Board of Directors (BoD) - Open Meeting (Thursday 31 July 2025)

Thu 31 July 2025, 01:00 PM - 04:30 PM

via Webinar videoconference

East Kent Hospitals University NHS Foundation Trust

Agenda

OPENING/STANDING ITEMS

01:00 PM - 01:10 PM
10 min

25/43
Welcome and Apologies for Absence

To Note *Chair*

Verbal

01:10 PM - 01:10 PM
0 min

25/44
Confirmation of Quoracy

To Note *Chair*

Verbal

01:10 PM - 01:10 PM
0 min

25/45
Declaration of Interests

To Note *Chair*

25-45 - BoD register of interests June 2025.pdf (3 pages)

01:10 PM - 01:10 PM
0 min

25/46
Minutes of Previous Meeting held on 5 June 2025

Approval *Chair*

25-46 - Unconfirmed BoD 05.06.25 Open Minutes.pdf (18 pages)

01:10 PM - 01:10 PM
0 min

25/47
Matters Arising from the Minutes on 5 June 2025

Approval *Chair*

25-47 - Front Sheet Open BoD Action Log.pdf (6 pages)

People

01:10 PM - 01:40 PM
30 min

25/48
Staff Story

Discussion *Chief People Officer (CPO)*

Verbal

REGULATORY AND GOVERNANCE

01:40 PM - 01:45 PM
5 min

25/49
Chair's Report

Information *Chair*

Verbal

01:45 PM - 01:55 PM
10 min

25/50
Chief Executive's (CE's) Report

Discussion *Chief Executive*

25-50 - CEO Report to Board 31 July 2025.pdf (6 pages)

01:55 PM - 02:10 PM
15 min

25/51
Integrated Performance Report (IPR)

Discussion *Chief Executive / Executive Directors*

25-51.1 - Front Sheet IPR Jun 25.pdf (3 pages)
25-51.2 - App 1 Board IPR_v6.0_Jun 25_FINAL.pdf (60 pages)

25/51.1
Month 3 Finance Report

Information *Chief Finance Officer (CFO)*

25-51.1.1 - Front sheet Finance Report M3 2025-26 Board.pdf (2 pages)
25-51.1.2 - App 1 M3 Finance Report Board Short.pdf (6 pages)

02:10 PM - 02:20 PM
10 min

25/52
Significant Risk Register Report

Assurance *Chief Nursing and Midwifery Officer (CNMO)*

25-52 - BoD Significant Risk Report Final Approved July 2025.pdf (41 pages)

02:20 PM - 02:30 PM
10 min

25/53
System Joint Committee

Approval *Director of Corporate Governance (DCG)*

25-53.1 - Board Front Sheet System Joint Committee July 25.pdf (3 pages)
25-53.2 - App 1 KM NHS partners TOR Joint Committee TS.pdf (14 pages)

02:30 PM - 02:40 PM
10 min

TEA/COFFEE BREAK 2:30 - 2:40 (10 MINS)

Quality and Safety - Patients

02:40 PM - 02:50 PM
10 min

25/54
Maternity and Neonatal Assurance Board (MNAB) Chair's Report

Assurance *CNMO / Deputy Director of Midwifery (DDoM)*

- **Clinical Negligence Scheme for Trusts (CNST) Compliance**
  - **Perinatal Mortality Review Tool (PMRT)**
  - **Medical Workforce (Obstetric, Neonatal, Medical & Nursing, and Maternity Workforce)**
  - **Maternity Serious Incident (SI) Report**
- **Perinatal Quality Surveillance Tool (PQST)**
- **Maternity and Neonatal Improvement Programme (MNIP)**

25-54.1 - BoD MNAB Overarching report June July 25.pdf (6 pages)

02:50 PM - 03:00 PM
10 min

25/55
Care Quality Commission (CQC) Update Report

Assurance *CNMO*

25-55 - CQC Board report July 25 FINAL.pdf (14 pages)

03:00 PM - 03:10 PM
10 min

25/56
Infection Prevention and Control (IPC) Annual Report 2024-2025

Approval *CNMO*

25-56.1 - Front Sheet DIPC Annual Report 24-25.pdf (2 pages)
25-56.2 - App 1 DIPC Annual Report 24-25 FINAL.pdf (24 pages)

03:10 PM - 03:20 PM
10 min

25/57
Complaints, Patient Advice and Liaison Service (PALS) and Compliments Annual Report 2024-2025

Approval *CNMO*

25-57.1 - Board Front Sheet Complaints PALS.pdf (3 pages)
25-57.2 - App 1 Board Complaints PALS Annual Report 2024-25.pdf (21 pages)

03:20 PM - 03:30 PM
10 min

25/58
Guardian of Safe Working (GoSW) Quarterly Report

Information *Chief Medical Officer (CMO)*

- **Quarter 2: 1 April 2025 to 30 June 2025**

25-58 - GoSW Q2 Report (Apr-25-Jun-25) Final BoD.pdf (10 pages)

Quality and Safety - Patients - People - Partnerships - Sustainability

03:30 PM - 04:10 PM
40 min

25/59
Board Committee - Chair Assurance Reports:

Board Committee Chairs

25/59.1
Quality and Safety Committee (Q&SC) - Chair Assurance Report (3.30 pm to 3.40 pm)

Assurance *Chair Q&SC - Dr Andrew Catto*

25-59.1 - QSC Chair's Report May 2025 FINAL.pdf (8 pages)

25/59.2
Finance and Performance Committee (FPC) - Chair Assurance Report (3.40 pm to 3.50 pm)

Assurance *Chair FPC - Richard Oirschot*

25-59.2 - FPC Assurance report 24.06.25 Final.pdf (4 pages)

25/59.3
People and Culture Committee (P&CC) - Chair Assurance Report (3.50 pm to 4.00 pm)

Assurance *Chair P&CC - Claudia Sykes*

- Equality, Diversity and Inclusion (EDI) (EDI is now a standing item on this committee/board meeting as part of NHSE Equality Delivery System and so EDI can be considered in all meetings and key decisions. Please discuss and consider how this meeting/decision may impact EDI and record this e.g. have an adverse or positive impact on staff or patients with protected characteristics e.g. race, age, disability etc.)

25-59.3 - PCC Board report 08.07.25.pdf (4 pages)

25/59.4
Charitable Funds Committee (CFC) - Chair Assurance Report (4.00 pm to 4.10 pm)

Assurance *Chair CFC - Claudia Sykes*

Verbal

CLOSING MATTERS

04:10 PM - 04:15 PM
5 min

25/60
Any Other Business

Discussion *All*

Verbal

04:15 PM - 04:30 PM
15 min

25/61
Questions from the Public

Discussion *All*

Verbal

- **Questions from the public - questions to be submitted in advance of meeting by 12.00 noon the day before meeting is held**

Date of Next Meeting: Thursday 9 October 2025

REGISTER OF DIRECTOR INTERESTS – 2025/26 FROM JUNE 2025

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

REGISTER OF DIRECTOR INTERESTS – 2025/26 FROM JUNE 2025

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
HOLLAND, CHRISTOPHER	Associate Non-Executive Director	Director of South London Critical Care Ltd **(1)** Shareholder in South London Critical Care Ltd **(2)** Dean of Kent and Medway Medical School, a collaboration between Canterbury Christ Church University and the University of Kent **(4)** South London Critical Care solely contracts with BMI The Blackheath Hospital for Critical Care services **(5)**	13 December 2019 (Second term)
MUSGROVE, ROBERT	Non-Executive Director	Employee of IBM UK Ltd **(1)**	1 May 2025 (First term)
OIRSCHOT, RICHARD	Non-Executive Director	Non-Executive Director, Puma Alpha VCT plc (July 2019) **(1)** Director, R Oirschot Limited (August 2010) **(3)** Trustee, Camber Memorial Hall (June 2016) **(4)**	1 March 2023 (First term)
OLASODE, OLU	Senior Independent Director (SID)/Non-Executive Director	Executive Chairman, TL First Group (started 9 May 2020) **(3)** Chairman, Governance and Leadership Academy UK (started 11 September 2018) **(1)** Non-Executive Director, Priory Care Group (started 1 June 2022) **(1)** Independent Chair of Audit and Governance, London Borough of Croydon (started 1 October 2021) **(4)**	1 April 2021 (Second term)
STEVENS, BEN	Chief Strategy and Partnerships Officer	None	1 June 2023 (substantive) (20 March 2023 interim)
SYKES, CLAUDIA	Non-Executive Director	Director, Cloudier Skies Ltd **(1)** (started 21 December 2022) Chair, East Kent Health and Care Partnership (HCP) (**1**) (1 January 2024) Chair, Kent and Medway VCSE Alliance **(5)** (September 2022)	1 March 2023 (First term)

REGISTER OF DIRECTOR INTERESTS – 2025/26 FROM JUNE 2025

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
van der LEM, ANGELA	Chief Finance Officer	Board Member, NHS Commercial Solutions Management Board **(1)**	6 November 2024
WALKER, CATHERINE	Non-Executive Director	Chair of Advisory Appointments Committee, Kings College NHS Foundation Trust **(1)** Tribunal Member, Ministry of Justice **(1)** Panel Member/Chair, High Speed 2 **(1)** Panel Member/Chair, East West Rail **(1)**	25 October 2024 (First term)
YOST, NATALIE	Executive Director of Communications and Engagement	None	31 May 2016

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

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

Categories:

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

UNCONFIRMED MINUTES OF THE ONE HUNDRED AND FOURTY FOURTH MEETING OF THE BOARD OF DIRECTORS (BoD) THURSDAY 5 JUNE 2025 1.00 PM HELD IN THE CONFERENCE ROOM, EDUCATION CENTRE, WILLIAM HARVEY HOSPITAL (WHH), KENNINGTON ROAD, WILLESBOROUGH, ASHFORD, KENT, TN24 0LZ AND WEBINAR VIDEOCONFERENCE

PRESENT:

Dr A Doherty	Trust Chair (Chair)/Nominations and Remuneration Committee (NRC) Chair	AD
Mr N Blissett	Chief People Officer (CPO)	NB
Dr A Catto	Non-Executive Director (NED)/Quality and Safety Committee (Q&SC) Chair	AC
Ms T Fletcher	Chief Executive (CE)	TF
Mr D Gibbs	Chief Operating Officer (COO)	DG
Ms F Griffith	NED	FG
Ms S Hayes	Chief Nursing and Midwifery Officer (CNMO)	SH
Dr D Holden	Chief Medical Officer (CMO) (left meeting at 3.45 pm)	DH
Mr R Musgrove	NED	RM
Mr R Oirschot	NED/ Finance and Performance Committee (FPC) Chair	RO
Dr O Olasode	NED/Senior Independent Director (SID)/Integrated Audit and Governance Committee (IAGC) Chair	OO
Mr B Stevens	Chief Strategy and Partnerships Officer (CSPO)	BS
Ms C Sykes	NED/Charitable Funds Committee (CFC) Chair/People & Culture Committee (P&CC) Chair	CS
Ms A van der Lem	Chief Finance Officer (CFO)	AvdL
Mrs C Walker	NED	CW

ATTENDEES:

Ms A Archer	Teenage and Young Adult Clinical Liaison Nurse Specialist (CLNS) (*minute number 25/27*)	AA
Mr M Blakeman	Improvement Director, NHS England (NHSE)	MB
Ms M Carliell	Head of Patient Voice and Involvement and Volunteering (*minute number 25/27*)	MC
Dr P Christian	Associate Medical Director (AMD), Women, Children & Young People Care Group (WCYPCG) *(minute number 25/35)*	PC
Ms M Cudjoe	Director of Midwifery (DoM) *(minute number 25/35)*	MC
Mr K Desai	Director of Corporate Governance (DCG) (non-voting Board member)	KD
Ms C Kerr	Head of Nursing (HoN), WCYPCG *(minute number 25/35)*	CK
Mr A Littlefield	Lead for Patient Voice and Involvement (*minute number 25/27*)	AL
Ms C Maynard	Associate Director of Nursing, Cancer, Clinical Haematology and Haemophilia (*minute number 25/27*)	CM
Miss 'R'	Patient, Patient Story (*minute number 25/27*)	R
Ms F Trundle	Managing Director (MD), Kent and Medway Pathology Network (KMPN) Programme, Maidstone and Tunbridge Wells NHS Trust *(minute number 25/34)* (joined by Webinar)	FT
Mrs N Yost	Executive Director of Communications and Engagement (EDC&E) (non-voting Board member)	NY

IN ATTENDANCE:

Mr N Daw	Governor and Membership Lead	ND
Miss S Robson	Board Support Secretary (BSS) (Minutes)	SR

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

Ms S Alihodzic	Member of Staff
Ms S Barton	Governor
Ms C Heggie	Member of the Public
Ms V Jerram	Member of Staff
Ms C Knight	Member of Staff
Ms A Mitchell	Member of Staff
Ms A Moore	Member of the Public
Ms K Sawyer	Member of the Public
Mr J Verrier	Member of the Public
Ms L Williams	Member of Staff

MINUTE NO.		ACTION
25/022	**CHAIR'S WELCOME AND APOLOGIES FOR ABSENCE** The Chair opened the meeting, welcomed everyone present, and noted apologies received from Professor C Holland, Associate NED (non-voting Board member).	
25/023	**CONFIRMATION OF QUORACY** The Chair **NOTED** and confirmed the meeting was quorate.	
25/024	**DECLARATION OF INTERESTS** The Chair **NOTED** there were no new interests declared.	
25/025	**MINUTES OF THE PREVIOUS MEETING HELD ON 3 APRIL 2025** **DECISION:** The BoD **APPROVED** the minutes of the previous meeting held on 3 April 2025 as an accurate record.	
25/026	**MATTERS ARISING FROM THE MINUTES ON 3 APRIL 2025** The BoD **NOTED** the action log, **NOTED** the updates on actions, **NOTED** the actions for future Board meetings, and **APPROVED** the one action recommended for closure.	
25/027	**PATIENT STORY** The patient Miss 'R' highlighted the following key elements (positive learning) from her story after being diagnosed with breast cancer at the age of 23 (two years ago) and treated at Queen Elizabeth the Queen Mother Hospital (QEQM): • Immediately contacted GP following finding a lump, referred to Trust, had ultrasound and biopsy (was very nervous about procedure, staff were very attentive, calming influence and felt very looked after), within about two weeks was diagnosed; • Was a very scary experience, was asked whether wished to have someone present at appointment, thought it would be fine and decided not to. Looking back would have benefited from clinical staff being more insistent that someone attended with her at appointment; • Staff were very compassionate giving diagnosis (by a consultant and accompanied by three nurses), provided time to digest news, emphasised as soon as hearing the word cancer don't hear much else. Given time to contact her Mum to be present whilst diagnosis and treatment explained;	

- Staff very supportive explaining if wished to get pregnant in the future the options available (steps were taken arranging oocyte cryopreservation (extracting and storing woman's eggs)), arrangements put in place quickly before treatment commenced. Procedure and chemotherapy treatment was very frightening, treatment commenced quickly, chemotherapy made her feel very unwell, all staff were very kind, supportive and always available to talk to, acknowledging the support from all the Viking Ward staff, the Cancer Nurse Specialists (CNS), particularly valuing the individual support and regular consistent contact from CLNS during treatment, checking in on how she was, and knowing always had staff available to talk things through with;
- Positive experience, treatment, compassionate care, wrapped around a holistic approach;
- Treatment was over a period of 18 months, and was given the all clear the previous year.

The CLNS explained her role in supporting those diagnosed with cancer aged between 16 to 24 through their patient pathway, diagnosis and treatment (explaining procedures and what would happen), providing additional support to these young patients at a very difficult time. Discussions with individual patients, about their home support network, their wellbeing, and tailoring support around their individual needs.

The following questions were raised by Board members:

- Recognised the request to have someone else present when diagnosed was subtle and whether this was appropriate. Miss 'R' commented this was an area for learning, for staff to be more open and insistent in being accompanied for the diagnosis (acknowledging the sensitive discussion she experienced), recognising this may panic some people, noting benefits of having someone to think clearly about questions that needed to be asked.
- Raised the important role of the CLNS in supporting young patients and queried whether there was sufficient capacity to provide this support to all young cancer patients. The CLNS stated her role was not full time (worked 30 hours per week over four week days, did not work during weekends), noting gap during periods of absence (annual leave/sickness), had no impact on provision of cancer treatment. Currently 68 patients on list (20 undergoing treatment, remaining treatment finished and follow up).

The Chair thanked Miss 'R' for sharing her emotional story, her courage in attending this meeting, recognising her strength and how hard it was to present. She also thanked the team and all the staff demonstrating the Trust's values with compassionate care and kindness.

The BoD **NOTED** the Patient Story and the following:

- The service and teams involved in R's care demonstrated compassion and lived the Trust's values;
- Modelling compassionate leadership at a consultant level supporting compassionate care in the wider patient journey;
- Flexibility in care planning and treatment plans that benefit the patient, by improving their experience and outcomes.

25/028 **CHAIR'S REPORT**

The Chair highlighted the following key points:

- Thanks to former Trust Acting Chair, Stewart Baird, leading the organisation through a journey of improvement, as well as the Trust's CE and Board members for their insights and experience during her induction;
- Welcomed the two new NEDs, Ffion Griffith and Robert Musgrove;
- Valued visiting sites and meeting staff on wards, Emergency Department (ED), maternity, Intensive Therapy Unit (ITU), stroke and renal services, insightful seeing the dedication of staff in caring for patients. Staff being open and honest about how services could be improved with investment around business cases being progressed;
- Areas of challenge on services (particularly demand in the EDs), recognising still more work to be done to address these, as well as aim to diagnose and treat patients as fast as possible;
- Commitment of the BoD to monitor closely actions to address comments and feedback from the Staff Survey to improve the environment and staff experience whilst at work.

The BoD **NOTED** the contents of the Chair's report.

25/029 **CHIEF EXECUTIVE'S (CE's) REPORT**

The CE highlighted the following key issues:

- Significant achievement Maternity Services (at QEQM and WHH) rated 'good' following report from the Care Quality Commission (CQC) inspection in December 2024, from previous 'inadequate' rating. Inspection team recognised significant improvements, leadership, as well as improved culture and its positive impact. Recognised the hard work and support from leadership and wider teams, noting there were still more further improvement work to be done;
- Establishment of Staff Congress with elected Chair and Vice Chair, working with the BoD, wider leadership team, and change ambassadors to drive cultural change by listening to and acting on voice of staff;
- Update on the inquest that took place over the last few weeks would be included in next CE report;
- Great news following the Government's announcement of funding to address NHS infrastructure issues, Trust allocated with additional capital of £13m to address its significant backlog maintenance programme.

ACTION: Include in CE's report presented at next BoD meeting at end of July update on the inquest took place at end of May/beginning of June 2025. — CE

The BoD **NOTED** the Chief Executive's report.

25/030 **INTEGRATED PERFORMANCE REPORT (IPR)**

The COO highlighted the following key performance against metrics:

Patients

- Good progress during previous Financial Year (FY) against core operational performance standards, recognising still more improvements needed. Focus current FY to reduce number of patients waiting over 12 hours in EDs (currently one in five, working to reduce to one in ten), Trust remained poor performer against this target. Work in place to support this reduction (including patient flow, pathways, managing patient demand, and increasing discharges where appropriate) should see improvements in coming months

moving towards Trust's 19.7% (currently 21.7%) target trajectory, lower is better;
- Programme of work to reduce long waits for planned care;
- Performance against cancer 28 day faster diagnosis compliance currently 74.8% against static target of 77.0% higher is better.

The Chair enquired what support was needed to further improve performance and for this to be sustained. The COO emphasised it was important to engage all multi-disciplinary team (MDT) staff working together supporting improvements, patient flow, outcomes and experience. Noting discussion sessions with staff challenging how things could be done differently, more effective working together across all teams throughout the Trust. A key element was continuing to work collaboratively with system partners (including the Health and Care Partnership (HCP)).

The NEDs raised increased patient demand and ensuring staff were supported in managing patients. The COO commented on the staff engagement across the Trust supporting to effectively manage patient flow, with MDT ward rounds (looking at patients holistically, being on the right patient pathway around their required support and care, and if could be treated elsewhere in the community/virtual wards). The CNMO stated wellbeing services available for staff, as well as senior leadership support to ensure any safety incidents were addressed promptly. The CPO highlighted team working was a key theme that would be covered in the Trust's People Strategy as well as the role of people leaders, noting the Strategy to be presented in due course to the BoD once finalised.

The Chair and NEDs queried whether increased patient demand reflected seasonality pressures, noting there had been a real difference in demand when visiting the two EDs (significant demand and provision of corridor care at one and much less demand at the other, at different weeks but on the same day). The COO commented there was an element around seasonality (e.g. winter /respiratory illnesses), and working closely with system partners looking at embedding effective processes around better use of beds and ensuring increased appropriate discharges, reducing length of time for patients to access the appropriate pathways for their treatment, and putting in place individual onward care provision (that could sometimes be approximately two weeks).

The CNMO highlighted the following key points:

Quality & Safety

- New Never Event (NE) reported, fall from an unrestricted window, checks undertaken with mitigations put in place, Patient Safety Incident Investigation (PSII) had commenced;
- Significant increase from previous month in mixed sex breaches at 118, with ongoing work to reduce further occurrence, and confident this would positively impact to reduce numbers;
- Continued focus improving environmental factors and compliance Infection, Prevention and Control (IPC) precautions around cleaning and hygiene;
- Pressure Ulcers (PUs) remained below trajectory, number were higher than wanted, with discussions and actions to address themes and reduce these.

The Chair enquired about the reasons for the increase in PUs and actions to resolve. The CNMO stated actions were around an MDT approach, bespoke training by the Tissue Viability (TV) team for individual areas (including EDs with patients waiting longer in the departments), including focus on shear related damage, and a future summit to be held looking at this.

The NEDs asked whether there had been a reduction in the number of returned complaints to complaint responses. It was also enquired about actions to reduce the overall number of complaints received. The CNMO confirmed there had been a slight positive reduction in returned complaints. She commented on work progressing to enable improved availability of the Patient Advice and Liaison Service (PALS) team for patients around in person conversations and early resolution that was hoped would effectively reduce complaint numbers and expectation to see a difference in the next six to eight months.

The CPO highlighted the following key points:

People

- Staff turnover remained at 7.8% (continued positive trend), possibly reflecting the current NHS environment challenges and likely to remain;
- Continued focus ensuring quality of appraisals was good;
- Slight increase in statutory training compliance, 92.8% against 91% threshold, continue to be closely monitored to ensure this was maintained.

The NEDs acknowledged the work and progress supported by the CMO with Care Group Medical Directors to improve statutory training compliance for medical staff.

The Chair enquired how feedback from staff was collated and actions to address any reports of poor quality appraisals. The NEDs asked whether there was training for managers and whether this was having a positive impact, raising concern about the low 73.1% appraisal compliance for Corporate. The CPO reported approximately 20/23% of staff felt their appraisals were poor, was a key area for the P&C team to drive forward improvements, highlighting the importance and value of good appraisals for staff development and career pathway progression. He emphasised the Trust's leadership development programme that would support improvements, noting the challenges for managers in meeting demand for services whilst regularly checking in with their staff.

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

25/030.1 **MONTH 1 (M1) FINANCE REPORT**

The CFO reported on the following key issues:

- Trust developing its long term financial plan to reduce its deficit, return to financial balance, deliver sustainable services, and continue improvements;
- Previous FY delivered largest cost improvement programme (CIP) of £49m, and achieved its end of year deficit plan of £85.8m, reduction in deficit from the year before. Thanks to all Trust staff for their hard work and support;
- Trust's planned gross deficit for 2025/26 of £64.2m, total CIP of £80m, this level of savings would be a real challenge, similar to that all other trusts required to make;
- Continued focus on financial management and sustainability, monitoring progress of CIP efficiencies, and financial planning for future years and achieving balanced plan.

The NEDs commented on looking at how services were delivered, ensuring these were efficient and effective to reduce costs. The CSPO stated utilisation of some of the £13m infrastructure funding would support to reduce the risk of operational interruption, increase productivity and reduce costs.

The NEDs raised concern of any potential risks associated with cost savings. The CNMO reported each savings scheme robustly reviewed, quality impact assessment (QIA) undertaken prior to implementation, with oversight from Q&SC.

The BoD **NOTED** the financial performance of Month 1.

25/031 **REPORT ON JOURNEY TO EXIT NATIONAL OVERSIGHT FRAMEWORK SEGMENT 4 (NOF4) AND INTEGRATED IMPROVEMENT PLAN (IIP)**

The CSPO reported on the following key elements:

- Update on the positive progress and regular oversight, following completion of 2024/25 IIP following external review (by Integrated Care Board (ICB), South East (SE) Region and Recovery Support Programme (RSP) representatives) of existing evidence collated against improvement of the four programmes (Leadership, Governance & Culture; Urgent & Emergency Care (UEC); Planned Care; and Finance);
- 74 of the 87 quarterly set metrics had been met by end of March 2025, taking into consideration the continued operational and financial challenges. Recognising lots more work still remained to improve the scores in next year's staff survey, improving 12 hours waits in EDs, patients waiting extended time for elective care, and challenges around delivery of the financial performance and efficiency savings;
- National review of this improvement work awaited.

NHSE's Improvement Director noted the Trust's internal governance and resources to support sustaining its improvement journey.

The NEDs highlighted the new framework that was likely to have a significant focus on financial performance. The CSPO stated notification of the final new framework and assessment criteria was awaited, noting trusts in deficit would have a ceiling of where they would not be able to progress through the framework levels.

The Chair congratulated the Executive Directors and staff on the progress achieved recognising there was still more improvement work needed.

The BoD **NOTED** the Journey to Exit NOF4 and IIP report.

25/032 **SIGNIFICANT RISK REGISTER (SRR) REPORT**

The CNMO highlighted the following key issues:

- Oversight of significant risks reported and discussed in detail at each of the Board Committees, with robust internal governance monitoring of risks and risk management process by the Trust Management Committee (TMC) and Risk Review Group;
- Five new risks approved and added to SRR;
- 11 risks with associated overdue actions, recognising more focussed work was needed to progress these.

The NEDs suggested it be made clear in future reports to identify where assessments had not been completed for risks where there had been no movement in risk scores, and to include narrative around any progress improvements.

ACTION: Arrange for future reports presented to be made clear identifying where assessments had not been completed and were awaited for risks where there had — CNMO

been no movement in risk scores, and include narrative around any progress improvements.

The Chair stated the need to ensure dates set and target scores were realistic, that mitigations were effective and resulting in improvements.

The NEDs raised the implementation of the new risk management system InPhase and asked for a progress update. The CNMO provided an update on the planning process for the transition from Datix to InPhase, this had proved much more complex due to the large size of the Trust and its complexity. Assurance InPhase were working with the Trust to implement this new system, with mitigations including extension of contract with Datix during this transition process.

The BoD **NOTED** assurance from the SRR and visibility of key risks facing the organisation.

25/033 **BOARD ASSURANCE FRAMEWORK (BAF)**

The DCG highlighted the following key elements:

- BAF presented Trust's structured system for Board Committees to oversee and monitor risks against achieving its strategic objectives that informed their agendas and areas of focus at each meeting, risks linked to the SRR;
- FPC agreed inclusion of a digital/cyber risk and mitigations;
- Update of Q&S risk around improving experience of women and their families following the actions taken in response to the *Independent Investigation into East Kent Maternity Services* and other reviews;
- Future BoD Strategic Session to include discussion of Trust's risk appetite.

The Chair noted the good process to review this at each Board Committee meeting and suggested at the end of each meeting to evaluate and review whether each Committee felt there had been any changes.

ACTION: Board Committees to evaluate and review at the end of each Committee meeting whether it felt there had been any changes to the BAF risks as a result of the discussions at the meeting.

Board Committee NED Chairs

The BoD reviewed and **NOTED** the status of the Principle Risks in the BAF.

25/034 **CASE FOR CHANGE FOR KENT AND MEDWAY PATHOLOGY NETWORK (KMPN) JOINT VENTURE**

The CSPO highlighted the following key points:

- Case for change to establish a Pathology Network across K&M outlining next steps to implement formal joint venture consolidating the clinical and managerial leadership into a single team;
- Proposal to provide a more efficient and sustainable pathology services in respect of workforce and service provision around productivity and infrastructure opportunities through a network rather than by individual provider Trust services;
- Three phases, with clear gateways against essential criteria, with appropriate mitigation of any risks to be met to progress to the next phase (providing necessary governance assurance):
  - Phase 1 – 2025/26 set up single governance and oversight structure for pathology services across K&M replacing existing separate processes, creation of a Joint Committee (formal sub-committee of the four Trust

Boards). Leadership representation on Committee from each organisation, Executive and NED, proposed for EK to be CSPO and Dr Catto;
    - Phase 2 – from October 2025 support revised KMPN management structure (key leadership posts) and delivery of current projects, new Head of Quality, Risk and Governance, and for pathology manager to report directly into the joint oversight arrangements with line management from KMPN's Managing Director. This leadership team to develop the full business case and service delivery model;
    - Phase 3 – after April 2027 work towards implementation of fully consolidated joint venture around governance structure (following delivery of the single Laboratory Information Management System (LIMS) programme. At this point KMPN would be a legal entity, with host employer and provider of pathology services, for pathology staff and fully integrated management structure with specialty leadership for K&M.
- Key reporting Committees (Finance and Investment, Q&S, P&C, and Digital) to sit under the Joint Committee, with senior leadership representation on each Committee from each of the four Trusts;
- Further work needed to look at and identify opportunities around how pathology services could work more efficiently and effective, with benchmarked evidence suggesting that mature Networks had real opportunities to be much more efficient and effective;
- Case for change proposal presented and discussed by Trust's FPC and Q&SC recommending to the BoD for approval. The other three Trust Boards had approved the proposal for case for change;
- Associated risks with not yet understanding what the final service provision would look like, and the scale and opportunities around efficiencies.

The DCG confirmed the Joint Committee arrangements had been discussed at the KMPN Legal and Governance Steering Group, with each organisation delegating decision making and responsibility to this Joint Committee (governance forum) in respect to the pathology service's agreed budget and decisions which fall within the agreed strategic plan, including delegating responsibility for oversight of the day to day operational decision making of the KMPN. Any significant decisions such as moving through the phases and location of services would be the remit of each member organisation's Board for a decision.

Critically, in phases 1 and 2, it was highlighted the legal and regulatory responsibility for pathology services remained with each member organisation and its Board, including employment relationships with staff within the KMPN. This would remain the case until KMPN became a legal entity. The DCG explained this separation of operational responsibility from legal accountability in phases 1 and 2 was a key risk identified in the existing approach to creating the KMPN. Some mitigation is in place by adopting a unanimity requirement for decisions of the Joint Committee and the Joint Committee requiring two representatives of each organisation.

KMPN's Managing Director commented the case for change had been developed from the strong collaborative foundation of K&M pathology services working together, with clinical and leadership engagement, as well as provision of mutual aid, and confident to deliver KMPN consolidating into a formal governance Pathology Network arrangement.

The FPC NED Chair confirmed the Committee took assurance from the gateways before each subsequent phase which had to be decided upon by each Trust; the

safeguards and governance arrangements in place; and having Executive and NED representation from the Trust on the Joint Committee.

The Q&SC NED Chair raised the significance of learning from implementing other Pathology Networks in respect of those that had been successful and those not so, and incorporating these learning outcomes with the implementation of KMPN.

The NEDs queried whether Joint Committee decisions would be presented to each organisation's Board for ratification. The DCG confirmed that in respect of matters within the delegated remit of the Joint Committee, they would be for the Joint Committee; noting decisions would be reported to each organisation's Board for information and noting.

The CE acknowledged and recognised the potential benefits of a pathology network and particularly one across the South East region, highlighting her experience of having been involved in developing the establishment of a network previously. However, the CE highlighted the underlying risk that remained until this was a legal entity in respect of delegation of responsibility for finances, quality, safety, and workforce while retaining the legal responsibility and, in the CE case, accountability within each Trust. The CEs, as the Accountable Officers (AO), would be exposed in early phases noting it had not yet been worked through how this would be managed and escalated during the period of delegation of day to day operational decision making to the Joint Committee. The CE also noted the identified savings were with a single network managed equipment service contract, which were offset by the increased costs of the LIMS, and that there would remain the need for investment. Acknowledging the opportunities around what could be done significantly differently/new ways of working to realise real potential efficiency and productivity benefits had not been worked through

The NEDs commented on the benefits around learning from this collaboration, including culture, staffing issues and teams working together across the system, and look at developing a learning template for future system projects. The CSPO commented on the anticipated evaluation and identifying learning as the project progressed through each of the phases. He agreed to raise this with the KMPN Joint Committee as well as the learning outcomes from other Pathology Networks implemented.

ACTION: Raise with KMPN Joint Committee the need to develop a learning template for future system projects (identifying learning outcomes from other Pathology Networks implemented). As well as evaluating and identifying learning as KPMN project progress through each of the phases (around culture staffing issues and teams working together across the system) to clearly show where things went well and not so well). — CSPO

The Chair emphasised the importance of moving forward at pace with implementation and working towards delivery of the intended savings earlier than that set out over the five year period by 2030. This case for change was clinically driven to provide improvements for patients around improved quality of care services, faster testing and diagnosis, with better patient outcomes. Regular project progress reports were needed on the implementation of KPMN and delivery of the savings, as well as an agreed robust escalation process to each organisation's CE (AO) working through potential scenarios of potential future issues and risks around finances, quality, safety and workforce and how these would be resolved.

ACTION: Arrange presentation of regular project progress reports on implementation of KMPN and delivery of the savings, as well as an agreed robust — CSPO/

escalation process to each organisation's CE (AO) working through potential scenarios of potential future issues and risks with finances, quality, safety and workforce and how these would be resolved. KMPN MD

DECISION: The BoD **APPROVED** the following:

- Set up in 2025/26, a single governance and oversight structure for pathology services replacing existing separate Trust oversight processes (Phase 1). To include creating a new Joint Committee for pathology services, a formal sub-committee of the four Trust Boards with an Executive and NED representatives from each organisation (Phase 1);
- Trust's CSPO (Executive) and Dr Catto (NED) representatives on the Joint Committee;
- Support revised KMPN management structure (from October 2025) to ensure delivery of the current projects; including a new Head of Quality, Risk and Governance, and for current pathology managers to report directly into the joint oversight arrangements with line management from the KMPN MD (Phase 2);
- Committed to working towards a fully consolidated joint venture following the delivery of the single LIMS programme (after April 2027) with a host employer for pathology staff and a full integrated management structure with specialty leadership for Kent and Medway (Phase 3).

25/035 **WOMEN'S CARE GROUP MATERNITY AND NEONATAL ASSURANCE GROUP (MNAG) CHAIR'S REPORT**

- **Review of Neonatal deaths at EKHUFT (April 2023 – May 2024)**

The DoM highlighted the following key points from the MNAG Chair's Report:

- Clinical Negligence Scheme for Trusts (CNST) Compliance: now in the Maternity Incentive Scheme (MIS) year seven:
  - All stillbirths and neonatal death cases reviewed and reported against the Perinatal Mortality Review Tool (PMRT) within required timeframe. During quarter 4 (Q4) 12 cases, with actions taken on any themes and lessons learnt. There had been a decline in perinatal deaths;
  - Q4 Serious Incidents (SIs): one case referred to Maternity and Newborn Safety Investigations (MNSI) for external Patient Safety Incident investigation (PSII), duty of candour (DoC) compliance for all cases, and learning from internal reviews;
  - Q4 Avoiding Term Admissions into Neonatal Units (ATAIN) rate positively below national average;
  - Q4 validated compliance against Saving Babies Lives Care Bundle (SBLCB) currently 93%;
  - Perinatal Quality Surveillance Tool (PQST): 100% reported compliance of 1:1 in labour care at both WHH and QEQM during February and March 2025. Three reported maternal deaths, DoC with families, identified direct staff member contact for families, all cases referred to MNSI (two accepted for MNSI investigation, one for an independent external investigation). Compliance above 90% against PRactical Obstetric Multi-Professional Training (PROMPT);
- Hypoxic-ischaemic encephalopathy (HIE) review of 11 reported cases in 2024 (five babies born elsewhere and transferred to WHH for level 3 care and excluded from review), service remained below national target range of 2.8 per 1000 and review undertaken as there had been an increase in case numbers in 2024 (against nine in 2023). Review concluded there were no obvious Equality, Diversity and Inclusion (EDI) components impacting

outcome, and no clear commonalities identified. Actions to address all recommendations, including inclusion of MDT PROMPT and maternity mandatory training addressing loss of situational awareness.

The NEDs raised the impact of smoking and what support was in place to help women to stop smoking. The DoM reported lots of work being done around smoking cessation, with good response from the interventions in place, supported from the provision of additional funding.

The NEDs highlighted the body mass index (BMI) risk and enquired about what dietetics support there was for women within the maternity services. The DoM stated dietetics as well as diabetes support, working with Region on this national public health issue, and the importance of sensitively managing BMI.

The WCYPCG AMD and HoN highlighted the following key elements from the Review of Neonatal deaths at EKHUFT (April 2023 – May 2024):

- Trust asked for an independent review following increase in neonatal deaths (14 babies reviewed and 13 maternal case notes reviewed), although the number of deaths remained below national average. Looked at deaths as a group, to identify any common factor or themes, and any required learning/training. Mother's care and care of babies reviewed, seven under 24 weeks gestation, five between 24 to 26 weeks gestation, and two over 26 weeks gestation;
- Trust's neonatal unit caring for increased numbers of extremely premature babies, who sadly had a low chance of survival;
- Findings of review shared with families of the babies whose care included within the report, families also offered consultation discussion with Consultant, Deputy DoM and HoN;
- Review found care in maternity units and neonatal unit was of a good standard, maternity care was timely and responsive, no major factors which would have influenced the outcomes. Trust implementing their wider learning recommendations in full to further improve standard of care. This included those related to five minor factors that the team considered might have made a difference, to ensure care was the highest possible standard;
- Modifiable factors relating to care detailed in report. To review processes around thermal measures recognising thermal regulation for extremely premature babies was difficult. To ensure the sepsis screening record in the relevant section on the neonatal electronic record completed for each septic screen done on every baby.

The Chair acknowledged the team's open and honest approach proactively initiating external review of patient pathways, care and learning, noting the review report available on the Trust's website within this BoD meeting papers. WCYPCG's AMD noted working together collaboratively across the local system and benefits of linking feedback from the review across the maternity and neonatal network.

DECISION: The BoD **NOTED** the MNAG Chair Assurance Report from the 8 April and 13 May 2025 MNAG meetings, **APPROVED** the Hypoxic-ischaemic encephalopathy (HIE) Review, and **NOTED** the Review of Neonatal deaths at EKHUFT (April 2023 – May 2024) Report.

25/036 **CHIEF MEDICAL OFFICER'S (CMO's) REPORT**

- **Appraisal and Revalidation**

The CMO highlighted the following key elements:

- Currently 887 connected doctors, 754 (85%) appraisals completed or within guidelines, and remaining 15% of those missed their milestones/in progress were currently under review;
- Since July, 223 doctors successfully revalidated. Revalidation process was over a five year period requiring 360° feedback to be undertaken every five years (with colleagues and patients), now to be carried out in year three ensuring completion by the end of the five year period.

The Chair enquired about what if a doctor did not obtain their revalidation. The CMO stated the individual doctor would need to present to the General Medical Council (GMC) with a valid reason.

The NEDs raised the overseas doctors, challenges around culture and the support in place for these staff. The CMO confirmed support in place and available for overseas doctors.

The BoD **NOTED** the CMO's report and assurance in relation to appraisal and revalidation.

25/037 **CERVICAL SCREENING ANNUAL REPORT 2024-2025**

The CMO highlighted the following key points:

- Performance against national targets were met across all areas with the exception of the following (with an action plan being developed to address):
  - Women receiving biopsy (diagnostic or treatment) results within four weeks of test date, below 90% against the over 90% target;
  - Women receiving biopsy (diagnostic or treatment) results within eight weeks of test date, 99% against the 100% target.
- Referral volumes remained historically high, with a decline in referrals by 13.3% in the most recent reporting period (2024/25). Task and finish group being established to ensure a robust and inclusive cervical screening pathway that met the needs of all communities.

The NEDs raised the aging equipment that was essential to maintaining full colposcopy services, reviewed as part of the Care Group's risk register, and whether there was a programme for when this would be replaced. It was also raised the variation in appointments per clinic (some were eight and some were seven) and queried the reasons for this. The CMO noted the variation was around increased requirement for length of appointment resulting in allocation of less available slots. He commented submission for charitable funding and secured provision of a second colposcope at Buckland Hospital Dover (BHD), noting the original colposcope at BHD was recently condemned, taken out of service and reallocation of colposcope from BHD to QEQM whilst awaiting replacement. He emphasised the pressure and demand on capital funding.

The BoD **NOTED** the 2024-2025 Cervical Screening Annual Report and issues detailed within it.

25/038 **PATIENT VOICE AND INVOLVEMENT ANNUAL REPORT 2024-25**

The CNMO highlighted the following key points:

- Patient experience feedback was vital, day to day gathered in the Friends and Family Test (FFT) as well as reaching out to local community groups;
- Responding to patient feedback, including provision of training to WHH ED staff covering 'Seeing the Person' presentation;

- Key themes about less positive feedback included the following:
  - Poor communication and information;
  - Poor care given by staff and poor staff attitude;
  - Quality of treatment received;
  - Long waiting times: on-site appointments, in EDs, follow-up treatment.

The NEDs highlighted the positive 93.9% patient response to the FFT survey, noting their good/very good positive experience feedback and the need to promote and celebrate this good news within the community and media (utilising social media). The EDC&E stated the Patient Voice and Involvement team provided patient feedback to the relevant individual teams, good news was shared with staff by the Trust's internal communications, and externally by staff sharing positive patient stories and feedback (posts on social media). The CNMO commented patient feedback was provided on the Trust's staff intranet celebrating good news. The CPO commented on the contrast with the feedback from the staff survey and the need to explore this in more detail. The Chair commented on the benefits of publishing feedback received from patient surveys to support promoting good news and to look at what more could be done externally to raise awareness of the good work and positive patient feedback.

ACTION: Explore what more could be done internally with staff as well as externally to raise awareness, promote and celebrate good news about the Trust's services around positive patient feedback on their experiences. — EDC&E/ CNMO/ CPO

The DCG emphasised community engagement with harder to reach community groups around EDI and whether visiting churches/mosques had been considered. The CNMO confirmed this had already with raised with the Patient Voice and Involvement team who would be looking at this.

The NEDs highlighted the great source of support that volunteers could provide at the front door to assist patients when entering the hospitals to direct them to the services they required. The CNMO reported the Trust had in excess of 500 volunteers that provided support across various areas in the hospitals, which included provision at the front door, noting increasing number of youth volunteers.

The BoD **NOTED** the 2024-25 Patient Voice and Involvement Annual Report, progress in delivering the Patient Voice and Involvement Strategy, and supporting the Trust to comply with NHSE Access Information Standard (AIS) 2016 and NHS England Involving People and Communities guidance 2022.

The CMO left the meeting at this point.

25/039 **SAFETY, FIRE AND STATUTORY COMPLIANCE UPDATE**

The CSPO highlighted the following key elements:

- More work needed to ensure sufficient numbers of nominated fire wardens, and provision of training, continued monitoring by Fire Safety Group (FSG);
- Focussed work with WHH and QEQM care groups to support to improve their Health and Safety Toolkit Audits (HASTAs) overall poor scores of 66.8% and 59.9%. To be assisted by individual devised recovery plans;
- Enhancing staff personal safety following feedback from staff with violence and aggression, with the provision of additional security support for the two EDs at WHH and QEQM, to be mobilised by July with the award of new security contract. QEQM ED had trialled body worn video cameras that was currently in an evaluation phase;

- Improvement in estates statutory compliance towards achieving the 95% target, with 94% in January (2% increase on December). Noting the positive impact following the announcement of additional funding across the NHS to address critical infrastructure.

The NEDs raised the issue about ensuring sufficient fire wardens in place and that regular checks were basic day to day requirements, shouldn't wait for audits to identify any areas that needed to be addressed and whether there was an element around manager training. The CSPO commented a key focus was ensuring appropriate availability of link staff to provide support and guidance to ensure checks being undertaken and addressing any actions identified.

The Chair enquired how progress was being assessed against the longer term Fire Safety Improvement Plan and whether the necessary fire remediation work was being completed at pace. The CSPO reported 2gether Support Solutions (2gether) had prioritised this work, noting the challenges with accessibility due to having to decant clinical areas, as well as operational pressures. There was a programme of work in place to carry out the necessary work up to October 2025, and reviewing how work could be done in theatre and ITU areas with as little impact as possible. He stated mitigations were in place and Kent Fire Rescue were happy with these, with continued review and monitoring of this work.

The NEDs enquired whether a fire response was included within the Trust's disaster recovery plan. The COO stated a future table top exercise to be undertaken covering most of these elements, noting at WHH there would be horizontal decanting. He agreed to share with the NEDs information from this table top exercise and the outcome debrief, that would provide beneficial assurance.

ACTION: Share with NEDs information from the disaster recovery plan table top exercise and the outcome debrief, providing beneficial assurance of plans in place. — COO

The BoD **NOTED** the update report, Trust's current position in relation to Health & Safety (H&S), and Statutory Compliance, especially in respect to the prevailing risks. Care Group Directors to nominate representatives and deputies for the safety related groups (Strategic H&S Committee, Health and Safety Group, Fire Safety Group and Security Management Group).

25/040 **BOARD COMMITTEE – CHAIR ASSURANCE REPORTS:**

25/040.1 **BOARD COMMITTEE TERMS OF REFERENCE (ToR)**

- **Nominations and Remuneration Committee (NRC)**
- **Quality and Safety Committee (Q&SC)**
- **Finance and Performance Committee (FPC)**
- **People and Culture Committee (P&CC)**
- **Integrated Audit and Governance Committee (IAGC)**

The DCG reported on the following key points:

- Building on external Governance Review and improving corporate governance, individual Board Committees undertook survey review, considered and discussed its outcome as well as review of the ToR and annual work programmes;
- Feedback from discussions incorporated in ToR presented for approval. These included for NRC being clear of its role around Very Senior Manager (VSM) appointments, and for P&CC around EDI and leadership;
- Board Committees all functioning well;

- Good feedback from staff invited to attend meetings for specific items, and the need to enhance patient voice;
- Changes to NED Board Committee membership following appointment of two new NEDs. Annette Doherty (Trust Chair) Chair of NRC, Robert Musgrove member of FPC, Ffion Griffith member of P&CC, Andrew Catto stepping down as member of P&CC following taking on Trust NED representative on KMPN Joint Committee (would continue as Q&SC Chair).

The IAGC NED Chair confirmed assurance report on the Committee survey review outcomes discussed at the last IAGC meeting.

DECISION: The BoD **APPROVED** the following Board Committee ToR:

- NRC;
- Q&SC;
- FPC;
- P&CC;
- IAGC.

25/040.2 **NOMINATIONS AND REMUNERATION COMMITTEE (NRC) – CHAIR ASSURANCE REPORT**

The NRC Chair reported on the following key issues:

- Thanks to the NED, Andrew Catto, for chairing NRC;
- NRC ToR amended, NRC's remit to approve all VSM roles;
- Discussed looking at developmental Associate NED, draft role description, and review of current skills gaps to be addressed. Welcomed feedback from Board members of any current NED skills and experience gaps;
- Assurance of annual NHS Fit and Proper Person Test (FPPT) submission;
- Succession planning would be a future focus of the Committee;
- Noted new NHSE's Board member appraisal approach for adoption in 2025/26.

ACTION: Feedback to Trust Chair any current NED skills and experience gaps to be addressed with the Associate NED developmental role. — Board members

The BoD **NOTED** the 6 May 2025 NRC Chair Assurance Report.

25/040.3 **QUALITY AND SAFETY COMMITTEE (Q&SC) – CHAIR ASSURANCE REPORT**

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

- Majority of issues discussed by Q&SC had been covered at this meeting;
- Continuing to monitor overall progress on quality governance that was on a continued and sustained improvement trajectory;
- Progress against recommendation from Association for Perioperative Practice (AfPP), with Kent & Canterbury Hospital (K&C) theatres awarded accreditation, and an action plan in place to achieve accreditation for both QEQM and WHH.

The NEDs emphasised the need for the BoD to continue to be updated about corridor care in the EDs and the work and actions to address and eliminate this. The Q&SC NED Chair would continue to provide updates to BoD on ED corridor care, the work and actions to address and eliminate this as part of future Q&SC Chair Assurance Reports.

The NEDs raised the issue around pharmacy staffing CQC must do actions and whether there was an associated business case to address this. The CNMO on behalf of the CMO reported ongoing discussions with the CMO and pharmacy team in respect of how the team could work differently. It was agreed the CMO to present a progress report on the actions to address the pharmacy staffing CQC must do actions at the next BoD meeting.

ACTION: Present progress report on the actions to address the pharmacy staffing CQC must do actions at the next BoD meeting. — CMO

The BoD **NOTED** the 25 March 2025 Q&SC Chair Assurance Report.

25/040.4 **FINANCE AND PERFORMANCE COMMITTEE (FPC) – CHAIR ASSURANCE REPORT**

The FPC Chair reported on the following key issues:

- Verbal report from May 2025 FPC meeting noting the following:
  - Met planned deficit and CIP for 2024/25, commending the efforts of all staff in achieving this that had been significantly challenging;
  - 2025/26 plan included £80m CIP target, with around £45m schemes identified, that would be really challenging to deliver and progress would be closely monitored by the Committee;
  - Good progress improving operational performance and reducing waiting times.

The BoD **NOTED** the 29 April 2025 FPC Chair Assurance Report and verbal update from the 27 May 2025 FPC meeting.

25/040.5 **PEOPLE AND CULTURE COMMITTEE (P&CC) – CHAIR ASSURANCE REPORT**

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

- Lots of ongoing work on workforce planning, developing People Strategy to be presented to P&CC at its July meeting, requested when presented to include information on workforce demographics around succession planning, promoting EDI, and focus on management training and development;
- Black, Asian and Minority Ethic (BAME) staff experience was not good, highlighting there was still much more EDI improvement work needed to ensure positive staff experience, supported by EDI data and areas for focus. The need to encourage staff to speak up where Trust values were not being adhered to and vital training and support for managers around de-bias in the recruitment process.

The CPO confirmed EDI would be a key element covered within the People Strategy. He agreed to liaise with the DCG to include a session on EDI at a future BoD Strategy Session for a discussion and progress update on the EDI improvement work and actions.

ACTION: Liaise with DCG for inclusion of a session on EDI at an appropriate time at a future BoD Strategy Session for a discussion and progress update on the EDI improvement work and actions. — CPO

The Chair emphasised the importance of reviewing and evaluating the new Freedom to Speak Up (FTSU) service, in respect of its effectiveness, whether was

an improvement on the previous service provision, and any learning. The P&CC Chair stated an internal audit review would be undertaken in about six months following implementation to review the new service. Following this a report would be presented to P&CC and an update provided to the BoD in the P&CC Chair Assurance report.

The COO suggested an area for consideration looking at and reviewing social degradation and de-bias and whether this occurred within the Trust by its staff. It was noted this was an area along with EDI being looked at and regularly reviewed by P&CC.

The BoD **NOTED** the 13 May 2025 P&CC Chair Assurance Report.

25/040.6 **INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC) – CHAIR ASSURANCE REPORT**

- **SCHEME OF DELEGATION (SoD)**

The IAGC Chair reported on the following key issues:

- Board development programme actions and timeframes;
- Identified gap receiving assurance of progress updates on CQC Well Led inspection actions and learning, report to be presented at next IAGC meeting;
- SoD recommended for approval.

The NEDs highlighted assurance required around the quality and care provided by virtual wards, for this to be looked at and a deep dive report to be presented at a future Q&SC meeting.

ACTION: Present a deep dive report on the provision of virtual wards and the quality of care of this service at a future Q&SC meeting. — COO/ CMO/ CMNO

DECISION: The BoD **NOTED** the 2 May 2025 IAGC Chair Assurance Report and **APPROVED** the recommended changes to the SoD.

25/041 **ANY OTHER BUSINESS**

There were no other items of business raised.

25/042 **QUESTIONS FROM THE PUBLIC**

The CNMO responded to a question raised by Ms K Sawyer ‘How was the Trust ensuring and monitoring whether staff were reporting all safety incidents through the correct channels, namely the incident management system, and what was the audit process to ensure this was happening?’ The CNMO welcomed a discussion with Ms Sawyer to meet with her and the CMO. She confirmed a Patient Safety Incident Response Framework (PSIRF) process in place, promoting incident reporting in Trust clinical policies, the triangulation of feedback through PALS and sharing information and learning through the Trust’s governance structure, and staff training.

The Chair closed the meeting at 4.25 pm.

Date of next meeting: Thursday 31 July 2025

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Matters Arising from the Minutes on 5 June 2025**

Meeting date: **31 July 2025**

Board sponsor: **Annette Doherty, Chair**

Paper Author: **Board Support Secretary**

Appendices:

None

Executive summary:

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

Implications:

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

Assurance route:

Previously considered by: None

MATTERS ARISING FROM THE MINUTES ON 5 JUNE 2025

1. Purpose of the report

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

2. Background

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

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

Action No.	Action summary	Target date	Action owner	Status	Latest Progress Note (to include the date of the meeting the action was closed)
B/32/24	Schedule meeting with Trust to review and discuss current position, progress made (focus against current criteria), assessment against any new guidance, and confirm when would be in a position to be considered for exiting NOF4 and make a presentation to NHSE (potentially end of April/May 2025).	~~Jun-25~~/ Jul-25	NHS England's (NHSE's) Improvement Director/ Chief Strategy & Partnerships Officer (CSPO)	To Close	**April 2025 -** Q4 evidence review meeting scheduled, meeting with National team to be scheduled. **July 2025 -** Assessment on NOF4 exit expected imminently. **Action for agreement for closure at 31.07.25 Board meeting.**
B/01/25	Provide report at a future Q&SC or FPC meeting on data information differentiating patient attendance against factors around health inequalities and deprivation in the EK communities and any detrimental impact for these patients around poorer outcomes.	~~Jun-25~~/ Jul-25	Chief Operating Officer (COO)/ CSPO	To Close	**May 2025 -** COO has asked the Chief Analytical Officer to review progress. **July 2025 -** Results to be discussed at Board Committees. **Action for agreement for closure at 31.07.25 Board meeting.**

B/02/25	Include in CE's report presented at next BoD meeting at end of July update on the inquest took place at end of May/beginning of June 2025.	Jul-25	Chief Executive (CE)	To Close	Update on inquest and Prevention of Future Deaths (PFD) discussed at 15.07.25 Q&SC. See Q&SC Chair's Assurance Report. **Action for agreement for closure at 31.07.25 Board meeting.**
B/03/25	Arrange for future reports presented to be made clear identifying where assessments had not been completed and were awaited for risks where there had been no movement in risk scores, and include narrative around any progress improvements.	Jul-25	Chief Nursing and Midwifery Officer (CNMO)	To Close	Progress has been made with residual risk scores and this is because there is a more robust mechanism for reviewing and updating risks, although we still recognise that there is more work to do. **Action for agreement for closure at 31.07.25 Board meeting.**
B/04/25	Board Committees to evaluate and review at the end of each Committee meeting whether it felt there had been any changes to the BAF risks as a result of the discussions at the meeting.	Jul-25	Board Committee Non-Executive Director (NED) Chairs	To Close	Board Committees implementing. **Action for agreement for closure at 31.07.25 Board meeting.**
B/05/25	Raise with KMPN Joint Committee the need to develop a learning template for future system projects (identifying learning outcomes from other Pathology Networks implemented). As well as evaluating and identifying learning as KPMN project progress through each of the phases (around culture staffing issues and teams working together across	Jul-25	CSPO	To Close	CSPO will follow up on these as part of the KMPN meetings. **Action for agreement for closure at 31.07.25 Board meeting.**

	the system) to clearly show where things went well and not so well).				
B/06/25	Arrange presentation of regular project progress reports on implementation of KMPN and delivery of the savings, as well as an agreed robust escalation process to each organisation's CE (AO) working through potential scenarios of potential future issues and risks with finances, quality, safety and workforce and how these would be resolved.	Jul-25	CSPO	To Close	KMPN assurance reports added to Q&SC and BoD annual work programmes for six monthly reporting at future meetings. **Action for agreement for closure at 31.07.25 Board meeting.**
B/07/25	Explore what more could be done internally with staff as well as externally to raise awareness, promote and celebrate good news about the Trust's services around positive patient feedback on their experiences.	Jul-25	Executive Director of Communications and Engagement (EDC&E)/CNMO/ Chief People Officer (CPO)	To Close	We are doing more to share the Friends and Family Test (FFT) data through monthly infographics broken down by service, shared with staff and externally on social media. Latest results also published on new section of public website. Quotes from patients shared through internal and external comms with monthly round-up feature included in Trust News. Patients encouraged to fill in the FFT through posters, digital screens and social channels, changes made as a result of feedback shared through internal and external channels. We now share 30-40 unique positive news items a week. Board members receive a weekly summary of activity emailed from EDC&E. Key to increasing awareness is teams and care groups using these communication materials locally in their teams to increase engagement. This year's Trust awards resulted in second highest number of nominations (253), many will be used as individual good news stories. Exploring

					use of Greatix to further share good news and recognition. Board members see reading room for examples of Friends and Family Test (FFT) communications (Appendix 13). **Action for agreement for closure at 31.07.25 Board meeting.**
B/08/25	Share with NEDs information from the disaster recovery plan table top exercise and the outcome debrief, providing beneficial assurance of plans in place.	Jul-25	Chief Operating Officer (COO)	To Close	EKHUFT resilience response plans are aligned with the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework (2022) definitions of Major, Critical and Business continuity incidents. This consists of a large repository of specific plans rather that a Trust wide disaster recovery plan. The Incident Response Framework overarches all of these plans in order to provide a consistent response to all incidents. The EPRR exercise programme reflects the emergency planning cycle for validation of arrangements and key risks. Fire incident response is a concurrent theme within that programme due to the risk across all sites. The exercises that have been carried out for the last three years relating to fire are documented. In addition EPRR have carried out a three year workstream on hospital evacuation, where EKHUFT EPRR have presented at Regional workshops and led a Kent & Medway multiagency table top and have an second planned with health partners in September focusing on the evacuation of William Harvey Hospital. This programme of work has been exercised and the new plans will be published this month. EPRR are planning with the local fire stations at the three main sites to run live initial response exercises later in the year. **Action for agreement for closure at 31.07.25 Board meeting.**

B/09/25	Feedback to Trust Chair any current NED skills and experience gaps to be addressed with the Associate NED developmental role.	Jul-25	Board Members	To Close	Feedback provided to Chair direct for consideration. **Action for agreement for closure at 31.07.25 Board meeting.**
B/10/25	Present progress report on the actions to address the pharmacy staffing Care Quality Commission (CQC) must do actions at the next BoD meeting.	Jul-25	CMO	To Close	Update included in CQC report presented to 31.07.25 Board meeting. **Action for agreement for closure at 31.07.25 Board meeting.**
B/11/25	Liaise with DCG for inclusion of a session on EDI at an appropriate time at a future BoD Strategy Session for a discussion and progress update on the EDI improvement work and actions.	Jul-25	CPO	To Close	Included as an agenda item for the next BoD Strategic Session to be held on 04.09.25. **Action for agreement for closure at 31.07.25 Board meeting.**
B/12/25	Present a deep dive report on the provision of virtual wards and the quality of care of this service at a future Q&SC meeting.	Jul-25	COO/CMO/ CNMO	To Close	Added on Q&SC annual work programme for the September 2025 Q&SC meeting agenda. **Action for agreement for closure at 31.07.25 Board meeting.**

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

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

Meeting date: **31 July 2025**

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

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

Appendices:

N/A

Executive summary:

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

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Board Assurance Framework (BAF):	The report links to the corporate and strategic risk registers.
Link to the Corporate Risk Register (CRR):	The report links to the corporate and strategic risk registers.
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: N/A

East Kent Hospitals University NHS Foundation Trust

CHIEF EXECUTIVE'S REPORT

1. PURPOSE OF THE REPORT

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

2. TRUST MANAGEMENT COMMITTEE (TMC)

At meetings of the TMC in June and July 2025, the Committee approved a Long-Term Conditions Compendium as a criteria for determining which patient records require longer retention periods in the absence of a national standard and to ensure compliance with the Records Management Code of Practice.

The Committee also approved a revised Acting Down policy for senior medical staff and a revised short form business case template, simplified and streamlined, avoiding unnecessary time being spent on cases that are unlikely to proceed.

3. INTERNAL UPDATE

3.1 Performance update

Our Emergency Department (ED) performance continued to demonstrate steady improvement in June, with 76.4% of patients across all ED types being admitted, transferred, or discharged within the four-hour standard. This positions the Trust 42nd of the 122 Trusts nationally for combined types performance, representing a positive benchmark for our urgent and emergency care (UEC) services.

As a Trust, we processed 25,266 attendances across our EDs and Urgent Treatment Centres (UTCs) last month, while successfully reducing 12-hour trolley waits from 1,210 to 1,159 patients. Most encouragingly, our improvement efforts at the Queen Elizabeth the Queen Mother Hospital (QEQM are yielding tangible results, with the proportion of Type 1 'Major' patients experiencing over 12-hour waits falling from 17.6% in April to 15.6% in June, effectively reducing extended waits by five patients per day, with a similar approach adopted at the William Harvey Hospital (WHH) from July onwards.

3.2 Finance update

As at month 3 (June) the Group's Financial position remains on plan, -£27.3m pre-deficit support funding (DSF) and -£7.2m post DSF. We have seen our spend on pay reduce from month 2, which is an indicator that the additional controls embedded across the Trust are starting to take effect, however, further reductions to our expenditure are required to ensure delivery of the agreed plan.

The Integrated Care System (ICS) also remain on plan, which is important for the Trust to secure the DSF, which is linked to system delivery.

Our External Audit has now concluded and I am happy to report that on 26 June 2025, our external auditors were able to report to the Board an unqualified opinion of the accounts for 2024/25.

4. EXTERNAL UPDATE

4.1 Launch of the NHS 10-year strategy

On 3 July 2025, the Prime Minister launched the Government's fit for the future 10 Year Health Plan which establishes three core principles that are aligned to the Trust's strategic direction: delivering care in the community, maximising digital technologies, and focusing on prevention of ill health.

The plan's central ambition to end the 'hospital by default' status quo presents significant opportunities for the Trust, requiring care to be delivered as locally as possible through a hierarchy of digital-first approaches, home-based care where feasible, neighbourhood health centres when needed, and hospital care only when necessary.

While representing a substantial shift from our current operations, this transformational vision, provides a clear framework for future decision-making and service development across our local health and care partnership (HCP).

As a Trust we will review our draft strategy to ensure alignment with the national direction while addressing the specific needs of patients in East Kent. The Secretary of State's open letter to NHS colleagues provides further context for how this plan will drive ambitious reconfiguration of how we deliver care across our communities over the coming decade.

4.2 Recovery support programme – National Oversight Framework (NoF)

The Trust has made significant progress against the milestones and exit criteria for the 2024/25 integrated improvement plan (IIP) as part of being a NoF 4 organisation in the recovery support programme (RSP).

Evidence has been presented at a system and regional level in support of the progress that has been made in the delivery of the IIP, with the next stage being consideration of the evidence by the national team to assess whether the Trust has successfully met the exit criteria that was set.

We are hopeful that the outcome of the national review will be confirmed in the coming weeks and an update will be provided at the meeting.

4.3 Spencer Private Hospitals (SPH) – Care Quality Commission (CQC) inspection update

Spencer Private Hospitals are still awaiting publication of their CQC report although indications from the CQC team have not suggested any serious concerns

and the feedback for the recent CQC inspection at the QEQM has been generally positive.

The report remains in the process of being finalised, however, following verbal feedback the inspectors recognised and highlighted the dedication, professionalism, and compassionate care delivered by staff, as well as the open and supportive approach to management that is demonstrated throughout the organisation.

4.4 Submission of annual accounts

The Quality Accounts and Annual Report were approved on 26 June 2025 and recognise the progress has been achieved in clinical performance and operational efficiency over the past 12 months.

The Trust has made significant progress towards reducing patient waiting times, with the number of patients waiting longer than 65 weeks for planned care dropping dramatically from a peak of 2,698 in January 2024 to just 33 patients by the end of March 2025, alongside notable improvements in diagnostic test times and cancer treatment pathways, however, emergency care services continue to face capacity pressures with patients experiencing extended waits for beds. Looking ahead, we have set ambitious targets to treat 60% of patients within 18 weeks and reduce long-term waits to no more than 1% by March 2026.

Strong financial discipline has been demonstrated by meeting the challenging cost savings target of £49 million and achieving the agreed financial deficit of £85.8 million for the year. Whilst this represents progress toward financial balance, meeting this year's financial targets will require continued focus and innovation, balancing the need to improve patient care and maintain fiscal responsibility.

Significant quality and safety improvements have also been delivered, recognised by the CQC upgrading maternity services at both the WHH and QEQM hospitals from 'inadequate' to 'good' ratings across all assessed domains. This improvement demonstrates the Trust's commitment to implementing the lessons learnt from the 'Reading the Signals' report and creating a culture where staff and patients feel safe to raise concerns. We have also enhanced our staff engagement initiatives, with 63% participation in the annual staff survey, and a renewed focus on improving leadership consistency, ensuring staff voices are heard through new programmes including a Staff Congress and Trust-wide awards scheme.

5. OTHER AREAS TO NOTE

5.1 Clinical Symposium - celebrating clinical audit excellence

The third annual Clinical Audit Symposium was held on 4 June 2025 at the Canterbury Cricket Ground to celebrate the power of clinical audit in driving quality and safety improvements.

Organised by Dr Ali Mehdi (chair of the Clinical Audit and Effectiveness Group), Gary Hodges (clinical audit manager), and hosted by Michael Jackson (deputy lead clinical services pharmacist), the day brought together clinicians, managers, and digital transformation experts to reflect on a year of outstanding audit projects, celebrate impactful quality and safety improvements and to share visions for the future.

Key innovations presented included the new My Health App and Quality Insights Audit Tool, alongside demonstrations of our digital transformation strategy's impact on clinical audit capabilities.

With sponsorship from major healthcare partners including Pfizer UK, Boehringer Ingelheim, and AstraZeneca, the symposium reinforced our commitment to continuous improvement, patient safety, and digital innovation with overwhelmingly positive feedback received from attendees.

5.2 Nursing Times Award nominees

Individuals and teams from across the Trust have been shortlisted for the prestigious Nursing Times Awards, demonstrating our commitment to clinical excellence.

Midwives Leisa Foad and Katie Christie are finalists in the Midwife of the Year category, with Leisa recognised for her transformative leadership as the Professional Midwifery Advocate and Katie acknowledged for establishing innovative joint obstetric and midwifery birth choices clinics.

Additionally, our Infection Prevention and Control team have earned finalist status for their impactful CLEAN campaign, which systematically addresses healthcare-associated infections through targeted interventions to keep patients and colleagues safe and facilitate better patient outcomes.

Finalists will each present to a judging panel in London in September ahead of winners being announced at the ceremony in October. These nominations build on last year's success when the ED team at the WHH secured the prestigious Team of the Year award.

5.3 National recognition for domestic services team

Three members of the 2gether Support Solutions (2gether) domestics team at the QEQM have achieved finalist status in the British Institute of Cleaning Science Awards.

Stephen Butterworth (Cleaning Operative of the Year), Zoe Biela (Outstanding Candidate of the Year), and Rose Dalton (Lifetime Achievement Award) will compete at the national finals in September.

Their nominations are reflective of the positive feedback they have received from their colleagues and are recognition for their strong work ethic, dedication, and

commitment to upholding the British Institute of Cleaning Science (BICS) standards.

5.4 HSJ digital awards

Our Information Department and Staff Experience Team were finalists at the HSJ Digital Awards, competing in the "Enhancing Workforce Engagement, Productivity and Wellbeing Through Digital" category with their project "From Statistics to Stories: A Digital Solution to Workforce Wellbeing and Engagement."

While the teams did not secure the top prize at the ceremony held in Birmingham, this recognition validates their initiative to improve how we interpret the staff survey results—helping turn data into meaningful insights that drive positive change for our workforce.

The Board of Directors are requested to **DISCUSS** and **NOTE** the 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: **31 July 2025**

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

Paper Author: **Ben Stevens, CSPO**

Appendices:

APPENDIX 1: June 2025 IPR

Executive summary:

Action required:	Discussion
Purpose of the Report:	The report provides the monthly update on Operational Performance, Quality & Safety (Q&S), Workforce, Financial and Maternity organisational metrics. The metrics are directly linked to the Strategic and Annual objectives. The reported metrics are derived from: 1. Statutory reporting 2. Executive agreed key metrics
Summary of key issues:	The IPR has been subject to a review and refresh and a revised format is being presented from May 2024 onwards. The reported metrics have been grouped to give a detailed view of progress against the quarterly milestones for the Integrated improvement plan 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 and 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 (June Reported Month): **Patients** • Incremental improvements across all key cancer metrics in month. 62 day (62D) compliance at 76.7% (from May's 75.6%) and remains above the NHS England (NHSE) year-

	end target for 62D of 75%. The 62D backlog has reduced to back under 200 (June 170, May 222), and Faster Diagnosis Standard (FDS) improved by nearly two percentage points (June 76.8%, May 74.9%).
	• The end of June position was that there were 67 patients waiting greater than 65 weeks including 4 x 104 and 8 x 78 week waits.
	• Overall four-hour compliance maintained improvements into June with performance across all types of department at 76.4% and Type 1 departments at 54.0%.
	• Diagnostics Waiting Times and Activity (DM01) performance at the end of June is 81.5%.
	
	Quality & Safety
	• There were no never events reported in June.
	• The Trust at the end of June had:
	  ○ Eight nationally reportable Patient Safety Incident Investigations (PSIIs) ongoing.
	  ○ 12 Local PSIIs.
	  ○ One local Multidisciplinary Team (MDT).
	• The number of overdue incidents reduced to 728 in June.
	• There were 109 occurrences of mixed sex accommodation breaches in June.
	• Healthcare-associated infection (HCAI) trajectories for June 2025 are slightly over for *Clostridium difficile* (C. diff), and *Escherichia coli* (E.coli) (*Methicillin-resistant Staphylococcus aureus* (MRSA) two cases to date – one in April and one in May).
	
	People
	• Sickness absence rates have improved to 4.19%, from 4.66% the previous month.
	• Appraisal compliance has fallen again to 72.9%.
	• Statutory training compliance remains at/around 93.3%.
	
	Finance
	• The Month 3 Year to Date (YTD) position achieved by the Group (Pre-deficit support) was a £27.3m deficit. As at Month 3 the Group remains on plan.
	• As at Month 3, the Trust has a small surplus of £0.3m.
	• The Trust's YTD Month 3 position shows income from patient care (excluding drugs and devices) is currently £0.6m higher than planned.
	
	Maternity
	• The extended perinatal rate remains consistently below the threshold of 5.42 per 1,000 births, with the June 12 month rolling rate reducing to below the average at 3.73 per 1,000 births. This rate includes both stillbirths and neonatal deaths.
	• In June the neonatal death 12 month rate decreased below the MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

	average of 1.82 for the second time in 12 reporting periods, to 1.02. The service reported zero neonatal deaths >24 weeks in month. • No new Maternity and Newborn Safety Investigations (MNSI) referrals made in June. • Three moderate/severe patient safety incidents were reported in June.
Key recommendations:	The BoD is asked to **CONSIDER** and **DISCUSS** the metrics reported in the IPR.

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

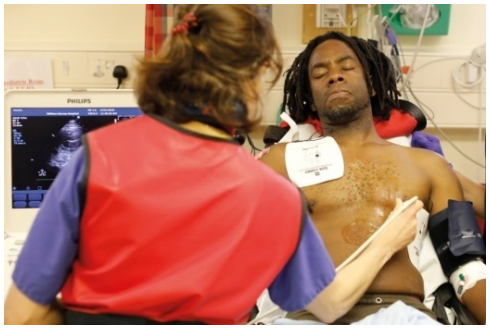
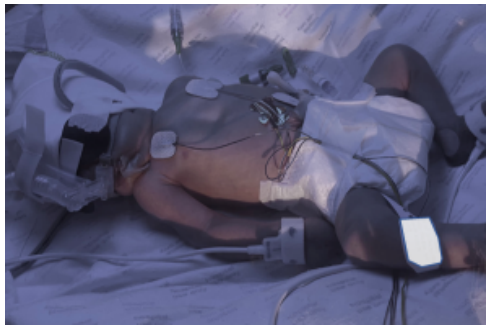
Integrated Performance Report

JUNE 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

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

Patients

Scorecard View

Urgent & Emergency Care Metrics & Cancer Waiting Times

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Patients	NAT		ED Compliance			73.0%	76.3%	77.4%	76.8%	74.4%	74.1%	74.4%	73.4%	73.2%	74.6%	76.2%	76.6%	76.4%
	IIP		Type 1 Compliance 4hrs			52.0%	54.7%	56.2%	56.5%	54.1%	53.7%	54.7%	51.0%	50.1%	51.4%	54.2%	54.6%	54.0%
	IIP		12 Hr Total Time in Department			18.4%	18.6%	18.5%	18.0%	18.7%	18.8%	19.4%	21.3%	20.7%	20.8%	21.7%	20.2%	20.6%
	NAT		12Hr Trolley Waits			0	1,085	1,033	1,017	1,171	1,121	1,326	1,385	1,177	1,327	1,256	1,210	1,150
	NAT		Ambulance Handovers within 30m			95.0%	87.7%	89.8%	88.7%	86.6%	90.0%	88.4%	88.2%	87.7%	90.5%	92.7%	93.9%	94.7%
	IIP		% Beds Occupied 14+			30.0%	30.0%	30.8%	34.3%	32.0%	28.2%	29.1%	33.9%	34.9%	35.4%	34.1%	33.2%	29.4%
	KEY		Super Stranded >21D			107	203	212	237	212	178	184	224	239	236	232	219	191
	NAT		Not Fit to Reside (pats/day)			100.0	180.8	189.7	197.4	195.5	157.8	155.3	165.7	171.0	172.9	173.0	161.8	154.5
	IIP		Cancer 28d Combined Performance			80.0%	72.5%	71.0%	69.8%	71.3%	71.8%	74.9%	66.5%	78.4%	76.3%	75.0%	74.9%	76.8%
	NAT		Cancer 31d Combined Performance			96.0%	96.1%	95.2%	95.2%	92.7%	94.3%	97.1%	92.8%	96.2%	97.2%	96.8%	95.7%	95.5%
	IIP		Cancer 62d Combined Performance			85.0%	71.6%	73.2%	72.9%	70.4%	74.1%	73.9%	69.0%	70.8%	77.3%	76.4%	75.6%	76.7%
	IIP		Cancer Over 62d on PTL			200	203	244	215	193	203	216	197	183	167	192	222	170
	KEY		Cancer Over 104d on PTL			0	39	54	50	36	40	33	40	44	46	34	42	38
	KEY		Cancer Rapid Access Perf			93.0%	93.4%	90.6%	92.7%	82.3%	88.1%	93.2%	96.7%	97.7%	94.0%	96.1%	96.5%	92.6%

Patients

Scorecard View

Referral to Treatment Waiting Times, Diagnostics & Productivity Measures

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
	NAT		RTT Incomplete Performance			49.9%	50.3%	50.8%	50.9%	50.5%	51.2%	52.0%	52.5%	52.8%	53.3%	54.0%	54.7%	55.0%
	NAT		RTT 1st OPA Performance			56.9%	57.5%	58.3%	57.8%	57.1%	57.5%	57.4%	58.3%	58.8%	60.4%	61.9%	63.0%	63.5%
	NAT		RTT 52w Performance			3.9%	5.6%	5.3%	4.3%	3.9%	3.6%	3.6%	3.5%	3.2%	2.8%	3.2%	3.0%	2.8%
	NAT		RTT Total Incomplete Pathways			84.3K	85.6K	88.1K	86.7K	86.0K	85.6K	83.0K	81.2K	81.3K	81.0K	83.1K	82.1K	80.7K
	NAT		RTT 52w Breaches			3,351	4,773	4,657	3,735	3,353	3,119	2,959	2,861	2,621	2,272	2,648	2,466	2,222
	IIP		RTT 65w Breaches				1,360	1,269	572	346	247	216	164	148	33	45	69	68
	IIP		RTT 78w Breaches				35	32	34	11	10	7	4	17	6	12	17	9
	IIP		RTT 104w Breaches			0	0	1	0	0	0	0	0	9	1	3	3	5
	IIP		Endoscopy Backlog				3,018	1,997	1,304	663	391	373	247	258	206	255	268	314
	IIP		DM01 Compliance			78.0%	61.3%	64.0%	68.5%	77.2%	83.3%	81.0%	83.9%	86.2%	87.0%	82.8%	83.2%	81.5%
	KEY		Theatre Session Opp.			25	40	51	39	44	35	45	36	39	29	30	26	25
	NAT		Outpatient DNA Rate			7.0%	6.8%	7.0%	6.8%	6.6%	6.9%	7.1%	6.7%	6.4%	6.5%	6.6%	6.5%	6.2%
	NAT		Theatre Uncapped Utilisation			85.0%	77.9%	79.2%	77.1%	77.7%	78.0%	76.7%	77.5%	76.6%	78.0%	80.3%	80.1%	80.3%

Patients

Executive Summary

Urgent and Emergency Care & Planned Care

Urgent and Emergency Care

- Overall four-hour compliance maintained improvements into June with performance across all types of department at 76.4% and Type 1 departments at 54.0%. Compliance in Type 1 departments has 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 June has shown improvement at the QEQM site at 15.6% and a decline at WHH to 25.5% for an overall steady position against May performance at 20.6%. This remains a significant challenge and focus for the Trust and system partners. A trajectory to get to 10% by March 2026 in in place in line with the national UEC plan.
- Ambulance handover performance improved again to 94.7% of patients handed off to the Emergency Departments within 30 minutes. Performance is now positively alerting demonstrating continued improvements in this measure.
- The number of patients in ED corridor >30 mins in June was slightly higher than the previous year, with 1,621 patients (54 per day) experiencing corridor care. This is at a similar level to that seen in May 2025, with slightly reduced total patient hours spent in corridor locations.
- The occupancy levels of patients spending >7 days on the RTS caseload reduced in June to an average of 132 patients (from 148 in May). Patients recorded as having No Criteria to Reside (NCTR) and remaining in hospital at midnight was an average occupancy of 155 patients throughout June, a reduction of 7 from May. Delayed discharges contributes to the increased LOS observed and challenges in flow through the three main sites.

Planned Care

- At a Trust level planned care activity for quarter one exceeded plan across all points of delivery.
- Incremental improvements across all key cancer metrics in month. 62D compliance at 76.7% (from May's 75.6%) and remains above the NHSE year end target for 62D of 75%. The 62D backlog has reduced to back under 200 (June 170, May 222). And FDS improved by nearly two percentage points (June 76.8%, May 74.9%)
- The end of June position was that there were 67 patients waiting greater than 65 weeks including 4 x 104 and 8 x 78 week waits. The plan remains to achieve and sustain zero patients waiting greater than 65 weeks with work in progress to achieve the new standards for 2025/26 i.e. no more than 1% of patients waiting greater than 52 weeks for treatment from the end of March 2026 from a baseline of 3.6%. A series of improvement workstreams are in the process of being initiated to increase productivity.
- Theatre utilisation sustained the improvement with performance remaining over 80% in June. The Theatre (Perioperative) Improvement Programme and Outpatients Improvement Programmes are focused on continued improvements designed to help the Trust reach the 85% minimum standard for 2025/26 as well as the new RTT standards.
- DM01 performance at the end of June is 81.5%. Key areas for on-going recovery continue to be Cardiac MRI and Echocardiography although recovery and sustainability plans are being enacted across all modalities not meeting target trajectory.

Patients

Urgent & Emergency Care

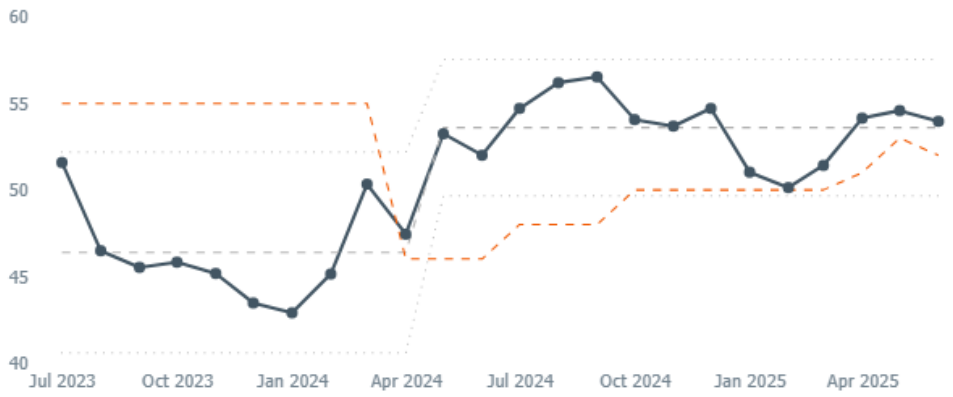
Type 1 Emergency Department; Four Hour Compliance

Type 1 Compliance 4hrs

Timescale	Value	SPC
Jul-24	54.7%	
Aug-24	56.2%	
Sep-24	56.5%	
Oct-24	54.1%	
Nov-24	53.7%	
Dec-24	54.7%	
Jan-25	51.0%	
Feb-25	50.1%	
Mar-25	51.4%	
Apr-25	54.2%	
May-25	54.6%	
Jun-25	54.0%	

XMR Run Chart

No Special Cause Flags



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/06/2025 the latest Type 1 Compliance 4hrs performance is 54.0% against a Trajectory target of 52.0% (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 54.6% is exceeding trajectory target of 51%. Clinically lead Improvement Weeks for WHH and QEQM are scheduled across 25/26. Week 1 working together to review Processes in Hospital has successfully taken place on both hot sites. • Visit to SPOA scheduled to take place in July to enable further discussions with partners around the service. • As part of the SDEC steering group for the new capital builds on both sites, all direct access pathways will be reviewed.
Safe and Effective ED	• Standards and quality indicators will be reviewed on both of the hot sites to ensure timely delivery of patient care within the constraints of the Department. • Review of CDU model on both sites.	• Dep COO UEC • MDs	• Q1 to Q4 • Q1 to Q4	• Internal professional standards have been reviewed and monitored at WHH by the improvement team following Improvement week 1. The outcome is scheduled to be reviewed with the MD in month 3. • CDU walkaround at WHH has taken place and enabling changes are scheduled with estates for month 5.
Admission avoidance	Front door alternatives to ED: • SDEC capital plans being developed for WHH and QEQM with a steering group and workstream mdt approach. • Review UTC models and pathways with partners considering location and GP streaming 7 day service for all walk in patients.	• SiteTri • Dep COO UEC	• Q1 to Q4 • Q2	• Patient flow and pathways for emergency patients will be considered and reviewed as part of the Emergency Village capital development at WHH and QEQM. • UTC's to be co located within the SDEC plans at both sites for walk-in patients with streaming to enable full utilisation of the emergency footprint for patient pathways .

Patients

Urgent & Emergency Care

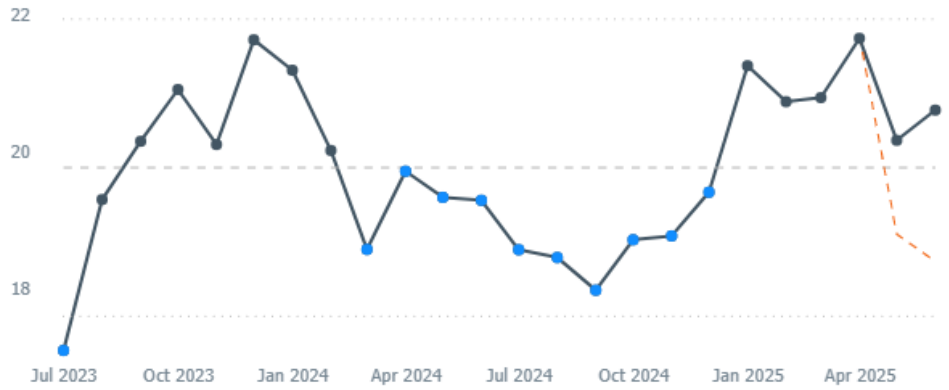
12 Hour Total Time in Emergency Department

12 Hr Total Time in Department

Timescale	Value	SPC
Jul-24	18.6%	
Aug-24	18.5%	
Sep-24	18.0%	
Oct-24	18.7%	
Nov-24	18.8%	
Dec-24	19.4%	
Jan-25	21.3%	
Feb-25	20.7%	
Mar-25	20.8%	
Apr-25	21.7%	
May-25	20.2%	
Jun-25	20.6%	

XMR Run Chart

No Special Cause Flags



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/06/2025 the latest 12 Hr Total Time in Department performance is 20.6% against a Trajectory target of 18.4% (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
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/ QEQM	Q1 to Q4	• Acute sites to have agreed steps and plans in place for surge and/or excess demand with governance and transparency for space and staffing. • Introduce CDU within the acute sites with SOP's for patient flow to reduce los and admissions. • Position for 12hrs is showing improvement at QEQM but a worsening position at WHH for an overall position remaining steady at 20.6% following steps taken forward. Implementation of action cards for ED and the site team to agreed escalation points for patients at a 8 hour and 10 hour perspective.
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/ QEQM	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.
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 • SAFEHAVEN roll out underway across both sites • Review Medway and lessons learned from safe Haven introduction and impact on patient wait times at the front door	• CG Tri WHH/ QEQM	Quarter 1	• 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 24/25 on escalation and capacity to manage long stayers- SOP for escalation developed by MD for WHH and QEQM

Patients

Urgent & Emergency Care

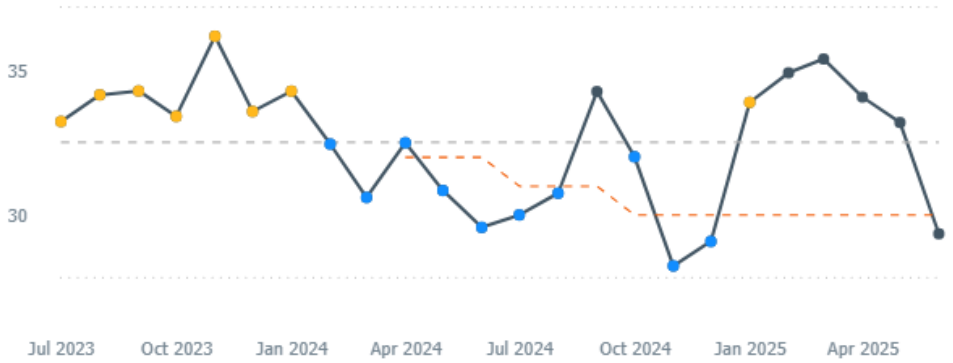
In-Hospital Spells with a Length of Stay over 14 Days

% Beds Occupied 14+

Timescale	Value	SPC
Jul-24	30.0%	
Aug-24	30.8%	
Sep-24	34.3%	
Oct-24	32.0%	
Nov-24	28.2%	
Dec-24	29.1%	
Jan-25	33.9%	
Feb-25	34.9%	
Mar-25	35.4%	
Apr-25	34.1%	
May-25	33.2%	
Jun-25	29.4%	

XMR Run Chart

No Special Cause Flags



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/06/2025 the latest % Beds Occupied 14+ performance is 29.4% against a Trajectory target of 30.0% (lower is better).

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

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

Patients

Cancer Care

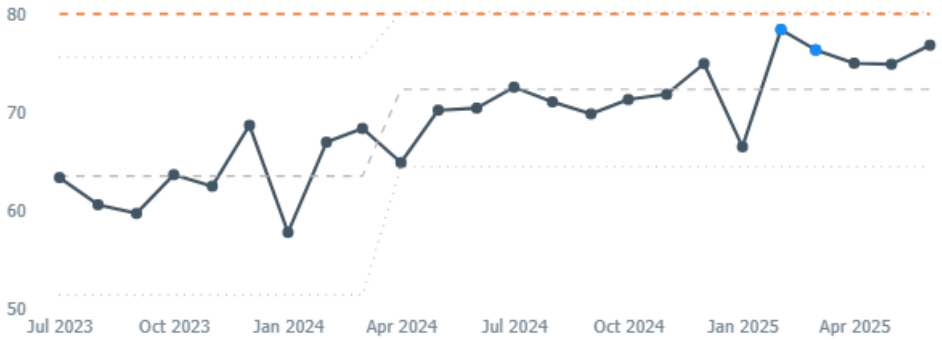
Cancer 28 Day Faster Diagnosis Compliance

Cancer 28d Combined Performance

Timescale	Value	SPC
Jul-24	72.5%	
Aug-24	71.0%	
Sep-24	69.8%	
Oct-24	71.3%	
Nov-24	71.8%	
Dec-24	74.9%	
Jan-25	66.5%	
Feb-25	78.4%	
Mar-25	76.3%	
Apr-25	75.0%	
May-25	74.9%	
Jun-25	76.8%	

XMR Run Chart

No Special Cause Flags



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/06/2025 the latest Cancer 28d Combined Performance performance is 76.8% 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: 07 - Lower GI (53.8% , 288*), 11 - Urological (60.0% , 208*), 09 - Gynaecological (71.0% , 114*). *Breaches

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Access to timely diagnostics		• Radiology • Endoscopy	• Ongoing	• Access to diagnostics continues to be monitored through weekly escalation meetings held with Radiology Leads. Some diagnostic timelines are extended in June, most notably Breast One Stop, CT and Biopsy capacity; to monitor the position a second touchpoint radiology touchpoint takes place in week. • The Breast and Radiology team are closely linked to work through solutions to improve the wait times. • CT has been subject to numerous machinery failures over the last month resulting in a backlog of re-booking • Biopsy wait times have extended due to radiology staff sickness – escalation comms are being reviewed by Radiology
Letter backlog	• Timely consultant dictation of cancer letters to patients • Timely admin support to process dictated letters	• Cancer compliance • Admin • Consultant	• 25/26	• Ensuring our patients are informed promptly when they do not have cancer remains a key priority for our specialty teams. We recognise the need to reduce the time between diagnostic results and the receipt of outcome letters for both GPs & patients. • There has been an increase in the letter backlog position in month. • Teams continue to review the administrative processes in place to support the quick turnaround of letters however, there have been some recognised admin resource challenges across some specialties • The letter position is monitored at the weekly Trustwide operational Access meeting
Lower GI	• Key contributing specialty to the non compliant position • Low ranking specialty for 28D against national benchmarking data	• Spec Team	• Q4	• There have been significant improvements in the LGI pathway – 1st OPA regularly taking place within one week of referral, Endoscopy wait times are stable at 10 days, and VC requests (typically adding 3+ weeks to pathway) continue to reduce. • The newly ratified pathway will continue to be adopted in practice throughout 25/26. • The FDS position has been stable over the last three months. Early indications of the July position show an improvement in performance. Note 62D performance has reported three months of consecutive improvement.

Patients

Cancer Care

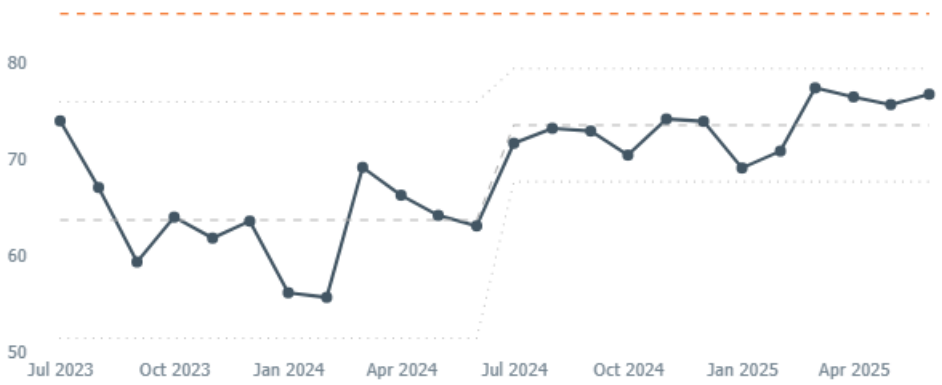
Cancer 62 Day Performance

Cancer 62d Combined Performance

Timescale	Value	SPC
Jul-24	71.6%	
Aug-24	73.2%	
Sep-24	72.9%	
Oct-24	70.4%	
Nov-24	74.1%	
Dec-24	73.9%	
Jan-25	69.0%	
Feb-25	70.8%	
Mar-25	77.3%	
Apr-25	76.4%	
May-25	75.6%	
Jun-25	76.7%	

XMR Run Chart

No Special Cause Flags



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/06/2025 the latest Cancer 62d Combined Performance performance is 76.7% against a static target of 85.0% (higher is better).

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

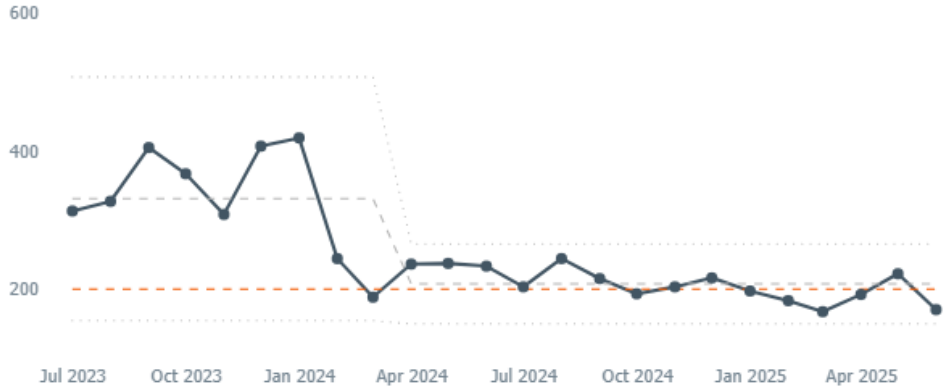
The biggest contributing factors are: 11 - Urological (46.7% , 52*), 01 - Breast (71.7% , 15*), 08 - Skin (85.9% , 13*). *Breaches

Cancer Over 62d on PTL

Timescale	Value	SPC
Jul-24	203	
Aug-24	244	
Sep-24	215	
Oct-24	193	
Nov-24	203	
Dec-24	216	
Jan-25	197	
Feb-25	183	
Mar-25	167	
Apr-25	192	
May-25	222	
Jun-25	170	

XMR Run Chart

No Special Cause Flags



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/06/2025 the latest Cancer Over 62d on PTL performance is 170 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 (73*), 11 - Urological (51*), 06 - Upper GI (13*). *Number

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.
Capacity for diagnostics	• Extended booking lead times and reporting turn around	• Radiology	• Ongoing	• Visibility on vetting lead times now being discussed at escalation meetings. • Close management of booking capacity in place due to increased number of CT breakdowns requiring patient rebooking and the removal of overtime options to support
Urology treatment capacity	• Limited consultant robotic capacity • Limited oncology capacity	• Urology	• Q2	• Following a period of increased referrals throughout Q4 24/25, resulting in an increased number of patients breaching 62D, the position is now recovering. Patient numbers in the 62D backlog have reduced week-on-week since early June. • Surgical demand continues to exceed current capacity. All theatre utilisation is being actively monitored and adjusted where feasible. Surgical capacity is expected to increase in the coming months as it is hoped the Trust's second robotic prostate consultant will transition to performing two procedures per day, but only if clinically appropriate. • Surgical capacity has been further challenged by sickness within the Surgical Care Practitioner team.
Oncology provision	• Extended wait times for Oncology • Excessive patient caseload from some Oncologists • Increase chemotherapy treatments per patient	• MTW SLA Agreement	• Q2	• A review is currently underway of the Service Level Agreement between MTW and EK for the provision of Oncology services to EK. • Early findings indicate a need for increased Oncology capacity to meet the growing demand for the service. • Key areas identified for action include improving the oncologist-to-caseload ratio and addressing the resulting impact on patient wait times. • Additionally, changes to chemotherapy regimens, with patients now receiving treatment over longer periods and requiring more cycles, are contributing to the rising demand. • This increase has been factored into the 2025/26 business planning cycle, and a draft business case is in development. • Following a review of cancer compliance roles and responsibilities an Oncology tracker has been moved into post to provide additional oversight of patients awaiting oncology appointments and treatment.

Patients

Planned Care

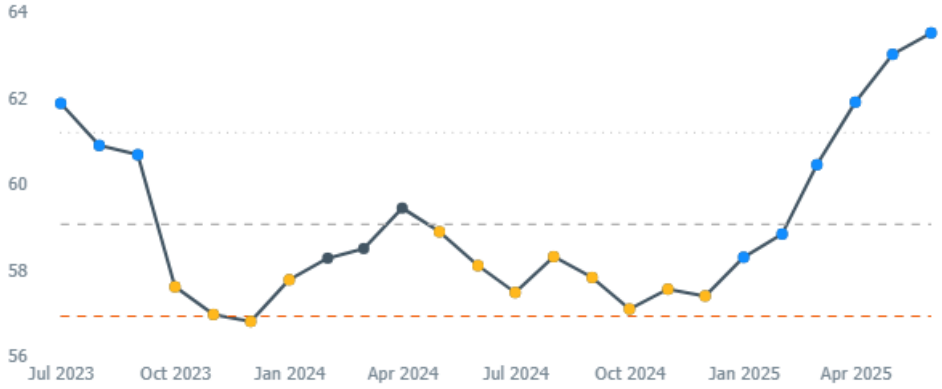
Referral to Treatment Waiting Times; 1st OPA and 52ww Performance

RTT 1st OPA Performance

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

XMR Run Chart

Astronomical Point | Ascending 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 01/06/2025 the latest RTT 1st OPA Performance performance is 63.5% against a (6 Sigma Threshold) target of 56.9% (higher is better).

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

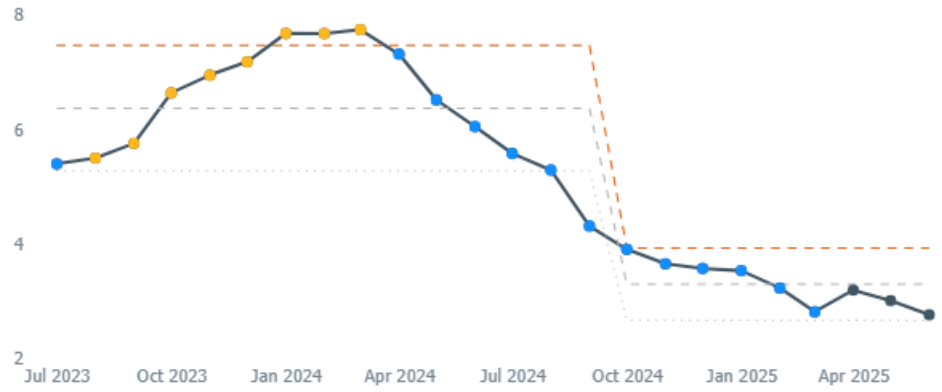
The biggest contributing factors are: 301 - GASTROENTEROLOGY (52.9% , 1,925*), 320 - CARDIOLOGY (47.8% , 1,853*), 410 - RHEUMATOLOGY (46.3% , 1,782*). *Breaches

RTT 52w Performance

Timescale	Value	SPC
Jul-24	5.6%	
Aug-24	5.3%	
Sep-24	4.3%	
Oct-24	3.9%	
Nov-24	3.6%	
Dec-24	3.6%	
Jan-25	3.5%	
Feb-25	3.2%	
Mar-25	2.8%	
Apr-25	3.2%	
May-25	3.0%	
Jun-25	2.8%	

XMR Run Chart

No Special Cause Flags



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/06/2025 the latest RTT 52w Performance performance is 2.8% against a (6 Sigma Threshold) target of 3.9% (lower is better).

Performance is not changing significantly is likely to continue to deliver the target moving forward.

The biggest contributing factors are: 110 - ORTHOPAEDICS (1.0% , 6,681*), 120 - EAR NOSE AND THROAT (2.9% , 6,199*), 502 - GYNAECOLOGY (0.8% , 5,533*). *Breaches

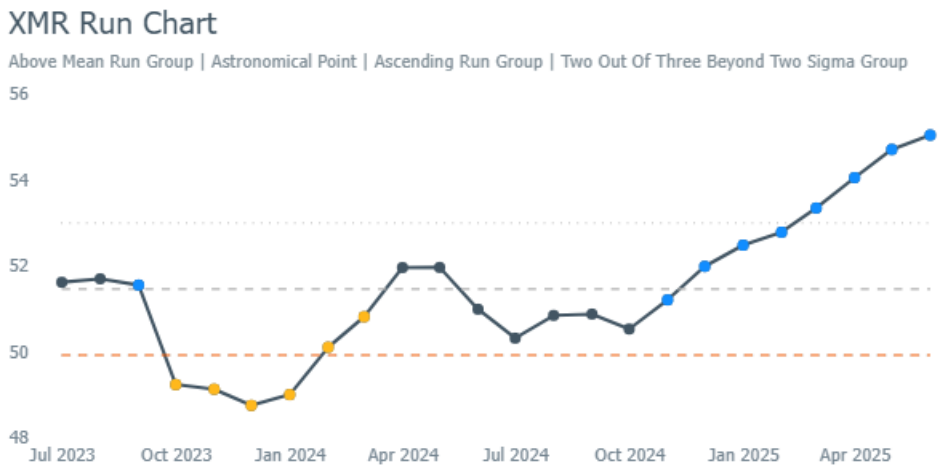
Patients

Planned Care

Referral to Treatment Waiting Times; Incomplete Pathways Performance

RTT Incomplete Performance

Timescale	Value	SPC
Jul-24	50.3%	
Aug-24	50.8%	
Sep-24	50.9%	
Oct-24	50.5%	
Nov-24	51.2%	
Dec-24	52.0%	
Jan-25	52.5%	
Feb-25	52.8%	
Mar-25	53.3%	
Apr-25	54.0%	
May-25	54.7%	
Jun-25	55.0%	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/06/2025 the latest RTT Incomplete Performance performance is 55.0% against a (6 Sigma Threshold) target of 49.9% (higher is better).

Performance is statisticaly improving and is likely to continue to deliver the target moving forward. (you may need consider if it is time to recalculate the process limits).

The biggest contributing factors are: 110 - ORTHOPAEDICS (49.3% , 3,418*), 145 - ORAL AND MAXILLOFACIAL SURGERY (44.0% , 3,214*), 320 - CARDIOLOGY (43.7% , 3,021*). *Breaches

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

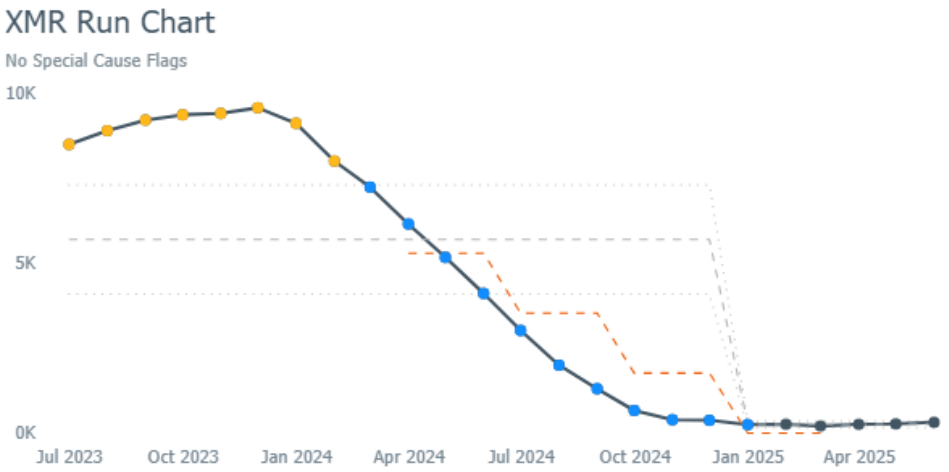
Patients

Planned Care

Endoscopy Backlog; Overdue Surveillance and Routine Waits

Endoscopy Backlog

Timescale	Value	SPC
Jul-24	3,018	
Aug-24	1,997	
Sep-24	1,304	
Oct-24	663	
Nov-24	391	
Dec-24	373	
Jan-25	247	
Feb-25	258	
Mar-25	206	
Apr-25	255	
May-25	268	
Jun-25	314	



Understanding the Latest Performance

No Special Cause Variation

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

The biggest contributing factors are: OGD (149*), Dual (80*), Colon (65*). *Overdue Waiters

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

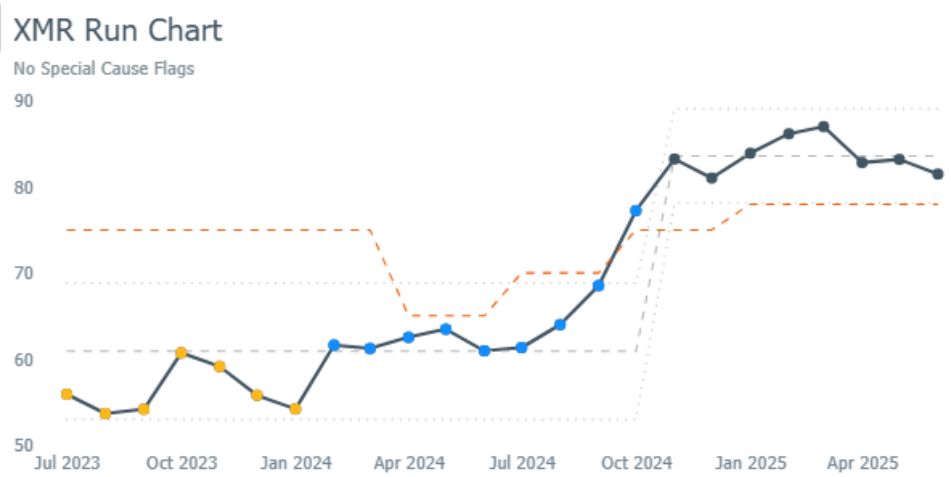
Patients

Planned Care

Diagnostics; DM01 Compliance % Patients Waiting less then 6 Weeks

DM01 Compliance

Timescale	Value	SPC
Jul-24	61.3%	
Aug-24	64.0%	
Sep-24	68.5%	
Oct-24	77.2%	
Nov-24	83.3%	
Dec-24	81.0%	
Jan-25	83.9%	
Feb-25	86.2%	
Mar-25	87.0%	
Apr-25	82.8%	
May-25	83.2%	
Jun-25	81.5%	



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/06/2025 the latest DM01 Compliance performance is 81.5% against a Trajectory target of 78.0% (higher is better).

Performance is not changing significantly is likely to continue to deliver the target moving forward.

The biggest contributing factors are: MRI (85.4% , 968*), CT (80.1% , 962*), Non Obstetric Ultrasound (89.0% , 373*). *Breaches

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Echocardiography Back log		• Cardiology GM • Cardiology Lead Clinical Scientist	• Ongoing	• Echo overall finished June at 70.9%, a drop on last months performance. • Non-achievement driven by complex echo however, waiting list continues to reduce for these modalities. On going echo insourcing continues as part of 25/26 business plans. • Activity gap mitigation to be addressed with continued insourcing as required – requires review to ensure maintenance of DM01. • Decline in performance due to some long-term sickness within administrative teams. Now resolving with NHSP in place. • Performance for July is improving again currently based on weekly monitoring.
Cardiac MRI Backlog	• Recruitment to vacant consultant posts.	• Cardiology GM	• March 2026	• One post holder goes on mat leave September 2025. • Vacancy now approved for advertisement. • 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

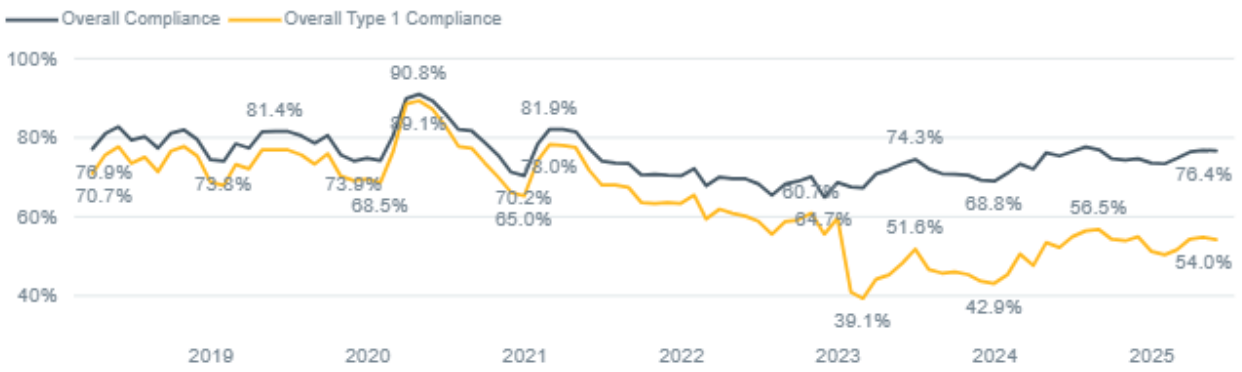
Benchmarking Data

Urgent & Emergency Care: Patients seen in the Emergency Department within four hours

National Data and Comparisons [EKHUFT SUMMARY / REGIONAL/ RANK AND DISTRIBUTION

Overall Compliance and Overall Type 1 Compliance by Month (Selected Site)

Nationally Published Datasets



Latest 4 Hour Position

Nationally Published Datasets

76.42%

Jun-25

Latest Type 1 Position

Nationally Published Datasets

53.97%

Jun-25

Sites Submitting Type 1 Attendances

Nationally Published Datasets

121

EKHUFT Ranking:

Nationally Published Datasets

42
Ranked for Overall Compliance

93
Ranked for Type 1 Compliance

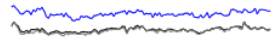
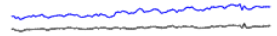
Nationally Published Datasets

Provider Name	Overall Type 1 Compliance	Type 1 Ranking	Overall Compliance	Total Attends	Overall Compliance Ranking
ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST	51.54%	100	65.81%	10,172	98
EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	53.97%	93	76.42%	25,266	42
UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST	57.25%	79	60.80%	13,102	113
FRIMLEY HEALTH NHS FOUNDATION TRUST	57.43%	78	72.45%	35,965	65
ISLE OF WIGHT NHS TRUST	58.13%	73	69.14%	6,092	83
HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST	59.34%	68	69.10%	14,156	84
SURREY AND SUSSEX HEALTHCARE NHS TRUST	64.42%	43	64.42%	10,423	104
DARTFORD AND GRAVESHAM NHS TRUST	65.16%	41	74.55%	15,089	55
UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST	65.21%	40	68.70%	32,265	88
PORTSMOUTH HOSPITALS UNIVERSITY NHS TRUST	65.39%	39	74.84%	17,159	53
ROYAL BERKSHIRE NHS FOUNDATION TRUST	66.27%	36	75.17%	17,532	52
EAST SUSSEX HEALTHCARE NHS TRUST	66.63%	34	75.83%	14,836	46
MEDWAY NHS FOUNDATION TRUST	67.06%	31	77.63%	17,995	31
BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	69.38%	23	77.69%	15,242	29
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	72.74%	17	79.99%	19,691	19
ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST	73.16%	15	78.65%	9,609	24
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	80.75%	5	82.75%	21,660	11

Patients

Benchmarking Data

Urgent & Emergency Care: 12hr Stays in Emergency Departments

Outcome measures - Stays in ED The below metrics highlight the length of stay in ED, and whether high numbers of length of stay is driven by those aged 65+	Data period	Provider value	Peer average	National value	National value method	Chart
Attendances with a 12-hour+ stay in ED, as a proportion of all ED attendances (weekly average)	23/03/2025	9.4%	7.6%	7.2%	Provider median	
Number of attendances per day with a 12-hour+ stay in ED (weekly average)	23/03/2025	96	37	34	Provider median	
Number of attendances per day in ED (weekly average)	23/03/2025	1,016	516	498	Provider median	

Patients

Benchmarking Data

Cancer Waiting Times & Referral to Treatment Waiting Times

All cancers: overview	Data period	Provider value	Peer average	National value	National value method	Chart
Suspected all cancers: diagnosed or ruled out	May 2025	4,157	2,211	1,973	Provider median	
All cancers: patients treated	May 2025	392	240	197	Provider median	
Suspected all cancers: diagnosed or ruled out within 28 days%	May 2025	74.9%	76.6%	80.0%	Benchmark value	
All cancers: treated within 62 days%	May 2025	75.5%	74.5%	75.0%	Benchmark value	
Suspected all cancers: <28 days%, change since April 2024	May 2025	10.0%	4.8%	0.8%	Provider median	
All cancers: <62 days%, change since April 2024	May 2025	9.4%	0.4%	0.2%	Provider median	
Suspected all cancers: median days to diagnose or rule out	Jan 2025	8.9	9.1	10.0	Provider median	
All cancers: median days to receive treatment	May 2025	39.8	42.5	43.8	Provider median	

All specialties: <18 weeks wait%	06/07/2025	55.1%	57.1%	65.0%	Benchmark value	
All specialties: <18 weeks% wait, 1st appointments	06/07/2025	64.2%	63.4%	72.0%	Benchmark value	
All specialties: <18 week wait%, change since Nov 2024	06/07/2025	4.4%	2.2%	5.0%	Benchmark value	
All specialties: <18 week wait%, change since Nov 2024, 1st appointments	06/07/2025	6.6%	3.3%	5.0%	Benchmark value	
All specialties: >52 weeks wait%	06/07/2025	2.8%	3.0%	1.0%	Benchmark value	
All specialties: median weeks wait	06/07/2025	16.8	16.2	15.0	Provider median	
All specialties: median weeks wait, 1st appointments	06/07/2025	13.5	13.8	13.0	Provider median	

Patients

Benchmarking Data

Cancer Waiting Times & Referral to Treatment Waiting Times

Missed outpatient appointments (DNAs)	Data period	Provider value	Peer average	National value	National value method	Chart
Number of outpatient appointments where patients missed outpatient appointments (DNAs)	May 2025	5,688	2,937	2,980	Provider median	
Missed outpatient appointments (DNAs) rate	May 2025	6.4%	5.9%	6.7%	Provider median	

Total outpatient activity	Data period	Provider value	Peer average	National value	National value method	Chart
Number of outpatient attendances	May 2025	83,879	52,649	48,170	Provider median	
Ratio of follow up : first appointment	May 2025	1.7	1.8	2.0	Provider median	

Utilisation Reporting is weekly and the date displayed represents the Week Ending Date.	Data period	Provider value	Peer average	National value	National value method	Chart
Capped elective theatre utilisation %	29/06/2025	78.0%	80.5%	80.6%	Provider median	

Session Efficiency: Late starts Reporting is weekly and the date displayed represents the Week Ending Date.	Data period	Provider value	Peer average	National value	National value method	Chart
% of planned time in valid elective sessions lost due to late starts	29/06/2025	5.2%	5.2%	4.8%	Provider median	
Average late start (of all valid elective sessions) (minutes)	29/06/2025	18	17	18	Provider median	

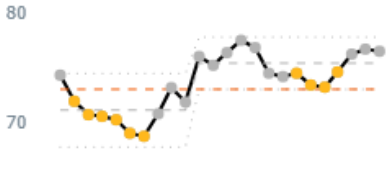
Session Efficiency: Early finishes Reporting is weekly and the date displayed represents the Week Ending Date.	Data period	Provider value	Peer average	National value	National value method	Chart
% of planned time in valid elective sessions lost due to early finishes	29/06/2025	10.3%	10.0%	10.7%	Provider median	
Average early finish (of all valid elective sessions) (minutes)	29/06/2025	35	36	37	Provider median	

Patients

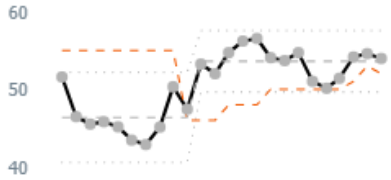
Trend Analysis

Patient Domain Metrics

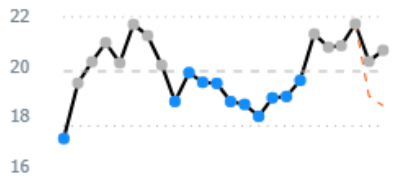
ED Compliance



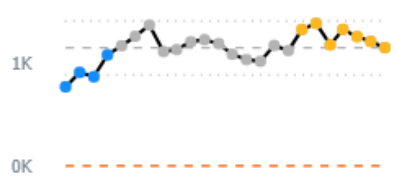
Type 1 Compliance 4hrs



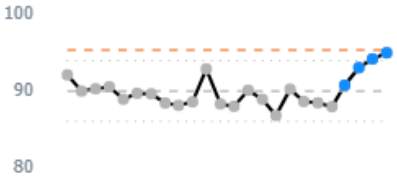
12 Hr Total Time in Department



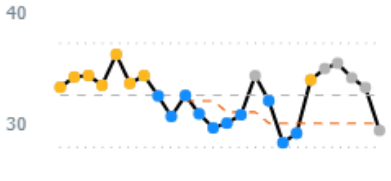
12Hr Trolley Waits



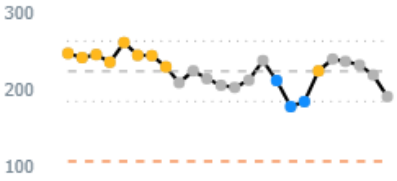
Ambulance Handovers within 30m



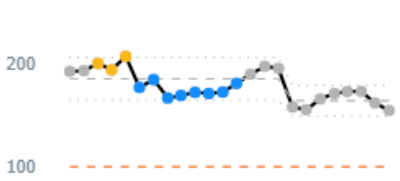
% Beds Occupied 14+



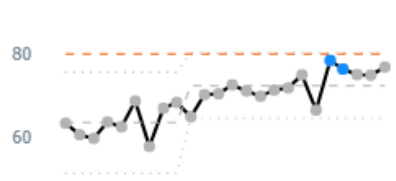
Super Stranded >21D



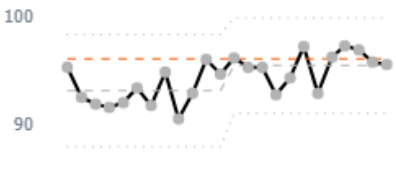
Not Fit to Reside (pats/day)



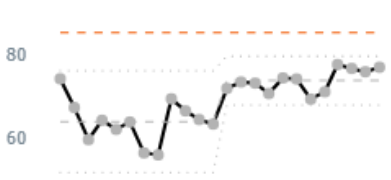
Cancer 28d Combined Performance



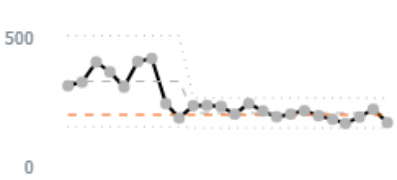
Cancer 31d Combined Performance



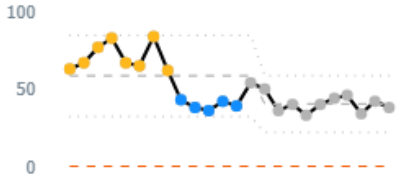
Cancer 62d Combined Performance



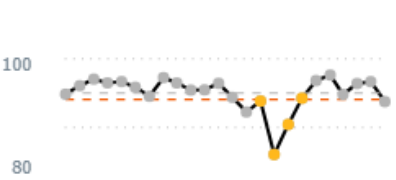
Cancer Over 62d on PTL



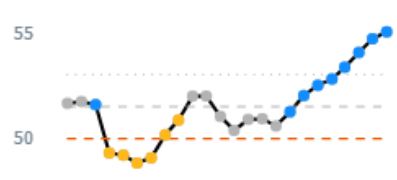
Cancer Over 104d on PTL



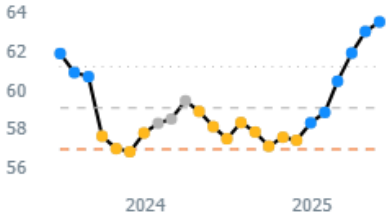
Cancer Rapid Access Perf



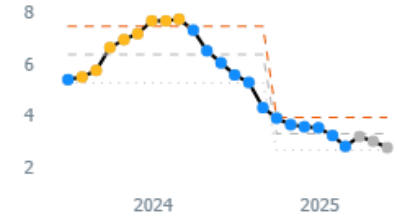
RTT Incomplete Performance



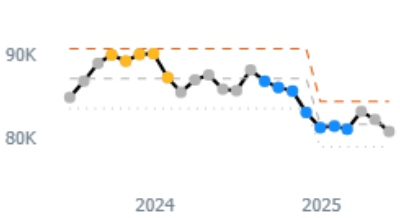
RTT 1st OPA Performance



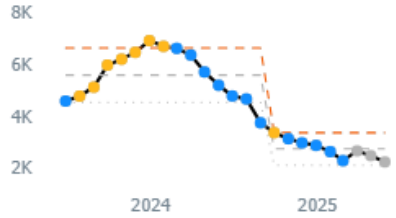
RTT 52w Performance



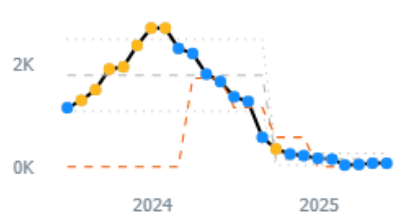
RTT Total Incomplete Pathways



RTT 52w Breaches



RTT 65w Breaches

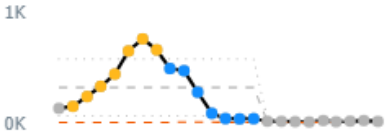


Patients

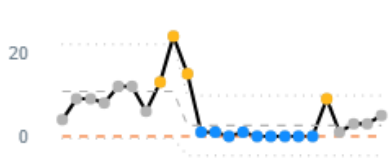
Trend Analysis

Patient Domain Metrics

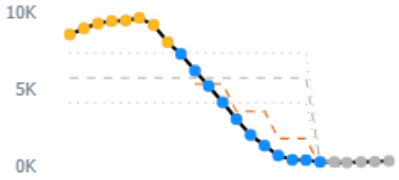
RTT 78w Breaches



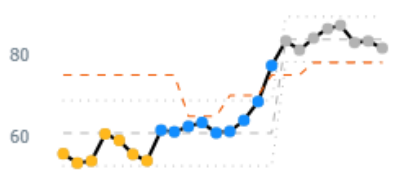
RTT 104w Breaches



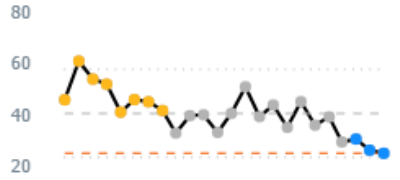
Endoscopy Backlog



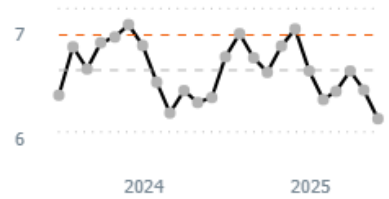
DM01 Compliance



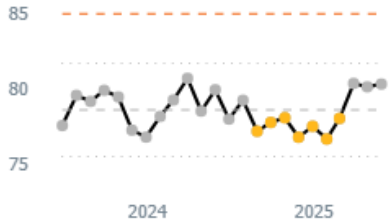
Theatre Session Opp.



Outpatient DNA Rate



Theatre Uncapped Utilisation



Quality and safety

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)		Duty of Candour - Verbal Duty of Candour - Written 15wd IPC: Klebsiella Infections PSII - National Theatre recovery Mixed Sex Breaches VTE Assessment Compliance	
No Significant Change	FFT Satisfaction Level - Outpatient NICE Compliance Safeguarding Children Training	After Action Reviews (AARs) Complaint Response Duty of Candour - Findings Falls with Harm FFT Satisfaction Level - Inpatient IPC: CDiff Infections IPC: EColi Infections IPC: MRSA Infections IPC: MSSA Infections IPC: Pseudomonas Infections Mixed Sex Breaches Never Events Patient Safety Incidents	AARs Overdue FFT Satisfaction Level - ED HSMR Overdue Incidents
Concerning Variation (High or Low)	Safeguarding Adults Training	Complaints Number SHMI	

Quality and safety

Scorecard View

Incident Reporting, Compliments/Complaints & Safeguarding

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Quality	NAT		Patient Safety Incidents			2,311	2,042	1,872	1,893	2,114	2,085	2,002	2,181	1,974	1,981	2,177	2,013	2,076
	NAT		Patient Safety Incidents - Mod/Sev			65	38	38	33	48	40	37	40	62	50	51	39	51
	KEY		Overdue Incidents			0	1,164	724	688	659	734	757	974	1,202	1,160	965	756	728
	NAT		PSII - Local			0	1	2	0	0	2	0	2	2	1	2	1	1
	NAT		PSII - National			0	4	3	2	2	1	1	0	0	1	1	1	0
	NAT		After Action Reviews (AARs)			0	10	5	5	7	14	15	8	12	12	4	8	4
	NAT		AARs Overdue			0	45	27	23	24	26	25	35	37	42	39	35	25
	NAT		Never Events			0	0	2	2	1	0	0	0	0	0	0	1	0
	NAT		Duty of Candour - Findings			100%	91.7%	75.0%	94.6%	87.5%	100%	100%	100%	100%	100%	90.9%	100%	90.6%
	NAT		Duty of Candour - Written 15wd			100%	50.0%	82.1%	88.5%	96.4%	97.2%	100%	100%	96.0%	100%	100%	100%	95.5%
	NAT		Duty of Candour - Verbal			100%	86.4%	87.5%	100%	95.8%	97.1%	100%	100%	96.3%	100%	100%	100%	100%
	KEY		Complaints Number			130	92	87	90	85	83	94	117	99	97	117	130	129
	KEY		Complaint Response			85.0%	16.2%	18.6%	31.6%	54.1%	71.4%	84.2%	86.1%	87.3%	86.0%	87.5%	85.3%	86.3%
	NAT		FFT Satisfaction Level - ED			90.0%	83.6%	87.5%	83.9%	82.4%	81.3%	81.4%	82.7%	81.8%	84.7%	84.6%	84.3%	83.9%
	NAT		FFT Satisfaction Level - Outpatient			90.0%	95.4%	95.6%	95.7%	95.3%	95.7%	95.7%	96.0%	95.7%	95.4%	95.7%	95.3%	95.5%
	NAT		FFT Satisfaction Level - Inpatient			90.0%	92.1%	90.8%	89.4%	88.9%	91.3%	91.2%	89.2%	88.5%	91.4%	92.1%	92.8%	90.5%
	NAT		Safeguarding Incidents			58	29	27	31	33	38	34	16	25	32	26	36	36
	NAT		Safeguarding Children Training			90.0%	92.3%	91.8%	91.2%	91.3%	91.5%	91.7%	91.7%	91.4%	90.9%	91.1%	90.9%	90.7%
	NAT		Safeguarding Adults Training			90.0%	93.0%	93.4%	92.7%	93.0%	93.1%	93.3%	93.3%	92.9%	92.5%	92.4%	92.4%	91.9%

Quality and safety

Scorecard View

IPC, Patient Safety & Mortality

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
	NAT		IPC: EColi Infections			13	14	13	16	9	9	13	14	12	10	13	11	16
	NAT		IPC: CDiff Infections			12	9	8	12	11	11	9	11	8	11	9	9	9
	NAT		IPC: Klebsiella Infections			7	9	7	11	5	6	9	6	5	9	5	1	1
	NAT		IPC: Pseudomonas Infections			2	5	2	4	2	7	4	5	1	2	0	2	2
	NAT		IPC: MRSA Infections			0	0	1	0	0	1	0	0	0	0	1	1	0
	NAT		IPC: MSSA Infections			6	8	6	8	5	2	7	9	11	13	5	6	9
	IIP		Falls with Harm			15	3	9	5	7	10	8	1	7	11	2	2	10
	IIP		Pressure Ulcers			121	79	72	77	96	85	85	119	101	101	110	79	78
	NAT		Mixed Sex Breaches			145	76	56	57	68	52	65	92	33	49	118	133	109
			Theatre recovery Mixed Sex Breaches			2	0	0	0	0	0	0	0	0	0	0	7	0
	KEY		HSMR			96.0	102.4	101.4	102.1	101.2	101.4	100.3	99.3	100.2				
	KEY		SHMI			1.070	1.133	1.131	1.140	1.140	1.142	1.127	1.114	1.126				
	NAT		VTE Assessment Compliance			95.0%	92.9%	93.7%	93.9%	94.4%	94.0%	92.9%	94.0%	94.7%	94.2%	94.9%	94.9%	95.7%
			NICE Compliance			90.0%	25.2%	34.4%	50.0%	62.9%	63.4%	74.6%	83.1%	91.9%	98.5%	98.5%	98.5%	96.4%

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. PSIIs explore decisions and actions as they relate to the situation. The method is based on the premise that actions or decisions are consequences, not causes, and is guided by the principle that people are well-intentioned and strive to do the best they can.

The Trust at the end of June had:

8 nationally reportable PSIIs are ongoing: 2 NEs, 1 medication incident identified through LfD, and 5 Maternity and Neonatal Safety Investigations (MNSI).

12 Local PSIIs (three are overdue- two of which are at the final approval stage, and one has date for LRAP booked)

1 Local MDT

Overdue Incidents:

The number of overdue incidents reduced to 728 in June. The average number of incidents breaching the 6 weeks overdue in June 2025 remained static at 19 new per day. Quality Governance staff continue to provide daily support to Care Group staff and the overdue incident report circulated twice a week 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. The SOP 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. A review of incidents overdue by 6 months or more has identified the small proportion open for justifiable reasons such as safeguarding reviews awaiting KCC, remaining SI, and PSIIs. A weekly overdue and anomalies report is shared weekly, this aims to address all overdue incidents, actions, DoC compliance and LfPSE data quality issues.

Duty of Candour:

In June, Doc was 100% compliant for verbal component, however written element was 95.5% due to one (1) WCYP letter being sent outside of the 10-day KPI (which was completed within 15 days).

The findings component was recorded on the score care as being 90.6% due to three (3) being completed outside of KPI, on investigation it was identified that one (1) WHH incident was confirmed as having findings shared outside the KPI of 10 days (but completed within 15 days), the other two (2) incidents were flagged as breached in error as a clinical member of staff closed the two (2) incidents prematurely, on the day before the data was pulled for the scorecard, when the investigations were not yet completed. This was amended however the data could not be changed for the scorecard. The corrected compliance is 97%.

DoC compliance data is reviewed by the Patient safety Team prior to scorecard data being finalised to ensure data quality, however the amendments were made after this quality check. It has now been agreed with BI team that data will be frozen post quality check completion to prevent future inaccurate data. Monitoring and compliance will continue to be shared in the weekly report to executives to provide assurance.

Quality and safety

Executive Summary

Systems Update, Safeguarding & Patient Privacy

InPhase:
The ongoing development and implementation encompass the following modules: Risk, Policies, CQC, Clinical Audit, Audit Oversight, NICE, and CAS.
A review of the functionality, project delivery and delays has been completed by the operational team. This has been completed to determine if the system is fit for what we require, if it matches what we understood its functionality was and how we will manage its implementation whilst being mindful of other system license deadlines and therefore costs.
A meeting with InPhase execs took place on 1/07/2025 to discuss on-going issues and resolution.

Safeguarding :
Our overall training compliance as a Trust is at level 2 90.5% and at level 3 84.2% for Adult Safeguarding and 87.4 % for Children Safeguarding. Medical and dental staffing groups is 70.5 % for safeguarding children and 60.5% for safeguarding adults. Level 3 this is below the required 85% compliance described in CR3733, escalation has been made through safeguarding assurance group, Trust management committee and care group performance review meetings; additional medical sessions have been put in place. Additional staff have required training due to the uplift for staff from band 2 to band 3 roles , the safeguarding team have reviewed number of training sessions provided we expect overall compliance to return to over 85% by the end of September.

Mixed Sex Breaches
109 breaches occurred in the month.

- There was a further increase in patients being unable to be stepped down from critical care within the four-hour standard: 41 at WHH, 4 at KCH and 14 at QE.
- SDEC and SEAU at QEQM had a total of 48 breaches. This increase is owing to a change in reporting methodology; Patient pathways and remodelling of the environment continue to be reviewed by the QEQM triumvirate

Complaint Response:
The Trust continues to meet the metric maintaining over 85% of complaints responded to within the agreed time scale. The increase in new complaints continues, 129 received in June 2025, a 53.6% increase, when compared to June 2024 when 84 were received.

Executive Summary

Infection Prevention Control

Infection Prevention and Control:
HCAI trajectories for June 2025 are slightly over for C. diff, and E.coli (MRSA 2 cases to date – one in April and one in May).

No outbreaks or PIIs in June 2025.
C. diff 9 cases - 5 HOHA and 4 COHA with no obvious linked cases.
E.coli 16 cases - 9 HOHA and 7 COHA with no obvious linked cases
Klebsiella 1 case which is a COHA
Pseudomonas 2 cases which were HOHA (not linked)

The IPC team has a trust wide improvement plan in place, and whilst there is a focus on mandatory training requirements, the main themes focus on themes identified through post infection reviews. In addition, the IPC team works collaboratively with partners internally and externally to share learning. Currently there is a 'CLEANTogether' campaign in place across the Trust which is focussing on decluttering and a wide range of 'back to basics'.

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

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

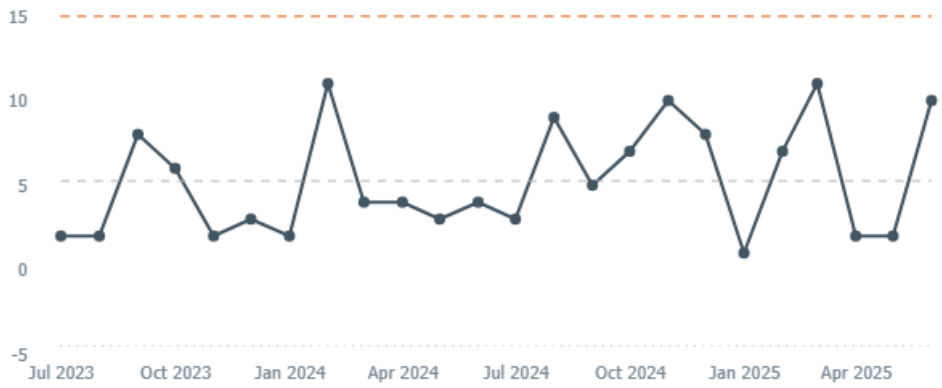
Patient Falls with Moderate or Above Harm Recorded

Falls with Harm

Timescale	Value	SPC
Jul-24	3	
Aug-24	9	
Sep-24	5	
Oct-24	7	
Nov-24	10	
Dec-24	8	
Jan-25	1	
Feb-25	7	
Mar-25	11	
Apr-25	2	
May-25	2	
Jun-25	10	

XMR Run Chart

No Special Cause Flags



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/06/2025 the latest Falls with Harm performance is 10 against a (6 Sigma Threshold) target of 15 (lower is better).

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

The biggest contributing factors are: WCJ1 - WHH CAMBRIDGE J1 WARD (3*), WCL - WHH CAMBRIDGE L WARD (1*), FF - WHH FOLKESTONE WARD (1*). *Number of Falls

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Following an increase in falls in March similar to Nov–Dec 2024, the harm from falls dropped to 2 in both April and May. June has seen a significant increase in harm with a total of 10.	• Meeting with falls team and ADoNs at WHH to discuss falls in June and further action required to address concerns • Strengthening governance through the After Action Review (AAR) processes using SEIPS model to ensure detailed learning and targeting of actions.	Falls lead/ ADoNs WHH Falls lead/ Care groups	July 2025 August 2025	• Meeting booked • AAR's being undertaken for all falls with harm and learning themed. • Themed learning assisted in defining actions for individual areas with action plans. • Learning from AARs to be presented and shared through the Falls Steering Group.

Safe Care

Falls with Harm; Actions Table

Falls with Harm (con't)

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
MFRACP risk assessments are not always fully completed in a timely manner.	• Falls dashboard to be created to include MFRACP completion, including time of medical reviews, radiology reports and status of clinician completing review.	Falls Lead	June 2025	• IT agreed and in queue for Sunrise amendments.
Identified gap in knowledge regarding undertaking dynamic risk assessments and redeployment of staff as patient's acuity and dependency changes during shift	• SIM training to be created to support clinical staff in practice to identify risk and manage patients safely. Model to be created in line with the Dynamic Risk assessment	ADoN FoC/ADoN WDET.	June 2025	• Tabletop exercise designed and shared with colleagues for wider comment.
	• Dynamic risk assessment to be developed to support staff with managing shift and mitigation • To provide training and education on dynamic staff deployment risk assessment.	Falls Lead/ADoN FoC/ADON WDET	July 2025	• 1st draft completed, meeting with wider FoC to be arranged to approve assessment tool. Once agreed will need to be presented through governance processes, Falls Steering Group (FSG) and Fundamentals of Care Committee (FoCC) and NMEC. • Training areas identified. Band 7 invites to be sent

Quality and safety

Safe Care

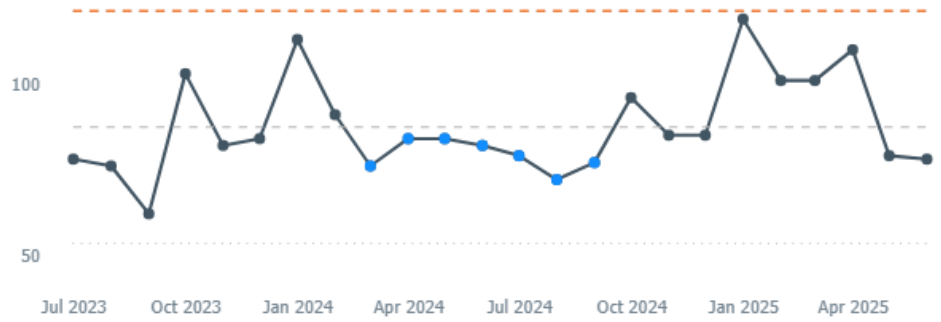
Pressure Ulcers; Hospital Associated

Pressure Ulcers

Timescale	Value	SPC
Jul-24	79	
Aug-24	72	
Sep-24	77	
Oct-24	96	
Nov-24	85	
Dec-24	85	
Jan-25	119	
Feb-25	101	
Mar-25	101	
Apr-25	110	
May-25	79	
Jun-25	78	

XMR Run Chart

No Special Cause Flags



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/06/2025 the latest Pressure Ulcers performance is 78 against a (6 Sigma Threshold) target of 121 (lower is better).

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

The biggest contributing factors are: WKC1 - WHH KINGS C1 WARD (6*), UNK - Unknown (5*), WCC - WHH CRITICAL CARE (5*).
*Number of Cases

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Following an increase in pressure ulcers in April- May & June have shown an overall decrease.	• To be part of a working group through the Kent and Medway network to look at wider issues across the system to improve outcomes for patients in relation to pressure ulcer prevention.	Tissue Viability Lead	July 2025	• Pressure Ulcer Task and finish group meeting set up for 30th June 2025. • Update to be presented to FoCC in July 2025

Safe Care

Pressure Ulcers; Action Table

Pressure Ulcers (con't)

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Increased pressure damage noted due to long gaps in repositioning. Contributing to the development of unstageable and moderate harm pressure damage.	• To review current foam mattresses and tender for replacements to ensure all mattresses are of higher specification for higher risk patients. • To review equipment to assist staff in repositioning complex patients, meaning fewer staff are required to reposition these patients appropriately .	Manual Handling & TV Leads Manual Handling Team Manual Handling Lead	September 2025 September 2025 October 2025	• Update at Bed & Mattress meeting 9/7/25- new evac mattresses progressing & should be received in Trust by September. • The project with the tubular slide sheets will incorporate hoist assisted repositioning utilising less staff to position. • Manual Handling team to raise awareness of available equipment for repositioning. • Trial to commence on improved patient chairs in August 2025
An increase in heel damage has been noted in the months of April and May with an identified lack of appropriate heel offloading technique noted.	• Trust wide heel offloading campaign to highlight appropriate offloading technique. • TV support workers to conduct heel offloading compliance and technique audit.	Tissue Viability Team Tissue Viability Support workers	August 2025 July 2025 August 2025	• Communications sent out via TV times Tissue Viability Newsletter & via Trust News safety pins. • Teaching package updated to reflect new offloading technique • Full Heel Offloading Audit report shared with TVSG, plan to repeat full audit in 6months, sooner at QE & K&C to rule out any bias as completed by only 1 member of staff.
A consistent theme in audits and incidence data is that risk assessments are incomplete or inaccurate leading to delayed pressure ulcer prevention strategies and increase in pressure ulcer development or deterioration.	• Risk assessment documentation on admission and dynamic assessments during admission to be reviewed. • Review the Risk assessment process on Sunrise to only save when risk assessment is complete.	TV lead/Chief Nursing Information Officer	August 2025 September 2025	• Meeting being arranged with TV team & Sunrise team in August to discuss how risk assessment can be amended to improve compliance & to save only if fully completed. • Icon for PTL boards has been added to review list at part of rebuild of whiteboards by IT team.

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.		Lead Tissue Viability Nurse ED	September 2025 August 2025	• Newly updated TWIP includes action for matrons/ward managers to role model categorising of 1 & 2 pressure ulcers. TVSG 9/7/25 feedback- to ensure actions for wards are clear- to create separate tab for ward owned actions for ease. • First ED working group took place 25/6/25-, however good discussion regarding progress ED are making to improve pressure ulcer prevention; lots of positive work to improve skin inspection & documentation, tracker board now set up to highlight at risk patients.
Medical device related pressure ulcers at QEQM & WHH	• Provide a targeted approach based on learning from incidents involving face to face training in the appropriate clinical areas • Trials of medical devices/fixation devices to help reduce Medical Device Related Pressure ulcers • Improve ability to evidence repositioning of medical devices.	Lead Tissue Viability Nurse/Matron for ICUs	September 2025	• Trials completed of NG fixation device & new heel offloading boots (boots in place with training supported by company). A reduction in incidence at WHH ITU has been noted as a direct result of the NG trial. • 9/7/25 Learning from device incidents discussed at TVSG- to explore idea of list of trained practitioners in collar care being held by wards to support outliers when needed; being explored by QE matron. • Medical device care guide has been added to the Pressure Ulcer Policy and the Intranet page for guidance. • July- new column added on Repositioning Regime to specific which device was repositioned. • The tissue viability team have been working with procurement to provide clinical areas with the catheter securing devices to secure the SRC tubing avoiding pressure to the skin. Discussed at recent PAG to explore alternative products.

Quality and safety

Safe Care

Patient Safety Incidents

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Patient Safety Incident Response (PSIR) Framework.	• The PSIRF policy has been updated to reflect how the processes have evolved and to align with national requirements published in the last year. The revised policy strengthens the principles of engagement and the development and oversight of effective safety actions, with the focus on improvement. The revised policy has been submitted to OQGC meeting approval. • Patient safety training programme in place: PSIRF, Swarm, AAR, Incident Investigation, Engagement/Duty of Candour, Human Factors. • Trust compliance with Level 1 Patient Safety Syllabus training is 91.4%. • Development of the Patient Safety Partners policy is underway, with the plan to recruit two Patient safety Partners by end of August. • An audit of PSIIs and a select proportion of learning responses is being undertaken to assess quality of reports and the learning actions from investigations. A report will be presented to OQGC of findings.	• Head of Patient Safety and Improvement	30/07/2025	• Weekly report to Executives includes details of PSIIs. • Training Needs Analysis in place. A review of training content has been completed to align with the patient safety syllabus. • Incident Investigation, Swarm and AAR training dates are available on to book on ESR
One local PSII was commenced in June 2025 (Obstetric AKI and bladder injury)	The incident was presented at IRP by WCYP care group • DoC has been completed with the patient who will contribute to the development of ToR for investigation • The investigation lead is being identified	• Head of Patient Safety and Improvement	10/10/2025	Updates will be provided in the weekly report to executives.
25 of the 49 open AARs are overdue for completion.	• Ten (10) overdue AARs were closed in June 2025 • Quality Governance staff continue to support clinical handlers responsible for completion of the AARs. • It has been identified that adopting SEIPS (system-based analysis) within the AARs requires strengthening through coaching support and prompting to use the SEIPS tool during AAR discussions. • All inquest AAR's will be approved via LRAP for executive oversight. • One (1) Obstetric overdue AAR is from 2022 is now going to have a tabletop review to identify the learning due to the time that has lapsed since the incident occurred.	• Head of Patient Safety and Improvement	31/07/2025	Weekly updates on progress with AAR's is provided in the weekly executive report and at IRP.

Quality and safety

Safe Care

Infection Prevention Control & Patient Privacy

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
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. • The Trust participated in World Hand Hygiene Day 2025, with awareness activities held across the three main sites in May 2025. The event was well attended by a wide section of staff. • Clinical skills training programme in place focussing on themes from PIRs, such as ANTT and line care. • Ongoing IPC audits of environment and clinical practices.	IPC Team	Ongoing and measured against monthly trajectories to achieve below 25/26 year end.	- Post infection reviews continue to identify learning - Trust wide review of FR cleaning ratings and additional protocols continue - Trust wide review of roles and responsibilities for cleaning in process - Trust wide awareness activities around hand hygiene
Mixed sex breaches	• Review continue to be undertaken at QEQM surgical SDEC and emergency assessment areas by care group triumvirate	• DoN QEQM	• July 2025	• Review underway

Quality and safety

Safe Care

Patient Experience; Friends & Family Test (FFT)

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

Quality and safety

Safe Care

Patient Experience; Friends & Family Test (FFT)

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
FFT Inpatient: satisfaction levels remain around the Trust target of 90% satisfaction, dipping slightly in January and February 2025. There are significant disparities between satisfaction levels at the three sites, with K&CH scoring much higher than WHH and QEQM. Patient experience once on a ward can be poor (e.g. being moved several times, lack of handover of key information). Lack of carer / family involvement is an on-going theme.	• New inpatient survey to be developed to capture feedback whilst patients are with us (youth volunteers to support getting feedback).	• Patient Voice and Involvement team / Volunteer service	• By end of May 2025	**COMPLETED**: first group of youth volunteers trained. Survey is now live. Youth volunteers started to gather feedback from the last week in May 2025.
	• Feedback from the new inpatient survey to be reported to the Patient Experience Committee	• Patient Voice and Involvement team	• From September 2025	ON TRACK: survey data being reviewed regularly. First report will go to PEC at the end of September.
	• Promotion of the carers leaflet and carers survey	• Patient Voice and Involvement team	• June 2025	**COMPLETED:** Leaflet and survey promoted during Carers Week 9-15 June.
		• QIWA team	• By September 2025	**IN PROGRESS:** Additional question re Carers leaflet To be discussed with QIWA team
	• Communication passport for people with hearing or visual impairments to be offered to patients on the wards.	• Associate Director of Patient Experience / Heads of Nursing / Ward staff	• By June 2025	**COMPLETED**: Communication passport for people who are Deaf, have hearing loss or a visual impairment is now available. Communications to go out to staff w/c 21st July 2025.
	• Pilot 'What Matters to me' communication posters behind patient beds on each site.	• Associate Directors of Nursing for SAGE and GM	• May to July 2025	**ON TRACK**: 'What Matters to Me' posters now being piloted. Wards at QEQM are Seabathing and Cheerful Sparrows female, wards at WHH are Kings D2 and Cambridge M1. Wards at K&CH are Kingston and Harvey wards.

Quality and safety

Safe Care

Safe Staffing

Staff Type	Vacancy Rate Jun-25 (Target 10%)	Sickness Rate Jun-25 (Target 5%)	Safe Care Red Flags Jun-25
Registered Nursing & Midwifery	4.4%	4.42%	303
Registered Nursing Associate	N/A	N/A	
Health Care Support Worker	26.29%	N/A	

Staff Type	Care Hours Per Patient Day (CHPPD) Jun-25	Avg Fill Rate Day Jun-25	Avg Fill Rate Night Jun-25
Registered Nursing & Midwifery	6.6	86%	91%
Registered Nursing Associate	0.1	100%	100%
Health Care Support Worker	3.2	85%	102%

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. Currently our CHPPD is higher than our peer organisations but is improving. CHPPD is higher for Midwifery at WHH due to a nominal cumulative patient count across the month.

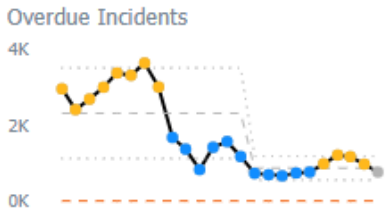
The average fill rates for June 2025 remain at an acceptable level overall. Following EQIA's, Kingston K&C and Brabourne K&C are trialling staff movements, with altered skill mix, impacting on fill rates. St Lawrence K&C remained closed for the first five days of June and St Augustine's QEQM closed on the 9th June, with staff redeployed to support other clinical areas, impacting on fill rates and actual CHPPD.

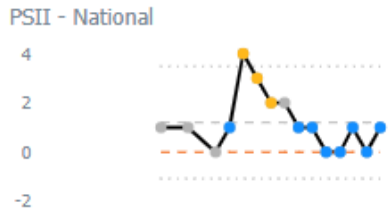
Several areas did work on amber shifts, as defined within our organisation. There were 2 red shifts; 1 night shift on Kennington and 1 day shift (just for break times) on Kings D2. Round table reviews have been undertaken to recognise real time escalation of shifts and to support learning.

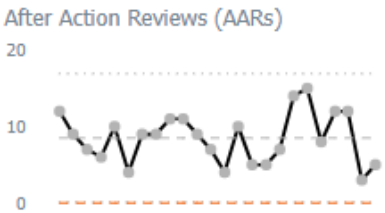
Quality and safety

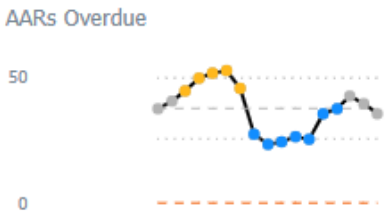
Trend Analysis

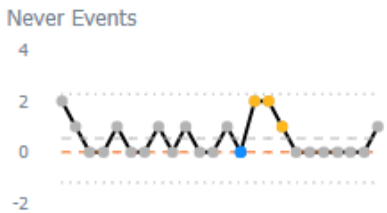
Quality Domain Metrics

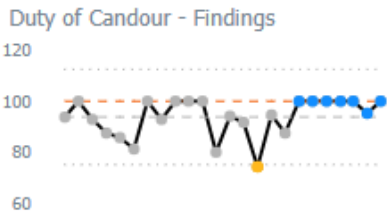


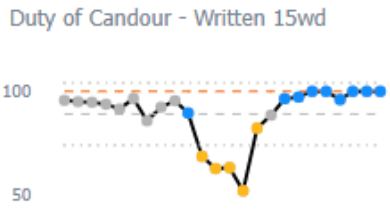


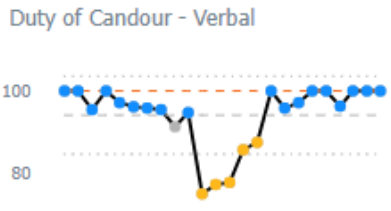


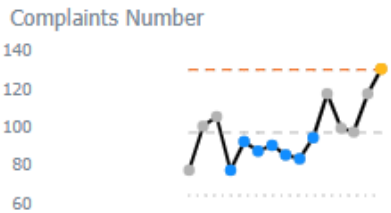


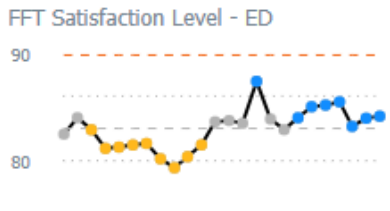


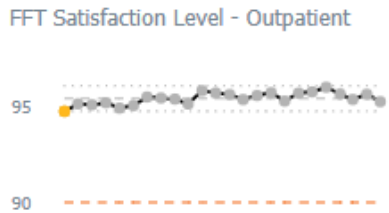


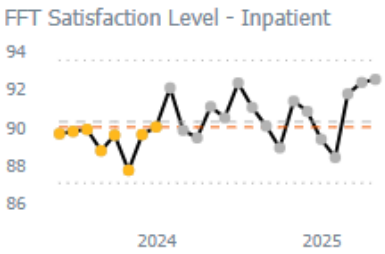


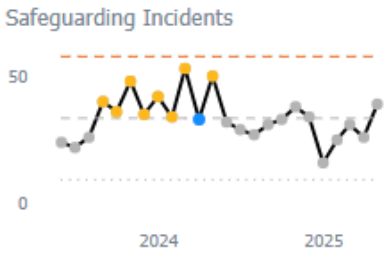


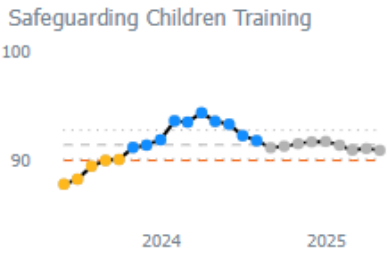


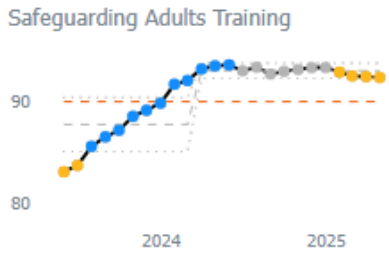


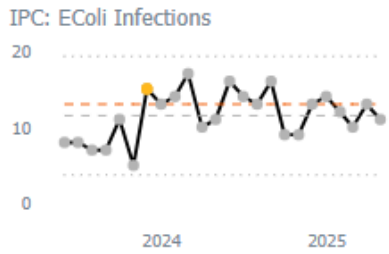








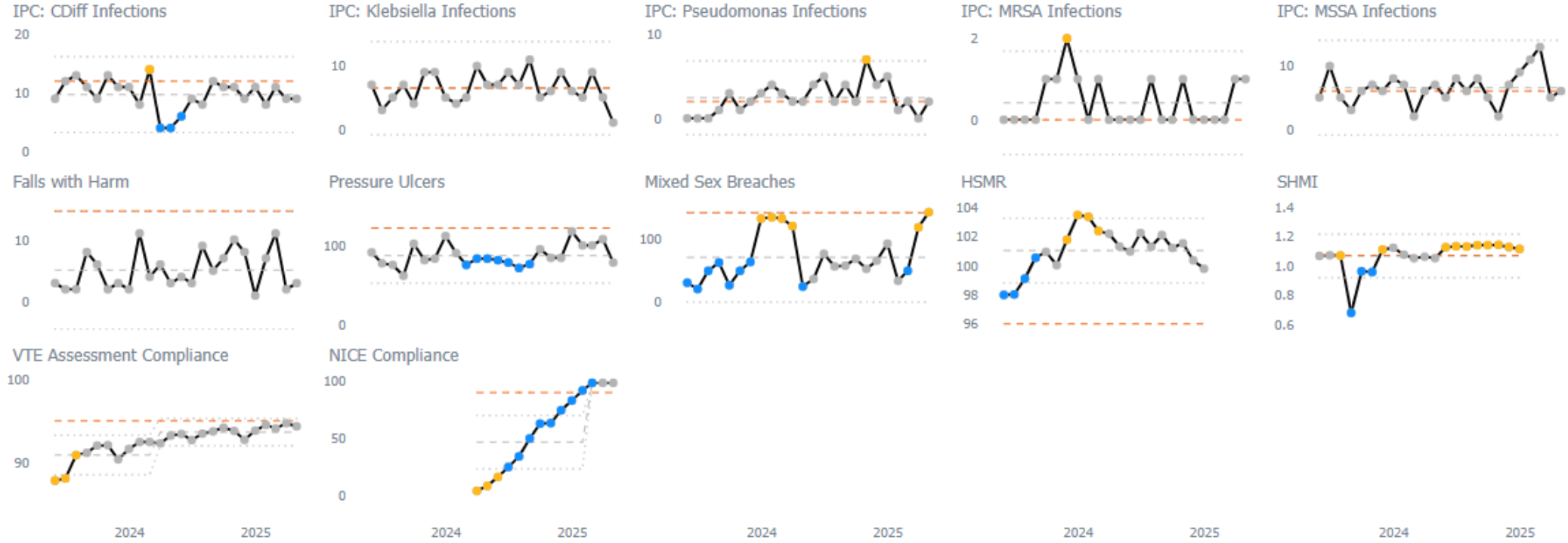




Quality and safety

Trend Analysis

Quality Domain Metrics



People

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

People Scorecard View

Workforce Metrics

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
People	NAT		Sickness			5.0%	4.8%	4.4%	4.6%	4.9%	5.2%	5.4%	5.5%	5.0%	4.4%	4.6%	4.5%	4.2%
	NAT		Vacancy Rate			10.0%	8.7%	9.6%	8.7%	8.6%	8.7%	8.8%	9.0%	10.1%	8.9%	9.2%	9.3%	9.0%
	NAT		Staff Turnover Rate			10.0%	8.9%	8.9%	8.9%	8.8%	8.7%	8.4%	8.3%	8.2%	7.8%	7.8%	7.6%	7.6%
	NAT		Premature Turnover Rate			25.0%	15.2%	14.9%	14.8%	14.8%	14.4%	13.5%	13.5%	12.7%	12.1%	12.5%	12.6%	12.9%
	KEY		Appraisals Compliance			80.0%	75.0%	74.8%	77.9%	79.4%	80.3%	80.0%	81.4%	80.8%	80.5%	81.1%	74.8%	72.9%
	IIP		Staff Engagement Score			6.80	5.95	5.95	5.95	6.35	6.35	6.35	6.04	6.04	6.04	5.97	5.97	5.97
	KEY		Staff Advocacy Score			6.70	5.34	5.34	5.34	5.80	5.80	5.80	5.55	5.55	5.55	5.49	5.49	5.49
	NAT		Statutory Training			91.0%	92.2%	92.4%	92.2%	92.2%	92.4%	92.4%	92.5%	92.3%	92.4%	92.8%	93.4%	93.3%
	KEY		Infection Control Training			90.0%	93.4%	93.7%	93.5%	93.4%	93.3%	93.2%	93.1%	92.9%	92.8%	93.1%	93.3%	93.1%
	KEY		Hand Hygiene Training			85.0%	79.7%	79.2%	79.0%	79.1%	93.1%	92.9%	92.7%	91.7%	91.4%	91.7%	91.8%	91.0%
	KEY		Medical Job Planning Rate			90.0%	36.5%	33.3%	32.5%	30.3%	32.0%	27.9%	27.9%	32.1%	31.1%	30.5%	18.0%	36.4%

People

Executive Summary

Workforce Metrics & Statutory Training

Sickness absence rates have improved to **4.19%**, from 4.66% the previous month. This remains below the alerting threshold (5%), although this is a seasonal trend, with sickness absence at 4.3% in the same month 12 months ago. There were 118 less episodes in June when compared to May. This was largely the result a reduction in coughs colds and flu (down 94 episodes month-on-month), although there has been an uptick in absence related to stress, anxiety and depression (by 22 episodes month-on-month).This uptick reinforces the need for an ongoing face-to-face counselling service. Funding for the existing provision is due to conclude in September.

Vacancy rate has reduced back to **9.0%**, and has remained below the 10% threshold for most of the last 12 months. The highest vacancy rate is in the KCRVH Care Group 11.8%). The lowest is across the QEQM Care Group (6.9%). It is anticipated that new VCP process along with ongoing consultations will impact vacancy rates moving forward. Vacancies will need to be carefully monitored to ensure patient safety and activity are not detrimentally affected.

Staff turnover remains at **7.6%** - it has improved slightly from 7.63% to 7.55%. This continues the positive trend that has been observed across the last 2 years. Whilst turnover is now the lowest it has been in over 2 years, attention is drawn to the current uncertainty that exists across the NHS as a whole and as a result of consultations. It is likely this will impact turnover rates positively, whist not necessarily representing an improvement in overall climate. Nursing turnover has improved further to 6.9% following a small inflection upward in April. It remains over 3% below alerting threshold. Health Care Support Worker turnover has also improved to 8.8%. Premature turnover has increased to 12.9%. This is the third successive increase and often acts as a barometer of culture. A new starter insights dashboard was published (18/07) to allow more granular insight to this trend.

Appraisal compliance has fallen again to **72.9%.** This is below the same time point in 2024 (74.1%), although mirrors the trend at this time of year with an annualised cycle. It was anticipated this would improve in the June metrics and it has not. The lowest rates are currently across the KCRVH and Corporate Care Groups (65.4% and 65.8% respectively). The highest appraisal rates are in DCB (76.5%) and WCYP (76.2%).

Statutory training compliance remains at/ around **93.3%**. This exceeds the Trust-level threshold (91%) and has been on an upward trajectory for the past 18 months. Every Care Group has compliancy rates above 90% (90.2% in Corporate to 94.5% in WCYP), and although compliance for medical staff remains below the expected threshold, this continues to improve and now stands at 86.9%. Compliancy is highest against the Equality and Diversity modules (96.0%) and lowest against Safeguarding Children (90.7%).

People

Integrated Improvement Plan (IIP)

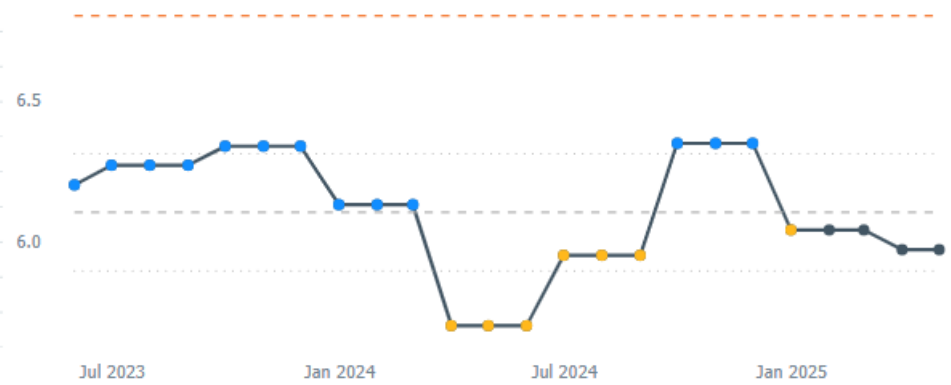
Staff Engagement Score

Staff Engagement Score

Timescale	Value	SPC
Jun-24	5.70	
Jul-24	5.95	
Aug-24	5.95	
Sep-24	5.95	
Oct-24	6.35	
Nov-24	6.35	
Dec-24	6.35	
Jan-25	6.04	
Feb-25	6.04	
Mar-25	6.04	
Apr-25	5.97	
May-25	5.97	

XMR Run Chart

No Special Cause Flags



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/05/2025 the latest Staff Engagement Score performance is 5.97 against a static target of 6.80 (higher is better).

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Staff Engagement levels (5.97) are below the national average (6.78).		Head of Staff Experience	End Mar 26	• An overall plan regarding staff survey results was agreed at TMC (16/07). This provided an overview of the approach and ongoing activity. This included the mapping of staff survey feedback and results into a People and Culture Delivery Plan. It was followed by a three-tiered programme of work. The first identified targeted support for 20 priority teams to accelerate improvement and address urgent/ emergent challenges. The second was developmentally focussed, mobilising Quality Improvement in mid-performing areas to drive progress. The third tier highlighted the importance of recognising and celebrating high-performing teams – elevating their impact and sharing learning to scale-up.
Actions/ interventions initiated to improve staff engagement	• Activity taking place across NSS plan, CLP immediate actions delivery plan and local Care Group People Plans	Head of Staff Experience	End Mar 26	• Intensive support is taking place against 20 priority teams identified through the NHS Staff Survey results. An overview of activity to-date includes: 1:1 coaching, monthly working groups, away days & team development, ongoing (confidential) HR processes, consultations, a review of structures, new appointments and delivery of conflict/ early resolution workshops. This is to address some of the areas where staff engagement scores as low as 4.07 (out of 10). The rollout of Quality Improvement has taken place across CCASS and KCRVH, and across nine frontline teams 13 wards / departments. The highest performing teams in the Trust have been identified, along with those who have most improved. Work is currently taking place to understand drivers of this performance.
2025 NHS Staff Survey	• Driving response rates across the 2025 NSS is key to improving engagement and the credibility of results	Head of Staff Experience	End Nov 25	• The National Quarterly Pulse Survey (NQPS) is currently taking place, with a response rate 2% ahead of the national average (15%). This equates to 1,717 respondents (or a 17% RR as at 21/07). Whilst this rate is comparatively low in the context of the NHS Staff Survey, this is largely because organisations, ourselves included, avoid overcommunicating against this barometer in order to avoid survey fatigue across the 3-month national survey due to launch on 15th September.

People

Integrated Improvement Plan (IIP)

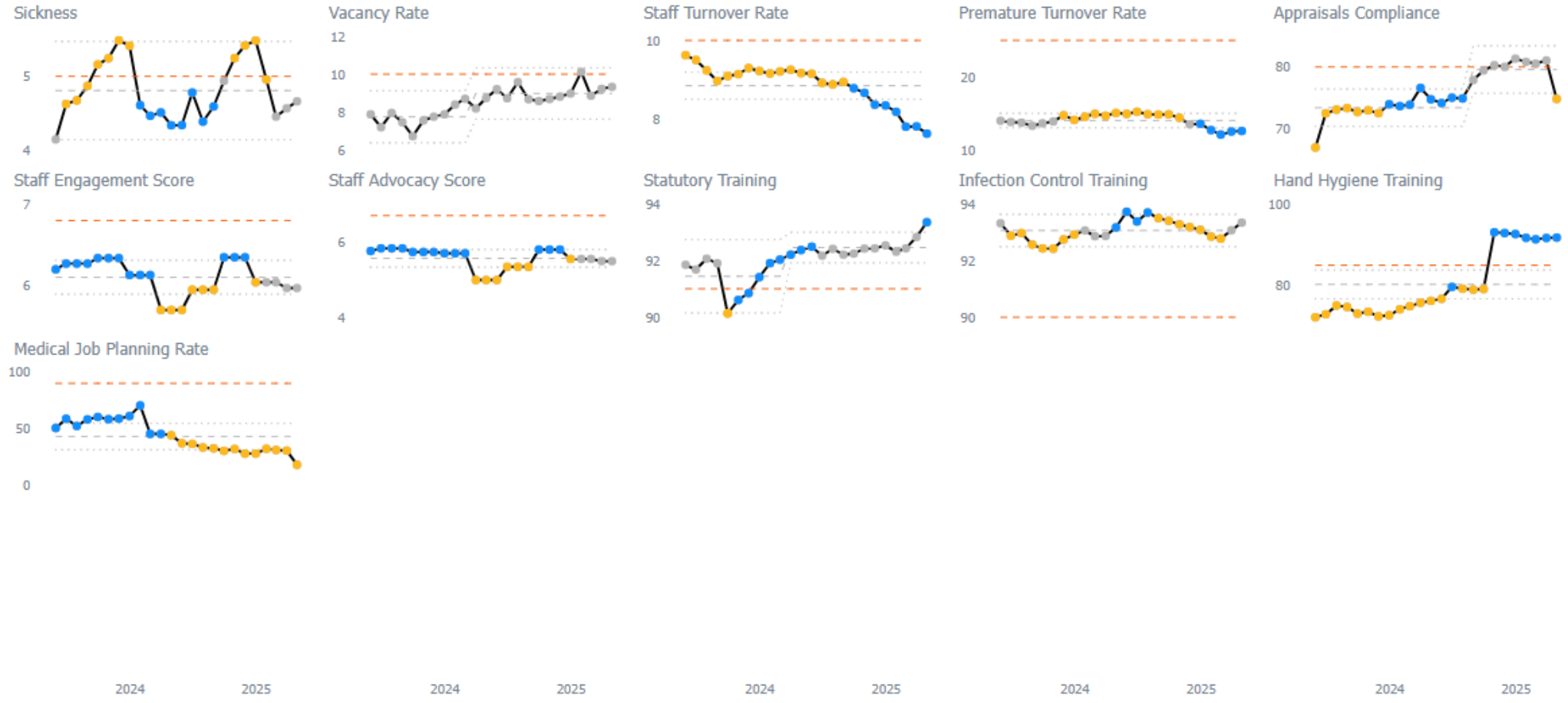
Workforce Metrics

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 **9.2%** 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	• 445 staff have accessed the service since January, with the CORE-OM score falling by 3.95 on average, from 15.05 to 11.09 (moderate to mild levels • A new bid for funding is being prepared with the existing 6-month extension due to expire in September 2025.
Maintaining **Staff Turnover** against a gold standard of 10%	• Improving HCSW, Nurse & Premature retention which are the main contributors to overall turnover	Head of Staff Experience	• Ongoing	• Staff Turnover remains below 8% (**7.55%**) 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. It is noted that the ongoing improvement may also be related to uncertainty within the organisation.
Update calculation used to denote premature turnover as acutely sensitive to improvements in total turnover	• New method of calculation agreed bringing PT in-line with other methods of measure & reducing sensitivity to wider improvements	Head of Staff Experience	• Complete	• Premature turnover (**12.9%**) has increased for the third month in succession. A new starter insights dashboard has been developed to provide more granular insight to this.
Staff Engagement levels (5.97) are below the national average (6.78)	• Priorities identified through NSS have been acted on, with a wide variety of actions initiated. • Focus on improving engagement and response rate for 2025 staff survey.	Head of Staff Experience	• Sept 25	• Survey feedback has actively led to the development of a People and Culture Strategy – and associated delivery plan. Intensive support is taking place against 20 priority teams identified through the NHS Staff Survey results. Work is also taking place across mid- and high-performing teams to accelerate improvement.
Medical staff levels of statutory training compliance are consistently low at an average of 75%. Has been below 80% for 4 years.	• Identifying those staff who are not compliant, and working with GMs and Clinical Leads to address compliance. • Care Groups contacting individuals directly to support improvement of compliance, particularly with trainee doctors.	CMO	• Dec 24	• Compliance improved to **86.9%**, which is the highest it has been in 4 years and approaching the Trust-level threshold (90%). All Care Groups are targeting improvement within medical staff compliance – with medical staff compliance lowest in the Corporate Care Group (77.5%).

People

Trend Analysis

People Domain Metrics



Sustainability

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)			
No Significant Change		Deficit In Month Group (£) Efficiencies YTD Variance (£M) Premium Pay Total Pay Spend In Month Variance to Plan (£) WTE worked (All Pay Spend) WTE worked (Premium Pay)	
Concerning Variation (High or Low)			Efficiencies Green Schemes (£M)

Sustainability

Scorecard View

Financial Metrics

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Sustainability	IIP		Deficit In Month Group (£)			8.7M	8.3M	6.3M	7.3M	7.5M	9.8M	7.0M	6.5M	4.9M	5.2M	9.7M	8.8M	8.8M
	KEY		Variance to Plan (£)			0K	20K	53K	1K	-31K	1K	-2,07...	3,990K	-2K	240K	25K	10K	-35K
	KEY		Premium Pay			10M	8.8M	8.9M	8.0M	8.6M	8.6M	8.0M	7.6M	8.3M	9.1M	8.7M	8.7M	7.9M
	KEY		WTE worked (Premium Pay)			1,226	1,031	1,049	1,017	996	967	975	964	1,072	1,108	1,041	971	864
	KEY		Total Pay Spend In Month			62M	51M	52M	51M	66M	54M	54M	53M	55M	49M	57M	56M	56M
	KEY		WTE worked (All Pay Spend)			10,370	10,049	10,048	10,105	10,138	10,096	10,144	10,110	10,237	10,309	10,301	10,219	10,121
	KEY		Efficiencies Green Schemes (£M)			40	11	15	16	20	25	28	35	40	45	0	6	9
	IIP		Efficiencies YTD Variance (£M)			0.0	0.1	0.3	0.3	0.3	0.3	0.3	0.4	0.4	0.5	-1.5	0.0	0.0

Sustainability

Executive Summary

Financial Position

The Month 3 the YTD position achieved by the Group (Pre-deficit support) was a £27.3m deficit. As at month 3 the Group remains on plan.

As at month 3, the Trust has a small surplus of £0.3m.

The Trust's YTD month 3 position shows Income from patient care (excluding drugs and devices) is currently £0.6m higher than planned. This includes NHSE Wider Variable Income including Chemotherapy (£0.2m) and Compensation Recovery Unit (£0.1m). Income from drugs and devices is £0.4m above plan.

Other operating income is £0.6m favourable to plan YTD, driven by LIMS income (which is offset against cost) received in May and higher than planned education and training income relating to pay award funding.

Employee expenses re £0.1m favourable in-month but £1.3m adverse YTD. Substantive staff costs are under plan, while temporary staffing, particularly bank staff, drives the overspend.

Other operating expenses are £0.5m adverse to plan YTD driven by overspends in general supplies. These are partially offset by underspends in clinical supplies, drugs, and purchased healthcare.

Sustainability

Financial Measures

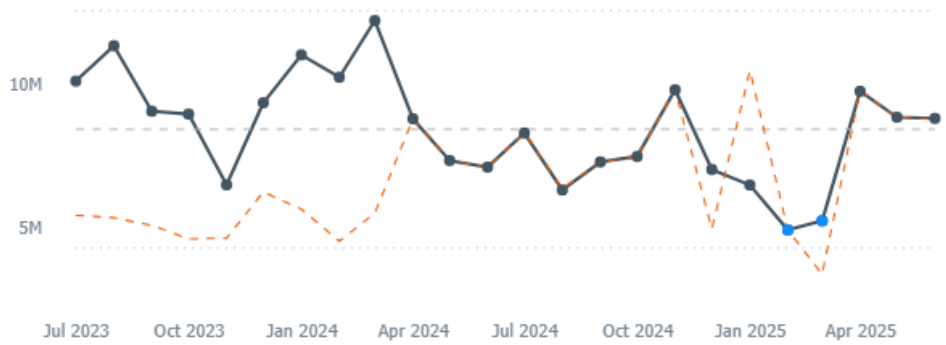
Income & Expenditure Monthly Deficit (Group)

Deficit In Month Group (£)

Timescale	Value	SPC
Jul-24	8.3M	
Aug-24	6.3M	
Sep-24	7.3M	
Oct-24	7.5M	
Nov-24	9.8M	
Dec-24	7.0M	
Jan-25	6.5M	
Feb-25	4.9M	
Mar-25	5.2M	
Apr-25	9.7M	
May-25	8.8M	
Jun-25	8.8M	

XMR Run Chart

No Special Cause Flags



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/06/2025 the latest Deficit In Month Group (£) performance is 8.8M against a Trajectory target of 8.7M (lower is better).

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Achievement of financial plan for 25/26	• Cash out CIP target of £80m is needed to support the agreed £62.4m deficit (Pre DSF) position as submitted on the 30th of April.	• Theme leads • PMO	• On-going	• As at month 3 the Groups financial position is on plan at a deficit of £27.3m • Work is continuing with the Care Groups and Corporate areas to deliver the financial plan along with the workforce and activity plan. • EKHUFT is continuing to support the system wide savings schemes to support the delivery of the K&M ICS financial position. • Increased levels of reporting are being requested from NHSE including reporting greater level of CIP delivery, workforce triangulation and underlying run rate data.

Sustainability

Financial Measures

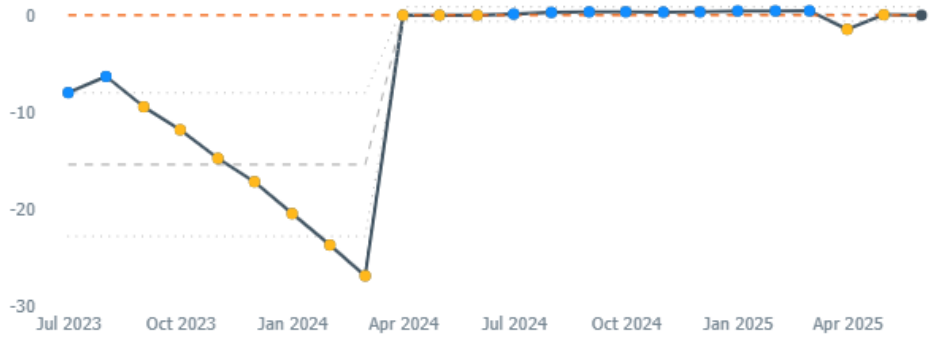
Financial Efficiencies; YTD Variance

Efficiencies YTD Variance (£M)

Timescale	Value	SPC
Jul-24	0.1	
Aug-24	0.3	
Sep-24	0.3	
Oct-24	0.3	
Nov-24	0.3	
Dec-24	0.3	
Jan-25	0.4	
Feb-25	0.4	
Mar-25	0.5	
Apr-25	-1.5	
May-25	0.0	
Jun-25	0.0	

XMR Run Chart

No Special Cause Flags



Understanding the Latest Performance

ALERT: Variation flag has changed from Concern to Common Cause

For the month beginning 01/06/2025 the latest Efficiencies YTD Variance (£M) performance is 0.0 against a static target of 0.0 (higher is better).

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Ensure identification of CIP opportunities sufficient to reach the required £80m cash out, recurrent CIP target for 2025/26	• Financial Recovery Director in post • Director of Transformation in Post • PMO roles are being recruited to	Financial Recovery Director	• On-going	• The trust has a current pipeline of £80.07m unadjusted and £44.98m risk adjusted • The £80m CIP plan has been transacted in month 2 allocating all (albeit £3.5m still to allocate) of the CIP targets into the care group and corporate areas • Work is continuing to develop PID's and QIA's with the Theme leads & FBPs through the governance gateways to increase the risk adjusted value and support delivery of the CIP programme.
Ensuring robust CIP reporting of achievement	• Streamlined reporting process • Robust CIP Methodology	Financial Recovery Director	• On-going	• CIP Methodology defined for each scheme. • CIP reporting process streamlined. • CIP delivered YTD at M03 £8.85m is on plan of which £2.29m is recurrent.. • CIP forecasting in process of validation with Theme leads and Finance business partners.

Sustainability Financial Measures

Agency & Temporary Workforce Spend

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
ID Medical finding it challenging to swap out high pay premium medical workers and/or negotiate alternative terms, such as becoming Direct Engagement (DE). Many of the high cost agency have been working with the Trust long term and embedded in the organisation.	• ID Medical Managed Service meeting with each Care Group, reviewing each Medical worker for alternative options. • Working with CMO/DCMO to meet with Managing Directors and Medical Directors to highlight the issue and gain support to reduce premium pay workers. • Need to increase DE workers, making the savings on VAT payments.	CPO	Ongoing	• Joint sessions with ID Medical, CG MDs, Temp Workforce and PMO to review agency usage, agree exit plans and discuss recruitment plans. • Monthly meetings are now scheduled with all Care Groups. ID Medical reviewed current rates against the rate caps and discussed plans to reduce these to improve our compliance. • Our DE throughput has increased to 94%. Plans are now in place to remove/replace the long term standard placement locums and our DE throughput has already reached 96% in July to date. • Notice was served for 10x long term agency locums in June who are looking to migrate to the bank, this is due to be completed in July. • IDM process map developed to incorporate VCP process – shared with teams. • Bank and Agency trackers tools shared with CG's; to be monitored monthly via PMO and CG finance meetings.
Agency management across the South East NHS Region means disparity across Kent and Medway Trusts for AfC rates.	• Sign up to the Kent and Medway Collaborative AFC Rate Card • Areas above cap to work with IDM & South East Temp Staffing Collaborative team to reduce inline with stepping down timescales.	CPO	• July 25	• Agency Hours (all staff groups) also saw a significant decrease in June 2025, down 34% when compared to May 2025. Overall AfC agency hours also continued to reduce (down 16% compared to May). • Signed up to the rate card and commenced on 1st June 24, with the second step down to be applied from the 1st October 24. • New AfC rate card (agency) implemented on the 1st April 2025. The only areas above the new caps are Maternity and Paediatrics. A plan is now in place to remove all agency usage (AfC) by the end of July 2025. This has led to a number of agency staff migrating to the bank (11 in June 2025). • The South East Temporary Staffing Programme has published their next step down rates for both agency and bank, these are now being reviewed with an implementation date of no later than October 2025. • On the 1st March 2025 the Trust will be implemented a restriction on the use of agency staff for bands 2 and 3. Agency hours (AfC) has reduced by 54% since this was implemented. • A mandate was sent to the ID Medical managed service to inform them that no further FY1 requirements should be filled by agency locums. • No off-framework usage recorded. • Working with the ICB, a number of new controls/processes have been implemented to support with controlling overall demand and reduce our reliance on agencies. This will also support the Trust in achieving our objectives in relation to the workforce CIP schemes. We are now looking to implement similar controls for the bank.

Sustainability Financial Measures

Agency & Temporary Workforce Spend

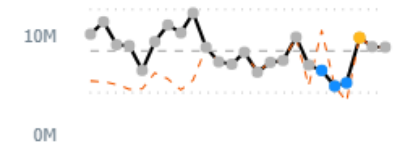
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Agency management across the South East NHS Region means disparity across Kent and Medway Trusts for Medical rates.	• Sign up to the Kent and Medway Collaborative Medical Rate Card • Areas above cap to work with IDM & South East Temp Staffing Collaborative team to reduce inline with stepping down timescales. • Regular meetings now held across the collaborative to current issues as we worked towards rate parity across the region.	CPO	• Ongoing	• New agency AfC ceiling rates proposed, with a plan to implement these in September 2025. • Temp Staffing, PMO & South East Collaboration; weekly meetings scheduled, to progress and implement actions – delivery. • To date the managed service has successfully reduced the hourly rates of 10 long term agency locums. • As a result of tighter controls a number of agency locums are now considering migrating to the bank or joining the Trust substantively. 10 locums and 11 AfC agency staff served notice in June with their transition to the bank to be completed in July.

Sustainability

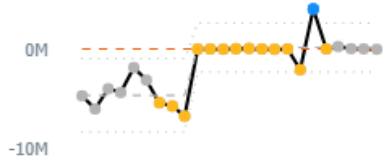
Trend Analysis

Sustainability Domain Metrics

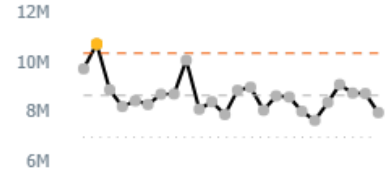
Deficit In Month Group (£)



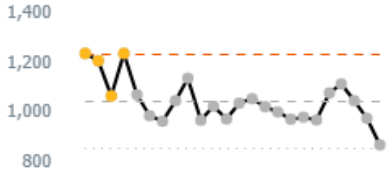
Variance to Plan (£)



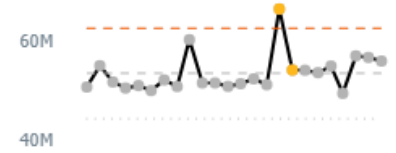
Premium Pay



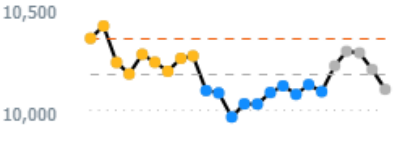
WTE worked (Premium Pay)



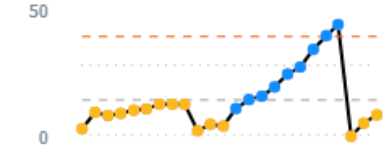
Total Pay Spend In Month



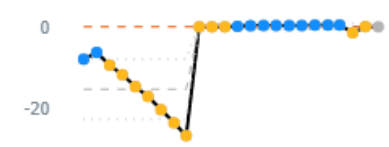
WTE worked (All Pay Spend)



Efficiencies Green Schemes (£M)



Efficiencies YTD Variance (£M)



Maternity


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

Maternity: Scorecard View

Maternity Metrics

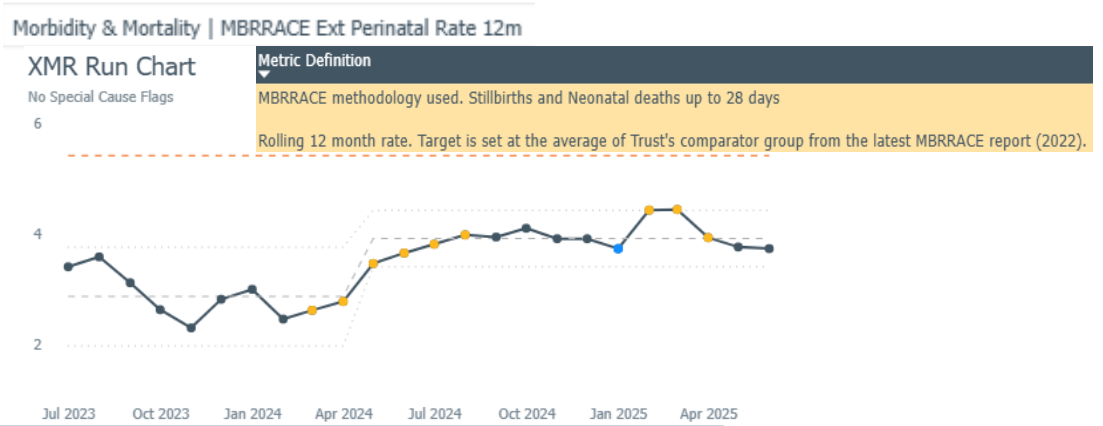
Domain	Nat	Flag	KPI	SPC	Ass...	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Maternity	KEY		Mat Patient Safety Incidents Mod/Sev			7	2	2	1	0	3	2	5	5	7	3	4	3
	NAT		PSII - National (Maternity)			0	4	1	0	1	0	1	0	0	1	1	0	0
	NAT		PSII - Local (Maternity)			0	0	1	0	0	0	0	1	0	0	0	1	1
	KEY		Maternity Complaints			15	8	9	13	1	5	2	8	6	7	7	4	5
	KEY		Maternity Complaint Response			85.0%	42.9%	66.7%	50.0%	85.7%	100%	100%	100%	60.0%	80.0%	100%	75.0%	100%
	KEY		Extended Perinatal Mortality			5.87	3.81	3.98	3.94	4.10	3.91	3.91	3.73	4.43	4.44	3.93	3.76	3.73
	NAT		FFT Maternity Response Rate			15.0%	11.1%	10.7%	10.2%	12.0%	10.6%	10.1%	10.1%	12.6%	11.1%	8.7%	20.2%	9.5%
	NAT		FFT Maternity Recommended			90.0%	92.4%	88.4%	92.2%	95.6%	92.8%	90.1%	93.9%	90.9%	90.4%	90.3%	89.3%	87.1%
	NAT		FFT Maternity (IP) Recommended			90.0%	93.0%	89.3%	95.8%	97.0%	91.9%	95.2%	93.9%	94.9%	94.1%	97.8%	93.4%	96.6%
	KEY		WH Engagement Score			6.90	6.12	6.12	6.12	6.40	6.40	6.40	6.19	6.19	6.19	6.03	6.03	6.03

Maternity: Executive Summary

Maternity Mortality Measures

The extended perinatal rate remains consistently below the threshold of 5.42 per 1,000 births, with the June 12 month rolling rate reducing to below the average at 3.73 per 1,000 births. This rate includes both stillbirths and neonatal deaths.

In June the neonatal death 12 month rate decreased below the MBRRACE average of 1.82 for the 2nd time in 12 reporting periods, to 1.02. The service reported 0 neonatal deaths >24 weeks in month. The stillbirth rate increased in month, above the upper threshold, from 2.56 in May to 2.72 in June. The stillbirth rate remains below the threshold of 3.61. The service reported 1 stillbirth in month.

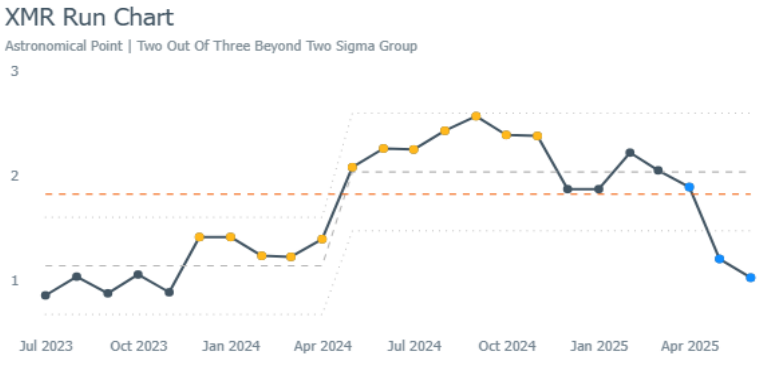


MBRRACE NND Rate 12m

Metric Definition

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

Datasource: Euroking & PAS
Threshold based on the average of the Trust's comparator group (MBRRACE 2022). Average was 1.82

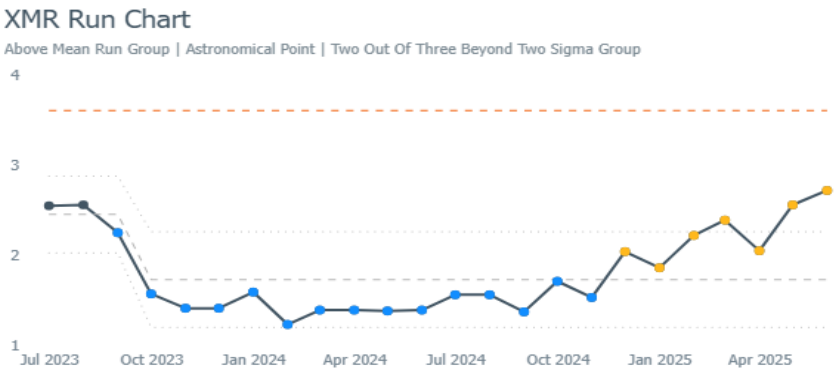


MBRRACE Stillbirth 12m rate

Metric Definition

MBRRACE Methodology used - stillborn babies born at 24+0 weeks gestation at EKHUFT. Reported by birth month. Terminations excluded.

Threshold is 24 per year, based on the range of the Trust's comparator group in the latest MBRRACE report (2021)



In response to the upward trajectory demonstrated in the stillbirth rate an aggregate review is underway, the findings of which will be reported through the Maternity and Neonatal Board

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

Maternity: Executive Summary

Maternity Mortality Measures

There were no new referrals made and accepted to MNSI in June 2025.

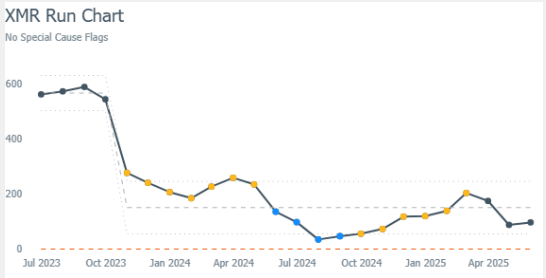
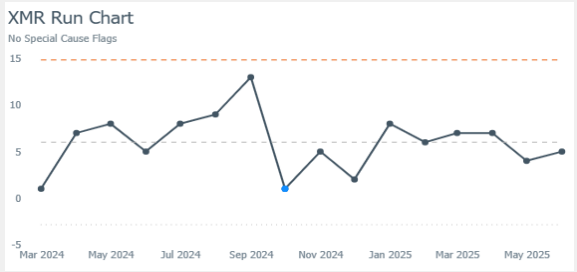
Current open MNSI investigations	Case Summary	Progress
	Maternal death following collapse - admission to ITU and transfer to Tertiary centre.	MNSI referral made by Tertiary centre therefore this MNSI investigation is not evident in the EKHUFT maternity scorecard - Investigation remains in progress
	Maternal death following collapse in community and admission to ITU.	- MNSI investigation in progress
	Case Summary	**Progress**
		Investigation complete and draft report shared with family. Final report due for presentation at LRAP on 21st July 2025
	Neonatal death at 24 weeks gestation	Investigation in progress
	Intrauterine death at term	Final report awaiting Trust sign off
1 New PSII in June	Unexpected term admission to NNU	Investigation in progress

3 moderate /severe patient safety incident were reported in June under the following categories:

- Post partum haemorrhage blood loss >1500mls
- Unexpected admission to Neonatal Unit
- Communications in obstetric theatre related to change in management plan.

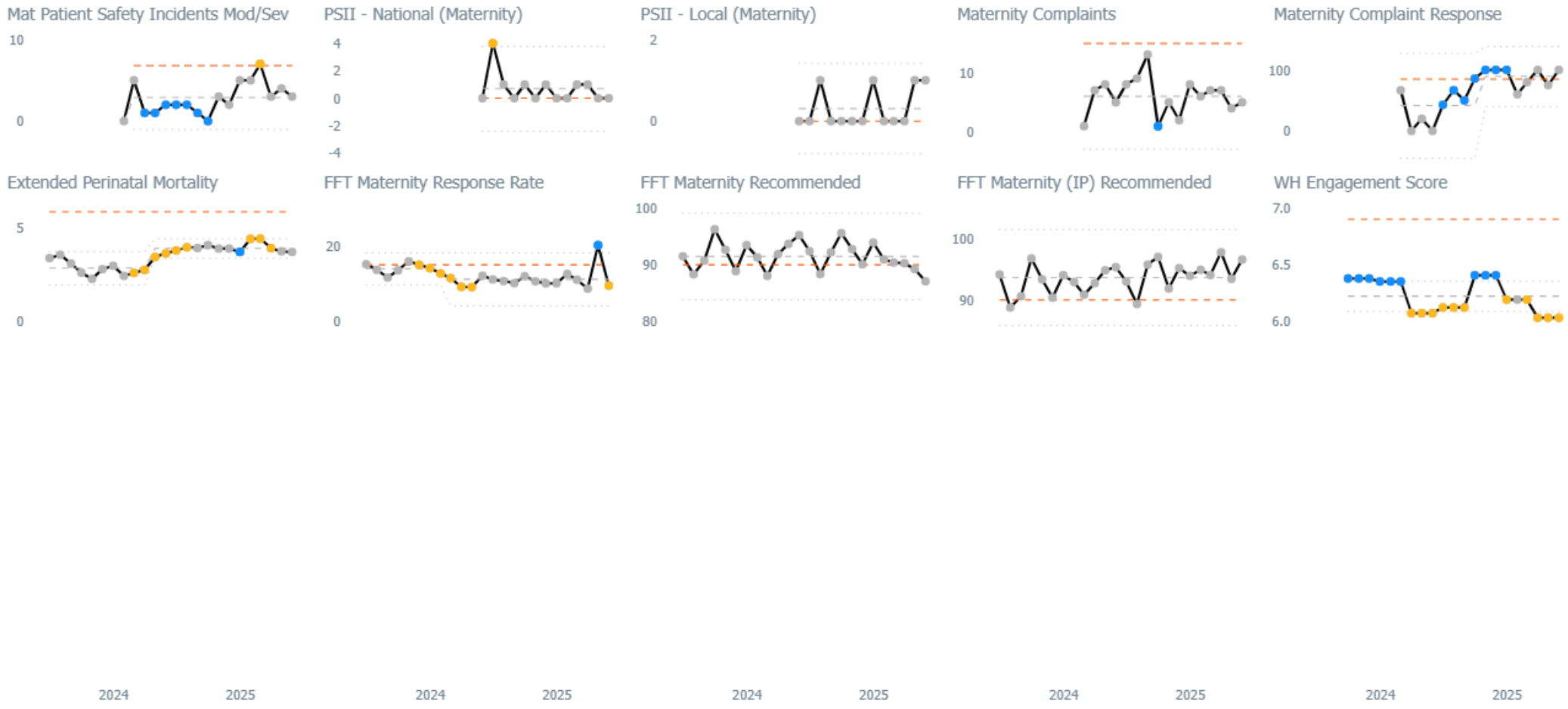
Maternity: Maternity Care

Patient Experience, Incident Reporting & Complaints

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
FFT scores		• Patient Experience Team		FFT maternity response rate in June 9.5% The 'go live' of EDNv2 happened on 28th April where every EDN should have an individualised QR code for women / birthing people to scan prior to discharge unfortunately this aspect has been delayed due to an issue with how to get the Sunrise VisitGUID allowable in the URL web address given to the patient and embedded in the QR code , this action is with Information who believe they now have a solution. We are awaiting a go live date for this. Service users will continue to receive a text for the 36 week, discharge from community and hearing screening elements.
Overdue Incidents	• Email and communication with individual overdue incident and action owners with ongoing monitoring of expected completion date • Agreed with corporate team an understanding that some maternity incidents will remain open for longer than 6 weeks, given the complex nature of some investigations.	• Head of Governance		• The number of maternity overdue incidents in June is 97 • Continued monitoring of incident management with increased surveillance and support through weekly 'Stop the clock' meetings • Focus on management of open incidents approaching 6 week threshold to prevent them becoming overdue 
Complaints		• Head of Governance		• Total of 5 maternity complaints received in June • Complaint response rate was 100% in June. 

Maternity: Trend Analysis

Maternity Domain Metrics



East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: M3 FINANCE REPORT

Meeting date: 31 JULY 2025

Board sponsor: ANGELA van der LEM, CHIEF FINANCE OFFICER (CFO)

Paper Author: MICHELLE STEVENS, DIRECTOR OF FINANCE (DoF)

Appendices:

APPENDIX 1: M3 FINANCE REPORT

Executive summary:

Action required:	Information
Purpose of the Report:	The report is to update the BoD on the financial performance for June 2025 (M3).
Summary of key issues:	**The Finance Report**: The M3 Year to Date (YTD) position achieved by the Group (Pre-deficit support) was a deficit of (£27.3m).

	YTD Plan	YTD Actual	YTD Variance
£'000			
Patient care income	234,726	236,030	1,304
Other income	18,313	15,120	(3,193)
Employee Expenses	(181,438)	(183,168)	(1,730)
Other operating expenses	(97,063)	(94,167)	2,896
Non-operating expenses	(2,042)	(1,348)	694
Operating Surplus/Deficit	(27,504)	(27,533)	(29)
Technical adjustments	177	206	29
TECHNICALLY ADJUSTED SURPLUS/(DEFICIT) EXCLUDING DEFICIT SUPPORT	**(27,327)**	**(27,327)**	**0**

The Trust's YTD M3 position shows Income from patient care (excluding drugs and devices) is currently £0.6m higher than planned. This includes NHS England (NHSE) Wider Variable Income including Chemotherapy

	(£0.2m) and Compensation Recovery Unit (£0.1m). Income from drugs and devices is £0.4m above plan. Other operating income is £0.6m favourable to plan YTD, driven by Laboratory Information Management System (LIMS) income (which is offset against cost) received in May and higher than planned education and training income relating to pay award funding. Employee expenses £0.1m favourable in-month but £1.3m adverse YTD. Substantive staff costs are under plan, while temporary staffing, particularly bank staff, drives the overspend. Other operating expenses are £0.5m adverse to plan YTD driven by overspends in general supplies. These are partially offset by underspends in clinical supplies, drugs, and purchased healthcare. 2gether Support Solutions (2gether) reported a surplus of £0.6m for M3, which is £0.2m below plan. This shortfall is primarily due to lower than anticipated retail income. Spencer Private Hospitals (SPH) reported a deficit of £0.004m for M3, which is £0.09m below plan, mainly due to staff costs above plan offset against higher levels of patient care income. The Trust cash balance (excluding subsidiaries) at the end of June was £46.6m. The appendix (as standard) provides the full cash flow forecast for the year.
Key recommendations:	The BoD is asked to review and **NOTE** the financial performance of M3.

Implications:

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

Assurance route:

Previously considered by: Finance and Performance Committee (FPC) – 22 July 2025

East Kent Hospitals University NHS Foundation Trust

Finance Performance Report 2025/26

June 2025

Chief Finance Officer
Angela van der Lem

Group Summary
Month 03 (June) 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	213.655	214.284	0.629	0.000	0.000	0.000	5.199	5.457	0.258	(0.262)	(0.736)	(0.474)	218.592	219.005	0.413
NHS Income From Commissioners - Drugs	14.687	15.201	0.514	0.000	0.000	0.000	0.000	0.000	0.000	(0.455)	0.000	0.455	14.232	15.201	0.969
NHS Income From Commissioners - Devices	1.902	1.824	(0.078)	0.000	0.000	0.000	0.000	0.000	0.000	(0.000)	0.000	0.000	1.902	1.824	(0.078)
Other Income	15.875	16.426	0.551	42.032	40.286	(1.746)	0.014	0.010	(0.004)	(39.608)	(41.602)	(1.994)	18.313	15.120	(3.193)
Total Income	**246.119**	**247.736**	**1.616**	**42.032**	**40.286**	**(1.746)**	**5.213**	**5.467**	**0.254**	**(40.325)**	**(42.339)**	**(2.013)**	**253.039**	**251.150**	**(1.889)**
Substantive Staff (inc. Apprenticeship Levy)	(149.099)	(148.396)	0.703	(11.171)	(11.445)	(0.274)	(1.937)	(2.343)	(0.406)	0.181	0.294	0.113	(162.026)	(161.890)	0.136
Bank Staff	(12.121)	(13.756)	(1.635)	0.000	0.000	0.000	0.000	(0.011)	(0.011)	0.000	0.011	0.011	(12.121)	(13.756)	(1.635)
Agency/Contract	(6.549)	(6.940)	(0.391)	(0.538)	(0.461)	0.077	(0.204)	(0.121)	0.083	0.000	0.000	0.000	(7.291)	(7.522)	(0.231)
Total Employee Expenses	**(167.769)**	**(169.092)**	**(1.323)**	**(11.709)**	**(11.906)**	**(0.197)**	**(2.141)**	**(2.475)**	**(0.334)**	**0.181**	**0.305**	**0.124**	**(181.438)**	**(183.168)**	**(1.730)**
Drugs	(26.060)	(25.532)	0.528	0.000	(0.003)	(0.003)	(0.662)	(0.698)	(0.036)	0.611	0.559	(0.052)	(26.111)	(25.674)	0.437
Rechargeable Devices	(1.902)	(1.824)	0.078	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	(0.000)	(1.902)	(1.824)	0.078
Supplies and Services - Clinical	(14.487)	(11.846)	2.641	(14.401)	(16.558)	(2.157)	(0.557)	(0.409)	0.148	1.969	1.939	(0.030)	(27.476)	(26.874)	0.602
Supplies and Services - General	(35.044)	(38.589)	(3.546)	(8.326)	(4.385)	3.941	(0.062)	(0.074)	(0.012)	35.618	38.175	2.558	(7.814)	(4.873)	2.941
Clinical negligence	(9.442)	(9.102)	0.340	0.000	0.000	0.000	0.000	0.000	0.000	0.000	(0.000)	(0.000)	(9.442)	(9.102)	0.340
Depreciation and Amortisation	(6.681)	(6.649)	0.032	(0.129)	(0.273)	(0.144)	(0.057)	(0.085)	(0.028)	0.000	(0.000)	(0.000)	(6.867)	(7.007)	(0.140)
Other non pay	(11.206)	(11.749)	(0.543)	(6.580)	(6.721)	(0.141)	(1.606)	(1.706)	(0.100)	1.941	1.364	(0.577)	(17.451)	(18.813)	(1.362)
Total Other Operating Expenses	**(104.822)**	**(105.291)**	**(0.469)**	**(29.436)**	**(27.940)**	**1.496**	**(2.944)**	**(2.972)**	**(0.028)**	**40.139**	**42.037**	**1.898**	**(97.063)**	**(94.167)**	**2.896**
Non Operating Expenses	(1.965)	(1.525)	0.440	(0.048)	0.195	0.243	(0.031)	(0.016)	0.015	0.002	(0.002)	(0.004)	(2.042)	(1.348)	0.694
Profit/Loss	**(28.437)**	**(28.173)**	**0.264**	**0.839**	**0.635**	**(0.204)**	**0.097**	**0.004**	**(0.093)**	**(0.003)**	**0.002**	**0.005**	**(27.504)**	**(27.533)**	**(0.029)**
Less Technical Adjustments	0.177	0.206	0.029	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.177	0.206	0.029
Technically Adjusted Profit/Loss	**(28.260)**	**(27.967)**	**0.293** 1	**0.839**	**0.635**	**(0.204)** 2	**0.097**	**0.004**	**(0.093)** 3	**(0.003)**	**0.002**	**0.005** 4	**(27.327)**	**(27.327)**	**0.000** 5
Non Recurrent Deficit Support Revenue Allocation	20.164	20.164	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	20.164	20.164	0.000
Deficit Support Adjusted Profit/Loss	**(8.096)**	**(7.803)**	**0.293**	**0.839**	**0.635**	**(0.204)**	**0.097**	**0.004**	**(0.093)**	**(0.003)**	**0.002**	**0.005**	**(7.163)**	**(7.163)**	**0.000**

1. Trust:
The Trust has been allocated non-recurrent Deficit Support Funding (DSF) totalling £57.6m for the year. This non-recurrent allocation reduces the Group's planned deficit from £64.2m to £6.6m. Since this allocation is non-recurrent the finance report will focus on the deficit prior to the DSF. DSF is shown below the line to maintain emphasis on the recurrent position. Excluding the non-recurrent DSF allocation the Trust's position for month 3 is £0.3m favourable. The key drivers of this position include:

- Income from patient care (excluding drugs and devices) is currently £0.6m higher than planned. This includes NHSE Wider Variable income including Chemotherapy (£0.2m) and Compensation Recovery Unit (£0.1m). Estimated Q1 ERF overperformance for Specialised Commissioning has been included at a value of £0.2m. Income from drugs and devices is £0.4m above plan.
- Other operating income is £0.6m favourable to plan YTD, driven by LIMS income (which is offset against cost) received in May and higher than planned education and training income relating to pay award funding.
- Employee expenses re £0.1m favourable in-month but £1.3m adverse YTD. Substantive staff costs are under plan, while temporary staffing, particularly bank staff, drives the overspend.
- Other operating expenses are £0.5m advise to plan YTD driven by overspends in general supplies. These are partially offset by underspends in clinical supplies, drugs, and purchased healthcare.

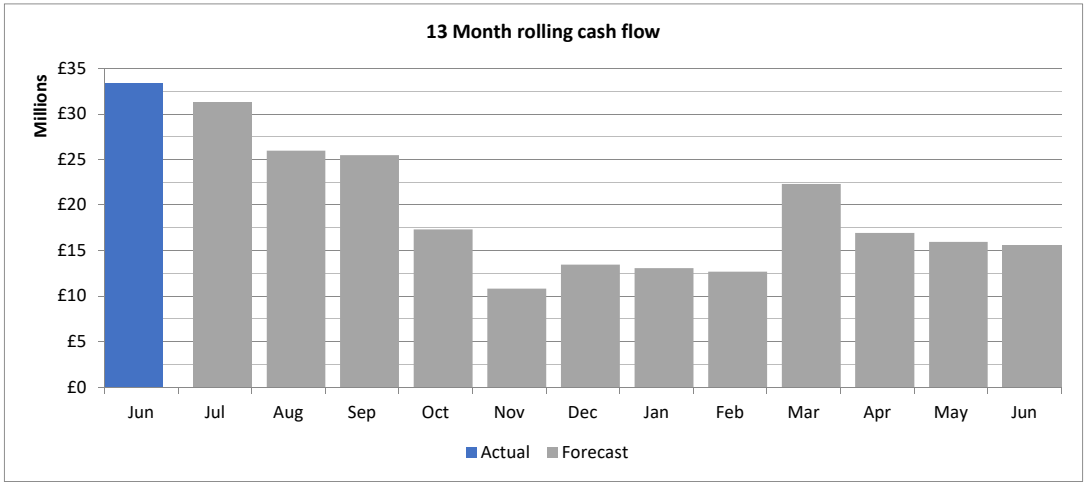
2. 2gether Support Solutions
2gether Support Solutions reported a surplus of £0.6m for Month 3, which is £0.2m below plan. This shortfall is primarily due to lower than anticipated income from retail income offset with an underspend on clinical supplies & services.

3. Spencer Private Hospitals
Spencer Private Hospitals reported a surplus of £0.004m for Month 3, which is £0.09m below plan, due to pay costs above plan offset against higher levels of patient care income.

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

5. Group
The Month 3 deficit for the group stands at £27.3m, which is in line with plan.

Cash Flow
Month 03 (June) 2025/26



Unconsolidated Cash balance was £46.6m at the end of June 2025, £6.2m above plan.

Cash receipts in month totalled £92.7m (£5.7m below plan):

- K&M ICB paid £74.5m in June (Below plan by £6.1m due to DSF, plan phased per I&E but cash paid in 12ths)
- NHS England paid £6.6m in June
- VAT received was £5.8m in June
- Other receipts totalled £5.8m (this includes £3.1m from other NHS organisations and £2.7m from Non NHS debtors)

Cash payments in month totalled £93.1m (£6.0m below plan)

- Creditor payment runs were £28.2m (£5.2m below plan).
- £14.8m payments to 2gether were £1.2m below plan.
- Total payroll was £50.1m - £0.4m above plan in Month 3

2025/26 Cash Plan

A revised plan was 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 plan.

Risk to the cashflow:

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

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

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

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

Creditor Management

The Trust paid to 37 day creditor terms for suppliers in Month 03. At the end of June 2025, the Trust was recording 40 creditor days (Calculated as invoiced creditors at 30th June/Forecast non-pay expenditure x 365).

Statement of Financial Position

Month 03 (June) 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**	**357.747**	**(3.026)**	**64.913**	**65.077**	**0.164**	**4.349**	**4.303**	**(0.046)**	**(141.301)**	**(141.265)**	**0.036**	**288.734**	**285.862**	**(2.872)**
Inventories	7.546	7.506	(0.040)	6.022	6.022	0.000	0.060	0.026	(0.034)	0.000	0.000	0.000	13.628	13.554	(0.074)
Trade Receivables	34.729	34.880	0.151	17.299	13.096	(4.203)	4.056	4.440	0.384	(21.540)	(18.278)	3.262	34.544	34.138	(0.406)
Accrued Income and Other Receivables	(3.870)	(3.781)	0.089	(0.115)	(0.131)	(0.016)	(0.083)	(0.083)	0.000	0.000	0.000	0.000	(4.068)	(3.995)	0.073
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	46.586	(1.109)	24.189	25.667	1.478	3.048	2.902	(0.146)	0.000	0.000	0.000	74.932	75.155	0.223
Current Assets	**86.100**	**85.191**	**(0.909)**	**47.395**	**44.654**	**(2.741)**	**7.081**	**7.285**	**0.204**	**(21.540)**	**(18.278)**	**3.262**	**119.036**	**118.852**	**(0.184)**
Payables and Accruals	85.542	93.737	8.195	23.409	19.717	(3.692)	4.421	4.593	0.172	(17.889)	(14.619)	3.270	95.483	103.428	7.945
Deferred Income and Other Liabilities	6.262	7.494	1.232	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	6.262	7.494	1.232
Provisions	10.424	6.424	(4.000)	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	10.424	6.424	(4.000)
Borrowing	4.244	4.273	0.029	2.468	2.367	(0.101)	0.079	0.065	(0.014)	(4.485)	(4.523)	(0.038)	2.306	2.182	(0.124)
Current Liabilities	**106.472**	**111.928**	**5.456**	**25.877**	**22.084**	**(3.793)**	**4.500**	**4.658**	**0.158**	**(22.374)**	**(19.142)**	**3.232**	**114.475**	**119.528**	**5.053**
Provisions	3.724	3.724	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	3.724	3.724	0.000
Borrowing	67.533	66.152	(1.381)	48.231	47.709	(0.522)	1.887	1.876	(0.011)	(111.229)	(110.083)	1.146	6.422	5.654	(0.768)
Non Current Liabilities	**71.257**	**69.876**	**(1.381)**	**48.231**	**47.709**	**(0.522)**	**1.887**	**1.876**	**(0.011)**	**(111.229)**	**(110.083)**	**1.146**	**10.146**	**9.378**	**(0.768)**
Net Assets	**269.144**	**261.134**	**(8.010)**	**38.200**	**39.938**	**1.738**	**5.043**	**5.054**	**0.012**	**(29.238)**	**(30.318)**	**(1.080)**	**283.149**	**275.808**	**(7.341)**
Public Dividend Capital	609.877	609.877	0.000	30.267	30.267	0.000	0.048	0.048	(0.000)	(30.315)	(30.315)	0.000	609.877	609.877	(0.000)
Retained Earnings	(394.090)	(402.100)	(8.010)	9.008	9.666	0.658	2.185	2.191	0.006	0.000	0.002	0.002	(382.897)	(390.241)	(7.344)
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**	**261.132**	**(8.010) 1**	**39.275**	**39.933**	**0.658 2**	**5.045**	**5.051**	**0.006 3**	**(30.315)**	**(30.313)**	**0.002 4**	**283.147**	**275.803**	**(7.344)**

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 £0.9m from 2024/25, driven by a £1.1m reduction in cash. See cash and working capital pages for details**.**

Current Liabilities - Current liabilities have increased by £5m, primarily driven by an £8m rise in payables, partially offset by a £4m reduction in provisions and a £1m increase in deferred income. (Refer to the Working Capital sheet for details.)

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

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

2. 2gether Support Solutions:

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

Current Assets - Current assets have decreased by £2.7m, primarily due to an £4.2m reduction in receivables, partially offset by a £1.5m increase in cash.

Current Liabilities - Current liabilities have decreased by £3.8m, mainly due to a reduction in payables.

3. Spencer Private Hospitals:

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

Current Assets: Increased by £0.2m, driven by higher trade receivables.

Current Liabilities: Increased by £0.1.6m, primarily due to a increase in invoice payables.

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

Capital Expenditure
Month 03 (June) 2025/26

Capital Programme	Annual	Annual	Year to Date		
£000	**Plan**	**Forecast**	**Plan**	**Actual**	**Variance**
PEIC (Critical Estates Priorities)	4,000	4,000	500	159	341
MDG (Medical Devices Replacement)	3,000	3,000	410	0	410
ERP (Equipment Replacement Programme)	3,800	3,800	875	338	537
IDG (IT Hardware and Systems Replacement)	2,300	2,300	980	589	391
Fire Compartmentation Strategy	4,930	4,930	575	795	(220)
Subsidiaries - 2Gether Suport Solutions (2SS)	450	450	40	0	40
Subsidiaries - Spencer Private Hospitals (SPH)	64	64	23	35	(12)
Thanet CDC	4,340	4,340	20	0	20
Hyper Acute Stroke Unit (HASU)	3,580	3,580	550	264	286
Diagnostics Imaging (QEQM MRI) - 2025/26 (Year 2)	2,050	2,050	1,820	1,532	288
WHH Cardiac Catheter Lab	1,190	1,190	10	0	10
Aseptic Suite Remedial Works	750	750	0	0	0
Block and Beam replacement - WHH - 2025/26 (Year 2)	350	350	170	172	(2)
Nursery Major Refurbishment Works	300	300	7	0	7
Maternity Information System (MIS)	125	125	0	0	0
Pathology Pneumatic Tubes - System Replacement	100	100	0	0	0
Procurement of 2x Mobile CT Scanners - 2025/26 (Year 2) - Enabling Wo	60	60	60	0	60
NHSE Maternity Scheme (Early Release Fees) - 2025/26 (Year 2)	800	800	560	42	518
2025/26 National Diagnostics Programme	1,218	1,218	0	0	0
2025/26 National UEC Programme	23,765	23,765	714	17	697
2025/26 National CIR Programme	12,637	13,232	0	1	(1)
Donated Assets	600	600	43	143	(100)
Right of Use Assets (RoUA) - IFRS16 Leases	758	758	0	0	0
All Other	0	0	0	49	(49)
	71,167	**71,761**	**7,357**	**4,136**	**3,221**

Funded By:	**Plan**	**Forecast**
Operational Capital	29,175	29,175
Donations	600	600
PDC	38,420	39,015
	68,195	**68,790**
Funding Under/(Over) utilisation	**(2,972)**	**(2,972)**

The Trust submitted the 2025/26 Capital Plan to NHSE on 21st May 2025, as part of a final re-submission of the wider operational plan for the year. The **2025/26 Capital Plan totalled £71.2m** and included £3m of over-programmed schemes against the £68.2m planned funding. This approach was endorsed by the Executive Management Team as part of the Capital Prioritisation process undertaken in January-March 2025.

At the request of NHSE, the 2025/26 capital plan submitted included the indicative external funding allocations based on bids the Trust submitted to NHSE in Q4 2024/25.

The Constitutional Standards bids were formally confirmed as successful by the K&M ICB in June 2025. The Trust was awarded £1.218m under the National Diagnostics Programme and £28.95m under the National UEC Programme. In liaison with the national team, the latter was agreed to be phased across two financial years, with £23.765m in 2025/26 and £5.185m in 2026/27. This is consistent with the indicative national funding that was included in the 2025/26 Capital Plan at the request of the national team.

The Estates Safety Funding bid (also known as the Critical Infrastructure Risk programme) was included at £12.6m in the 2025/26 Capital Plan. In June, the funding award has been confirmed by the national team at £13.2m, which is £0.585m higher. This has now been reflected within the M3 forecast and corresponding MOUs have been signed by the DHSC and the Trust.

The **Group's gross capital year-to-date spend to the end of Month 3 was £4.1m**, representing a £3.2m underspend against the year-to-date plan of £7.3m. Of this underspend, c.50% relates to externally funded schemes that cannot proceed until business cases have been approved by NHSE and funding confirmation received.

For both internal and external schemes, a re-forecasting exercise by month is currently underway to determine the capital expenditure profile for the rest of the 2025/26 financial year. The output, which will be reported in Month 4, is expected to highlight potential opportunities to reduce the over-programming element to a break-even position and provide a robust delivery timeline for the externally funded schemes now that funding has been confirmed by NHSE.

Cost Improvement Summary

Month 03 (June) 2025/26

Delivery Summary

Programme Themes £000	This Month Plan	This Month Actual	This Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	Annual Plan	Annual Forecast	Annual Variance
01. Estate Utilisation & Rationalisation	113	102	(11)	299	142	(157)	2,489	2,250	(239)
02. Procurement	217	254	37	649	614	(35)	5,448	6,847	1,399
03. Digital Utilisation & Rationalisation	3	-	(3)	9	-	(9)	164	164	-
05. Medical Workforce	166	51	(115)	447	150	(297)	5,803	5,550	(253)
06. AHP | Nursing | Midwifery Workforce	50	-	(50)	138	28	(110)	1,506	3,015	1,509
07. Non-Clinical Workforce	71	418	347	207	542	334	2,333	10,631	8,299
08. Diagnostics	29	123	94	89	198	109	734	1,033	298
09. Integrated Urgent and Emergency Care	75	42	(33)	222	63	(159)	2,000	1,689	(311)
10. Theatre Utilisation	46	12	(34)	140	31	(109)	1,263	1,417	154
11. Outpatients	13	-	(13)	38	1	(37)	343	1,043	700
12. Medicines Management and Devices	58	147	89	176	438	263	703	1,202	500
13. Subsidiaries - 2gether	417	-	(417)	1,250	-	(1,250)	5,000	5,000	-
14. Subsidiaries - Spencer	6	-	(6)	17	-	(17)	300	600	300
15. Service Efficiency Review	-	-	-	-	-	-	-	525	525
16 to 23 Care Group Led Schemes	2,044	539	(1,505)	5,169	882	(4,287)	51,914	24,749	(27,165)
25. Central	-	1,574	1,574	-	5,762	5,762	-	5,929	5,929
Grand Total	**3,308**	**3,261**	**(47)**	**8,850**	**8,850**	**0**	**80,000**	**80,071**	**71**

Delivered £000

Month	Target	Actual
April	2,290	2,040
May	3,252	3,549
June	3,308	3,261
July	3,594	
August	4,074	
September	3,803	
October	10,152	
November	9,810	
December	9,845	
January	9,909	
February	9,941	
March	10,022	
	80,000	**8,850**
		11.1%

Efficiencies

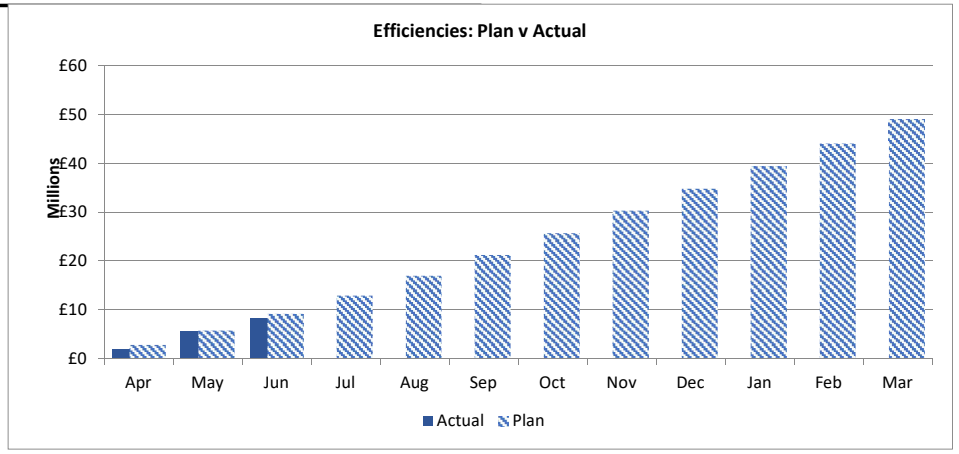
The agreed Efficiencies plan for 2025/26 is £80.0m. CIP delivery is below plan for Month 03 by £0.05m and on plan YTD YTD. Recurrent savings of £1.16 have been delivered in June and £2.29 YTD.

Note that the Care Group Led Schemes include the planned allocation of "Fair Share" for the previously unidentified schemes in order to reflect the Efficiency targets in the ledger. This amounted to £33.0m for the year and £2.33m YTD. Subsequently, stretch ideas and opportunities have been agreed by EMT, some of which are included in Miscellaneous and System. Expected delivery to commence in October.

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

The PMO is collaborating effectively with the Financial Recovery Director and Director of Continuous Improvement. The focus is now on delivery of the identified schemes and moving pipeline scheme PIDs for FY25/26 through the governance gateways for delivery. The Financial Recovery Director is developing ideas with the Executive Team as described above.

The key task is to deliver cash out / run rate reductions through CRES 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: **31 July 2025**

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

Paper Author: **Head of Risk Management and Assurance (on behalf of Director of Quality Governance)**

Appendices:

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 16 July 2025, when the Significant Risk Register was extracted there are currently 43 risks on the Significant Risk Register. There are six risks with associated overdue actions. These have been escalated with risk owners and delegates – most actions have recent dates. There have been significant improvements in ensuring records are reviewed and updates provided but it is essential that this process becomes embedded within strengthened business as usual governance arrangements. Monthly meetings are in place with the executive leads for each significant risk (and their deputy/wider team as requested) to ensure regular monthly oversight and scrutiny. The Risk Review Group on 15 July received a Deep Dive from Queen Elizabeth the Queen Mother Hospital (QEQM) Care Group and an overview of Health and Safety risks and the work planned with Care Groups from July to October to ensure improved visibility of risks and improved governance and oversight. A short paper was also presented on work underway on Estates and Equipment – which is taking a similar approach to ensure risks are visible at the appropriate level (Trust wide or Care Group) and mitigations and actions are up to date. The Deep Dive for Corporate Nursing was

East Kent Hospitals University NHS Foundation Trust

	received but due to lack of time in the meeting was deferred until the next Risk Review Group meeting on 21 August 2025. There is good engagement with the Deep Dive process, the process is improving the quality of risk register entries and ensuring there is an opportunity for collective challenge and discussion There have been delays in the rollout In Phase (Quality Management System) for Risk - due to issues with the supplier which have been escalated. Work continues. The Annual audit of risk management was completed by RSM and the final draft issued. The report was reviewed by Risk Review Group on 23 April 2025 and then received at TMC on 7 May 2025. The action plan is underway. The report showed sustained improvement (with a sustained 'reasonable assurance' rating) with further work to do in areas that are already recognised within the work planner – for example training around risk management. A formal update on progress will be received at the Risk Review Group in August 2025 with escalations to TMC as required. Some of the actions (for example training and development) will also form part of the Risk Management Strategy refresh which is due to come to Integrated Audit and Governance Committee (IAGC) in October 2025. Since the last Board report in June, five new risks have been approved. In addition, three existing risks were escalated to the Significant Risk Register. One risk was closed. Full details are in Section 4. There were no areas of escalation from the last Risk Review Group on 15 July but Care Groups and Corporate areas were asked to ensure their significant risks have been updated and that emerging risks are also reviewed as part of Care Group Governance meetings. The Training Needs Assessment and rollout plan agenda item (verbal update) was deferred to the next meeting with an update to be sent to all attendees via email in the meantime. As above an update on the Annual Audit action plan will be presented at the August Risk Review Group and then to TMC.
Key recommendations:	The BoD 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).

East Kent Hospitals University NHS Foundation Trust

Resource:	Yes. Additional resource will be required to mitigate some of the significant risks identified.
Legal and regulatory:	Yes. The Trust is required to comply with the requirements of a number of legal and regulatory bodies including but not limited to: • NHS England • Care Quality Commission • Health and Safety Executive
Subsidiary:	2gether Support Solutions Spencer Private Hospitals

Assurance route:

This was previously considered by:

The Risk Review Group on 15 July 2025. New approved risks are reflected in this paper to ensure timely reporting but will be formally presented at TMC on 6 August 2025.

Reporting will be received by the Finance and Performance Committee (FPC) on 26 August 2025, Quality and Safety Committee (Q&SC) on 23 September 2025 and People and Culture Committee (P&CC) on 16 September 2025. These papers will also be reflective of risks approved at the Risk Review Group on 21 August 2025.

It should be noted that as the Risk Register is a live document the supporting information was extracted on 16 July 2025.

East Kent Hospitals University NHS Foundation Trust

SIGNIFICANT RISK REPORT

1. Purpose of the report

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

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

1.3 The last Risk Review Group took place on 15 July 2025. A deep dive presentation was provided by QEQM Care Group and a presentation was provided by Health and Safety. Risk approvals are detailed within the paper in Section 4 as well as the escalations agreed 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 (up from 33 in the June Board report).

3.2 There has been change to several of the residual risk scores of the risks reported in June. These are marked on the table below.

3.3 There are overdue actions associated with six of the risks (marked in bold for clarity). These have been escalated for immediate attention with the Risk Owners and Delegates. One of the risks (risk ref: 1628) that has an associated overdue action has been put forward for potential closure (the outstanding action is a duplication from a Corporate Medical risk) but this requires Care Group governance oversight.

3.4 The Significant Risk Register is summarised below:

East Kent Hospitals University NHS Foundation Trust

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to June report	Target Risk Score	Actions summary
678	Care Group - Diagnostics, Cancer and Buckland **Accountable Executive: Chief Medical Officer (CMO)**	Insufficient Pharmacy support for the safe (and secure) use of medicines on wards	High (15)	⟺	Low (4)	Request purchase of Sunrise medicines app for use by pharmacy staff with aim of improving processes on the system which have been impacted when switching to epma e.g. ordering and screening (Home function is required to improve MR process) Request is still outstanding with IT team. To contact Deputy Lead CS Pharmacist to see if escalation helpful given risks in this area. Person Responsible: Deputy Lead CS Pharmacist Due: 31 July 2025 Await confirmation of paeds and Neonatal Intensive Care Unit (NICU) case submitted in December 2024. Case was to increase staffing numbers in line with benchmarking and national guidance. If approved recruit and if decline then note Trust decision to maintain current service. Person Responsible: Deputy Lead CS Pharmacist Due: 1 Sept 2025

East Kent Hospitals University NHS Foundation Trust

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to June report	Target Risk Score	Actions summary
						Await confirmation as to whether case for service to medical wards (Care Quality Commission (CQC) medical wards) is approved or declined. Case submitted >12 months. If approved then action will move to recruitment and if declined, update the risk with the Trust decisions. Person Responsible: Deputy Lead CS Pharmacist Due: 1 Sept 2025 Review effectiveness and limitations of weekend service (review to be completed by Pharmacy Medicines Value Team Lead) to identify whether any clinical capacity can be released and skill mix is correct (service extended two years ago). Person Responsible: Lead Pharmacist for Clinical Operations and Workforce Due: 1 Oct 2025 Review impact of new workflow procedures and identify how to reduce workload for clinical team further in the dispensary

East Kent Hospitals University NHS Foundation Trust

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to June report	Target Risk Score	Actions summary
						Person Responsible: Lead Pharmacist for Clinical Operations and Workforce Due: 1 Oct 2025 Identify causes of late nights for clinical pharmacy staff and identify strategies to reduce the commitment (clinical staff provide a late-night commitment which is Time Off In Lieu (TOIL) based which reduces clinical capacity). Person Responsible: Lead Pharmacist for Clinical Operations and Workforce Due: 1 Oct 2025 Consider Full 7-day service from Pharmacy following action from CQC Must do implementation. With CQC must do case declined consideration required as to the operation of a traditional clinical pharmacy services and whether or not this is feasible as given the financial challenge there is insufficient resource for delivering this. Person Responsible: Will Willson, Director of Pharmacy Due: 1 Apr 2026

East Kent Hospitals University NHS Foundation Trust

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to June report	Target Risk Score	Actions summary
679	Care Group – Diagnostics, Cancer and Buckland **Accountable Executive: CMO**	Failure to supply, from Pharmacy, scheduled chemotherapy treatments to patients	Extreme (20)	⟺	Extreme (20)	**Capital new build of aseptic unit now one of six key capital projects within EKHUFT financial recovery plan to be presented to NHS England (NHSE). There is an upcoming meeting with Medway NHS Foundation Trust (MFT)/EKHUFT to look at the situation in the light of the broader discussion around aseptic hubs.** **Person Responsible: CMO** **Due: 31 Mar 2025** Assurance of completion of Air Handling Unit (AHU) Airis Q action plan by the Accountable pharmacist/Estates/production manager. Action plan and document uploaded and in process via the refurb work planned Person Responsible: Pharmacy Quality Assurance & Quality Control Lead To be implemented by: 27 July 2025 Create and appoint to a substantive Accountable pharmacist to replace current interim role. Approved via the care

East Kent Hospitals University NHS Foundation Trust

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						group process and due for consideration by the Vacancy Control Panel (VCP) 4 July 2025 Person Responsible: Will Willson, Director of Pharmacy To be implemented by: 30 September 2025 Replacement of the unit with offsite licensed facility as part of the Integrated Care System (ICS) strategy and linked to the national aseptic review. Work progressing at Integrated Care Board (ICB) level, although that is more aligned to the proposed aseptic hub, but it may well expand to encompass spoke activities. Not clear yet and meeting in June 2025. Person Responsible: Will Willson, Director of Pharmacy To be implemented by: 30 September 2029 Replacement of Hepa-filters in the Cirrus isolators. Cirrus are waiting on delivery of the HEPA filters, a date will then be agreed to fit them. Person Responsible:

East Kent Hospitals University NHS Foundation Trust

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to June report	Target Risk Score	Actions summary
						Aseptic Services Manager Due: 31 July 2025 For the Project Governance to be set up, the remedial work to be agreed upon for work to be commenced on 1 September 2025 (this work cost is £750k approved from capital funding) Refurb work still planned to start 25 September 2025, however, no documented plan and there is a space issue highlighted as a result of what now is planned Person Responsible: Interim Accountable Pharmacist Due: 29 August 2025 Commencement of the remedial aseptic work at Kent & Canterbury Hospital (K&C) Person Responsible: Interim Accountable Pharmacist Due: 17 September 2025 Completion of remedial aseptic work and validation of the facilities at K&C Person Responsible: Will Willson, Director of Pharmacy

East Kent Hospitals University NHS Foundation Trust

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to June report	Target Risk Score	Actions summary
						Due: 19 December 2025
1350	Care Group – Diagnostics, Cancer and Buckland (DCB) **Accountable Executive: CMO**	Failure to provide ward stock medicines in a timely fashion due to obsolescence of Pharmacy TWS Distribution robot	High (15)	⟺	Very Low (3)	Replace Robot – Present case for replacement to DCB finance and performance meeting to get the case approved in advance of business planning and should capital become available in the interim Quote now received from Trust Quantity Surveyor for enabling works. Business case will be updated for Business Case Scrutiny Group (BCSG). Person Responsible: Chief Pharmacy Technician Due: 30 September 2025
1628	Care Group – William Harvey **Accountable Executive: CMO**	Staffing mix and experience impact on the ability of the Care Group to provide services to paediatric patients in line with the Royal College of Paediatrics and Child Health (RCPH) standards	High (16)	⟺	Low (4)	**Medical staff to attend advanced training (Paediatric Immediate Life Support (PILS) and then Advanced Paediatric Life Support (APLS)). Paediatric Emergency Department (ED) Consultants in place for WHH and QEQM. Not compliant at present with Paed Resus training.** **Person Responsible: Consultant** **Due: 30 May 2025**

East Kent Hospitals University NHS Foundation Trust

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to June report	Target Risk Score	Actions summary
						It has been proposed that this risk is de-escalated. There is PEM cover at QEQM and WHH site and nursing staffing are RCPCH compliant. Remaining risk re statutory and mandatory training to be linked to existing Corporate Medical risk 3733. To be approved via Care Group governance.
1679	Corporate People and Culture **Accountable Executive: Chief People Officer (CPO)**	There is a risk of failure to address poor organisational culture	High (15)	⟺	Low (4)	Implementation of the design and deliver responses in relation to the Cultural Leadership Programme diagnostic stage. Person Responsible: Norman Blissett, CPO Due: 30 July 2025
1814	Corporate – Strategic Development & Capital Planning **Accountable Executive: Chief Strategy & Partnerships Officer (CSPO)**	Loss of access to key operational / clinical systems from threats (cyber air con, break of external circuits, fire, floods etc) for a protracted period	High (15)	⟺	Moderate (10)	Review cyber team roles and responsibilities. Waiting on output from Cyber Assessment Framework (CAF)/Data Security and Protection Toolkit (DSPT) assessment, which is due to be submitted at the end of June 2025. Person Responsible: Head of Infrastructure, Cyber and Frontline Services Due: 30 September 2025

East Kent Hospitals University NHS Foundation Trust

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to June report	Target Risk Score	Actions summary
						Training needs analysis to be undertaken for IT staff in relation to cyber. Person Responsible: Head of Infrastructure, Cyber and Frontline Services Due: 30 September 2025 Review and update current IT incident and cyber response plans Implementation date extended as awaiting the DSPT toolkit result to ensure any potential recommendations were captured. Result received 30 June 2025 – meets expectations Person Responsible: Head of Infrastructure, Cyber and Frontline Services Due: 30 August 2025 Review of all systems to include planned upgrades and patches are part of the department/trust annual cycle - to ensure adequate management and control. Person Responsible: Head of IT Applications Due: 31 July 2025 Servicing of Uninterruptible Power

East Kent Hospitals University NHS Foundation Trust

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to June report	Target Risk Score	Actions summary
						Supply (UPS) within data centre Person Responsible: John Kelly Due: 30 September 2025 Run regular (at least yearly) internal exercises to test plan and response with the IT team Person Responsible: Head of Infrastructure, Cyber and Frontline Services Due: 30 September 2025 Bi- annual testing of network Wide Area Network (WAN) resilience for mitigation of external circuit failure Person Responsible: Head of Infrastructure, Cyber and Frontline Services Due: 30 September 2025 Annual servicing of air con within data centres Person Responsible: John Kelly Due: 31 October 2025 Review privileged access rights to key infrastructure systems (as per DocIT)

East Kent Hospitals University NHS Foundation Trust

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to June report	Target Risk Score	Actions summary
						Person Responsible: Head of Infrastructure, Cyber and Frontline Services Due: 31 March 2026 Review of external facing systems that currently do not support Multi-Factor Authentication (MFA) Person Responsible: Head of IT Applications Due: 31 March 2026
1831	Queen Elizabeth Queen Mother Care Group **Accountable Executive: CNMO**	Privacy and dignity will be adversely affected when patients are treated in non-care spaces	High (15)	⟺	Low (6)	Fortnightly QEQM UEC delivery Group set-up with a wide range of improvement programmes to support improvements in flow across the site. Person Responsible: Susan Brassington, Director of Nursing (DoN) Due: 30 September 2025 Assess progress of clinical harm reviews and associated learning Harm reviews are still being reviewed regularly. Delays in the ED are slowly improving as coming out of winter. Trying to highlight patients on Sunrise who are looked after in non-care areas or delayed in ambulance queues

East Kent Hospitals University NHS Foundation Trust

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to June report	Target Risk Score	Actions summary
						Person Responsible: Jonathan Purday, Associate Medical Director Due: 30 September 2025 Reverse RATing streaming in place to identify patients who need resus and those who are well enough to be cared for in a non-care space. Ongoing monitoring via incident reporting. Person Responsible: Charles Steadman, Deputy Head of Nursing (HoN) Due: 30 September 2025 Fundamentals of care training to be completed by staff re privacy and dignity. Training remains ongoing. Person Responsible: Charles Steadman, Deputy HoN To be implemented by: 30 September 2025
1891	Corporate Operations **Accountable Executive: Chief Operating**	Misalignment between Demand and Capacity across the Trust's urgent and emergency care pathway	Extreme (20)	⟺	Low (6)	Demand and capacity modelling to be confirmed by all systems partners for all P1 to P3 patients as part of the system wide better use of beds programme to

East Kent Hospitals University NHS Foundation Trust

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to June report	Target Risk Score	Actions summary
	Officer (COO)					inform 2025/26 redesign. Person Responsible: Alison Pirfoe, Deputy COO Due: 31 October 2025 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 Clinical Decision Unit (CDU) model as part of Same Day Emergency Care (SDEC) capital build process as an enabler. Colocation of Urgent Treatment Centre (UTC) to fully utilise Emergency Floor footprint. A series of improvement weeks across both sites are taking place throughout the year looking to improve ED process and patient flow with partners. From a capital perspective, a new SDEC will be built on both sites from August 2025 to May 2026 and a revised clinical model will be introduced upon completion.

East Kent Hospitals University NHS Foundation Trust

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to June report	Target Risk Score	Actions summary
						Person Responsible: Alison Pirfoe, Deputy COO Due: 30 September 2025
2123	Care Group – Diagnostics, Cancer and Buckland **Accountable Executive: CSPO**	Health and Safety Risk to staff and the potential unavailability of records at the point of need due to lack of storage space for Health Records.	Extreme (20)	⟺	Low (4)	Owner has changed to CSPO (with involvement of CMO as relates to Medical Records strategy). Associate Director (AD) Quality Governance to meet with Managing Director (MD) for Care Group to review the wording of this risk and actions.
2158	Care Group - Diagnostics, Cancer and Buckland **Accountable Executive: CMO**	Risk of Patient harm and treatment due to unreported Accident & Emergency (A&E) chest xrays.	High (16)	⟺	Low (4)	External review to be undertaken by Regional Advisor (Tony Newman-Saunders). Meeting to be arranged with care group leaders to discuss outputs of report. Person Responsible: CMO Due: 29 August 2025
2234	Care Group – Diagnostics, Cancer and Buckland **Accountable Executive: CMO**	Failure to meet national histopathology Turnaround Time (TAT's) to support cancer pathway	High (16)	⟺	Moderate (8)	Review a workforce/workload points-based manager system to manage workload in line with RC Path Guidance Internal appointment of workload points based distribution manager made (band 5) and workload distribution rolled out by sub-discipline. At time of writing, breast, Gastrointestinal (GI), Head & Neck (H&N),

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to June report	Target Risk Score	Actions summary
						urology and skin work now being distributed according to the job plans of the consultants. This has ensured against deprioritised cases being left behind, while more effectively demonstrating the pathologist shortfall and workload distribution by sub-discipline. Gynae, haempath and lymphoid will follow Person Responsible: Head Biomedical Scientist Cellular Pathology Due: 31 July 2025 Kent & Medway Pathology Network (KMPN) Digital Histopathology & AI project to improve performance & resilience. NB: this is an adjunct to maintaining service delivery and performance and NOT all histology cases can be reported using AI. The digital pathology project is on hold at Maidstone and Tunbridge Wells NHS Trust (MTW), but validation of reporting by digital image is proceeding slowly at EKHUFT, with the breast pathologists about to enter phase 2 (live case dual reporting

East Kent Hospitals University NHS Foundation Trust

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to June report	Target Risk Score	Actions summary
						with digital image and microscope). Each pathologist will have to be validated for each sub-discipline they report before they can switch to digital reporting. AI roll out for assisted reporting can only follow after validation of digital reporting. Person Responsible: Head Biomedical Scientist Cellular Pathology Due: 31 December 2025 Trust involved in discussions regarding a Kent & Medway Joint Venture. Trust to ensure areas of pressure are highlighted and worked up. Rolled out the workload points across all specialities and are working on an analysis of consultant Direct Clinical Care (DCC) reporting availability (according to JPs - >80% done in cell path) vs workload coming in to give an accurate position. On a wider scale, discussion demand management including at PRM. Person Responsible: CMO Due: 29 August 2025

East Kent Hospitals University NHS Foundation Trust

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2406	Care Group - Diagnostics, Cancer and Buckland **Accountable Executive: CSPO**	Delay to patient diagnosis from potential loss of Nuclear Medicine (NM) service at WHH	High (16)	⟺	Low (4)	Associated work is required to allow camera under NM to open on. discussed at PRM on the 29 August 2024 and awaiting update. this Administration of Radioactive Substances Advisory Committee (ARSAC) licence renewal to allow operational services to commence Person Responsible: Chief Technologist Nuclear Medicine & Osteoporosis Due: 29 August 2025
2599	Corporate – Medical **Accountable Executive: CMO**	There is a risk of inadequate medical staffing levels and skills mix to meet patients' needs	High (15)	⟺	Moderate (9)	**Establishment review at WHH to determine the number of consultants required to run the service** **Person Responsible: CMO** **Due: 30 June 2025** Programmes to support career progression and attraction of consultant posts for long term locums becoming substantive (i.e. Certificate of Eligibility of Specialist Registration (CESR)). There are now portfolio pathway posts in the Trust. Acute Medicine WHH and Obstetrics & Gynaecology (O&G)

East Kent Hospitals University NHS Foundation Trust

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to June report	Target Risk Score	Actions summary
						QEQM have converted posts and are using this pathway. Person Responsible: Head of Medical Workforce Due: 29 August 2025 To develop and implement a standard operating procedure for recruitment for hard to recruit posts Person Responsible: Head of People and Culture Services Due: 31 October 2025
2853	Care Group – Kent & Canterbury and Royal Victoria **Accountable Executive: COO**	Renal – Dialysis Capacity	High (16)	NEW (escalation)	Low (6)	Dialysis matron to support the recruitment of Phase 2 nursing posts for additional twilight at K&C, Maidstone and QEQM plus Home Dialysis expansion Person Responsible: Dialysis Matron Due: 31 July 2025
2899	Care Group – Women's Health **Accountable Executive: CMO**	Consultant obstetric vacancies at QEQM may result in an inability to deliver the service	High (16)	⟺	Moderate (9)	Re-advertise for the 3 vacancies at QEQM. Post held off until after April so that the cohort who get their Certificate of Completion of Training (CCT) in October could apply Shortlisted 2 substantive posts at QEQM – awaiting interview date – aim for end of July. Ockenden post sitting

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to June report	Target Risk Score	Actions summary
						with leadership team for approval – this will cover the 3 new QEQM posts when complete Person Responsible: Women's Services Associate Medical Director Due: 31 October 2025
3105	Care Group - Critical Care, Anaesthetics and Specialist Surgery **Accountable Executive: CMO**	Patient harm to Head and Neck cancer operations delayed or aborted due to aged Leica microvascular microscope breakdown	High (16)	NEW	Low (4)	**Trials underway ahead of purchase. Once finished analysis to Medical Devices Group (MDG) to inform next steps and funding to be identified.** **Person Responsible: Procurement Facilitator – Decontamination Contract Manager** **Due: 4 July 2025**
3354	Queen Elizabeth Queen Mother Care Group **Accountable Executive: CSPO**	Clinical environment not fit for purpose in many areas	High (16)	⟺	Moderate (9)	Estates issues for all ward areas to be addressed with the Estates team to ensure an ongoing programme of maintenance and repair. List of estates issues from closed ward risks attached March 2025 - A comprehensive list of all new Estates work required as well as outstanding estates work is being compiled via the daily Quality Improvement Meetings

East Kent Hospitals University NHS Foundation Trust

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to June report	Target Risk Score	Actions summary
						Person Responsible: DoN To be implemented by: 31 August 2025 Working with 2gether to create a clear targeted investment list of areas required to improve environment Person Responsible: Sunny Chada, Managing Director Due: 30 September 2025 Targeted review of heating and cooling needs across the estate to inform a focussed long-term capital investment programme Person Responsible: Estates Lead Due: 30 September 2025 Creation of a transparent system to see open estates requests and to be prioritised by triumvirate with 2gether Person Responsible: CSPO Due: 7 November 2025 Pilot of handyman role approved by 2gether to focus on patient and staff environment improvements

East Kent Hospitals University NHS Foundation Trust

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to June report	Target Risk Score	Actions summary
						Person Responsible: Estates Lead Due: 4 December 2025 Consider external review of 2gether cleaning service to enhance standards and gain best value for money Person Responsible: To be agreed Due: 25 December 2025
3367	Corporate Medical **Accountable Executive: CMO**	Lack of timely review of diagnostic test results	Extreme (20)		Low (6)	**Developing the Compass technology for the Inbox on Sunrise for consultants to review and all results that are allocated to them. To trial this functionality within a team or number of users to identify any potential flaws.** **Person Responsible: Michael Bedford, Chief Clinical Information Officer** **Due: 30 June 2025** A copy of the radiology results are sent to the requesting clinician. Every week a spreadsheet is generated based on specific Systematized Nomenclature of Medicine Clinical Terms (SNOMED) codes. This is sent to all the

East Kent Hospitals University NHS Foundation Trust

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						Multidisciplinary Meeting (MDM) coordinators who will look for any new cases relevant to their speciality. The MDM coordinators will add it to the MDM list for discussion. Regular audits (weekly) will take place to ensure that MDM coordinators workload is acceptable in identifying new cases relevant to their speciality. Person Responsible: Consultant Histopathology Due: 31 July 2025
3384	Corporate – Strategic Development & Capital Planning **Accountable Executive: CSPO**	The ability to deliver safe and effective services & implement improvements across Trust estate is compromised due to financial constraints for capital funding and assets replacement	High (16)	⟺	Moderate (12)	Progress to full business case for the replacement of maternity facilities at QEQM The Business Case continues to progress well with good engagement and leadership from the Care Group and Clinical Teams. Person Responsible: Nicky Bentley, Director of Strategy & Business Development Due: 1 September 2025
3386	Care Group – Women, Children and Young People	Potential risk of inaccurate records due to Euroking back copying	High (16)	⟺	Low (4)	**Work continues to implement MSR 2.1.1 into the Euroking Test environment to then be tested. If the testing is successful, then**

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	Accountable Executive: CNMO					**Trust to decide whether to move this into the live Euroking environment or stick with the current bespoke MSR. We were informed by Magentus that there are clinical risks noted against the bespoke MSR (which MSR 2.1.1 mitigates) so Magentus are going to send documentation regarding this so the Trust can make an informed decision.** **End date of Magnetus support as part of NPSA project unclear. Update to provided monthly.** **Person Responsible: Clinical Information Systems (CIS) Manager** **Due: 30 June 2025** Claire to attend quality board to again communicate what staff can do to help mitigate the risk Person Responsible: Digital Lead Midwife Due: 31 July 2025
3553	William Harvey Hospital Care Group	Failure of Cardiac Catheter Suite equipment (Lab 1, 2 & 3) WHH	High (16)	⟺	Very Low (3)	Working on solution for a new lab that will act as a decent lab initially, to be implemented by end of financial year. Further lab replacements will

East Kent Hospitals University NHS Foundation Trust

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	Accountable Executive: CSPO					then be reviewed once this is completed Person Responsible: General Manager Due: 30 April 2026
3556	William Harvey Hospital Care Group **Accountable Executive: CNMO**	Delays in delivery and personal care are resulting in an increased risk of pressure ulcers and falls occurring	High (15)	⟺	Low (6)	Improved access to direct alternative to ED (ATED) pathways Person Responsible: Head of Operations Due: 29 August 2025
3557	William Harvey Hospital Care Group **Accountable Executive: COO**	Increased length of stay for mental health patients awaiting inpatient community beds	High (16)	⟺	Moderate (9)	Senior ED leads to review good practice Discharge to Assess (DTA) framework with Deputy COO that could be used for deciding whether a patient with mental health (MH) needs (and no physical health needs) should be admitted into an inpatient bed whilst awaiting an MH bed. Person Responsible: Alison Pirfo, Deputy COO Due: 31 March 2026
3700	Corporate – Finance & Performance Management **Accountable Executive: CFO**	Failure to agree a Medium-term Financial Recovery Plan with System / Region and National Partners	Extreme (20)	⟺	Moderate (12)	Agreement of the Medium Term Financial Plan (MTFP) with Board, ICB & NHSE Person Responsible: Angela van der Lem, Chief Finance Officer (CFO)

East Kent Hospitals University NHS Foundation Trust

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						Due: 31 July 2025
3701	Corporate – Nursing **Accountable Executive: CNMO**	Staff may experience physical and psychological harm as they are frequently subjected to verbal and physical abuse from patients exhibiting challenging behaviours	High (16)	⟺	Low (6)	Security service provision contract will form basis of specification for 2gether to tender the service. Service to be re-tendered, contract awarded and live by April 2025. New security contractor will be appointed by end of May with the intent to mobilise by August 2025. The increase in provision to the ED departments is already in place and the vast majority of existing security offers have been upgraded to a higher SIA door supervisor level. Person Responsible: Associate Director of Safety Due: 29 August 2025
3702	Care Group – Critical Care, Anaesthetics and Specialist Surgery **Accountable Executive: COO**	Delayed discharge of patients from Critical Care when medically fit to be transferred to the ward	High (16)	⟺	Moderate (8)	Work with site triumvirate on priority for critical care wardables to be discharged from Critical Care Implementation date changed. We care project now underway, process mapping exercise commenced to understand the responsibilities Person Responsible: Gemma Oliver, DoN

East Kent Hospitals University NHS Foundation Trust

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						Due: 31 July 2025
3719	Care Group – Diagnostics, Cancer and Buckland **Accountable Executive: CMO**	There is a risk of patient harm from availability, delays and errors in Systemic Anti-Cancer Therapy (SACT) prescribing for adults due to system failures with the ARIA medonc system being out of date at Kent and Medway Cancer Collaborative (KMCC)	High (15)	⟺	Low (5)	ARIA system failure to be included in local business continuity plans (BCP) Local BCP sent to emergency planning to review Person Responsible: Clinical Matron Due: 31 August 2025 New E-prescribing system to be procured and implemented across the Cancer Alliance. Digital Transformation Group leading on the work to mitigate this risk Person Responsible: Head of Operations Due: 30 September 2025
3725	Corporate Services **Accountable Executive: CNMO** **The legal portfolio has transferred to Corporate Nursing/Quality Governance. Risk owner changed and risk to**	Risk of inadequate legal services support due to vacancies and resignations	High (16)	⟺	Moderate (12)	Agreement on structure of legal function for example numbers of staff, through agreement with the Trust, and to commence permanent recruitment. Hopes to offer a candidate position on 13 June 2025 after interviewing Person Responsible: Hannah Smith, Director of Quality Governance (DQG) Due: 1 September 2025

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to June report	Target Risk Score	Actions summary
	be refreshed.					
3748	Care Group – Critical Care, Anaesthetics and Specialist Surgery	Ophthalmology operating microscopes in need of replacement	High (16)	NEW (escalation)	Very Low (1)	Replacement of existing asset. Specification generated and clinically reviewed. Device added to MDG portal for replacement. Procurement exercise underway. Person Responsible: Procurement Facilitator – Decontamination Contract Manager Due: 30 August 2025
3752	Corporate – Nursing **Accountable Executive: CNMO**	There is a risk that the Trust is non-compliance with HBN 04-01 2009 as additional beds have historically been put in permanently into four bedded bays to create six bedded bays	High (15)	↓	Low (4)	Recommendation to Executive to pilot removing two additional beds on three wards – decision pending Person Responsible: Sarah Hayes, CNMO Due: 29 August 2025 Undertake Trust-wide, a bed space measurement review (to be supported by DoNs on each site). Plan to be agreed as to the process for doing this Person Responsible: DoN Due: 31 July 2025
3764	Care Group - Women's Health	Lack of infrastructure to enable training provision to	High (16)	↔	Low (4)	Business case for extension of the lease at St Pauls Until costs confirmed case not required

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to June report	Target Risk Score	Actions summary
	Accountable Executive: CNMO	meet national requirements				Person Responsible: Head of Operations Due: 31 July 2025 Pursue renewing the St Paul's House lease Head Landlord chased again. There is a potential we may need to move out of building for a month before new contract takes place. This is to be confirmed to landlord and Christchurch who are leaving their license agreement Person Responsible: Head of Operations Due: 31 July 2025
3776	Care Group – Children and Young People	There is a risk of children with hearing loss not being diagnosed and treated in a timely manner leading to delay in acquiring developmental skills	High (16)	NEW (escalation)	Low (6)	Agree ENT pathway and map out capacity and demand required for all children to be seen within paediatric service Person Responsible: Therapy Manager Due: 21 October 2025 Capacity modelling to be completed to understand what additional resource is required to provide hearing aid support to children with temporary conductive hearing loss (previously provided by Acute/Adult Audiology) Meeting planned with Kent Community Health NHS Foundation Trust

East Kent Hospitals University NHS Foundation Trust

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to June report	Target Risk Score	Actions summary
						(KCHFT) and reps from adult/acute to discuss 3 June 2025 Person Responsible: Therapy Manager Due: 21 October 2025 An additional Band 6 Audiologist and Assistant Technical Officer (ATO) are out to advert Audiologist has been recruited but is coming from S Africa so still undergoing checks. ATO already in post after successful recruitment Person Responsible: Operations Officer Due: 21 October 2025
3782	Corporate – Operations **Accountable Executive: COO**	Overdue Appointments for Patients on the Diabetes and Endocrine Outpatients Patient Tracking List (PTL)	Extreme (20)	⟺	High (16)	This risk is being re-written to reflect the Trust wide risk related to Non Referral to Treatment (RTT) waiting lists as this is not specific to diabetes and endocrine. A paper went to Q&SC on 15 July 2025 and AD QG liaising with Interim Director of Planned Care Recovery, Titus Burwell/COO to agree.
3787	Corporate – People & Culture	Potential Industrial Action and potentially a precedent-	High (15)	⟺	Low (6)	ICB led negotiations should ensure scheduled, fully briefed discussions with agreement on actions

East Kent Hospitals University NHS Foundation Trust

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	Accountable Executive: CPO	setting tribunal claim				Person Responsible: Norman Blissett, CPO Due: 31 July 2025
3789	Care Group – QEQM **Accountable Executive: COO**	A growing waiting list with insufficient staffing in respiratory diagnostics/lung function with the risk of harm delays to patients and increased pressure of work to staff	High (16)	⟺	Low (6)	Thanet Community Diagnostic Centre will be able to staff 2 rooms if able to employ into substantive posts Person Responsible: General Manager Due: 30 September 2025 Approval required of a workforce plan that has been submitted for 205/26 increasing the service by 1xB6, 2xB5, 1xB4 posts via EKHUFT business case and an additional 2xB7 through the Community Diagnostic Centre business case Person Responsible: General Manager Due: 30 September 2025 Triumvirate to liaise with COO to discuss the service and liaise with the ICB Person Responsible: Sunny Chada, Managing Director Due: 30 September 2025 Insourcing extended for 6 months

East Kent Hospitals University NHS Foundation Trust

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						Person Responsible: General Manager Due: 30 November 2025
3799	Care Group – William Harvey **Accountable Executive: COO**	Insufficient capacity to deliver gastro OPA in a timely manner	High (15)	⟺	Very Low (2)	Continuation of ID Medical gastro clinics being held at the weekend until end of March 2025 Person Responsible: General Manager Due: 1 September 2025
3803	Care Group – Diagnostics, Cancer and Buckland **Accountable Executive: CSPO**	Risk of total failure of DartOCM	Extreme (20)	⟺	Moderate (8)	Project plan in place – Trust IT, Path IT and KMPN Programme Management Office (PMO) team supporting to deliver Tactical solution by 1 December 2025 Person Responsible: General Manager - Pathology Due: 1 December 2025
3804	Care Group – Women, Children and Young People **Accountable Executive: CNMO**	There is a risk to babies that they will not receive mechanical ventilation when being nursed in the Special Care Baby Unit (SCBU) transport rig	High (16)	NEW	Low (6)	To purchase a transport rig that is up to date to allow spare parts to be purchased. To take to medical devices group. Person Responsible: Clinical Scientist Due: 30 December 2025
3810	Corporate – Nursing	Lack of capital funding to adequately	High (16)	⟺	Low (4)	Continue with Infection, Prevention and Control (IPC) surveillance,

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to June report	Target Risk Score	Actions summary
	Accountable Executive: CNMO	maintain the estate it is not always possible to comply fully with Health Technical Memoranda (HTM) and Health Building Note (HBN) standards which enable prevention control measures including cleaning and ventilation				monitoring and implementation of clinical policies Person Responsible: Lisa White, Deputy Director IPC Due: 30 September 2025
3829	Care Group - Women's Health **Accountable Executive: CNMO**	A lack of Maternity and Neonatal Voices Partnership (MNVP) infrastructure to meet safety standards required to achieve Maternity Incentive Scheme (MIS)/Clinical Negligence Scheme for Trusts (CNST) year 7 due to lack of funding provision for the role	High (16)	NEW	Low (6)	Additional funding sourced to enable the Trust to employ the MNVP leads to be present and meet the requirements of Safety Standard 7 Person Responsible: Michelle Cudjoe, Director of Midwifery (DoM) Due: 30 September 2025 Communications with NHS Resolution (NHSR) Person Responsible: Michelle Cudjoe, DoM Due: 30 September 2025 Discuss with CNST about the lowering of CNST Safety Standard

East Kent Hospitals University NHS Foundation Trust

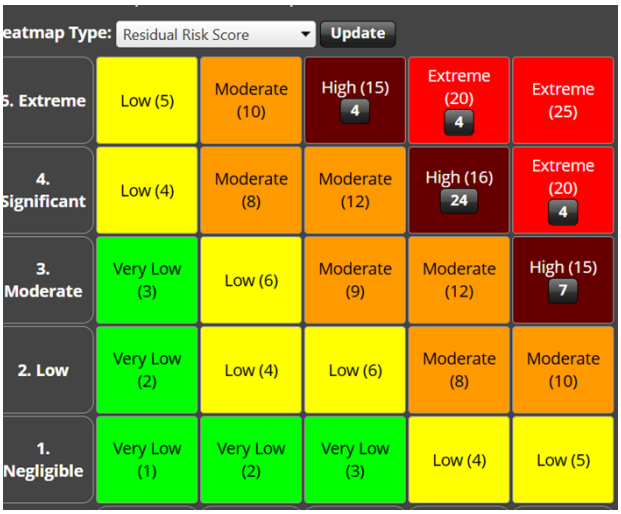
Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to June report	Target Risk Score	Actions summary
						expectations that MNVP leads are required to join meetings and maintain quoracy to release Trusts from fulfilling the expectations Person Responsible: Michelle Cudjoe, DoM Due: 30 September 2025 Communications with ICB Person Responsible: Michelle Cudjoe, DoM Due: 30 September 2025
3833	Care Group – QEQM **Accountable Executive: CSPO**	Lack of Health and Safety Oversight Impacting Safety Culture	High (16)	NEW	Low (6)	Monthly Health & Safety (H&S) meetings with core attendance Person Responsible: Sunny Chada, Managing Director Due: 25 July 2025 Review of departmental H&S leads and Ops and Nursing oversight Person Responsible: Sunny Chada, Managing Director Due: 29 August 2025 Regular review of H&S audit to determine investment plan for 2026 Person Responsible: Sunny Chada, Managing Director

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to June report	Target Risk Score	Actions summary
						Due: 31 December 2025 Pro-active review of Health and Safety Training and Assessment (HASTA) prep quarterly ahead of audits to ensure compliance Person Responsible: Nurse Due: 31 December 2025
3837	Corporate Finance and Performance Management **Accountable Executive: CFO**	25-26 System delivery of the Financial Position	Extreme (20)	NEW	Moderate (12)	Twice monthly Financial Improvement Programme Board. Person Responsible: Michelle Stevens, Director of Finance Due: 31 March 2026 Monthly reporting into the Trust's Finance and Performance Committee and Trust Board. Person Responsible: Angela van der Lem, CFO Due: 31 March 2026
3838	Corporate Finance and Performance Management **Accountable Executive: CFO**	Failure to deliver the Trust Financial Plan for 2025/26	High (16)	NEW	Moderate (12)	Mitigating actions will need to be taken if the Trust moves away from plan mid-year. Person Responsible: Michelle Stevens, Director of Finance Due: 31 March 2026

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

East Kent Hospitals University NHS Foundation Trust

	Residual Risk Score				
Care Group	**15**	**16**	**20**	**25**	**Total**
CCASS CG		3			3
DCB CG	3	3	3		9
K&C CG		1			1
QEQM CG	1	3			4
WHH CG	2	2			4
WCYP CG		6			6
Corporate Medical	1		1		2
Corporate Nursing	1	2			3
Corporate Operations		1	2		3
Corporate Strategic Development	1	1			2
Corporate Finance		1	2		3
Corporate Services					1
Corporate People and Culture	2				2
TOTAL	**11**	**23**	**8**	**0**	**43**
CHANGE SINCE LAST REPORT	**+2**	**+7**	**+2**	**0**	**+10**



4. Changes since the last report

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

There are 5 significant risks approved by the Risk Review Group since the last Board of Directors report. These are listed below:

- There is a risk to babies that they will not receive mechanical ventilation when being nursed in the SCBU transport rig (risk ref: 3804), Women, Children and Young People Care Group, residual risk 16 (high).
- A lack of MNVP infrastructure to meet safety standards required to achieve MIS/CNST year 7 due to lack of funding provision for the role (risk ref: 3829), Women, Children and Young People Care Group, residual risk 16 (high).
- Lack of Health & Safety Oversight Impacting Safety Culture, QEQM Care Group, (risk ref: 3833) residual risk 16 (high).
- 25-26 System delivery of the Financial Position, Corporate Finance and Performance Management, (risk ref: 3837), residual risk 20 (extreme).

- Failure to deliver the Trust Financial Plan for 25/263838, Corporate Finance and Performance Management, (risk ref: 3838) residual risk 16 (high).

4.2 Other Trust wide risks brought to the attention of the Risk Review Group (12 and above)

The below Trust wide risk was approved:

- Insufficient access to single rooms across the Trust impacting on our ability to provide the appropriate environment based on patient need and risk (risk ref: 3811) Corporate Nursing, residual risk 12 (moderate).

4.3 Escalations of existing risks to the Significant Risk Report

- Ophthalmology operating microscopes in need of replacement - Trust Wide, (risk ref: 3748) CCAS Care Group, residual risk increased from 12 (moderate) to 16 (high) on 17/06/25.
- Renal - Dialysis Capacity, Kent and Canterbury Care Group, (risk ref 2853), risk scoring was raised from 12 (moderate) to 16 (high) on 16/06/25.
- There is a risk of children with hearing loss not being diagnosed and treated in a timely manner leading to delay in acquiring developmental skills (risk ref: 3776), Women, Children and Young People Care Group, residual risk scoring was raised from 12 (moderate) to 16 (high) on 27/06/25.

4.4 Closure of risk from the Significant Risk Report

The following risk was closed since the last report

- Failure to deliver the Trust financial plan for 2425, Corporate Finance, (risk ref: 3664), residual risk 12 (trust wide), closed on 07/07/25.

5. Escalations from Risk Review Group

5.1 There were no areas of escalation from the last Risk Review Group on 15 July but Care Groups and Corporate areas were asked to ensure their significant risks have been updated and that emerging risks are also reviewed as part of Care Group Governance meetings. The Training Needs Assessment and rollout plan agenda item (verbal update) was deferred to the next meeting with an update to be sent to all attendees via email in the meantime.

6. Risk Management Audit 2024/25 and InPhase Developments

6.1 The Annual Risk Management Audit for 2024/25 was conducted by RSM and the final report received. Reporting has been via Risk Review Group and TMC. Integrated Audit and Governance Committee (IAGC) will also have been cited on the report via the Internal Auditors report. An overall rating of 'reasonable assurance' has been maintained with an action plan to be agreed in respect of the management recommendations. An update on actions will be formally received by the Risk Review

Group in August 2025 with escalations via TMC. Some of the actions (for example training and development) will also form part of the Risk Management Strategy refresh which is due to come to IAGC in October 2025.

6.2 There have been significant delays in the rollout In Phase (Quality Management System) for Risk - due to issues with the supplier, including data migration, functionality and user acceptance testing which have been escalated accordingly and under mitigation. The current 4Risk contract has been extended to end of September 2025. Work continues.

7. Conclusion

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

End.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **System Joint Committee**

Meeting date: **31 July 2025**

Board sponsor: **Khaleel Desai, Director of Corporate Governance**

Paper Author: **Khaleel Desai, Director of Corporate Governance (DCG)**

Appendices:

Appendix 1: Kent & Medway (K&M) – NHS Joint Committee Terms of Reference (ToR)

Executive summary:

Action required:	For **APPROVAL**
Purpose of the Report:	Chairs and Chief Executives across NHS organisations in K&M met on 8 April 2025 to discuss the current challenges faced by the system and how to accelerate change. It was agreed the time had come to establish more formal collaboration across the system. The purpose of this is to strengthen joint decision-making and governance with the Integrated Care Board (ICB) and streamline our delivery for local people in K&M. In order to achieve this a Joint Committee is being established. This paper sets out the approach and next steps as far as EKHUFT Board approving their delegation to the Joint Committee.

Summary of key issues:	The Joint Committee exists to formally bring together NHS organisations across K&M to collaborate effectively and drive improvements and efficiencies in the delivery of services at scale. The Committee will seek to continually improve the function, delivery and sustainability of care in Kent and Medway, ensuring that its work aligns with existing programmes without overlap or duplication. The Committee will work together to build capability and accelerate change through the delivery of:
	
	• A robust plan for 2025-26 which is both cash-releasing and ensures safe services within the allocation for the population of K&M.
	• A quantified strategic plan for clinical and financial (including estates and workforce) sustainability over the next three years.
	• Specifically, the Committee is designed to:
	  ○ Provide leadership, oversight, and enable partnership working to improve care outcomes of the population of K&M.
	  ○ Ensure the delivery arrangements avoid duplication.
	  ○ Ensure a strategic focus, acknowledging wider development of the K&M system and the collaboration required to deliver our Long-Term Plan ambitions.

	○ Provide clear oversight of financial recovery work. ○ Provide support and challenge to clinically driven improvement programmes, including oversight of resource alignment. ○ Maintain effective working relationships across the K&M system. ○ Identify risks and issues to delivery and agree to mitigations to effectively resolve these. ○ Empower providers to deliver shared solutions that meet the needs of K&M collectively by providing a framework within which to operate where appropriate. ○ Ensure that programmes of work are being delivered effectively, reviewing any specific reporting by exception. ○ NHS Partner organisations will now work to add the Joint Committee to their schemes of delegation. The ToR are being discussed and agreed between Partner Members and will cover the Joint Committee's: — functions; — membership; — quoracy; and — decision making. Of particular note, is the following: ***Functions delegated from Committee Members to the Committee*** • *A combined estate plan.* • *A unified digital plan and purchasing of digital products.* • *A shared back office collaborative.* • *Rapid implementation of agreed clinical service transformation in 2025/26. Subsequent clinical service transformations should then be progressed, and local clinical leaders should be empowered to do so.* • *Evidence-driven standardised care models in hospitals and in the community/neighbourhoods.* • *Reset and accountable clinical networks.* • *A new model for integrated neighbourhood teams.* • *Joint arrangements for commissioning and provision across health and social care (in both the short and medium term).* <u>Legal framework</u> This is permitted pursuant to section 65Z5 of the National Health Service Act 2006, which deals with joint working and delegation arrangements within the NHS. Specifically, it allows for bodies such as NHS Foundation Trust (FT) to make arrangements to delegate functions to other bodies. Section 65Z5 facilitates collaboration between different NHS bodies and other health and social care organisations. *Delegation* The section allows for the delegation of functions from one body to another, meaning one body can authorise another to carry out a specific task or responsibility on its behalf.

East Kent Hospitals University NHS Foundation Trust

	Restrictions on Delegation While delegation is permitted, the law also includes provisions that prevent bodies from making arrangements that would unduly restrict or prohibit the delegation of their functions. *Exercise of Delegated Functions:* When a function is delegated, the body receiving the delegation must exercise it in accordance with any relevant statutory requirements and any specific instructions or limitations associated with the delegation. As far as NHS FTs**,** delegation arrangements under section 65Z5 are governed by its Board.
Key recommendations:	The BoD is being asked to **APPROVE** EKHUFT's participation in the region-wide Joint Committee and instruct the DCG to negotiate ToR with other proposed members. This will be a delegation in accordance with s65Z5 of the National Health Service Act 2006 and the Board are asked to approve the principle of the Joint Committee approach and delegate the Chief Executive (CE) and Chair to move forward with agreeing the ToR in collaboration with system partners.

Implications:

Links to Strategic Theme:	• Our patients • Our people • Our future • Our sustainability • Our quality and safety
Link to the Significant Risk Register:	N/A
Resource:	N
Legal and regulatory:	Yes, 65Z5 of the National Health Service Act 2006, which deals with joint working and delegation arrangements within the NHS.
Subsidiary:	N

Assurance route:

N/A

KENT & MEDWAY – NHS JOINT COMMITTEE

Terms of Reference

June 2025

Document History

Version	Date	Author	Comments
V0.1	23/04/2025	J Hannon	Adapted from PC Board TOR
V0.2	24/04/2025	J Hannon	Incorporated M Gilbert and S Stenson comments
V0.3	02/05/2025	J Hannon	Incorporated feedback from Joint Committee meeting
V0.4	06/05/2025	JHannon	Incorporated new suggested wording on dispute resolution
V0.5	07/05/2025	JHannon	Incorporated feedback from B Evans
V0.6	08/05/2025	JHannon	Incorporated clarity on decision making following feedback B Evans and M Gilbert
V0.7	09/05/2025	JHannon	Incorporated comments from S Stenson
V0.8	25.06.25	TSaroy	Amendments following feedback from various Boards

CONTENTS

INTRODUCTION AND CONTEXT

Since late 2023, leaders of NHS providers have been participating in a Provider Collaborative Board to oversee system wide programmes of work.

Chairs and Chief Executives across NHS organisations in Kent and Medway met on 8 April 2025 to discuss the current challenges faced by the system and how to accelerate change.

The group aligned on a shared problem statement to reflect the basis of joint working and collaboration. “How can we work together in Kent and Medway to build capability and accelerate change through the delivery of:

- A robust plan for 2025/26 which is both cash-releasing and ensures safe services
- A quantified strategic plan for clinical and financial (including estates and workforce) sustainability over the next 3 years”

Challenges included

- Lack of clarity on the decision-making process
- Difficulty progressing from planning into implementation for the agreed areas of service transformation
- Availability of resource to deliver change
- Lack of overall clarity on the accountability and owners for delivery of the plans
- Insufficient use of evidence and data to drive decisions across the system

To address the problem the group outlined a set of solutions including

- A combined estate plan
- A unified digital plan and purchasing of digital products
- A shared back office collaborative
- Rapid implementation of agreed clinical service transformation in 2025/26. Subsequent clinical service transformations should then be progressed, and local clinical leaders should be empowered to do so.
- Evidence-driven standardised care models in hospitals and in the community/neighbourhoods
- Reset and accountable clinical networks
- A new model for integrated neighbourhood teams
- Joint arrangements for commissioning and provision across health and social care (in both the short and medium term)

This Committee is being established to enable that joint decision-making, transparently and at pace in order to underpin delivery of these solutions. By strengthening our governance, we will send a signal to our organisations and to the wider system of our commitment to work together.

These terms of reference build on the previous detailed work to develop the Provider Collaborative Board terms of reference in 2023, which included alignment with local and national policy and strategies.

1. PURPOSE

1.1. The Joint Comittee (hereafter known as 'the Committee') exists to formally bring together NHS organisations across Kent and Medway to collaborate effectively and drive improvements and efficiencies in the delivery of services at scale. Membership of the Committee is set out at Clause 4. Strategic in nature, the Committee will seek to continually improve the function, delivery and sustainability of care in Kent and Medway, ensuring that its work aligns with existing programmes without overlap or duplication. The Committee will work together to build capability and accelerate change through the delivery of:

- A robust plan for 2025-26 which is both cash-releasing and ensures safe services within the allocation for the population of Kent and Medway.
- A quantified strategic plan for clinical and financial (including estates and workforce) sustainability over the next 3 years.

1.2. Specifically, the Committee will:

- Provide leadership, oversight, and enable partnership working to improve care outcomes of the population of Kent & Medway
- Ensure the delivery arrangements avoid duplication and there is clear accountability
- Ensure a strategic focus, acknowledging wider development of the Kent and Medway system and the collaboration required to deliver our Long-Term Plan ambitions
- Provide clear oversight of financial recovery work
- Provide support and challenge to clinically driven, corporate and estates improvement programmes, including oversight of resource alignment
- Maintain effective working relationships across the Kent and Medway system
- Identify risks and issues to delivery and agree to mitigations to effectively resolve these
- Empower providers to deliver shared solutions that meet the needs of Kent and Medway collectively by providing a framework within which to operate where appropriate
- Ensure that programmes of work are being delivered effectively, reviewing any specific reporting by exception

1.3. To facilitate the above, the boards of the Committee Members have agreed to enter into a joint working arrangement, as permitted by s65Z5 of the National Health Service Act 2006, for the functions as set out at Appendix B. Each of those functions will be exercised jointly by each and every Committee Member, through the Committee as permitted by s65Z6 of the National Health Service Act 2006.

2. PRINCIPLES

2.1. This Clause 2 sets out the principles for the Committee.

2.2. **What we're delivering**

- A clear programme of work to release cash in 2025 - 2026 and ensure safe services within the allocation for the population of Kent and Medway.
- A quantified strategic plan for clinical and financial (including estates and workforce) sustainabilty over the next three years.

2.3. **How we're delivering**

- Sharing expertise and resources to tackle issues as if we were a single organisation
- Joined up governance that avoids duplication and enables dynamic delivery with clear accountabilty
- Supported by the right resources and supporting governance – to enable us to deliver the ambition
- Cognisant of the time frames we need to operate in - delivering quick tactical benefits and longer term more strategic solutions
- Clarity of the problems we are attempting to resolve and avoid creating additional tiers of bureaucracy
- Joint programmes delivered together and resourced as part of BAU delivery
- Decision making at the appropriate level in the system, involving the right individuals
- No part of the system holds unmitigated risk without a mitigation plan

2.4. The Committee shall act in accordance with, and in pursuance of, these principles.

3. SCOPE AND RESPONSIBILITIES

3.1. The Committee will work together to build capability and accelerate change through the delivery of:

- A robust plan for 2025-26 which is both cash-releasing and ensures safe services within the allocation for the population of Kent and Medway.
- A quantified strategic plan for clinical and financial (including estates and workforce) sustainability over the next 3 years.

4. MEMBERSHIP

4.1. The Committee is made up of members as set out at Appendix A. They shall be collectively known as 'Committee Members'

4.2. The Chair of the Committee will be appointed by the Committee Members.

4.3. The Committee may agree to appoint a Deputy Chair if required.

4.4. The Committee may call additional individuals to attend adhoc meetings or to attend on a regular basis. Attendees may present at the Committee's meetings and contribute to discussions, but are not allowed to participate in any decision making.

4.5. The Committee may invite or allow people to attend meetings as observers. Observers may not present or contribute to any Committee discussion unless invited by the Chair and may not participate in any decision making.

5. QUORUM

5.1. There is a requirement for a minimum number of members to be present to enable the business of the Committee to be effectively undertaken.

5.2. For the meeting to be considered quorate at least one representative from each Committee Member needs to be in attendance, one of whom will be the Chair or Vice Chair of the Committee.

5.3. Deputies may be appointed in the absence of a member, subject to the agreement of the Chair, but may not be another member of the Committee or represent more than one member.

5.4. Members who are not physically present at a meeting but are present through the means of teleconference or other acceptable digital media shall be deemed to be present.

5.5. If any representative is conflicted on a particular item of business they may not participate in the discussion and may be asked to leave the meeting at the discretion of the Chair. These individuals shall not count towards the quorum for any decision/recommendation made. If this renders a meeting or part of a meeting non-quorate, subject to the discretion of the Chair:

- a non-conflicted person may be temporarily appointed or co-opted to satisfy the quorum requirements; or
- the requirement for that category of member to be present may be relaxed.

- Members have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence, and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

6. MEETING FREQUENCY AND DURATION

6.1. Meetings will be held monthly. Duration of meetings will be two hours every other month and one hour for the months in between. There will be in person meetings approximately twice a year.

6.2. The Committee Chair may request additional meetings if they consider it necessary,

7. AGENDA AND PARTICIPATION

7.1. The agenda and associated papers will be issued four working days in advance of each meeting.

7.2. Requests for agenda items should be sent a minimum of two weeks in advance of the meeting. The Chair will decide if items can be added, depending on previous commitments and time constraints.

7.3. To ensure that meetings run smoothly and effectively, members will be expected to:

- Read circulated papers and other materials in advance of meetings
- Follow planned agendas
- Show respect by listening to others and not interrupting
- Operate on a consensus and aim to seek general agreements
- Identify actions that result from discussions and commit to following through those actions
- Address items through the Chair of the meeting.

8. DECISION MAKING

8.1. The Committee will make decisions in relation to its purpose as described in Clause 1 on behalf of the Committee Members.

8.2. Where required, Committee Members will, within a reasonable period of time, adjust their organisational strategy and/or schemes of delegation so as to faciliate the Committee's activities.

8.3. Committee Members must ensure that matters requiring a decision are anticipated and that sufficient time is allowed prior to the Committee's meetings for discussions and negotiations between them to take place.

8.4. The Committee will make decisions through consensus wherever possible.

8.5. Where it has not been possible, despite the best endeavours of the Members to come to a consensus decision on any matter before the Committee, the Chair may defer the matter for further consideration at a later meeting.

8.6. Each Representative at the Committee will have one vote per Committee Member.

8.7. A motion will only be carried if all Committee Members present vote in favour of the motion.

8.8. For decisions outside the scope of the delegated levels of a Committee Member, the Committee will make recommendations to the respective boards as appropriate so as to faciliate the execution of the Committee's decision.

8.9. Decisions made in accordance with Committee Members' organisational strategies and schemes of delegation will be binding on all Committee Members.

9. DISPUTE RESOLUTION

9.1. Where a dispute or concern arises regarding the operation or management of the Committee, Committee Members must use their best endeavours to resolve in good faith.

9.2. Where any dispute is not resolved following best endeavours, the Chair may convene a meeting of the Committee to resolve the dispute ('Resolution Meeting').

9.3. If the dispute remains unresolved, following best endeavours and the Resolution Meeting, the Committee will consider appointing a mediator to attempt to resolve the dispute. The cost of the mediator will be borne by the disputing Committee Members.

9.4. If the dispute remains unresolved, the Committee will consider an independent body able to facilitate resolution. The cost of this will be borne by the disputing Committee Members.

9.5. For clarity, any decision made by the Committee, including decisions not to support a proposal, cannot be challenged where the proposal has been put to a vote in accordance with these Terms of Reference.

10. REPORTING PROCEDURE AND MINUTES

10.1. Actions and key decisions will be noted at each meeting and distributed to Committee Members no later than two weeks after each meeting.

10.2. The Committee will provide quarterly progress reports to the boards of Committee Members. Routine highlight reports will be shared with local Health and Care Partnership across Kent & Medway to ensure at scale improvement and transformations are aligned with local place-based priorities.

11. POLICY AND BEST PRACTICE

11.1. The Committee may instruct professional advisors and request the attendance of individuals and authorities with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its responsibilities.

11.2. The Committee is authorised to establish such sub-groups as it deems appropriate in order to assist in discharging its responsibilities.

11.3. Unless stated otherwise in these Terms of Reference, the Committee will be conducted in accordance with the NHS Kent and Medway's Standing Orders and Standards of Business Conduct and Managing Conflicts of Interest Policy.

11.4. Specific best practice expected of the committee includes

- There must be transparency and clear accountability
- Members must declare any interests and /or conflicts of interest at the start of the meeting. Where matters on conflicts of interest arise, the Chair will determine what action to take in discussion with the lead executive officer as appropriate. This may include requesting that individuals withdraw from any discussion/voting until the matter is concluded.
- The Committee shall undertake a self-assessment of its effectiveness annually
- Members of the Committee should aim to attend all scheduled meetings, but must attend at least 75% of scheduled meetings in any financial year.
- Members, attendees and/or invited observers must maintain the highest standards of personal conduct and in this regard must comply with:
    - The laws of England and Wales
    - The spirit and requirements of the NHS Constitution
    - The Nolan Principles
    - The standards of behaviour set out in their employing organisation's policies, as they would be reasonably expected to know

12. CONFIDENTIALITY

12.1. The Committee is not subject to the Public Bodies (Admissions to Meetings) Act 1960 due to the commercial nature and sensitivity of matters being discussed. Admission to meetings of the Committee is at the discretion of the Members.

12.2. Matters discussed at any Committee meeting shall be deemed confidential to the Committee Members.

12.3. Recommendations and actions of the Committee will be detailed in the minutes of the meeting, and these shall be disclosable under the Freedom of Information Act 2000, except where a lawful exemption applies.

13. REVIEW

13.1. The Terms of Reference of the Committee shall be reviewed after 6 months and then at regular intervals to reflect the priorities of the Committee and the environment within which it is operating as part of the Kent and Medway ICS.

Appendix A: Membership

Representative	Role Title	Committee Member	Representing at Committee
John Goulston (Chair)	Chair	Kent Community Health NHS Foundation Trust Medway NHS Foundation Trust	Kent Community Health NHS Foundation Trust Medway NHS Foundation Trust
Cedi Frederick	Chair	NHS Kent and Medway ICB	NHS Kent and Medway ICB
Annette Doherty	Chair	Maidstone and Tunbridge Wells NHS Trust East Kent Hospitals University NHS Foundation Trust	Maidstone and Tunbridge Wells NHS Trust East Kent Hospitals University NHS Foundation Trust
Jackie Craissati	Chair	Kent & Medway NHS and Social Care Partnership Trust Dartford & Gravesham NHS Trust	Kent & Medway NHS and Social Care Partnership Trust Dartford & Gravesham NHS Trust
Sheila Stenson	Chief Executive of KMPT and SRO of Provider Collaboratives	Kent & Medway NHS and Social Care Partnership Trust	Kent & Medway NHS and Social Care Partnership Trust
Paul Bentley	Chief Executive	NHS Kent and Medway ICB	NHS Kent and Medway ICB
Miles Scott	Chief Executive	Maidstone & Tunbridge Well NHS Trust	Maidstone & Tunbridge Well NHS Trust
Jon Wade	Chief Executive	Dartford & Gravesham NHS Trust	Dartford & Gravesham NHS Trust

		Medway NHS Foundation Trust	Medway NHS Foundation Trust
Mairead McCormick	Chief Executive	Kent Community Health NHS Foundation Trust	Kent Community Health NHS Foundation Trust
Tracey Fletcher	Chief Executive	East Kent Hospitals University NHS Foundation Trust	East Kent Hospitals University NHS Foundation Trust
Primary Care Members – non-voting			
Vijay Khoshal	Medical Director	West Kent HCP/ West Kent GP Federation	The Wells Medical Practice
Julie Taylor	Medical Director	Dartford, Gravesham & Swanley HCP	The Wellcome Practice
Subhro Mukherjee/Anouska Hari	Medical Director	Medway & Swale HCP	Marlowe Park Medical Centre
Jonathan Bryant	Medical Director	East Kent HCP	White House Surgery
Other non-voting members in attendance			
Ed Waller	Chief Strategy and Partnerships Officer	Kent and Medway ICB	NHS Kent and Medway ICB
Jane Hannon	Provider Collaborative Programme Director	Kent and Medway Provider Collaborative	KMPT
Others will be invited to attend as required such as Financial Recovery Director and those leading programmes that make up the Committee's work plan			

Appendix B – Functions delegated from Committee Members to the Committee

- A combined estate plan
- A unified digital plan and purchasing of digital products
- A shared back office collaborative
- Rapid implementation of agreed clinical service transformation in 2025/26. Subsequent clinical service transformations should then be progressed, and local clinical leaders should be empowered to do so.
- Evidence-driven standardised care models in hospitals and in the community/neighbourhoods
- Reset and accountable clinical networks
- A new model for integrated neighbourhood teams
- Joint arrangements for commissioning and provision across health and social care (in both the short and medium term)

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: **11 June and 8 July 2025**

Chair: **11 June – Sarah Hayes, Chief Nursing and Midwifery Officer (CNMO)**
8 July – Ben Stevens, Chief Strategy and Partnerships Officer (CSPO)

Paper Author: **Michelle Cudjoe, Director of Midwifery (DoM)**

Quorate: **Yes**

Appendices:
None

Declarations of interest made:
None

Assurances received at the Committee meeting:

Papers for discussion /approval	Summary
Clinical Negligence Scheme for Trusts (CNST) Compliance	The Maternity Incentive Scheme (MIS) Year Seven data collection period commenced on 2 April 2025. At the June and July MNAB meetings the following papers were discussed and are presented to the Trust Board in compliance with CNST reporting: **Perinatal Mortality Review Tool (PMRT) Q1 Report – CNST Safety Action 1** The purpose of this report is to assure the MNAB and Trust Board that all stillbirths and neonatal deaths are reviewed using the national electronic PMRT. • The report confirms that during the Q1 reporting period the service has used the tool to the required standard as set out in NHS Resolution (NHSR), CNST MIS Year 7. • The CNST Year 7 reporting period is from 1 December 2024 to 30 November 2025 for this Safety Action (SA). The report includes PMRT activity between 01/04/2025 – 30/06/2025. There is a risk linked to SA7 and the requirement for the Maternity and Neonatal Voices Partnership (MNVP) lead to be present at all meetings. • During Q1, a total of six cases were reported. Of these six cases, one case was not supported within the criteria for PMRT review. Of the five supported cases, two were neonatal deaths and

three were still births/intrauterine deaths (IUD'S).

- Within the last quarter the Trust reported all eligible cases to MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK within seven days of the death, with factual questions completed within one calendar month.
- Within the last quarter 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. The bereavement teams within the Local Maternity and Neonatal System (LMNS) meet quarterly to discuss ongoing themes and issues. All cases are on schedule to be completed in the time frame and adhering to the time frames set by the national framework for PMRT reviews.

Medical Workforce Papers - CNST SA4

Obstetric Workforce Requirements

CNST SA4 requires the Board to have oversight of obstetric medical workforce in relation to four key outputs:

1) The employment of short-term (two weeks or less) locum doctors.
2) The implementation of the Royal College of Obstetricians and Gynaecologists (RCOG) guidance on engagement of long-term locums and provide assurance that they have evidence of compliance.
3) The implementation of RCOG guidance on compensatory rest where Consultants and Senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day.
4) Trusts should ensure they are compliant with Consultant attendance in person to the clinical situations listed in the RCOG workforce document for a minimum of 80% of applicable situations: 'Roles and Responsibilities of the Consultant providing acute care in obstetrics and gynaecology'.

This paper confirms that in relation to these standards the Trust has not employed short-term locum obstetric locums over the last year.

If there was a need to employ a short-term locum an up to date Standard Operating Procedure (SOP) for this is on policy centre and includes the need for a certificate of eligibility as per the RCOG guidance.

In the last 12 months (June 2024 – June 2025) two long term locums have been employed: one middle grade and one consultant. Both have had a formal induction in line with the RCOG requirements. An audit of

	compliance is undertaken every six months. To comply with the standard, compliance for each new long-term locum who starts at the Trust will be audited over a six-month period after February 2025 and brought back to MNAB in October 2025. The job plans for Consultants and SAS doctors are set up such that no clinical duties the day after our twilight / night on call are required. This can be evidenced by the medical rosters. Any consultant failure to attend when on call, will result in a datix being completed. This will be investigated and discussed at the MNAB. A regular audit is undertaken looking at the consultant attendance when on call in line with national RCOG guidance and local guidelines. The 2025 audit will be presented in October 2025. **Action**: Audit of Consultant attendance and short-term locums to be repeated within CNST timescale and presented to the Board prior to the end of the MIS Year 7 timescale. **Neonatal Workforce – Medical and Nursing** A paper was presented to MNAB in relation to Neonatal workforce (Medical and Nursing) It was agreed that the associated action plan would be discussed with the Chief Medical Officer (CMO) ahead of presentation to the Board. This paper will be brought to the Board prior to the end of the MIS Year 7 timescale. **Maternity Workforce report – CNST SA5** This paper is presented in compliance with NHSR MIS; CNST SA5 in relation to MIS Standards for Safe Staffing in Maternity Settings. The requirement is that a systematic review of the midwifery establishment is submitted to the Board bi-annually. • The last Midwifery Workforce report was received by the Board in November 2024 and covered the period of May 2024 – October 2024. • This report covers the reporting period of November 2024 - April 2025. • The funded establishment within maternity is compliant with the Birthrate plus (BRplus) calculations for both midwifery and specialist staff. The review was undertaken in 2023 and showed an overall positive variance. • There is evidence from the BRplus acuity tool that demonstrates 100% compliance with the supernumerary status of the co-ordinator and 1:1 care in labour at both sites within the timeframe of the review. • Details of planned vs actual midwifery staffing levels with evidence to support mitigation and escalation for managing shortfalls in staffing is provided.

	• The funded and worked midwife to birth ratio aligns to the BRplus analysis. Compliance is reported against CNST SA5 Standards **Q1 Maternity Serious Incident (SI) report – CNST SA10** **1 April – 30 June (2025/2026)** **<u>Maternity and Newborn Safety Investigations (MNSI)/Patient Safety Incident Investigation (PSII)</u>** During this reporting period, one case was referred to and accepted by MNSI for external investigation. Two further cases were referred to but not accepted by MNSI for investigation. Both cases will be investigated via internal governance processes. The service received one final report from MNSI – the report contained no safety recommendations for the service. The report provided four safety prompts for consideration and to support ongoing learning. On receipt of the MNSI final reports, the findings, learning and any safety actions required are shared with the maternity service team and the LMNS. This report confirms that during the Q1 reporting period the service has reported 100% of qualifying cases to MNSI and to NHSR's Early Notification Scheme (ENS) as set out in NHSR, CNST MIS Year 7. Two cases were presented at the Trust Incident Review Panel (IRP) which resulted in the proportionate response being the requirement for internal PSIIs. **Brought for assurance and oversight in line with CNST.**
Perinatal Quality Surveillance Tool (PQST) April and May	The PQST report is presented to the Board in keeping with the Ockenden recommendation. It contains the minimum dataset that the Board requires oversight of for the months of April and May 2025. • The total number of babies born in April was 485 and 517 in May. • Supernumerary status compliance was reported at 100% on both sites for both months. • Compliance of 1:1 in Labour was reported as 100% on both sites for both months. • Level 3 Adult Safeguarding compliance as of the end of April has increased to 93.9%. This is above the 90% threshold. • Child protection level 3 compliance as of the end of April remains compliant at 91.4%.

	• In April the service reported zero MBRRACE stillbirths or neonatal deaths. Two MBRRACE stillbirths were reported in May. • Three moderate/severe harms were reported in April and five in May which are being investigated. **MNSI Issue of concern escalation:** received by the Trust on the 22 May 2025 to which the Trust has responded within the set timeframe with an accompanying action plan. MNSI has since confirmed acceptance of the Trust's immediate actions and closure of this escalation. **Patient Experience** • Friends and Family Test (FFT) received 295 responses, which is an overall 7.5% response rate. Improvement plan in place to increase the uptake of the survey and an increase noted in May in which there was a response rate of 11.5%. **Training** • Training remains on the Care Group risk register **(Risk Reference 3764)**, due to training space to enable the Maternity Training Programme to be delivered at full capacity. If training space is not secured there is a real risk that training will become unavailable for all staff groups and that SA6 and SA8 of CNST will not be achieved for this year. The Procurement team should be meeting with the Head Landlord to review the lease and determine the level of risk in November as a result of the change of Landlord and this is being chased. **MNVP Funding escalation** • The service remains unable to provide adequate MNVP Lead time to enable MNVP attendance as a quorate member at all of the required Trust assurance and Governance meetings as set out in Year 7 CNST guidance. This has been escalated to the Integrated Care Board (ICB) awaiting a response. Failing to achieve the SA can compromise compliance with MIS Year 7 **Brought for assurance and oversight in line with Ockenden and CNST SA9.**
Maternity and Neonatal Improvement Programme (MNIP) Update	The MNIP highlight report was presented. 74% of the overall programme of work has been completed. The Year 2 engagement session took place on the 25 June to prioritise QI for the final year of the programme. There is an Executive Senior Responsible Officer (SRO) aligned to each workstream. Highlights:

	• Positive NHS England (NHSE) Insight visit. • Care Quality Commission (CQC) Good rating and lifting of Section 31 notice. • Launch of the new twinkling stars bereavement facility at William Harvey Hospital (WHH). • Confirmation from national team regarding exit from the Maternity Safety Support Programme (MSSP). Areas of focus • Kent & Canterbury Hospital (K&C) estates. • MOSOS connectivity on Folkestone Ward (linked to CNST funding). • Possible need to decant Triage at WHH to progress remodelling of facility. • Aggregate review of stillbirths to be undertaken given an observation of a slight increase in the number of stillbirths (The rate remains below the expected benchmark for comparator sites). **Brought for information in relation to the improvement programme.**
Matters to escalate to Quality & Safety Committee (Q&SC) and Board	• Positive progress with estates work but focus now needs to be on K&C and possible need to decant Triage at WHH to facilitate remodelling. • Section 31 lifted by CQC. • Risk in relation to renewal of contract at St Pauls – this will negatively impact on achieving CNST. • MNSI escalation within PQST has since been closed by MNSI. • Escalation in relation to MNVP hours and changes to MIS standards - risk of non-compliance with MIS Year 7 linked to the impact on both SA1 and SA7. • Moving towards phase two of the restorative process for families involved in the Kirkup inquiry.

Other items of business: None

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

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

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

Item	Purpose	Date
MNAB asks the BoD to discuss and **NOTE** this MNAB Chair's Report.	Assurance	31 July 2025

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

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

Meeting date: **31 July 2025**

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

Paper Author: **Jane Burgess, Compliance and Assurance Manager for Director of Quality Governance**

Appendices:

None

Executive summary:

Action required:	Assurance
Purpose of the Report:	This report provides an update on CQC inspection activities, oversight, assurance and related improvement work. This report covers the period mid-May to June and includes: • information on the inspection of Maternity Services in December 2024 and update on Maternity Section 31 enforcement notice; • information on the inspection of Spencer Wing at Queen Elizabeth the Queen Mother Hospital (QEQM) in January 2025; • summary of progress with the CQC self-assessment and check and challenge meeting programmes; • ward and clinic accreditation update; • update on performance against the CQC inspection reports from May and July 2023, published in December 2023; • update on performance against 'historical' open CQC action plans (2018, 2020 and 2021); • summary of CQC queries; • update on engagement meetings with the CQC; • recent CQC publications.
Summary of key issues:	The Trust has received the CQC Maternity inspection report. Both QEQM and William Harvey Hospital (WHH) Maternity Services have been rated as Good overall. The Trust has completed and submitted the application to remove the Maternity Section 31 notice. The CQC has confirmed, on the 2 June 2025, that the Section 31 notice has been removed and no further reporting is required. The schedule for the next six months of CQC Self-Assessment Check and Challenge meetings has been confirmed.

East Kent Hospitals University NHS Foundation Trust

	There are now only 4% of actions remaining open from the 2023 inspections. Multiple actions are associated with medical compliance with statutory and mandatory training (urgent and emergency care (UEC) and medical care) which is still not at Trust target albeit the percentage compliance has improved significantly. Leadership is being provided by the Chief Medical Officer (CMO) and performance is being monitored via the Performance Review Meetings (PRMs). The remaining Must Do action is around pharmacy staffing and there is one outstanding Should Do in relation to Allied Health Professional (AHP) staffing levels. A workforce review has recently been undertaken, the outputs of which will be presented to Trust Management Committee (TMC). Reviews of themes and numbers of queries received from the CQC have been undertaken and these show a decline in the numbers received, particularly since February 2025.
Key recommendations:	The BoD is asked to receive the attached report and **NOTE** the assurance provided in relation to positive ratings from the most recent maternity inspection, query management, and the self-assessment and check and challenge meeting programme.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients
Link to the Trust Risk Register:	There is a risk of non-compliance with CQC regulations which would have an impact on registration and may lead to repeat enforcement action, improvement notices and a critical report (ref 3636). Residual Risk 12 (moderate).
Resource:	Y: Two outstanding CQC requirements relate to pharmacy (Must Do) and AHP staffing (Should Do).
Legal and regulatory:	Y: Inability to provide assurance to our regulators impacting on the quality and safety of care provided to our patients and service users.
Subsidiary:	N

Assurance route:

Previously considered by:

CQC Oversight and Assurance Group (6 May 2025).
Regulatory Oversight Group (9 June 2025).
A bi-monthly Chairs report is received from Regulatory Oversight Group to TMC (including CQC escalations). This was received at TMC on 7 May 2025.
Quality and Safety Committee (Q&SC) (15 July 2025).

East Kent Hospitals University NHS Foundation Trust

Care Quality Commission (CQC) Update Report

1. Purpose of the report

1.1 This report provides an update on CQC inspection activities, oversight, assurance and related improvement work. This report covers the period May 2025 to June 2025 and includes:

- information on the inspection of Maternity services in December 2024 and update on Maternity Section 31 enforcement notice;
- information on the inspection of Spencer Wing at QEQM in January 2025;
- summary of status of the CQC self-assessment and check and challenge meeting programmes;
- ward and clinic accreditation update;
- update on performance against the CQC inspection reports from May and July 2023, published in December 2023;
- update on performance against 'historical' open CQC action plans (2018, 2020 and 2021);
- summary of CQC queries;
- update on engagement meetings with the CQC;
- recent CQC publications.

2. Background

2.1 The CQC rated our Trust as 'requires improvement' following inspections in May and July 2023. Improving our CQC rating is a Trust Strategic Initiative, a key part of our Quality Strategy and is referenced in the Integrated Improvement Plan (IIP), in particular in relation to improvements in maternity, quality and safety and leadership and governance.

3. CQC Inspection of Maternity Services, December 2024, and update on Maternity Section 31 enforcement notice

3.1 The CQC report following the inspection in December 2024 was published on the 8 May 2025. Both QEQM and WHH Maternity Services have been rated as 'good' overall. The CQC rated both units as 'good' for caring, effective, responsive and well-led. Due to some of the known issues with the maternity estates, including the QEQM obstetric theatre, the Safe domain was rated as 'requires improvement' for both sites.

3.2 The Trust submitted the monthly Section 31 report for maternity on 1 May 2025. There remained only two Must Do requirements open, relating to staffing and the aging estate.

3.3 The Trust submitted the application to remove the Section 31 notice following receipt of the inspection reports, and the CQC confirmed on the 2 June 2025 this has been removed and no further reporting is required.

4. CQC Inspection of Spencer Services, January 2025

4.1 The CQC made a short-notice announced one-day visit to Spencer Wing located at the QEQM on the 21 January 2025. The inspection report is still awaited.

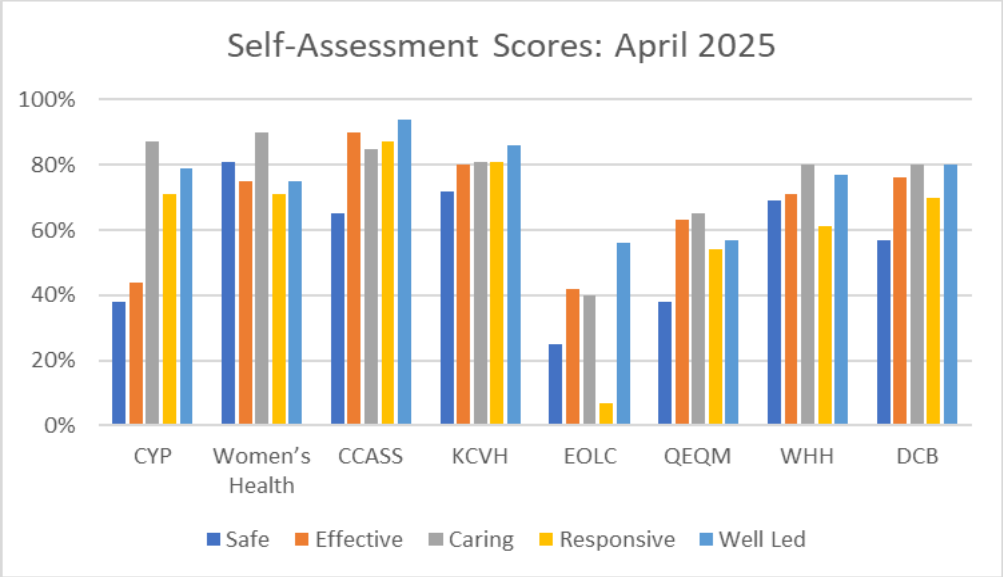
4.2 Spencer Private Hospitals (SPH) were required to provide a Standard Operating Procedure (SOP) for inter-hospital transfers. This requires agreement and approval by the Trust. A draft SOP has been presented to the Trust but further updates are required by SPH before the SOP is signed off by the Trust.

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

5.1 The self-assessment Check and Challenge meetings, chaired by the Chief Nursing and Midwifery Officer (CNMO), and attended by the Chief Medical Officer (CMO), Chief Operating Officer (COO), Director of Quality Governance (DQG), Associate Director of Quality Governance and members of each Care Group's leadership team, commenced in May 2024. All Care Groups have now completed two rounds of self-assessments and meetings and the latest figures are shown below:

Date of meeting	No of assessments completed	Percentage of Quality Statements rated as fully met					
			Safe	Effective	Caring	Responsive	Well Led
23.05.24 12.12.24	3	Children & Young People (CYP)	13% 38%	17% 44%	67% 87%	48% 71%	50% 79%
09.07.24	2	Women's Health	81%	75%	90%	71%	75%
23.05.24 20.11.24	14	Critical Care, Anaesthetics & Specialist Surgery (CCASS)	46% 65%	83% 90%	78% 85%	79% 87%	90% 94%
23.07.24 06.01.25	17	Kent & Canterbury Victoria Hospital (KCVH)	43% 72%	57% 80%	72% 81%	74% 81%	81% 86%
14.08.24 03.02.25	2	End of Life Care (EOLC)	25% 25%	42% 42%	40% 40%	7% 7%	56% 56%
11.09.24 04.03.25	4	QEQM	28% 38%	33% 63%	60% 65%	53% 54%	47% 57%
18.09.24 10.03.25	5	WHH	33% 69%	33% 71%	52% 80%	40% 61%	58% 77%
07.10.24	17	Diagnostics, Cancer &	49%	71%	80%	70%	78%

14.04.25		Buckland (DCB)	57%	76%	80%	70%	80%



5.2 The next six month schedule of Check and Challenge meetings was confirmed at the CQC Oversight and Assurance meeting 1 July 2025.

5.3 The CQC application on the Trust's new InPhase information system will be implemented over the coming months; self-assessments will be completed on this system after it has been piloted and implemented. This will enable improved visibility of current status, reporting, action plan management and evidence collation functionality. Implementation has been delayed by the supplier and an implementation date has not yet been confirmed.

6. Ward and Clinic Accreditation Programme

6.1 All wards have completed a first assessment for cycle 1 for 2025. Not all wards have been signed off for cycle 1. Between April and June 2025, 20 areas have had a clinical accreditation completed. 14 areas are currently white, with reassessments scheduled. Reassessments will continue monthly from July 2025.

6.2 The Ward Accreditation tool has had adjustments for cycle 2. Wards that achieved a bronze award are now entering cycle 2. Six wards have already had their initial cycle 2 accreditation.

6.3 Special Care Baby Unit (SCBU) have a silver award signed off; they dropped from 92% in cycle 1 to 89% in cycle 2, however, did not achieve all mandatory areas in cycle 1, so were capped at bronze. In cycle 2 SCBU achieved all mandatory areas on initial assessment so achieved a silver award. The other five wards that have had cycle 2

assessments require reassessment. All these wards have missed mandatory areas so are currently graded white.

6.4 A review has been completed of the Ward Accreditation tool to ensure this aligns with the CQC framework and can be used for the purpose of self-assessment at Ward and Clinic level. The refreshed tool has been in use from the January 2025 accreditation visits. The specialist tools for Emergency Department (ED), Neonatal Intensive Care Unit (NICU) and Maternity will also now be reviewed.

6.5 The Ward Accreditation visits are being supported by the Compliance and Assurance team – and the Care Group Leadership teams and their Speciality teams are being encouraged to release multi professional staff for the visits.

6.6 A Ward and Clinic Accreditation Steering Group continues to meet monthly but attendance is poor. This is currently under review.

6.7 The non-inpatient accreditation tool has been piloted. Further updates are required before this can be rolled out as part of the accreditation programme. No confirmed date has been given but will commence as soon as possible. This accreditation tool has been reviewed by the Head of Compliance and Assurance to ensure it is aligned with CQC framework.

7. Update on performance against the 2023 CQC inspection report

7.1 Reports from the inspections that took place in May 2023 (medical care, children and young people and urgent and emergency care at WHH and QEQM) and July 2023 (well led) were published in January 2024 and an action plan was developed by each Care Group/speciality. The following action plans are in place:

- 2gether action plan - closed
- CYP action plan - closed
- DCB action plan
- QEQM General Medicine (GM) action plan
- QEQM UEC action plan
- WHH GM action plan
- WHH UEC action plan
- Well Led action plan - closed
- Corporate Nursing/Medical/Operations action plan - closed

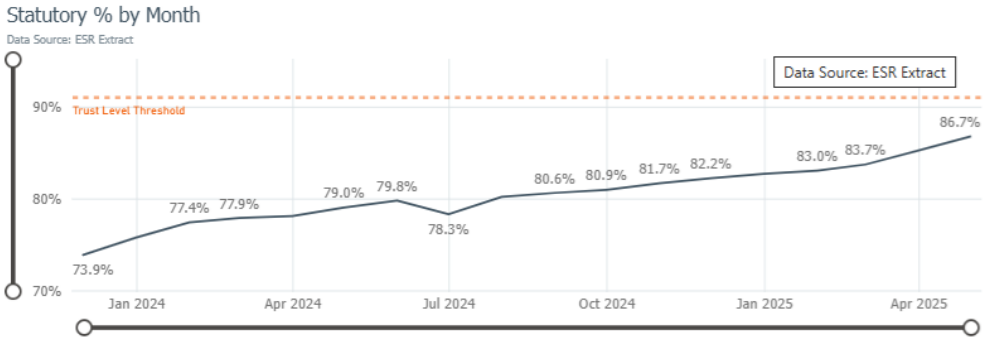
7.2 Monthly reports showing progress and status of each action plan have been provided to the CQC Oversight and Assurance Group and on to the Regulatory Oversight Group (ROG) and Quality and Safety Committee (Q&SC) since the plans' commencement in January 2024. To ensure pace of delivery a fortnightly meeting is held with the CNMO and DQG.

7.3 This report includes the current status of the Must and Should do requirements, and how many associated actions remain open. It shows the status at 9 June 2025, as reported to

ROG. There have been no action closures since the last report to Q&SC in May 2025.

7.4 Statutory and mandatory training for doctors had an extended target date of 30 September 2024, as agreed by the Chief Medical Officer (CMO). This target was not met and the CMO was informed. Actions are in place to recover this position – there have been significant improvements, as can be seen in the two graphs below – although there is further work to do at Service level to evidence compliance at a subject level.

Statutory training compliance for medical and dental, May 2025

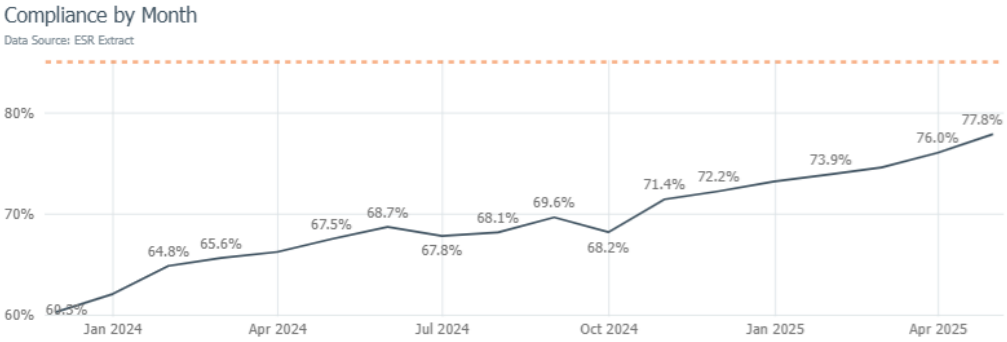


Statutory Training Breakdown

Data Source: ESR Extract

Care Group	Completed Courses	Staff Eligible	Outstanding Courses	Statutory %
CORPORATE	223	288	65	77.4%
CRITICAL CARE, ANAESTHETICS AND SPECIALIST SURGERY CARE GROUP	2,173	2,512	339	86.5%
DIAGNOSTICS, CANCER AND BUCKLAND HOSPITAL CARE GROUP	824	952	128	86.6%
KENT & CANTERBURY AND ROYAL VICTORIA HOSPITALS CARE GROUP	1,362	1,600	238	85.1%
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL CARE GROUP	1,501	1,752	251	85.7%
WILLIAM HARVEY HOSPITAL CARE GROUP	1,661	1,944	283	85.4%
WOMEN, CHILDREN AND YOUNG PEOPLE CARE GROUP	1,493	1,600	107	93.3%
Total	**9,237**	**10,648**	**1,411**	**86.7%**

Mandatory training compliance for medical and dental, May 2025



Mandatory Training Breakdown

Data Source: ESR Extract

Care Group	Completed Courses	Staff Eligible	Outstanding Courses	Compliance
CORPORATE	146	191	45	76.4%
CRITICAL CARE, ANAESTHETICS AND SPECIALIST SURGERY CARE GROUP	2,376	3,121	745	76.1%
DIAGNOSTICS, CANCER AND BUCKLAND HOSPITAL CARE GROUP	776	1,004	228	77.3%
KENT & CANTERBURY AND ROYAL VICTORIA HOSPITALS CARE GROUP	1,398	1,864	466	75.0%
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL CARE GROUP	1,497	2,019	522	74.1%
WILLIAM HARVEY HOSPITAL CARE GROUP	1,719	2,245	526	76.6%
WOMEN, CHILDREN AND YOUNG PEOPLE CARE GROUP	1,621	1,805	184	89.8%
Total	**9,533**	**12,249**	**2,716**	**77.8%**

7.5 There are five Must Do (out of 28) and one Should Do (out of 25) requirements that remain open (some requirements feature on multiple action plans or on two sites). There is a total of eight out of 206 (4%) actions open across all action plans, as shown in the table below. Three actions (1%) on the Well Led plan have been closed since the last report to the Board in April 2025. This resulted in closure of the Well Led action plan.

OPEN REQUIREMENTS AND ACTIONS

Action plan	Open Must Do Requirements	Open Should Do Requirements	Total number of actions on plan	Number of open actions (30/04/2025)
Well led	0 of 4 (0%)	0 of 8 (0%)	56	0
2gether	0 of 4 (0%)	N/A	7	0
QEQM UEAM	1 of 6 (17%)	0 of 3 (0%)	26	1
QEQM GM	1 of 7 (7%)	0 of 5 (0%)	26	1
WHH GM	2 of 8 (25%)	0 of 4 (0%)	33	2
WHH UEAM	1 of 4 (25%)	0 of 2 (0%)	13	1
WCYP	0 of 11 (0%)	0 of 9 (0%)	28	0
DCB	1 of 11 (9%)	1 of 1 (100%)	12	3
Corporate	0 of 4 (0%)	0 of 1 (0%)	5	0
TOTAL			**206**	**8 (4%)**

7.6 Of these eight open actions:

- Five relate to medical training compliance. See detail in 7.4 above.
- Three actions relate to staffing (AHPs and pharmacy):
    - Pharmacy: The business case for pharmacy has been reviewed by Executives. Discussions between Executives and the Care Group about affordability/new ways of working/level of investment are ongoing and the Business Case has not been approved in its current format. Discussion to be arranged with the CQC Pharmacy Lead to understand best practice workforce models and how other Trusts are mitigating the risk within their existing workforce. This is a Must Do requirement.
    - AHPs: A therapies Workforce Review has been completed and signed off by Trust Management Committee (TMC). The Deputy Chief AHP is now reviewing resources across AHP's to report back to TMC in two months time.

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

8.1 There are four open inspection action plans relating to CQC inspections that took place between 2018 and January 2023. These action plans are also subject to regular review and update by the specialities, supported by the Compliance & Assurance Team (C&AT).

8.2 The following requirements remain open:

Care Group (CG) and Speciality	Requirement	Status
WHH UEC 2020	MD01.UEC.WHH The trust must ensure staff complete their mandatory training and each module meets their compliance targets, including; Mental Capacity Act training, life support training, and dementia training. (Also, on May 2023 action plan) MD28.UEC.QEQM&WHH.2023	Data 26/06/2025 **Medical compliance WHH UEAM**: May 25 Statutory compliance – 82.9% (target 91%) 8 of 8 courses below Trust target Mandatory compliance – 74.8% (target 85%) 10 of 11 courses below Trust target
WHH UEC 2020	SD05.UEC.WHH The trust should ensure all staff have access to the training needed for their role including advanced life support.	Data 26/06/2025 **Medical:** May 25 RESUS Adult 63.1% (target 85%) RESUS Paed 72.4% (target 85%)
WHH GM 2021	SD02.MED.KCH & WHH.2021 The trust should ensure that all staff complete their mandatory training. (Also, on May 2023 action plan)	Data 26/06/2025 **Medical WHH GM** May 25 Statutory compliance – 89.0% (target 91%) 3 of 8 courses below Trust target Mandatory compliance – 77.3% (target 85%)

Care Group (CG) and Speciality	Requirement	Status
		8 of 10 courses below Trust target
KCH GM 2021	SD02.MED.KCH & WHH.2021 The trust should ensure that all staff complete their mandatory training. (Also on May 2023 action plan)	Data 26/06/2025 **Medical KCH** May 2025 Statutory compliance – 85.1% (target 91%) 5 of 8 courses below Trust target Mandatory compliance –75.0% (target 85%) 9 of 13 courses below Trust target.
WHH UEC 2020	MD16.UEC. WHH The trust must ensure critical fluids and medicines are administered and recorded in a timely manner.	Discussions ongoing with CMO and Director of Pharmacy. Further pharmacy support for ED WHH recruited. Missed Dose Dashboard used to monitor compliance and reported through Medicines Safety Group. **Recommendation to close this requirement made to CMO.**
QEQM UEC 2020	MD01.UEC.WHH The trust must ensure staff complete their mandatory training and each module meets their compliance targets, including; Mental Capacity Act training, life support training, and dementia training. Also on 2023 action plan MD28.UEC.QEQM&WHH.2023	Data 26/06/2025 **Medical QEQM UEAM** May 25 Statutory compliance –89.6% (target 91%) 4 of 8 courses below Trust target Mandatory compliance – 80% (target 85%) 9 of 12 courses below Trust target
WHH & QEQM UEC 2020	SD03.UEC.QEQM & WHH The trust should ensure medicines reconciliation is undertaken in a timely manner	Discussions ongoing with CMO and Director of Pharmacy to ascertain outcome measures to provide assurance that this can be closed. This remains an issue due to long waiters as full reconciliation happens on admission. Mitigating actions proposed to ensure review of high priority patients.
QEQM UEC 2020 S29a	SD01.UEC.QEQM & WHH (2020) The trust should consider how to recruit a full establishment of emergency department consultants and SD02.UEC.QEQM (2021) The trust SHOULD meet the Royal College of Emergency Medicine requirements for the number of consultants employed within the department.	**Full recruited to. Recommendation to close this requirement made to CMO.**

East Kent Hospitals University NHS Foundation Trust

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

9. CQC Queries Update

9.1 March-April 2025
There were ten queries received from the CQC during March and April 2025, which is a decrease in comparison to the previous two months. During that period, 11 were fully responded to. Four of these queries had deadlines set by the CQC, four of which were met with one requiring an extension. One query did not require a response, this query was sent in error by the CQC. At the end of April, 16 query responses remained open, ten remain open from 2024 and seven remain open from 2025.

9.2 May-June 2025
There were 11 queries received from the CQC during May and June 2025, which is an increase of one compared to the previous two months. During that period, 15 were fully responded to. Five of these queries had deadlines set by the CQC, four of which were met with one requiring an extension. At the end of June, 13 query responses remained open, six remain open from 2024 and seven remain open from 2025.

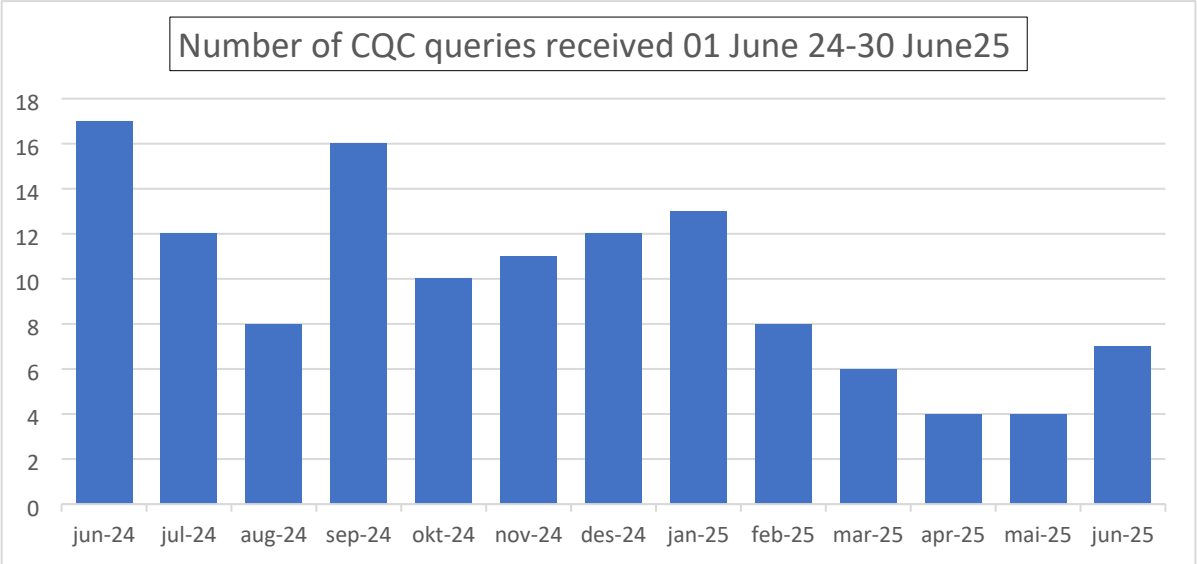
9.3 Six month analysis October 2024-March 2025
A six month analysis of CQC queries was presented to the CQC Oversight and Assurance Group (O&AG) on 6 May 2025. A total of 60 information requests/queries were received from the CQC in the six month period October 2024 to March 2025; this was a reduction in comparison to the 71 received in the previous six-month period (April to September 2024).

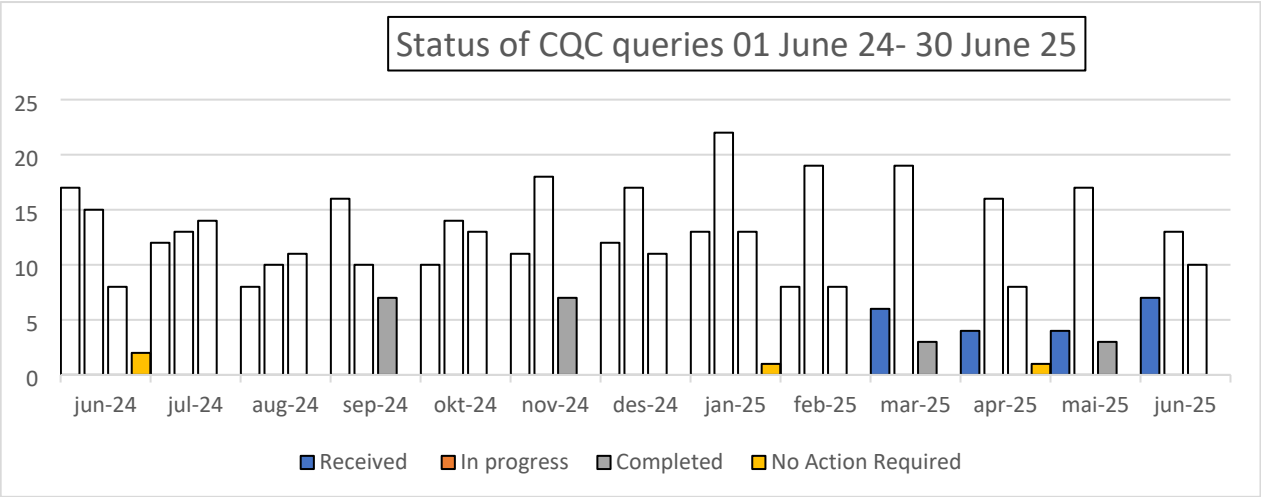
9.4 Of those 60 queries, 30 queries had deadlines set by the CQC. 24 responses were returned within the deadline. Five extensions were requested, all five met the extension deadline given by the CQC. 80% of response deadlines were met in this report period, this was an increase compared to 28% in the previous six-month period.13 queries were returned before the CQC deadline date, this equates to 43% of responses.

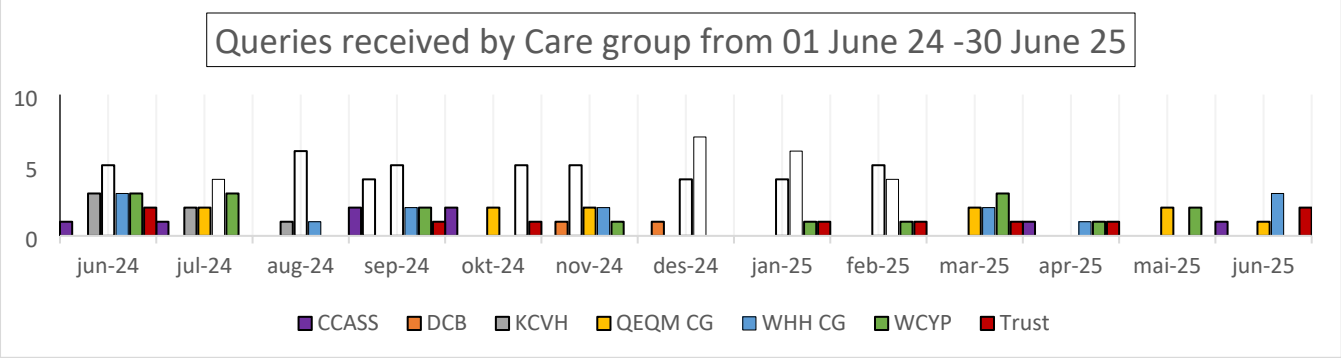
9.5 Patient care and safeguarding remain the main themes of query received.

9.6 Annual review June 2024-June 2025
An annual review of numbers of queries received for the period 1 June 2024 to 30 June 2025 has also recently been undertaken, and will be reported to CQC O&AG at its September 2025 meeting. The graphs below show a decline in the number of queries received from the CQC particularly between February and June 2025:

East Kent Hospitals University NHS Foundation Trust







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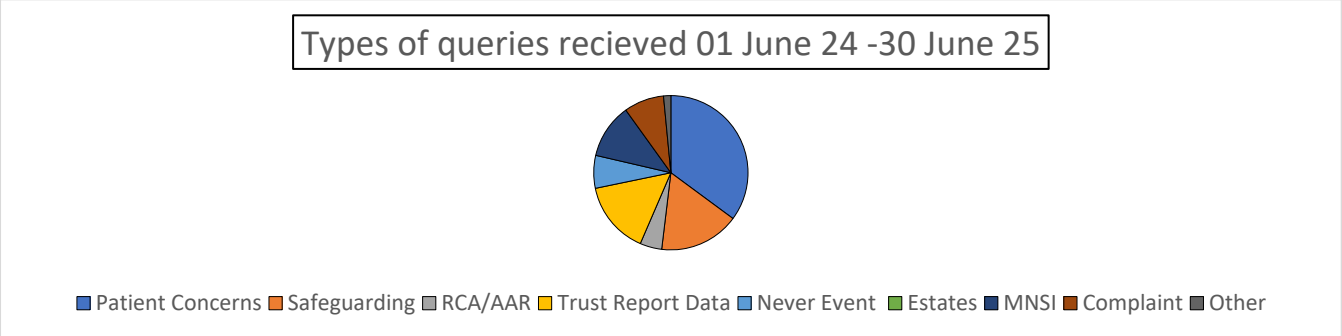

10. CQC Engagement

10.1 The CQC postponed the engagement meeting arranged for 29 May and rescheduled to 26 June, due to the appointment of a new operations manager. This has been stood down at the CQC's request and the next meeting is scheduled for 5 August 2025.

11. CQC publications

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

- Taking action to progress stuck assessments;
- CQC response to the Care Provider Alliance's review of the single assessment framework;
- New self-assessment and improvement framework for integrated care systems address health inequalities through engagement with people and communities;
- CQC appoints Interim Chief Inspector of Healthcare;
- Dr Arun Chopra appointed as CQC's first Chief Inspector of Mental Health;
- Independent review of CQC technology published;
- Integrated care system assessments update March 2025;
- CQC welcomes Secretary of State's decision to appoint Professor Sir Mike Richards as Chair;
- Responding to challenge;
- Monitoring the Mental Health Act;
- An update on the actions CQC are taking to improve.

12. Conclusion

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

12.2 The CQC has published the Maternity inspection report following the inspection in December 2024. Both QEQM and WHH Maternity Services have been rated as 'good' overall.

12.3 Following report publication, the Trust submitted the application to remove the maternity Section 31 notice. The CQC has confirmed the Section 31 notice has been removed and no further reporting is required.

12.4 The schedule for the next six-months of Check and Challenge meetings was confirmed at the CQC Oversight and Assurance meeting on 1 July 2025.

12.5 Reviews of themes and numbers of queries received from the CQC have been undertaken and these show a decline in the numbers received, particularly since February 2025.

End.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Infection Prevention and Control (IPC) Annual Report 2024-2025**

Meeting date: **31 July 2025**

Board sponsor: **Sarah Hayes, Director of IPC**

Paper Author: **Lisa White, Deputy Director of IPC**

Appendices:

Appendix 1: IPC Annual Report 2024-2025

Executive summary:

Action required:	**Approval**
Purpose of the Report:	The Director of Infection Prevention and Control (DIPC) is required to produce an Annual Report on the state of healthcare associated infection (HCAI) in the organisation for which s/he is responsible and release it publicly according to the *Code of Practice on the prevention and control of infections and related guidance* (The Health and Social Care Act 2008).
Summary of key issues:	Overall, 2024-2025 was extremely busy with a wide variety of IPC activity, in meeting key standards and regulatory requirements. Below is a summary of activity and achievements: • Reduction in healthcare associated *Clostridioides difficile (C. diff)* infections with 105 cases against a threshold of 145. • Reduction in E. coli healthcare associated infections with 147 cases against a threshold of 160. • Two *Methicillin-resistant Staphylococcus aureus* (MRSA) bacteraemia reported for this period which was a 75% reduction from the previous year. MRSA bacteraemia has no threshold with a 'Zero Tolerance'. • The Trust exceeded thresholds for all other gram-negative blood stream infections (Pseudomonas and Klebsiella). • *Methicillin-Susceptible Staphylococcus aureus Bloodstream Infection* (MSSA BSI) were at 87 compared to 72 in the previous year. • Norovirus outbreaks affected a large number of patients at both William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother Hospital (QEQM). The outbreaks resulted in a number of beds and wards being closed. • IPC audits of the environment, equipment and clinical procedures continued throughout the year, and there were

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	notable improvements with scores based on previous yearly audit programmes. • IPC education and training continued throughout the year, with year-end compliance with training. • The IPC link worker programme delivered a programme of training focusing on themes and learning from investigations. • Improved focus on IPC aspects in the ward accreditation. • Fit testing for the use of FFP3 respirators is undertaken by a dedicated person within the IPC team, and over 600 staff members were tested. • Successful launch and implementation of the CLEAN campaign through joint working with 2gether Support Solutions (2gether). • The age and state of our estate and physical infrastructure remains very challenging and does not support good IPC practice.
Key recommendations:	The BoD is asked to **APPROVE** the IPC Annual Report 2024-2025.

Implications:

Links to Strategic Theme:	Quality and Safety
Link to the Trust Risk Register:	No
Resource:	No
Legal and regulatory:	Y- Supports compliance with The Code of Practice on the Prevention and Control of Infections (Health and Social Care Act).
Subsidiary:	Y – 2gether activities are included in the reporting.

Assurance route:

Infection Prevention Control and Antimicrobial Stewardship Committee - July 2025

East Kent Hospitals University NHS Foundation Trust

INFECTION PREVENTION AND CONTROL ANNUAL REPORT

APRIL 2024 – MARCH 2025

Contents

East Kent Hospitals University NHS Foundation Trust

INFECTION PREVENTION AND CONTROL ANNUAL REPORT

April 2024 – March 2025

1. Introduction

The Director of Infection Prevention and Control (DIPC) is required to produce an Annual Report on the state of healthcare associated infection (HCAI) in the organisation for which s/he is responsible and release it publicly according to the *Code of Practice on the prevention and control of infections and related guidance* (The Health and Social Care Act 2008). The Annual Report is aligned to the ten compliance criteria as outlined in the Code of Practice. This report covers the period from 1 April 2024 to 31 March 2025.

The Annual Report is produced for the Chief Executive and Trust Board of Directors, and describes infection prevention and control activity during the year, including progress made against the work plan and objectives identified in the infection prevention and control annual programme, and against any external objectives.

Healthcare associated infections (HCAIs) can cause harm, and can lead to suboptimal patient experiences. This report also provides assurance to patients, public and all staff of the work undertaken throughout the year, including celebrating the successes and highlighting the challenges.

2. Executive Summary – The Year 2024/2025

The Chief Nursing and Midwifery Officer is the accountable board member for infection prevention and control (IPC), and undertakes the role of Director of Infection Prevention and Control (DIPC). The Trust also has a deputy DIPC who is responsible for managing the IPC team across all hospital sites.

The DIPC continued to report to the Quality and Safety Committee and periodically to the Trust Board on the status of infection prevention and control throughout this reporting year, and presented the updated 'infection prevention and control board assurance framework' and associated work streams.

The IPC and Antimicrobial Stewardship Committee (IPCAMS) has a function to fulfil the requirements of the statutory IPC obligations, and formally reports to the Quality and Safety Committee.

Overall, 2024/2025 was extremely busy with a wide variety of IPC activity, in meeting key standards and regulatory requirements. Below is a summary of activity and achievements:

- Reduction in healthcare associated *Clostridioides difficile (C. diff)* infections with 105 cases against a threshold of 145.
- Reduction in E. coli healthcare associated infections with 147 cases against a threshold of 160.
- 2 MRSA bacteraemia reported for this period which was a 75% reduction from the previous year. MRSA bacteraemia has no threshold with a 'Zero Tolerance'.
- Norovirus outbreaks affecting a large number of patients at both WHH and QEQM. The outbreak resulted in a number of beds and wards being closed.

- IPC audits of the environment, equipment and clinical procedures continued throughout the year, and there were notable improvements with scores based on previous yearly audit programmes.
- Hand hygiene audit of compliance was 91.7% overall for the Trust.
- IPC education and training continued throughout the year, and the IPC link worker programme delivered a programme of training focusing on themes and learning from investigations.
- Improved focus on Infection prevention and control aspects in the ward accreditation
- Fit testing for the use of FFP3 respirators in undertaken by a dedicated person within the IPC team, and over 600 staff members were tested.
- Successful launch and implementation of the CLEAN campaign through joint working with 2Gether Solutions.

Surgical site infection surveillance (SSIS) is carried out for repair of neck of femur fracture, hip and knee replacements. The SSI Steering Group met regularly throughout the year, and the group holds responsibility for overseeing the progress of the agreed improvement plan. In addition, as well as identifying learning outcomes from deep dive investigations into T&O SSI incidents, the group successfully implemented a number of key improvements, this included standardisation of wound dressings, education on tissue viability and patient information for wound management.

Antimicrobial stewardship (AMS) is led by a consultant pharmacist, two advanced pharmacists and a medical microbiologist who is the AMS lead. The AMS pharmacy team audited antimicrobial prescribing across all care groups, and have made a significant difference with the reduction of inappropriate prescribing. The AMS team also work closely with the IPC team on post infection reviews to identify and share learning.

3. The Infection Prevention and Control Team (IPCT)

The Chief Executive holds overall responsibility for infection prevention and control, with the management and co-ordination delegated to the DIPC. The DIPC works closely with the deputy DIPC who provides the day to day strategic and operational management of the IPC service.

The IPC team provides specialist advice, support, education and training to all sites across the Trust. Each site has a dedicated team in place with occasional cross site cover to ensure delivery of service. In addition, the IPC nursing team work on a seven-day rota to provide on-site cover 365 days per year. The IPC team also provide the Trust wide fit testing service, and have a surveillance nurse leading on Surgical site infection surveillance. Working alongside the IPC team are medical microbiology and virology consultants. There is no specific named IPC lead microbiologist, but all microbiologists support the team and implementation of this role is being actively pursued. There is also a Trust consultant pharmacist leading on antimicrobial stewardship 3 days a week, with 2 part time antimicrobial stewardship pharmacists supporting, and 1 consultant microbiologist has this as part of their portfolio.

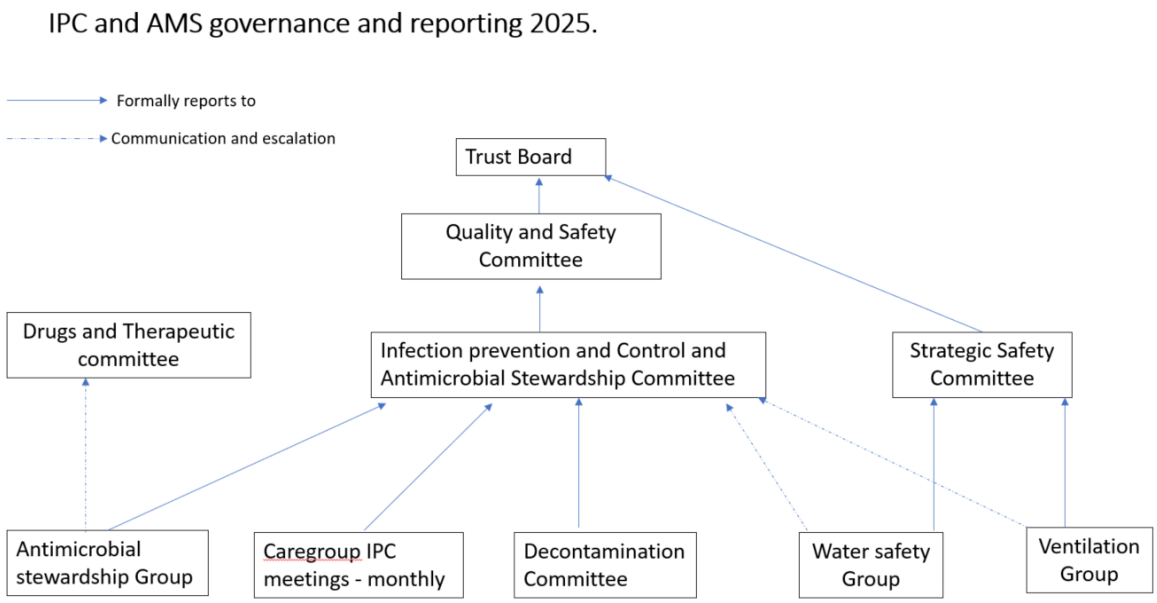
4. Infection Prevention and Control Committee and Reporting Structure

The structure includes Care Group Infection Prevention and Control meetings, chaired by the Caregroup Director, supported by the Infection prevention and control lead. These site groups are operationally focused and bring together clinical and non-clinical colleagues to discuss challenges and successes and share the learning from investigations. Each of these groups

along with groups for decontamination, water safety, ventilation safety and antimicrobial stewardship report to a new quarterly Infection Prevention and Control and Antimicrobial Stewardship Committee (IPCAS).

The IPCAS Committee takes a strategic perspective and gathers themes and learning from across the Trust and is a vehicle for wider sharing, including with colleagues from external bodies such as the Kent and Medway Integrated Care Board (ICB) and the United Kingdom Health Security Agency (UKHSA). The IPCAS Committee reports to the Board via the Quality and Safety Committee and directly through the DIPC in accordance with the Code of Practice on the Prevention and Control of Infections (Health and Social Care Act 2008). The structure is shown below.

IPC Reporting Structure



5. The Care Quality Commission (CQC)

There were no IPC specific or focussed CQC inspections in 2024/25. A CQC inspection took place within maternity which identified good IPC practice, and recognised the environmental challenges within the service, and the mitigations in place to address them.

6. Education and Training

The *Code of Practice* requires that all staff undertake mandatory infection prevention and control training on a regular basis. The specific requirement is:

'that relevant staff, contractors and other persons whose normal duties are directly or indirectly concerned with patients care receive suitable and sufficient training, information and supervision on the measures required to prevent and control risks of infection'.

The IPC team worked continuously to review and update the trust IPC training, which remained a combination of face to face and virtual learning as well as practical hand hygiene training.

At the end of this reporting period (March 2025) compliance with IPC mandatory training requirements was 92.9% (see table below):

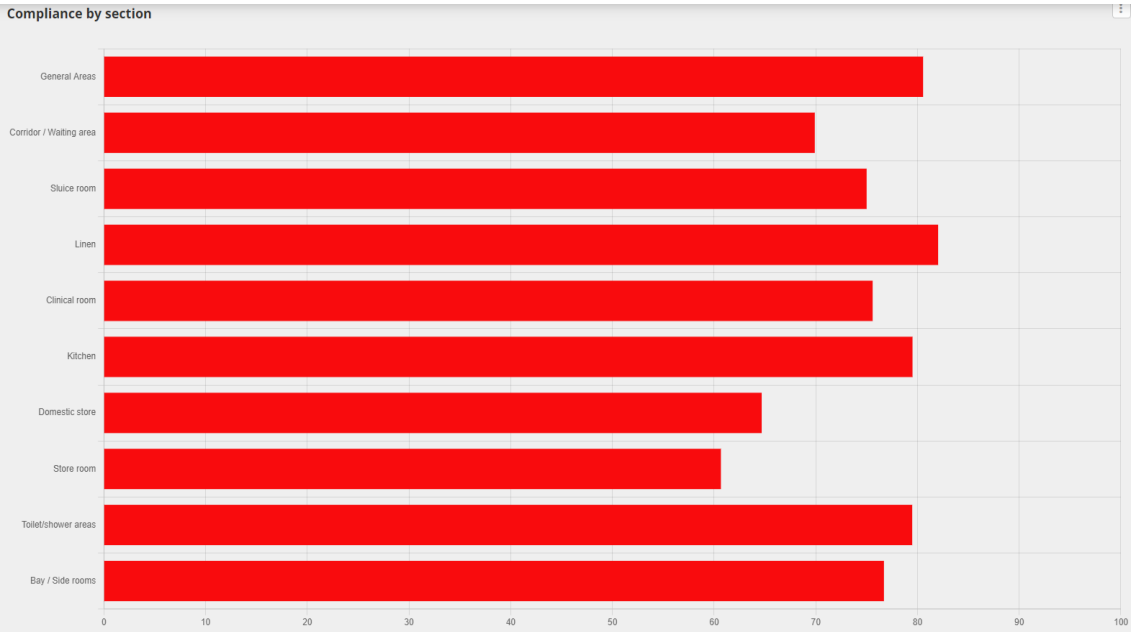
Care Group	No. Compliant Staff	Staff Eligible	Outstanding Courses	Compliance (%)
WOMEN, CHILDREN AND YOUNG PEOPLE CARE GROUP	1,248	1,306	58	95.6%
WILLIAM HARVEY HOSPITAL CARE GROUP	1,465	1,549	84	94.6%
UNMAPPED CARE GROUP	1	1	0	100.0%
STRATEGIC DEVELOPMENT AND CAPITAL PLANNING	214	258	44	82.9%
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL CARE GROUP	1,120	1,215	95	92.2%
KENT & CANTERBURY AND ROYAL VICTORIA HOSPITALS CARE GROUP	952	1,024	72	93.0%
DIAGNOSTICS, CANCER AND BUCKLAND HOSPITAL CARE GROUP	2,097	2,264	167	92.6%
CRITICAL CARE, ANAESTHETICS AND SPECIALIST SURGERY CARE GROUP	1,541	1,627	86	94.7%
CORPORATE	497	594	97	83.7%
Total	**9,135**	**9,838**	**703**	**92.9%**

7. Audit

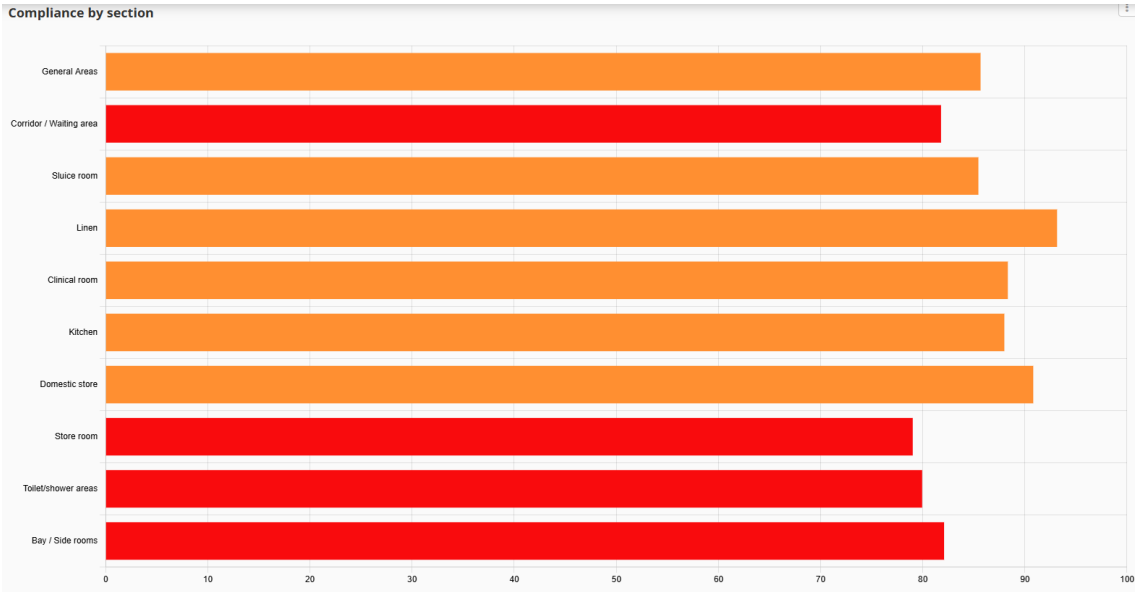
The annual audits are undertaken by the IPC team, and where possible, jointly with support from estates, facilities and clinical colleagues. Actions are managed by the care groups and issues escalated through this committee. Below is the comparison between 2023/24 and 2024/25 – there is a notable improvement in the environmental scores between the years, following a significant focus on environmental improvements.

The clinical practice results identify ongoing areas for improvement, and these are included in the IPC TWIP.

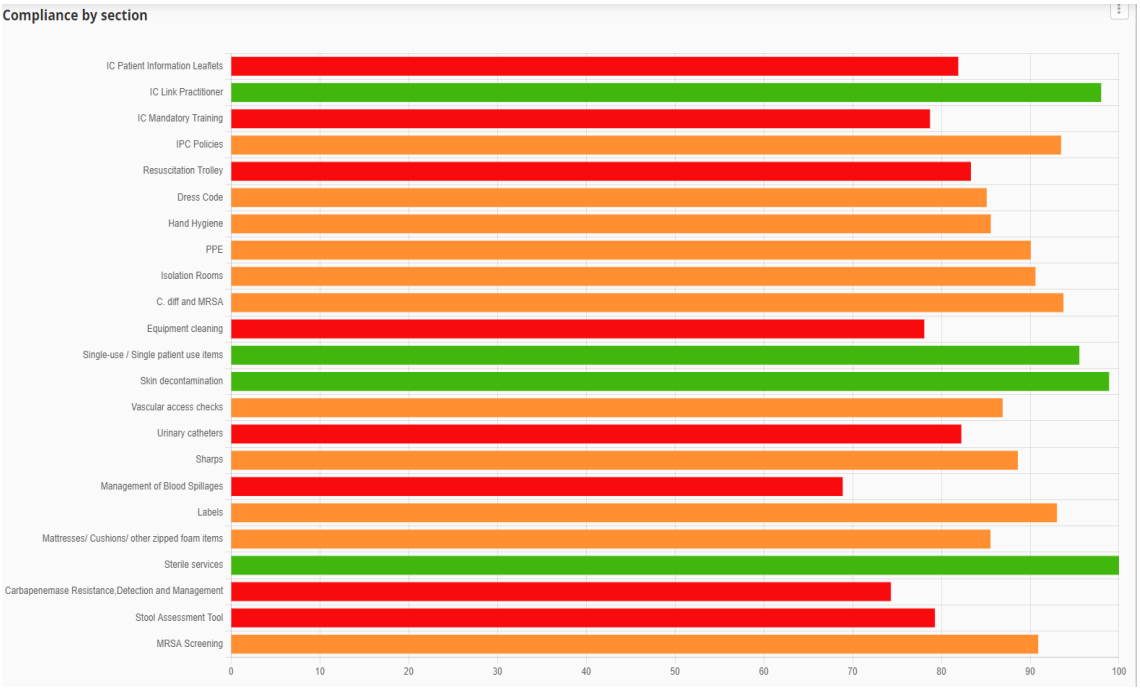
For the reporting year 2023-2024 the following audits continued:



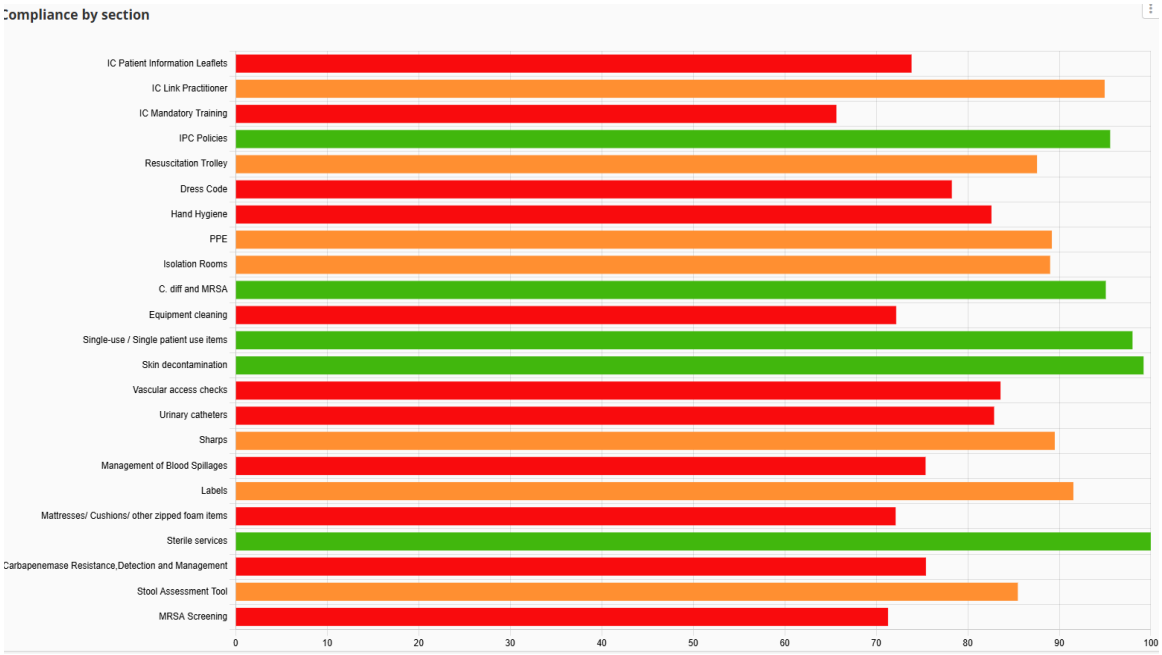
Trust wide environmental audits for 2024/25:



Annual clinical practice audit on MEG for 2023/24:



Annual Clinical practice audit on MEG for 2024/25:



The link worker programme continued throughout 2024/25 within the Trust, with support and training focussing on hand hygiene, *Clostridioides difficile* recognition and UTI reduction tools. The link worker programme was developed based on themes from learning following healthcare associated infection reviews.

8. Hospital Hygiene and the Healthcare Environment

The IPC Team have continued to monitor standards of cleanliness within the Trust and promote good practice in conjunction with the Hospital and 2gether Support Solutions Facilities Managers through participation in the following activities:

- Patient-led Assessment of the Care Environment (PLACE).
- Environmental audits of cleanliness and the healthcare environment.
- Advising contractors/contract management on cleaning and domestic issues.
- Day to day advice/intervention/escalation to facilities management as appropriate, with regard to cleaning issues.
- Advising, with engineering colleagues from 2gether Support Solutions, through the site based and trust wide Water Safety Groups on the safe management of water supplies, to prevent risks associated with Legionella and, in augmented care settings, *Pseudomonas aeruginosa*.
- Attending joint cleaning audit training to ensure parity of audit standards.
- Advising, with engineering colleagues from 2gether Support Solutions, through the Trust wide Ventilation Safety Groups

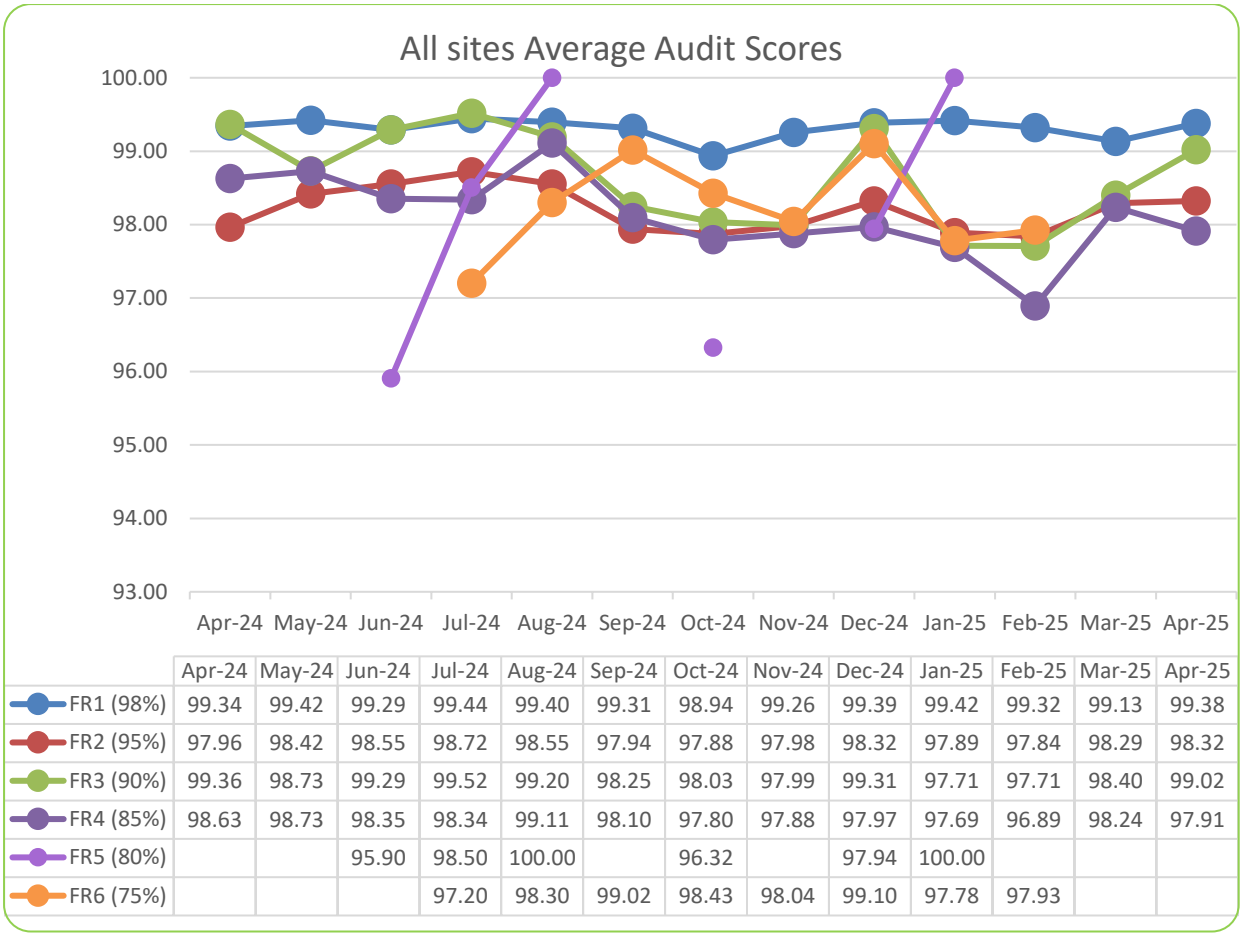
During 2024-2025 the IPC team has continued to work with 2gether colleagues to review and manage cleanliness standards across the organisation. The Trust has, with a small number of exceptions, a very old estate and a very significant backlog of maintenance and need for refurbishment of clinical environments. This creates a major challenge to effective cleanliness as a large amount of the estate is beyond the scope of cleaning and therefore does not support good IPC practice or lead to a good patient experience. The DIPC and DDIPC work with the trust and 2gether to prioritise the very limited capital investment available, taking into consideration the range of patient and safety risks, not limited to IPC risks. These challenges

are reflected in the trust's corporate risk register. 2024-2025 has seen a significant joint trust and 2gether focus on cleaning standards with stakeholder groups engaged in both strategic and operational planning to drive increased standards of cleanliness. This has led to a review of the cleaning standards in place, commencing initially with looking at all published cleaning arrangements and reviewing accountability and understanding of the detail surrounding those arrangements.

All 50 cleaning elements listed in the New Cleaning Standards have been reviewed in relation to whether the element has an estates, facilities or clinical responsibility, traced back to review of relevant IPC/Trust policies and then the method and frequency of clean has been appraised and agreed by all parties. Whilst this piece of work had been done previously at a high-level during mobilisation of the standards, the detailed evaluation of "local protocol arrangements" had not yet been fully formalised. Particular focus has been paid to areas that provide risk in relation to potential infection such as vents, grilles, sluices and related equipment, commodes, but there has also been a robust review of items such as mobility aids, all types of trolley (crash, linen, drugs), lighting and so on, with any element that may have had any ambiguity surrounded the context of the item being split into a subsection of the standards to ensure absolute clarity. It is important not to underestimate the volume and detail of the work that has been needed to ensure all elements are agreed and clear for staff across all services.

The ongoing work between IPC and 2gether has led to the CLEAN 2 campaign being planned in for 2025, working jointly with 2gether to ensure clinical and 2gether staff have this clarity on their own responsibility for cleaning but also to ensure there is work carried out co-operatively on cleaning standards. Work has also focused on providing information for staff on how to log concerns, report estates issues, record items that are condemned and request the right type of cleaning for their areas – these items have been focused on based on feedback from staff.

All areas of the Hospital are audited in accordance with the national cleaning standards requirements. All staff are BICS trained auditors and have been trained independently by the Chair of the British Cleaning Council is partnership with representatives from IPC. The average scores from the audits are highlighted below:



	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
FR1 (98%)	99.34	99.42	99.29	99.44	99.40	99.31	98.94	99.26	99.39	99.42	99.32	99.13	99.38
FR2 (95%)	97.96	98.42	98.55	98.72	98.55	97.94	97.88	97.98	98.32	97.89	97.84	98.29	98.32
FR3 (90%)	99.36	98.73	99.29	99.52	99.20	98.25	98.03	97.99	99.31	97.71	97.71	98.40	99.02
FR4 (85%)	98.63	98.73	98.35	98.34	99.11	98.10	97.80	97.88	97.97	97.69	96.89	98.24	97.91
FR5 (80%)			95.90	98.50	100.00		96.32		97.94	100.00			
FR6 (75%)				97.20	98.30	99.02	98.43	98.04	99.10	97.78	97.93		

Throughout the year, as issues are identified, action plans are put in place, these action plans are reviewed, discussed at local committees and then any escalations are taken to the IPC committee.

9. Incidents/Outbreaks of Healthcare Associated Infection

Throughout the year there was a significant number of COVID-19 and Influenza outbreaks, mainly contained within individual wards, however the impact on patient flow at all the sites had been significant. A Hospital wide outbreak of Norovirus in QEQM in January 2025 closed many wards to admission, requiring novel ways of utilising the remaining estate, Norovirus continued to circulate and impacting patient flow. In 2025/26, a review of testing procedures will take place summer 2025, in order to ensure we have adequate rapid testing facilities and capabilities for 2025/26 winter, as this was a key learning output from the outbreaks.

The Trust identified cases of Candidozyma Auris, from patients identified as contacts at Guys hospital renal transplant units. Internal guidelines and policies were amended, and will be reviewed again throughout 2025/26 owing to a change in national guidance due to a national increase in cases and outbreaks.

There were 5 Tuberculosis positive results that required risk assessment and contact tracing, in all cases, those identified as at risk were either notified by letter and followed up by the community Tuberculosis team, or our occupational health team. There were no onward transmission cases identified.

10. Surveillance and Epidemiology

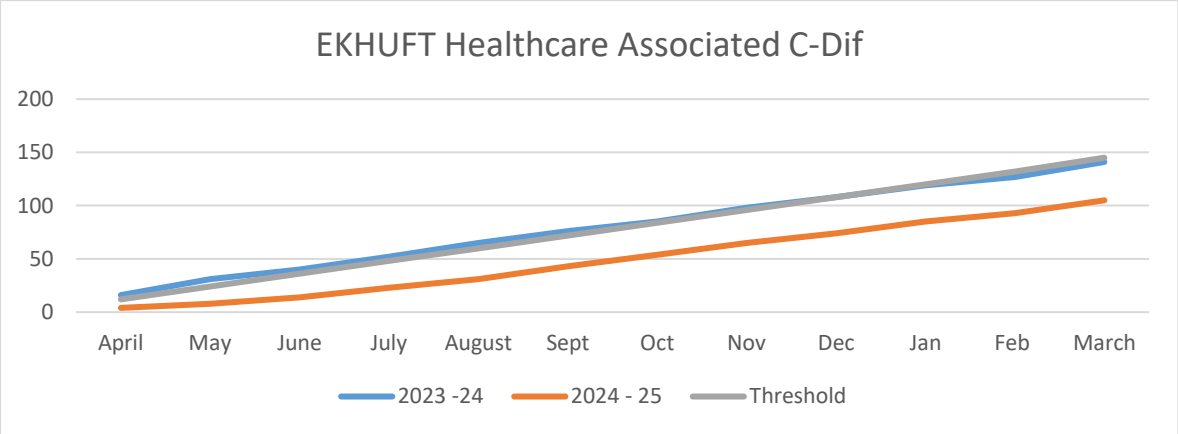
Reportable Infections

Thresholds for *Clostridioides difficile* and Gram-negative bloodstream infections (see below for details) were published for the year 2024/25, Trust performance against these thresholds and data for those infections where no threshold has been set are given below.

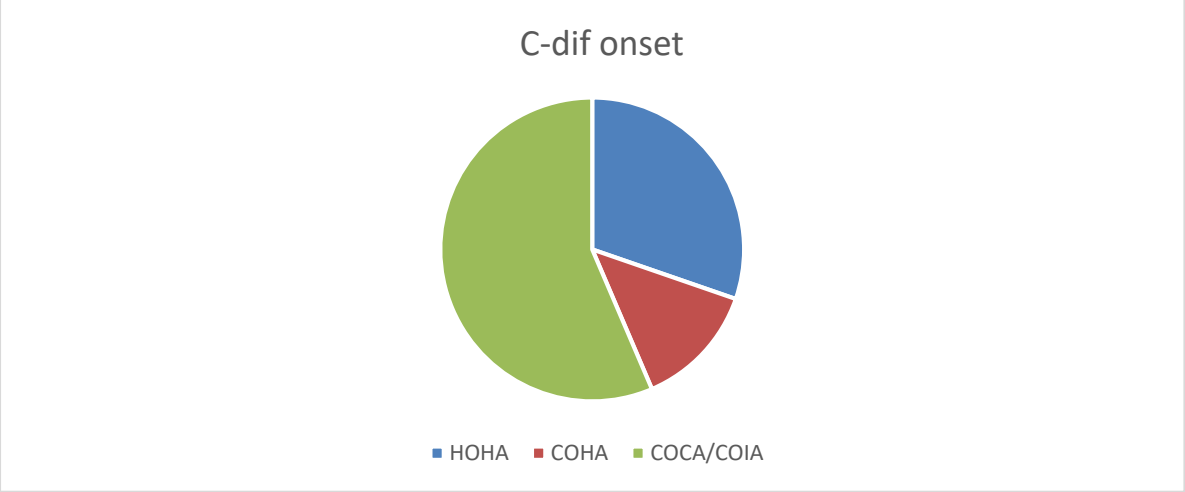
10.1 Clostridioides difficile (previously known as *Clostridium difficile*)

All cases of *Clostridioides difficile* identified from samples taken on day 2 of admission (where the day of admission is day 0) are hospital attributable.

These cases are described as Hospital Onset Healthcare Associated (HOHA). In addition, any patient discharged from hospital in the 28 days prior to a positive test for *C. difficile* are also hospital attributable. These cases are described as Community Onset Healthcare Associated (COHA). These two categories are combined in figure 4 showing performance compared with 2023-2024 and a linear trajectory to the externally set threshold.



Following a significant focus on the reduction of C. diff the total attributable cases in 2024/25 was 105 – which is a 25% decrease on the previous year. In total 241 patients tested positive for C. diff in EKHUFT, highlighting that once again the community burden is very high. 3 key focusses this year were environmental and cleaning improvements, antimicrobial stewardship and a trial of use of Fidaxomicin as first line treatment.



All cases reviewed following PSIRF methodology, with a rapid review initially, followed by SWARM if required, and all cases reviewed by a multidisciplinary panel every 2 months to identify themes, and ensure any learning added to Trust Wide Improvement Programme (TWIP). Themes remain similar to the previous year, but significant improvements have been noted:

Likely Source/Indication	**2023/24**	**2024/25**
Cross infection	10%	2.5%
Antibiotic associated	63%	75%
Of those antibiotic associated (percentage of non-compliance)	26%	19%
Samples that were actually community cases, but delay in sending made attributable to Trust	9%	3%
Relapse	11%	2.5%

Actions focussed predominantly around antimicrobial stewardship (see section 11), environmental cleaning, and hand hygiene.

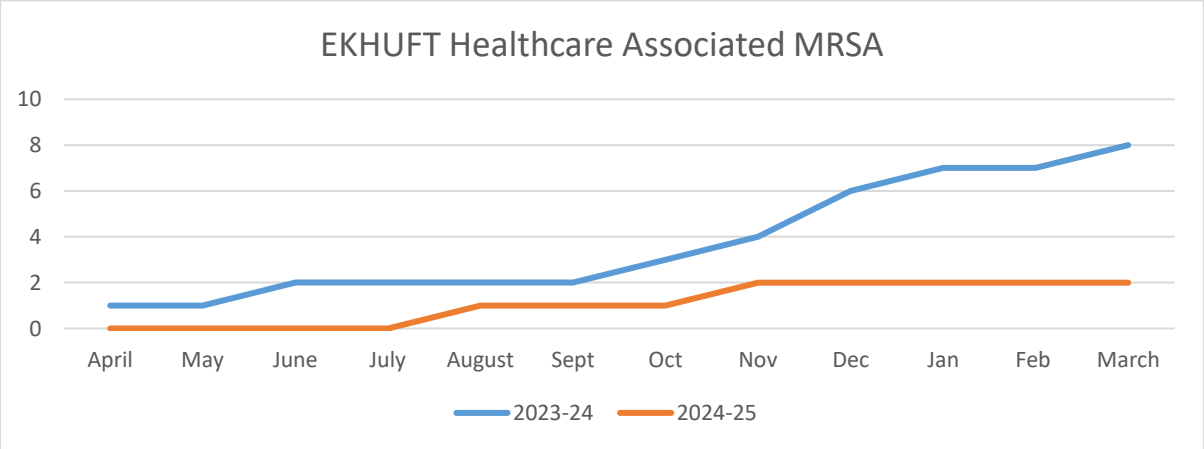
10.2 *Staphylococcus aureus* Infections (MRSA and MSSA) bloodstream infections

10.2.1 MRSA

MRSA bloodstream infections should be extremely rare events, and avoidable healthcare onset cases should be regarded with 'Zero Tolerance'.

In 2024/2025 Compliance with MRSA screening for non-elective patients varied throughout the year with poor compliance of just 50% reported in May 2024, improving as months went by, with 75% compliance in Feb 25, and 100% in March 25. In this year the Trust reported 2 MRSA bacteraemia cases, a 75% reduction on 2024/25.

Both cases were COHA's, and were reviewed for good practice and or learning following PSIRF methodology. One case was deemed a contaminant, but learning identified regarding decolonisation of patients with higher risk factors for infection, such as those with a learning disability, and an updated protocol implemented. The second case identified learning in relation to education for patient's post-surgery, when caring for wounds at home, and the information provided to patients was updated.



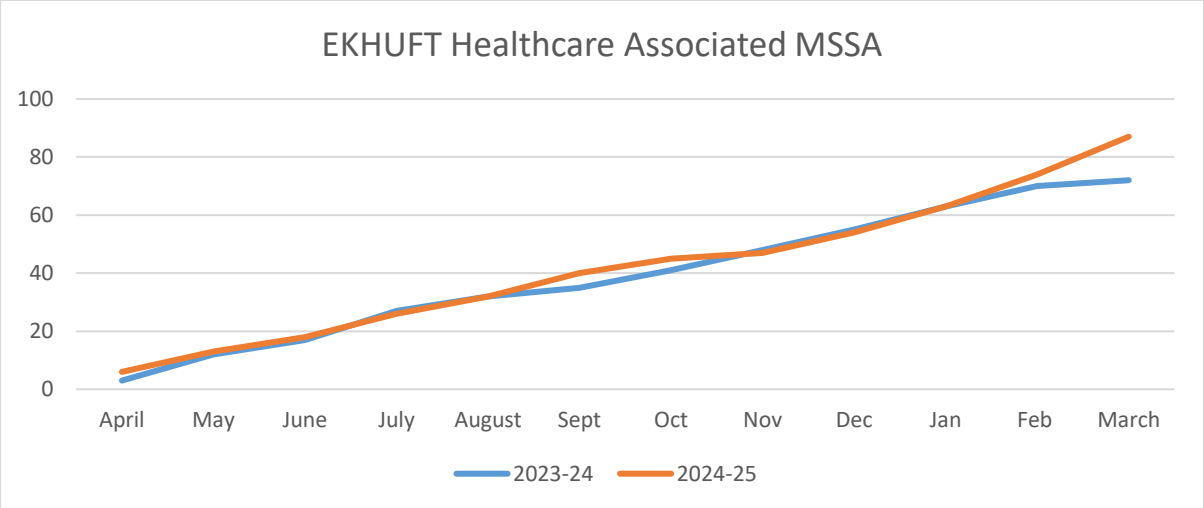
10.2.2 MSSA

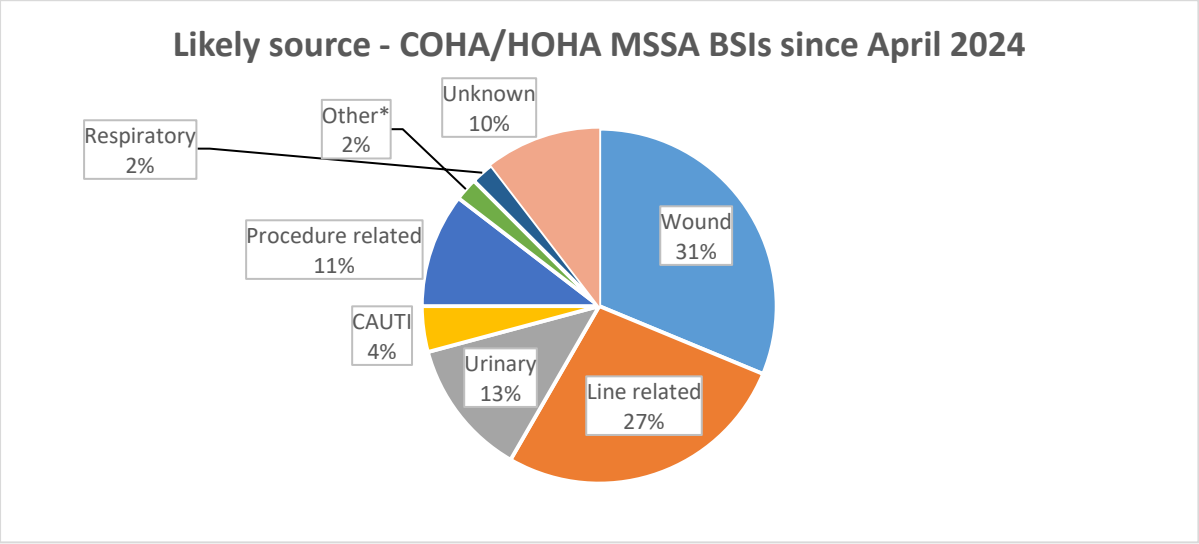
Meticillin sensitive *Staphylococcus aureus* (MSSA) bloodstream infections are common in both community and hospital settings. Healthcare associated infections are commonly related

to vascular access catheters or surgical site infection. There is no externally set objective for MSSA bloodstream infections.

No threshold has been set for these infections, however in the last quarter of the year, EKHUFT reported a sharp increase in MSSA cases (87) compared with last year's cases (72). These were reviewed for learning, and are associated with devices and wounds, actions to help reduce these sources form part of the IPC TWIP for 2025/6.

All HOHA and COHA cases are investigated by the IPC team with associated action plan where learning is identified, the learning for MSSA's is similar to MRSA, and predominantly wound care and line care focus.





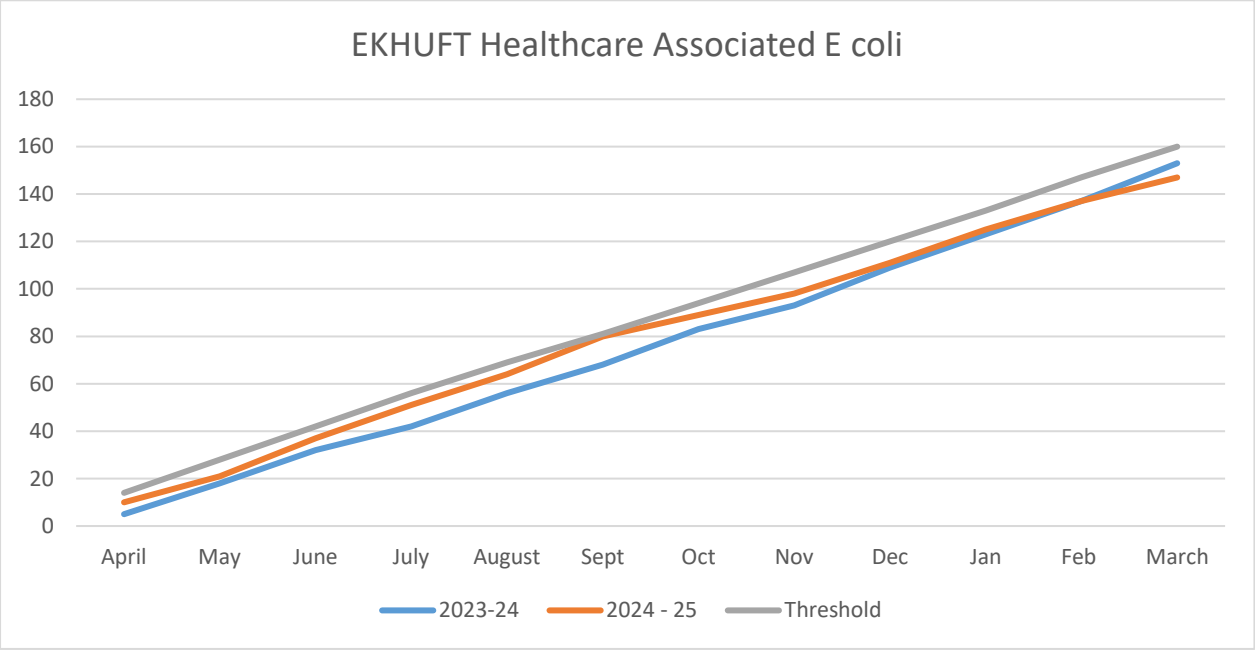
10.3 Gram Negative Bloodstream Infections

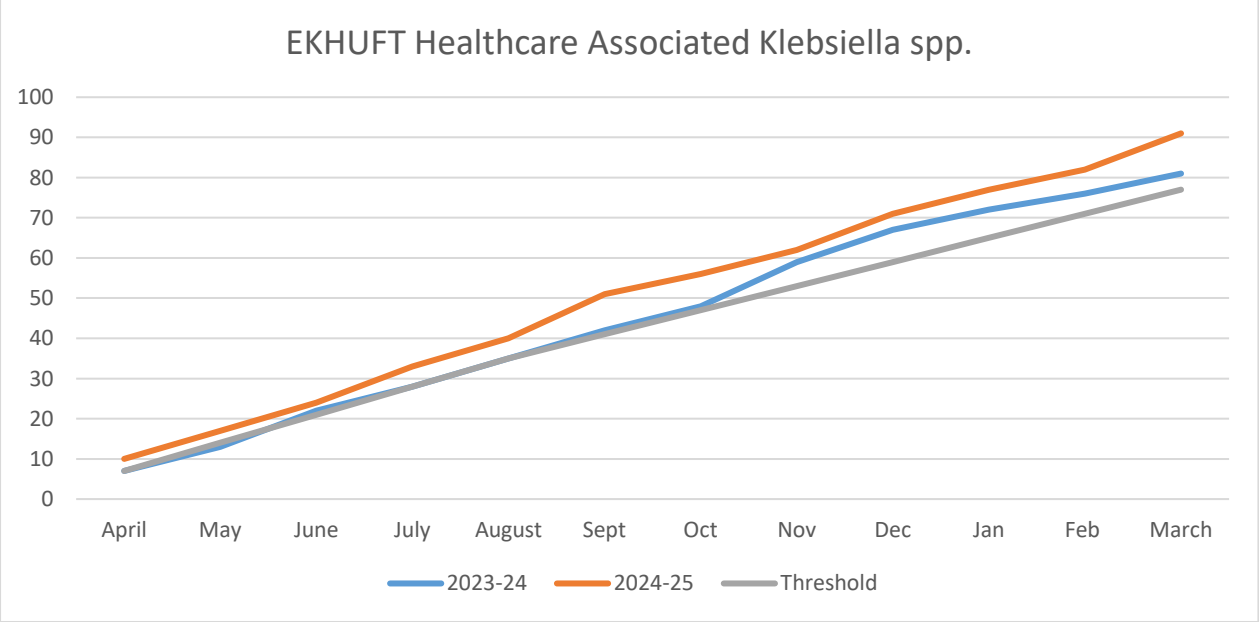
The UK 5-year action plan for antimicrobial resistance (AMR) 2024 to 2029 includes a target (1b) to prevent any increase in Gram-negative bloodstream infections in humans from the 2019 to 2020 financial year baseline by 2029.

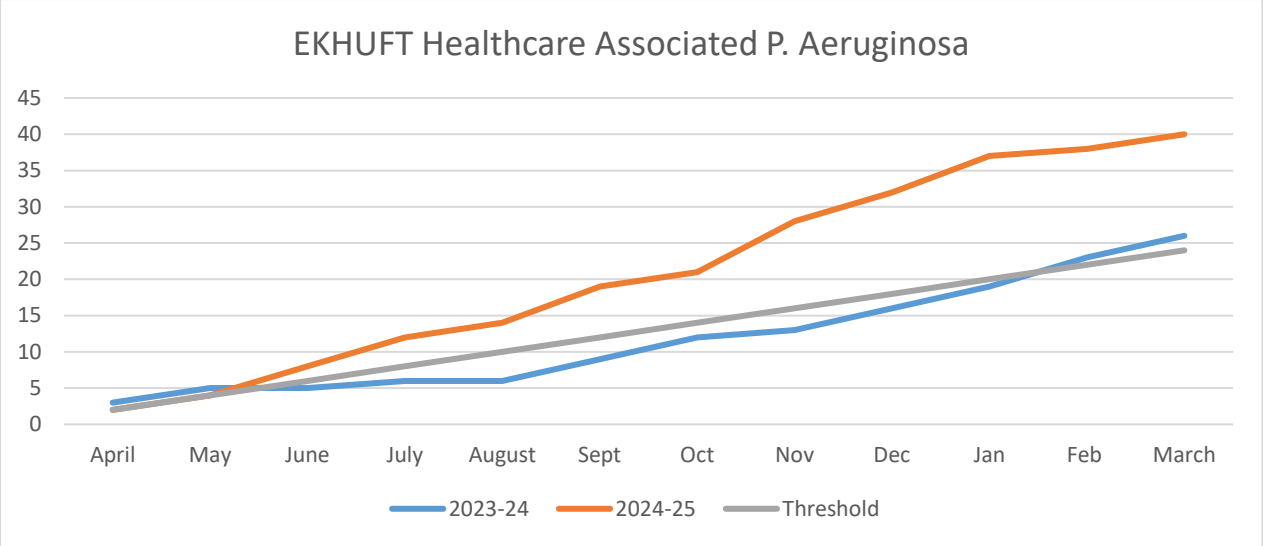
Results for reduction of gram negative bacteraemias varied this year, E. coli cases reduced, and reported less than the threshold of 160, with 147 cases, however, we are over trajectory for both Klebsiella and pseudomonas. Whilst there are actions continuing to focus on reduction of these cases, the targeted interventions for both E. coli and Klebsiella infections

are similar, therefore it is hard to understand why the difference in cases, especially when the E. coli is reducing. Within the IPC TWIP for this year we continue to focus on environmental aspects of care provision and wound and bladder / catheter QI projects.

The data for the three nationally reportable Gram-negative bloodstream infections are given below:







10.4 Carbapenemase Producing Organisms (CPO)

CPO are of concern as organisms producing Carbapenamases (enzymes that confer antimicrobial resistance) are resistant to many of the antimicrobials of last resort. In some areas of the UK, CPO have become endemic and once established in a healthcare facility, they can be extremely difficult to eradicate. Management of CPO follows published guidance from UKHSA. For EKHUFT where CPO are not endemic this is based on targeted screening of certain patient groups. Although this screening has identified sporadic cases, no cluster or outbreaks have been identified. Vigilance remains high.

11. Antimicrobial Stewardship

11.1 Current Antimicrobial Stewardship Team

Consultant Medical Microbiologist (Lead Consultant for AMS) – with ≤0.2 wte for AMS
Consultant Pharmacist (AMS) – 0.6WTE – in post
Advanced Pharmacist (AMS) based at WHH– 0.64 WTE – in post
Advanced Pharmacist (AMS) based at QEQM– 0.6 WTE- in post from September 2024
Other Consultant Medical Microbiologists and Clinical Fellows are available for advice/ward rounds if needed.

11.1.1 Expectations from clinical staff.

Prescribers are asked to refer any patients they are concerned about to the Consultant Microbiologists/Clinical Fellows via the Careflow app. A response can be added to the referral recommending a treatment plan and duration.

Clinical ward pharmacists are asked to review all antibiotic prescriptions to ensure that:

- there is an accurate indication and stop/review date on the Sunrise chart
- they are prescribed as per guidelines, microbiology advice or as per culture and sensitivity results (and they are asked to challenge anything that does not fit these criteria)
- they prompt clinical teams to refer patients to Microbiology via Careflow if duration of treatment is at 10 days or more or if the antibiotic choice is a restricted antibiotic / not as per guidelines or microbiology advice

11.1.2 Main aims of the AMS Team for 2024-25

- Reduce inappropriate antimicrobial prescribing; total consumption, broad spectrum and high *Clostridioides difficile* risk antibiotics (in particular: co-amoxiclav, piperacillin/tazobactam, fluoroquinolones, clindamycin, carbapenems and 3rd generation cephalosporins)
- Work pro-actively to prevent increasing antimicrobial resistance and healthcare associated infections e.g. *C. difficile*.

The pharmacy AMS team produced a monthly highlight report summarising activities conducted during 2024 whilst ASG was occurring quarterly. ASG has now been moved to monthly meetings with a split agenda.

11.1.3 Data

Unless stated otherwise, the graphs and tables presented in this report uses data collected from the RxInfo database. In order to compare data across different timeframes, the data is presented as Defined Daily Doses (DDDs/1000 admissions).
It should be noted that since April 2020, admissions for the Emergency Department (ED) is not complete. The effect this has on the data presented, is not known.
FP10s have been included in the usage data. ED use a lot of FP10 prescriptions to facilitate discharge. To not include them would potentially skew the data and not give a true representation of the prescribing patterns within ED.

11.1.4 Standard Contract 2024/25

The consumption of antibiotics in the Watch and Reserve categories of the AWaRe list is monitored under the NHS Standard Contract. All the 'High *C. difficile* risk antibiotics' monitored by the AMS team in the list above fall under the Watch and Reserve categories.
A full list of WHO AWaRe (Access, Watch and Reserve) category antibiotics can be found at the following link: https://www.who.int/publications/i/item/2021-aware-classification

In previous years, the contract has included a provision requiring Trusts to use all reasonable endeavours to reduce their broad-spectrum (UK Watch and Reserve category) antibiotic usage by a specific percentage each year, in accordance with the overall target reduction set out in the UK five-year action plan for antimicrobial resistance 2019 to 2024. This is now coming to an end and the Contract provisions need to be revised.
As the new Action Plan had not been published in time for the start of the 2024/25 Standard Contract, there were no specific percentage targets for annual reduction in 2024/25, but is expected to be reviewed for the 2025/26 contract.
The new National Action Plan (NAP) for 2024-29 has a theme related to AMS and 2 objectives to achieve by 2029:

1. Reduce the total antibiotic usage in humans by 5% on 2019 baseline data
2. Achieve 70% of antibiotic usage to be from ACCESS group

Co-amoxiclav is the most used Watch and Reserve antibiotic in the trust, followed by clarithromycin, ciprofloxacin, levofloxacin and Tazocin® (piperacillin/tazobactam). Use of co-amoxiclav has tripled across the trust between 2014 and 2024 and from 2023-24 we see a probable plateau in the trend, however there is still an excess of Co-amoxiclav usage (these are standardised data).

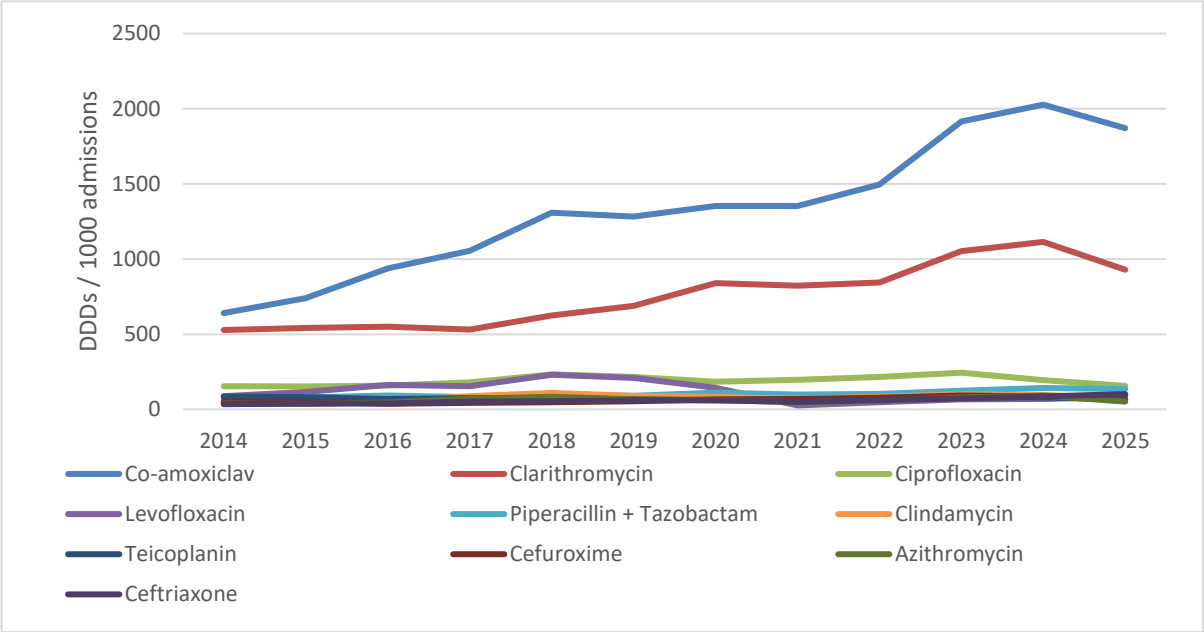


Figure 1: Consumption of Top 10 Watch and Reserve Antibiotics by drug in DDDs/1000 total admissions for 2014-2024 (**including FP10s)**

Figure 2 represents the Co-amoxiclav usage per specialty. Please note: WHH AMU and QEQM AMU B is included in Emergency Medicine data point. Remainder of QEQM AMU is included in Acute Medicine data.

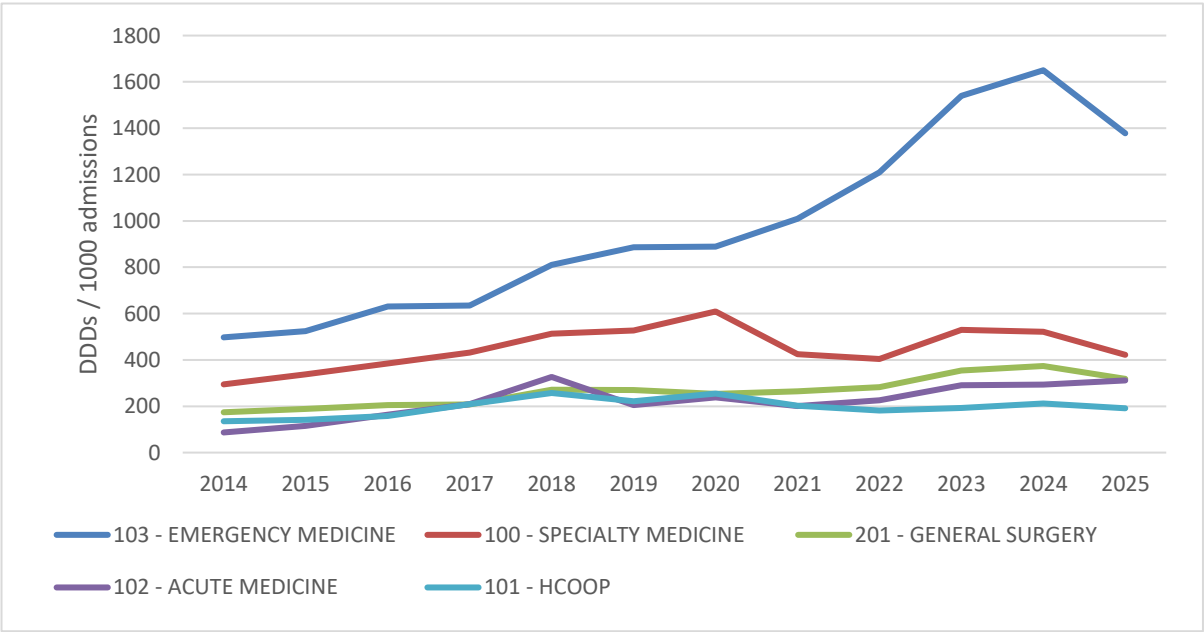


Figure 2: Consumption of Watch and Reserve Antibiotics by Top 5 local directorate in DDDs/1000 total admissions for 2014-2024 (**including FP10s**)

Emergency Medicine is the biggest user of Watch and Reserve antibiotics (figure 2). ED uses three times as many antibiotics as the second highest user (Specialty Medicine) and more than the rest of the Top 5 combined, however it should be noted that the admissions data for ED from 2020 onwards is not complete.
Antibiotic usage has been steadily increasing in ED and across the trust since 2014, with co-amoxiclav and clarithromycin forming the largest portion.
ED and AMU AMS Key Performance Indicator audits were redefined for September and October 2024 to capture more information on which specialties are starting antibiotics in ED, for which indications and their compliance to guidelines.
September data has been presented at ED clinical governance meetings and discussions have been started on how to address poor compliance to guidelines in this area.

Figure 3 represents the Co-amoxiclav usage per in ED. Please note: WHH AMU and QEQM AMU B is included in Emergency Medicine data point. Remainder of QEQM AMU is included in Acute Medicine data. This information is intrinsic to the how the systems have been set up.

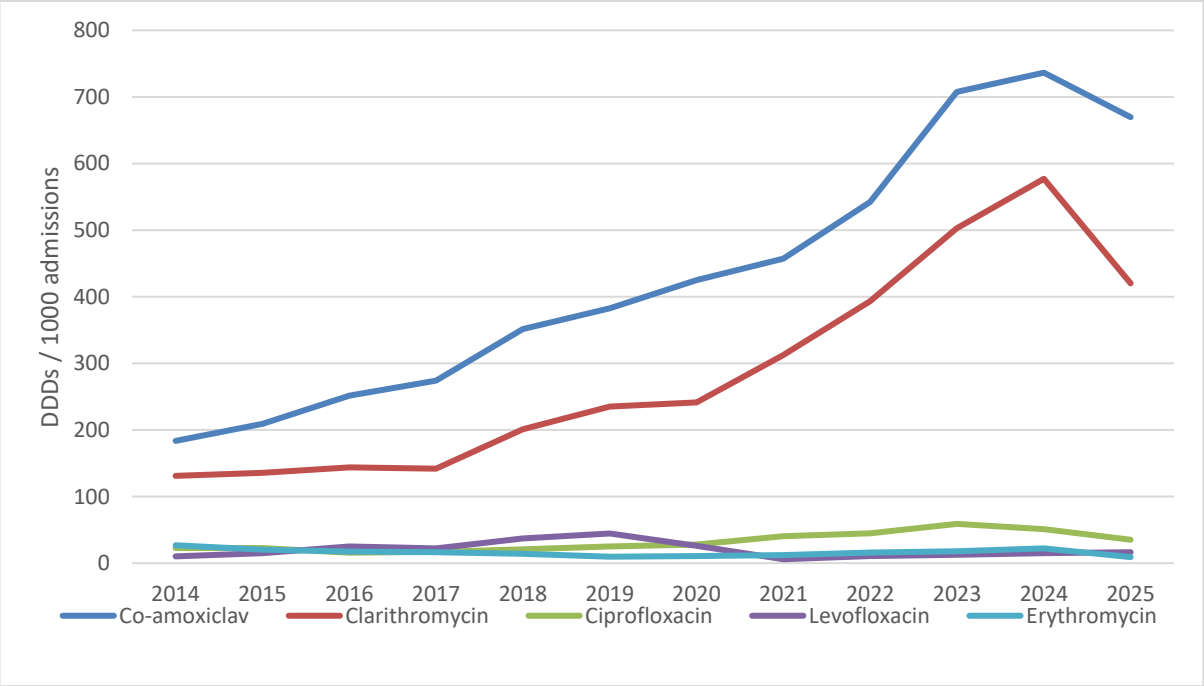


Figure 3: Consumption of Top 5 Watch and Reserve Antibiotics in ED **(including FP10s) (excluding AMU units, but including UTCs)**

11.1.4 AMS Team audits/projects conducted

- KPI audits were defined with a link to risk of CDI and conducted during 2024-25 in each different ward regularly. KPI results have been discussed at different specialties.
- Tazocin usage monitoring started in 2024 due to an increase of its demand. This usage and the KPI results confirm the Trust has opportunities in improving following guidelines.

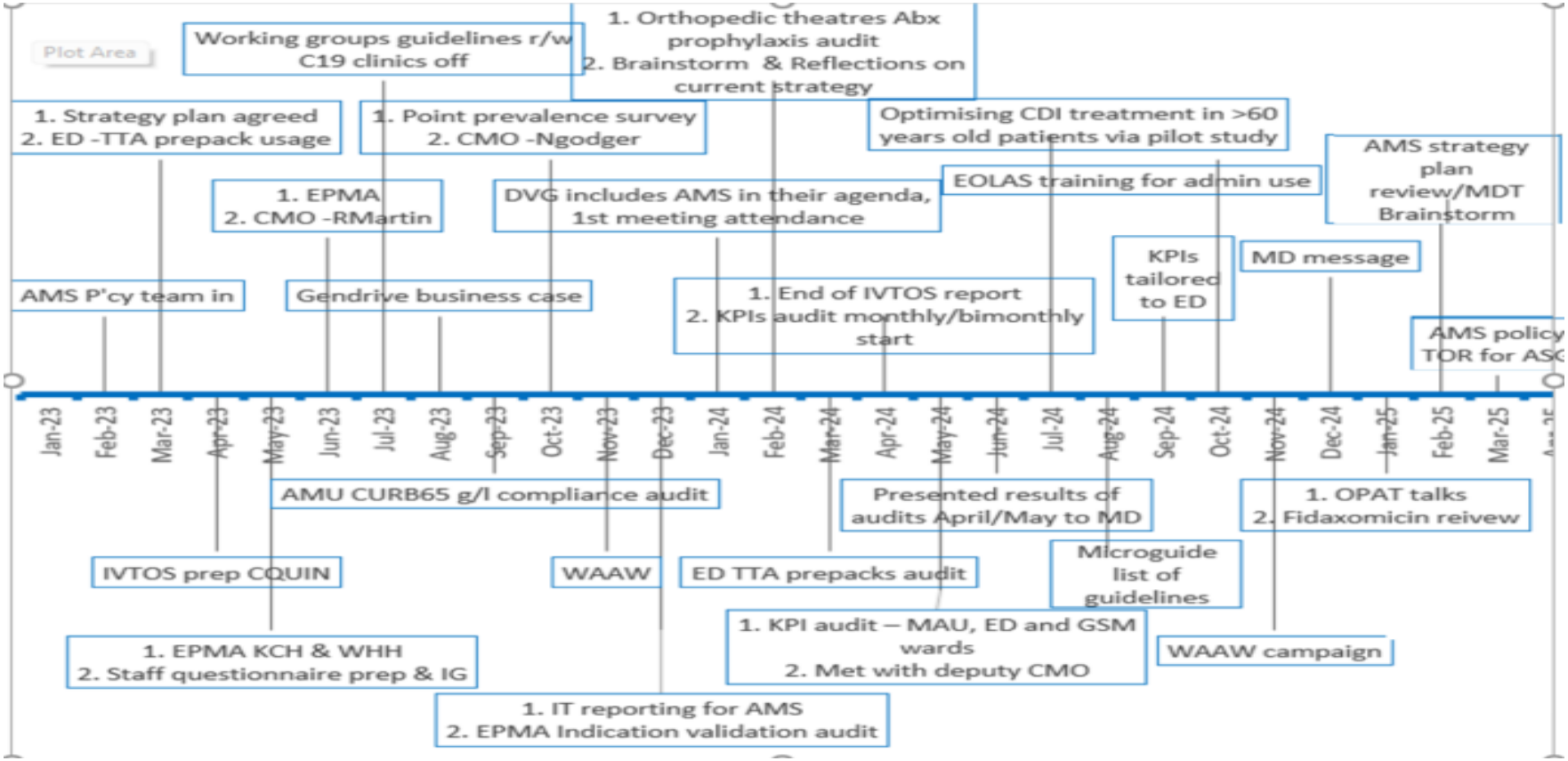
- Junior doctors were asked to participate in a snapshot of the IVTOS quality improvement project as an element of embedding AMS to their practice.

11.1.5. Next audits and AMS projects

The KPI audits will continue less frequently whilst AMS team focusses in developing the junior workforce in pharmacy embedding AMS in their practice and escalate unoptimized use of antimicrobials to the AMS team.

11.1.6. Highlights

Next figure shows the highlights for AMS team during the establishing of the team post pandemic.


Plot Area
Working groups guidelines r/w C19 clinics off
1. Orthopedic theatres Abx prophylaxis audit
2. Brainstorm & Reflections on current strategy
1. Strategy plan agreed
2. ED -TTA prepack usage
1. Point prevalence survey
2. CMO -Ngodger
Optimising CDI treatment in >60 years old patients via pilot study
AMS strategy plan review/MDT Brainstorm
1. EPMA
2. CMO -RMartin
DVG includes AMS in their agenda, 1st meeting attendance
EOLAS training for admin use
KPIs tailored to ED
MD message
AMS P'cy team in
Gendrive business case
1. End of IVTOS report
2. KPIs audit monthly/bimonthly start
AMS policy
TOR for ASC
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
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Apr-24
May-24
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Aug-24
Sep-24
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Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
AMU CURB65 g/l compliance audit
Presented results of audits April/May to MD
1. OPAT talks
2. Fidaxomicin reivew
IVTOS prep CQUIN
WAAW
ED TTA prepacks audit
Microguide list of guidelines
1. KPI audit – MAU, ED and GSM wards
2. Met with deputy CMO
1. EPMA KCH & WHH
2. Staff questionnaire prep & IG
WAAW campaign
1. IT reporting for AMS
2. EPMA Indication validation audit

12. Decontamination

12.1 Sterile Supplies (CSSD)

The Trust has a Decontamination Committee that is chaired by the Deputy DIPC as the designated decontamination lead for the Trust. Instrument reprocessing is outsourced to In House Sterile Services (IHSS) and the contract is managed through agreed key performance indicators. In 2024/25 the turnaround performance was above 95%, with quality performance above 98%, and issues identified related to potential contamination of sets. A number of sets were switched to tins to reduce the risk of contamination and it was agreed to focus on orthopaedic instruments which has seen a reduction in cancellations of surgery.

The deputy DIPC and deputy decontamination lead undertook an annual review of IHSS Aylesham branch in March 25. Full compliance with decontamination practices was identified, having reviewed their annual independent audit results which had identified non-conformities in other IHSS services, but not those that reprocess EKHUFT instruments. Local audits and reports from their independent authorising engineer and Andersen Caledonian were also reviewed, and any non-conformities had been rectified, and therefore no concerns were found.

IHSS continue to work alongside EKHUFT, and aim to further increase the amount of tins they can reprocess, and continue to review the paper used on their shelving for ongoing improvements. The unidentified contaminants have now significantly reduced, and monitoring remains in place through the contractual agreements

12.2 Endoscope reprocessing

The EKHUFT authorising engineer for decontamination undertook the annual review of endoscopy units and overall general compliance was found, with some actions required relating to evidencing of ventilation and water reports. However two decontamination rooms (KCH urology and endoscopy) do not meet full best practice standards as they are built in one room, but they do meet the basic HTM requirements, through implementation of good dirty – clean flow utilising PPE and cleaning processes.

13. Surgical Site Surveillance

Surveillance of surgical site infection (SSI) following orthopaedic surgery is included in the mandatory healthcare-associated infection surveillance system.

All NHS Trusts where orthopaedic surgical procedures are performed are expected to carry out a minimum of three months surveillance in at least one of the three orthopaedic categories:

- Total hip replacements
- Knee replacements
- Hip hemiarthroplasties

EKHUFT undertake continuous surveillance in all three categories (rather than limiting participation to the mandatory single quarter per year).

Every quarter, surgical site infection surveillance (SSIS) is carried for the following UKHSA orthopaedic procedures: Repair of NOF fracture, Hip and Knee replacements. These procedures are carried out in Queen Elizabeth Queen Mother (QEQM) Hospital, William Harvey Hospital (WHH) and the Elective Orthopaedic Centre (EOC) at Kent & Canterbury Hospital (KCH).

In addition, an internal trust-wide SSIS was carried out for elective and emergency caesarean sections between August and October, 2024. SSI rates were obtained using the patient-reported SSI method – patients whose wound complaints met a nationally defined criteria for patient-reported SSI.

The table below illustrates the confirmed orthopaedic SSIs rates attributed to each hospital site since April 2024:

SSI (Inpatient & Readmission Data)
National average in bracket ()

Quarter	EOC		QEQM	WHH
	Knee Replacement	Hip Replacement	Repair of NOF	Repair of NOF
Apr – Jun 2024	0% (0.2%)	1.8% (0.3%)	0% (0.9%)	2% (0.9%)
Jul – Sept 2024	1.4% (0.2%)	0.9% (0.3%)	1.5% (0.9%)	0% (0.9%)
Oct – Dec 2024	0% (0.2%)	0.9% (0.3%)	1.6% (0.9%)	0% (0.9%)
Jan- March 2025	0.6% (0.2%)	1.6 % (0.3%)	5.2% (0.9%)	0% (0.9%)

Caesarean Section SSI (August – October 2024)
Quarter trust-wide average – 17%

	WHH	QEQM	Trust-Wide
August	11.4%	18.6%	14.9%
September	24.2%	18.8%	21.9%
October	14.8%	14.3%	14.5%
Total Average	**16.8%**	**17.2%**	**17.1%**

Several key improvements were implemented during 2024–25, including:

- **Standardisation of dressings** used for patients undergoing Total Hip Replacement (THR) and Total Knee Replacement (TKR) surgeries.
- **Wound management training sessions** delivered by the Tissue Viability and Infection Prevention and Control teams.
- **SSI-related training and awareness activities** conducted across all three hospital sites.
- **Wound care leaflets** provided to patients upon discharge.
- **Patient information leaflets** developed for those undergoing THR and TKR; the leaflet for NOF patients is in the final stages of approval.
- **Theatre teams' adoption of AfPP audit tools** to enhance perioperative practice.
- **Establishment of a pre-operative washing process** for patients undergoing NOF repair, with corresponding documentation in place.
- **Commissioning and use of antimicrobial sutures** across all three sites.

14. Conclusion

There has been a strong and sustained focus on IPC and antimicrobial stewardship during the last twelve months and there has been significant progress, despite the context of extreme operational pressures, and challenging outbreaks of Norovirus at both the William Harvey and Queen Elizabeth Queen Mother hospitals. The Trusts aging estate continues to cause significant impact on the ability of the staff to be able to effectively clean, and manage care in a safe environment, and this remains a key focus going forward with the CLEAN campaign. The IPC and antimicrobial stewardship teams are established and work continuously to improve practice and outcomes for patients and staff.

In the last year we have:

- Maintained a fully established team, with the exception of one team member (band 6 IPC charge nurse) leaving for promotion, however, there was a successful recruitment into this position.

- Reviewed the IPC training needs and education for all trust staff.
- Successful continued the IPC Link Practitioner programme.
- Implemented care group/site lead IPC meetings focusing on operational issues associated with IPC.
- Continued to implement the standards of the National Infection Prevention and Control Manual (NIPCM).
- Revised the governance structure for the water safety and ventilation safety groups.
- Revised the IPC Business Continuity Plans.
- Reviewed the scope and quality of the surveillance of HCAI and continued a programme of improvement work.
- Continued to work collaboratively with system partners to develop a Kent and Medway IPC Strategy.

We have achieved success in the following areas:

- The IPC team remained fully established.
- The Trust was below the external threshold for *C diff* infections reporting 105 against a threshold of 145.
- The Trust was below threshold for *E.coli* bloodstream infections (BSI).
- Meticillin Resistant Staphylococcus aureus (MRSA) BSI was lower this year compared to previous year with 2 cases being reported against 8 in the previous year.
- Continued to implement robust processes for surgical site infection surveillance in Trauma and orthopaedics – Total hip, total knee replacements and fractured neck of femur repairs.
- Reduced SSI's relating to fracture neck of femur repairs.
- Introduced SSI surveillance on caesarean sections.
- Fit testing for the use of FFP3 respirators is undertaken by a dedicated person within the IPC team, and over 600 staff members were tested.

The remaining challenges and areas of focus include:

- The Trust exceeded thresholds for all other gram-negative blood stream infections (Pseudomonas and Klebsiella).
- MSSA BSI were at 87 compared to 72 in the previous year.
- Overall the state of our estate and physical infrastructure remains very challenging and does not support good IPC practice.

Focus for coming year:

- Review the clinical skills training for staff with a focus on ANTT (line related), and urinary catheter care.
- Relaunch of the CLEAN Together campaign to focus on environmental and decluttering issues:
  'C' Clutter and cupboards.

  'L' Linen and laundry

  'E' -Environmental and equipment cleaning

  'A' All the waste in the right place

  'N' Nobody should walk by

- Focussed Trust-wide improvement plan on learning identified from current year – Sampling, isolation, and aspects of CLEAN campaign.

CLEAN Campaign in 2024

East Kent Hospitals University NHS Foundation Trust

REPORT TO THE BOARD OF DIRECTORS (BoD)

Report title: **Complaints, Patient Advice and Liaison Service (PALS) and Compliments Annual Report 2024-2025**

Meeting date: **31 July 2025**

Board sponsor: **Hannah Smith, Director of Quality Governance (DQG)**

Paper Author: **Sue Holland, Head of Complaints, PALS and Bereavement Services**

Appendices:

Appendix 1: **Complaints, PALS and Compliments Annual Report 2024-2025**

Executive summary:

Action required:	**Approval**
Purpose of the Report:	An annual review of complaints, compliments and PALS received by the Trust. To meet the requirements of the Local Authority Social Services and National Heath Service Complaints (England) Regulations 2009.
Summary of key issues:	A performance review of complaints and PALS, along with the themes related to complaints and PALS. Details of the actions and learning from complaints and PALS, including any actions from complaints reviewed by the Parliamentary and Health Services Ombudsman. A detail of the achievements in 2024-2025, alongside the plan for continuous improvement in 2025-2026.
Key recommendations:	The Board of Directors is asked to discuss and **APPROVE** the report to be published on the Trust website, for public review.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Trust Risk Register:	**Y** – complaint performance within timeframes.

We care

East Kent Hospitals University NHS Foundation Trust

Resource:	**N**
Legal and regulatory:	**Y** – this report meets the requirements of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.
Subsidiary:	**N**

Assurance route:

Previously considered by: None

East Kent Hospitals University NHS Foundation Trust

Complaints, PALS and Compliments Annual Report 2024-2025

1. Purpose of the report

1.1 This attached Annual Report provides an overview of the activity of complaints, PALS and compliments during 01 April 2024 to 31 March 2025 (2024-2025).

2. Background

2.1 This report is to meet the requirements of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and the East Kent Hospitals University NHS Foundation Trust Complaints Management Policy.

2.2 It is considered good practice and was recommended by the 2020 Healthwatch report Shifting the Mind-Set, for NHS trusts to publish their annual performance report on the organisation's website.

2.3 The Parliamentary and Health Services Ombudsman (PHSO) NHS Complaint Standard came into effect during the spring of 2024 and this report details some of the work to improvement the complainants experience, alongside meeting these standards.

3. Summary

3.1 This report is for approval to be added to the Trust's website.

3.2 The report meets the requirements of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. The regulation and the Complaints Management Policy stipulate the following information forms the basis of the report:

- 3.2.1 Specify the number of complaints received;
- 3.2.2 The number of complaints that were upheld, partially upheld or not upheld;
- 3.2.3 The number of complaints referred to the PHSO;
- 3.2.4 The subject matter of complaints;
- 3.2.5 Any matters of general importance arising out of those complaints or the way in which they were handled;
- 3.2.6 Lessons learnt from complaints, including any actions or service improvements made;
- 3.2.7 The number of complaints acknowledged within three working days;
- 3.2.8 The timescale complaints were acknowledged within.

4. Conclusion

4.1 This report is provided for approval, presented at the Quality and Safety Committee (15 July 2025), and the Trust Management Committee (TMC) (2 July 2025), before presentation at the Trust Board meeting 31 July 2025.

East Kent Hospitals University NHS Foundation Trust

Complaints, Patient Advice and Liaison (PALs) and Bereavement Services

Annual Report 2024-2025

1. Introduction

Our Trust provides care across a wide variety of services, both hospitals based and within the community. We actively encourage people to provide feedback, through a variety of means, including formal complaints, Patient Advice and Liaison Service (PALS) and compliments. We use this information to help shape how we provide our services and to make changes, to ensure we are able to meet our patient's need in the best way possible.

Complaints, PALS and compliments just a part of feedback information the Trust receives. The feedback does offer intelligence on how our Trust is performing, and how our patients and their families, feel about our: services, facilities, and staff. When our services receive compliments, we can share great working practices, or initiatives with other teams and departments.

To ensure clients (patients, friends, families, advocates or person representatives) feel confident to talk to us about any concerns, we reassure them that any negative feedback, will not affect any future care or treatment they may need and will not appear on their patient records.

This Annual Report provides an overview of the activity of complaints, PALS and compliments during 01 April 2024 to 31 March 2025 (2024-2025).

2. Summary

- 2024-2025 there has been a 15.2% increase in new complaints. 1191 new complaints received in 2024-2025, compared to 1034 in 2023-2024.
- On average, 98% of new complaints were acknowledged within three working days; the Key Performance Indicator (KPI) is 90%. The KPI has been consistently met for the year.
- There has an increase in performance of complaints responded to within agreed timescales.
- There has been a 7% increase in new PALS; 5963 received in 2024-2025, compared to 5567 received in 2023-2024.
- 53% of calls into the PALS team were answered live during 2024-2025.
- On average, 65% of PALS were responded to within timescales.
- 2024-2025 there has been a 15.7% decrease in compliments.
- 82% of deaths were processed and the Medical Certificate of Cause of Death (MCCD) completed within five working days.

3. The process for giving feedback

The Trust's process for managing the complaints, compliments and PALS is client and patient-focused. The process, which was redesigned in spring 2024 is based on the Parliamentary Health Service Ombudsman (PHSO) NHS Complaint Standards and their six principles for good complaint handling:

- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement.

The main role of the complaints and PALS teams are to assist clients in obtaining information, a resolution, or supporting them with information.

PALS provide advice, information and support to help resolve concerns a client may have, as well as providing information on all Trust services, and where appropriate, signposting people to other NHS

trusts or healthcare providers. The PALS Officers works closely with services to resolve concerns quickly and effectively; they also ensure themes/trends, along with any learning, are identified and shared.

If we are unable to resolve a PALS or the PALS team feel a more in-depth investigation is required, the concerns may be escalated to a formal complaint.

For complaints we ensure an appropriate investigation is carried out and a written response provided. The Trust will also offer meetings to help explain and/or resolve concerns.

Wards and services record compliments as they are received, in order that information can be shared, this information is themed. Areas of high compliments are encouraged to share great working practices, or initiatives; this information is shared within monthly reports.

4. Overall Themes for Complaints, PALS and Compliments

The top 5 primary subject themes recorded across the Trust received in 2024-2025 are:

Complaints		PALS		Compliments	
Clinical Management	265	General Enquiries	1747	Nursing care	9587
Communication	158	Delays	784	Attitude	2669
Delays	135	Communication	739	Communication	2429
Attitude	131	Appointments	565	Communication	1719
Nursing Care	84	Patient Experience	542	Food	1014

In comparison, the top 5 primary subject themes received in 2023-2024 were:

Complaints		PALS		Compliments	
Clinical Management	352	General Enquiries	1601	Nursing care	15,243
Communication	91	Delays	853	Attitude	2640
Delays	78	Communication	628	Clinical Management	2209
Surgical Management	75	Appointments	437	Communication	2200
Attitude	71	Patient Experience	335	Food	1666

There has been no change in the top theme for each feedback source and for compliments there has been no change in the themes, although they are in a slightly different order.

For complaints, surgical management, which featured in 2023-2024, is replaced by nursing care.

For PALS the top five remain the same, in the same order as 2023-2024; the number of contacts regarding general enquiries, communication, appointments and patient experience has increased. The number of contacts regarding delays has decreased compared to 2023-2024.

NHS
East Kent
Hospitals University
NHS Foundation Trust

5. Performance:

Below is a record of the numbers received between April 2024 and March 2025 and is colour coded where there is a KPI (red - target not met, amber – target partially met and green – fully met)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Number of contacts to PALS and complaint teams	1305	1193	1078	1231	1004	1157	1288	1202	1030	1401	1307	1311
New complaints received	109	107	84	102	98	100	92	89	95	119	99	97
% difference in nos. of new complaints from 2023-2024	70.3% ↑	18.8% ↑	4.5% ↓	9.7% ↑	19.5% ↑	13.8% ↑	6.9% ↑	2.2% ↓	48.4% ↑	12.3% ↑	13.8% ↑	16.9% ↑
Complaints acknowledged within 3 working days	97%	100%	99%	95%	97%	95%	97%	99%	99%	99%	100%	98%
Complaints responded to within agreed timescales	0% 0 of 53	4.5% 3 of 67	7.6% 7 of 92	16.8% 13 of 77	20.3% 15 of 74	32.1% 41 of 78	52.6% 41 of 78	70.4% 62 of 88	85.0% 70 of 82	86.4% 70 of 81	87.3% 55 of 63	86.0% 80 of 93
New PALS received	530	467	447	519	419	456	559	472	412	568	558	556
% difference in nos. of new PALS from 2023-2024	26.1% ↑	3.7% ↑	7.0% ↓	18.7% ↑	7.0% ↓	1.3% ↓	25.9% ↑	6.9% ↓	12.8% ↑	5.3% ↑	10.4% ↑	11.6% ↑
No of telephone calls into PALS	666	619	547	610	487	601	637	641	523	714	650	658
% of live calls answered	55%	62%	50%	56%	20%	42%	39%	49%	74%	69%	57%	42%
Responded to within agreed timescales	70%	69%	66%	66%	42%	34%	45%	71%	76%	84%*	77%*	79%*
Compliments received	3083 ↑	1948 ↓	2726 ↑	1684 ↓	2033 ↓	2255 ↑	2897 ↑	2003 ↓	1901 ↓	1475 ↓	1852 ↓	1981 ↓
Complaints to complaints ratio	1.28	1.18	1.33	1.17	1.21	1.23	1.32	1.23	1.20	1.12	1.19	1.20
MCCD* completed within 5 working days across the Trust	88%	96%	93%	93%	84%	87%	89%	81%	64%	61%	81%	82%

*There are open PALS contacts received during January to March 2025 that still need closing. Compliments are retrospectively input by services. PALS and compliments data will therefore change as cases are closed/entered.

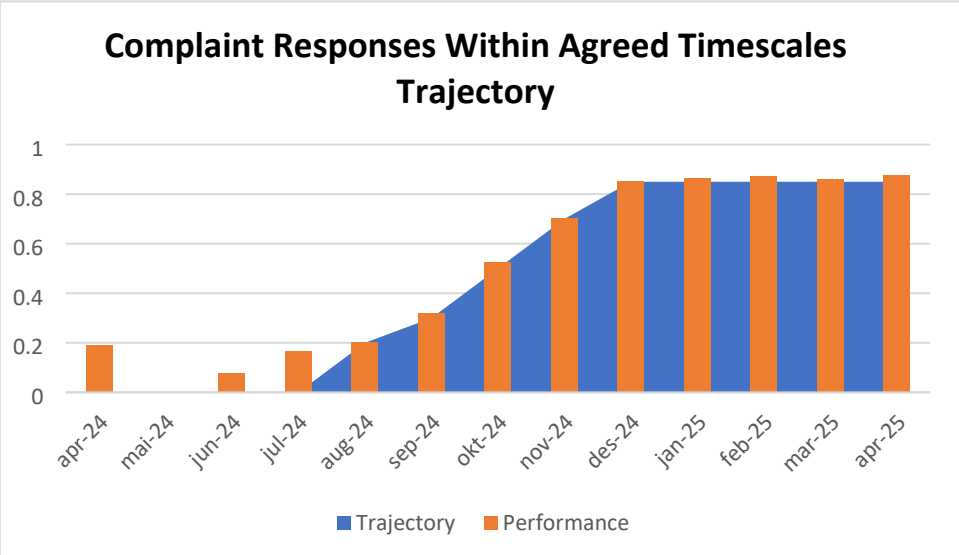
- Over the period from April 2024 to March 2025 there has been a total of 14507 contacts with the team, which resulted in 8.2% (1191) formal complaints and 41.1% (5963) new PALS.
- There is a clear decrease in PALS cases being responded to within 10 working days between August and October 2024; this is primarily due to long term sickness in the PALS team at that time, impacting on the team being able to process the contacts in a timely manner and forward to the care groups within timeframe.
- Compliments have decreased by 15.7%.

6. Complaints

There has been a consistent increase in complaints, which has been the case since the start of the pandemic. During 2023-2024 there were 1034 and during 2024-2025 complaints totalled 1191. This equates to a 15.2% increase.

The complexity of concerns and the number of issues being raised, has meant that more complaints were identified during the initial triaging of phone calls, emails and letters received. The PALS and complaints teams work closely to ensure, where possible, concerns are resolved as quickly as possible and the formal complaints process is used, when the situation warrants it. The complexity of concerns adds to the time taken for an investigation and providing a response. More complaints cover several care group services and also external services.

In September 2024, a trajectory to drive the performance of responsiveness to complaint responses was set. The KPI is 85% of complaints responded to within agreed timescales. The trajectory has been consistently met and the complaint team successfully continue to perform, meeting or exceeding the KPI.



2024-2025 saw change to the complaints team, as resources within care groups were centralised into one team. This enabled complaints to be more effectively managed, with one case handler acknowledging the complaint, reviewing the complaint with the client and working with the care group services to review the concerns raised.

Centralising the team meant re-engineering the complaints process, to ensure a more consistent implementation of the PHSO NHS Complaint Standards. Further work has been carried out to

ensure senior oversight of complaints and responsiveness, promoting a better complainant experience. These actions have included:

- Weekly reporting to the Chief Nursing and Midwifery Officer and Director of Quality Governance.
- Weekly reporting to the care group services and triumvirates, to identify breaching complaints and also age of complaints.
- An escalation process with the care group triumvirates supporting to promote quality and responsive resolutions.
- Fortnightly meetings with care group services to review complaints.
- Training being provided for all complaints staff, with ongoing weekly sessions.
- Training provided to the care group service staff, this is an ongoing piece of work.
- Clients are updated throughout the complaints process.
- Focus on reviewing complaint responses and care group triumvirates reviewing both the complaint and response, before an executive review.
- From November 2024, the complaints team, support care group colleagues to actively lead local resolution meetings, which will enable faster reviews of draft complaint responses for new complaints and returners

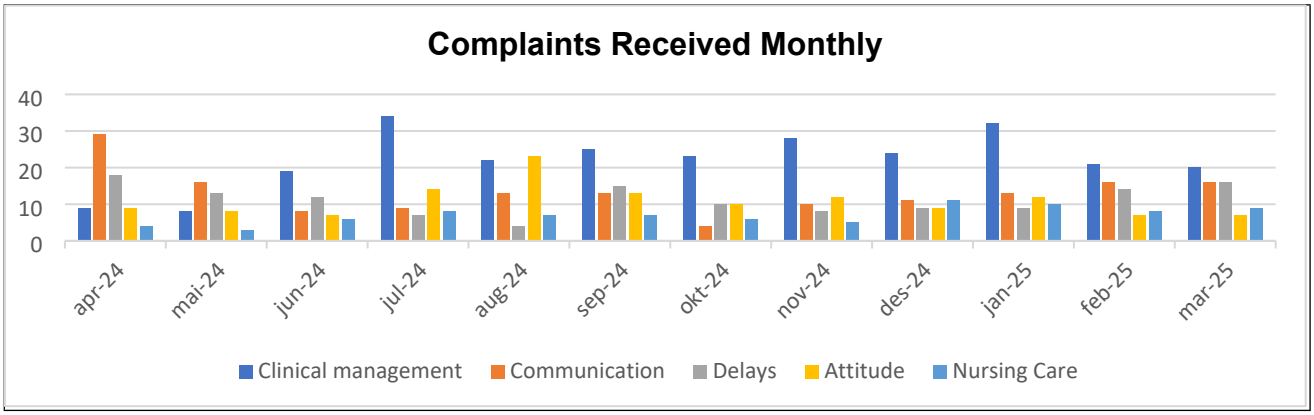
Themes:

The top five themes for complaints have been reasonably stable over 2024-2025. The top five complaints themes are detailed below, broken down into the specific issues. It should be noted that one complaint can have several concerns, which may relate to several themes and sub-subjects.

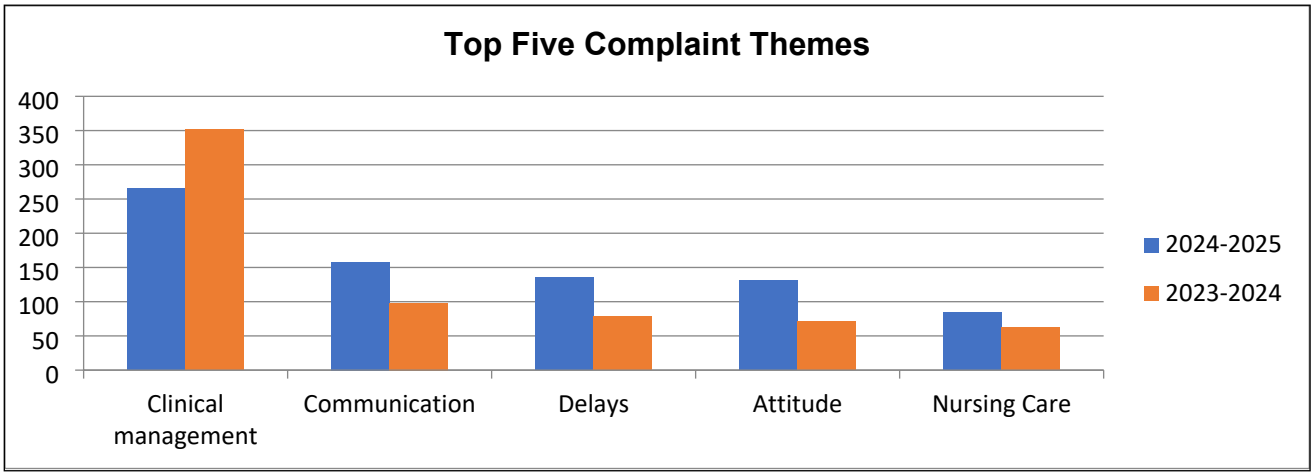
Clinical Management	**265**
Blood tests not carried out	1
Inappropriate ward	6
Incomplete examination carried out	12
Lack of / inappropriate pain management	13
Palliative care	5
Referral issues	8
Scans / X-rays not taken	10
Unhappy with treatment	210
Communication	**158**
Misleading or contradictory information given	6
A&C staff communication issues	8
Doctor communication issues	78
Other communication issues (i.e. old literature, phones not working	5
Unhappy with info on medical records	3
Nursing communication issues	33
Other staff communication issues	8
Unable to contact department / ward	5
Lack of information / explanation of how procedure went	4
Delays	**135**
Delay in allocation of outpatient appointment	9
Delays in being seen in A&E	22
Delay in referral	11
Delay with elective admission	10
Delay with emergency admission	4
Delay in being see in outpatient department	2
Delay in going to theatre	10
Delays in receiving treatment	60

Delay in sending / receiving copies of medical records	2
Delay in receiving x-ray results	5
Attitude	**131**
Problems with doctor's attitude	73
Problems with nurse's attitude	45
Problems with other staff attitude	13
Nursing Care	**84**
Delay in receiving treatment	8
Inappropriate physical handling	4
Lack of response to the call button	1
Problems with nursing care	66
Pressure ulcer care	1
Nutrition	2
Staffing levels	3

Clinical management has remained the top theme for complaints during the year. Communication and delays feature in the PALS top five themes. Clinical management, communication, attitude and nursing care also feature in the top five themes for compliments.



Top five themes of complaints received in 2023-2024 compared to 2023-2025



Clinical management remains the top concern for complaints.

Complaint Outcomes and Actions from 2024-2025:

The following are some of the actions and learning identified from complaints:

Care group	Action
CCASS CG Anaesthetics	A guideline poster from the Association of Anaesthetists, listing advice of anaesthesia and sedation in breastfeeding women. This is now displayed in the admission waiting rooms and pre-assessment.
Corporate CG	EKHUFT has now been accredited as Veteran Aware. The accreditation was confirmed by the national Veterans Covenant Healthcare Alliance (VCHA), which includes representatives from the government and the NHS nationally, as well as veterans.
DCB CG Cancer	A post lymph node clearance patient information leaflet has been developed by the Skin Cancer CNS team.
DCB CG Radiology	Following concerns from a patient over a significant adverse reaction to the Radioactive Tracer for a Nuclear Medicine Thyroid scan, the consenting procedure was reviewed. As a result, the procedure includes possible adverse effects and rare occurrences. The appointment letter has been amended to provide more information on radiation exposure.
KCRVH CG T&O	Following concerns over a displaced distal radius fracture not being picked up, new guidance has been put in place, to review all distal radius fractures five weeks after surgery, unless otherwise specified by the surgeon.
QEQM HCOOP	Wards are now taking part in a yearly in-depth assessment across twelve areas, including: patient care, fundamentals of care, patient experience, medication safety and progressiveness of the ward.
QEQM CG - ED & A&E	The ED team now have two flow co-ordinators in place and have recently introduced a 'talk to us' patient experience hotline.
	A patient raised concerns over the lack of patient care in the observation ward in ED. QEQM has now become a national pilot site, to trial a new way of being assessed when patients present to ED. The ED are providing further training to staff around 'red flags' h a patient might mention or display, that would trigger a faster response from the doctors in ED.
WC&YP CG	A midwife made a comment to a patient trying to feed her baby, which caused conflict and distress. The Senior Midwifery team are in the process of scoping infant feeding clinics, with the community, to provide an extra layer of support.
WHHCG HCOOP	From 1 May 2024, the Trust has agreed that patients are no longer to be placed in the corridor areas of our wards, unless a move is imminent to a bed space on the ward.
WHH CG Cardiology	Concerns were raised over the delays patients are experiencing in being seen by cardiology. The Trust has recruited a specialist nurse and locum cardiology consultant, to help reduce the waiting time for patients. A Rapid Access Chest Pain working group has also been formed, meeting weekly, to review the pathway when patients are referred into the service.
WHHCG ED	The ED team is currently producing patient information leaflets, with QR codes, which will ensure that, as well as the information provided by staff prior to their discharge, our patients are able to review this information again once they are at home and feeling less stressed.
	A client was unhappy with the ED waiting time for a patient who was suicidal. Inhouse specialist mental health support workers and registered mental health nurses are being recruited.
WHH CG Surgical	A patient with poor medication compliance, overdosed when provided with a large bottle of Oramorph on discharge. Two hourly intentional care rounds have now been introduced Trust wide, with ward pharmacists arranging teaching sessions every four months for junior doctors.
Trust wide	The Eds have signage in the triage areas, indicating that a private area will be found for patients who wish to have a more discreet area for initial assessment.

Outcome of complaints closed in 2024-2025:

It is deemed good practice, by the PHSO, to record outcomes of complaints, under one of the categories in the table below. This within the NHS and Local Authority Complaint Regulations 2009 and was reinforced by the 2020 Healthwatch report 'Shifting the Mind-set'.

Period	Upheld	Partly Upheld	Not Upheld	Meeting Held	Withdrawn	On Hold
2023-2024	95	387	204	72	169	18

2024-2025	192	632	140	51	144	31

7. PHSO Investigations

The complaints team closely monitor the number of cases that become formal investigations. There has been an increase in the number of cases the PHSO has asked for initial information, this is to consider if they should undertake an investigation. We have seen a significant increase in the number of cases being investigated.

PHSO Cases Received	Enquiries	Formal Investigations
2023-2024	25	13
2024-2025	11	6

PHSO outcomes

The following are outcomes from cases that were reviewed and investigated by the PHSO. The outcome of their investigation is included for reference.

DCB CG Radiology **PHSO decision:** **Partially Upheld**	The client complained about aspects of care received within the Trust, specifically: • When the client attended the Emergency Department (ED), the Trust failed to assess his condition properly, including failing to follow the Cauda Equina Protocol and arrange an urgent MRI scan. • It took too long to arrange, report on and of the MRI scan results. • The Trust misinterpreted the results of the MRI scan and failed to adequately explain why the reported outcome was inconsistent with a previous scan. • When attending the ED, the Trust again failed to assess, perform another MRI and follow its Cauda Equina Protocol. This has caused the client significant and the client has lost faith in the Trust. The mistakes have prevented diagnosis of his back pain. The client now experiences significant back pain and reduced mobility. He believed his condition is getting worse, he is falling over daily and has a lack of feeling in his limbs. <u>OUTCOME:</u> • The PHSO feel it was reasonable for the client to be concerned about cauda equina whilst in Accident & Emergency (A&E) and the failings in the care he received caused him distress and worry. • In relation to the MRI report, the PHSO found the delay in the Trust sending the report to the client's GP and the mistakes in the report, caused further distress and frustration. • The client had to chase the Trust and wait one month for urgent MRI results. Once received, the client complained to the Trust about several mistakes in the report. The PHSO have found the Trust should have acknowledged at this stage the report was suboptimal. • The PHSO are unable to conclude the failings in the client's care caused the Trust to miss a diagnosis of cauda equina on either occasion, there is no evidence of nerve root compression, at the time. From the evidence available, there were no clinical consequences to the client from the failings the PHSO have identified in his care. <u>ACTIONS:</u>

	The PHSO recommended that a letter of apology and payment in recognition of the significant distress and frustration the service failures caused the client. The Trust is to produce an Action Plan, explaining what it will do as a result to improve the service, to ensure the failing identified will be less likely to happen in the future.
QEQM CG A&E **PHSO decision:** **Partially Upheld**	Complaint over the care and treatment the patient received between September 2020 and January 2021: • Not enough appropriate diagnostics on the loss of sensation in the patient's legs. • Incorrectly downgraded the patient's urgent rheumatology referral from their GP. • Unacceptable delays in the provision of appropriate physiotherapy treatment, following surgery. • The patient had to pay for private physiotherapy treatment in order to recover. As a result of the events, the patient suffered leg paralysis and permanent nerve damage. Patient had to learn to walk again, required six months sick leave from work and was only able to return to work, with the use of a wheelchair. They are now registered disabled. <u>OUTCOME:</u> • The PHSO found the Trust should have instigated further action, such as onward referrals, when discharging the client. • PHSO found evidence the Trust did not process the client's rheumatology referral in October 2020, in the timeframe set out in the policy. It should also have either maintained the referrals urgent status or used more an appropriate rational when downgrading the referral to routine. • The case should be shared with rheumatology staff, to be reminded of the internal processing policy, the importance of clear and robust rationales regarding any delays in processing. <u>ACTIONS:</u> The PHSO recommended that the Trust should send a letter of apology to the client, with payment. Produce an action plan to evidence the PHSO findings have been shared with the A&E clinicians and the rheumatology department.
QEQM CG A&E **PHSO decision:** **Partially Upheld**	The client considered the patient could have survived a stroke, poor care meant the patient developed aspiration pneumonia, caught Covid-19 and sadly died. This caused the client significant worry and upset and has had an ongoing emotional impact on the wider family. • Failed to give the patient food and drink • Did not refer the patient for a swallow assessment, despite their suspected stroke and problems swallowing. • Did not isolate the patient is a side room, even though they patient was extremely vulnerable to Covid-19. • The client wanted the Trust to acknowledge it's mistakes, apologise for the impact this had, make improvements and pay financial remedy. <u>OUTCOME:</u> • The PSHO can see the Trust has accepted the failing and agrees the patient should have been nil by mouth, and been referred for a swallow assessment. It has also created an action plan, which sets out how it intends to improve services. This includes training for medical and nursing staff, recirculation guidance, completing documentation audits, providing improved signage and sharing the case in

	governance meetings and literature. A new nutritional screening tool and green alert bands for patients who need swallow assessments has been developed. • The Trust did not express sincere regret or acknowledge the impact of actions. Response letters did not say sorry for mistakes and only apologises that the client was distressed by her concerns. ACTIONS: The Trust writes to the client to provide a sincere apology. The Trust needs to show it is sorry for what happened and recognise the impact of actions. The letter should confirm the actions in the plan have been completed and explain how those actions are working to prevent a recurrence of the failing.
QEQM CG Gastro - enterology **PHSO decision:** **Upheld**	The client complains that EKHUFT did not give the patient a gastroenterology care plan following their discharge from hospital in April 2022, when faecal incontinent. The client says the lack of communication and care plan from the Trust was frustrating and they had to pay for goods to manage the patient's condition. The client wanted service improvements and compensation. OUTCOME: • The PHSO were pleased the Trust had taken the complaint seriously by apologising, explaining what happened and making some service improvements to prevent the same thing from happening again. • They do not consider the Trust fully acknowledged or remedied the distress this caused the client and what she wanted to achieve. • The Trust's actions fell short of NHS guidance when it did not communicate a gastroenterology follow up care plan for the patient, when discharged. • The Trust did not fully reflect on the impact this caused the client, nor have the Trust done enough to remedy what happened. ACTIONS: The Trust should acknowledge the failings the PHSO have found in the patient's care and the distress this caused the client. Financial payment in recognition of the distress experienced due to the lack of a clear follow up plan with gastroenterology. In line with looking for continuous improvement the Trust should also develop an action plan to address the failing identified relating to the lack of a clear follow up plan.
WC&YP CG Gynaecology **PHSO decision:** **Partially Upheld**	Concerns over the care and treatment provided to the patient in 2021. The patient was discharged after three days, with no support plan in place. It was a further three weeks before a care plane was put in place. This was a very distressing experience for the client and their family, the patient's condition deteriorated without any care in place. The client would like a financial remedy for the distress he and his family had to suffer in the final weeks of the patient's life. OUTCOME: • The Trust acted within standards and guidelines by discharging the patient. • The Trust failed to provide the appropriate level of care and support after discharging the patient. This caused the client and their family further distress in the final weeks of the patient's life, which exacerbated their bereavement. • The PHSO partly upheld this complaint. ACTIONS: The PHSO has therefore recommended the Trust made a payment to the client in recognition of the impact this had on them.

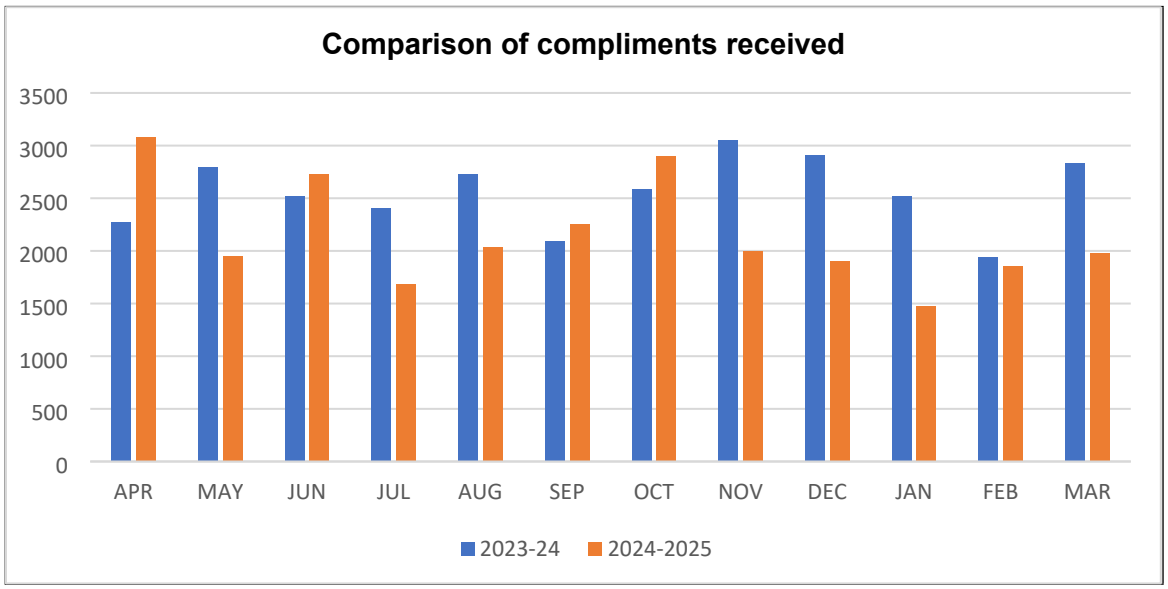
	An action/improvement plan to show how the Trust will ensure the same failings do not happen again with future patients.

Currently there are 13 cases being formally investigated by the PHSO and 10 enquiries from the PHSO are under review.

8. Compliments

Compliments are entered, in the main, by wards and services, onto the Trust's compliments database. This information is added retrospectively, it should be noted that the data reported, may be subject to change.

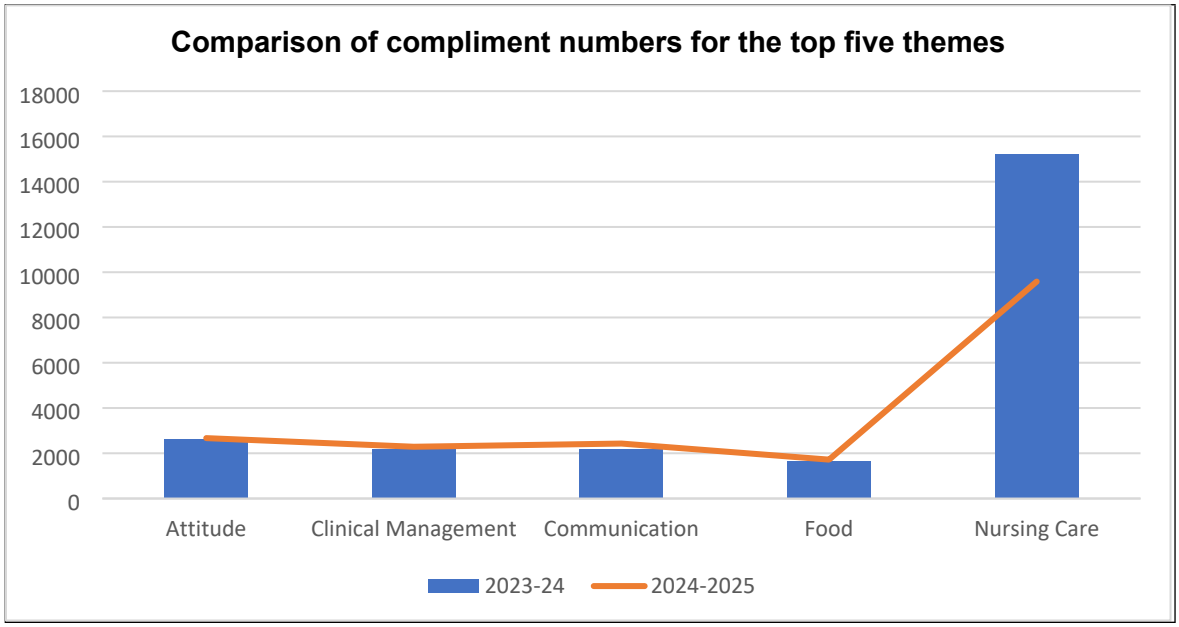
There has been a significant decrease in compliments received, 25,838 compliments in 2024-2025, compared to 30,668 in 2023-2024, a decrease of 15.7%. Notably the reduction is in the top theme, nursing care, there has been a 37% drop in complaints received.



Themes and trends

The top five themes identified from compliments during 2023-2024 and 2024-2025 are nursing care, clinical management, attitude, communication and food.

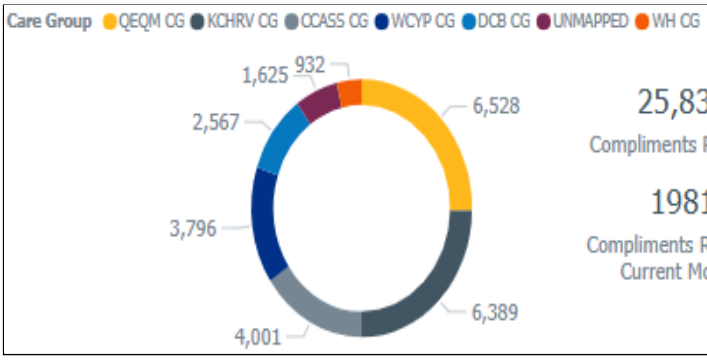
Communication also features in both complaints and PALS top five themes. Attitude and clinical management are also featured in compliments. Food is grouped into the patient experience category for PALS.



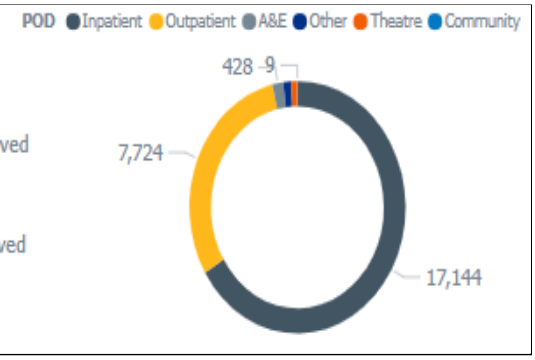
Compliments below are broken down by care group and also by place of delivery (POD). We can see that the Critical Care, Anaesthetics and Surgical Services care group (CCASS CG) received the most compliments in 2024-2025, which is consistent with 2023-2024.

The majority of the compliments for place of delivery, came from inpatient admissions; again, this is consistent with 2023-2024.

Care group compliments:



Place of delivery for compliments:



The following table shows the breakdown of the top 15 compliments received. The top 15 are the same as 2023-2024, although in a slightly different order. It is pleasing to see the majority of compliments received in both 2023-2024 and 2024-2025 relate to nursing care.

Compliment Group	Compliments Received
Nursing Care	9,587
Attitude	2,669
Communication	2,429
Clinical Management	2,288
Food	1,719
Appointment	1,014
Service Provision	978
Cleanliness	907
Discharge	899
Privacy and Dignity	790
Surgical Care	722
End of Life Care	676
Timeliness	609
Medication	346
Diversity and Equality	205

To see which areas have received the most compliments, we have identified the top ten wards:

Ward	Compliments Received
K&C OUTPATIENT	2,819
QEQM QUEX WARD	2,239
K&C INTENSIVE CARE AND HIGH DEPENDENCY UNIT	1,541
QEQM SEA BATHING WARD	1,440
K&C KINGSTON WARD	1,274
K&C EAST KENT NEURO REHAB	931
X MAID RENAL UNIT	889
QEQM DISCHARGE LOUNGE	763
QEQM FORDWICH WARD	731
WHH CRITICAL CARE	726

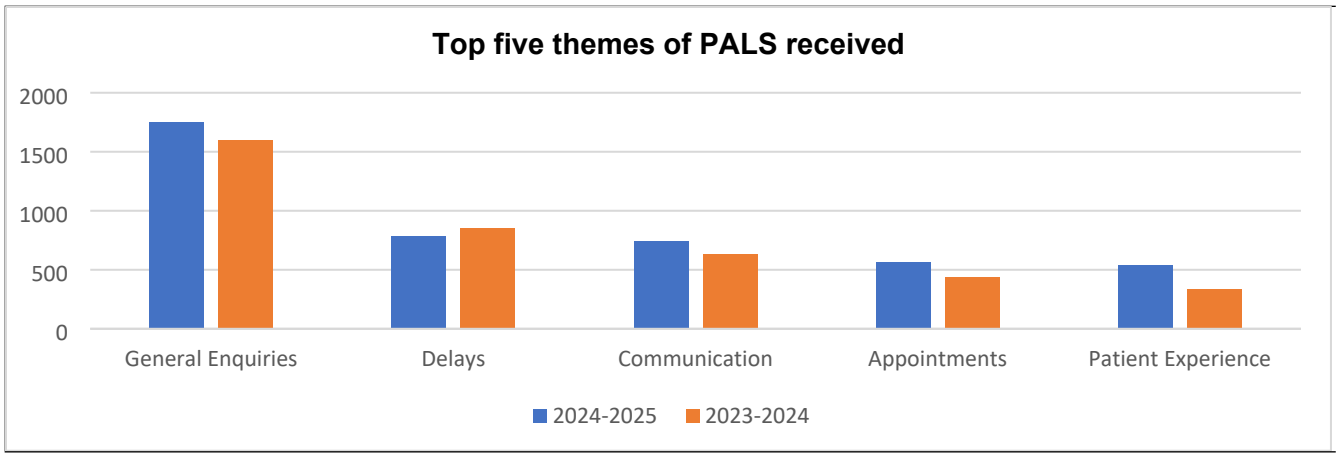
9. PALS

The top five themes for PALS, like complaints, have been stable during 2024-2025. The top five PALS themes are detailed below, with the themes broken down into the specific issues. It should be noted that PALS may have several concerns, which may relate to several themes and then sub-themes.

The complexity of PALS has, like complaints, generally increased. The team work to resolve as many issues as possible, to avoid the longer formal complaint process.

The PALS team are challenged to provide a responsive service, this has been identified as an area of improvement and focus, details are included in section 12, The future – plans for 2025-2026.

General enquiries	**1747**
Question / query asked	780
Chasing outpatient appointment	377
Chasing referral	186
Chasing elective admission	150
Chasing other results	136
Chasing radiology results	78
Equipment enquiry	17
Forms completed	10
Chasing emergency admission	6
Medical literature / information provided	6
Help for patient via volunteer / or staff	1
Delays	**784**
Delays in receiving treatment	256
Delay in referral	169
Delay in allocation of outpatient appointment	120
Delay in receiving x-ray results	100
Delay with elective admission	69
Delays in being seen in A&E	27
Delay in being see in outpatient department	15
Delay in sending / receiving copies of medical records	15
Delay with emergency admission	6
Delay in going to theatre	4
Delay in receiving hearing aid / repair or surgical fittings	3
Communication	**739**
Unable to contact department / ward	279
Doctor communication issues	184
A&C staff communication issues	70
Misleading or contradictory information given	53
Other staff communication issues	49
Other communication issues (i.e. old literature, phones not working	33
Lack of information / explanation of how procedure went	30
Nursing communication issues	26
Unhappy with info on medical records	10
Issues with interpreter service	2
Therapist communication issues	2
Hotel Services communication issues	1
Appointments	**565**
Problems with department appointment	353
Problems with outpatient appointments	82
Change of appointment date	68
Problems with administration	62
Patient Experience	**542**
Signposting	383
Raise complaint / comment	118
Shoulder to cry on / talk through issues / comfort and support	21


Top five themes of PALS received
2000
1500
1000
500
0
General Enquiries
Delays
Communication
Appointments
Patient Experience
2024-2025
2023-2024

	access team. The Phlebotomist had omitted to sign the blood sample, so it was rejected. The patient's experience was shared with the Phlebotomist, and the team for learning, in the team meeting and huddle.
DCB, Radiology,	The patient arrived very shortly after their appointment time. Advised by the receptionist and Radiographer they should have arrived 20 minutes before the appointment time, to complete necessary paperwork. The patient advised they only received an email with the appointment time and felt very rushed as a result. The patient felt the Radiographer lacked compassion. The patient accessed the appointment information via the patient portal; all portal messages are sent out with links for patients to read, including an MRI safety questionnaire across the Trust and includes about arriving 20 minutes early to MRI scans – this can only be accessed once by the patient. A staff member has been asked to review the portal page and see if it can be updated to make it more accessible.
	A patient advised they had regular scans every three months. By their next appointment, the scan had not been reported on, this was not the first time. The Radiology Governance, Patient Safety and Quality Manager contacted the patient and apologised A discussion will also be held around escalation of patients for reporting on the purple pathway.
QEQMCG, HCOOP, Bishopstone Ward	A patient was unhappy with the lack of communication about results on the ward. Patient was unable to get to a commode and was left in her own urine, due to the buzzer not being responded to quickly enough. The Ward Sister spoke to the patient and apologised. The Ward Sister advised the safety brief will include to check incontinent patients and answer/ acknowledge the buzzer as quickly as possible. Concerns shared with the ward team.
QEQMCG, Birchington ward	The mother of a patient was concerned that antibiotics were put into her daughter's PEG, known to block PEGs. Subsequently advised the PEG needs replacing, which cannot be done for another four days. The ward manager contacted the patient's mother and explained the nutrition team were contacted to gauge the national guidelines for 1st and 2nd safe administration of anti-biotics. The 2nd line antibiotics given via the PEG (Suspension Clarithromycin) are known to be viscous and block up the peg when not diluted, with the same concentration of water as the medication. The prescription was generated from EPMA did not state this. The ward manager offered apologies and raised this with Pharmacy. Pharmacy discussed with the clinicians. to share awareness when prescribing this antibiotic via a PEG.
QEQMCG, ED	A relative was concerned with the care and treatment for a child attending the ED. The child was issued with a yellow fast-tracked card, by the other Trust; to be seen and isolated as quickly as possible. The young patient was in a side room in the ED for 40 hours, before a bed was located. The relative was concerned for staff, coping with up to 12 patients. The Deputy Head of Nursing (DHON) for the ED contacted the family and apologised for the child's experience. The DHON has spoken to the staff concerned and reminded them about ensuring patients with fast track cards are treated urgently.
	A patient felt there was a lack of awareness by staff in communicating with nonbinary patients, in particular staff not being fully aware of appropriately referring to transgender and nonbinary people. The Interim Associate Director of Nursing for UEAC contacted the patient and offered their apologies. The following actions were taken: • The patient's experience shared with the staff to increase awareness. • Issue raised with the LGBTQIA+ Network to seek their support.

	• The LGBTQIA+ Network providing training during team days ,to ensure staff are better equipped to communicate respectfully and inclusively.
WCYP, Gynaecology & ED	A patient attended an urgent appointment at gynaecology assessment. She felt rushed and there was a lack of information given. She then attended the ED with bleeding. The patient felt she was given conflicting information by midwives, nurses and doctors. She attended for a scan and was surrounded by pregnant women. The Deputy Matron for Gynaecology contacted the patient and discussed her concerns – sincere apologies were given. This has been shared with the staff involved.
WCYP, Gynaecology	A patient advised she has waited 11 months for a Gynaecology outpatient appointment, for an issue that has been going on for 1.5 years. Gynae are actively working on putting on extra clinics where possible on a weekly basis, so it is likely the appointment will be brought forward at some point. There is a 39 week wait.
WCYP, Obstetrics	A patient attended maternity triage at WHH, for reduced foetal movements. The patient was advised a monitor would be attached to track the baby, CTG monitoring wouldn't be used as mum was 27+6 weeks and she needed to be 28 weeks. The patient's husband was frustrated at the conflicting information and raised his concern. He felt the midwife was rude to them and not interested as a result. The Maternity Triage Manager contacted the patient and husband, she explained that it was not an unreasonable request to perform a CTG at 27+6wks, this gestation is used as a guideline for being able to accurately auscultate the foetal heart without loss of contact. It should take into consideration the maternal BMI, size of baby etc. The Manager agreed to discuss their experience with the midwife concerned and remind her of the Trust values, NMC code of conduct and to complete a BSOTS training before returning to triage.
WCYP Paediatrics	Concerns were raised about the air conditioning in Children's Assessment Unit. Engineers will review the heating system. In the interim, it was considered having the fridge close to a heating element may have been affecting the temperature, the fridge was moved.
WHHCG, SEAU	A client raised concerns about the care their partner received in SEAU, including lack of pain medication and water, despite asking several times. The Matron offered reassurances that is not acceptable to have waited for water and pain medication. The Matron is identifying the agency nurses on the unit that night and feedback regarding their lack of care.
WHH CG ED	More comfortable chairs have been ordered for high risk patients or those who have a longer length of stay.
	Patient attended the ED and felt staff were using he/him pronouns and made inappropriate remarks regarding their gender. The ED Service Manager and General Manager met with the patient and their parent. Apologies were offered and the Matron discussed with the staff involved for learning purposes.
WHHCG, Respiratory Medicine	A patient arrived for a clinic appointment, booked in and was directed to a clinic. The clinic was empty and a staff member advised the appointment had been cancelled due to the consultant being poorly. The patient returned to the front desk, who advised the clinic wasn't cancelled on the system. The patient was later contacted by the medical secretary who advised they had tried to contact the patient to cancel the appointment, they had no missed calls or messages. The Senior Operations Manager contacted the patient and apologised for the confusion around the cancelled appointment ad reassured the patient that this had been discussed with the medical secretaries, to ensure clinics are cancelled on the system and must contact patients to advise them.

10. Risks for the Complaints and PALS services: 2025-2026

The identified risks to services, which should be highlighted are:

- PALS offices across sites are not visible to the public and all sites do not have meeting areas for people wanting to use the PALS service.
- PALS and Complaint numbers are high and complexity impacts on the responsiveness in being able to investigate and provide a quality response within agreed timescales.
- Resource in Bereavement Services, particularly during the winter months, continues to be a concern. The service is supported by PALS during periods of pressure.
- Resource in PALS is a concern. There are not sufficient staffing numbers, for the service to be resilient when there is sickness or annual leave within the team. The team are constantly struggling to be responsive and cover all the sites, and as a result the team are unable to work within the process timescales detailed in the PALS policy.
- The PALS team database is Datix Client, which is no longer supported by Datix. A new database for complaints and PALS, InPhase, has been purchased, the build and configuration will mean the new system will be rolled out in 2026. This will require considerable work to be able to design, agree with the InPhase and test.
- Lost property has also been recently included to the PALS portfolio, this will impact on the PALS service.

11. Achievements for Complaints and PALS

2024-2025 has overall been a year of change and settling for the Complaints team. The PALS and Bereavement teams have seen a turnover of staff, due to career advancement, within the Trust or retirement. In light of the changes, resource levels, the performance of the team and their resilience to cope with the volume of work, should be commended.

- Nine staff (8.34 Whole Time Equivalent (WTE)) were centralised into the complaints team, from the care group governance teams, with a new team structure and job descriptions.
- The complaints process was redesigned and been mapped, all complaints are managed and coordinated by one case manager from start to finish, to ensure a better complainant experience, along with planned improvements for response quality and timeliness.
- Training for the complaints team, starting at point zero, to ensure confidence and improve knowledge and skills across the team – twice weekly, one-hour sessions implemented, including the PALS team.
- An escalation process has been implemented to ensure that care groups are aware of timescales for responding, along with providing a framework for requesting more senior input, when this response is not provided.
- All complaints are reviewed by a clinical, nursing and an operational lead, a member of staff not directly involved in the care of the patient.
- Twelve months the KPI for acknowledging complaints in three working days has been exceeded.
- The trajectory for complaint responses within agreed timescales was set in September 2024. The trajectory was consistently met and the complaints team continue to meet the monthly KPI.
- The PALS team, on average, have resolved and closed over 59% of PALS within ten working days.
- The PALS team, on average, have answered 51% of calls live.
- Training on complaints and PALS has been carried out for various staffing groups.
- PHSO NHS Complaint Standards were introduced in Spring 2024. Expectations from the Ombudsman are to align all NHS providers to deliver the same service, enabling a better

experience for the complainant and better learning from Trusts. We have improved our process to be more closely aligned with the standards.
- The Bereavement team have worked with the medical examiners team to implement the changes in relation to the legal introduction of medical examiners and reforms to death certification in September 2024.
- Twelve months the target for completion of death certification has been met or exceeded by the Bereavement Team.

12. The future – plans for 2025-2026

We are keen to ensure the level of review and self-reflection continues for our services. For the coming year we have identified further actions and improvements we can make, to ensure a responsive and sustainable service is available to patient and families, who might need our assistance. Some of the reviews and improvements include:

- To continue to work on improving our performance, to achieve the timescales agreed, when responding to complaints and PALS.
- To work with care groups to better capture outcomes and learning from complaints and PALS and to be part of the sustainable improvements.
- Working jointly with our Quality Directorate services, to promote learning from complaints and PALS.
- To continue the close working with the Patient Safety team to ensure the Patient Safety Incident Response Framework (PSIRF) is fully considered during the complaints and PALS process. To creates opportunities for improved triangulation between the patient safety incidents and complaints, along with learning and improvements.
- To implement the InPhase system and to ensure the robust systems of collating data, along with providing accurate and informative reports for complaints and PALS for the Trust.
- During the build of InPhase to review the work of returned complaints, capturing the reasons, themes/trends, to help focus on services/staff, who may need further support/development.
- To actively support sites to be able to have a PALS office in a visible and accessible location for our patients and their families. There is a project looking at improving the entrance way for St Peter's Road, QEQM, to involve a meeting POD for PALS, this has been funded by the EKHUFT charity.
- To work with the volunteer service to boost the PALS experience, provide more accessibility and the visibility of a presence in our hospitals.
- Actively work on the education of the teams to ensure and promote inclusivity.
- To continue working with the Patient Voice team, ensuring full accessibility for the public to make a complaint, compliment or PALS. This includes all of the information provided on the Trust's web pages for this service, written complaint responses and any interaction with users of the service.
- To continue to work on the quality of written responses from PALS and the complaints team, to ensure they meet the needs of the recipient.
- To review the PALS and complaint processes, to ensure it meets the needs of clients, PHSO standards and Care Quality Commission (CQC) Key Lines of Enquiry (KLOEs).
- To identify any service efficiencies, across the three teams.
- To meet, agree and monitor complaint and PALS progress with services within each care group, to eliminate barriers for responding to PALS and complaints within timescales and support care group colleagues.
- Benchmarking of the PALS team for a comparison of trusts within the region, to establish if the team is banded appropriately and sufficiently staffed to meet the needs of service.
- The services to update and align process/SOPs with best practice, PHSO and incorporate PSIRF methodology.

- To provide regular training to the Bereavement Services teams, online and twice a year face to face.

Abbreviations:

Care groups:
Corporate (Corp)
Diagnostics, Cancer and Buckland Hospital (DCB CG)
Critical Care, Anaesthetics and Surgical Services (CCASS CG)
Kent and Canterbury Hospital and Royal Victoria Hospital (KCH&RV CG)
Queen Elizabeth the Queen Mother Hospital (QEQM CG)
Women's, Children and Young People's Health (WCYPH CG)
William Harvey Hospital (WHH CG)

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report Title: **Guardian of Safe Working (GoSW) Quarterly Report Quarter 2 (Q2): 1 April 2025 - 30 June 2025 (three months)**

Meeting Date: **31 July 2025**

Board Sponsor: **Des Holden, Chief Medical Officer (CMO)**

Paper Author: **Miss Elizabeth Sharp, 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 Terms and Conditions of Service 2016 (TCS).
Summary of key issues:	• Work to establish vacancy rates is ongoing. • Continue to promote exception reporting for all grades of resident doctors, including for loss of education and training. • A three-month pilot project at Queen Elizabeth the Queen Mother Hospital (QEQM) took place to enable Local Education Doctors (LEDs) to participate in exception reporting. The uptake was low and the CMO and GoSW to hold a listening event for the LEDs at QEQM to understand why they did not participate. • Action was taken to increase the attendance of resident doctors to attend the Resident Doctors Forum (RDF), this resulted in some resident doctors attending the June meeting of the RDF. • In September 2024 the resident doctors, via the British Medical Association (BMA), accepted the Government pay deal. The agreement includes changes to exception reporting and role of the GoSW. Currently NHS Employers and the BMA Resident Doctors Committee were negotiating what these changes will be. The BMA Resident Doctors Committee balloted the resident doctors in England following the Review Body on Doctors' and Dentists' Remuneration (DDRB) recommendation for an average pay rise of 5.4%. The resident doctors voted for further industrial action and a strike is planned from 25 to 30 July. • The changes planned for exception reporting have not yet been agreed and the contract changed, so implementation on 12 September is likely to be delayed. • The GoSW and Medical Workforce Rota Manager have implemented prospective cover leave entitlement for all rotas from January 2025. A review of rotas worked between February 2020 and December 2024 with prospective cover is planned. • 1 x GoSW post vacant, exploring expressions of interest.

Key recommendations:	The BoD is asked to **NOTE** this GoSW quarterly report and improving the working lives of resident doctors with good rostering practices.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Trust Risk Register:	No
Resource:	N/A
Legal and regulatory:	N/A
Subsidiary:	N/A

Assurance route:

Previously considered by: N/A

East Kent Hospitals University NHS Foundation Trust

GUARDIAN OF SAFE WORKING (GOSW) QUARTERLY REPORT
Q2: 01 April 2025 - 30 June 2025 (3-months)

1. Introduction

As per the Terms and Conditions of Service for NHS Doctors and Dentists in Training 2016 (TCS), 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 Education that doctors are safely rostered and are working hours that are safe and in compliance with the TCS.

As part of the Terms and Conditions of Service for NHS Doctors and Dentists in Training 2016, 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 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: 13/09/2024** - Foundation Year 1 (FY1's) = 65 - FY2's = 64 - Other Resident Doctors (CT1 / ST1 to ST8) = 250 Locally Employed Doctors: - Trust FY1's = 4 - Trust FY2's = 14 - Other Trust Doctors = 143 **Validated: 13/12/2024** - FY1's = 64 - FY2's = 65 - Other Resident Doctors (CT1 / ST1 to ST8) = 249 Locally Employed Doctors: - Trust FY1's = 4 - Trust FY2's = 14 - Other Trust Doctors = 161 **Validate 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 **Awaiting Data: 30/06/2025**

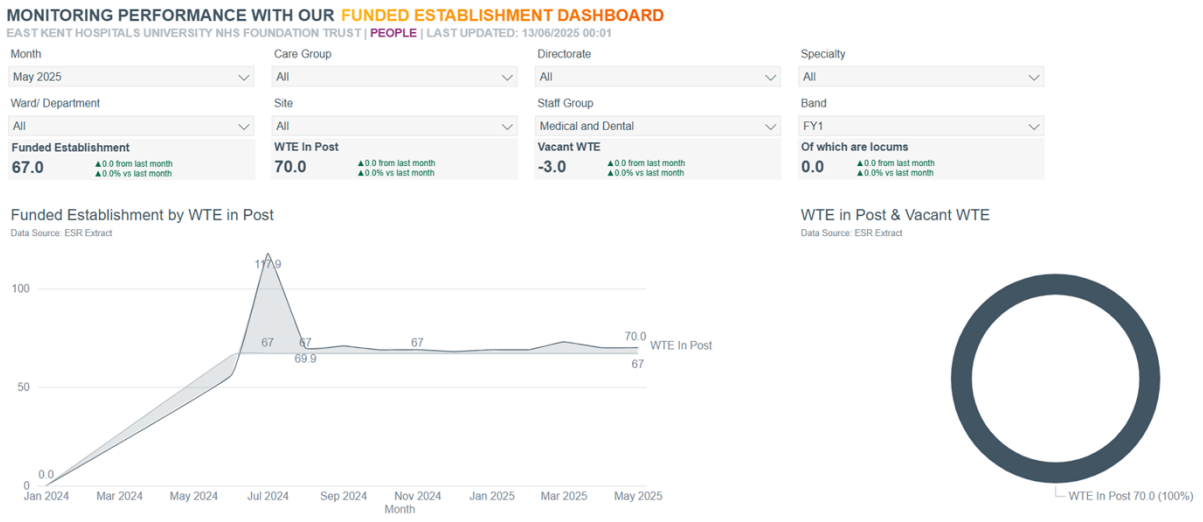
East Kent Hospitals University NHS Foundation Trust

Amount of time available in job plan for guardian to do their role:	2 Programmed Activities (PA's) for GoSW (8 hours per week) Two GoSW - one PA each. One post vacant and currently exploring expressions of interest.
Admin support provided to the guardian (if any):	0.50 Whole Time Equivalent (WTE)
Amount of job-planned time for educational supervisors:	0.25 PA's (1 hour per week, per trainee)

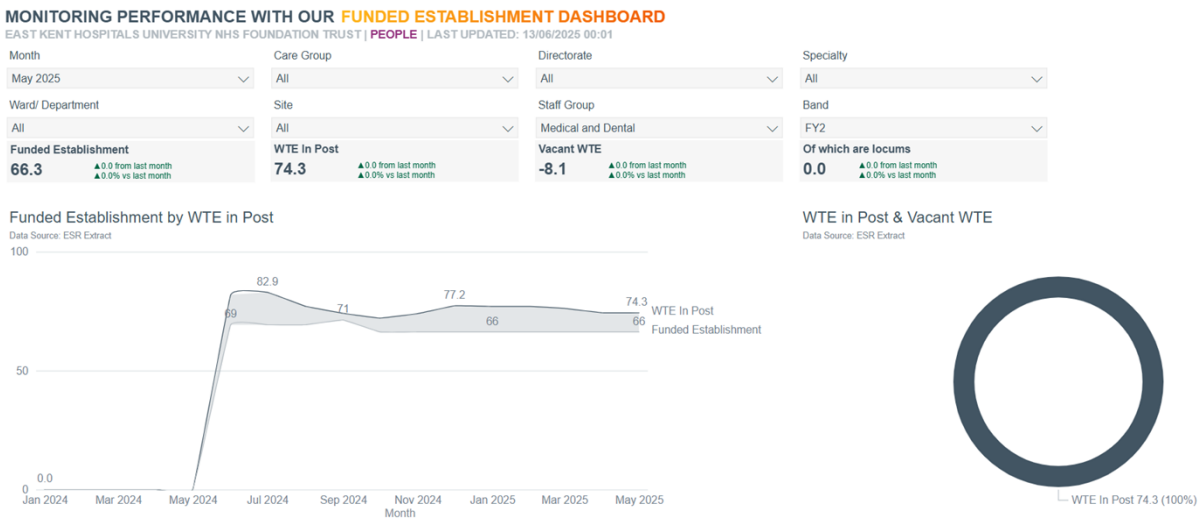
Q2 - Data Summary

Please note that the following information has been obtained form the EKHUFT Funded Establishment Dashboard. This data is maintained by Medical Resourcing and HR Systems and has not been subject to independent scrutiny by our team.

Establishment & Rota Gaps - FY1 Level (Resident and Locally Employed Doctors)



Establishment & Rota Gaps - FY2 Level (Resident and Locally Employed Doctors)



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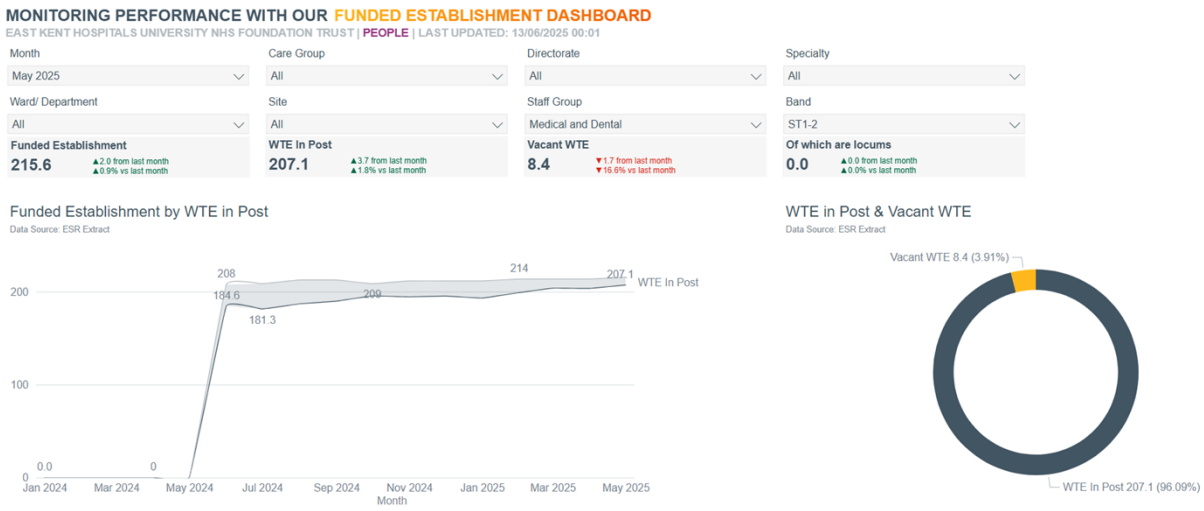
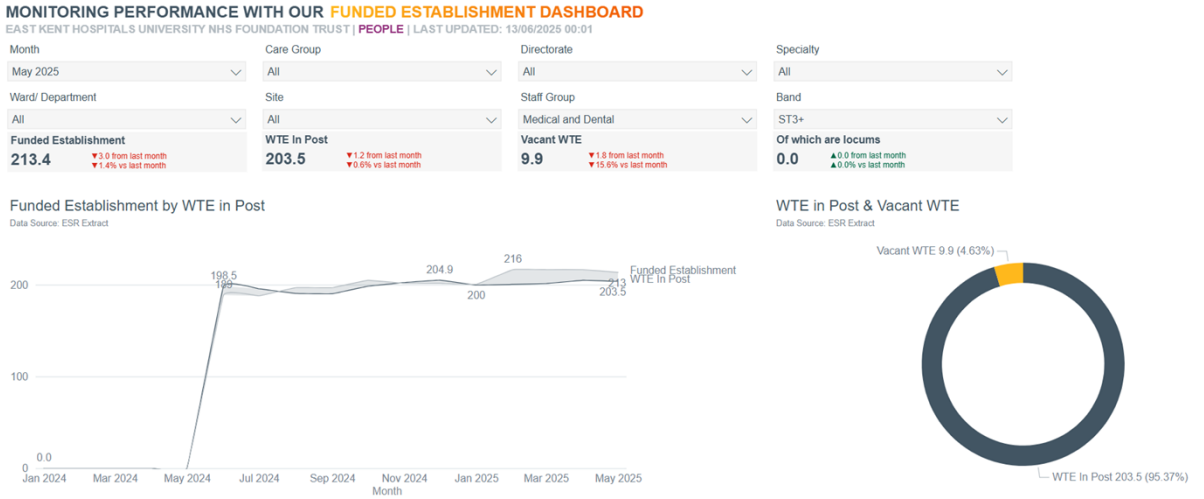
Establishment & Rota Gaps - CT1-2/ST1-2 Level (Resident and Locally Employed Doctors)



Establishment & Rota Gaps - ST3-8 Level (Resident and Locally Employed Doctors)



3. Exception Reporting Analysis (Period: 01-Apr-25 to 30-Jun-25)

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

Note: Q2 has seen a notable decrease in exception reporting for hours and rest and missed breaks, this is disappointing but is likely due to the foundation doctors completing their final rotation of their training year. The GoSW and the Medical Workforce Rota Manager will continue 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, but rarely submit an exception report just for missed breaks and the low numbers reflect the overall reduction in exception reporting this quarter. The high volume of patients with complex medical conditions presenting to our hospital continues. 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
Acute/Emergency Medicine	3	13		
Anaesthetics	5	6		
General Internal Medicine	68	8		
Obstetrics & Gynaecology	12	10		
Paediatrics (including Neo-natal)	8	4		
Surgery (General & Upper)	47	38		
Others (i.e. GP, Hospice)	0	2		

Note: In Q2 the increase in exception reporting in Acute and Emergency Medicine has continued, reflecting the acuity and number of patients attending the acute services.

In General Internal Medicine, the number of exception reports has fallen this quarter and may reflect the work undertaken by the care groups and medical education to improve the working lives of resident doctors or may be transient and increase next quarter. It remains unclear whether these reports relate specifically to specialty work or to on-call duties, making detailed analysis challenging.

In Q2 the overall number of exception reports submitted by the surgical specialities remains high. Further analysis of the number of exception reports submitted for General Surgery at QEQM has fallen, reflecting the work by the surgical tutor. Ophthalmology doctors have submitted a number of exception reports due to clinic overruns, the department is working to resolve this issue.

Q2 has seen the very high number of exception reports from Vascular and Urology services at Kent & Canterbury Hospital (K&C) from the Foundation doctors, which reflects our understanding of the issues of high intensity workload with complex high acuity patients.

Exception Reports by Grade	Total Q1	Total Q2	Total Q3	Total Q4
FY1	84	31		
FY2	36	28		
Core Trainees 1-2 (CT1-2) / Specialty Trainees 1-2 (ST1-2)	13	8		
CT3 / ST3-5	7	4		
ST6-8	0	0		
GP Specialty Training 1+ (GPST1+)	3	9		
IMT1+	0	1		

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		
William Harvey Hospital (WHH)	60	27		
K&C	40	18		
Other (i.e. GP, Hospice)	0	2		

Note: We have observed an increase in the number of exception reports at K&C, primarily driven by a high volume of submissions from resident doctors within the Vascular and Urology services.

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	6	6	1	0
Anaesthetics	0	6	0	0
General Internal Medicine	3	4	1	0
Obstetrics & Gynaecology	5	5	0	0
Paediatrics (including Neo-natal)	0	3	1	0
Surgery (General & Upper)	8	24	6	0
Others (i.e. GP, Hospice)	1	1	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 Terms and Conditions 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 Rota 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 Agreed	Total Q1	Total Q2	Total Q3	Total Q4
Not agreed	3	1		
Time off in lieu (TOIL)	84	44		
Additional Pay	36	23		
No effect on time or pay / No effect	20	13		
Awaiting Response	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.

TOIL remains the preferred option among resident doctors for compensating additional hours, as it is actively encouraged by the GoSW. This approach promotes

doctors' health and well-being while offering greater flexibility in managing their time off.

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

None to report.

6. Positives / Good Practice

Resident Doctor Forum (RDF) Collaboration

Back in March 2025, we held our Quarterly Resident Doctor Forum (RDF), which unfortunately saw lower than expected attendance. During the forum, those present shared valuable feedback and proposed a number of ideas to help improve engagement moving forward.

One suggestion was to align the RDF with the Doctors' Voice Group (DVG) meetings, given the consistently high levels of engagement these sessions attract. This proposal was subsequently shared with the DVG and received strong support. We believe that aligning these two events presents a great opportunity to maximise the reach and impact of both forums and ensure we are engaging effectively with the right audience.

The RDF took place on Tuesday 24 June from 1:00 pm to 2:00 pm at WHH, Seminar Room, before the DVG meeting at 2:00 pm. with the option to attend virtually as well. Eleven resident doctors attended, for the majority it was their first attendance and they provided positive feedback on their rotations. The resident doctor BMA representative raised a number of issues for discussion.

Exception Reporting for Locally Employed Doctors (LEDs)

Following approval from the CMO, a pilot project has been launched to introduce exception reporting for LEDs. The pilot is currently being implemented at QEQM across all specialties.

The primary aim of this initiative is to monitor the impact and operational feasibility of extending exception reporting to all LEDs within the Trust. The project will also explore potential mechanisms for recognising additional hours worked, including the provision of TOIL or financial remuneration. This forms part of a wider strategy to improve the working environment and overall experience for LEDs.

During the three month trial (March 2025, April 2025 and May 2025), three data submissions have been received from only one specialty - Women's Health. We are keen to understand why so few LED reported working beyond their contracted hours and the CMO and GoSW are planning a Listening Event for the LEDs at QEQM.

7. Areas for highlight

Prospective Cover

The purpose of prospective cover is to ensure that there is always a doctor available to meet the needs of the service. This is achieved by proactively planning the rota in advance and arranging coverage for periods when a doctor may be unavailable, such as during planned leave or for shifts that require additional staffing.

As part of this process, the generic rota system should have accounted for an additional leave entitlement of 15 days for FY2 doctors, and 30 days for those at higher grades. Unfortunately, this additional leave entitlement was not initially included, necessitating a review of generic rotas dating back to February 2020 to determine if additional compensation is due for the affected doctors.

To address this, the GoSW and the Medical Workforce Rota Manager selected a sample of doctors across different grades. They then reviewed the rotas worked between February 2020 and December 2024, incorporating the additional leave entitlement, which allowed for the calculation of any outstanding payments to those doctors.

Subsequently, the Head of Medical Workforce has requested a comprehensive review across all grades, which is currently in progress. Once the findings have been thoroughly analysed, a decision will be made regarding the appropriate compensation for the affected doctors. This work is yet to start.

The GoSW and Medical Workforce Rota Manager have implemented prospective cover leave entitlement for all rotas from January 2025.

Urology & Vascular Work Environment

There have been ongoing concerns regarding the intensity of work and the training environment for Foundation Doctors within both the Urology and Vascular specialties. 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 and Urology services across EKHUFT. Nevertheless, it is recognised that the current number of doctors at this level is insufficient to safely manage the workload and patient acuity.

Q2 has seen increasing numbers of exception reports from the foundation doctors working in Urology and Vascular. The reports highlight working over there scheduled hours, missing breaks and loss of education. These reports triangulate with the feedback to the medical education team. Increasing the numbers of foundation level doctors in the department is part of the solution, but both clinical and educational supervision of these doctors is also essential.

Resident Doctors

In September 2024 the Resident Doctors, via the BMA, accepted the Government pay deal. The agreement includes changes to exception reporting and role of the GoSW. Currently NHS Employers and the BMA Resident Doctors Committee were negotiating what these changes would be.

Exception Reporting Reform for Resident Doctors

On 31 March 2025 a framework agreement was published outlining plans for exception reporting reform for resident doctors in England.

The British Medical Association Resident Doctors Committee (BMA RDC) has announced it has accepted the framework agreement for exception reporting. The acceptance of the framework agreement has formally ended the BMA RDC's current dispute with the government and the document has been ratified by Department of Health and Social Care (DHSC) Ministers.

The framework agreement is a document outlining the upcoming exception reporting reforms for the 2016 Terms and Conditions of Service (TCS) in England. The content of the framework agreement was based on the key principles agreed between the BMA RDF and NHS Employers, outlined below.

Key points of the deal include:

- All educational exception reports will go to the Directors of Medical Education (DME) for approval.
- All other exception reports to go to HR or medical workforce HR for approval.
- The GoSW will retain oversight of all exception reports.
- A three-tier system will be used to determine if hours were indeed worked.
- Doctors will have their choice of TOIL or pay - except when a breach of safe working hours mandates the award of TOIL.
- Additional fines: fines will be introduced to ensure that doctors have timely access to systems and are not prevented from exception reporting. Employers will face additional fines to ensure that doctors are not adversely affected by the unnecessary sharing of exception reporting information.

NHS Employers and the BMA RDC will be agreeing the necessary changes to the 2016 TCS contract, amending existing resources and producing new guidance to help employers apply the reforms.

12 September 2025, was the implementation date for employers to have in place the agreed reforms.

The BMA Resident Doctors Committee balloted the resident doctors in England following the DDRB recommendation for an average pay rise of 5.4%. The resident doctors voted for further industrial action and a strike is planned from 25 to 30 July.

The changes planned for exception reporting have not yet been agreed and the Contract changed, so implementation on 12 September is likely to be delayed.

East Kent Hospitals University NHS Foundation Trust

BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)

Committee:	**Quality and Safety Committee (Q&SC)**
Meeting date:	**20 May 2025**
Chair:	**Dr Andrew Catto, Non-Executive Director (NED)**
Paper Author:	**Executive Assistant & Q&SC Chair**
Quorate:	**Yes**

Appendices:

None

Declarations of interest made:

None

East Kent Hospitals University NHS Foundation Trust

Assurances received at the Committee meeting - focus on learning and improvement:

Agenda item	Summary

KENT AND MEDWAY PATHOLOGY NETWORK (KMPN) JOINT VENTURE CASE FOR CHANGE	The Committee received the report and **NOTED** the following updates.
	
	• It had been recognised nationally that establishing pathology networks offered benefits, both economically and for the sustainability of services.
	• The joint venture had a 3-stage approach.
	  ○ **Phase 1**: to establish a single governance and oversight structure for pathology services that replaces the existing separate Trust oversight processes. This would include forming a new joint committee for pathology services, which would become a formal subcommittee of the four Trust boards with an executive and non-executive representative from each organisation.
	  ○ **Phase 2:** to support a revised KMPN management structure from October 2025 to ensure the delivery of current projects, including appointing a new Head of Quality, Risk and Governance, and enabling current pathology managers to report directly into the joint oversight arrangements with line management from the KMPN managing director.
	  ○ **Phase 3:** to commit to working towards a fully consolidated joint venture with a host employer for pathology staff and a fully integrated management structure with speciality leadership for Kent and Medway.
	• £15.5 million has been invested in the development of the network so far, with the potential for greater efficiencies over the next five years. The £28 million savings target by 2030 could be reached by implementing single-managed equipment and consolidating services on one or a limited number of sites.
	• The Committee supported progressing to phase 1 and continuing work towards stages 2 and 3. The creation of the Joint Committee would require approval from the Trust Board, and the Committee agreed to reaffirm its support.

East Kent Hospitals University NHS Foundation Trust

QUALITY GOVERNANCE REPORT (PATIENT EXPERIENCE, INQUESTS, CLAIMS, INCIDENTS AND CENTRAL ALERTING SYSTEM (CAS))	The Committee received the report and **NOTED** the following updates. • There was an increase in maternal deaths during the last reporting period. However, no themes or trends had been identified across the deaths, and most of the deaths were not related to the patient's maternity care. An independent cluster review of the deaths has now been arranged. • There has been a decline in the number of overdue incidents. Additional support has been provided to the Women, Children, and Young People Care Group, and progress has been made. • Duty of Candour remained at 100% compliance. • Complaints performance continued to meet the Key Performance Indicator (KPI) of 85%. • Losses and compensation have now been transferred from the Legal team to the Patient Advice and Liaison Service (PALS) Team. • The implementation of Inphase has been delayed. • It was agreed that there should be a clear trajectory for the closure of overdue patient safety alerts.
QUARTERLY MENTAL HEALTH UPDATE	The Committee received and **NOTED** the following updates. • The Associate Director of Nursing for Mental Health started their role in November 2024. The Learning Disability & Autism (LD+A) Liaison Nurses and the Dementia Team are now members of the Mental Health team. • The Aggression and Violence survey for staff has been live since December 2024. • De-escalation and restraint training are being organised for the priority cohort of Trust staff. A longer-term training program is to be developed. • The body camera pilot at Queen Elizabeth the Queen Mother Hospital (QEQM) Emergency Department (ED) began on 24 December and continued until the end of April 2025; the analysis of staff experiences and incidents was scheduled to follow. • The Supporting Positive Behaviours Group was overseeing the work. • A significant concern was the administration of the Mental Health Act, and a new training program was underway.

East Kent Hospitals University NHS Foundation Trust

PROFESSIONAL STANDARDS UPDATE	The Committee **NOTED** the following updates. • The Information Teams were looking to analyse the data, request a specialist review in the ED, and track the time between the request and the review taking place, as well as the ward reviews by consultants. • There are currently issues with Sunrise preventing data from being tracked for the speciality reviews in the ED. • A Task and Finish Group was being set up to address the current issues concerning how existing systems connect.
MONTHLY SIGNIFICANT RISK REGISTER REPORT	The Committee received the report and **NOTED** the following updates. • There were 19 quality risks on the Significant Risk Register, which is an increase of four since the last report in March. • 12 of the risks currently had overdue actions; it was advised that the work had been carried out, but there had been delays in updating the system. • One risk associated with staff attending resuscitation training has been de-escalated.
CARE QUALITY COMMISSION (CQC) UPDATE REPORT	The Committee received the report and **NOTED** the following updates. • In their most recent inspection, the CQC rated our maternity services as good in all areas, apart from the element related to our estate, which was rated as requiring improvement. • The Trust had applied to have the Section 31 Enforcement Notice lifted and was currently awaiting feedback from the CQC. • The Trust was still awaiting the CQC Spencer Inspection report. • Round two of the Care Group check and challenge sessions has been completed and is being incorporated into the ward accreditation process. • The CQC Inphase module has been acquired to improve monitoring efficiency. • There are currently five should and must-do actions which remain outstanding. • A joint letter had been sent by the Chief Medical Officer and Chief People Officer to clinicians regarding their completion of statutory and mandatory training. • The Allied Health Professionals (AHP) workforce review has been completed and was scheduled to be presented to the Trust Management Group for their review. • The Pharmacy Business case is currently being progressed. • The Trust recently received the results of the Children's and Young People survey; in some areas, we showed improvements, while in others, performance declined. An action plan was developed and is being monitored by the Patient Experience Committee.

East Kent Hospitals University NHS Foundation Trust

REGULATORY COMPLIANCE GROUP CHAIR'S REPORT	The Committee received the report and **NOTED** it.
INFECTION PREVENTION AND CONTROL (IPC) REPORT	The Committee received the report and **NOTED** the following updates. • Attributable Clostridioides difficile infections remained below the annual threshold for the year at 105, compared to a threshold of 145 (a 25% reduction from 23/24). However, both Klebsiella and Pseudomonas exceeded the threshold, prompting significant attention to environmental factors influencing these. • Two Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemias were reported during the reporting period, marking a 75% reduction from 2023/24. Both cases were reviewed for good practice and learning following Patient Safety Incident Response Framework (PSIRF) methodology. • MRSA infections have risen compared to the 2023/24 data, and a continuous review for potential new insights from recent cases will be conducted. • Enhanced surveillance of mandatory surgical site infections continued to identify cases effectively, and maternity was now being incorporated into the programme. A steering group was established to oversee and monitor the actions and changes needed to reduce incidents. • There have been several respiratory viral outbreaks mainly affecting individual bays, including a notable Norovirus outbreak at William Harvey Hospital (WHH) and QEQM Hospital.
QUALITY ACCOUNT	The Committee received the report and **NOTED** the following key update. It was confirmed that the timetable for completion was on schedule, and the Committee was informed that a document summary and an easy-read version were being prepared.
PAEDIATRIC AUDIOLOGY IMPROVEMENT UPDATE	The Committee received the report and **NOTED** the following updates. • The scheduled NHS England (NHSE)/Integrated Care Board (ICB) visit took place on 12-13 February 2025. It was part of a national review of audiology services. • East Kent Children's Hearing Service (EKCHS) and Acute Adult Audiology Service were assessed as low assurance, with significant concerns identified in key areas needing urgent action. The following four immediate actions have been identified for swift implementation: ○ All children who were fitted with hearing aids by the adult acute service must be reviewed, and those without objective verification need to be recalled. This should be carried out by trained paediatric audiologists rather than in the adult service.

East Kent Hospitals University NHS Foundation Trust

	The children have now been reviewed, and their parents or guardians have received Duty of Candour letters. ○ All new patients requiring hearing aid fitting who would previously have been seen by the adult service must, with immediate effect, be seen by a trained paediatric audiologist. The adult service is no longer responsible for any paediatric hearing aid fittings. This change has now been implemented. ○ East Kent Children's Hearing Service must review all children with incomplete assessments and organise for them to be seen again. The nine children who had incomplete assessments have now been reviewed and were seen by the end of April 2025. ○ An ENT clinic supported in Kingsnorth where paediatric patients were tested in non-soundproof booths. The service at Kingsnorth has now been discontinued. • The team was participating in an ICB national process and has now attended a bimonthly meeting. • The team was working hard to recruit more staff to support the service change, and efforts were ongoing with Emeritus, an organisation that collaborates with senior retired NHS staff who still want to contribute to the NHS. • The issues were identified and discussed during the Care Group Performance Review Meeting.
LEGAL SERVICES UPDATE	The Committee received the report and **NOTED** the following updates. • Two secondees, one each from Capsticks and DAC Beachcroft, joined the team on 21 May for three months. • The head of legal role was in the process of being shortlisted. An interim solution until they were able to start still needed to be worked through. • We continued engaging with the senior Coroner. • Legal Services was on the current risk register, as the team needed to be recruited to.
NON-REFERRAL TO TREATMENT (RTT) PATIENT LEVEL TRACKING LIST (PTL) UPDATE	The Committee received and **NOTED** the following updates. • Non-RTT was not a new issue; in May 2020, there were 320,870 unresolved pathways, and currently, there are 510,500 cases, of which 338,377 were overdue beyond their target to be seen date. Therefore, a risk existed. The actions being taken to address the issue were. ○ Implementing a data-driven algorithm for initial validation to detect bulk closures. ○ Risk stratifying patient groups for clinician review. ○ A business case to justify increasing support for the necessary validation. • A risk-based decision needed to be made concerning this cohort of patients, focusing on prioritising clinical risks. The issue had been raised with the commissioner.

East Kent Hospitals University NHS Foundation Trust

	• The Chief Operating Officer will give regular progress updates to this Committee moving forward.
MATERNITY & NEONATAL ASSURANCE GROUP (MNAG) AND NEO-NATAL DEATHS REPORT	The Committee received and **NOTED** the following updates. • MNAG is now the Maternity and Neonatal Board, and the Reading the Signals Group has been disbanded. The two family representatives who attended the Reading the Signals Group are now invited to join the Maternity and Neonatal Board. • The 11 cases of hypoxic-ischaemic encephalopathy (HIE) have been reviewed, and no key themes were identified. • The escalation concerning anaesthetic staffing rotas was being reviewed separately, and work continued ongoing. • Review of neonatal deaths. The families had been spoken to, and they were grateful for the discussion, which was scheduled to go to the Public Board in June.
CLINICAL ETHICS COMMITTEE REPORT	The Committee received and **NOTED** the following updates. • The work and role of the Ethics Committee was expanding, and they were working hard to raise awareness and understanding of the committee, as well as exploring more ways the Committee could support the Trust. • Targeted work had been undertaken with maternity and paediatrics, and the committee members attended Grand Rounds and audit days to raise awareness and enhance engagement. • The Committee endorsed the approved Ethics Committee Terms of Reference.
INTEGRATED PERFORMANCE REVIEW (IPR)	The Committee received and **NOTED** the IPR.
PATIENT EXPERIENCE COMMITTEE ASSURANCE REPORT	The Committee received and **NOTED** the Patient Experience report.
MORTALITY SURVEILLANCE & STEERING GROUP (MSSG) CHAIR'S REPORT	The Committee received and **NOTED** the Mortality Surveillance & Steering Group report.

East Kent Hospitals University NHS Foundation Trust

CLINICAL AUDIT AND EFFECTIVENESS CROUP (CAEG) CHAIR'S REPORT	The Committee received and **NOTED** the Clinical Audit and Effectiveness Group report.
PATIENT SAFETY COMMITTEE (PSC) CHAIR'S REPORT	The Committee received and **NOTED** the Patient Safety Committee (PSC) report.
SAFEGUARDING COMMITTEE ASSURANCE REPORT	The Committee received and **NOTED** the Safeguarding Committee report.

Referrals from other Board Committees:

Pathology Network and the workforce implications will be presented to the People and Culture Committee.

Item	Purpose	Date
The Committee requests that the BoD discuss and **NOTE** this Q&SC Chair Assurance Report.	Assurance	31 July 2025

East Kent Hospitals University NHS Foundation Trust

BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)

Committee: **Finance and Performance Committee (FPC)**

Meeting date: **24 June 2025**

Chair: **Richard Oirschot, Non-Executive Director (NED)**

Quorate: **Yes**

Appendices: **None**

Declarations of interest made:

No declaration of interest was made outside the current Board Register of Interest.

Assurances received at the Committee meeting:

Agenda item	Summary
Significant Risk Register (SRR)	The Committee received and **NOTED** the May SRR relevant to its remit. The Committee Chair expressed concern that the Risk 2796 *(Delay in dialysis treatment due to high number of renal dialysis machines that are over 15 years old)* was still on the SRR and commented that it was taking a long period of time to get the new dialysis machines operational. The Chief Nursing and Midwifery Officer (CNMO) assured the Committee that this was imminent and highlighted the complexity of the installation process.
Review of FPC Board Assurance Framework (BAF) Risks	The Committee received and **NOTED** its BAF risks and highlighted the importance of assurance around cyber risks and how these risks would be managed within the risk process.
Month 2 Finance Report	The Committee received the Month 2 Finance Report and **NOTED** its content. The Chief Finance Officer (CFO) informed the Committee that at Month 2, the Group has achieved its planned year to date deficit of £18.5m excluding Deficit Support Funding (DSF). It is expected that the challenges associated with the deficit plan will increase starting from Month 7 and, therefore, a tight focus on the delivery of Cost Improvement Programme (CIP) is required. The Chief People Officer (CPO) described the exercise being undertaking by the Programme Management Office (PMO), People and Culture team and the Care Groups to identify the trajectory for bank and agency reduction through this financial year to achieve 40% of agency and 10% of bank reductions.

	The CNMO added that the ambition was to have a zero nursing agency staff at the Trust by September 2025. Monitoring mechanisms are in place for both agency and bank staff, and trends indicate an ongoing reduction. The Committee Chair sought clarity around the timescale of Care Groups' budget approval and the Committee was informed that these would be finalised by Month 3. The Committee felt **ASSURED** around the cash flow forecast at the current time.
Cost Improvement Programme (CIP) Oversight and Assurance	The Committee received and **NOTED** the CIP progress report. The Committee sought assurance in the process of identifying and delivering CIPs noting that there were still opportunities that had not been included into the CIP schemes. The CPO updated the Committee on the ongoing workforce review noting that a more detailed report will be presented to the People and Culture Committee (P&CC) in July 2025. The CPO explained that the Trust was hoping to achieve most of the workforce reductions through turnover management and strong controls on recruitment. The Trust will be required to pay for redundancies from its budget and aims to minimise any redundancies required. The CPO informed the Committee that a reduction of 60-70 Whole Time Equivalent (WTE) through redundancies would be financially achievable for the Trust when balancing the cost implications. The Committee had a detailed discussion regarding potential trigger points for additional interventions in the event that turnover management does not achieve the expected results. Concerns were specifically noted regarding the potential impact on achieving the £80 million CIP target if workforce reduction efforts were delayed. The Committee acknowledged the CNMO's concerns around quality and safety aspect of the workforce reduction and noted the Quality Impact Assessment (QIA) process being overseen by the Quality & Safety Committee (Q&SC).
Financial Sustainability Plan (FSP) Update	The Committee received and discussed the FSP update, and **AGREED** for submission of the FSP to Trust Board in advance of the Strategic Session on 3 July 2025.
We Care Integrated Performance Report (IPR) (M12): National Constitutional Standards for Emergency Access, Referral to Treatment (RTT), Cancer and Diagnostics	The Committee received the May 2025 IPR operational metrics and in particular **NOTED** the following points: – Overall Emergency Department (ED) performance improved in May 2025, especially around the total time in the department. Following a peak in performance in April for patients waiting in the EDs for over 12 hours, May performance has reduced to 20.4%, from 21.7%. This remains a significant challenge and focus for the Trust. A trajectory to

	get to the 10% target by March 2026 is in place in line with the national Urgent and Emergency Care (UEC) plan. – Ambulance handover performance remains strong with 93.8% of patients handed over to the EDs within 30 minutes. – The number of no longer fit to reside patients reduced slightly in May 2025 compared to April 2025; however, delayed discharges continues to contribute to the increased length of stay and to present challenges in patient flow across the main sites. – At the end of May 2025, there were 69 patients waiting for treatment for over 65 weeks including three patients waiting for 104 weeks and 17 patients waiting for 78 weeks. – There was an improvement in theatre utilisation in May 2025 from 77% to over 80% and the team is striving to achieve the 85% target in the near future. – There is ongoing work around managing appointment non-attendance and late cancellations as well as exploring triaging opportunities at the Outpatients to ensure efficient use of face-to-face appointments. The Committee requested the Chief Operating Officer (COO) to undertake data analysis to determine as to whether or not existing health inequalities in deprived communities are increasing due to the appointment scheduling process.
Business cases: over £1.75m Requiring Investment £2.5m for Self-Funding. Capital Business Cases Over £1m	The Committee noted there were no business cases to discuss. The Committee **APPROVED** the proposed changes to the Business Cases signatories as outlined in the presented proposal.
Digital Strategy and Update	The Committee received and **NOTED** an update on the draft Digital, Data, Analytics, and Technology Strategy, outlining the strategic direction in this area aligned with the new organisational strategy. The NEDs highlighted concerns regarding the clarity of the Trust's long-term objectives for digital development and the strategic initiatives planned to achieve these goals. The Committee sought assurance around resources to deliver the strategy and highlighted the need to determine short-term actions to build the foundation for delivering the strategy.
Update on Health-Ex	The Committee noted that the three-year financial audit of Health-Ex had been completed. The subsequent steps required to wind-up Health-Ex will be determined within the upcoming weeks and a paper shared at the next meeting.
National Cost Collection 2025	The Committee **APPROVED** the National Cost Collection 2025 and **AGREED** for the report to be submitted to the Trust Board.

East Kent Hospitals University NHS Foundation Trust

Feedback to Board of Directors (BoD)	The Committee agreed to seek formal Board approval of the FSP and the National Cost Collection 2025 report at the Board Strategic Session on 3 July 2025.
Referrals to Other Board Committees	The Committee noted no referrals to Board Members.

Item	Purpose	Date
FPC asks the BoD to discuss and **NOTE** this FPC Chair Assurance Report.	Assurance	31 July 2025

East Kent Hospitals University NHS Foundation Trust

BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)

Committee: People & Culture Committee (P&CC)

Meeting date: 8 July 2025

Chair: Claudia Sykes, Non-Executive Director

Paper Author: Claudia Sykes, Non-Executive Director

Quorate: Yes

Appendices: None

Declarations of interest made: None

Assurances received at the Committee meeting: See below

Agenda item	Summary
Board Assurance Framework (BAF) risk: recruitment and retention	The Committee reviewed the Chief People Officer's (CPO's) report, covering updates on: - Staff recruitment - Employee relations activity and Tribunal cases - Occupational health activity - Agency and bank usage - Wellbeing - Staff turnover - Appraisals - Equality, Diversity and Inclusion (EDI) The Committee noted that staff turnover was 7.6%, the lowest it has been for two years. This remains positive, but also reflects the wider uncertain NHS employment environment. It may also have implications for achieving the Trust's staff cost reductions mainly through turnover. The Trust appraisal completion rate had dropped to 74.8% in May, after meeting the 80% target for the last six months. The Committee was informed that this was due to the current annual cycle of appraisals, but work was being done to improve the metric for June. The Committee noted that the Corporate area was the lowest at 70.8%, and this had been consistently one of the lowest areas of appraisal completion over the last 18 months – the Chief Nursing and Midwifery Officer (CNMO) noted this as an action. The Committee remained ASSURED around appraisals. The Committee discussed the Medical Job Planning Rate which had been significantly under the target of 90% for the whole year, and had dropped again in May to 18%. The Chief Medical Officer (CMO) had previously

	advised that clinical leads were receiving training on this. The Committee requested a detailed update for the next meeting on action on this metric. The Committee was NOT ASSURED around the medical job planning rate
BAF risk: culture and values **Freedom to Speak Up (FTSU)**	The new Guardian service started on 17 March. The Committee reviewed the report on the service for its first few months of operation, with 25 cases being opened to the end of May. The Committee noted that William Harvey Care Group had 44% of the reported cases.
BAF risk: culture and values **Staff voice**	The Committee heard from three of the Staff Networks: the Women's Network; the Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, Asexual (LGBTQ+) Network; and the Disability Network. These were now working well, with Executive sponsors. The Networks shared several concerns, around the lack of physical support for their needs (e.g. many places in the Trust are inaccessible to staff with disabilities; theatres do not have places for people identifying as transgender to change). In addition, many managers still do not understand the legal requirement to make reasonable adjustments for staff with a disability, or do not have the local budget for new equipment. The Committee discussed the concerns raised, and noted the poor estate and limited budget. The Chief Executive Officer (CEO) and CNMO explained that the Executives are working with 2gether Support Solutions (2gether) to ensure that provision is made for adequate facilities for all staff, as areas are upgraded, however, this would take time. They would also look at the suggestion of having a central budget and process for equipment for reasonable adjustments, which other Trusts have done. The Committee thanked the Chairs of the Staff Networks, and noted that this will be a regular agenda item.
BAF risk: culture and values **Sexual safety**	The Committee received an update on the Sexual Safety charter, and noted that the Trust had signed up to this in November 2023. An action plan had been developed to implement the ten main recommendations. The Committee requested further information on the work required to fully embed the recommendations, and for a gap analysis to be completed.
BAF risk: organisational development and resilience **Workforce planning**	The Committee reviewed the Trust's plans to reduce its workforce in order to achieve its Cost Improvement Plans (CIP) for 2025/26. This would require reducing the substantive workforce by 378 Whole Time Equivalent (WTE) in the Trust and another 55 within 2gether. The Trust was hoping to achieve most of these reductions through staff leaving naturally, and strong controls on recruitment. The Trust aimed to minimise any redundancies required.

	The CPO explained that NHS England required Trusts to reduce their Corporate staffing levels, and so this was an area where some redundancies would be happening, along with specific areas within Care Groups. Consultations in some areas had started, with more planned in July. It was expected that 60-70 posts would be made redundant. The Committee discussed the processes being undertaken around the reductions, specifically how to ensure patient safety was not compromised, and ensuring that staff were treated fairly and compassionately during the process. The CPO and CNMO explained that all proposals were subject to a Quality Impact Assessment (QIA), which was being monitored through the Quality and Safety Board Committee and also through an Equality Impact Assessment, which would be monitored through the P&CC. The CPO explained how workforce reductions were going to be monitored each month, and what controls were in place to manage recruitment. These included the Vacancy Control Panel, and also specific head count targets for each Care Group. The Committee noted that there was not a recruitment freeze in place, as some areas still had key vacancies which needed to be filled. The Committee noted that the approach to workforce reductions was less disruptive, and aimed to be more compassionate, than a wider compulsory redundancy scheme, but it also carried inherent risk. The Committee also noted that the People and Culture team, and many leaders in the Trust, would be under a lot of pressure during this very difficult time – the level of savings required was unprecedented. The Committee was ASSURED of the processes around monitoring staffing numbers.
BAF risk: organisational development and resilience **People Strategy**	The Committee reviewed the People Strategy. This is based on the six key themes previously agreed: - Creating a Sustainable Workforce - Compassionate and Inclusive Leadership - Developing Diverse Leadership - Team working and collaboration - Career skills and development - Improving our staff experience The Strategy was clearly set out, with timelines and actions for each theme. The Committee noted thanks to the CPO and his team for this vital piece of work. Comments were shared on the draft. The Strategy will be shared with the Board in September.

East Kent Hospitals University NHS Foundation Trust

Other items of business: None

Actions taken by the Committee within its Terms of Reference: None

Items to come back to the Committee outside its routine business cycle: None

Items referred to the BoD or another Committee for approval, decision or action: An action was referred from the Integrated Audit and Governance Committee (IAGC) for the P&CC to monitor compliance with the Annual Declaration of Conflicts of Interest. Excellent work has been done by the Director of Corporate Governance in the last two months, and compliance is now at 74% at June 2025 (after being at 20-30% for many years). To be reported back to IAGC.

Item	Purpose	Date
P&CC asks the BoD to discuss and **NOTE** this P&CC Chair Assurance Report.	Assurance	31 July 2025