,253**		



Ranked Origins Group Level Profile

Origins Group	File (Adults)	%	Base (Adults)	%	Index
K : Hindu South Asian	176	2.6%	948	2.0%	132
G : Jewish/Armenian	15	0.2%	83	0.2%	128
L : East Asian	63	0.9%	375	0.8%	119
F : Greek/Greek Cypriot	21	0.3%	126	0.3%	118
I : Muslim	229	3.4%	1,398	3.0%	116
H : Black African & Caribbean	123	1.8%	807	1.7%	108
C : Hispanic	80	1.2%	530	1.1%	107
D : Western European	277	4.2%	1,843	3.9%	107
B : Celtic	1,062	15.9%	7,290	15.4%	103
A : Anglo-Saxon	4,215	63.2%	30,787	65.2%	97
E : Eastern European	399	6.0%	2,997	6.3%	94
J : Sikh	8	0.1%	69	0.1%	82
Total	**6,668**		**47,253**		



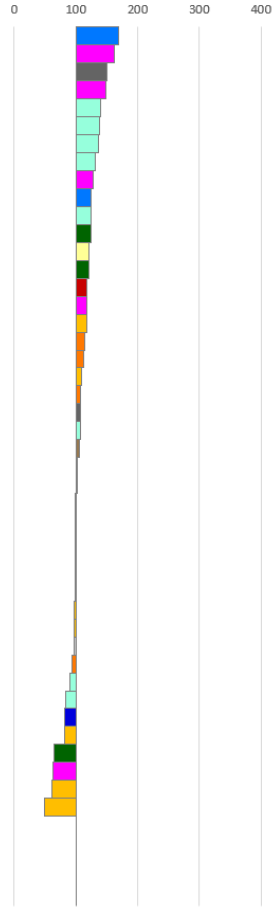
Ranked Origins Sub-Group Profile of Elective Caesarean vs All Births

File: Elective Caesarean
Base: All Births
Date of report: 21/01/2024

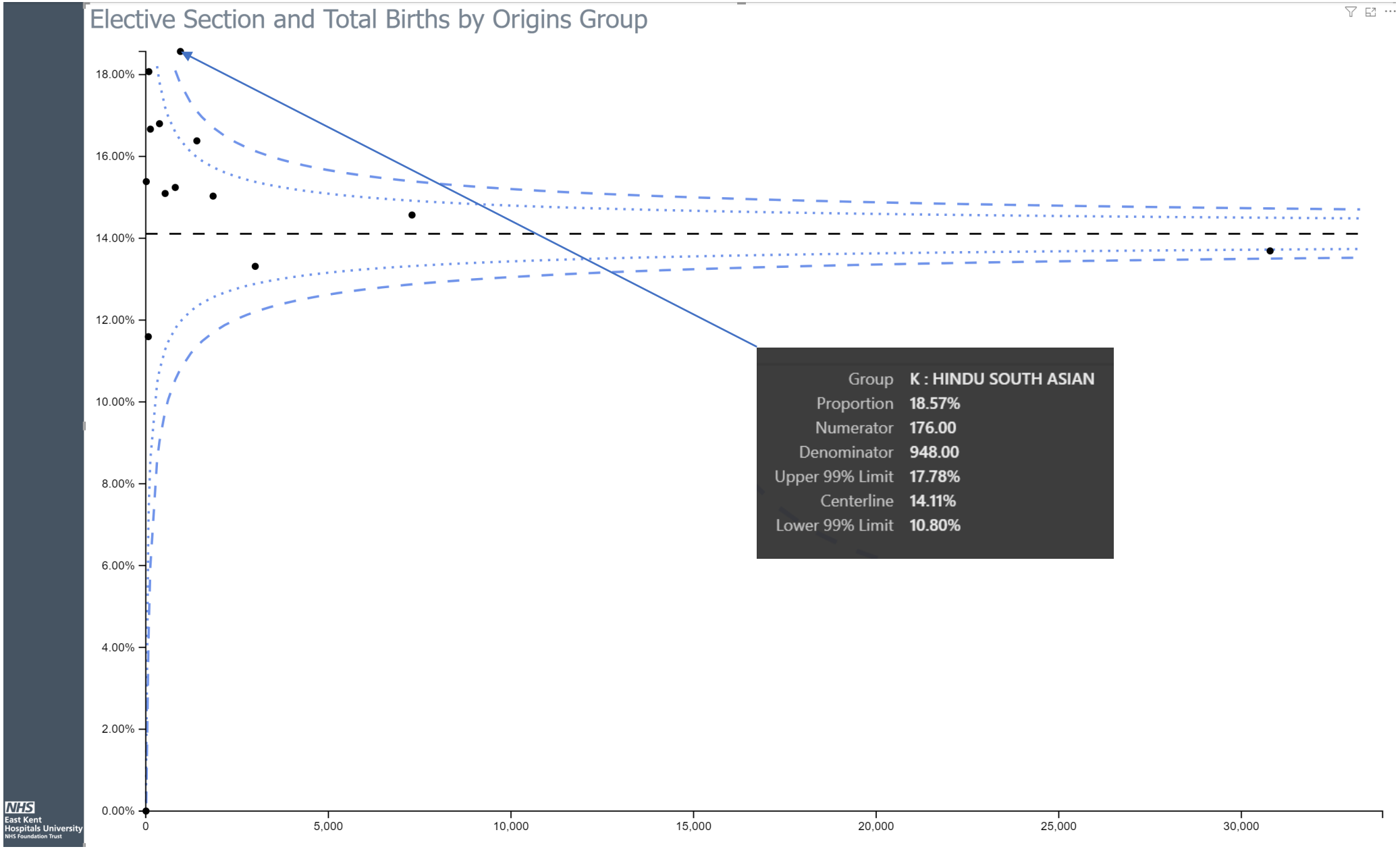
Origins is a segmentation system which classifies consumers according to the part of the world from which their forebears are most likely to have originated.

Ranked Origins Sub-Group Level Profile

Origins Sub-Group	File (Adults)	%	Base (Adults)	%	Index
KBA : Tamil Or Sri Lankan	34	0.5%	142	0.3%	170
LBB : Cantonese Chinese	21	0.3%	92	0.2%	162
BBA : Northern Irish	24	0.4%	113	0.2%	151
LZZ : Other East Asian	16	0.2%	76	0.2%	149
IAZ : North African Muslim	19	0.3%	96	0.2%	140
IHZ : Pakistani	31	0.5%	159	0.3%	138
IKA : Bangladeshi	27	0.4%	140	0.3%	137
IZZ : Other Muslim	48	0.7%	259	0.5%	131
LBA : Mandarin Chinese	14	0.2%	78	0.2%	127
KAA : Hindu Indian	142	2.1%	805	1.7%	125
IIZ : Kashmiri and Afghan	41	0.6%	233	0.5%	125
HDZ : Black South African	24	0.4%	137	0.3%	124
CCA : Portugese or Brazilian	32	0.5%	186	0.4%	122
HBA : Nigerian	52	0.8%	306	0.6%	120
FAZ : Greek Or Greek Cypriot	21	0.3%	126	0.3%	118
LAA : Japanese	5	0.1%	30	0.1%	118
EMZ : Formerly Yugoslav	25	0.4%	151	0.3%	117
DCA : Dutch or Flemish	52	0.8%	321	0.7%	115
DHA : Italian or Maltese	76	1.1%	478	1.0%	113
EPZ : Russian Or Ukrainian	78	1.2%	510	1.1%	108
DAA : French or Walloon	66	1.0%	434	0.9%	108
BAA : Scottish	397	6.0%	2,627	5.6%	107
IBZ : Somali	8	0.1%	53	0.1%	107
GAA : Jewish	11	0.2%	74	0.2%	105
DZZ : Scandinavian	23	0.3%	160	0.3%	102
BBB : Irish	312	4.7%	2,180	4.6%	101
CAA : Spanish	45	0.7%	319	0.7%	100
HCA : Ghanaian	13	0.2%	93	0.2%	99
BAB : Welsh	316	4.7%	2,266	4.8%	99
EKA : Hungarian	21	0.3%	151	0.3%	99
HAA : Black Caribbean	20	0.3%	144	0.3%	98
ELZ : Baltic States	30	0.4%	216	0.5%	98
EIA : Polish	96	1.4%	697	1.5%	98
EOA : Romanian	78	1.2%	569	1.2%	97
AAA : English	4,228	63.4%	30,891	65.4%	97
DDA : German	60	0.9%	455	1.0%	93
IFA : Iranian	14	0.2%	110	0.2%	90
ICA: Turkish	41	0.6%	348	0.7%	83
JAA : Sikh	8	0.1%	69	0.1%	82
EJZ : Czech Or Slovak	52	0.8%	451	1.0%	82
HZZ : Other Black African	10	0.1%	109	0.2%	65
LCA : Vietnamese	6	0.1%	67	0.1%	63
ENA : Bulgarian	7	0.1%	81	0.2%	61
EMF : Albanian	12	0.2%	171	0.4%	50
CBA : Filipino	3	0.0%	20	0.0%	Not Robust
GBA : Armenian	4	0.1%	9	0.0%	Not Robust
HED : Ethiopian	4	0.1%	18	0.0%	Not Robust
KCA : Bangladeshi Hindu	0	0.0%	1	0.0%	Not Robust
LAB : Korean	1	0.0%	32	0.1%	Not Robust
Total	**6,668**		**47,253**		



Elective Caesarean - 2016-2023 EKHUFT



Emergency Caesarean

East Kent Hospitals University NHS Foundation Trust

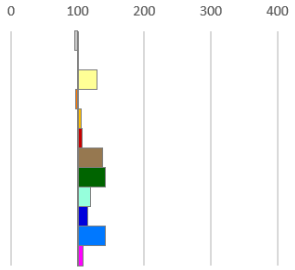
Origins Group Profile of Emergency Caesarean vs All Births

File: Emergency Caesarean
Base: All Births
Date of report: 21/01/2024

Origins is a segmentation system which classifies consumers according to the part of the world from which their forebears are most likely to have originated.

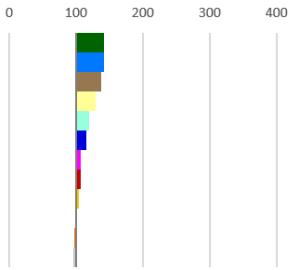
Origins Group Level Profile

Origins Group	File (Adults)	%	Base (Adults)	%	Index
A : Anglo-Saxon	5,911	62.3%	30,787	65.2%	96
B : Celtic	1,473	15.5%	7,290	15.4%	101
C : Hispanic	137	1.4%	530	1.1%	129
D : Western European	358	3.8%	1,843	3.9%	97
E : Eastern European	630	6.6%	2,997	6.3%	105
F : Greek/Greek Cypriot	27	0.3%	126	0.3%	107
G : Jewish/Armenian	23	0.2%	83	0.2%	138
H : Black African & Caribbean	230	2.4%	807	1.7%	142
I : Muslim	335	3.5%	1,398	3.0%	119
J : Sikh	16	0.2%	69	0.1%	115
K : Hindu South Asian	269	2.8%	948	2.0%	141
L : East Asian	81	0.9%	375	0.8%	108
Total	**9,490**		**47,253**		



Ranked Origins Group Level Profile

Origins Group	File (Adults)	%	Base (Adults)	%	Index
H : Black African & Caribbean	230	2.4%	807	1.7%	142
K : Hindu South Asian	269	2.8%	948	2.0%	141
G : Jewish/Armenian	23	0.2%	83	0.2%	138
C : Hispanic	137	1.4%	530	1.1%	129
I : Muslim	335	3.5%	1,398	3.0%	119
J : Sikh	16	0.2%	69	0.1%	115
L : East Asian	81	0.9%	375	0.8%	108
F : Greek/Greek Cypriot	27	0.3%	126	0.3%	107
E : Eastern European	630	6.6%	2,997	6.3%	105
B : Celtic	1,473	15.5%	7,290	15.4%	101
D : Western European	358	3.8%	1,843	3.9%	97
A : Anglo-Saxon	5,911	62.3%	30,787	65.2%	96
Total	**9,490**		**47,253**		



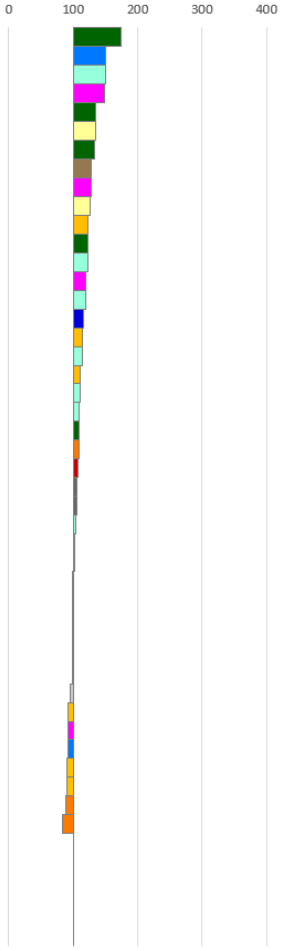
Ranked Origins Sub-Group Profile of Emergency Caesarean vs All Births

File: Emergency Caesarean
Base: All Births
Date of report: 21/01/2024

Origins is a segmentation system which classifies consumers according to the part of the world from which their forebears are most likely to have originated.

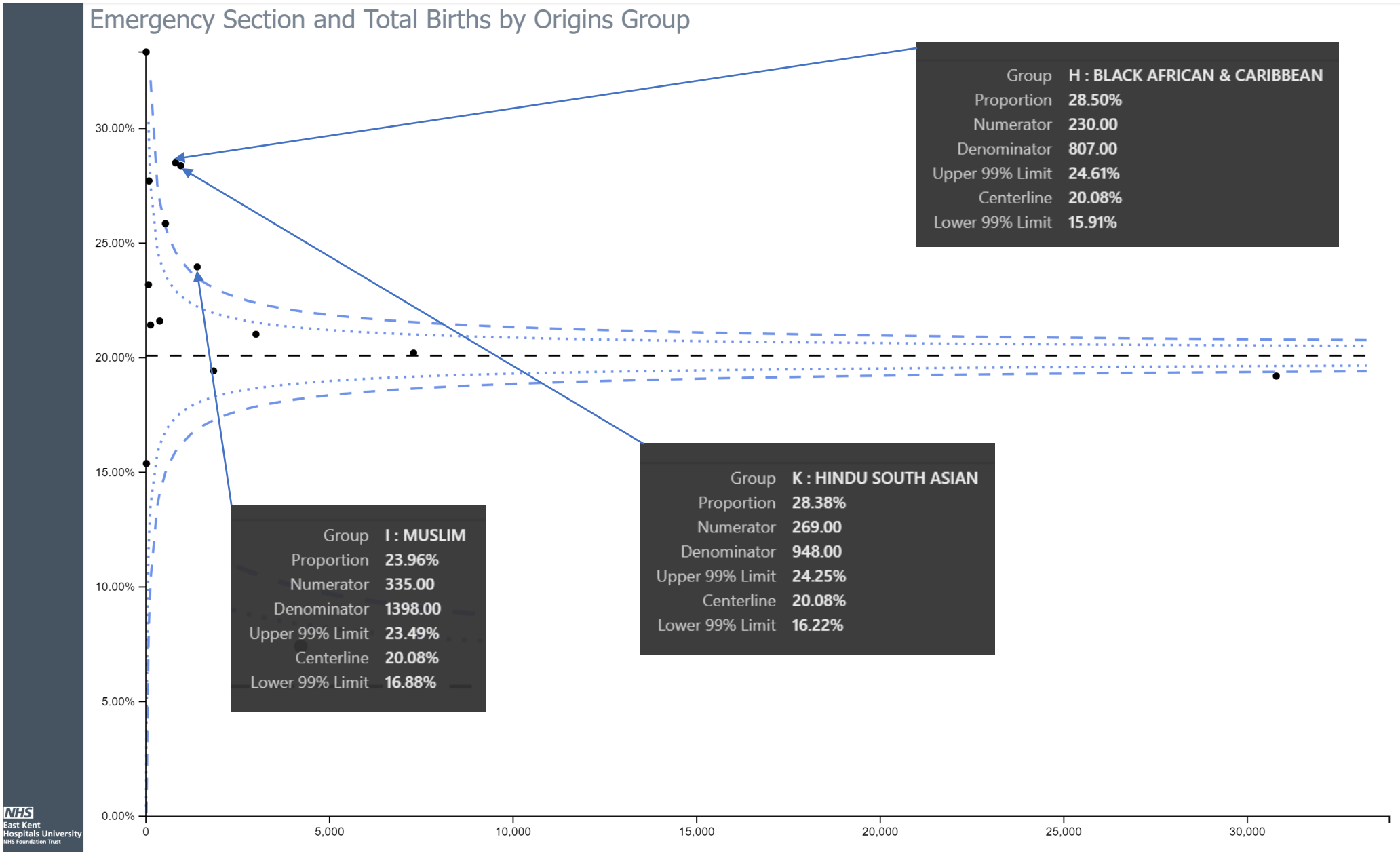
Ranked Origins Sub-Group Level Profile

Origins Sub-Group	File (Adults)	%	Base (Adults)	%	Index
HBA : Nigerian	107	1.1%	306	0.6%	174
KAA : Hindu Indian	243	2.6%	805	1.7%	150
IIZ : Kashmiri and Afghan	70	0.7%	233	0.5%	150
LCA : Vietnamese	20	0.2%	67	0.1%	149
HAA : Black Caribbean	39	0.4%	144	0.3%	135
CAA : Spanish	86	0.9%	319	0.7%	134
HZZ : Other Black African	29	0.3%	109	0.2%	132
GAA : Jewish	19	0.2%	74	0.2%	128
LBA : Mandarin Chinese	20	0.2%	78	0.2%	128
CCA : Portugese or Brazilian	47	0.5%	186	0.4%	126
EOA : Romanian	141	1.5%	569	1.2%	123
HCA : Ghanaian	23	0.2%	93	0.2%	123
IHZ : Pakistani	39	0.4%	159	0.3%	122
LBB : Cantonese Chinese	22	0.2%	92	0.2%	119
ICA: Turkish	83	0.9%	348	0.7%	119
JAA : Sikh	16	0.2%	69	0.1%	115
EPZ : Russian Or Ukrainian	117	1.2%	510	1.1%	114
IAZ : North African Muslim	22	0.2%	96	0.2%	114
EMF : Albanian	38	0.4%	171	0.4%	111
IKA : Bangladeshi	31	0.3%	140	0.3%	110
IZZ : Other Muslim	57	0.6%	259	0.5%	110
HDZ : Black South African	30	0.3%	137	0.3%	109
DDA : German	99	1.0%	455	1.0%	108
FAZ : Greek Or Greek Cypriot	27	0.3%	126	0.3%	107
BBB : Irish	465	4.9%	2,180	4.6%	106
BBA : Northern Irish	24	0.3%	113	0.2%	106
IBZ : Somali	11	0.1%	53	0.1%	103
DZZ : Scandinavian	33	0.3%	160	0.3%	103
DHA : Italian or Maltese	96	1.0%	478	1.0%	100
IFA : Iranian	22	0.2%	110	0.2%	100
EIA : Polish	139	1.5%	697	1.5%	99
EKA : Hungarian	30	0.3%	151	0.3%	99
BAA : Scottish	520	5.5%	2,627	5.6%	99
ENA : Bulgarian	16	0.2%	81	0.2%	98
BAB : Welsh	447	4.7%	2,266	4.8%	98
AAA : English	5,928	62.5%	30,891	65.4%	96
EMZ : Formerly Yugoslav	28	0.3%	151	0.3%	92
LZZ : Other East Asian	14	0.1%	76	0.2%	92
KBA : Tamil Or Sri Lankan	26	0.3%	142	0.3%	91
EJZ : Czech Or Slovak	82	0.9%	451	1.0%	91
ELZ : Baltic States	39	0.4%	216	0.5%	90
DAA : French or Walloon	77	0.8%	434	0.9%	88
DCA : Dutch or Flemish	54	0.6%	321	0.7%	84
CBA : Filipino	3	0.0%	20	0.0%	Not Robust
GBA : Armenian	4	0.0%	9	0.0%	Not Robust
HED : Ethiopian	2	0.0%	18	0.0%	Not Robust
KCA : Bangladeshi Hindu	0	0.0%	1	0.0%	Not Robust
LAA : Japanese	4	0.0%	30	0.1%	Not Robust
LAB : Korean	1	0.0%	32	0.1%	Not Robust
Total	**9,490**		**47,253**		



Emergency Caesarean - 2016-2023 EKHUFT

East Kent Hospitals University NHS Foundation Trust



Induced Labour

East Kent Hospitals University NHS Foundation Trust

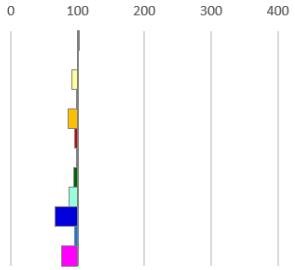
Origins Group Profile of Induced Labour vs All Births

File: Induced Labour
Base: All Births
Date of report: 21/01/2024

Origins is a segmentation system which classifies consumers according to the part of the world from which their forebears are most likely to have originated.

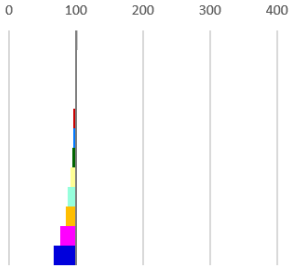
Origins Group Level Profile

Origins Group	File (Adults)	%	Base (Adults)	%	Index
A : Anglo-Saxon	9,704	67.0%	30,787	65.2%	103
B : Celtic	2,250	15.5%	7,290	15.4%	101
C : Hispanic	148	1.0%	530	1.1%	91
D : Western European	554	3.8%	1,843	3.9%	98
E : Eastern European	783	5.4%	2,997	6.3%	85
F : Greek/Greek Cypriot	37	0.3%	126	0.3%	96
G : Jewish/Armenian	25	0.2%	83	0.2%	98
H : Black African & Caribbean	233	1.6%	807	1.7%	94
I : Muslim	374	2.6%	1,398	3.0%	87
J : Sikh	14	0.1%	69	0.1%	66
K : Hindu South Asian	278	1.9%	948	2.0%	96
L : East Asian	88	0.6%	375	0.8%	77
Total	**14,488**		**47,253**		



Ranked Origins Group Level Profile

Origins Group	File (Adults)	%	Base (Adults)	%	Index
A : Anglo-Saxon	9,704	67.0%	30,787	65.2%	103
B : Celtic	2,250	15.5%	7,290	15.4%	101
G : Jewish/Armenian	25	0.2%	83	0.2%	98
D : Western European	554	3.8%	1,843	3.9%	98
F : Greek/Greek Cypriot	37	0.3%	126	0.3%	96
K : Hindu South Asian	278	1.9%	948	2.0%	96
H : Black African & Caribbean	233	1.6%	807	1.7%	94
C : Hispanic	148	1.0%	530	1.1%	91
I : Muslim	374	2.6%	1,398	3.0%	87
E : Eastern European	783	5.4%	2,997	6.3%	85
L : East Asian	88	0.6%	375	0.8%	77
J : Sikh	14	0.1%	69	0.1%	66
Total	**14,488**		**47,253**		



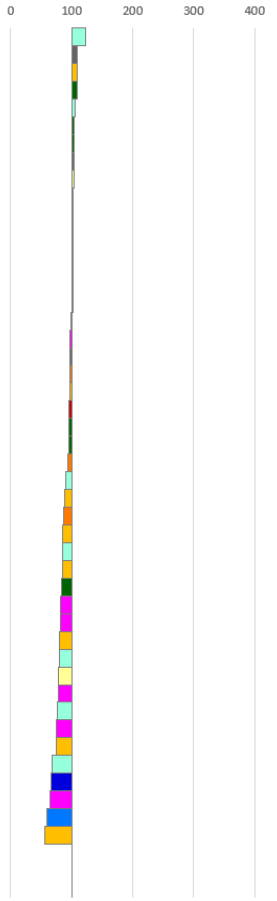
Ranked Origins Sub-Group Profile of Induced Labour vs All Births

File: Induced Labour
Base: All Births
Date of report: 21/01/2024

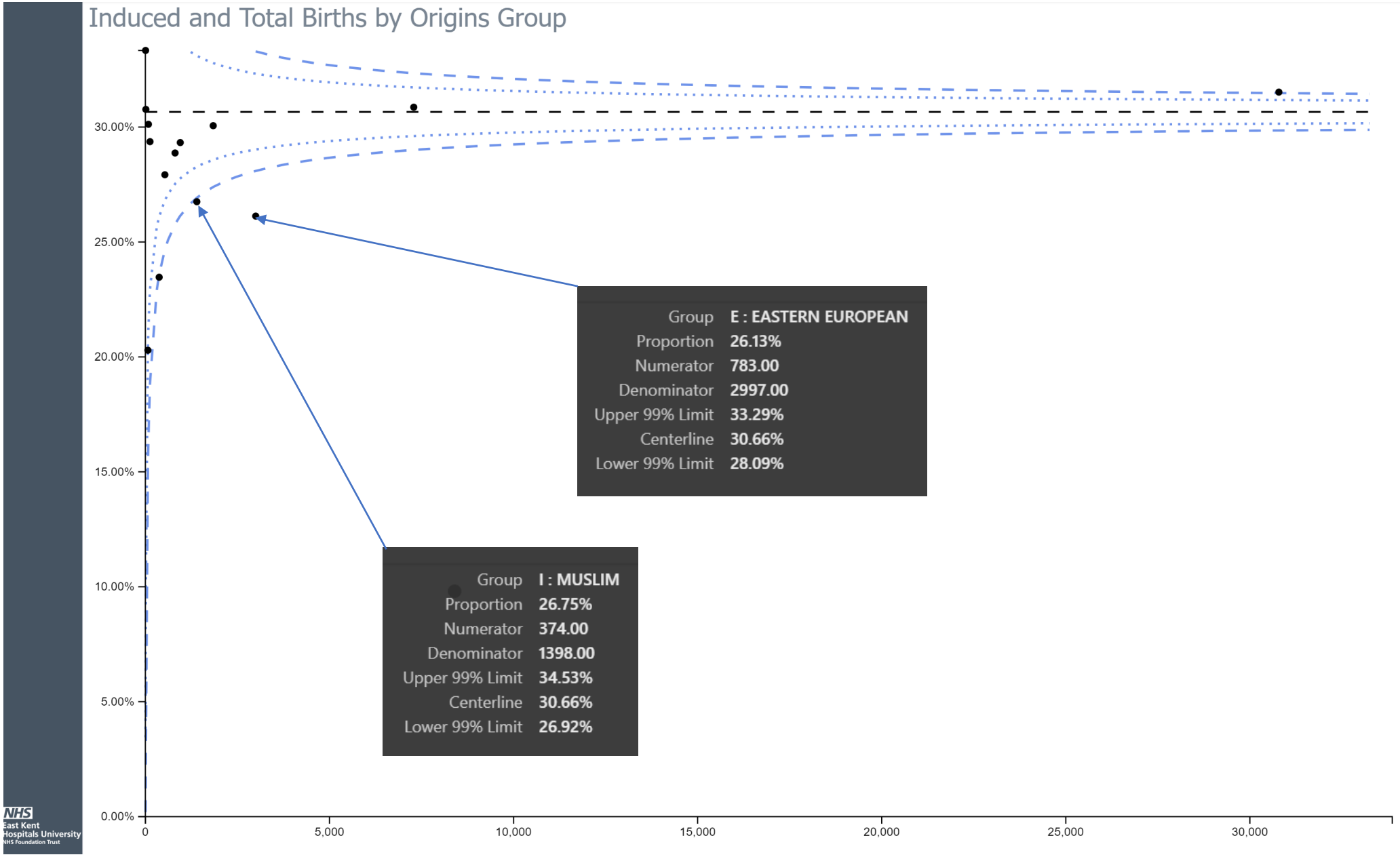
Origins is a segmentation system which classifies consumers according to the part of the world from which their forebears are most likely to have originated.

Ranked Origins Sub-Group Level Profile

Origins Sub-Group	File (Adults)	%	Base (Adults)	%	Index
IBZ : Somali	20	0.1%	53	0.1%	123
BBA : Northern Irish	38	0.3%	113	0.2%	110
ELZ : Baltic States	72	0.5%	216	0.5%	109
HED : Ethiopian	6	0.0%	18	0.0%	109
IAZ : North African Muslim	31	0.2%	96	0.2%	105
HZZ : Other Black African	35	0.2%	109	0.2%	105
HAA : Black Caribbean	46	0.3%	144	0.3%	104
BBB : Irish	696	4.8%	2,180	4.6%	104
CAA : Spanish	101	0.7%	319	0.7%	103
AAA : English	9,732	67.2%	30,891	65.4%	103
DHA : Italian or Maltese	150	1.0%	478	1.0%	102
KAA : Hindu Indian	252	1.7%	805	1.7%	102
DDA : German	142	1.0%	455	1.0%	102
GAA : Jewish	23	0.2%	74	0.2%	101
EMF : Albanian	53	0.4%	171	0.4%	101
BAB : Welsh	700	4.8%	2,266	4.8%	101
IHZ : Pakistani	48	0.3%	159	0.3%	98
LAA : Japanese	9	0.1%	30	0.1%	98
BAA : Scottish	788	5.4%	2,627	5.6%	98
DCA : Dutch or Flemish	96	0.7%	321	0.7%	98
EKA : Hungarian	45	0.3%	151	0.3%	97
FAZ : Greek Or Greek Cypriot	37	0.3%	126	0.3%	96
HDZ : Black South African	40	0.3%	137	0.3%	95
HCA : Ghanaian	27	0.2%	93	0.2%	95
DAA : French or Walloon	124	0.9%	434	0.9%	93
IZZ : Other Muslim	72	0.5%	259	0.5%	91
EMZ : Formerly Yugoslav	41	0.3%	151	0.3%	89
DZZ : Scandinavian	43	0.3%	160	0.3%	88
EJA : Polish	183	1.3%	697	1.5%	86
ICA: Turkish	91	0.6%	348	0.7%	85
EPZ : Russian Or Ukrainian	133	0.9%	510	1.1%	85
HBA : Nigerian	79	0.5%	306	0.6%	84
LAB : Korean	8	0.1%	32	0.1%	82
LZZ : Other East Asian	19	0.1%	76	0.2%	82
EOA : Romanian	139	1.0%	569	1.2%	80
IKA : Bangladeshi	34	0.2%	140	0.3%	79
CCA : Portugese or Brazilian	45	0.3%	186	0.4%	79
LCA : Vietnamese	16	0.1%	67	0.1%	78
IIZ : Kashmiri and Afghan	55	0.4%	233	0.5%	77
LBA : Mandarin Chinese	18	0.1%	78	0.2%	75
EJZ : Czech Or Slovak	103	0.7%	451	1.0%	74
IFA : Iranian	23	0.2%	110	0.2%	68
JAA : Sikh	14	0.1%	69	0.1%	66
LBB : Cantonese Chinese	18	0.1%	92	0.2%	64
KBA : Tamil Or Sri Lankan	26	0.2%	142	0.3%	60
ENA : Bulgarian	14	0.1%	81	0.2%	56
CBA : Filipino	1	0.0%	20	0.0%	Not Robust
GBA : Armenian	2	0.0%	9	0.0%	Not Robust
KCA : Bangladeshi Hindu	0	0.0%	1	0.0%	Not Robust
Total	**14,488**		**47,253**		



Induced Labour - 2016-2023 EKHUFT



3rd – 4th Degree Tears

East Kent Hospitals University NHS Foundation Trust

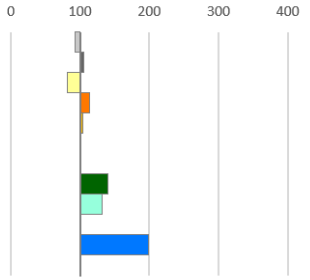
Origins Group Profile of 3rd-4th Degree Tears vs All Births

File: 3rd-4th Degree Tears
Base: All Births
Date of report: 21/01/2024

Origins is a segmentation system which classifies consumers according to the part of the world from which their forebears are most likely to have originated.

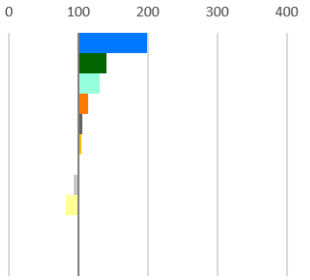
Origins Group Level Profile

Origins Group	File (Adults)	%	Base (Adults)	%	Index
A : Anglo-Saxon	528	60.2%	30,787	65.2%	92
B : Celtic	143	16.3%	7,290	15.4%	106
C : Hispanic	8	0.9%	530	1.1%	81
D : Western European	39	4.4%	1,843	3.9%	114
E : Eastern European	58	6.6%	2,997	6.3%	104
F : Greek/Greek Cypriot	3	0.3%	126	0.3%	Not Robust
G : Jewish/Armenian	1	0.1%	83	0.2%	Not Robust
H : Black African & Caribbean	21	2.4%	807	1.7%	140
I : Muslim	34	3.9%	1,398	3.0%	131
J : Sikh	0	0.0%	69	0.1%	Not Robust
K : Hindu South Asian	35	4.0%	948	2.0%	199
L : East Asian	7	0.8%	375	0.8%	101
Total	**877**		**47,253**		



Ranked Origins Group Level Profile

Origins Group	File (Adults)	%	Base (Adults)	%	Index
K : Hindu South Asian	35	4.0%	948	2.0%	199
H : Black African & Caribbean	21	2.4%	807	1.7%	140
I : Muslim	34	3.9%	1,398	3.0%	131
D : Western European	39	4.4%	1,843	3.9%	114
B : Celtic	143	16.3%	7,290	15.4%	106
E : Eastern European	58	6.6%	2,997	6.3%	104
L : East Asian	7	0.8%	375	0.8%	101
A : Anglo-Saxon	528	60.2%	30,787	65.2%	92
C : Hispanic	8	0.9%	530	1.1%	81
F : Greek/Greek Cypriot	3	0.3%	126	0.3%	Not Robust
G : Jewish/Armenian	1	0.1%	83	0.2%	Not Robust
J : Sikh	0	0.0%	69	0.1%	Not Robust
Total	**877**		**47,253**		



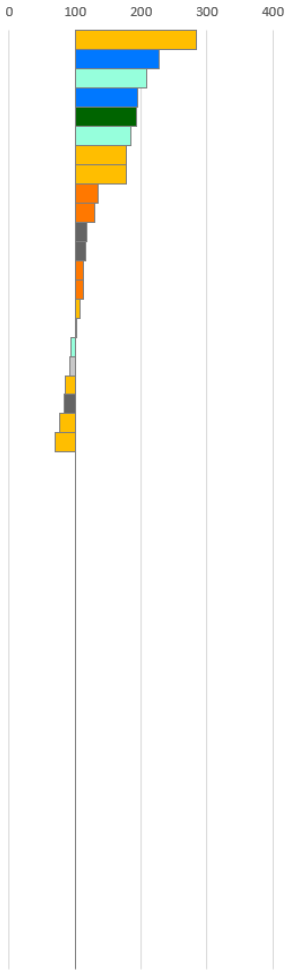
Ranked Origins Sub-Group Profile of 3rd-4th Degree Tears vs All Births

File: 3rd-4th Degree Tears
Base: All Births
Date of report: 21/01/2024

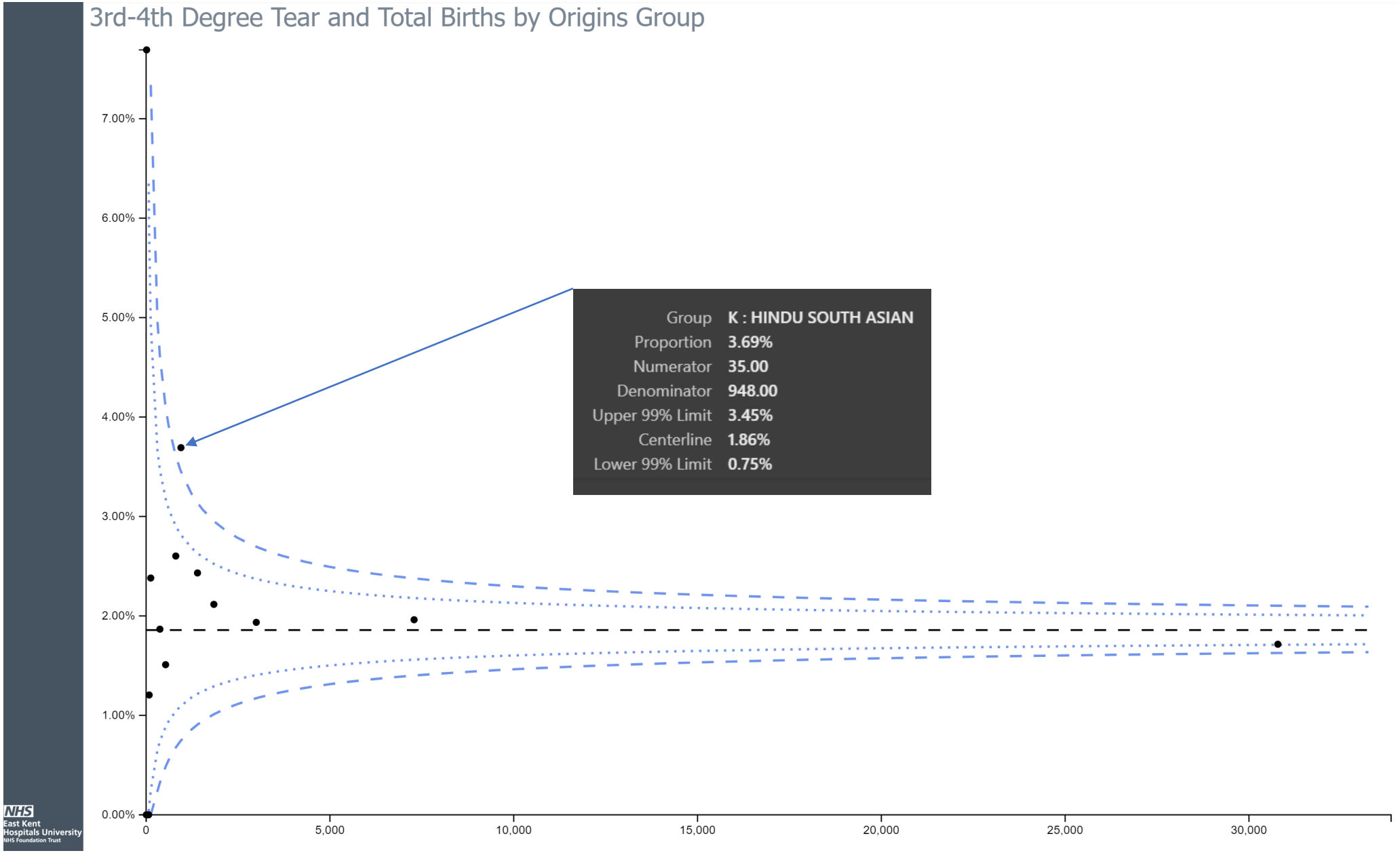
Origins is a segmentation system which classifies consumers according to the part of the world from which their forebears are most likely to have originated.

Ranked Origins Sub-Group Level Profile

Origins Sub-Group	File (Adults)	%	Base (Adults)	%	Index
EMF : Albanian	9	1.0%	171	0.4%	284
KBA : Tamil Or Sri Lankan	6	0.7%	142	0.3%	228
IZZ : Other Muslim	10	1.1%	259	0.5%	208
KAA : Hindu Indian	29	3.3%	805	1.7%	194
HBA : Nigerian	11	1.3%	306	0.6%	194
IIZ : Kashmiri and Afghan	8	0.9%	233	0.5%	185
EKA : Hungarian	5	0.6%	151	0.3%	178
EMZ : Formerly Yugoslav	5	0.6%	151	0.3%	178
DCA : Dutch or Flemish	8	0.9%	321	0.7%	134
DDA : German	11	1.3%	455	1.0%	130
BAA : Scottish	57	6.5%	2,627	5.6%	117
BAB : Welsh	49	5.6%	2,266	4.8%	117
DHA : Italian or Maltese	10	1.1%	478	1.0%	113
DAA : French or Walloon	9	1.0%	434	0.9%	112
EJZ : Czech Or Slovak	9	1.0%	451	1.0%	108
CAA : Spanish	6	0.7%	319	0.7%	101
ICA: Turkish	6	0.7%	348	0.7%	93
AAA : English	529	60.3%	30,891	65.4%	92
EPZ : Russian Or Ukrainian	8	0.9%	510	1.1%	85
BBB : Irish	34	3.9%	2,180	4.6%	84
EOA : Romanian	8	0.9%	569	1.2%	76
EIA : Polish	9	1.0%	697	1.5%	70
BBA : Northern Irish	2	0.2%	113	0.2%	Not Robust
CBA : Filipino	0	0.0%	20	0.0%	Not Robust
CCA : Portugese or Brazilian	2	0.2%	186	0.4%	Not Robust
DZZ : Scandinavian	1	0.1%	160	0.3%	Not Robust
ELZ : Baltic States	2	0.2%	216	0.5%	Not Robust
ENA : Bulgarian	3	0.3%	81	0.2%	Not Robust
FAZ : Greek Or Greek Cypriot	3	0.3%	126	0.3%	Not Robust
GAA : Jewish	1	0.1%	74	0.2%	Not Robust
GBA : Armenian	0	0.0%	9	0.0%	Not Robust
HAA : Black Caribbean	1	0.1%	144	0.3%	Not Robust
HCA : Ghanaian	2	0.2%	93	0.2%	Not Robust
HDZ : Black South African	4	0.5%	137	0.3%	Not Robust
HED : Ethiopian	0	0.0%	18	0.0%	Not Robust
HZZ : Other Black African	3	0.3%	109	0.2%	Not Robust
IAZ : North African Muslim	2	0.2%	96	0.2%	Not Robust
IBZ : Somali	2	0.2%	53	0.1%	Not Robust
IFA : Iranian	1	0.1%	110	0.2%	Not Robust
IHZ : Pakistani	3	0.3%	159	0.3%	Not Robust
IKA : Bangladeshi	2	0.2%	140	0.3%	Not Robust
JAA : Sikh	0	0.0%	69	0.1%	Not Robust
KCA : Bangladeshi Hindu	0	0.0%	1	0.0%	Not Robust
LAA : Japanese	1	0.1%	30	0.1%	Not Robust
LAB : Korean	0	0.0%	32	0.1%	Not Robust
LBA : Mandarin Chinese	0	0.0%	78	0.2%	Not Robust
LBB : Cantonese Chinese	1	0.1%	92	0.2%	Not Robust
LCA : Vietnamese	4	0.5%	67	0.1%	Not Robust
LZZ : Other East Asian	1	0.1%	76	0.2%	Not Robust
Total	**877**		**47,253**		



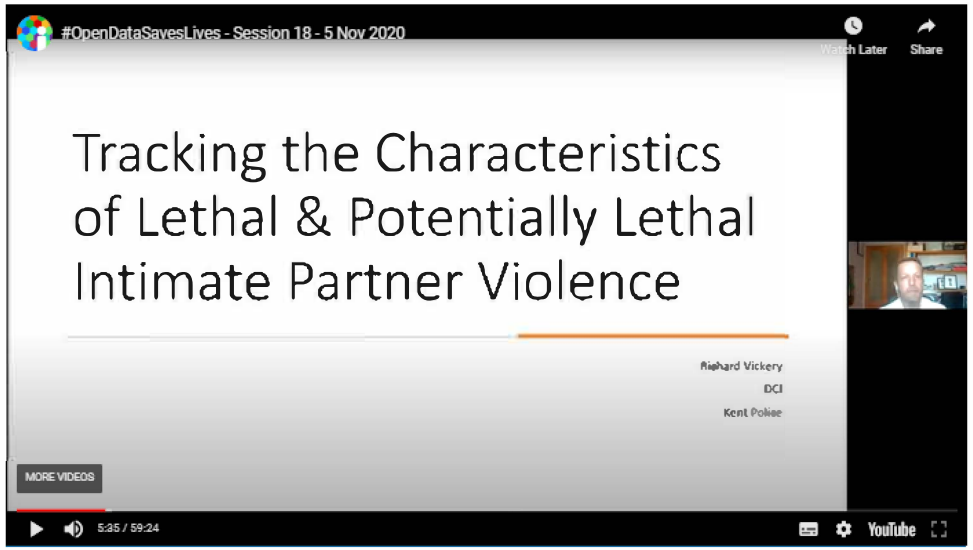
3rd-4th Degree Tear- 2016-2023 EKHUFT



NHS
East Kent
Hospitals University
NHS Foundation Trust

Session 18

Date: 5 November 2020, 12PM



Richard Vickery from **Kent Police** talks about the importance of sharing data and will also share the origins of a study in Kent focusing on domestic abuse.

Professor Chris Farmer from **Kent University** describes how we can link data from different organisations to create longitudinal studies of disease prevalence.

Open-source wizard **Chris Beeley** from **Nottinghamshire NHS** on why the government must share its code.

You can find notes from the session in the Shared Google Doc

Richard Vickey, DCI, Kent Police

Share

Resourcing our drive to reduce inequalities

Educating staff and creating resources

Increased Governance around inequalities monitoring

Use of AI

Professional accreditation

NHS
East Kent
Hospitals University
NHS Foundation Trust

Space tools

Health Inequalities Reporting

Created by Imogen Davies, last modified by Marc Farr on Mar 01, 2023

"Health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups" – World Health Organisation.

Inequality Variables

Main NHS focus: Ethnicity and Deprivation

Because ethnicity and deprivation were identified as being correlated with Covid-19 outcomes, these two variables are the main focus in NHS guidance currently (see 2022/23 Operational Planning guidance).

Resources on data quality/recording:

- NHSE/I Ethnicity and Deprivation Information Standardt 2021
- Data Dictionary: Ethnic Category

Challenges:

- NHS Race & Health Observatory 2021 report: Data quality issues in hospital ethnicity data
- NHS ethnic categories are still based on 2001 Census rather than 2011/2021
  - 'Chinese' is under Other in 2001, rather than Asian 2011 onwards
  - 'Arab' doesn't exist yet in 2001
  - 'Gypsy or Irish Traveller' doesn't exist yet in 2001
- Deprivation uses IMD-2019, which categories patients according to the average deprivation in their local area, rather than their own personal level of deprivation.
  - May already be out of date.
  - Other measures e.g. Occupation or Educational Attainment Level are better for individual level of deprivation, but harder to get data.

Protected characteristics

There are 9 "protected characteristics" in UK law (Equality Act 2010). These are:

- Age
- Disabilityt
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternityt
- Race
- Religion or belief
- Sex
- Sexual orientation

As public bodies, NHS organisations have a duty to avoid discrimination against these groups, and NHS England guidance mentions that inequalities for these characteristics should be monitored where relevant/appropriate.

Resources on data quality/recording:

- NHSE/LGBT Foundation guidance on monitoring sexual orientation and trans status 2021
  - Full specification here
- Data Dictionary: Disability
- ... more to add

Challenges:

- In NHS data, disability includes people who consider themselves to be disabled, as well as people diagnosed with a condition that means they might consider

Other "key groups"

This is a list of all the other groups mentioned in NHS England guidance here and new NHS Englnd Health Inequalities reduction programme, Core20Plus5. Sometimes called "Inclusion Health Groups".

- Learning Disability
- Severe Mental Illnesst
- Frailty
- Homeless people
- Gypsy/Roma/Traveller
- People in prison or "in contact with the justice system"
- Immigrantst/ "vulnerable migrants"
- Sex workers
- Ethnic minority groups
- Coastal communities
- People with multi-morbidities
- People with drug and alcohol dependence
- Victims of modern slavery
- "Other socially excluded groups"

Idea is for local areas (ICS-level) to set their own priorities on which groups to focus on from this list.

Resources:

- Coding of homelessness
- Postcodes of prisons and immigration detention centres 2021-22
- Chief Medical Officer 2021 report on health challenges int Coastal Communities

East Kent Hospitals University NHS Foundation Trust

TERMS OF REFERENCE

INEQUALITIES AND UNWARRANTED VARIATION COMMITTEE

1. CONSTITUTION

1.1 This Committee is constituted by CEMG as the senior operational group responsible for addressing inequalities.

1.2 The EKHUFT We Care programme has a strategic initiative for 'Sustaining Access' and within that to do it equitably. This working group will put in place the analysis capability for the trust to be able to deliver on the commitment in the operational planning guidance and consider what actions should be carried out to address any inequalities.

1.3 These terms of reference set out the committee's response to the remit in terms of its constitution, governance, operation and activities.

2. PURPOSE

The Working Group shall:

2.1 Provide an analytical framework for analysing inequalities and variation in the

Re-imagining Health Equity

Prof. Marc Farr
Chief Analytical Officer,

East Kent Hospitals NHSFT
Kent and Medway ICB

NHS
East Kent
Hospitals University
NHS Foundation Trust

HEALTH AND CARE ANALYTICS
Conference 2024

Predicting missed outpatient appointments in East Kent: past, present, and future

NHS
East Kent Hospitals University
NHS Foundation Trust

Figure 1. Dashboards are employed to track DNA interventions and display reasons for cancellation.

It is possible to monitor attendance by speciality, appointment type, wait time, age, and inequality. Furthermore, DNA rates, alerts, and opportunities can be viewed (not illustrated).

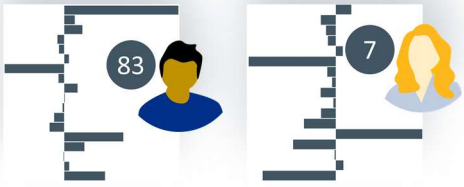


Figure 2. Each DNA Score has been normalised for readability to an integer between 0 and 100.

Whilst the scale is arbitrary, the Score retains ordinal significance, allowing for comparison and intervention prioritisation when resources are limited. A higher Score indicates that the patient may benefit from an intervention; a lower Score is suggestive that the patient is more likely to make the appointment without any reminder.

	January 2024			February 2024			March 2024			
Appointment Type	**Appts**	**DNA**	**(%)**	**Appts**	**DNA**	**(%)**	**Reduction**	**Appts**	**DNA**	**(%)**	**Reduction**
• Follow-Up	601	29	(4.8)	429	19	(4.4)	8%	527	20	(3.8)	21%
• New	319	27	(8.5)	222	6	(2.7)	68%	228	7	(3.1)	64%
Booking Type	**Appts**	**DNA**	**(%)**	**Appts**	**DNA**	**(%)**	**Reduction**	**Appts**	**DNA**	**(%)**	**Reduction**
• Partially	837	53	(6.3)	621	24	(3.9)	39%	681	26	(3.8)	40%
• Fully	83	3	(3.6)	64	1	(1.6)	57%	74	1	(1.4)	63%
Consultation Method	**Appts**	**DNA**	**(%)**	**Appts**	**DNA**	**(%)**	**Reduction**	**Appts**	**DNA**	**(%)**	**Reduction**
• Face-to-Face	860	53	(6.2)	619	25	(4.0)	34%	714	24	(3.4)	45%
• Telephone	60	3	(5.0)	32	0	(0.0)	100%	41	3	(7.3)	-46%
PSC to Book	**Appts**	**DNA**	**(%)**	**Appts**	**DNA**	**(%)**	**Reduction**	**Appts**	**DNA**	**(%)**	**Reduction**
• No	598	29	(4.8)	422	19	(4.5)	7%	537	20	(3.7)	23%
• Yes	322	27	(8.4)	229	6	(2.6)	69%	218	7	(3.2)	62%
Total	**920**	**56**	**(6.1)**	**651**	**25**	**(3.8)**	**37%**	**755**	**27**	**(3.6)**	**41%**

Table 1. Results from the Pilot Study carried out on the sub-specialty Trauma and Orthopaedics (Lower Limb) in early 2024.

The month of January was used as a control from which to calculate reductions in DNA rate for February and March. Overall there were fewer DNAs recorded in February and March combined than in January; fully booked appointments exhibit with a lower DNA rate than those partially booked.

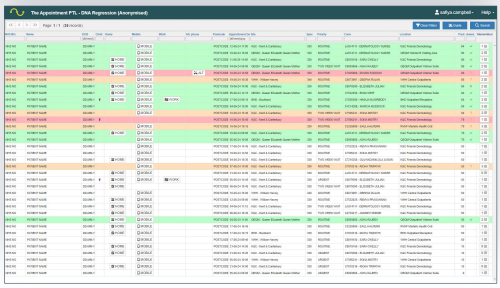


Figure 3. The Patient Tracking List showing outpatient and appointment details including DNA Score.

Interventions are colour-coded, such that green indicates confirmation of attendance, amber indicates no contact made, and grey indicates declination; red fields indicate that outpatient contact details are incorrect. The Patient Service Centre is able to use this PTL to efficiently target outpatients for interventions and record responses for analysis and future model development.

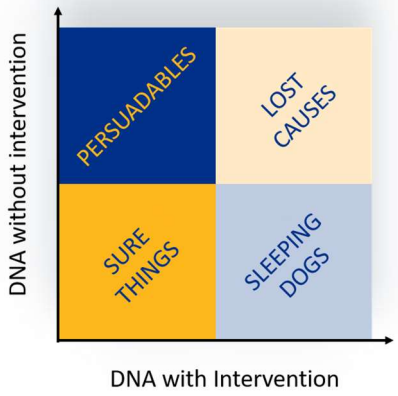


Figure 4. The four quadrants of response.

These allow for more selective and appropriate outpatient targeting:
'sure things' - attend irrespective of intervention strategy;
'lost causes' - DNA irrespective of intervention strategy;
'persuadables' - DNA if disregarded but attend with intervention;
'sleeping dogs' - DNA with intervention and attend if disregarded.

Conclusions

Factors contributing to non-attendance are multiple and diverse; understanding and modelling their complexity can lead to predicting behaviour and developing appropriate targeted intervention strategies capable of reducing DNA rates. These strategies will benefit from bespoke Trust-specific solutions that understand the localised heterogeneous reasons for non-attendance. Consequently, EKHUFT will see increased patient engagement, improvements in the quality of care, and optimised clinical resource allocation. Targeting may then be combined with the Trust's channel shift strategy to create an appropriate intervention methodology for the reduction of DNAs.

Many state-of-the-art techniques consider DNA prediction as a binary problem and provide a probability estimation for each population cohort. However, there is no benefit in predicting DNA unless a favourable outcome can be achieved. An optimal strategy for predicting and handling appointment no-shows will therefore have to consider the likelihood of attendance with and without intervention, and the potential success of disparate intervention methodologies.

Acknowledgements

We would like to thank all of the staff at the EKHUFT PSC for their ongoing help in both performing and recording the outpatient interventions. We would also like to thank Sadia Kauser for her initial investigative work into DNA modelling.

Reference

Kauser, Sadia. "Reducing Inequalities and Variation." MSc thesis, University of Exeter, 2023.

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: **8 December 2025 and 13 January 2026**

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. The service has continued to work towards achieving compliance with all of the Year 7 requirements. At the 8 December and 13 January MNAB, the following papers were discussed in compliance with CNST reporting: **CNST Safety Action 1 (SA1)-Quarter 3 (Q3) Perinatal Mortality Review Tool (PMRT) report** • The report confirms that during the Q3 reporting period the service used the PMRT tool to the required standard as set out in NHS Resolution (NHSR), CNST MIS Year 7. • During Q3, a total of 11 cases were reported. All 11 cases were supported for a full review. The supported cases consist of four Neonatal Deaths (NNDs) and seven stillbirths/Intrauterine deaths (IUDs). • Within the Q3 the Trust reported all stillbirths/IUDs to MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK within seven days of the death, and NNDs within two working days; with Factual Questions completed within one calendar month. • Within Q3 the Trust had a 100% compliance rate of commencing the review within the allocated time scales. • There is a 100% compliance with external reviewers at PMRT Meetings.

	CNST SA 10-Q3 Serious Incidents (SI)/Duty of Candour (DoC)/Early Notification Scheme (ENS) report 1 October – 31 December 2025 <u>Maternity and Newborn Safety Investigations (MNSI)/Patient Safety Incident Investigation (PSII)</u> During this reporting period two cases were referred to MNSI. One case was accepted for MNSI investigation and one case is currently being triaged to assess whether it meets the criteria for MNSI investigation. On receipt of the MNSI final reports, the findings, learning and any safety actions required are shared with the maternity service team and the Local Maternity and Neonatal System (LMNS). This report confirms that during the Q3 reporting period the service has reported 100% of qualifying cases to MNSI and to NHS Resolution's (NHSR's) ENS as set out in NHSR, CNST MIS Year 7. The paper also provides the Board with information in relation to progress and compliance of DoC in relation to MNSI and internal PSII investigations undertaken during the Q3 reporting periods. The service has involved specialist translation services to enable meaningful DoC with families whose first language is not English. One case was presented at the Trust Incident Review Panel (IRP) which resulted in the proportionate response being the requirement for internal PSII.
Perinatal Quality Oversight Monitoring (PQOM) December 2025 (October data) January 2026 (November data) **Homebirth Prevention of Future Deaths (PFD) published by Senior Coroner at Manchester North and Urgent Homebirth Safety Review request**	The PQOM report is presented to the Board in keeping with the Ockenden recommendation. It contains the minimum dataset that the Board required oversight of. • The total number of babies born in October was 478 and November was 453. • Supernumerary status compliance was reported at 100% at both sites in October and November 2025. • Compliance of 1:1 in Labour was reported at 100% at both Queen Elizabeth the Queen Mother Hospital (QEQM) and William Harvey Hospital (WHH). • Neonatal death (NND) rate increased to 0.85 (two NNDs in October). • Increase in stillbirth rate to 3.22 (three Stillbirths reported in October) with a Level 1 Maternity Outcomes Signal System (MOSS) signal being generated. The local perinatal team has completed a MOSS critical safety check which is shared. • Overall extended perinatal increased to 4.07 and remains lower than the MBRRACE threshold.

- Hypoxic-ischaemic encephalopathy (HIE) rate increased to 1.4 (one grade 2 HIE in October) but remains below the national average rate.

Patient Experience

- Friends and Family (FFT) had a 27.2% response rate in October.
- Over 90% of people spoken to were positive about their antenatal care.
- Almost 87% of people were positive about their intrapartum care.
- Above 80% of people were positive about their postnatal and neonatal care.
- Both positive and negative themes in October included quality of treatment, communication and information provision.

Training and Education

- Training remains on the Care Group risk register (Risk Reference 3764) in relation to estates for the provision of PRactical Obstetric Multi-Professional Training (PROMPT) training. The contract for St Paul's is now secured and a lease has been agreed for three years.
- Obstetric doctor compliance for PROMPT and Newborn Life Support (NLS) was below 90% in October but data from November demonstrated 100% compliance.
- Compliance for Neonatal / Paediatric doctor or NLS annual update was below 90% in October, however, compliance was 95% in November.
- Maternity Support Workers compliance for PROMPT and NLS in October was below 90% but November data demonstrated compliance at 97%.

National Home birth PFD (Escalation and Benchmarking)

A homebirth-related PFD report was published on 5 November 2025 by the Senior Coroner for Manchester North. In response to this a letter was issued by Kate Brintworth (Chief Midwifery Officer for England) on 26 November 2025 regarding an 'Urgent Homebirth Service Safety Review' . The Kent & Medway Integrated Care Board (K&M ICB) then issued an 'Urgent Homebirth Service Assurance Request' on 1 December 2025 to all system-wide Maternity services.

While no formal response to NHS England (NHSE) was required, trusts were asked to report findings to their Boards and contact regional teams immediately if safety concerns are identified. Assurance was requested on the three domains highlighted in the Chief Midwifery Officer's letter:

1. Operational service delivery and workforce.
2. Care planning, risk assessment and informed choice.

	3. Governance, oversight and continuous improvement. A full benchmarking exercise was undertaken. None of the associated assurance requirements have been rated as red. A number of areas of good practice particularly in relation to oversight and continuous improvement were identified and have been outlined in the document. The following three requirements were rated as partially achieved: 1. The transfer audit which is currently underway (Completion date February 2026). 2. Separation of local outcome data by site on the local dashboards to ensure that any changes in outcomes are specifically flagged within the PQOM reports. This has already been addressed. The November PQOM report contains data specifically linked to Homebirths. Future reports will include outcome data linked to specific sites (Completion date February 2026). 3. As it applies to sustainability of the service, the current homebirth model is under review and is a registered Quality Improvement (QI) project within the Maternity and Neonatal Improvement Programme (MNIP). (Completion date December 2026). The service submitted over 90 documents for the 93% of work completed, and work has already been done against the three outstanding actions. This was shared with members of K&M ICB on Tuesday 6 January 2026 for review and at MNAB in January 2026.
MNIP highlight reports and overview of programme	A programme level highlight report and six individual reports including culture, safety culture, clinical pathways, listening to women and families, workforce and infrastructure were shared at MNAB in the month of November. **Highlights for October from the Neonatal Programme include**: • Success with the Early Days gentle ways programme which received a Trust award and was shortlisted for a national award. • Improved compliance with Newborn Early Warning Track and Trigger (NEWTT2). Areas of focus: • Increase in stillbirth and neonatal deaths. • Organisational Culture. **Highlights for November from the Maternity Programme include**: • Progress with the restorative work. • A series of values based away days. • Improved Maternity Care Quality Commission (CQC) patient satisfaction survey results.

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	• Positive progress with recruitment and Band 5s completing preceptorship and progressing to Band 6. Resultant cessation of Agency utilisation in Maternity. Areas of focus: • Independent stillbirth review. • Deep dives into complaints regarding attitudes and behaviours. • Procurement of IT system. • QEQM refurbishment.
Matters to escalate to Quality & Safety Committee (Q&SC) and Board	• **Increase in Stillbirth rate noted and MOSS Signal**. Analysis of local Statistical Process Control (SPC) charts demonstrated an increase in the stillbirth rate. This increase was lower than the MBBRACE threshold and as such the service was not an outlier nationally. An internal aggregate review of stillbirths was undertaken. Commonalities included lower Index of Multiple Deprivation (IMDs) and smoking in pregnancy. An independent aggregate review has also been commissioned alongside internal reviews that have been undertaken with independent input. The national signalling system MOSS was launched in November 2025 and the service received a level one signal. For further assurance and whilst awaiting the outcome of the independent stillbirth review, the perinatal team (DoM, Governance Lead, Ops lead and senior midwives have undertaken the MOSS Critical Checklist). One action was identified and has since been closed. • **National Maternity Review** - initial feedback and reflections have been shared nationally. Further to the site visits, the service received a provider information request and has reviewed and submitted in excess of 560 pieces of information. • **Manchester Homebirth PFD** and local benchmarking has been undertaken as outlined in this paper. • **Year 7 MIS**: Further to the local self-assessment and ongoing ICB reviews, the service is declaring full compliance with all 10 safety actions within CNST Year 7. • **Anaesthetic Staffing:** Future proofing staffing requirements.

Other items of business: None

Items to come back to the Committee outside its routine business cycle:
There was no specific item over those planned within its cycle that it asked to return.

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

Item	Purpose	Date
MNAB asks the Board of Directors to discuss and **NOTE** this MNAB Chair Assurance Report.	Assurance	5 February 2026

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REPORT TO BOARD OF DIRECTORS (BoD)

Report Title: **Guardian of Safe Working (GoSW) Quarterly Report Quarter 4 (Q4): 1 October 2025 - 31 December 2025**

Meeting date: **5 February 2026**

Board Sponsor: **Dr Des Holden, Acting Chief Executive**

Paper Authors: **Miss Elizabeth Sharp & Dr Ahmed Kamal Ahmed (GoSW)**

Appendices:

None

Executive summary:

Action required:	Information
Purpose of the Report:	The purpose of this report is to give assurance to senior management (and to doctors themselves) that doctors and dentists in training (known as Resident Doctors from September 2024) are safely rostered and that their working hours are compliant with the NHS Doctors and Dentists in training Terms and Conditions (England) 2016 (T&C's).
Summary of key issues:	• Work to establish numbers of resident doctors and locally employed doctors within the Trust and vacancy rates is ongoing. • The Framework Agreement for exception reporting is being implemented from 4 February 2026. • The '10 Point Plan' aimed at improving the working conditions for resident doctors is under way by Medical Workforce and the GoSW in East Kent. • Options for Locally Employed Doctors to exception report will be considered by the Joint Local Negotiating Committee (JLNC). • Vascular Surgery and Urology – The NHS England (NHSE) Kent, Surrey and Sussex (KSS) Education Quality team undertook a Risk-based review in Vascular Surgery on 6 November. This resulted in eight mandatory requirements for the Trust, one was related to exception reporting.
Key recommendations:	The Board of Directors is asked to **NOTE** this GoSW report, and improving the working lives of resident doctors with good rostering practices and promoting the use of exception reporting for resident doctors.

Implications:

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

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Link to the Trust Risk Register:	No
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: N/A

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GUARDIAN OF SAFE WORKING (GOSW) QUARTERLY REPORT
Q4: 01 October 2025 - 31 December 2025 (3-months)

1. Introduction

As per the Terms and Conditions of Service for NHS Doctors and Dentists in training Terms and Conditions (England) 2016 (T&C's), the Guardian of Safe Working (GoSW) acts as a champion of safe working hours for doctors and dentists in training (known as resident doctors from September 2024) and ensures that action is taken to address any areas of concern, providing support and assurance to enable a safe and positive working and learning environment for our doctors. The GoSW is responsible for providing assurance (or otherwise) to the Trust Board, senior management and the Director of Medical Education that doctors are safely rostered and are working hours that are safe and in compliance with the T&C'S.

As part of the T&C's, all doctors in training are provided an opportunity to report exceptions to their standard work schedules as set out below:

- Working beyond the average weekly hours limit
- Extended hours of work beyond their expected shift length
- Breaches of weekend or night work frequency
- Failure of opportunity to take adequate natural rest breaks
- Failure of opportunity to attend formal teaching and training sessions in their work schedule
- Lack of support available to doctors during service commitments.

2. High level data for East Kent Hospitals University Foundation Trust (EKHUFT)

Number of doctors / dentists in training (total) employed within reporting period.	**Validated 16/04/2025** - FY1's = 71 - FY2's = 67 - Other Resident Doctors (CT1 / ST1 to ST8) = 257 Locally Employed Doctors: - Trust FY1's = 6 - Trust FY2's = 15 - Other Trust Doctors = 167 **Validated 06/08/2025** - FY1's = 87 - FY2's = 78 - Other Resident Doctors (CT1 / ST1 to ST8) = 283 - Resident Doctors (Lead Employer model) = 85 Locally Employed Doctors: - Data not available **Validated 31/12/2025** - FY1's = 83 - FY2's = 71 - Other Resident Doctors (CT1 /ST1 to ST8) = 376 - Total = 530

	Locally Employed Doctors: - Trust FY1's = 6 - Trust FY2's = 16 - Other Trust Doctors = 167 - Total 189 - Total Resident & Trust Grade 719
Amount of time available in job plan for guardian to do their role:	• 2 PA's for GoSW (8 hours per week) • Two GoSW - one PA each. • Second GoSW appointed Dec-25.
Admin support provided to the guardian (if any):	0.50 WTE
Amount of job-planned time for educational supervisors:	0.25 PA's (1 hour per week, per trainee)

Note: The increase in resident doctors in training in Qtr4 is due to the inclusion of Community posts (General Practice, Psychiatry and Palliative Care) and a small number of additional training posts from the KSS Deanery.

3. Exception Reporting Analysis (Period: 01-Oct-25 to 31-Dec-25)

Type of Exception Report raised	Total Q1	Total Q2	Total Q3	Total Q4
Total number of exception reports submitted	143	81	156	168
Number relating to immediate safety concern	5	2	3	2
Number relating to hours and rest	139	77	155	163
Number relating to missed breaks	44	16	30	37
Number relating to educational opportunities	9	7	18	5
Number relating to difference in work pattern	1	2	7	0

Note: Exception Reporting numbers remain static and reflect the acuity of the patient and workload. The GoSW and the Medical Workforce Manager have continued to emphasise the importance of exception reporting to resident doctors, educational/clinical supervisors, and administrative staff.

Immediate safety concerns are reviewed by the GoSW and if a genuine patient safety concerns is identified then this is reviewed and investigated with the department and GoSW. We encourage the doctors to highlight potential safety concerns as part of an open and transparent culture.

We believe that resident doctors continue to miss their breaks, and exception reporting for this reason is encouraged and that is reflected in the data for Q4. High volumes of patients with complex medical conditions are presenting to our hospitals. In such working conditions it is essential that doctors are able to take their breaks for their own health and wellbeing. To address this, we highlight the importance of fostering a collaborative approach among doctors to plan and take sequential breaks where possible.

Exception Reports by Department/Specialties	Total Q1	Total Q2	Total Q3	Total Q4
Anaesthetics	5	6	0	0
Acute / Emergency Medicine	3	13	49	65
General Internal Medicine	68	8	35	35
Neurology / Stroke	0	0	4	2

Obstetrics & Gynaecology	12	10	7	2
Paediatrics (incl. Neo-natal)	8	4	4	4
Renal	0	0	5	2
Surgery (General & Upper)	47	38	42	54
Vascular Surgery and Urology	0	0	10	3
Others (i.e. GP, Hospice)	0	2	0	1

Note: In Q4 there is a further increase in exception reporting from the medical specialities (Acute / Emergency Medicine and General Internal Medicine). It remains unclear whether these reports relate specifically to specialty work or to on-call duties, making detailed analysis challenging. But the number of exception reports reflects the acuity and number of patients attending the acute services.

In Q4 the overall number of exception reports submitted by the surgical specialities remains high, the majority of the exception reports are from General Surgery FY1's in General Surgery at Queen Elizabeth the Queen Mother Hospital (QEQM). Q4 has seen a further reduction in the number of exception reports from Vascular Surgery and Urology services at Kent & Canterbury Hospital (K&C) from the Foundation doctors, but the issues remain and we are concerned about the high intensity workload with complex high acuity patients the foundation doctors are exposed to.

Exception Reports by Grade	**Total Q1**	**Total Q2**	**Total Q3**	**Total Q4**
FY1	84	31	116	121
FY2	36	28	16	13
IMT1+	0	1	3	11
CT1-2 / ST1-2	13	8	8	5
CT3 / ST3-5	7	4	4	3
ST6-8	0	0	0	0
GPST1+	3	9	9	15

Note: The majority of exception reports continue to be submitted by FY1 doctors, which aligns with the national trend. However, we are aware that resident doctors, particularly those above Foundation level, tend to under-report. To address this, we are actively promoting exception reporting across all training levels by implementing targeted strategies. Our efforts focus on effectively engaging and encouraging resident doctors to utilise exception reporting, equipping them with essential skills and fostering habits that will support their development as future healthcare leaders.

Exception Reports by Site	**Total Q1**	**Total Q2**	**Total Q3**	**Total Q4**
QEQM	43	34	87	105
William Harvey Hospital (WHH)	60	27	50	55
K&C	40	18	19	7
Other (i.e. GP, Hospice)	0	2	0	1

Note: The high numbers of exception reports from QEQM are predominantly from the medical specialties and General Surgery, these two groups make up the majority of resident doctors on the site.

Exception Reports by Response Time	**Addressed** (within 0-2 days)	**Addressed** (within 3-7 days)	**Addressed** (longer than 7 days)	**Still open**
Acute/Emergency Medicine	29	34	2	0
Anaesthetics	0	0	0	0
General Internal Medicine	7	25	3	0
Neurology / Stroke	1	1	0	0
Obstetrics & Gynaecology	1	1	0	0

Paediatrics (incl. Neo-natal)	1	3	0	0
Renal	0	0	2	0
Surgery (General & Upper)	13	37	4	0
Vascular Surgery and Urology	0	3	0	0
Others (i.e. GP, Hospice)	1	0	0	0

Note: The Junior Doctors' Contract stipulates that exception reports must be responded to within seven days. Failure to resolve these reports in a timely manner not only constitutes a breach of the T&C's for Resident Doctors but also impacts the trainee's ability to take Time Off in Lieu (TOIL). Additionally, delays can negatively affect trainees' perceptions of the quality of supervision and the overall reputation of the Trust.

Exception reports exceeding the seven-day timeframe are typically closed by the Medical Workforce Manager, with a request for the trainee to discuss the submission with their supervisor. However, in some cases, reports remain open due to outstanding queries or periods of annual leave.

Actions on Exception Reports	**Total Q1**	**Total Q2**	**Total Q3**	**Total Q4**
Not agreed	3	1	3	0
Time off in lieu (TOIL)	84	44	43	40
Additional Pay	36	23	106	120
No effect on time or pay / No effect	20	13	4	8
Awaiting Response	0	0	0	0

Note: Following the approval of an exception report, resident doctors may choose either Time Off in Lieu (TOIL) or payment for additional hours worked.

When TOIL is selected as the preferred option, the resident doctor must liaise with their rota co-ordinator to ensure it is implemented within the required four-week fulfilment period. Once TOIL has been taken, the resident doctor is responsible for updating the exception report to confirm its completion.

Additional payment has been the preferred option among resident doctors for compensating additional hours in Q4. It is concerning that lack of compensatory rest may result in burnout. TOIL is actively encouraged by the GoSW. This approach promotes doctors' health and well-being while offering greater flexibility in managing their time off.

Note: The figures presented above reflect the position at the time this report was prepared. Additional exception reports relating to Q4 may have been submitted subsequent to the report's drafting and are therefore not included in these figures.

4. Vacancies

We have requested the vacancy data from the Electronic Staff Record (ESR) team. The information supplied has not been validated by the GoSW and we do not feel able to publish it. We will work with the ESR team to have validated data for future reports.

5. GoSW Fine Monies

The GoSW has not issued any recent fine for breaches in the T&C's. Any residual monies from a previous fine money are held in the GoSW account and ring-fenced year on year. The monies raised through fines must be used to benefit the education, training and working environment of trainees. The GoSW should devise the allocation of funds in collaboration with the care group or department where the breach occurred and the Resident Doctors' Forum (RDF).

Residual fine monies are held in a GoSW account and currently stand at £3,204. This money is to be spent on improving the working lives and facilities for resident doctors.

6. Positives / Good Practice

Resident Doctor Forum (RDF) Collaboration

The RDF meetings in 2026 will align with the DVG meetings where possible, to encourage resident doctor participation at the RDF.

Exception Reporting for Locally Employed Doctors (LED's)

When the T&C's were introduced for doctors and dentists in training, exception report was introduced and the role of the GoSW. However, this contract did not apply to LED's.

Following previous discussions at RDF's a three-month pilot commenced at the beginning of March 2025 for LEDs at QEQM across all specialties, enabling them to submit exception reports via a spreadsheet. Communications regarding the process was distributed to HR Business Partners, Consultants, and Rota Co-ordinators, who were instructed to relay the information to the relevant doctors. The process was for the rota coordinators to forward any data collected to the Medical Workforce Manager for analysis. The aim of this pilot was to identify potential issues and evaluate the next steps. The findings confirm the Trust received three exception reports across the pilot duration, all coming from the same specialty. The information received correlated very well with the information that we knew from resident doctors.

Following recent discussion at the RDF in December 2025 the JLNC Chair has agreed to raise options for Exception Reporting for LED's in East Kent at the next JLNC meeting.

7. Areas for highlight

Prospective Cover

Prospective cover is a key mechanism to ensure that medical staffing levels consistently meet service requirements. This is achieved through proactive rota planning, with arrangements in place to cover periods of anticipated absence, such as planned leave or shifts requiring enhanced staffing.

It has been identified that the generic rota model did not originally account for additional leave entitlements—15 days for Foundation Year 2 (FY2) doctors and 30 days for doctors at higher grades. As a result, a retrospective review of generic rotas from February 2020 onwards is required to determine whether affected doctors are entitled to additional remuneration.

This work has commenced; however, due to the absence of additional staffing resources, progress is slow and time-intensive. To date, the Medical Workforce Manager has undertaken a detailed review using a representative sample of doctors across higher specialty grades (20). Rotas worked between February 2020 and December 2024 were reassessed incorporating the correct leave entitlements, enabling the calculation of any potential underpayments.

The Chief Medical Officer (CMO) has confirmed that a formal plan has been developed to address any identified underpayments. The issue has been presented to the Hospital Trust Board, and a constructive meeting has taken place with the Finance team to agree next steps.

The initial phase will prioritise doctors currently employed by the Trust, as engagement and payment processes are more straightforward. The objective is to resolve all outstanding payments for current staff within the current financial year. Following this, the Trust will make reasonable efforts to contact former employees to address any underpayments, recognising that it may not be possible to reach all individuals. Support from the British Medical Association (BMA) will be sought where appropriate, noting that not all former staff will be BMA members.

The CMO has confirmed that financial provisions are being established to enable settlement of any outstanding amounts, in line with agreements reached with Finance.

In parallel, prospective cover leave entitlements have now been correctly implemented across all rotas with effect from January 2025.

Vascular Surgery and Urology Work Environment

There have been ongoing concerns regarding the intensity of work and the training environment for Foundation Doctors within both the Vascular Surgery and Urology specialties at K&C. Foundation Doctors are allocated to either Vascular Surgery or Urology for their routine duties. Exception reports indicate that those assigned to Vascular Surgery are consistently working beyond their scheduled hours, frequently staying past their contracted time and encountering difficulties in taking designated breaks.

Foundation Doctors provide on-call cover for both Vascular Surgery and Urology patients. During on-call periods, they face a particularly high workload, managing a significant volume of Urology patients in the Emergency Care Centre (ECC) alongside complex Vascular Surgery cases.

The transition of Vascular services in April 2023 from West Kent & Medway to the Vascular Unit at K&C did not result in the anticipated increase in resident doctor staffing levels.

These concerns have been acknowledged by the Specialties, Clinical Leads, Medical Education, and the GoSW. An action plan has been jointly developed between the Specialties and Medical Education teams and forms part of a broader review of Vascular Surgery and Urology services across EKHUFT. Nevertheless, it is recognised that the current number of doctors at this level is insufficient to manage the workload and patient acuity.

Q3 and Q4 have seen few exception reports from the resident doctors in Vascular Surgery and Urology. But the issues around work intensity and supervision remain. The NHSE KSS Education Quality team undertook a Risk-based review in Vascular Surgery on 6th November 2025. One of the mandatory requirements from the visit relate to exception reporting and the GoSW.

Mandatory Requirement - to ensure that exception reporting for both late finishes and missing educational opportunities is encouraged and not actively discouraged by all senior and middle grade clinical staff.

Evidence required: a report from the GoSW to be presented at the work programme meeting in the new year (timing to be advised), which includes feedback from foundation doctors.

In order to meet this mandatory requirement, the GoSW attended the Vascular Surgery and Urology Foundation Induction in December 2025 to encourage the resident doctors to use exception reporting for working beyond their scheduled hours, missed breaks and loss of education and training. This will continue to be monitored.

Exception Reporting Reform for Resident Doctors

In September 2024, Resident Doctors, through the British Medical Association (BMA) Resident Doctors Committee (RDC), accepted the NHS Employers pay deal. Acceptance of the framework agreement formally concluded the 2024 industrial dispute between the BMA RDC and NHS Employers. The agreement has since been ratified by the Department of Health and Social Care (DHSC).

The agreement includes substantive reforms to exception reporting and the role of the Guardian of Safe Working Hours (GoSWH). These changes were set out in the *Framework Agreement for Exception Reporting*, published on 31 March 2025. While implementation was originally scheduled for 12 September 2025, ongoing national discussions between NHS Employers and the BMA RDC have resulted in a revised implementation date of 4 February 2026.

NHS Employers and the BMA RDC are jointly responsible for agreeing the required amendments to the national Terms and Conditions of Service (TCS), updating existing resources, and producing new guidance to support employers in implementing the reforms. The framework agreement has now been published and is based on twelve principles jointly agreed by the Government and the BMA. It is expected to result in significant changes to resident doctor contractual arrangements.

Locally, the Medical Workforce Manager has drafted a Standard Operating Procedure (SOP) to support implementation of the exception reporting reforms. This will be submitted to the Local Negotiating Committee (LNC) in February 2026 for review, discussion, and agreement.

The SOP, which will come fully into effect on 4 February 2026 in line with Version 13 of the 2016 Terms and Conditions of Service, introduces a simplified, confidential exception reporting process. The new approach removes educational and clinical supervisors from the initial review stage and provides resident doctors with greater autonomy in determining appropriate outcomes.

Key procedural changes include:

- **Reporting timeframe:** Exception reports must be submitted within 28 days of the incident.
- **Submission method:** Reports must be submitted electronically (e.g. via mobile or desktop application). Paper-based submissions will no longer be accepted.
- **Direct reporting routes:**
    - Reports relating to additional hours worked will be submitted directly to the Medical Workforce Team.
    - Reports relating to missed educational opportunities will be submitted directly to the Director of Medical Education (DME).
    - Educational and clinical supervisors will not routinely be involved unless requested by the doctor or in exceptional escalated cases.
- **Confidentiality:** Access to identifiable information is strictly limited to designated individuals (Medical Workforce, GoSWH, and DME where relevant). Breaches of confidentiality will attract financial penalties.
- **Evidence requirements:** Doctors must provide evidence of the time, date, and location of the exception (e.g. timestamped photographs or call logs for non-resident on-call work). Where electronic evidence is unavailable, corroboration from another regulated professional will be accepted.
- **Processing times:** Exception reports must be reviewed and actioned within seven calendar days of receipt.
- **Additional penalties:** New fines will apply where doctors are not provided with timely access to exception reporting systems or where inappropriate information sharing impedes the reporting process.

In accordance with the updated Terms and Conditions of Service, exception reports relating to periods of less than two hours must be actioned within seven calendar days. The requested outcome—either payment or time off in lieu (TOIL)—must be approved within this timeframe, except where TOIL is mandated for safety reasons (for example, following a rest breach after overnight work). The preferred outcome will be specified by the submitting resident doctor.

For isolated exception reports of less than two hours, there is no requirement to investigate the underlying reasons for the additional work undertaken; confirmation that the reported hours were worked is sufficient.

Exception reports exceeding two hours will be managed through a locally agreed process. While the GoSWH and supporting team will apply the standard process wherever possible, reports of greater duration require a proportionate investigation to understand the circumstances, identify contributory factors, and implement actions to reduce the risk of recurrence. This approach is intended to support resident doctors effectively while ensuring compliance with safe working standards.

In addition, the Guardian of Safe Working Hours (GoSWH) will host a virtual briefing session for resident doctors to support understanding of the exception reporting reforms and their practical implications. The session is scheduled for Monday 26 January, 13:00–14:00. Promotional materials will be displayed across Medical Education Centres to raise awareness and encourage attendance.

10 Point Plan to Improve Resident Doctors Working Lives

At the end of August 2025 NHS England published a “10 Point Plan to improve resident doctors’ working lives”, setting out ten ways in which NHS Employers were planning to improve resident doctors working conditions initially over the twelve weeks. This work has now evolved into an ongoing project to improve resident doctors working lives.

Summary of the 10 Point Plan

1. Trusts should take action to improve the working environment and wellbeing of resident doctors

2. Resident doctors must receive work schedules and rota information in line with the Code of Practice

3. Resident doctors should be able to take annual leave in a fair and equitable way which enables wellbeing

4. All NHS trust boards should appoint two named leads: one senior leader responsible for resident doctor issues, and one peer representative who is a resident doctor. Both should report to trust boards.

5. Resident doctors should never experience payroll errors due to rotations

6. No resident doctor will unnecessarily repeat statutory and mandatory training when rotating

7. Resident doctors must be enabled and encouraged to Exception Report to better support doctors working beyond their contracted hours

8. Resident doctors should receive reimbursement of course related expenses as soon as possible

9. We will reduce the impact of rotations upon resident doctors' lives while maintaining service delivery

10. We will minimise the practical impact upon resident doctors of having to move employers when they rotate

The trust is committed to this plan and medical workforce, medical education and the GoSW are working together to ensure change happens and submit the required data returns to NHS England as required.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Equality Delivery System (EDS) Report 2025**

Meeting date: **5 February 2026**

Board sponsor: **Norman Blissett, Chief People Officer (CPO)**

Paper Author: **Karen Edmunds, Associate Director of Patient Experience & Head of Culture & Inclusion**

Appendices:

Appendix 1: EDS Report 2025

Executive summary:

Action required:	Assurance
Purpose of the Report:	This report presents the findings of East Kent Hospitals University NHS Foundation Trust's 2025 EDS assessment. The EDS is a national NHS framework designed to support organisations in reviewing and improving their performance on equality, diversity and inclusion across three domains: patient services, workforce health and wellbeing, and inclusive leadership. The report outlines the Trust's current rating, progress against previous actions, and a two-year action plan to address identified gaps and inequalities. It is submitted to provide assurance to the Board on the Trust's compliance with national Equality, Diversity and Inclusion (EDI) standards and its commitment to reducing health inequalities and improving inclusion for patients and staff.
Summary of key issues:	The Trust has been rated as **Developing** under the EDS framework, reflecting meaningful progress across all domains, while recognising areas for further improvement. Notable advances include improved carer involvement in discharge planning, expanded use of virtual appointments, and strengthened wellbeing support for staff. However, disparities persist in patient satisfaction and access, particularly linked to ethnicity, age, and deprivation. The report highlights the need for deeper analysis of communication needs, more robust data collection, and continued leadership focus on embedding equity into decision-making and service design. Key Issues: **Patient Services** • Disparities in satisfaction and access linked to ethnicity, age, and deprivation. • High Did Not Attend (DNA) rates for short-notice respiratory appointments; accessibility concerns for non-English speakers. • Limited data capture on some protected characteristics; Accessible Information Standard (AIS) compliance requires review. • Carer involvement in care decisions improving but needs consistent implementation. **Workforce Health and Wellbeing**

East Kent Hospitals University NHS Foundation Trust

	• Disparities in disciplinary processes affecting global majority and disabled staff. • Low advocacy scores in staff survey, with significant variation across departments. • Strong uptake of wellbeing services, with measurable impact from counselling. **Inclusive Leadership** • EDI objectives are embedded in Non-Executive Director appraisals. • Equality and Health Inequalities Impact Assessment (EHIA) processes improving but require consistent application and quality assurance. • Visible sponsorship of Staff Networks and strong uptake of training for leaders
Key recommendations:	The Board of Directors is asked to discuss and **NOTE** the EDS Report 2025 and the following: • Strengthen data collection and reporting by protected characteristics across patient and workforce metrics. • Conduct a deep dive into AIS compliance, interpreter use, and translated patient information. • Promote carers' rights, increase feedback via carers survey, and embed Systematized Nomenclature of Medicine (SNOMED) codes. • Increase visibility and impact of staff networks through executive sponsorship and protected time. • Use staff survey and EDI dashboards to monitor disparities and escalate persistent inequalities to Board level. • Deliver targeted interventions to reduce disproportionality in disciplinary processes and improve advocacy.

Implications:

Links to Strategic Theme:	• Patients • People
Link to the Trust Risk Register:	N/A
Resource:	N
Legal and regulatory:	Implementation of the EDS is a requirement of both NHS commissioners and NHS providers.
Subsidiary:	N

Assurance route:

Previously considered by: People & Culture Committee (P&CC), Patient Experience Committee (PEC) and Trust Management Committee (TMC)

East Kent Hospitals University NHS Foundation Trust

25/119 – APPENDIX 1

NHS Equality Delivery System (EDS)

EDS Report 2025

The Equality Delivery System Report gives an overview of the Trust's approach to addressing health inequalities and promoting inclusion.

28 January 2026

EDI team: ekhuft.edi@nhs.net

Patient Voice and Involvement team:

ekhuft.patientvoice@nhs.net

We care

Contents

About the NHS Equality Delivery System (EDS)

Implementation of the Equality Delivery System (EDS) is a requirement of both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS in accordance with the EDS guidance documents.

The EDS is an improvement tool for patients, staff and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement and insight.

EDS rating and scores

The Rating and Score Card supporting guidance document has a full explanation of the new rating procedure.

First, score each outcome out of 3.

- 0 = Undeveloped activity
- 1 = Developing activity
- 2 = Achieving activity
- 3 = Excelling activity

Then, add the scores of all outcomes together. This will provide you with your overall score, or your EDS organisation rating:

- total score under 7 = Undeveloped
- total score between 8 and 21 = Developing
- total score between 22 and 32 = Achieving
- total score 33 = Excelling

.

Section 1 – Your information

Name of organisation: **East Kent Hospitals University NHS Foundation Trust**

Organisation Board Sponsor/Lead: **Chief Medical Officer (Domain 1) / Chief Executive / Chief People Officer (Domains 2 and 3)**

Name of Integrated Care System: **Kent and Medway**

EDS Leads: **Associate Director of Patient Experience (Domain 1) / Head of Culture & Inclusion (Domains 2 and 3)**

EDS engagement date(s): **May 2025 to November 2025**

Which level has this EDS tool been completed at?

Individual organisation level

Completed actions/activity from previous year

Domain 1:

- Patient caseload, waiting times and DNAs to be monitored by age, disability, ethnicity, gender identity, religion and belief, sexual orientation and Index of Multiple Deprivation

  The business intelligence team at EKHUFT provide a range of dashboards from which staff can analyse data about our patients, splitting them down by age, gender, ethnicity and deprivation (via the index of multiple deprivation). Data on disability, religion and belief, sexual orientation and veterans status are not recorded well and consequently a project is being developed to address this through the trust's Clinical Design Authority and DDAT board. A report now goes to our trust board on how the trust performs against the constitutional standards by age/sex/ethnicity/deprivation.

- Increase the number of Equality and Health Inequalities Impact Assessments (EHIAs) on service redesign and significant service or care pathway changes.

  EHIAs are now completed routinely on all cost improvement programmes, including team restructures. The Trust's new 10 Year Strategy (due to be published in late 2025) has an EHIA, as do all of the related sub-strategies. A new EHIA template and process has been approved. EHIA workshops are held quarterly to skill up staff who need to complete EHIAs.

- Video Relay Interpreting (VRI) on demand to support access to services for patients whose primary language is not English - additional tablet devices needed to maximise use of VRI on demand.

  The Fracture clinic at QEQM hospital now has a tablet device. Maternity services are exploring options to get devices. The Urgent, Emergency and Acute Medicines departments at QEQM and William Harvey Hospital have installed webcams on desktop computers.

- Ensure the Reasonable Adjustments Digital Flag (RADF) SNOMED coding is on the main patient record systems, and the Patient Portal, with appropriate flags.

  The RADF SNOMED codes are in PAS (one of the Trust's main patient record systems) and are being tested before they go live.

- EDI / health inequalities to be part of assurance reports, service performance reviews and service improvement plans.

  EHIAs are now completed for service changes including services improvement plans. There is not currently an EHIA section in assurance reports or service performance review reports.

- Patient harms to be reported and monitored based on demographic data including age, disability, ethnicity, gender identity, religion and belief, sex and sexual orientation.

  This has started to happen in a limited way, for example for falls data. As a Trust we are not yet routinely collecting data on patients' disability, religion and belief, sexual orientation. We do have some data by age, ethnicity and sex. This data is reflected in reports to the Fundamentals of Care Committee.

- Ensure we hear from people who are underserved, experience greater health inequalities and are less likely to get their voices heard.

  The Trust's Patient Voice and Involvement team has engaged with a number of underserved communities including homeless people, migrant women, and veterans. There have been patient stories taken to the Trust Board from this work, and a co-designed training pack for staff about homeless / unhoused people's experiences in accessing healthcare.

- Monitor and report patient experience by patients' protected characteristics.

This data is now included in the EDS report. The Patient Voice and Involvement team regularly review the Friends and Family Test (FFT) scores by age, ethnicity, sex and deprivation. We will be including this in future reports to the Patient Experience Committee.

Domain 2:

- System to be formulated to monitor sickness and absence data by protected characteristics, to identify groups or areas where focused support is needed.

  A new sickness absence monitoring system is in development and will be completed by the end of 2025/26. The dashboard will deliver monthly reporting by protected characteristic, enabling targeted interventions where absence rates indicate a need for focused support. Due to limitations in the existing system, a full rebuild has been required; this is now progressing, with testing underway in the new data warehouse.

- Survey demographics and protected characteristics of wellbeing champions, TRIM practitioners and Mental Health First Aiders. To assess whether staff in these roles are representative of the workforce.

  The demographic profile of wellbeing advocates, TRiM practitioners and Mental Health First Aiders is now routinely captured and published through the Wellbeing Dashboard (first release 13/10/25). This provides clear insight into the current advocate population, highlighting gaps in representation and enabling targeted development – for example, through focused MHFA or 'Leading for Wellbeing' training. Analysis of incident data highlights where demand is most pronounced, and this intelligence is used to prioritise development and ensure support is aligned to areas of greatest operational demand.

- the EDI Team will be working with the InPhase (formerly Datix) team to include protected characteristics on the incident reporting system to give an informed picture of types of incidents and groups impacted.

  The transition to InPhase (formerly Datix) was delayed, which has temporarily placed this development on hold. In preparation, the EDI team has worked with colleagues to scope the data requirements and ensure alignment with national standards for protected characteristics. This means that once the system transition is complete, the functionality to capture and analyse incidents by protected characteristic can be implemented at pace.

- The EDI Team and ER further analyse the data of grievances by protected characteristics and joint action plan to identify the disproportionally identified

Work to establish a formal process for joint analysis of grievance data by protected characteristic between Employee Relations and the EDI team has been delayed, with current collaboration taking place on an ad hoc basis for specific cases. In the interim, national WRES and WDES indicators provide valuable insight into whether race or disability affects the likelihood of entering a formal disciplinary process. Through revised and clearer reporting methodology developed by the Senior EDI Adviser, we are now able to evidence that global majority staff are 1.07 times more likely, and disabled staff 1.28 times more likely, to enter a formal disciplinary process. These findings are informing the development of priorities and targeted actions for 2026/27, ensuring that future work is evidence-based and focused on reducing disproportionality.

- The See Me First Anti-Racism campaign has been launched; this needs to be socialised with support from the Ethnic Diversity Engagement Staff Network (EDEN).

  Since its initial launch, the See Me First anti-racism campaign has secured 79 pledges from colleagues across the organisation. As part of Black History Month, the EDEN network is re-launching the campaign at its celebration day on 24/10/25, themed Standing Firm in Power and Pride. The event will feature keynote contributions from the campaign's award-winning co-founders, Delia Mills and Beverleigh Senior. The relaunch will also include the co-development of anti-racism e-learning and training resources with the EDEN and EDI team, ensuring the campaign is embedded in practice as well as visibility. This builds on significant growth in EDEN membership during Black History Month, with new members joining and total participation now at 310. The campaign will continue to be socialised across the organisation with EDEN's support, ensuring visibility, engagement and sustained impact.

- Formulate a plan to socialise/ raise awareness of the staff network policy.

  The Equality, Diversity and Inclusion (EDI) Team has progressed work across four key workstreams to strengthen awareness and impact of the Staff Network policy. Executive sponsorship has been expanded, with two senior leaders now sponsoring EDEN, reinforcing visible commitment at Board level. Engagement and collaboration with all staff networks are being enhanced through the Staff Network Inclusion Forum, which also provides a platform to explore key intersections between networks. In addition, a new annual action planning template has been co-developed with networks, enabling each to identify priorities and establish a clear rhythm of activity throughout the year. Use of staff network protected time is now reported monthly, with 32.5 hours reported on HealthRoster during September, providing assurance that colleagues are supported to participate meaningfully in network activity. Together, these developments are embedding stronger governance, visibility and alignment across the network community.

- Explore how to monitor exit interview data by protected characteristics, to provide an update. To identify if a disproportionate number of staff are leaving with protected characteristics.

  A comprehensive review of the exit interview process was completed on 06/10/25 as part of the KENT programme, led by the Senior Staff Engagement Adviser. This work has enabled exit interview data to be analysed by three protected characteristics (age, gender and ethnicity), providing new insight into potential disparities in staff turnover. Additional protected characteristics will be incorporated as part of the wider dashboard rebuild, scheduled for completion by the end of 2025/26, ensuring a more complete understanding of workforce trends and equity in retention.

- To socialise/ raise awareness of the workplace adjustment toolkit and policy to use alongside the NHS Health Passport, available on policy centre. This is to support staff who have disabilities and health conditions

  The Workplace Adjustment Toolkit and NHS Health Passport are promoted through the Staff Disability Network, Neurodiversity Network and Occupational Health, and are embedded within the 'Managing Staff with Long Term Health Conditions and Disabilities' training. Resources are also accessible via the Workplace Adjustments staff zone page, ensuring visibility and ease of use. While current uptake is not yet systematically recorded, a review is underway to establish monitoring arrangements. This will provide assurance on usage levels and inform future actions to strengthen awareness and accessibility.

Domain 3:

- As part of the NHS England EDI Improvement Plan High Impact Action of Board and Executives requirement to have EDI objectives, the Executive Team have these in place as part of their appraisals. The non-executive need to have these put these in place.

  Executive Directors actively champion equality, diversity and inclusion across the organisation. Each Executive sponsors at least one staff network – with some sponsoring multiple – providing visible leadership and advocacy. They treat EDI as a golden thread, raising the profile of initiatives such as Black History Month, sharing lived experiences of global majority colleagues, and offering visible support at times of political and social unease. A dedicated session has been held with the Deputy Director of Culture, Inclusion and OD to agree a collective EDI action for the Executive team, which will be confirmed and implemented in the coming period. With EDI objectives formally embedded within Executive & Non-Executive appraisals the Executive team demonstrate ambition and commitment to empowering others to embed EDI as a core element of organisational culture.

- EDI to be an integral part of agenda items on Committee and Board Papers. Equality and Health inequalities Impact Assessment section to be added to every Board paper setting out the impact, mitigations, and risks in terms of people with protected characteristics.

  Equality, diversity and inclusion is a regular standing item across a range of committees and Board reports, including the WRES and WDES updates, the Chief People Officer's report, and periodic deep dives into key workforce data such as recruitment conversion rates. Equality and Health Inequalities Impact Assessments (EHIAs) are systematically applied at the outset of new policies, strategies, service changes and service design, ensuring that potential impacts, mitigations and risks for people with protected characteristics are considered from the start. Training on how to complete EHIAs is available to staff, with quarterly workshops delivered throughout 2025 and 43 colleagues participating to-date. The training offer is scheduled for review to assess effectiveness and impact, supporting continuous improvement in how EDI considerations are embedded within decision-making.

- Board members and senior leaders to use the relevant EDI tools and regularly monitor their implementation: EDI High Impact Actions, Workforce Race Equality Standards, Workforce Disability Equality Standards, Equality and Health Impact Assessments, Gender Pay Gap reporting, Equality Delivery System

  EDI is embedded as a strategic enabler within the new People Strategy, rather than a standalone activity. Board members and senior leaders regularly use key EDI tools – including the NHS EDI High Impact Actions, WRES, WDES, EHIA, Gender

Pay Gap reporting and the Equality Delivery System – to inform decision making and track progress. This focus is reflected throughout the People Strategy, with priorities centred around closing experience gaps linked to health inequalities, increasing the proportion of staff from under-represented groups in leadership roles, improving the diversity of senior leadership teams so they better reflect the communities we serve, reducing discrimination experienced by global majority staff, and delivering on our commitments under the NHS Sexual Safety Charter.

Section 2 – Outcomes and evidence

Domain 1 – Cancer services – Diagnosis of Cancer at Stage 1 and Stage 2

Outcome	Evidence	Score / rating	Owner (Department/Lead)
1A: Patients (service users) have required levels of access to the service	**Core20Plus5 contains the goal of 75% of cancer being diagnosed at stage 1 or stage 2 by 2028.** Data shows that as of May 2025, 60% of people in Kent and Medway were diagnosed at stage one or two, compared to the England average of 59%. Research indicates that some people are more likely to be diagnosed later than others. Factors include low uptake of screening, lack of awareness of symptoms to look out for, access to primary care, delays in getting diagnostic tests, delays in getting treatment. Our assessment has particularly focused on the protected characteristic of race and on health inequalities linked to deprivation. • The percentage of people in East Kent with suspected cancer who are diagnosed, or cancer is ruled out within 28 days is 78.4%. This is below our peer median and below the national benchmark of 80%, which we are required to achieve by March 2026. • The percentage of people in East Kent with cancer who are treated within 62 days is 77.3%, which is above our peer median and above the national average and above the target for 2025-26. • We know patients who need an interpreter are more likely to experience delayed diagnostic tests due to the difficulty in getting interpreters for face-to-face appointments such as for an MRI or endoscopy. The Trust has contracted with a second interpreting provider that has local interpreters for Nepali, Slovak and Dari (some of our most requested languages) and we have started to see some improvements. Delayed diagnostic tests may mean people are diagnosed at a more advanced stage of their cancer.	**1**	Associate Director of Nursing, Cancer, Haematology and Haemophilia

Outcome	Evidence	Score / rating	Owner (Department/Lead)
1B: Individual patients (service users) health needs are met	The 2024 National Cancer Patient Experience Survey indicates that people with a pre-existing disability or health condition have a poorer experience when receiving treatment for cancer. The Friends and Family Test (FFT) survey: The top negative themes are waiting times to be seen / treated on site (small percentage, but top negative theme), communication and information, and medication, prescriptions and dispensing. The top positive themes are staff attitude, care given by staff and waiting time to be seen / treated on site, as most patients report they are seen promptly once on site . FFT additional question data indicates that from April to September 2025 **6.6%** of respondents said that their family were **not** involved as much as they wanted to be. This is an improvement compared to 2024 when it was **8.3%**. There is a personalised care lead nurse for cancer services. The services work closely with the Kent and Medway Care Alliance and Macmillan Cancer. Patient partnership work has taken place, with patient participation groups held in November 2024, March 2025, and July 2025 and a co-designed patient survey launched. Most patients are regular attenders following their first appointment, and so their communication needs are usually well known by the teams. Patients are asked about their communication needs at first point of contact and are asked if their needs have changed since their last visit at subsequent appointments. Patient communication needs are included in referral letters that both come into and out of cancer services. On-going quality reviews indicate that when requests for reasonable adjustments around communication have been made there have been none that the service has not been able to accommodate.	**2**	Associate Director of Nursing, Cancer, Haematology and Haemophilia

Outcome	Evidence	Score / rating	Owner (Department/Lead)
1C: When patients (service users) use the service, they are free from harm	Cancer Services hold a weekly Patient Safety Oversight Meeting to provide senior leadership oversight of patient safety incidents, complaints and risks and monitor progress of actions. There has been a recent focus on Learning disabilities following learning identified from an incident and a patient story with further improvement work planned. There is an established process for completing clinical harm reviews for patients on an active cancer pathway who reach 104 days and over. Each patient pathway is reviewed to establish if the patient has come to any clinical harm due to the delay in confirmation of a cancer diagnosis, understand and learn from delays and implement and share changes to improve patient experience and outcomes. Themes from delays are reviewed monthly with specialties and ensure the patient is supported through the delay in their pathway. Compliance and themes are reported to the service's quality meeting. Compliance with the completion of harm reviews is reported monthly to the Diagnostics, Cancer and Buckland Care Group Performance Review Meeting. Nursing Key Performance Indicators (KPIs) are reported monthly and include information on harms from falls and pressure ulcers. Training compliance data for Cancer services shows Dementia training has been completed by **84.7%** of staff (August 2025), compared to **82.3%** in August 2024 and Patient Safety Level 1 by **88.6%** of staff (August 2025), compared to **82%** of staff in September 2024. Compliance with Oliver McGowan level 1 training was **89.8%** in August 2025, compared with **84.4%** in August 2024.	**2**	Associate Director of Nursing, Cancer, Haematology and Haemophilia
1D: Patients (service users) report positive experiences of the service	Cancer services Friends and Family Test (FFT) satisfaction score in September 2025 was **96%**, compared to **95%** in September 2024. Looking at satisfaction levels by age groups, people aged **40 to 44** report a significantly lower level of satisfaction than other age groups. The score was **88.9%** in September 2025 compared to **88.7%** in September 2024. This age group regularly score the lowest levels of satisfaction. Looking at ethnicity, people of 'other' white background had lower satisfaction scores than white British people. They scored **91%** (57 people) compared to **96%** for white	**2**	Associate Director of Nursing, Cancer, Haematology and Haemophilia

Outcome	Evidence	Score / rating	Owner (Department/Lead)
	British people (1,916) in September 2025. The satisfaction scores are lower than in September 2024 when they were **98%** for people of 'other' white background (45 people), but improved for white British people (1,608), whose satisfaction score was **95%** in September 2024. Men and women rate their overall satisfaction similarly, scoring **95.8%** (1,375 women) vs **96.1%** (1,086 men) in September 2025. The satisfaction level of women has improved compared to September 2024 when it was **93.5%** (1,000 women) compared to **96%** for men (1,010 men). When looking at the FFT satisfaction score by level of deprivation, in September 2025 scores varied from **91%** for IMD 9 (187 people) to **100%** for IMD 1 (105 people). In September 2024 the score was **98%** for IMD1 (89 people) and **94%** for IMD 9 (161 people). In the National Cancer Patient Experience Survey 2024 (NCPES) women tend to score lower than men in many of the questions. The **35 to 44** age group tend to consistently score lower than other age groups. People from the most deprived areas tend to rate their experience as more positive than people in the least deprived areas. The 2024 survey was completed by 921 patients (a 52% response rate); 825 were White, 17 were White Other, 39 were not known, 10 were African or of mixed heritage and 30 were from other ethnic backgrounds. There was not sufficient responses from patients who were from Black, Asian or other ethnic backgrounds to analyse data by ethnicity.		
Cancer total score		**7**	

Domain 1 – Respiratory services

Outcome	Evidence	Score / rating	Owner (Department/Lead)
1A: Patients (service users) have required levels of access to the service	• The majority of patient contacts in respiratory medicine are outpatient appointments. The only day case treatments that sit within respiratory services are for pleural drains. In August 2025 there were 3,391 outpatient attendances for respiratory medicine. **32.7%** of these were virtual appointments – significantly higher than our peer group and the national average of **26.7%.** **36.7%** of respiratory medicine follow-up appointments were virtual in August 2025. • In August 2025 **56%** of attendances were first appointments and **44%** were follow-up appointments. • Waiting longer for an appointment impacts on patients' physical health and mental wellbeing. • The missed outpatient appointments (DNAs) rate in respiratory medicine in August 2025 was **8.7%.** This is **0.3%** higher than national average. • In August 2025 the missed outpatient appointments (DNAs) rate for **2 week wait** appointments was **10.8%** compared to the provider average of **3.5%.** • The missed outpatient appointments (DNAs) rate in 2 week wait first appointments was **13.8%** compared to the provider average of **2.5%.** The DNA rate in the 2 week wait for *follow up* appointments was much lower – **5.7%** compared to the provider median of **4%**. • Attending appointments at short notice can be harder for people with jobs that don't offer time off for medical appointments, for self-employed people and for people with caring responsibilities. Poverty is also a barrier, as is lack of access to transport. These are all barriers that we know our local communities experience. **Further investigation is needed to understand the factors that makes it harder for some people to attend initial appointments at short notice and to then find solutions to address this.**	**2**	Senior Operations Manager, General Medicine / Associate Director of Nursing for SAGE at QEQM and WHH

Outcome	Evidence	Score / rating	Owner (Department/Lead)
	• It should also be noted that short notice appointments and remote appointments may not be as accessible to people who speak little or no English or who need communication support at an appointment, such as a British Sign Language interpreter, Easy Read information or translated information. **Further investigation is needed on whether patients attending respiratory medicine appointments have their communication needs met or whether their appointments need to be re-booked if communication support was not arranged.**		
1B: Individual patients (service users) health needs are met	• The involvement of the patient's carer or family is part of ensuring that the patient's individual needs are met. The includes discussions about leaving hospital. Our data from the Friends and Family Test (FFT) survey additional question "Were your family and carers involved in discussions about [you] leaving hospital?" indicates a *significant improvement* between September 2024 and September 2025. Patients who answered 'no' were **28.6%** at QEQM and **11.5%** at William Harvey in September 2024. The percentage of patients who answered 'no' in September 2025 was **7.1%** at QEQM and **6.25%** at WHH. • We have a lack of data for whether respiratory medicine patients have their health needs met. As this is an outpatient service we would need to look into whether people are asked if they need any reasonable adjustments and once identified, whether these recorded, flagged, shared and met. **Currently the update on our patient administration system (PAS) that will enable us to do this has not gone live.**	**1**	Senior Operations Manager, General Medicine / Associate Director of Nursing for SAGE at QEQM and WHH
1C: When patients (service users) use the	• Never events: There were not any 'never events' between January and September 2025. A healthcare never event is a serious, largely preventable, patient safety incident that should not happen if existing national guidelines and safety recommendations are followed.		Senior Operations Manager, General Medicine / Associate Director of Nursing for

Outcome	Evidence	Score / rating	Owner (Department/Lead)
service, they are free from harm	• Emergency readmissions within 30 days following an asthma admission were **10%** in Q4 of 2024-25. This compares favourably with NHS trusts in our peer group across the south east region. • Emergency readmission rate for patients with admission for pneumonia was **11.1%** in Q4 of 2024-25, below the national benchmark of **14.5%** and well below the peer average for the south east region which was **16.4%.** • Part of keeping patients safe is ensuring staff are up to date with training related to patient safety. For respiratory medicine in September 2025 at QEQM staff compliance with statutory training was **92%** overall, with **90%** compliance for the Oliver McGowan level 1 e-learning and **100%** for infection prevention and control. At William Harvey staff compliance with statutory training was **98%** overall, with **100%** for Oliver McGownan level 1 e-learning and **92%** for infection prevention and control.	**2**	SAGE at QEQM and WHH
1D: Patients (service users) report positive experiences of the service	• Respiratory services use the FFT survey to get patient feedback. Overall patient satisfaction was higher at William Harvey Hospital than QEQM hospital, with scores of **98%** (WHH) and **94%** (QEQM) in September 2025. As a comparison scores in September 2024 were **96%** at QEQM and **97%** at WHH. Therefore, the QEQM overall satisfaction score has gone down by **2%**, whilst the WHH score has improved by **1%**. *It should be noted that QEQM provides some of the diagnostic services for respiratory medicine, e.g. lung function tests, along with the sleep service. These have longer waiting times and this may be one of the factors in lower satisfaction scores.* • **Race**: Looking at satisfaction scores by ethnicity, patients from a white British background scored lower at **93%** satisfaction at QEQM compared to patients of 'other white' background who scored **100%.** Patients at QEQM who were asked their ethnicity but declined to give it had an overall satisfaction score of **83%.**	**2**	Senior Operations Manager, General Medicine / Associate Director of Nursing for SAGE at QEQM and WHH

Outcome	Evidence	Score / rating	Owner (Department/Lead)
	• **Race**: Satisfaction scores by ethnicity for patients at William Harvey were much higher, with white British patients scoring **98%** and patients whose ethnicity is unknown or who declined to answer all scoring **100%** satisfaction. **These differences of patient satisfaction levels based on ethnicity need further exploration.** • **Age:** The FFT data shows differences in satisfaction levels by age: patients aged 60 to 64 and 70 to 74 have lower satisfaction levels (**96%**) than other age groups who score **100%** satisfaction at William Harvey Hospital. At QEQM it is the 45 to 49 age group that score the lowest level of satisfaction (**80%**) and the 50-54 age group (**86%**). The older age groups 70 to 74 and 80 to 84 score **95%** satisfaction. **These differences of patient satisfaction levels based on age need further exploration.** • **Sex**: The FFT data shows very little difference in satisfaction levels of male and female patients at QEQM and WHH. Women score fractionally higher (less than half a percent) at QEQM and men score fractionally higher (less than a third of a percent) at WHH. • **Deprivation**: FFT data shows that patient satisfaction is higher in IMD 7 to 10 (least deprived), scoring **100%** satisfaction and lower at IMD 4 and 3 (more deprived) scoring **96%** at William Harvey. At QEQM the lowest score is for IMD 10 (least deprived) at **88%** and highest satisfaction score is for people in IMD 3 (more deprived) scoring **100%**. These scores show a difference between patients at QEQM and WHH, with the least deprived patients scoring much higher satisfaction levels at QEQM than at WHH. **These differences of patient satisfaction levels based on deprivation need further exploration.**		
Respiratory total score		**7**	

Domain 1 – Children and Young Peoples' Diabetes

Outcome	Evidence	Score / rating	Owner (Department/Lead)
1A: Patients (service users) have required levels of access to the service	• The service has been working on ways to make information available at the appropriate time in other languages for the parents of children who are supported by the service. In particular information on what to do in emergencies when the child's insulin pump is faulty or lost, or when their glucose levels are too low or too high. A draft leaflet for translation is ready, and the service will provide this initially in the languages most requested. The service is looking at how to improve contact by telephone for parents with little or no English who need out of hours support. Both the Trust's interpreting providers are able to support three way telephone calls (parent – clinician – interpreter), and so the service is working on a process to make this as accessible as possible for parents. • National data shows that children's access to continuous glucose monitoring (CGM) is at very high levels in East Kent, with 95.5% of white children (269 children) and 100% of Black, Asian and minority ethnic children (16 children) using CGM. In terms of deprivation, the most deprived children are less likely to use CGM (93%) compared to the least deprived children (99%). In terms of age, children under 12 are slightly less likely to use CGM (94%) than children over 12 years of age (96%).	**2**	Consultant General Paediatrician and Consultant with East Kent Children's Diabetes team
1B: Individual patients (service users) health needs are met	Data from the National Paediatric Diabetes Audit shows that: • The percentage of key health checks carried out on children with type 1 diabetes who have not been diagnosed or transitioned into adult services are as follows: - In quarter 2 of 2025-26, just under 70% of children had the key health checks, which compares well with the England and Wales average of just over 70%.	**3**	Consultant General Paediatrician and Consultant with East Kent Children's Diabetes team

Outcome	Evidence	Score / rating	Owner (Department/Lead)
	- The percentage is 72% for Black, Asian and minority ethnic children, 72% for children under 12, and 68% for children in the most deprived areas. - The percentage of children with type 1 diabetes reaching or exceeding treatment targets is 19.4% since quarter 1 2024-25, which is slightly higher than the England and Wales average of 19%. This figure represents 376 children. - Children from Black, Asian and minority ethnic backgrounds and children under 12 years of age are *more* likely to reach or exceed treatment targets. There is no statistical difference based on deprivation. • The number of Diabetic ketoacidosis (DKA) admissions for children with type 1 diabetes, per 100 children is very low in East Kent. Nationally of those admitted, they are more likely to be from the most deprived areas and Black, Asian or minority ethnic children. We can't break down these figures for East Kent, but overall, it was less than 2 per 100 children each quarter, in the 18 months from quarter 1 2024-25 to the end of quarter 2 2025-26. • We have much higher percentages of children with type 1 diabetes using Hybrid Closed Loop systems (HCLs) – 85%, than 69% on average for England and Wales. Our data shows there is no statistical difference based on ethnicity or deprivation, which is reassuring.		
1C: When patients (service users) use the service, they are free from harm	• Never Events: There were not any never events in the Women, Children and Young People Care Group between January and September 2025. • After Action Reviews (AARs): the Women, Children and Young People Care Group had 17 AARs between January and September 2025. As of September 2025, 6 were overdue for completion. None of the AARs were for the Children's Diabetes service.	**3**	Consultant General Paediatrician and Consultant with East Kent Children's Diabetes team

Outcome	Evidence	Score / rating	Owner (Department/Lead)
	• Part of keeping patients safe is ensuring staff are up to date with training related to patient safety. For Children's Diabetes in September 2025 staff compliance with statutory training was **98%** overall, with **100%** compliance for the Oliver McGowan level 1 e-learning and **92%** for infection prevention and control. Compliance with Safeguarding children training was **100%.**		
1D: Patients (service users) report positive experiences of the service	• The children's diabetes service collects very small amounts of patient/parent feedback through the Friends and Family (FFT) test. This is likely to be before children stay with the service for many years. • There were 10 FFT responses in January 2025 (overall satisfaction score 90%). We cannot score the satisfaction level for fewer than 10 responses. There were 7 responses in February 2025, 7 in March, 4 in April, 5 in May, 4 in June, 5 in July, 4 in August 2025, and 10 in September 2025 (100% satisfaction score). Over the last 5 years the service has had 389 FFT surveys completed. 332 scored 'very good', 41 scored 'good', 3 scored 'very poor', 3 scored 'poor', 10 scored 'neither good nor poor'. • Because of the small number of FFT responses, there is no data by age, ethnicity, sex or deprivation. • The children's diabetes service have carried out a qualitative survey to get parents, older children and young people's feedback on a wide range of issues about how diabetes impacts on their everyday lives, including family and friends, school, social life etc. Although the number of responses were small, it was older children who felt diabetes impacted on their school, friendships and social life most. They were more likely to feel sad about having diabetes (64%). This also impacted on parents of children with diabetes age under 7 with 50% saying it made them feel sad. Over 57% of parents of children under 7 felt 'burnt-out' by having to manage their children's diabetes. 50% of children aged over 12 said they didn't feel their parents	**2**	Operational Manager, Children's Diabetes Service

Outcome	Evidence	Score / rating	Owner (Department/Lead)
	trusted them to manage their diabetes. 28.5% felt their parents and friends don't understand how difficult living with diabetes can be. A similar percentage constantly worried about what food they can / cannot eat. A number of these children commented that they found it embarrassing or difficult to ask to leave their classroom when their glucose monitor indicated high or low reading which needed to be addressed. Some had been refused, which added to their anxiety. • **Some education of parents of older children and their teachers could reduce older children's anxiety about living with type 1 diabetes.** • **Increasing qualitative feedback should be an action for the service in 2026.**		
CYP Diabetes services total score		**10**	

Total score for Domain 1: 8 (eight)
Please total the scores from Domain 1 (average of the three services scored):

Domain 2 – Workforce health and wellbeing

Outcome	Evidence	Score / rating	Owner (Department/Lead)
2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	EKHUFT has partnered with Randox and Kent County Council to provide a Health Check pilot between Nov '24 – May '25. This pilot provided 381 free health checks to staff, supporting them to identify opportunities to improve their physical health (*i.e.* lowering blood pressure, cholesterol or risk of heart disease and diabetes). NHS Staff Survey 2024 data indicates that a small majority of staff (50.22%) feel able to eat nutritious and affordable food at work, although this is approximately 5% below the national average. All staff have access to a comprehensive wellbeing and benefits platform (VIVUP), which provides a range of physical, mental (and financial) wellbeing support. To date, 67% of staff (6,818 colleagues) are registered on the platform and actively making use of its resources, demonstrating strong engagement with the offer and ensuring colleagues can access timely support to maintain their health and wellbeing. Through a combined Trust/Charitable funded partnership that introduced face-to-face counselling services on each of the acute sites, 409 individual staff attended 1,511 counselling sessions, with 85% seeing clinically reliable improvement, reducing CORE-OM scores by 7.41 points, from 16.28 (moderate clinical distress) to 8.87 (mild non-clinical).	**2**	
2B: When at work, staff are free from abuse, harassment, bullying and	NHS Staff Survey results show some progress in creating a safer and more respectful workplace. Reporting of physical violence has increased by 4.3%, which is 2.5% above the national average – a positive indicator of staff confidence in raising concerns following focussed attention.	**1**	

Outcome	Evidence	Score / rating	Owner (Department/Lead)
physical violence from any source	Fewer colleagues report experiencing harassment bullying or abuse from managers (a 2.5% reduction), from patients and the public (down 1.7%) and from colleagues (down 1.5%). The overall downward trend is positive, though the latter remains 5% above the national average – and this remains a clear area of focus for further improvement. Thankfully, physical violence levels remain low – with 98% and 99% of colleagues not experiencing this from their colleagues or managers respectively. However, 1.7% more staff have experienced physical violence from service users, their relatives, or members of the public.		
2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	Staff have access to a range of independent support and advice mechanisms when experiencing stress, abuse, bullying, harassment or physical violence. The Guardian Service has been introduced to provide confidential, independent support for colleagues to speak up about any concerns. A new Resolution Framework has been launched to encourage early, constructive resolution of workplace issues. The Stop, Talk, Change sexual safety campaign has also been introduced to ensure every member of staff feels safe at work and empowered to challenge inappropriate behaviour. This is supported by the introduction of Active Bystander training, equipping colleagues with the confidence and skills to intervene safely and effectively. In addition, the development of the Staff Congress has strengthened opportunities for staff voices to be heard directly in Trust decision-making	**2**	

Outcome	Evidence	Score / rating	Owner (Department/Lead)
	processes, ensuring concerns and ideas are represented at the highest level.		
2D: Staff recommend the organisation as a place to work and receive treatment	A minority of staff would recommend the organisation as a place to work (44%) or be treated (46%) – and less than two-thirds (62%) feel that care is the organisation's top priority. These questions are critical as they form the 'advocacy' domain, one of three components of staff engagement. At a ward/ departmental level, there are wide levels of variation, with recommend to work rates varying from nationally leading practice at 82% through to areas of immense challenge at 8%. This trend is mirrored when recommending as a place to receive treatment, with some wards/ departments as high as 88%, and others as low as 7%. Advocacy anchors staff engagement as the lowest of the three sub-themes (5.80) and has been consistently below the national average for the last 5 years. Among the five questions where the Trust shows the largest deviation from the national standard, three pertain to advocacy, with gaps ranging from 10-15%. *NB: Advocacy has fallen nationally from 7.15 (2020) to 6.80 (2021), 6.60 (2022), 6.75 (2023) and 6.70 (2024).*	**1**	

Total score:
Please total the scores for Domain 2**: 6**

Domain 3 – Inclusive leadership

Outcome	Evidence	Score / rating	Owner (Department/Lead)
3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	334 senior leaders have attended the suite of leadership development programmes available across the last year, with EDI and the commitment to reducing inequity a golden thread throughout. Senior leaders act with as sponsors for staff networks, attending events, and role-modelling inclusive behaviours. Their visible sponsorship shows their commitment to understanding and reducing inequity. Board members also routinely participate in listening events, whether that be monthly all-staff forums, team brief, or more bespoke staff-group related sessions, where equality and health inequalities are discussed.	**1**	Chief Executive Officer / Chief People Officer
3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	Equality and Health Inequalities Impact Assessments (EHIAs) are routinely included in all new policies, strategies and service changes/ redesigns. Training has been rolled out to report authors, and clear guidance and templates available on Staff Zone to improve the quality of EHIAs.	**2**	Chief People Officer

Outcome	Evidence	Score / rating	Owner (Department/Lead)
3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	Staff survey results are routinely monitored and reflected on throughout the year to monitor progress, with year-on-year comparisons and national benchmarking taking place. Reported under embargo, these remain a focus at Board, Executive Management Team meetings, Trust Management Committee and People & Culture Committee throughout the year. Evidence that equality and health inequality indicators are embedded in future operational planning or assurance can be evidenced, with the latest example the completion of an EHIA into Winter planning.	**2**	Chief Executive Officer / Chief People Officer Chief Medical Officer

Total score:
Please total the scores for Domain 3: **5**

Third-party involvement in Domain 3 rating and review:

Trade union reps:

Independent Evaluator(s)/Peer Reviewer(s):

EDS organisation rating (overall rating)

Name of organisation(s): **East Kent Hospitals University NHS Foundation Trust**

Overall score and rating: 2025 score was 19 – Developing (a 7-point improved score compared to the 2024 score of 12).

Note: Organisations are required to provide an organisation rating, created by adding outcome scores together.

*Using the middle score out of the three services from Domain 1, domain scores are added together to provide the organisation rating.

Below is a key to support understanding of organisation rating:

Those who score **7 or under,** adding outcome scores **across domains**, are rated **Undeveloped**

Those who score **between 8 and 21,** adding outcome scores **across domains**, are rated **Developing**

Those who score **between 22 and 30,** adding outcome scores **across domains**, are rated **Achieving**

Those who score **31 and above,** adding outcome scores **across domains**, are rated **Excelling**

Section 3 – EDS action plan

EDS leads: **Associate Director of Patient Voice and Involvement (Domain 1) / Head of EDI (Domains 2 and 3)**

Years active: **April 2025 to March 2027 (note two year action plan, with actions updated in October 2025)**

EDS sponsor: **Chief Medical Officer / Chief People Officer**

Authorisation date: **Trust Board, February 2026**

Domain 1 – Commissioned or provided service

Outcome	Objective	Action	Lead (s)	Completion date
1A: Patients (service users) have required levels of access to the service	Increase the use of Video Relay Interpreting (VRI) on demand to support access to services for patients whose primary language is not English. Identify what aspects of the patient profile in East Kent makes it less likely for people to attend initial appointments at short notice (e.g. 2 week wait respiratory medicine).	Additional tablet devices needed to maximise use of VRI on demand. Webcams to be available on desktop PCs at all patient touch points Analysis of respiratory medicine patient caseload attendance and DNA by age, ethnicity, sex and deprivation	Care Groups / IT Care Groups / IT Chief Analytical Officer / Information team	June 2026 September 2026 June 2026
1B: Individual patients (service users) health needs are met	The Trust fully implements the Reasonable Adjustments Digital Flag (RADF).	Ensure the RADF SNOMED coding is on the main patient record systems, and the Patient Portal, with appropriate flags.	I.T. teams	March 2026 (adjusted date)

Outcome	Objective	Action	Lead (s)	Completion date
		Communication plan to raise awareness of RADF amongst staff and patients / families / local communities	Associate Director of Patient Experience / Communications team	June 2026
	Carers: Improve the identification and involvement of patient's carers / family in discussions about care and treatment and decisions related to the patient leaving hospital	[a] Promote carers rights to involvement in decisions related to the patient leaving hospital (discharge)	Associate Director of Patient Experience / Communications team	March 2026
		[b] promote the Carers survey to get more feedback	Associate Director of Patient Experience / Communications team	March 2026
		[c] Carers SNOMED codes on PAS and Sunrise	IT	March 2027
	Accessible Information Standard (AIS): further investigation is needed into whether patients attending respiratory medicine appointments have their communication needs met or whether their appointments need to be re-booked if communication support was not arranged.	Deep dive into AIS compliance, the use of interpreters at appointments and translated patient information.	Associate Director of Patient Experience / Senior Operations Manager General Medicine	May 2026
1C: When patients (service users) use the service, they are free from harm	The Trust can provide evidence that patients with protected characteristics of age, disability, and ethnicity, do not disproportionately experience harm.	Patient harms to be reported and monitored based on demographic data including age, disability, ethnicity, gender identity, religion and belief, sex and sexual orientation.	Business Information team	June 2026

Outcome	Objective	Action	Lead (s)	Completion date
1D: Patients (service users) report positive experiences of the service	Monitor and report patient experience by patients' protected characteristics.	Report Friends and Family Test (FFT) satisfaction levels by age, ethnicity, sex and deprivation to Patient Experience Committee.	Patient Voice and Involvement team	From January 2026 onwards
		Pilot a patient experience survey in other languages.	Patient Voice and Involvement team	June 2026
	Understand why there are differences in satisfaction levels of the respiratory service based on age, ethnicity and deprivation and location.	Work with the respiratory services to explore variations in patient satisfaction based on age, ethnicity, deprivation and location of the service.	Patient Voice and Involvement team	September 2026
	Increase feedback from children and young people and parents on their experience of the Children's Diabetes service.	Work with the Children's Diabetes Service to increase the qualitative feedback from children and young people about their experience.	Patient Voice and Involvement team / Communication team	June 2026
	Support older children to reduce their anxiety / worries about living with type 1 diabetes	Develop (or utilise existing) educational materials for schools / teachers / parents about supporting children and young people aged 12 plus living with diabetes.	Children's Diabetes service	September 2026

Domain 2 – Workforce health and wellbeing

Outcome	Objective	Action	Lead(s)	Completion date
2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	Ensure that all staff have equitable access to proactive, evidence-based support for managing their health and wellbeing at work, with a particular focus on long-term health conditions and mental health, in line with our People Strategy commitment to a healthy, engaged workforce.	Build manager confidence to have supportive conversations, and strengthen peer support networks to reduce stigma. Track update, outcomes and equity of access across staff groups, using insights from the wellbeing dashboard to refine interventions. Provide targeted interventions for obesity, diabetes, asthma, COPD and mental health, while ensuring learning is transferable to other conditions.	Culture & Inclusion Team Wellbeing Team Wellbeing Team	October 2026 July 2026 October 2026
2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	Significantly reduce workplace abuse, harassment, and bullying, closing the disparity in experience reported by global majority and disabled staff.	Analyse staff survey, incident reporting and exit interview data to identify areas of high prevalence – and disaggregate findings by ethnicity, disability and other protected characteristics to surface disparities. Deliver an active programme of work that highlights disparities in experience, acknowledges their impact and sets our clear commitments to change.	Culture & Inclusion Team Equality, Diversity & Inclusion Team	July 2026 October 2026

Outcome	Objective	Action	Lead(s)	Completion date
2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	Provide a Freedom to Speak Up service that is independent, visible, and robust and provides regular reports to the People and Culture team and the Trust Board.	Ensure the service is clearly signposted across all sites and Staff Zone, with multiple routes for staff to access support (in-person, online, phone). Provide quarterly thematic reports to the People & Culture Team and Trust Board, highlighting trends, hotspots and progress against actions.	Communication Team The Guardian Service	April 2026 April 2026
2D: Staff recommend the organisation as a place to work and receive treatment	Create a culture of compassion and inclusivity where all staff feel valued and engaged, and where gaps in experience linked to inequity are actively closed.	Track staff survey 'recommend rates' by protected characteristic to identify disparities in experience. Use qualitative feedback to understand the drivers behind low levels of advocacy. Co-design improvement actions with Staff Networks to address inequities in experience.	Culture & Inclusion Team Equality, Diversity & Inclusion Team	April 2026 July 2026

Domain 3 – Inclusive leadership

Outcome	Objective	Action	Lead(s)	Completion date
3A: Board members, senior leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	Ensure leaders at every level are culturally competent, inclusive, and visibly committed to advancing workforce equality and reducing health inequalities for patients, families and communities	Assign senior leaders as sponsors of Staff Networks, ensuring they actively champion issues raised and provide visible support. Provide leaders with regular workforce equality and health inequalities data, highlighting disparities and progress.	Culture & Inclusion Team Equality, Diversity & Inclusion Team	April 2026 July 2026
3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	The Board is provided with assurance that the decisions they make, and the assurance reports they receive, will not lead to adverse impact on people (staff, patients, carers, families and communities) with protected characteristics or inclusion health groups.	Build capability by providing training and guidance for report authors, to ensure EHIAs are meaningful and evidence-based. Require all policies, strategies and services changes to include an EHIA section, completed consistently.	Equality, Diversity & Inclusion Team Equality, Diversity & Inclusion Team	April 2026 April 2026

Outcome	Objective	Action	Lead(s)	Completion date
3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	Ensure the Board and system leaders have clear levers, data and assurance to identify, monitor and reduce inequalities in workforce representation, career progression, and patient access – and to recognise and scale positive change.	Use staff survey metrics and the EDI dashboard as core tools for monitoring workforce and patient inequalities. Escalate areas of persistent inequality to Board level for targeted action. Highlight and celebrate areas of positive change to reinforce learning and motivation.	Culture & Inclusion Team Culture & Inclusion Team Culture & Inclusion Team	July 2026 October 2026 October 2026

Glossary:

AIS – the NHS England Accessible Information Standard

COPD - chronic obstructive pulmonary disease

EDI – Equality, Diversity and Inclusion

EDS – Equality Delivery System

EHIAs – Equality and Health inequality Impact Assessments

VSM – Very Senior Manager

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Update on Kent Fire and Rescue Service Regulatory Audit**

Meeting date: **5 February 2026**

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

Paper Author: **Stuart Hammerton, Associate Director of Safety and Brod Paul, Head of Fire Safety**

Appendices:

None

Executive summary:

Action required:	Information
Purpose of the Report:	Kent Fire and Rescue Service (KFRS) carried out an audit at the William Harvey Hospital (WHH) in November and December 2025. Following the audit, the Trust was served a Notice of Deficiencies. This paper is to provide an update to the Board on progress on the various actions and to make recommendations to be able to meet the requirements of the Notice. Failure to comply with a Notice of Deficiency may result in enforcement action.
Summary of key issues:	KFRS inspected the WHH over a period of two-weeks. A sample of clinical areas were inspected across the site. A further audit of this type is planned for Queen Elizabeth the Queen Mother Hospital (QEQM) in April 2026. The audit identified 92 breaches of the Regulatory Reform (Fire Safety) Order 2005. Some were minor repairs to fire doors or minor breaches in compartment lines (walls, ceilings and door sets). Other issues were major breaches in compartmentation. Several issues were with the alarm system, such as detector heads missing. Management issues (included poor clinical staff awareness of emergency/evacuation procedures, poor management of local risks (wedging doors open, blocking escape routes with work stations, putting bariatric patients in areas where evacuation would be very challenging)), lack of suitable and sufficient oversight of compliance, insufficient fire drills across the whole site and issues from fire risk assessment management was identified.

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	Adoption of Plan A comprehensive plan has been devised to ensure all 92 issues found are resolved. **Ward/Department support and engagement for management actions** There were many issues raised that require ward/department based actions. **2gether Support Solutions (2gether) actions** 2gether to be responsible for implementing the estate related actions. **Increase in Staff resource to achieve plan:** Given the size of the Trust and the fire risk profile, fire safety management is under resourced and this needs urgently addressing to enable the Trust to achieve a reasonable level of legal compliance.
Key recommendations:	The Board of Directors is asked to NOTE this update on KFRS Regulatory Audit report.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Trust Risk Register:	N/A
Resource:	A Fire Safety Trainer post fixed term for two years here will be a two year offset by £68,000 per annum potential savings on the fire risk assessment contract. Additional Fire Improvement Programme Director short term contract employed (costs are capitalised).
Legal and regulatory:	Non-compliance with the Regulatory Reform (Fire Safety) Order 2005 and under a Notice of Deficiencies. KFRS will be carrying out a similar audit in April 2026 on QEQM. Failure to comply with a Notice of Deficiencies which could lead to enforcement.
Subsidiary:	2gether Support Solutions.

Assurance route:

Previously considered by: N/A

East Kent Hospitals University NHS Foundation Trust

Update on KFRS Regulatory Audit of WHH in November/December 2025

1. Purpose of the report

1.1 Following a two-week fire safety compliance audit of WHH by KFRS in November/December 2025, the Trust was served a Notice of Deficiencies.

1.2 EKHUFT have until the 18 March 2026 to act on these deficiencies. At that point KFRS will return. If insufficient progress has been made they have the option of taking enforcement action against the Trust. If we are able to show good progress and detailed plans to complete any outstanding actions, we may be granted a further extension.

1.3 This paper is to provide an update the Board on progress on the action themes.

2. Background

2.1 Historically, KFRS compliance inspectors have carried out small scale audits focused on single wards. Although these have always identified numerous issues, these were seen as local issues and not systemic failures in how we manage fire safety.

2.2 From November 2025 KFRS have changed their auditing to cover whole-site audits using two to three auditors attending site for a two-week period. The WHH audit in November/December was the first of these site wide audits and has allowed us to identify systemic issues in addition to some significant individual issues. Future KFRS audits will follow the same pattern. We will have a whole site audit of Royal Victoria Hospital (RVH) in January/February and QEQM in March/April.

3. Managing Audit Property Actions for 2gether

3.1 2gether will be tasked with the estate related actions raised by the audit including repairs, compartmentation, alarm hardware etc. They are scoping work and instructing repairs for the smaller tasks and the larger items are being looked at by the Fire Compartmentation Project Team. Not all these actions will be completed on time for the KFRS revisit in March 2026, but if we have sufficiently robust plans we should be able to gain an extension to the Notice of Deficiencies.

4. Managing Audit Management Actions for the Trust

4.1 Management actions are a Trust liability. The Fire Safety Team have produced a spreadsheet of management actions. Issues for wards included poor staff awareness of evacuation procedures, poor management of local risks (wedging doors open, blocking escape routes with work stations, storing oxygen incorrectly and putting bariatric patients in areas where evacuation would be very challenging). Trust management were criticised for poor oversight of compliance due to the current paper-based systems of recording fire actions in physical fire folders, a lack of fire drills across the whole site (although KFRS only picked up a lack of drills on wards) and actions from fire risk assessments not being delivered in a timely way.

4.2 Staff resource increase

An interim resource has been procured for high level oversight. A Fire Improvement Programme Director started on 26/01/26.

The Safety Team has recently been increased to three with the original intent being to bring the fire risk assessments in-house and reducing consultancy costs. Due to the number of fire risk assessments for completion the current resource would not be able to undertake this within an acceptable time frame whilst also delivering the wider fire management resource to the Trust.

For at least the next two years, the Safety Team will focus on improving management systems, improving oversight and providing a surge in training to get the Trust to a point where staff are trained and competent in their roles.

To achieve this, it is recommended that one of the fire safety managers focuses on risk reduction and the other on training development. In addition, a dedicated trainer should be employed on a two-year fixed term contract to provide the surge training and ensure fire drills are instigated across the Trust.

5. Action Plan for Management Actions

5.1 Many of the management actions from the audit show systemic failings in how the Trust manages fire safety. Given the size of the Trust and the fire risk profile, fire safety management has been under-resourced for a considerable time and this needs urgently addressing to enable the Trust to achieve a reasonable level of legal compliance. The Fire Safety Team consists of a Head of Fire Safety and one Fire Safety Manager. There is currently a vacant post for a second Fire Safety Manager. The original purpose of the two Fire Safety Managers was to cover both fire safety training and the annual programme of 360 fire risk assessments (FRAs). The 360 FRAs are currently completed by external consultants at a cost of approximately £180,000 per annum.

5.2 Following the audit findings, it has been identified that the current FRA plan is not deliverable with the available resource.

5.3 For at least the next two-years the Safety Team need to focus on improving management systems, improving oversight and providing a surge in training to get the Trust to a point where staff are trained and competent in their roles.

5.4 As referenced above the recommendation has been made that one of the fire safety managers focuses primarily on risk reduction. This will include the setting up paperless monitoring of FRA actions and fire warden inspections and tracking all actions to completion. This would allow accurate reporting of compliance to senior management. Over the next two-years, with sufficient buy-in from clinical managers, this role should drive down the number of non-compliances across the Trust, reducing our overall risk.

5.5 This role would also manage the fire risk assessment programme and the team have already identified how, using a risk-based approach, the FRAs can be categorised by risk into annual, bi-annual and tri-annual assessments, reducing costs by around £68,000.

5.6 The second Fire Safety Manager would focus on training development. The current training programme for all staff consists of a short e-learning package. There is limited evidence of learning from this national package. Classroom training is mainly for Fire Incident Managers and Fire Wardens. Both courses are three-hours long and require significant abstractions from ward teams. Consequently, courses are not well attended and wards have insufficient trained staff to manage their fire risks and manage evacuations. Fire drills are not carried out routinely in the trust which is a major non-compliance although some wards carry out desk-top evacuation exercises but this is not consistent across all areas.

5.7 This role would develop a programme of short courses that could be delivered to all ward staff on the ward during team training days. We would also deliver extinguisher training on the wards and look at breaking warden training into modular packages. The training would be monitored using audits and feedback to check effectiveness.

5.8 This role would also manage the fire drill programme, ensuring that all non-clinical areas carry out two drills per year (normal national practice).

5.9 In addition, a dedicated trainer should be employed on a two-year fixed term contract to provide additional training and ensure fire drills are instigated across the Trust. This short-term surge in training is designed to bring the Trust up to a position of reasonable compliance over the two-year period, by supporting the Fire Safety Manager (training) in delivering the new programme.

5.10 The savings on the fire risk assessment programme would help with funding this position. At the end of the two-year period we could either lose the short-term trainer or look at taking the fire risk assessments in-house to reduce costs further. This will depend to a large extent on the uptake of training and improvement in safety culture over the next two years.

6. Conclusion

6.1 The audit carried out at the WHH has identified many areas of poor compliance resulting in the notice of deficiencies issued by KFRS. There are future site audits planned that, without significant input and change, will highlight similar issues and pose the Trust at risk of a further notice of deficiencies or an enforcement notice. The plan, of which the key points have been provided in this paper, designed to demonstrate a commitment to fire safety and reduce non-compliance over the shortest possible time in a way that will allow sustainable improvement for which there will be a cost.

6.2 The newly appointed Fire Safety Improvement Director has been asked to review the plans in the first instance to ensure that the correct areas of focus and activity have been captured. In addition, the individual will be assessing the position and readiness of the other sites ahead of any inspection.

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) (June - September 2025)**

Meeting date: **5 February 2026**

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

Paper Authors: **Clare Herridge, Lead Nurse for Workforce and Education**
Ian Setchfield, Associate Director of Nursing (ADoN) for Workforce and Education for Nursing, Midwifery and Allied Health Professionals (AHP)
Kim Perry, Deputy Chief Nurse, Workforce, Strategy and Professional Standards

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: Setting evidence-based nursing Establishments
Appendix 5: Establishment Review for existing adult and children's Inpatient areas and ED June 2025
Appendix 6: Care Group Recommendations
Appendix 7: Finance

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.
Summary of key issues:	• The January 2025 reviews recommendations were not requested to be approved for implementation, due to the reduced timeframe between the establishment review and the implemented changes of the January 2024 review, but have been used to inform decision making within this establishment review. • Changes from the January 2024 review and from the band 2/3 uplift are still being processed through Electronic Staff Record (ESR) and the financial ledger. • This paper provides the outcome of the review undertaken between June - September 2025. • Establishment changes have been recommended for several areas which need careful consideration and, for some, a Quality and Equality Impact Assessment (QEIA) to be completed.

Key recommendations:	The Board of Directors is invited to: 1. **NOTE** the content of the report as well as the processes and methodology underpinning the review. 2. Receive **ASSURANCE** that the safer staffing review has been undertaken in accordance with national guidance. 3. **APPROVE** the recommendations made within 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
Legal and regulatory:	Yes - National Quality Board Guidance & Care Quality Commission (CQC)
Subsidiary:	N

Assurance route:

Previously considered by: Nursing & Midwifery Executive Committee (NMEC) 11 November 2025
Trust Management Committee (TMC) 17 December 2025
People and Culture Committee (P&CC) 27 January 2026
Quality & Safety Committee (Q&SC) 3 February 2026

Nurse Staffing Establishment Review for In-Patient Wards, AMUs and EDs

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 the 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 June 2025 and the check and confirm meetings held in September 2025.

1.5 It outlines the recommendations, from the Chief Nurse and Midwifery Officer on safe staffing levels across adult and children inpatient 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 Healthcare Support Worker (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 ED's 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 5.2wte). Whilst approved, this change is still yet to be made.

2.4 The January 2025 nursing workforce review recommended changes across four Care Groups to support quality: Women's, Children's & Young Persons; Kent & Canterbury Hospital (K&C); WHH; and Queen Elizabeth the Queen Mother Hospital (QEQM) as indicated below:

- Women's, Children's and Young Persons were to increase HCSW by 2.62 whole time equivalent (wte).
- K&C were to decrease registered by 2.6 wte and increase HSCW by 2.6 wte.
- WHH were to decrease registered by 2.42 wte and increase HCSW by 15.5 wte.
- QEQM were to decrease registered by 3.78 wte and increase HCSW by 12.62 wte.

2.5 The January 2025 nursing workforce review has recently gone through the internal Trust governance process however owing to the reduced timeframe between this and the implemented changes of the January 2024 review, the recommendations made were not requested to be approved for implementation but have been used to inform decision making within the June 2025 review.

2.6 SNCT© data collections are achieved in June and January, allowing for seasonal variation to be captured.

2.7 The next bi-annual establishment review will be undertaken with SNCT© data collected in January 2026.

3. Care hours per patient day (CHPPD)

3.1 For inpatient areas, the CHPPD for EKHUFT is 9.4 compared to a peer median of 9.2 and a provider median of 8.5 (based on June 2025 data) on Model Health System as detailed in the graph (fig.1) below.

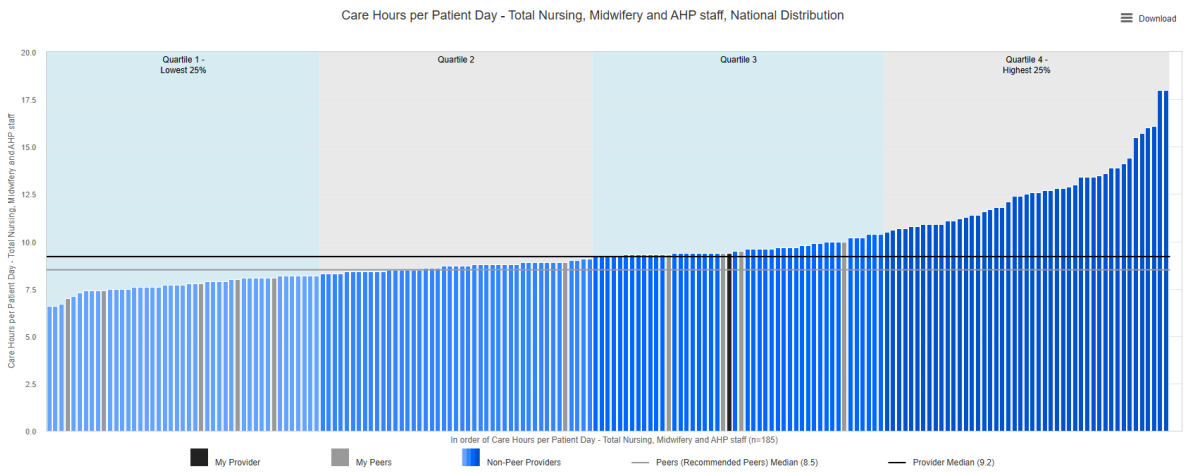

Figure 1 – Care Hours per Patient Day (Model Health System)

3.2 Continued improvement has been seen in the Trust's position for CHPPD but it is acknowledged there is further potential for continued improvement.

3.3 It is recognised the outstanding need to realign budgets and ESR coding to separate inpatient activity and clinic-based activity is delaying continued progress within this area.

4.0 Overview by care group

4.1 For the majority of the inpatient wards there was minimal change proposed. In clinical areas whereby change is suggested it is proposed this will be undertaken once the recommendations are approved.

4.2 SNCT data and quality indicators information, showing both January and June 2025 for all clinical areas included in this review, and as shared at the check and confirm meetings are in Appendix 3.

4.3 The overall acuity and dependency levels from both the SNCT© data collected in January and June as a comparative demonstrate minimal changes in patient profiles across the Trust (figure 2). A slight decrease is noted in level 0 patients, with a slight increase in level 1c patients and level 2 patients.

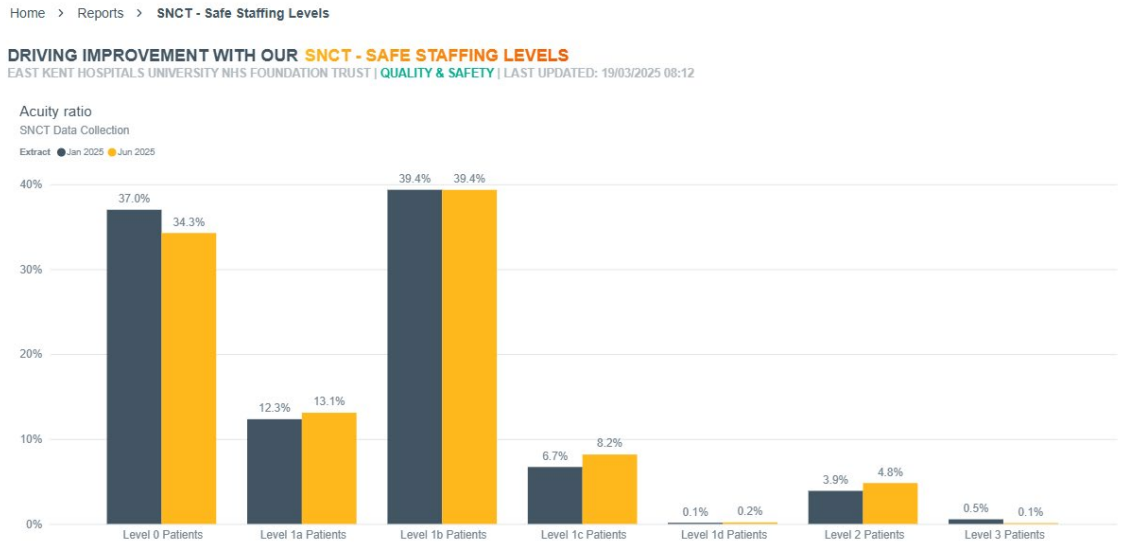

Figure 2 – Overall Trust acuity and dependency levels January & June 2025

4.4 William Harvey Hospital care group (excluding ED)

4.4.1 All areas were discussed over a four week period chaired by the Deputy Chief Nurse and supported by the Director of Nursing.

4.4.2 Where quality and safety concerns have been identified, this has supported informed decisions regarding staffing as detailed further below.

4.4.3 For the following inpatient ward areas, the **recommendation is for staffing levels to remain the same**; Bartholomew, Cambridge J1, Cambridge J2, Cambridge L, Cambridge M1, Cambridge M2, Coronary Care Unit (CCU) at WHH, Kennington, Kings A2, Kings B, Kings C1, Kings C2, Kings D1, Kings D2, Oxford and Richard Stevens.

4.4.4 AMU A and AMU B are proposed to **remain with the staffing level as recommended** when the clinical areas were split in November 2024. It is noted the ESR and Finance split for AMU A and AMU B has still not been actioned, with quality metrics still combined, requiring close monitoring by the Care Group. Staffing sickness has improved across both areas.

4.4.5 Cambridge J1 has seen a change in the patient profile to include endocrinology patients alongside Health Care of Older People (HCOOP) patients. The previous recommendation from January 2025 was to decrease the day shift by a registered nurse and increase the night shift by a HCSW. The current **recommendation is for the staffing levels to remain the same** as the existing staffing, without this change, and for the sixth registered nurse on a day shift to be flexed to a night shift as required.

4.4.6 Cambridge J2 staffing sickness is significantly improved however further work is required to decrease the number of pressure related incidents. As per the January 2025 establishment review, the **recommendation is for the overall establishment to remain the same** with the introduction of a registered nursing associate per day and night shift from the registered nurse funded establishment.

4.4.7 Cambridge K continues to see a high patient dependency, this coupled with a challenging ward layout, has required them to regularly using bank staffing for HCSWs, above their establishment, since January 2025 to support patient care at night, as evidenced within the wards fill rates. This has had a positive impact on their quality indicators. As per the January establishment review, the **recommendation is to increase the establishment by one HCSW per night shift.**

4.4.8 As per the January 2025 establishment review, Cambridge L have trialled a change in skill mix, reducing one registered nurse per day shift and increasing by one HCSW per day shift. This has been a successful trial, with stable quality indicators maintained and therefore the **recommendation is to permanently change the establishment to reflect this.** The care group will complete a QEIA for Chief Nurse approval.

4.4.9 Cambridge M1 staffing **recommended to remain the same** but due to a shift in patient profile are now seeing a mix of diabetes and endocrinology, HCOOP and general medicine. Patient dependency is fluctuating as a result of this, so temporary staffing will be used to support as required. The ward has been asked to collect data, between the formal SNCT data collections, on patient speciality mix triangulated with quality data to assess any impact.

4.4.10 As per the January 2025 recommendations, 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 and this continues to utilised through being displayed as an overrecruited establishment.

4.4.11 Following previous concerns across quality indicators on Bartholomew ward, the ward has made good progress with them also achieving a Bronze award for ward accreditation in June.

The **recommendation is for the staffing to remain the same**, with continued monitoring of their quality indicators.

4.4.12 **CCU at WHH is recommended to stay the same**. The Care Group are undertaking a full review of cardiac services to determine funded activity and establishment required to meet service need. Currently the ward co-ordinates referrals to the primary Percutaneous Coronary Intervention (PCI) service for Kent and supports Cardiac Assessment Day Unit (CADU).

4.4.13 CCU at QEQM has observed an increase in higher acuity patients however as per the January 2025 establishment review, the **recommendation is to decrease by an HSCW on the early shift owing to a continued change in pathways**. In addition to this, the band 4 Registered Nursing Associate night shift is requested to be amended to a band 5 registered nurse shift to support patient acuity and the administration and monitoring of complex cardiac medications. Overall **establishment is recommended to reduce by 2.5 wte HCSW**.

4.4.14 Kennington wards has seen a decrease in patient dependency, with a mixed patient profile of frailty and palliative. Quality indicators are continued to be monitored and the staffing managed, as currently the ward is over established on band 5s. The establishment is **recommended to remain the same,** with the budget lines requiring alignment.

4.4.15 Following the January 2025 establishment review, concern through quality indicators for patients and staff on Kings A2 was identified, with a recommendation made to move one registered nurse per day shift to a night shift. The June data collection demonstrated high acuity patients with high dependency needs, with the **recommendation to trial an additional HCSW at night** as required using temporary staffing. Time and motion studies are to be conducted by the care group to monitor impact of this. Kings A2 to also capture activity outside of ward with support for Virtual Acute Care (VAC) assessments for surgical wounds.

4.4.16 Kings B has seen a change in leadership, with a new ward manager commencing in post. With a reduction in compliance with risk assessments, quality indicators are to be closely monitored by the care group. Recommendation is for the **establishment to remain the same**, and to recruit into the existing vacancy of 11.2%.

4.4.17 Kings C1 quality indicators are of concern, with close monitoring and improvements required. Team engagement is required from organisation development teams to support a cultural shift on the ward as ward staff appear to be disconnected. The January 2025 recommendation was to reduce the registered nurse staffing at night by one, with an increase in HCSW by one to support higher patient dependency and enhanced therapeutic observation and care needs. However, the current recommendation is for the **establishment to remain the same whilst the other factors are worked through**.

4.4.18 Kings C2 continues to see an increase in patient dependency, with longer stay frailty patient, with a significant amount requiring 1:1 enhanced care. **Recommendation is for the establishment to remain the same**, but to book temporary staff as required. A significant number of risks were identified with the ward and its layout and operational function which needs to be actioned by the care group.

4.4.19 Despite the January recommendation for both Kings D 1 & 2 to increase by one HCSW at night, the June 2025 **recommendation is for the establishment to remain the same**, owing to the fluctuations in patient dependency and a demonstrated improvement in quality indicators. The ward will use temporary staff as required to maintain safety.

4.4.20 The recommendation for Oxford ward is for the **establishment to remain the same**, with movement of the registered nursing associate shifts from night to day shifts to offer better support to staff and the ward.

4.4.21 The patient profile on Richard Stevens remains mixed, with an average of six bariatric patients per month. The ward has a vacancy of 28.6% with a recruitment plan in place, but in the meantime, is to continue to utilise temporary staffing as required to manage quality and safety of ward. The **establishment is recommended to remain the same.**

4.5 QEQM Care Group (Excluding ED)

4.5.1 All areas were discussed over a two-day period chaired by the Deputy Chief Nurse and supported by the Director of Nursing.

4.5.2 Where quality and safety concerns have been identified, this has supported informed decisions regarding staffing as detailed further below.

4.5.3 For the following inpatient areas, the recommendation is for staffing levels to remain the same, which is the same recommendation made in the January 2025 establishment review**;** Bishopstone, Cheerful Sparrows Female, Cheerful Sparrows Male, Sandwich Bay and St Margarets**.** Due to ward closure the recommendation is for St Augustines to also remain the same, which differs from the January 2025 recommendations.

4.5.4 AMU A is **recommended to remain the same**. The education team, comprising of three Practice Development Nurses (PDNs), included in the AMU A establishment, provides support across the AMU floor. During this data collection, it was recorded the beds were empty for 4.7%, which is representative of the AMU activity. Patient safety incidents reporting to be monitored with quality indicators requiring continued improvement. Staff sickness has improved significantly. AMU A sees unpredictable but regular activity around patient escorts, with staffing shortfalls mitigated by the education team.

4.5.5 AMU B is **recommended to stay the same**. Falls continue to be monitored as part of an action plan across the AMU footprint, with training and mitigations implemented. To continue to monitor progress, but positive impact of full establishment observed in quality indicators. AMU B has seen an increase in level 1c patients, with complex needs, and longer lengths of stay, which requires monitoring.

4.5.6 Bishopstone is still receiving a mixture of different specialities within the ward and staff quality indicators remain a concern. As per the January establishment review, triangulation with quality is required to demonstrate need for staffing. Patient escorts occur on average six-seven times per month. Care Group to mobilise staff across the surgical floor to provide support as required, with assessment of impact. Red flags to be raised if there are concerns with staffing. To change the registered nursing associate late day shift to an early shift and to monitor impact.

Recommendation is for staffing levels to remain the same, with close monitoring of quality indicators by the senior leadership team.

4.5.7 Cheerful Sparrows Female is **recommended to remain the same**, with a focus on quality indicators and to realise improvement following the action plan implemented from the January 2025 establishment review. Quality needs to continue to be monitored through the care group governance process with a specific focus on the impact of the weekly patient escorts to WHH for ERCP.

4.5.8 Cheerful Sparrows Male is **recommended to remain the same.** Positive improvement on quality indicators observed which is testament to the new ward leadership. The challenge of short notice escort hours for procedures offsite, which was expected to decrease, has increased from an average of 80 nursing hours to 150 hours per month. Care group to consider mobilisation of staffing across the surgical floor to support this challenge.

4.5.9 Deal ward is a dynamic ward, with a diverse range of patients, that has continued to experience unpredictable patient care needs alongside patients requiring enhanced therapeutic observations and care. As the only ward that receives admission of younger patients this places pressure on the staffing. Both the January and June SNCT recommends the need for an increase in staffing, which is supported by the ward manager and senior leadership team. As per the recommendation of the January establishment review, the **recommendation is to increase by one HCSW at night**. A further review of the band 2/3 split is required, with the team needing to determine the overall staff skills required per shift. Ongoing support for mental health patients is to be closely monitored with support from the Associate Director of Nursing (ADoN) for Mental Health.

4.5.10 Fordwich requires 24-hour NIC cover, due to high patient acuity levels, so **requires an increase in band 6 registered nurses**. As the escalation beds are no longer utilised, the unfunded element of the template is not required, the **recommendation is to decrease the overall establishment by 0.8 WTE**. Adjustment to the roster template will support accuracy of fill rate data. Monitoring and support required with scoring patient acuity and dependency as showing significant proportion of level 1b and level 2 patients with no step down from either an acuity or dependency profile.

4.5.11 Quex ward has seen a considerable change in the last year, with 12 trollies/chairs now being utilised within two Same Day Emergency Care (SDEC) 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. In the January 2025 review, the recommendation was to increase by 4.2 WTE to meet demand of service and to closely monitor quality and safety indicators, which required improvement. However, due to the current reconfiguration of services (including Quex being housed within St Augustine's) at QEQM the **recommendation is to remain the same**. The ward will need to continue to use temporary staffing as required for additional activity as currently the proportion of bedded patients overnight is 33%. Activity within the frailty SDEC bays is to be fully captured in the January 2026 establishment review.

4.5.12 Sandwich Bay continues to see a high patient dependency profile, with patients requiring enhanced observations and care. The ward continues to only have 10.5 WTE staff substantively funded, with further review of the band 2/3 split required to ensure sufficient staffing with the

right skills are rostered per shift. **Recommendation is for the establishment to remain the same.**

4.5.13 Seabathing has seen an improvement in quality indicators through shift re-organisation and leadership, following significant concerns at the January 2025 review. The introduction of an enablement bay is supporting improvements in length of stay and preventing community admissions. **Recommendation to increase by one HCSW at night** to support high dependency, ward layout and to maintain continual improvement in quality indicators.

4.5.14 St Augustine's ward has remained closed since June and therefore no SNCT data has been collected for this cycle. Staff have been redeployed across site to mitigate staffing risks based on assessment of patient acuity and dependency. **Recommendation is for staffing to remain the same**.

4.5.15 St Margarets have stable quality indicators, with red flags requiring to be raised for any identified staffing concerns. Recommendation is for the **establishment to remain the same**.

4.6 K&C Care Group recommendations for In-patient Wards

4.6.1 For the following inpatient areas, the recommendation is to stay the same; Clarke, East Kent Neuro Rehab (Harvey), Invicta, Kingston, Marlowe and Mount McMaster**.**

4.6.2 Clarke ward has seen an improvement in quality indicators. Establishment is **recommended to stay the same**. Care Group and Operational staff to review additional surgical lists and associated bed usage as this is impacting on ward staffing. It has been agreed for additional bed usage, above the funded 36 beds, the Director of Nursing, will be consulted and agree if staffing levels are deemed safe. During the January 2026 SNCT data collection, the elective activity will also be captured.

4.6.3 East Kent Neuro Rehab (Harvey) sees a higher dependency profile, with future consideration and exploration to be given to a blended staffing model with increased therapy input. Staff statutory and mandatory training requires improvement. Establishment is **recommended to stay the same**.

4.6.4 Harbledown establishment is **recommended to stay the same**. However, the Quality indicators require improvement with concerns related to falls remaining, this will be monitored through the care group governance process. Work remains to separate the budgets and rosters for thrombolysis staffing and inpatient staffing to generate accurate CHPPD.

4.6.5 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. Included within the budget is staffing resource to support 180 telephone calls per month and four joint school sessions.

4.6.6 Kingston ward has successfully trialled changing one RN to one HCSW at nights to support high patient dependency levels, with positive staff results and with no negative impact on quality indicators. **Recommendation is for the establishment to remain the same but to implement a permanent skill mix change.**

4.6.7 Kent ward has seen an increase in both activity and patient acuity and dependency profiles, with SNCT recommending an increase in establishment. **Recommendation is to increase by one HCSW at night** to support identified risk, with quality indicators required continued improvement. Care Group to decide on use of unfunded beds and to monitor any associated impact.

4.6.8 The establishment for Marlowe is **recommended to remain the same**. The recent renal nurse staffing establishment reviewed identified the budgets and rosters still require separation for the inpatient ward staffing and the day case/haemodialysis bay staffing. Consistent Plan, Do, Study, Act (PDSA) cycles and implementation of change is required to realise improvement on quality indicators. Staff sickness remains consistently elevated, with sickness management required to see improvement.

4.6.9 Whilst the SNCT recommendations for Mount McMaster is to reduce staffing, the wards position in June was unusual with 21% empty beds, a reduction in level 1c patients and no telemetry patients. Separation of the budgets for the inpatient staffing and clinic activity remains outstanding in order to obtain accurate CHPPD. Establishment is **recommended to stay the same,** with a trial of changing one RN to one HCSW at nights to support patient dependency. Care Group to complete an EQIA for the Chief Nurses approval.

4.6.10 St Lawrence ward has seen an increase in patient dependency. The speciality of the ward is continuously evolving, despite the ward being referred to as a Medically Fit for Discharge (MFFD) ward. **Recommendation is to increase by one HCSW at night** to support enhanced care requirements and maintain quality.

4.7 Women, Children & Young People (WC&YP) Care Group

4.7.1 Despite recommendations and continued escalation for the budget to be separated, Birchington's establishment still shows staff for both inpatient and outpatient activity. This now urgently requires separating and aligning to the recommendations approved in the January 2024 review. For the inpatient activity, increasing patient complexity continues due to a high number of medical/surgical outliers being placed within the ward, including patients outside of the recommended criteria for admission. Despite a significant improvement in the sickness from 11.7% in January to 3.3% in June, the impact of patients outside speciality being admitted to the ward an extra HCSW continues to be utilised every night to maintain patient safety. A recent review of the outpatient area within the unit has demonstrated the current clinic activity requires 163 hours of inpatient staffing resource to support. **Recommendation is to increase by 4.29 wte,** with 1.53 wte required for registered staffing and 2.77 wte required for HCSW to support both inpatient and outpatient activity. This includes the increase of one HCSW at night to support complexity of patient mix and quality of care on the ward.

4.7.2 The establishment for both Rainbow and Padua is **recommended to remain the same** overall to ensure that staffing is mainly compliant with Royal College of Paediatrics and Child Health (RCPCH) guidelines. The budget urgently needs to be separated to enable rosters to accurately reflect establishment against inpatient, outpatient and day case 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. Rainbow ward saw 35% empty beds during the data collection period but the acuity and dependency level reported felt representative. This was assisted by

the high vacancy rate at the time which was not backfilled with temporary staff (which would have occurred if the ward was at full capacity). Temporary staffing usage for the provision of enhanced care was also not utilised for one-to-one care and meal supervision.

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, which is the same recommendation as per the January 2025 establishment review. The trial of having one HCSW per day and night shift (when able to adopt with staffing levels, rather than two HSCW per day shift) has been undertaken and deemed with feedback and some improvement in quality indicators to be successful. It is expected this will be maintained consistently when recruited to vacancy. Outside of the data collection periods the care Group needs to monitor the activity for triage telephone calls, chemo pump removals and chemo regimes and to determine the workforce demand required to match this additional activity.

6.0 Critical Care, Anaesthetics and Specialist Surgery (CCASS) Care Group

6.1 Rotary ward is a 16 bedded ward, with a layout that affects the ability of staff to be able to see multiple patients at any one time, indicating a high requirement of staff. Since June the ward has seen two complex specialities; ENT and Gynae, with competing patient care needs and with an increase in patient admission and discharge activity. The impact of this on acuity and dependency levels and quality indicators is to be monitored. Rotary ward continues to have staff on the establishment and rota which support both inpatient and outpatient activity, which urgently requires separation to enable key indicators to be monitored effectively. A business case is currently under review for the outpatient staffing. Establishment **is recommended to remain the same.**

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 Emergency Departments.

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

8.1 The SNCT recommends a significant decrease in establishment, which as advised above was noted with caution. ED had two medicine errors, five formal complaints, 100% compliance with sepsis screening and the initial assessment was recorded as 82% completed within time. Two hospital acquired pressure ulcers recorded, which is an improvement however the length of time patients remain in an undesignated care space remains an ongoing issue. Staff sickness improved to 2.4% through good leadership and team support. A recruitment plan has been developed to reduce the vacancy of 10.5%. **The recommendation is for the budgeted establishment to remain the same.**

9.0 Children's ED WHH

9.1 Some of the quality indicators for ED are currently unable to be separated however those that can are reflected. Paediatric ED had three medicine errors and no formal complaints or compliments recorded. Vacancy and turnover remain high, but is being addressed and managed and staff sickness has significantly improved to 2.5%. **The recommendation is for the budgeted establishment to remain the same.**

10.0 Adult ED QEQM

10.1 The SNCT recommends a significant decrease in establishment, which as advised above was noted with caution. Improvements required in SNCT data collection compliance, with support of education, to improve accuracy of SNCT results. ED had seen an overall improvement in quality indicators with three medicine errors, one hospital acquired pressure ulcer, one fall with harm, 10 formal complaints, 91.7% compliance with sepsis screening and the initial assessment was recorded as 97.6% completed within time. Sickness has improved to 3.6%, with stress recorded as the primary reason. A formal recruitment plan requested to support vacancy of 25.2%. **The recommendation is for the budgeted establishment to remain the same.**

11.0 Children's ED QEQM

11.1 Owing to the current configuration within our data systems, some of the quality indicators for the children's ED are currently unable to be separated from the adults, however, those that can are reflected. Children's ED had two medication errors and 0 formal complaints. Sickness has significantly improved to 3.7% with the current vacancy of 21.3% expected to be significantly reduced through the recruitment of the newly qualified nurses. Improvements are required with future data collection compliance to improve accuracy of SNCT results however, an increase in level 1c patients has been observed. **The recommendation is for the budgeted**

establishment to remain the same. This supports the department to have one registered children's nurse at the front door to ensure initial assessment and triage is completed within the 15 minutes as per the Royal College of Emergency Medicine (RCEM) and RCPCH guidance, and additionally allows for a registered children's nurse to attend ED resus as required (geographically distant from children's ED).

12.0 Recommendations

12.1 To proceed with changing the skill mix identified in the following areas:

- Coronary Care Unit – QEQM
- Fordwich – QEQM
- Kingston – K&C
- Cambridge L – WHH

12.2 To correct the error made in the implementation of the January 2024 establishment review for Cambridge M2.

12.3 To utilise the money released from 16.1 to reinvest within some of the areas identified as requiring an increase. These areas to be determined by a further professional judgement review undertaken by the Directors of Nursing and Chief Nurse, which is scheduled for 29 January 2026.

12.4 To continue to support all areas with daily assessment of acuity and dependency and approval of additional staff, as required, to maintain quality and safety.

13.0 Conclusion

15.1 The Trust Board is asked to acknowledge the bi-annual evidence-based nurse staffing review process undertaken in the Trust.

15.2 The Trust Board is asked to approve the recommendations made.

15.3 Work continues to align the ledger and ESR to the approved January 2024 establishment review.

15.4 Work continues to be undertaken to review outpatient activity and to work towards separating out all inpatient and outpatient activity within the budgets.

15.5 Work is being undertaken to support the right skill mix of band 2/3's across clinical areas.

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 EDs undertaken. 6 month bi-annual workforce establishment review to be undertaken in accordance with guidance – January and June 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 safe staffing data collection submitted to Strategic Data Collection Service (SDCS) 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/AMUs and 25% for EDs. Mandatory training available and bookable via ESR system.	Compliance with mandatory training is monitored through the Nursing Scorecard and Trust Dashboards by Care Group Directors of Nursing (DoNs) and ADoNs. Compliance of mandatory and statutory training reviewed at monthly Key Performance Indicator (KPI) meetings and within the bi-annual SNCT© 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, supported 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/Midwifery Advocate.

			Health and Wellbeing team engaged in provision of pastoral care, 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 imbedding. Nursing Scorecard developed with BIU 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. Standard Operating Procedure (SOP) implemented Trust wide. 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. BI powered Nursing Planning Tool to provide oversight of staffing numbers as aligned to Healthroster in advance for early identification of staffing shortfalls and for proactive mitigations.
3.3 Efficient employment and minimising agency	Yes	EKHUFT currently utilises NHS Professionals for Bank staff and ID Medical for agency staff.	Actively recruiting to vacancies. Care Group DoN sign off for all temporary staffing requests implemented early September 2025. Monitoring temporary staffing usage with consideration of impact on continuity and quality of care. BI Powered Premium Pay Dashboard to

		Agency usage for registered and unregistered nurse staffing very minimal.	show weekly and monthly spend for all clinical areas to support oversight and controls. Clear plans in place for remaining areas using agency (ED, AMU and Maternity) for when this will be stopped based on recruitment activity.

Appendix 2 Bed capacity included in the establishment review

Ward	Care Group	Beds
BRABOURNE WARD	DCB	8
CLARKE WARD	KCH	36 (+6 unfunded)
EAST KENT NEURO REHAB	KCH	19
HARBLEDOWN WARD	KCH	24
INVICTA WARD	KCH	24
KENT WARD	KCH	31
KINGSTON WARD	KCH	26
MARLOWE WARD	KCH	27
MOUNT MCMASTER WARD	KCH	22 (+4 unfunded)
ST LAWRENCE WARD	KCH	24
ACUTE MEDICAL UNIT A QEQM	QEQM	30
ACUTE MEDICAL UNIT B QEQM	QEQM	23
BISHOPSTONE WARD	QEQM	24
CHEERFUL SPARROWS WARD FEMALE	QEQM	32
CHEERFUL SPARROWS WARD MALE	QEQM	17
DEAL WARD	QEQM	28
FORDWICH WARD	QEQM	19
QUEX WARD	QEQM	22
SANDWICH WARD	QEQM	21
SEABATHING UNIT	QEQM	32
ST. AUGUSTINES WARD	QEQM	31
ST. MARGARETS WARD	QEQM	24
BIRCHINGTON WARD	WCYP	20 (17+3)
PADUA WARD	WCYP	28
RAINBOW WARD	WCYP	20 (+3 unfunded)
ACUTE MEDICAL UNIT A WHH	WHH	25
ACUTE MEDICAL UNIT B WHH	WHH	26
BARTHOLOMEW WARD	WHH	22
CAMBRIDGE J1 WARD	WHH	20
CAMBRIDGE J2 WARD	WHH	19
CAMBRIDGE K WARD	WHH	27
CAMBRIDGE L WARD	WHH	26
CAMBRIDGE M1 WARD	WHH	18
CAMBRIDGE M2 WARD	WHH	19
CCU - WHH	WHH	10
CCU - QEQM	WHH	13

KENNINGTON WARD	WHH	15
KINGS A2 WARD	WHH	20
KINGS B WARD	WHH	24
KINGS C1 WARD	WHH	27
KINGS C2 WARD	WHH	24
KINGS D1 WARD	WHH	19
KINGS D2 WARD	WHH	25
OXFORD WARD	WHH	14
RICHARD STEVENS WARD	WHH	28
ROTARY WARD	CCASS	16

Appendix 3: Summary of Current and Proposed Nursing Establishments with SNCT Recommendations and Quality Metrics (for In-Patient Wards, AMUs and EDs)

Provided as a separate document

Appendix 4

Setting evidence-based nursing Establishments

In line with the National Quality Board (NQB) guidance, nursing establishments at EKHUFT for both 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 full compliance now being achieved.

Appendix 5

Establishment Review for existing adult and children's Inpatient areas & ED June 2025

In-patient ward and AMU data collection began on 2 June 2025 and was completed on 1 July 2025.

ED data collection began on the 16 June 2025 and for WHH was completed on the 27 June 2025. The ED QEQM data collection period was extended due to challenges within the department and data non-compliance, with data collection complete by mid-July to capture the full 24-hour period required.

The results of the SNCT© were then analysed for each clinical area manually by the 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 RCN has recently updated its Workforce Standards and are recommending a minimum of 27% uplift to be applied. Whilst this is professional guidelines and not policy, it should be given consideration for future establishment reviews.

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, senior leadership for all clinical areas were provided with access to roster templates to present any recommended changes.

Check and confirm meetings were scheduled and held with each clinical area across September 2025, with a few delayed meetings held in early October 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 as where Individual ward environments and layouts.

The quality metrics considered for each adult and child in-patient area as applicable were: statutory training; mandatory training; Infection Prevention and Control (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; 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.

Since the completion of the review of the National Profile Change for Band 2/3 Health Care Support Workers (HCSWs) a one-off back pay arrangement has been agreed as a system. This payment was made in September 2025. However, there have been problems identified with some staff being over or underpaid, as well as receiving no payment. Work is nearing completion to rectify any discrepancies, as well as confirming the ratio of Band 2/3 HCSW skill mix with finance colleagues.

The Provider Workforce Returns (PWR) data shows a 20% HCSW vacancy factor (270 WTE), which makes EKHUFT an outlier within the region according to NHS England (NHSE) South East (SE) Nursing Workforce Team. The reasons for this are multifactorial but include the holding of Band 2/3 HCSW vacancies due to the National Profile Change and more recently the Band 4 Associate Practitioner consultation which is now nearing completion. There have been several Band 2/3 HCSW recruitment events held with further ones planned for February 2026, as well as individual care group recruitment so it is envisaged this will positively impact the vacancy factor.

To recruit all of the newly registered nurses at band 5 in September 2025, in line with the National ask, an agreement was made with Finance to temporarily utilise some band 4 posts using a 1.5 conversion rate. Care Groups hold responsibility for monitoring this and ensuring that individuals recruited into any converted band 4 posts are moved into available band 5 posts as soon as staff turnover allows.

Recent reviews for Outpatients, Renal and Cardiology have been undertaken with initial findings presented to care groups. Based on the recommendations they are leading workstreams to ascertain the workforce required to deliver sustainable services and will be presenting these findings.

APPENDIX 6: Care Group Recommendations

Whereby there are recommended changes to support quality, these have been concluded as below (Table 1). All values indicated are correct to two decimal places.

Care Group	Staff Group	Current (2dp)	Proposed (2dp)	Difference (2dp)
W, C&YP	Registered	106.19	107.72	+1.53
	HCSW	42.38	45.15	+2.77
	Total	148.60	152.89	+4.29
K&C	Registered	270.18	267.56	-2.62
	HCSW	140.16	148.02	+7.86
	Total	410.37	415.61	+5.24
WHH (AIPW & AMUs)	Registered	512.88	510.26	-2.62
	HCSW	273.94	269.7	+4.24
	Total	778.43	780.03	+1.6
QEQM (AIPW & AMUs)	Registered	350.65	348.91	-1.74
	HCSW	194.79	200.97	+6.18
	Total	545.47	549.91	+4.44

Table 1 – Care Group Recommendations

Consideration needs to be given to review the proposed aspiration from the January 2024 establishment review, 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. It is recognised that the updated Royal College of Nursing (RCN) workforce standards (2025) are recommending a minimum uplift of 27%.

APPENDIX 7: Finance

Using the information provided above the costs have been calculated using the 2025/26 Agenda for Change (AFC) payscales and the mid-point of the appropriate Pay Band (demonstrated in table 2 below).

Caregroup	Staff Group	Current £,000	Proposed £,000	Change £,000	Wards with proposed changes
W,C&YP	HCSW	610.5	733.8	123.3	
	Registered	1,251.9	1,251.9	.	1
	Total	1,862.4	1,985.7	123.3	
K&C	HCSW	1,880.8	2,237.7	356.9	
	Registered	4,381.2	4,231.4	(149.7)	3
	Total	6,261.9	6,469.1	207.2	
WHH	HCSW	1,734.3	2,023.4	289.2	
	Registered	4,192.4	4,066.5	(125.8)	3
	Total	5,926.6	6,089.9	163.3	
QEQM	HCSW	2,385.4	2,570.9	185.4	
	Registered	6,102.0	6,037.9	(64.1)	4
	Total	8,487.4	8,608.8	121.4	
Total		**22,538.4**	**23,153.5**	**615.2**	**11**

Table 2 – Costs as per care group recommendations

Included in the above in the WHH HCSW line is a 1.5 wte and £75k correction from the January 24 review (Cambridge M2 weekend roster correction) which is yet to be rectified in the ledger.

A further break down (in table 3 below) demonstrates the impact of the changes requested by area; firstly, outlining those where a reduction has been requested and then those with an increase.

Caregroup	Department	Original £,000	New £,000	Change £,000
QEQM	CORONARY CARE UNIT - QEQM	1,340.7	1,249.6	(91.1)
QEQM	FORDWICH WARD - QEQM	2,399.7	2,374.3	(25.5)
K&C	KINGSTON WARD - K&C	2,475.2	2,444.5	(30.8)
WHH	CAMBRIDGE L WARD - WHH	2,353.4	2,322.9	(30.6)
	Wards - Reduced budget	**8,569.1**	**8,391.2**	**(177.9)**
WHH	CAMBRIDGE M2 WARD - WHH	1,495.3	1,570.2	74.9
K&C	KENT WARD - K&C	2,103.3	2,222.3	119.0
K&C	ST LAWRENCE WARD - K&C	1,683.3	1,802.3	119.0
WHH	CAMBRIDGE K WARD - WHH	2,077.9	2,196.8	119.0
QEQM	DEAL WARD - QEQM	2,313.4	2,432.4	119.0
QEQM	SEABATHING WARD - QEQM	2,433.6	2,552.6	119.0
W, C&YP	BIRCHINGTON WARD - QEQM	1,862.4	1,985.7	123.3
	Wards - Increased budget	**13,969.3**	**14,762.3**	**793.1**
Total	**Total - Net impact**	**22,538.4**	**23,153.5**	**615.2**

It is recognised a number of the changes requested are favourable from both a quality and safety perspective and a financial one. However, others, whilst supporting an expected improvement in quality and safety, have a financial impact associated, some of which is already impacting owing to the use of temporary spend.

SNCT JUNE 2025

Ward	Care Group	Speciality	Budget Code	Beds	Clinics	IPC compliance	Statutory Training	Mandatory Training	Falls with harm	Pressure ulcers hospital acquired	Medication errors	Compliments	Complaints	Roster red flags	Vacancy	Sickness	Turnover	CHPPD	Current Establishment
BRABOURNE WARD	DCB	Haematolog	3335	8	No	95.0%	93.1%	93.0%		4		38	1	1	9.3%	6.5%	0.0%	8.9	18.93
CLARKE WARD	KCH	Surgical	2157	36 (+6)	No	100.0%	97.7%	94.8%	1	3		2			9.0%	4.8%	7.5%	8.0	50.36
EAST KENT NEURO REHAB	KCH	Neuro	1259	19	No	97.1%	92.9%	89.6%				36		2	10.0%	3.5%	11.6%	9.0	37.27
HARBLEDOWN WARD	KCH	Stroke	1479	24	ho team	100.0%	98.8%	97.8%			3		1		36.0%	2.3%	4.6%	11.3	61.84
INVICTA WARD	KCH	T&O	2571	24	ut school	96.9%	97.7%	95.7%		1	2	253	0		7.3%	4.2%	0.0%		34.92
KENT WARD	KCH	Vascular	2165	31	No	100.0%	92.0%	88.9%		1	2			5	24.1%	4.6%	14.9%	6.7	43.50
KINGSTON WARD	KCH	Stroke	1472	26	No	97.6%	99.1%	94.9%		2		135	0		21.2%	3.1%	6.0%	8.8	51.16
MARLOWE WARD	KCH	Renal	1240	27 (+4)	lysis bay	100.0%	92.3%	85.8%			1	15		7	7.4%	7.7%	5.2%	6.7	51.55
MOUNT MCMASTER WARD	KCH	Medical	1466	22 (+4)	No	100.0%	98.4%	96.4%			1	46	1		2.2%	1.3%	2.2%	11.1	45.12
ST LAWRENCE WARD *6 June-6 July	KCH	MFFD	2570	24	No	100.0%	95.4%	94.5%		2				2	14.8%	6.1%	7.7%	6.0	34.65
ACUTE MEDICAL UNIT A QEQM	QEQM	AMU	1626	30	No	98.4%	92.0%	90.8%		3	1		1	9	14.2%	4.8%	12.9%	8.2	71.18
ACUTE MEDICAL UNIT B QEQM	QEQM	AMU	1227	23	No	96.0%	92.5%	89.7%			3		2	41	4.0%	2.5%	9.0%	9.2	53.47
BISHOPSTONE WARD	QEQM	Surgical	2574	24	No	100.0%	97.1%	94.5%		4	2	18		2	4.1%	3.1%	8.8%	7.0	36.35
CHEERFUL SPARROWS WARD FEMALE	QEQM	Surgical	2156	32	No	96.0%	92.3%	91.2%		4		32	1	8	5.7%	9.4%	9.0%	6.8	52.98
CHEERFUL SPARROWS WARD MALE	QEQM	Medical	2164	17	No	100.0%	98.8%	89.7%			1	23			-7.1%	8.3%	0.0%	7.7	29.41
DEAL WARD *9 June-8 July	QEQM	Medical	1233	28	No	97.7%	96.3%	91.6%				28	0	20	11.3%	3.4%	3.7%	37.6	47.74
FORDWICH WARD	QEQM	Respiratory/	1470	19	No	97.8%	97.5%	91.8%				697	1	10	0.4%	5.0%	11.3%	11.6	48.54
QUEX WARD	QEQM	Frailty/HCOO	1484	22	No	94.6%	89.9%	81.0%			1				-0.7%	6.6%	1.8%	9.4	38.30
SANDWICH WARD	QEQM	Medical/Pal	1231	21	No	97.4%	96.1%	87.7%		2		102	0	1	-231.9%	2.2%	11.6%	8.3	34.69
SEABATHING UNIT	QEQM	Surgical	2560	32	No	98.0%	92.9%	88.4%			2	60	2	17	7.9%	5.2%	19.0%	7.6	50.36
ST. AUGUSTINES WARD	QEQM	Medical	1483	31	No														39.95
ST. MARGARETS WARD	QEQM	Medical	1232	24	No	100.0%	98.0%	92.2%			1	153		1	15.7%	3.0%	4.4%	7.7	42.50
BIRCHINGTON WARD	WCYP	Womens	3224	20 (19+1)	Yes	98.1%	95.7%	93.8%			1	5	2	13	-14.8%	3.3%	6.3%	8.1	38.13
PADUA WARD	WCYP	Childrens	3116	28	Yes	98.2%	98.6%	97.7%			5		2		12.8%	4.2%	3.6%	11.5	55.53
RAINBOW WARD	WCYP	Childrens	3121	20 (+3 unfunded)	Yes	98.0%	96.1%	97.5%			1	32	1		20.5%	9.5%	8.4%	7.7	54.94
ACUTE MEDICAL UNIT A WHH	WHH	AMU	1621	25	No	99.4%	94.6%	90.6%			3		1	24	-141.2%	3.1%	8.4%		55.01
ACUTE MEDICAL UNIT B WHH	WHH	AMU	1625	26	No	100.0%	94.6%	90.6%		1	1			65	-130.2%	5.3%	9.0%	9.9	53.01
BARTHOLOMEW WARD	WHH	Cardiology	1207	22	No	100.0%	96.0%	95.4%		2	1			1	7.5%	2.2%	11.4%	6.6	34.65
CAMBRIDGE J1 WARD	WHH	Medical	1453	20	No	97.2%	93.8%	91.6%	3	2	2		1	1	9.8%	7.4%	4.3%	8.3	39.88
CAMBRIDGE J2 WARD	WHH	Respiratory/	1205	19	No	95.7%	94.0%	93.0%				3	1		6.7%	2.6%	3.9%	10.1	47.74
CAMBRIDGE K WARD	WHH	Medical	1208	27	No	100.0%	96.2%	89.8%		3	2		2		11.2%	1.9%	5.7%	7.1	42.50
CAMBRIDGE L WARD	WHH	Medical	1452	26	No	100.0%	96.8%	94.1%	1	2	1		0	1	10.9%	3.3%	3.7%	8.6	47.74
CAMBRIDGE M1 WARD	WHH	Medical	1206	18	No	100.0%	98.2%	95.8%		1	1		1	4	2.1%	8.5%	3.5%	7.4	32.03
CAMBRIDGE M2 WARD	WHH	Gastro	1209	19	No	100.0%	98.6%	94.9%		3	3	40		7	-2.5%	4.3%	3.2%	6.9	30.53
CARDIAC CARE UNIT - WHH	WHH	Cardiology	1214	10	PPCI/Tel	100.0%	100.0%	97.5%						1	11.3%	0.5%	3.5%	15.8	32.03
CCU - QEQM	WHH	Cardiology	1215	13	No	100.0%	99.0%	97.7%		2	1	186		2	18.5%	5.2%	14.3%	8.6	26.68
KENNINGTON WARD	WHH	Frailty/Palli	1486	15	No	97.0%	94.7%	95.7%			3		0	11	0.9%	3.1%	3.2%	8.9	29.41
KINGS A2 WARD	WHH	Surgical	2358	20	No	97.2%	95.8%	91.7%		2	2	4	2	2	-4.3%	12.3%	8.2%	7.3	34.65
KINGS B WARD	WHH	Surgical	2167	24	No	100.0%	93.8%	96.1%		4	1			10	11.2%	3.2%	2.3%	6.7	37.27
KINGS C1 WARD	WHH	T&O	2555	27	No	100.0%	96.4%	92.0%		6	3			26	6.9%	8.4%	6.0%	7.4	45.12
KINGS C2 WARD	WHH	Medical	1485	24	No	100.0%	98.5%	97.2%			2			7	14.1%	5.5%	10.3%	6.6	37.27
KINGS D1 WARD	WHH	Surgical	2557	19	No	100.0%	96.9%	95.1%		1					14.2%	3.2%	0.0%		37.27
KINGS D2 WARD	WHH	Surgical	2573	25	No	96.6%	91.8%	86.6%		1	2	4	1	12	17.1%	4.1%	16.5%	7.2	32.03
OXFORD WARD	WHH	IPC	1230	14	No	100.0%	97.0%	92.0%		1	2		1	1	23.8%	5.4%	5.5%	10.9	37.27
RICHARD STEVENS WARD	WHH	Medical	1474	28	No	100.0%	95.1%	89.7%		2	1		2		28.6%	3.0%	9.6%	7.8	46.34
ROTARY WARD	CCASS	ENT	1613	16	Yes	97.7%	95.9%	88.0%	1	3				1	8.5%	3.6%	6.6%	11.5	42.88

Ward	Proposed Establishment January 2025			SNCT Recommended Establishment June 2025			Shift Detail		Check & Confirm Recommended Establishment June 2025 (22% headroom)			Sensecheck			
	Registered	Unregistered	Total	Registered	Unregistered	Total	Day Recommendation	Night Recommendation	Registered	Unregistered	Total	Skill Mix	N:P ratio (Day)	Check & Confirm Date	Outcome
BRABOURNE WARD	12.95	5.99	18.93	12.00	6.46	18.46	1 NIC 2 Reg, 1 HCSW	2 Reg, 1 HCSW	12.95	5.99	18.93	77/23	1:3.2	05/09/2025	Same
CLARKE WARD	32.03	18.33	50.36	30.00	16.16	46.16	1 NIC 6 Reg, 4 HCSW	1 NIC 4 Reg, 3 HCSW	32.03	18.33	50.36	67/33	1:5	05/09/2025	Same
EAST KENT NEURO REHAB	24.17	13.09	37.27	23.41	12.61	36.02	1 NIC 4 Reg, 3 HCSW	4 Reg, 2 HSCW	24.17	13.09	37.27	65/35	1:3.8	05/09/2025	Same
HARBLEDOWN WARD	46.12	15.71	61.48	27.60	14.86	42.46	1 NIC 7 Reg, 3 HCSW	1 NIC 4 Reg, 3 HCSW	46.12	15.71	61.84	75/25	1:3	05/09/2025	Same
INVICTA WARD	21.83	13.09	34.92	20.83	11.22	32.05	1 NIC 4 Reg, 3 HCSW	3 Reg, 2 HCSW	21.83	13.09	34.92	65/35	1:3.8	05/09/2025	Same
KENT WARD	27.79	15.71	43.5	38.69	20.83	59.52	1 NIC 5 Reg, 4 HCSW	4 Reg, 3 HCSW	27.79	18.33	46.12	60/40	1:4.6	05/09/2025	Increase 2.62 HCSW night
KINGSTON WARD	30.21	20.95	51.16	31.83	17.14	48.96	1 NIC 6 Reg, 4 HCSW	4 Reg, 4 HCSW	30.21	20.95	51.16	58/42	1:3.7	05/09/2025	Same - Decrease 1 x RN night & Increase 1 x HCW n
MARLOWE WARD	34.45	17.1	51.55	26.94	14.50	41.44	1 NIC 5 Reg, 3 HCSW	4 Reg, 2 HSCW	34.45	17.1	51.55	66/34	1:4.9	05/09/2025	Same
MOUNT MCMASTER WARD	29.41	15.71	45.12	22.47	12.10	34.57	1 NIC 5 Reg, 4 HSCW	5 Reg, 2 HSCW	29.41	15.71	45.12	65/35	1:3.7	05/09/2025	Same
ST LAWRENCE WARD *6 June-6 July	21.55	13.09	34.65	25.11	13.52	38.62	1 NIC 4 Reg, 3 HCSW	3 Reg, 2 HCSW	21.55	15.71	37.27	62/38	1:4.8	05/09/2025	Increase 2.62 HCSW night
ACUTE MEDICAL UNIT A QEQM	52.1	19.1	71.2	40.55	21.83	62.38	M-F 1 NIC 9 Reg, 3 H	1 NIC 8 Reg, 4 HCSW	52.1	19.08	71.18	74/26	1:3	11/09/2025	Same
ACUTE MEDICAL UNIT B QEQM	35.1	18.3	53.5	34.50	18.58	53.07	1 NIC 6 Reg, 4 HSCW	1 NIC 5 Reg, 3 HCSW	35.13	18.33	53.47	64/36	1:3.3	11/09/2025	Same
BISHOPSTONE WARD	23.26	13.09	36.35	26.88	14.47	41.35	1 NIC 3 Reg, 1 RNA 5	4 Reg, 2 HCSW	23.26	13.09	36.35	64/36	1:4.4	02/09/2025	Same
CHEERFUL SPARROWS WARD FEMALE	32.03	20.95	52.98	35.10	18.90	54.00	1 NIC 6 Reg, 4 HCSW	5 Reg, 4 HCSW	32.03	20.95	52.98	60/40	1:4.6	02/09/2025	Same
CHEERFUL SPARROWS WARD MALE	18.93	10.48	29.41	19.21	10.35	29.56	1 NIC, 3 Reg, 2 HCSW	3 Reg, 2 HCSW	18.93	10.48	29.41	62/38	1:4.3	02/09/2025	Same
DEAL WARD *9 June-8 July	29.41	20.95	50.36	34.57	18.62	53.19	1 NIC 5 Reg, 4 HCSW	5 Reg, 4 HCSW	29.41	20.95	50.36	58/42	1:4.7	02/09/2025	Increase 2.62 HCSW night
FORDWICH WARD	34.71	15.71	50.42	27.64	14.88	42.52	1 NIC 5 Reg, 3 HCSW	1 NIC 5 Reg, 3 HCSW	32.03	15.71	47.74	67/33	1:3.2	02/09/2025	Decrease overall establishment by 0.8 wte. Decrea
QUEX WARD	24.17	18.33	42.5	25.54	13.75	39.28	1 NIC 4 Reg, 4 HCSW	4 Reg, 3 HCSW	22.11	16.19	38.3	57/43	1:4.4	16/10/2025	Same
SANDWICH WARD	24.17	15.71	39.88	27.35	14.73	42.08	1 NIC 4 Reg, 3 HCSW	4 Reg, 3 HCSW	20.86	13.82	34.69	61/39	1:4.2	02/09/2025	Same
SEABATHING UNIT	32.03	20.95	52.98	37.61	20.25	57.87	1 NIC 6 Reg, 4 HCSW	5 Reg, 4 HCSW	32.03	20.95	52.98	59/41	1:4.3	02/09/2025	Increase 2.62 HCSW night
ST. AUGUSTINES WARD	24.17	20.95	45.12				1 NIC 5 Reg, 3 HCSW	4 Reg, 3 HCSW	24.23	15.71	39.95	61/39	1:5.2	N/A	Same
ST. MARGARETS WARD	26.79	15.71	42.50	30.36	16.35	46.71	1 NIC 4 Reg, 3 HCSW	4 Reg, 3 HCSW	26.79	15.71	42.50	61/39	1:4.8	02/09/2025	Same
BIRCHINGTON WARD				17.44	9.39	26.84	1 NIC 3 Reg, 3 HCSW	1 NIC 2 Reg, 2 HCSW	24.12	18.30	42.42	65/35	1:4	18/09/2025	Increase by 4.29 - Reg 1.53 & HCSW 2.77
PADUA WARD	44.72	10.8	55.53	21.9	11.1	33.0	1 NIC 6 Reg, 2 HCSW	1 NIC 6 Reg, 1 HCSW	44.72	10.8	55.53	81/19	1:4	02/10/2025	Same
RAINBOW WARD	38.88	16.05	54.94	16.6	8.4	25.0	1 NIC 5 Reg, 2 HCSW	1 NIC 4 Reg, 1 HCSW	38.88	16.05	54.94	71/29	1:4	29/09/2025	Same
ACUTE MEDICAL UNIT A WHH	39.27	15.71	[illegible]	28.45	15.32	43.77	1 NIC 6 Reg, 3 HCSW	1 NIC 6 Reg, 3 HCSW	39.3	15.71	55.01	71/29	1:3.6	12/09/2025	Same
ACUTE MEDICAL UNIT B WHH	37.27	15.71	52.98	32.80	17.66	50.46	1 NIC 6 Reg, 3 HCSW	1 NIC 6 Reg, 3 HCSW	37.3	15.71	53.01	70/30	1:3.7	12/09/2025	Same
BARTHOLOMEW WARD	24.17	10.48	34.65	21.03	11.32	32.35	1 NIC 4 Reg, 2 HCSW	1 NIC 3 Reg, 2 HCSW	24.17	10.48	34.65	70/30	1:4.4	10/09/2025	Same
CAMBRIDGE J1 WARD	24.17	15.71	39.88	27.35	14.72	42.07	1 NIC 5 Reg, 3 HCSW	1 NIC 3 Reg, 2 HCSW	26.79	13.09	39.88	61/39	1:3.3	10/09/2025	Same
CAMBRIDGE J2 WARD	29.41	18.33	47.74	22.51	12.12	34.64	1 NIC 5 Reg, 4 HCSW	5 Reg, 3 HCSW	29.41	18.33	47.73	62/38	1:3.2	12/09/2025	Same
CAMBRIDGE K WARD	26.79	18.33	45.12	34.62	18.64	53.26	1 NIC 5 Reg, 3 HSCW	4 Reg, 4 HCSW	26.79	18.33	45.12	59/41	1:4.5	12/09/2025	Increase 2.62 HCSW night
CAMBRIDGE L WARD	29.41	18.33	47.74	40.69	21.91	62.59	1 NIC 5 Reg, 4 HCSW	5 Reg, 3 HCSW	29.41	18.33	47.74	62/38	1:4.3	18/09/2025	Same - move 1 x RN to 1x HCSW
CAMBRIDGE M1 WARD	18.93	13.09	32.03	22.30	12.01	34.31	1 NIC 3 Reg, 3 HCSW	3 Reg, 2 HCSW	18.93	13.09	32.03	57/43	1:4.5	18/09/2025	Same
CAMBRIDGE M2 WARD	18.33	13.09	32.03	17.09	9.20	26.29	1 NIC 3 Reg, 3 HCSW	3 Reg, 2 HCSW	18.93	13.09	32.03	57/43	1:4.75	01/10/2025	Increase HCSW by 1.5 to rectify previous error
CARDIAC CARE UNIT - WHH	26.79	5.24	32.03	12.30	6.62	18.92	1 NIC 4 Red, 3 HCSW	1 NIC 4 Red, 3 HCSW	26.79	5.24	32.03	84/16	1:2	10/09/2025	Same
CCU - QEQM	19.73	6.03	25.76	15.70	8.45	24.15	1 NIC 3 Reg, 1 HCSW	1 NIC 2 Reg, 1 HCSW	18.93	5.24	24.17	78/22	1:3.25	10/09/2025	Decrease HCSW 2.5 wte
KENNINGTON WARD	18.93	10.48	29.41	18.90	10.18	29.07	1 NIC 3 Reg, 2 HCSW	3 Reg, 2 HCSW	18.93	10.48	29.41	64/36	1:3.75	25/09/2025	Same
KINGS A2 WARD	21.55	13.09	34.65	21.07	11.35	32.42	1 NIC 4 Reg, 2 HSCW	3 Reg, 2 HCSW	21.55	13.09	34.65	62/38	1:4	25/09/2025	Same
KINGS B WARD	24.17	13.09	37.27	24.37	13.12	37.49	1 NIC 4 Reg, 3 HCSW	1 NIC 3 Reg, 2 HCSW	24.17	13.09	37.27	64/36	1:4.8	01/10/2025	Same
KINGS C1 WARD	29.41	20.95	50.36	35.50	19.12	54.62	1 NIC 5 Reg, 4 HCSW	4 Reg, 3 HCSW	26.79	18.33	45.12	59/41	1:4.5	25/09/2025	Same
KINGS C2 WARD	24.17	13.09	37.27	31.99	17.23	49.22	1 NIC 4 Reg, 3 HCSW	4 Reg, 2 HCSW	24.17	13.09	37.27	65/35	1:4.8	25/09/2025	Same
KINGS D1 WARD	24.17	15.71	39.88	21.52	11.59	33.11	1 NIC 4 Reg, 2 HCSW	4 Reg, 2 HCSW	24.17	13.09	37.27	65/35	1:3.8	26/09/2025	Same
KINGS D2 WARD	18.93	15.71	34.65	25.95	13.97	39.92	1 NIC 3 Reg, 3 HCSW	3 Reg, 2 HCSW	18.93	13.09	32.03	59/41	1:4.75	25/09/2025	Same
OXFORD WARD	24.17	13.09	37.27	18.38	9.90	28.28	1 NIC 4 Reg, 3 HCSW	4 Reg, 2 HCSW	24.17	13.09	37.27	65/35	1:2.8	23/09/2025	Same
RICHARD STEVENS WARD	30.63	15.71	46.34	30.75	16.56	47.31	1 NIC 5 Reg, 3 HCSW	1 NIC 4 Reg, 3 HCSW	30.63	15.71	46.34	61/39	1:4.7	23/09/2025	Same
ROTARY WARD	25.15	17.73	42.88	17.76	9.56	27.32	1 NIC 4 Reg, 2 HCSW	4 Reg, 2 HCSW	25.15	17.73	42.88	57/43	1:3.2	04/09/2025	Same

Ward	Narrative & Comments
BRABOURNE WARD	Successful trial of 1 x HCSW day & night when able to adopt with staffing levels - to maintain with consistency. New pt presentations seen. P/U x4 June from x1 Jan - related to Miami J collar pt - pre-irp and learning for ward evident. Sickness increased to 6.5% June from 2.9% Jan, first sickness reviews completed & being managed. Data from the SACT telephone triage service informed additional activity undertaken on the ward out of hours and at weekends in addition to outpatient activity at weekends -e.g chemotherapy pump removals.
CLARKE WARD	Quality indicators improving - to continue with this work. CG/Ops to investigate & review bed usage & additional lists.
EAST KENT NEURO REHAB	Stat & Mand training requires attention. B2/3 skill mix to be reviewed. Give consideration to blended staffing model with therapy input. Quality indicators great for June - to be maintained.
HARBLEDOWN WARD	Quality indicators - 6 falls (Jan & June) altho not with harm - to ascertain trend/location of incidents to identify improvements. Meds, Jan x1 & June x3. Vacancy 36% - to recruit to ICB Thrombolysis funding & reduce reliance on temp staffing. Sickness improved. To work towards seperating budgets for thrombolyis staffing and inpt staffing - to explore seperated healthrosters to achieve accurate data/CHPPD. Staffing 61.84 + 6.0 ICB funded (Ward staffing Reg 34.65, HCSW 15.71, Total 50.36. Stroke Thrombolysis 10.48 + 6.0 ICB. Stroke Liason 1.0)
INVICTA WARD	Variable theatre activity - anticipated. 180 telephone calls per month & 4 x sessions joint school.
KENT WARD	Increase in activity & A&D. To continue to make quality improvements. Risk at night to be mitigated by extra HCSW. To complete Time & Motion study on ward - Adam to action. CG decision on use of unfunded beds to be made.
KINGSTON WARD	0.8 Stroke Liason nurse. Trial of moving 1 x RN? to 1 x HCSW at night successful - to be implemented with permanent skill mix change. To monitor quality indicators.
MARLOWE WARD	Request submitted for budgets & rosters to be seperated for inpt service & day case & HD services. Progress still required on quality indicators - consistent PDSA & implementation of change to realise improvement. Need to gain grip & control of sickness management. Katy & CG to discuss staffing further.
MOUNT MCMASTER WARD	To separate budgets for clinics & inpt ward to generate accurate data/CHPPD. CHPPD 11.1. To review skill mix of B2/3 & B3 capabilities. June - 22% empty beds, no telemetry patients, no 1:1 pts. To trial within establishment the move of 1 x reg to 1 x HCSW at night - to QIA.
ST LAWRENCE WARD *6 June-6 July	High dependency ward. Speciality of ward still evolving - anticipating elective ward on the orthopaedic pathway.
ACUTE MEDICAL UNIT A QEQM	Education team (1x B7 & 2 x B6 supporting AMU A/B & SDEC). ? Data collection issue - 4.7% empty beds doesn't feel representative. Increased level 1b pts. Falls x 4 June & P/U x3 (x1 Jan) - same as AMU B. Meds errors - ? if true data. Sickness improved from 11.7% to 4.8%. Vacancies, to be mitigated by Oct, x5 to start. Escort activity - unpredicatable but mitigated by education team. Over budget on B6's.
ACUTE MEDICAL UNIT B QEQM	Good stat/mand compliance. Falls x6 in June - mitigations implemented - falls teaching & DRA. P/U's improvements - recognised need for early identification & staff have worked through this - Jan = 7 & June = 0. Sickness improved 7.1% to 2.5%. Monitor complex patients with increased LOS, level 1c increased.
BISHOPSTONE WARD	Concerns around P/U - repositioning & completion of Purpose T. Inc Falls - no harm. Escorts to WHH 6-7 p/m. Need to provide quality detail & triangulation with need. Change Late day shift to early shift. Mobilise staff across surgical floor & assess impact. Raise red flags as appropriate.
CHEERFUL SPARROWS WARD FEMALE	Focus on quality metrics & realise improvement - Inc P/U, Meds errors & sickness. 1 x week ERCP WHH, RN 12 hrs needed.
CHEERFUL SPARROWS WARD MALE	Positive improvement on quality, testiment to leadership. Escort hrs were expected to decrease, but challenge has increased. Was 20 hrs per week and is now average 150 hours per month. Connsideration for surgical floor staffing to be mobilised to support challenge.
DEAL WARD *9 June-8 July	Unpredictable pt needs with high enhanced care needs - younger pts. Quality indicators improving. Increase to 4 HCSW @ night - increase by 2.62 HCSW. B2/3 ratio - further review needed, B3 15.71 & B2 5.24.
FORDWICH WARD	Quality indicators improving. 24/7 NIC cover - B6 5.24 wte needed. Adjust roster template & remove unfunded template. Allocate B7 clinical shifts as B6 NIC.
QUEX WARD	To redo 2 wk data collection for Frailty 16-17 beds. High enhanced obs. SDEC 33% pts bedded is the expectation. Initial data suggested 51% pts bedded, 17% amber enhanced obs, 122 pts/8.7 pts avg per day. Continue to use temp staffing as required. To complete full data collection with amended template in June - clear activity for Inpt/SDEC. To identify tasks for roles working in SDEC. SDEC 10 chairs.
SANDWICH WARD	Only 10.5 WTE substantively funded. Review required B2/3 ratio.
SEABATHING UNIT	Quality indicators improved by shift organisation & leadership. Bay 3 enablement bay x6 pts supporting improvements in LOS & prevening community admissions. Inc 1 x HCSW @ night to 4 HCSW's.
ST. AUGUSTINES WARD	Ward closed during SNCT data collection due to Fire works programme.
ST. MARGARETS WARD	SNCT recommends slight increase. Quality indicators stable. Good skill mix for 24 beds. Red flag reporting needed if concerned. Current template utilised 39.88 (Reg 24.17 & HCSW 15.71) - budgeted for 42.50 - impacting on fill rates
BIRCHINGTON WARD	High number of inappropriate patients being admitted - medical outliers. Need to datix. Continued work required with site team for admission criteria. Increased complexity of pts noted within last 3 SNCT reviews. Inpt & clinic staffing still not split by finance - continued escalation. 163 hrs staffing to support clinic activity. Recommendation to increase by 1 x HCSW at night. Sickness improved Jan 11.7%, June 3.3%. Vacancy of -14.8% not a true value - will resolve once budgets split.
PADUA WARD	To fill vacancies. Red flags not utilised on SafeCare - to use. To work towards seperating out budgets for inpt & clinic activity.
RAINBOW WARD	Budget incl's staffing for Dolphin, Rainbow & all OPD. Seperation of budgets in progress for OPD services. Vacancy 20.5% - recruited NQN, still 6.5 WTE HCSW vacancy to recruit too. 35% empty beds - representative A&D. Meds errors - increased reporting required. Staff sickness 9.5% to manage.
ACUTE MEDICAL UNIT A WHH	Workforce modelling, staffing demand, implications on quality & governance required. ESR/Finance not split for AMU A/B/SDEC/AAU - to be managed by KP/ZO. Quality metrics combined with AMU B still. Sickness improved. CHPPD high due to turnover of an AMU.
ACUTE MEDICAL UNIT B WHH	Workforce modelling, staffing demand, implications on quality & governance required. ESR/Finance not split for AMU A/B/SDEC/AAU - to be managed by KP/ZO. 1 x PDN & 1 x CSLF incl to cover AMU floor. Quality metrics combined with AMU B still. Sickness improved. CHPPD high due to turnover of an AMU.
BARTHOLOMEW WARD	No falls with harm in June. Fire escape planning has been done - no compartment in the ceiling - cameras now installed - 20 minutes from sprinkler evacuation to ceiling failure.
CAMBRIDGE J1 WARD	Now sharing the endocriniology caseload with CM1 as well as HCOOP capacity. Staff encouraged to increase number of red flags raised. Sometimes patients innapropriatly moved to the ward due to the location of the lock. ?Flex the 6th RN on day to night shift to cover where short.
CAMBRIDGE J2 WARD	Governance process - options appraisal & workforce modelling to be undertaken for potential move to RSU (28 beds - scheduled 8/10). To support staff education on pressure relief for resp pts. Sickness improved 7.5% to 2.6%. 1 x B5 vacancy. CHPPD 10.1 resp ward/NIV. Outreach to other wards to support with resp set up for pts - need to review, pts need to be in right place for care.
CAMBRIDGE K WARD	Governance process to be followed if function of ward changed. High dependency on ward. Positive improvement made in quality metrics. Have been putting out for bank cover for HCSW @ night since Jan review - evidenced in monthly fill rates. 1 x extra HCSW req 24/7 - 1 x HCSW at night supported by DoN at this time.
CAMBRIDGE L WARD	Successful trial of reducing by 1 RN day and increasing by 1 HCSW day - to permanently change. New skill mix 62/38. No neg impact on quality. WM would like a further change at nigth - not supported at this time.
CAMBRIDGE M1 WARD	Patient profile shifting - D&E, HCOOP & Gen Med. To collect data between now & next SNCT on quality indicators & speciality mix of pts. Continue to use temp staffing as required for increased dependency of pts at night.
CAMBRIDGE M2 WARD	12 escorts in April, patients need to be transferred to speciality hospitals. RN escort often required - can be multiple per day. High level of level 0 patients who require additional care. Ward bed base is too small for patient profile.
CARDIAC CARE UNIT - WHH	Unit takes referrals for the primary service. Manager and B6s are covering CADU alongside Bartholowmew Ward. Co-ordinates primary PCI service for Kent. Different activity is logged to be able to determine the need for each aspect of the ward's profile. Same until Cardiology paper approved.
CCU - QEQM	NA cannot administer bloods and critical cardiac drugs - swap B4 to B5 nights. Remove HCSW early shift on days - 2.5 wte reducation. To recruit into B6's 5.24 wte to have senior leadership on all shifts.
KENNINGTON WARD	Finance ledger to be updated - B4 5.24wte. June data not representative - more independent pts than usual, higher level 0 & less level 1b. Good stat/mand. Meds errors x3 (x2 Jan). Sickness good. Tendency to take RN from Kenn to support other wards. To manage/adjust the staff within budget as over established on B5's - minimal vacancy so unable to recruit to B6/B4.
KINGS A2 WARD	Negative vacancy -4.3% previous establishment/mat leave cover/LT sick. Over established B5/6. HCSW vacancy - recruitment event Oct. High sickness 12.3% - pregnancy/surgery. High maternity. Supports VAC assessments for surgical wounds - to capture activity outside ward. P/U Jan x3, June x2. Trial extra HCSW at night (temp staffing use) & measure impact now/with - time & motion study.
KINGS B WARD	RN vacancies for the ward are still to be filled - the ward feel no increase on day required if these are filled. Staff state they are struggling with acuity and are missing tasks. Band 6 post has been vacant, rotating other 6s in to support. 5 x HCSW vacancies to be filled. New manager in post and team behaviours have been unhelpful.
KINGS C1 WARD	Quality indicators of concern. P/U increased Jan x3, June x6. Sickness Jan 7.1% June 8.4% - mainly S/T sick - to be managed. Vacancy 6.9%. Red flags = 26. Higher pt dependency. Cultural shift required on ward - current disconnect. Consider OD input to support WM and team. To complete observations of care & review ASA levels.
KINGS C2 WARD	Due to fire evacuation issues should have 6 staff on ward - risks with fire doors - on risk register - still A/W fire evacuation plan. Significant other risks. Increased level 1b & 1c pts. No falls with harm but do have as longer stay frailty who are encouraged to mobilise/avoid deconditioning with frequent falls observed. Vacancy increased to 14.1% - recruitment plan. Sickness improved from Jan 10.4% to June 5.5%. To datix all pts admitted outside of ward inclusion criteria. Continue to use temp staff - HCSW - as required. To be considered as part of the WHH re-structure/configuration of wards. B4
KINGS D1 WARD	Quality indicators improved. To improve with raising datix's & reporting concerns around meds errors. Completion of RA challenging - system. To use temp staffing for day HCSW as required. To monitor & demonstrate activity as ward recently split & review Jan 2026.
KINGS D2 WARD	Jan recommendation was to increase 1 x HCSW night - not enacted. 105% fill rate HCSW night Aug. First audit of split Q&S indicators - Jan was combined KD1/2. Improvement in quality indicators observed. Does not feel A&D is indicative - fewer 1:1's (1c - Jan 8.9%, June 6.1%. Red flags x12. Meds errors x2. Vacancy 17.1% - HCSW to go on TRAC. Sickness 4.1% - HCSW.
OXFORD WARD	Respiratory & IPC. Roster 1.0 WTE B4 onto days. To review finance ledger as 5.24 WTE B4 under HCA & Other Support. Vacancy 23.8% attributed to HCSW.Stat & Mand good.
RICHARD STEVENS WARD	Mixed patient profile observed on ward. 6 x bariatric pts per month. Due to potential reconfiguration to remain the same and continue with temp staffing usage as required to maintain Q&S. Sickness improved.
ROTARY WARD	Impact of 2 x complex specialities, Gynae & ENT, on A&D and quality indicators to be monitored. To work towards splitting out tbe budgets for inpt activity & clinics. Inpt requires 24.17 Reg & 13.09 HCSW. Total 37.26 wte.

SNCT JUNE 2025

																		Proposed Establishment January 2025			SNCT Recommended Establishment			Shift Detail		Check & Confirm Recommended Establishment June 2025 (25% headroom)						
Ward	Care Group	Budget Code	Daily Avg vs SNCT daily Avg	IPC compliance	Statutory Training	Mandatory Training	Falls with harm	Pressure ulcers hospital acquired	Initial Assessment	Sepsis Screen	Medication errors	Compliments	Complaints	Vacancy	Sickness	Turnover	Current Establishment	Registered	Unregistered	Total	Registered	Unregistered	Total	Day	Night	Registered	Unregistered	Total	Skill Mix	Check & Confirm Date	Outcome	Narrative & Comments
ED ADULTS QEQM	QEQM	1606	173.4 vs 161	98.2%	97.7%	93.6%	1	1	97.6%	91.7%	3	35	10	25.2%	5.8%	6.6%	188.83	132.57	56.27	188.83	51.59	21.84	73.70	1 NIC, 24 Reg (Incl 2 x Late LD & 1 x RMN), 9 HCSW	1 NIC, 22 Reg (Incl 1 RMN), 9 HCSW	132.57	56.27	188.83	70/30	11/09/2025	Same	Real time x 25 vacancies (7xB4, 10xB5 & 8xB6) - need to implement recruitment plan & transfer StAugs x3 B5. Corridor care Huddle & SOP - positive improvement. HCSW in waiting room - ECG improvements & reviewed. Sepsis screen improved >90% National guidance. 1 x falls - unavoidable. Sickness improvements 5.8% to 3.6%. Complaints improving - most 'hot' & able to resolve.
ED PAEDIATRICS QEQM	QEQM	1656	37.6 vs 44	100.0%	95.5%	95.9%					1			21.3%	3.7%	4.0%	29.83	21.78	8.05	29.83	13.75	5.89	19.64	1 NIC, 3 Reg (1x Late LD), 2 HSCW	1 NIC, 2 Reg, 1 HCSW	21.78	8.05	29.83	71/29	11/09/2025	Same	0.8 PDN improved staff stat/mand compliance, Vacancy 21.3% - 3 x NQ due to start. Sickness improved from 9.4% to 3.7%. 1 RN front door, triage within 15 mins, meeting RCEM guidance/support resus. Level 1c patients increased from 3.5% to 11.8%. Must have minimum B6/7 in dept at any one time. Data collection concerns - to improve data compliance. Establishment includes Play Specialist.
ED ADULTS WHH	WHH	1605	168 vs 170.3	98.2%	96.2%	91.0%		2	82.0%	100.0%	2	22	5	10.5%	2.4%	7.2%	207.86	147.14	60.72	207.86	50.98	21.84	72.83	27 Reg (Incl 1 x RMN), 12 HCSW (Incl 2 x MH HCSW)	27 Reg (Incl 1 x RMN), 12 HCSW (Incl 2 x MH HCSW)	147.14	60.72	207.86	71/29	12/09/2025	Same	Ambulance queue is a risk - no staffing provision incl - ? Mitigations. Sickness improved to 2.4% - leadership & team support. P/U's management required - trolleys & mattresses to be addressed & resolved. Data collection good. Capture data/themes on level 1c patients. Minimal vacancies following NQ recruitment - current 10.5% - to advertise any B5's left although minimal and to work out B2/3 vacancies.
ED PAEDIATRICS WHH	WHH	1655	42.6 vs 51.8	96.0%	98.5%	89.2%								11.9%	2.5%	32.7%	26.83	18.78	8.05	26.83	14.28	6.12	20.41	1 NIC, 4 Reg (1 x Late LD) , 2HCSW	1 NIC, 2 Reg, 1 HCSW	18.78	8.05	26.83	70/30	01/10/2025	Same	Work is underway to support medication concern and compliment reporting, which is currently too low for a department of this type. Turnover feels too high for number of staff leaving over 12 months; department to raise with P&C. Work to be done to ensure the good work is displayed within the department.