East Kent Hospitals University NHS Foundation Trust

EKHUFT Board Chair's Report, June 2025

The June Board meeting marks my first full month in the role of EKHUFT's Chair.

It has been a fantastically action-packed and interesting month meeting lots of my new East Kent colleagues. I have really valued being able to focus my time on visiting our sites and meeting staff. Visits to wards and talking to staff in William Harvey Hospital (WHH), Queen Elizabeth the Queen Mother Hospital (QEQM), Kent & Canterbury Hospital (K&C) and Buckland Hospital Dover (BHD) have been very insightful and I wanted to share some of those reflections in my first report.

Before I turn to my first impressions and reflections I want to convey my thanks to Stewart Baird, the former Acting Chair of the Trust. Stewart gave me a considerable amount of his time and insight in aiding the transition. I am also aware Stewart made a considerable impact in his short time as the Acting Chair and I am sure we can build on that. I am also grateful to Tracey and other Board members – both executives and non-executives – who have similarly shared their insights, experience and time to aid my induction.

Most importantly, however, I want to thank staff for engaging with me so openly and warmly. From my introductory meetings and visits, I have seen and got a sense of the deep commitment our staff have to the treatment and care of our patients and supporting families. I have no doubt that our staff are fully determined to have a positive impact in very trying circumstances. Equally, there has been a recognition that there is more to do and our Trust must confront the myriad of challenges we and others continue to face in an acute trust. This was certainly evident on a very busy Emergency Department (ED) visit to William Harvey where I experienced the upsetting situation of corridor care. We all know that this kind of care is not what we aim to provide and we must continue to work hard to improve this situation for our patients, their families and our staff.

I have been particularly keen to discuss the Trust's Staff Survey results and what the Trust is doing with staff to improve their experience while at work. I am clear that the experience of our staff will undoubtedly impact the experience of our patients. Like our survey results, I have heard a broad range of views but universally colleagues have recognised the energy and focus of the Trust in this area. In conjunction with the People & Culture Committee I will ensure the Board stay close to the actions the Trust are taking in response to the Staff Survey.

My first month has also included a meeting with Roger Gale MP and I appreciated the honesty and transparency with which he shared his and his constituent's views. I look

forward to forthcoming meetings with other MPs in the area and other key stakeholders.

I have also chaired a Board Strategy Session on 8 May focused on the financial plan and staff engagement and a Council of Governors meeting on 30 May 2025, both of which were really engaging and productive. I also chaired the recruitment panel for the addition of two new non-executive directors to our Board. I am delighted to welcome Ffion Griffith and Robert Musgrove to the EKHUFT Board. They bring considerable estates, digital and transformation experience and we are all looking forward to working with them. Last but not least, I am also grateful to the chairs of 2gether Support Solutions and Spencer Private Hospitals for their time. Their insight into our subsidiary entities was very valuable.

From a system perspective, I attended a South East Regional Leaders briefing which focussed mainly on financial and operational performance expectations. At this event, there was also a discussion about a new Board appraisal process being introduced which aligns to the NHS leadership competency framework for board members. At the briefing, discussions have also taken place focussing on commissioning which is driven by population health outcomes. By embedding population health data into commissioning strategies, leaders aim to ensure that resources are targeted where they can deliver the most impact, supporting preventative care, reducing inequalities, and building collaboration across systems.

I close my first report by recognising the huge achievement of the Trust in achieving the 'Good' Care Quality Commission (CQC) rating of our maternity services. Whilst recognising the huge effort of staff in helping the Trust achieve this I also want to recognise the contribution of families using our services who have also shaped the improvements we have made through their active feedback and input. Each time I heard how pleased colleagues were that the CQC recognised the changes we have made they were also keen to say that there would be no complacency. This alignment between staff and the Board is a great place to end this report.

Chair
Dr Annette Doherty

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

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

Meeting date: **5 June 2025**

Board sponsor: **Chief Executive**

Paper Author: **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

We care

East Kent Hospitals University NHS Foundation Trust

CHIEF EXECUTIVE'S REPORT

1. PURPOSE OF THE REPORT

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

2. TRUST MANAGEMENT COMMITTEE

At meetings of the Trust Management Committee (TMC) in April and May 2025, the Committee approved ambitions developed for Allied Health Professionals (AHP) based on six key themes and aligned to national strategies and approved a revised policy for Safety Standards for Invasive Procedures Policy (LocSIIPS).

3. INTERNAL UPDATE

3.1 Performance update

Improvement weeks have been held at each of the acute sites. Through collaborative work with system partners, these improvement weeks have resulted in a reduction in the number of patients with no criteria to reside (NCTR), an increase in discharges and will inform future changes to further enhance urgent and emergency care flow.

Current performance for May shows 81.48% of all patient types meeting the 4-hour standard, demonstrating the positive impact of these focused improvement initiatives which will continue throughout the year.

3.2 Finance update

I am pleased to report that the group achieved its planned deficit of £85.8m for 2024/25 (excluding Deficit Support Funding), demonstrating an improvement of £31.6m from the 2023/24 deficit position of £117.4m, whilst delivering the Cost Improvement Programme (CIP) target of £49m.

For 2025/26, the group has submitted a planned gross deficit of £64.2m (excluding Deficit Support Funding), representing a further reduction of £21.6m from 2024/25, with allocated DSF of £57.6m resulting in a planned deficit of £6.6m.

The plan for 2025/26 includes an £80m CIP target which represents approximately 7% of the group's expenditure and is consistent with targets across other Trusts nationally given the challenging business planning environment for 2025/26.

4. EXTERNAL UPDATE

4.1 Publication of Care Quality Commission (CQC) Maternity Services reports

I am pleased to share that the Care Quality Commission (CQC) has published its reports following the inspection of our maternity services in December 2024, rating maternity services as 'good'. The CQC reported a number of significant improvements during its inspection, noting the positive impact of an improved culture in the service. This represents a significant achievement from the service's previous 'inadequate' rating and reflects the huge amount of work and dedication from all members of the maternity team.

The publication of these reports mark an important milestone in our continuing work across the Trust to improve our services and embed the lessons outlined in the 'Reading the Signals' report, published by Dr Kirkup in October 2022. Whilst recognising that there is more work to be undertaken, both within maternity services and across the rest of the Trust, which will only be achieved through our continued commitment to this improvement journey and further building on the positive changes that have been made for our women, patients and local communities.

4.2 Elective Tiering for Quarter 1 of 2025/26

Following a review of elective, cancer and diagnostic performance, and in agreement with the national team, NHS England (NHSE) have confirmed that the Trust will be stepped down from the elective Tiering programme for Quarter 1 of 2025/26.

Over the last three years, the Trust has all but eliminated two-year waits and 78-week waits whilst significantly reducing the number of patients waiting over 65 weeks, with recovery plans bearing fruit across the most challenged specialties and the volume of long waiters reducing significantly throughout 2024/25.

This decision reflects the excellent progress made by teams across the Trust over the last year in delivering elective care to our patients.

4.3 Triggered Quality visit to Queen Elizabeth the Queen Mother Hospital (QEQM) by NHSE South East

NHSE South East (Kent, Surrey and Sussex) conducted a triggered education quality review of Medicine in the Acute Medical Unit (AMU) at QEQM on 20 March 2025, in response to six below outlier domains being identified in the 2024 General Medical Council National Training Survey results, including the key indicator of supportive environment which was graded as level 2 (significant concerns) in the NHSE Intensive Support Framework.

Medical Education and the Care Group triumvirate formed a working group that developed an improvement plan to integrate medical education with eight key

recommendations, seven of which were successfully closed prior to the visit through collaborative actions and twice-weekly meetings with monthly oversight at Care Group board level.

The NHSE South East team made three mandatory requirements relating to handover structure and quality, escalation routes for patients requiring cardiology review on AMU A and AMU B, and department induction, alongside one recommendation concerning multidisciplinary relationships in the AMU environment particularly at weekends.

4.4 Quality Visit to QEQM by King's College London School of Medicine, May 2025

On 7 May 2025, King's College London conducted a quality visit to the QEQM as part of the routine quality assurance process for the Medicine, Bachelor of Surgery (MBBS) Medicine programme, engaging with students, supervisors, teachers, and medical education staff. While the formal report has yet to be received, preliminary feedback was very positive, with the visiting team characterising the quality of education offered to medical students as excellent and noting the strong culture of education, training, and student development cultivated by the entire interprofessional team. The visiting team expressed particular appreciation for the medical education fellows who facilitate peer learning and mentorship, the effectiveness of prescribing and radiology teaching programmes, the induction process, and the emphasis on providing constructive feedback to students, all contributing to a learner-focused environment supportive of professional development.

The visit team made one requirement for administrative staffing to be appointed within one month, and three recommendations with plans to be submitted within three month to: 1. conduct a review of furniture in QEQM accommodation to ensure it meets student needs; 2. provide clarity on financial matters and develop a plan for utilising any underspend from the 2023/24 and 2024/25 academic years; and 3. share a strategic plan for enhancing the use of Folkestone and Dover sites for medical students to optimise educational opportunities across these locations.

Further insight will be shared once the formal report is issued, but initial findings reflect positively on the commitment to medical education at the QEQM.

5. OTHER AREAS TO NOTE

5.1 Staff Congress update

Congratulations to Gill Hart and Stephanie Park, who have been elected as the new Chair and Vice Chair of our Staff Congress, having polled the most votes from fellow Congress members.

The Staff Congress will work with the Board and wider leadership team of the Trust to drive cultural change by listening to and acting on staff voice, creating a

vital connection with staff to establish a stronger and more responsive leadership structure across the organisation.

5.2 Launch of CLEAN Together Campaign

Our infection prevention and control team, in partnership with 2gether Support Solutions, have launched our new CLEAN Together campaign, which focuses on five guiding principles to help keep our hospitals and patients safe: Clear clutter and cupboards; proper Laundry and linen management; maintaining our Environment and equipment; ensuring All waste is segregated and disposed of correctly; and that Nobody should walk by without taking responsibility for keeping our hospitals clean.

The team will focus on one specific principle each month to ensure all staff have the information needed to maintain the highest standards.

5.3 Maternity Team Venous Thromboembolism (VTE) Awards Success

Congratulations to members of our maternity team, who won three awards for their work on tackling blood clots during pregnancy and post-birth at the national VTE awards ceremony hosted at the Houses of Parliament.

Our VTE task and finish group, led by consultant obstetrician and VTE lead Ms Rishu Goel with VTE lead nurse Lucy Ellenor, won awards for creating an outstanding patient resource and for their quality improvement project, which aimed to improve the prevention, assessment and management of VTE for maternity patients through updated guidelines, additional training, new patient leaflets and the introduction of Flowtrons to improve blood circulation.

Discharge co-ordinator Jody Philpott from the postnatal ward at the William Harvey Hospital (WHH) was our third winner, taking the Unsung Hero Award (non-clinical) for her conscientious efforts to improve patient experience and safety, including checking all postnatal notes to provide an additional safety net against potential errors and supporting VTE audit data collection and patient information provision.

5.4 Mobile MRI Unit at Deal Hospital

A mobile MRI unit is being set up temporarily at the Victoria Hospital in Deal while work continues on the new Community Diagnostic Centre (CDC) in Thanet, which is part of a new health hub at the Carey building in Northwood Road, Broadstairs.

The mobile unit, funded by the national NHSE CDC team, will offer patients an alternative to travelling to QEQM for MRI scans and is expected to open in the car park this summer for up to six months until the Thanet CDC is fully operational, with the new Thanet site serving as a 'spoke' to the Buckland Community Diagnostic Centre in Dover and being operated by the Trust.

5.5 MedStart4U Widening Participation Programme

The Trust's medical education team held two MedStart4U days at the William Harvey and QEQM hospitals as part of our widening participation scheme to encourage applications from students in schools that do not traditionally send pupils to medical schools.

Led and coordinated by medical education Fellows, with mentoring support from medical students at Kings College London and Kent and Medway Medical School, the programme provided 50 local school students (30 at William Harvey and 20 at QEQM) with hands-on experience of clinical skills including venepuncture, cannulation, NG tube insertion, hand tying sutures and otoscopy, alongside mock OSCE sessions, interview practice, application process guidance and 'day in the life' talks from medical students and foundation year doctors.

Feedback from participating students was excellent, with many expressing increased enthusiasm for pursuing medicine and appreciation for the insights gained into the medical profession, demonstrating the programme's success in inspiring the next generation of healthcare professionals.

The Board of Directors is 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: **5 June 2025**

Board sponsor: **Chief Strategy & Partnerships Officer (CSPO)/Chief Finance Officer (CFO)**

Paper Author: **Chief Strategy & Partnerships Officer**

Appendices:

APPENDIX 1: April 2025 IPR

Executive summary:

Action required:	Discussion
Purpose of the Report:	The report provides the monthly update on the Integrated Improvement Plan (IIP), Operational Performance, Quality & Safety, Workforce, Financial & Maternity organisational metrics. The metrics are directly linked to the Strategic and Annual objectives. The reported metrics are derived from: 1. The Trust Integrated Improvement Plan. 2. Other Statutory reporting. 3. Other 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: • **Integrated Improvement Plan (IIP).** • **Patients,** incorporating operational performance metrics. • **Quality and Safety (Q&S),** incorporating Q&S metrics. • **People,** incorporating people, leadership & culture metrics. • **Sustainability.** Incorporating finance and efficiency metrics. • **Maternity,** incorporating maternity specific metrics for quality and safety, Friends and Family Test (FFT) and engagement. Key performance points (April Reported Month): **Integrated Improvement Plan**

- DM01 Performance, Type 1 Emergency Department (ED) Compliance 4 hours, and all Cancer standards are all showing statistical improvement.
- 62d Combined Cancer performance continues to demonstrate statistical improvement and has maintained achievement of the national performance standards in April.
- The reduction in elective long waits has slowed now the Trust is reporting only small numbers of these each month. New metrics have been added for 2025/26 including a measure of the percentage of the elective waiting list currently waiting over 52 weeks for treatment and the percentage of the patients waiting more than 18 weeks for a first outpatient appointment. These measures will form the basing of national elective tiering for 2025/26.
- Staff Engagement Score has moved from demonstrating a concerning variation to no significant change over the 24-month period.

Patients

- The Trust reported a modest deterioration in performance for both Faster Diagnosis Standard (FDS) (from 76.4% to 74.8%) and 62d (from 77.3% to 76.4%). However, 62d performance remains above the Trust's target trajectory
- The Referral to Treatment (RTT) position deteriorated slightly throughout April with on-going challenges of late validations and complexity. The end of April position was that there were 45 patients waiting greater than 65 weeks including 3 x 104 and 12 x 78 week waits.
- Overall 4 hour compliance improved in April with performance across all types of departments at 76.2% and Type 1 departments at 54.2%.
- DM01 performance deteriorated at the end of April to 82.87%. 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.

Quality & Safety

- There were no new Never Events (NE) reported in April, however, a new NE was reported on StEIS 04/05/2025 (Fall from an unrestricted window) which has been presented at IRP and a Patient Safety Incident Investigation (PSII) has been commenced.
- The Trust at the end of March had:
  - Nine nationally reportable PSIIs ongoing.
  - Nine Local PSIIs.
- The number of overdue incidents reduced to 965 in April. A total of 634 incidents became overdue in April which has significantly reduced from 834 in March.

People

- Sickness absence rates are below the alerting threshold at 4.66%. This is the third successive month this has been the case after three months above the alerting threshold (5%) and appears primarily related to a steep reduction in the number of staff absent with coughs, colds and influenza.

	• Appraisal compliance has remained above the Trust-level threshold (80%), currently standing at 81.1%. • Statutory training compliance increased slightly to 92.8%. This continues to exceed the Trust-level threshold (91%). **Finance** • The Month 1 in month position achieved the Groups (Pre-deficit support) deficit of (£9.7m). • Income from patient care activity is £0.4m above plan, £0.2m variable chemotherapy and Cancer Alliance funding £0.08m above plan. • Other operating income is adverse to plan by £0.3m. Income for education and training was the largest (adverse) variance at £0.8m in month. • Employee expenses are £0.8m adverse to plan. Whilst substantive staff costs are breakeven, there are overspends of £0.7m in bank and £0.3m in agency mainly due to medical staffing usage. • Other operating expenses are £0.8m favourable to plan. There are three main areas of favourable performance in April. There is a minor underspend in drugs of £0.3m, a £0.3m underspend in purchase of healthcare usage and a £0.3m underspend in depreciation compared to plan. **Maternity** • The extended perinatal rate remains consistently below the threshold of 5.42 per 1,000 births, with the April 12 month rolling rate reducing to below the upper threshold at 3.76 per 1,000 births. This rate includes both stillbirths and neonatal deaths. • In April, 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 first time in 11 reporting periods, to 1.71. The service reported 0 neonatal deaths >24 weeks in month. The stillbirth rate also decreased in month, reducing to below the upper threshold from 2.39 in March to 2.05 in April. • No new Maternity and Newborn Safety Investigations (MNSI) referrals made in April. • Three moderate/severe patient safety incident were reported in April.
Summary recommendations:	The Board of Directors is asked to **CONSIDER** and **DISCUSS** the metrics reported in the Integrated Performance Report.

Implications:

Links to 'We Care' Strategic Objectives:	• Our patients • Our people • Our future • Our sustainability • Our quality and safety
Link to the Corporate Risk Register (CRR):	**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

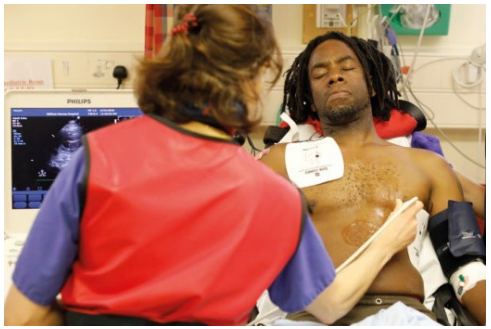
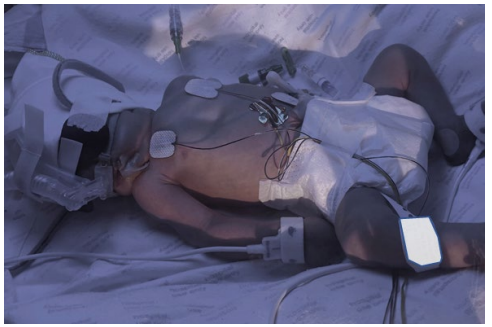
Integrated Performance Report

APRIL 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.

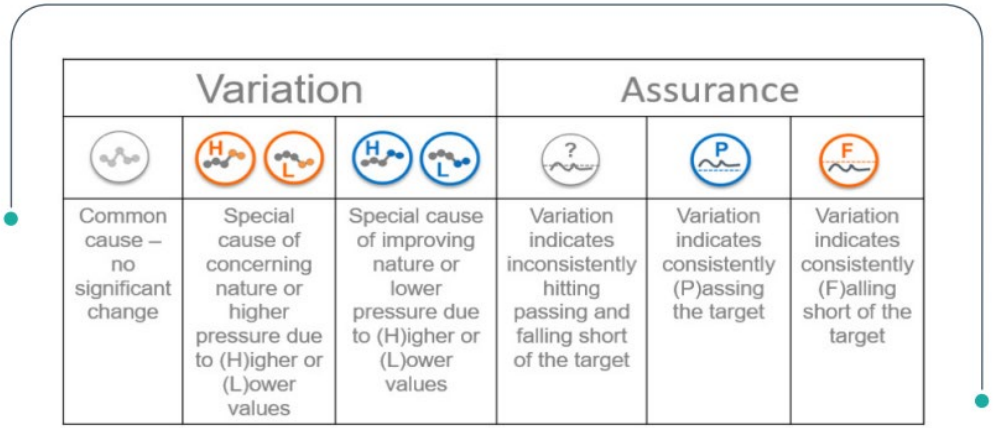
The main aims of using statistical process control charts is to understand what is different and what is normal, to be able to determine where work needs to be concentrated to make a change. The charts also allow us to monitor whether metrics are improving.

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

Integrated Improvement Plan (IIP)

Summary Highlights

Executive Summary:

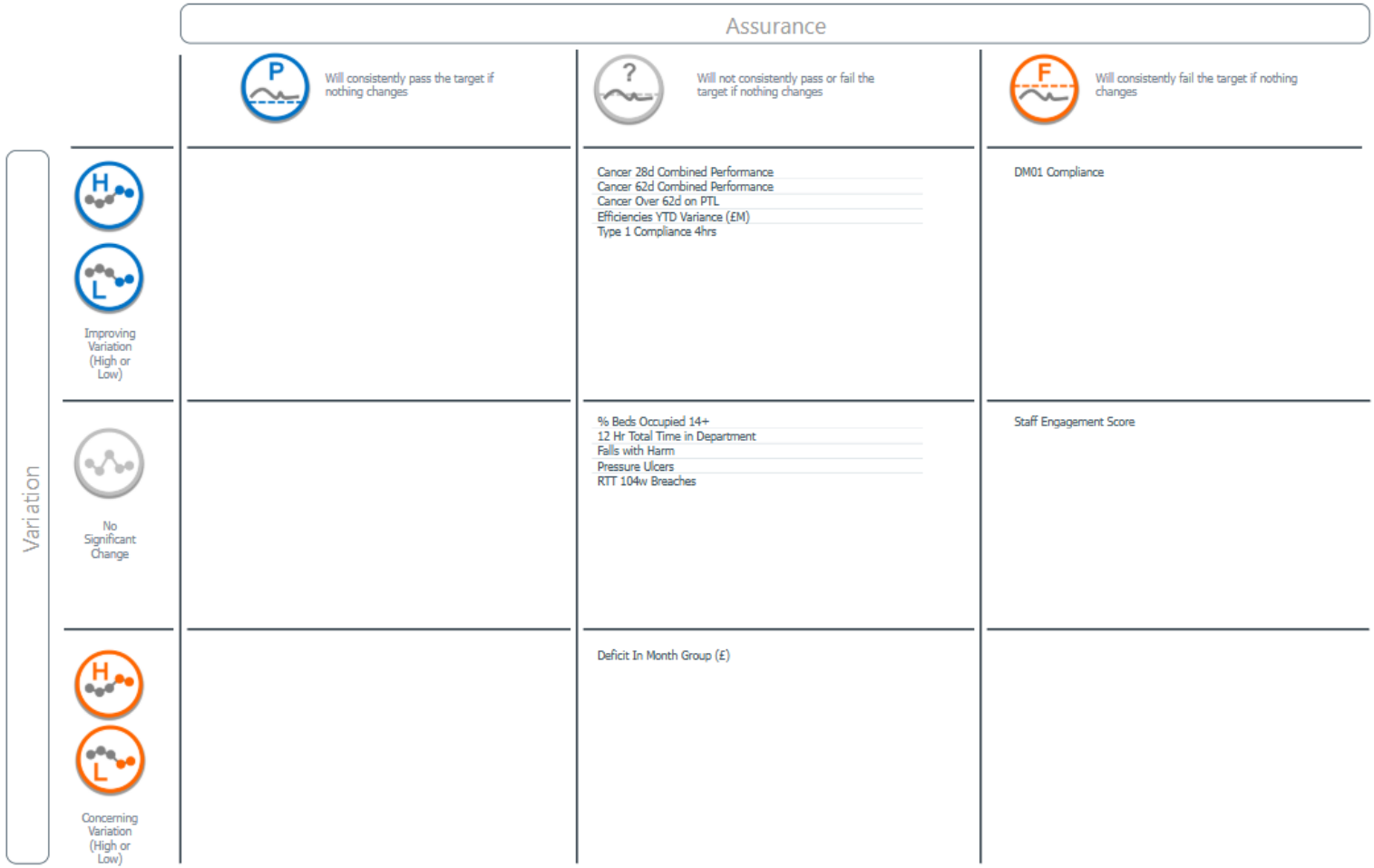
DM01 Performance, Type 1 ED Compliance 4hrs, and all Cancer standards are all showing statistical improvement.

A number of IIP metrics have started to show positive improvements with a reduction to 50% demonstrating no significant change on a monthly basis. These remaining metrics will not consistently pass or fail the assurance targets if nothing changes.

62d Combined Cancer performance continues to demonstrate statistical improvement and has maintained achievement of the national performance standards in April.

The reduction in elective long waits has slowed now the Trust is reporting only small numbers of these each month. New metrics have been added for 2025/26 including a measure of the percentage of the elective waiting list currently waiting over 52 weeks for treatment and the percentage of the patients waiting more than 18 weeks for a first outpatient appointment. These measures will form the basing of national elective tiering for 2025/26.

Staff Engagement Score has moved from demonstrating a concerning variation to no significant change over the 24 month period.



Integrated Improvement Plan (IIP)

Exit Criteria Metrics: Dashboard

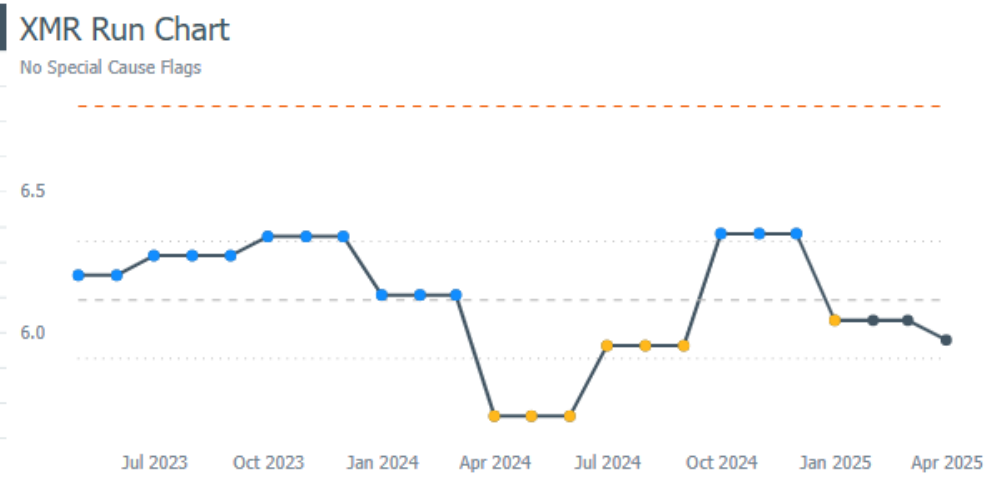
Domain	Nat	Flag	KPI	SPC	Ass...	Target	May-24	Jun-24	Jul-24	Aug-24	Sep-...	Oct-24	Nov-24	Dec-24	Jan-25	Feb-...	Mar-...	Apr-25
People	IIP		Staff Engagement Score			6.80	5.70	5.70	5.95	5.95	5.95	6.35	6.35	6.35	6.04	6.04	6.04	5.97
Patients	IIP		Type 1 Compliance 4hrs			51.0%	53.2%	52.0%	54.7%	56.2%	56.5%	54.1%	53.7%	54.7%	51.0%	50.1%	51.4%	54.2%
	IIP		12 Hr Total Time in Department			19.7%	19.3%	19.3%	18.6%	18.5%	18.0%	18.7%	18.8%	19.4%	21.3%	20.7%	20.8%	21.7%
	IIP		% Beds Occupied 14+			30.0%	30.8%	29.6%	30.0%	30.8%	34.3%	32.0%	28.2%	29.1%	33.9%	34.9%	35.4%	34.1%
	IIP		Cancer 28d Combined Performance			77.0%	70.2%	70.4%	72.6%	71.0%	69.9%	71.3%	71.8%	75.0%	66.5%	78.5%	76.4%	74.8%
	IIP		Cancer 62d Combined Performance			70.0%	64.1%	63.0%	71.6%	73.2%	72.8%	70.4%	74.1%	73.9%	69.0%	70.7%	77.3%	76.4%
	IIP		Cancer Over 62d on PTL			200	237	233	203	244	215	193	203	216	197	183	167	192
	IIP		RTT 65w Breaches				1,802	1,656	1,360	1,269	572	346	247	216	164	148	33	45
	IIP		RTT 78w Breaches				272	82	35	32	34	11	10	7	4	17	6	12
	IIP		RTT 104w Breaches			0	1	1	0	1	0	0	0	0	0	9	1	3
	IIP		Endoscopy Backlog				5,170	4,108	3,018	1,997	1,304	663	391	373	247	258	206	255
	IIP		DM01 Compliance			78.0%	63.5%	60.9%	61.3%	64.0%	68.5%	77.2%	83.3%	81.0%	83.9%	86.2%	87.0%	82.8%
Quality	IIP		Falls with Harm			14	3	4	3	8	5	7	10	8	1	5	11	2
	IIP		Pressure Ulcers			121	84	82	79	72	77	96	85	85	119	101	101	110
Sustainability	IIP		Deficit In Month Group (£)			9.8M	7.3M	7.1M	8.3M	6.3M	7.3M	7.5M	9.8M	7.0M	6.5M	4.9M	5.2M	9.7M
	IIP		Efficiencies YTD Variance (£M)			0.0	0.0	0.0	0.1	0.3	0.3	0.3	0.3	0.3	0.4	0.4	0.5	-1.5

Integrated Improvement Plan (IIP)

Staff Engagement Score

Staff Engagement Score

Timescale	Value	SPC
May-24	5.70	
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	



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/04/2025 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.

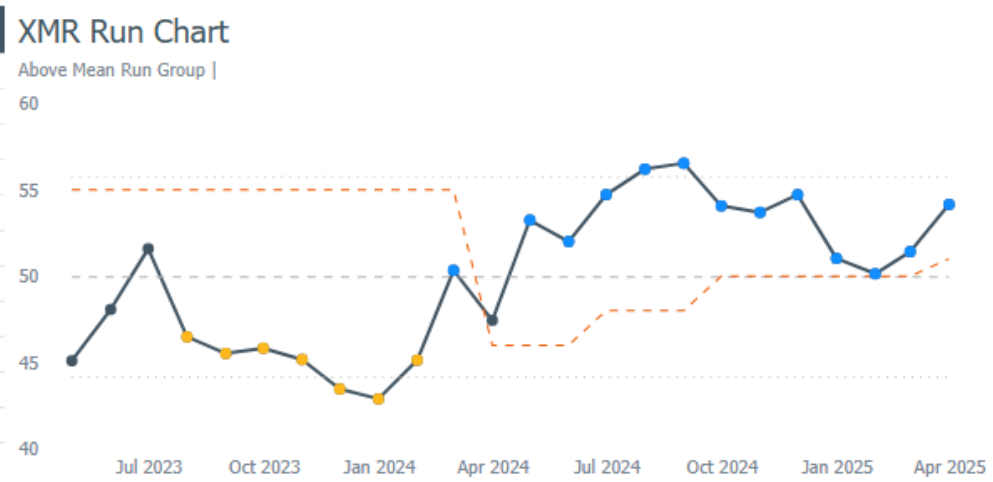
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Staff Engagement levels (5.97) are below the national average (6.78).	• Priorities identified through NSS have been acted on, with a wide variety of actions initiated	Head of Staff Experience	End Mar 26	• The latest NQPS results (April 2025) have been published and indicate a declining picture, with staff engagement falling to 5.97. This is higher than the same time last year, and is not uncommon in the months that follow the staff survey, but indicates a need for staff to feel confident that their experience represents a key priority. Staff survey priorities (x3) have been identified, root cause analysis completed and actions initiated to remedy/ mitigate. These are being tested, refined and co-developed through staff survey workshops throughout May. A staff survey action plan has also been developed, with strict governance through the CPO, PRMs, TMC and P&CC to ensure action is taken.
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 Feb 26	• A quality improvement (QI) approach has been taken to the staff survey results across three parallel, staggered workflows; Trust, Care Group and Corporate. Phases 1-4 of the A3 are complete for Trust and Care Group work, with actions clearly articulated through a staff survey delivery plan. These will be further refined through Trust-wide staff survey workshops, which are involving staff in testing and co-developing solutions. Activity taking place at a Care Group level is likely to have the most immediate impact on outcomes and will be reported monthly at P&C Senior Leads to ensure actions have the desired effect.
2024 NHS Staff Survey	• Driving response rates across the 2024 NSS is key to improving engagement and the credibility of results	Head of Staff Experience	End Mar 25	• This action is now complete. The Trust achieved the highest response rate in it's history (63%) – a 22% increase year-on-year and harnessing the voice of >2200 more staff. The Trust benchmarks in the top 10% nationally of all 122 Acute Trusts and is in the top three Acute Trusts for improvement year-on-year. An after-action review is taking place to ensure that staff voice is maximised throughout the 2025 NHS Staff Survey (and beyond).

Integrated Improvement Plan (IIP)

Type 1 Emergency Department; Four Hour Compliance

Type 1 Compliance 4hrs

Timescale	Value	SPC
May-24	53.2%	
Jun-24	52.0%	
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%	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/04/2025 the latest Type 1 Compliance 4hrs performance is 54.2% against a Trajectory target of 51.0% (higher is better).

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

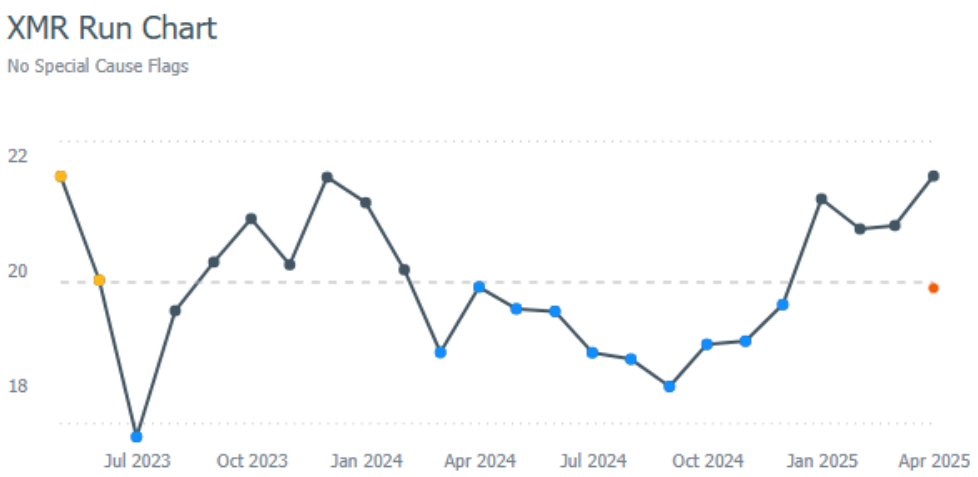
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Attendance Avoidance	• Working with partners to review the revised SPOA model for the impact and successes of the changes to ensure a 7 day service for maximum effectiveness and efficiencies for staff and patients. • Development of direct access pathways and extending use of the virtual wards and frailty services.	• COO • Dep COO UEC • CN/CL ED	• Q1 to Q4 • Q1	• Performance 54.2% is exceeding trajectory target of 51%. Clinically lead Improvement Weeks for WHH and QEQM are scheduled across 25/26 with week 1 working together to review Processes in Hospital. • Frailty model: winter funding secured to support QEQM and WHH frailty SDEC test of change – under evaluation Q1 for impact – business case required to continue. • Acute Virtual ward – winter funding secured for test of change for acute virtual ward at QEQM and WHH – expansion to 12 per site from Feb '25 – average achieved 11.
Safe and Effective ED	• Workstream associated with RLoS programme –focus on ensuring ED systems and processes are standardised across sites, workforce aligned to demand (medical and non-medical), internal standards are embedded with clear escalation, grip and control • Review of CDU model on both sites.	• CL ED • Dep COO UEC • MDs	• Q1 • Q1	• Internal professional standards to be reviewed and monitored with process mapping by the improvement team as part of the aims of the Improvement week 1, to include specialities and radiology provision and response. • Heatmap for demand profiles requested to ensure workforce alignment: due Q1
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 whilst considering location and GP streaming 7 day service for all walk in patients.	• SiteTri • Dep COO UEC	• Q1 to Q4	• Patient flow and pathways for emergency patients will be considered and reviewed as part of the Emergency Village capital development at WHH and QEQM. • GP streaming to be introduced at WHH from the end of April Monday to Friday.

Integrated Improvement Plan (IIP)

12 Hour Total Time in Emergency Department

12 Hr Total Time in Department

Timescale	Value	SPC
May-24	19.3%	
Jun-24	19.3%	
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%	



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/04/2025 the latest 12 Hr Total Time in Department performance is 21.7% against a Trajectory target of 19.7% (lower is better).

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

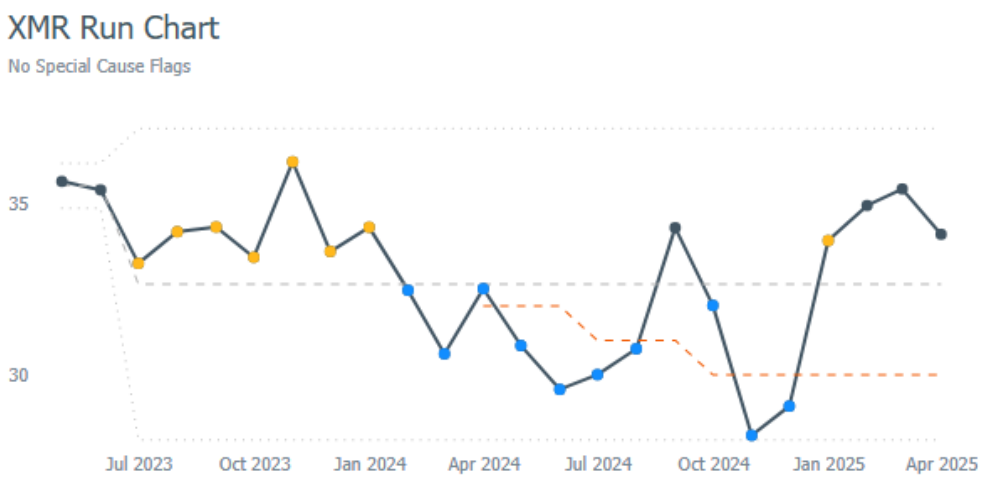
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Demand outstrips capacity	• Improve timeliness for decision to admit • Direct pathways to assessments units following decision to admit • Increase senior decision maker time on assessment units • Improve flow into downstream wards – internal flow workstream from RLoS and proactive site management • Reducing Length of Stay Programme – reduce delays in patient pathways and robust and proactive management of flow	• Tri MD Tri DoN	Quarter 1	• Medical workforce review supported by DCMO delayed – focus Q1 25/6 • RLoS programme roll out; Internal flow and SAFER bundle core improvement prog. • Workstream established to review direct admission pathways • Cross site ED T&F group in place; development of 12h recovery plan including establishment of effective CDUs on both sites – WHH to be implemented Q2 25/6 • RLoS; further reduction to support more patients managed through the core beds
Weekend profiles	• Improve discharge profile at weekends to match demand • Implement criteria led discharge • Review support functions at weekends to support discharges • Improve w/e planning & proactive transfer processes across sites	• CG Tri • DCMO	Quarter 1	• Diagnostics for key reasons for delays at weekend finalised – meeting with pharmacy established regarding times of operation and centralised model • Workstream to be established for criteria led discharge • Escalation and discharge policies under review; to be finalised quarter 1 25/6 & to include expectations to support 7d services being considered through CEMG
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 –partial completion. 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

Integrated Improvement Plan (IIP)

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

% Beds Occupied 14+

Timescale	Value	SPC
May-24	30.8%	
Jun-24	29.6%	
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%	



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/04/2025 the latest % Beds Occupied 14+ performance is 34.1% against a Trajectory target of 30.0% (lower is better).

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

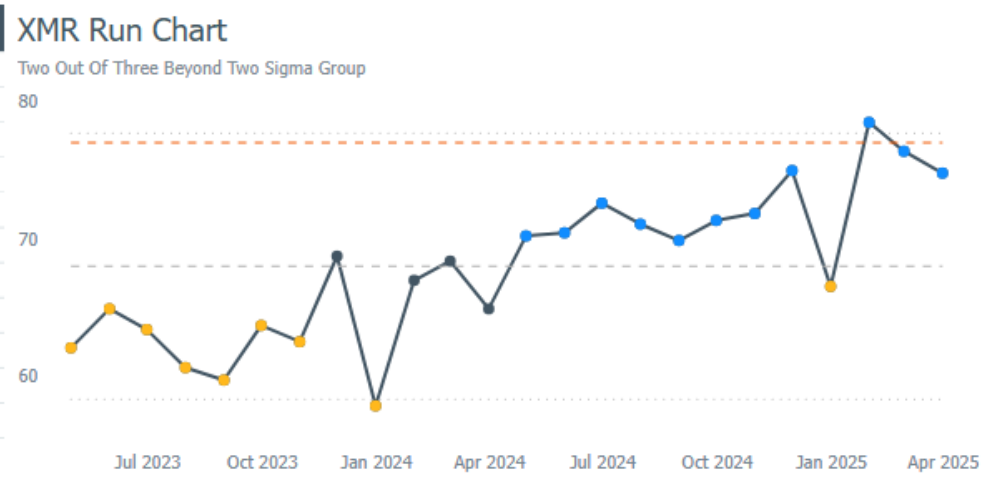
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Patients meeting the criteria to reside >14 days	• Revisit criteria to reside and develop training plan to improve data completeness and quality • Consider out of hospital alternatives to patients residing – virtual ward expansion, ESD, hospital at home, increased community capacity etc • Review discharge dependency requirements for therapy and diagnostics – alternative pathways to deliver this as part of RLoS programme	• Dep COO UEC/CG DoN • COO/Dep COO UEC • Deputy COO/MD DCB	• Q1 • Q1 • Q1	• Overview of training requirements developed as part of RLoS programme with regards to data quality and completeness for C2R • Virtual ward task and finish group established – revision of ToR to expand scope and opportunities – pilots for acute medicine virtual ward in place – average 11 beds saved • Therapy review underway. Test of change for ESD part of winter scheme • Review of function of site discharge coordinators – listening events held on both acute sites in October – follow up event May 25 with review also of IDT establishment wit the system partners
Patients not meeting the criteria to reside >14 days	• Demand and capacity for D2A pathways – working with HCP partners to review demand and capacity to mitigate delays for patients waiting to access D2A capacity • Review of internal codes – therapy reviews required for discharge – develop D2A approach	• COO/Deputy COO-UEC • System Partners	• Q1 • Q1	• Test of change in place for therapies at Board rounds and D2A approach in development across system wide therapy review • System schemes in development to expand capacity to support patients to be cared for OOH – on-going discussions with ICB to expand D2A pathways as part of winter resilience – reduction in wait times for P1 noted • Revised model for management of complex patients with escalation Q1
Grip and control: all LOS	• Implement weekly stranded reviews on all sites • Develop standards for managing complex patients across their pathway – internal and external • Develop escalation systems and processes	• Deputy COO-UEC • MDs	• Q1	• LOS for patients >14 days under review at specialty level – focus on frailty • Discharge and escalation policy signed off CEMG Dec – chair sign off Jan 25 • SAFER bundle – revisit and standardise process for consistent implementation– impact assessment q1

Integrated Improvement Plan (IIP)

Cancer 28 Day Faster Diagnosis Compliance

Cancer 28d Combined Performance

Timescale	Value	SPC
May-24	70.2%	
Jun-24	70.4%	
Jul-24	72.6%	
Aug-24	71.0%	
Sep-24	69.9%	
Oct-24	71.3%	
Nov-24	71.8%	
Dec-24	75.0%	
Jan-25	66.5%	
Feb-25	78.5%	
Mar-25	76.4%	
Apr-25	74.8%	



Understanding the Latest Performance

Improvement flag alerting for 3 periods

For the month beginning 01/04/2025 the latest Cancer 28d Combined Performance performance is 74.8% against a static target of 77.0% (higher is better).

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

The biggest contributing factors are: 07 - Lower GI (54.2% , 315*), 11 - Urological (56.5% , 216*), 09 - Gynaecological (65.9% , 170*). *Breaches

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Access to timely diagnostics	• Reduce wait times for CT and US Guided Biopsy, US. • Endoscopy booking times • Breast US booking times	• Radiology • Endoscopy	• Ongoing	• Access to diagnostics continues to be monitored through weekly escalation meetings held with the Deputy Head of Radiology. With some timelines expected in April as second touchpoint was added mid-week to continue to monitor progress. • A delay in vetting has been identified across certain modalities. There is a recognised need to increase the frequency of vetting in specific area, Virtual Colonography being one example, in order to reduce vetting backlogs and minimise delays for patients on cancer pathways.
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 significantly reduce the time between diagnostic results and the receipt of outcome letters for both GPs and patients. • At the end of April, the Trust had a backlog of 325, an improvement on the end of March position. However, earlier indications in May show the backlog is increasing. • A Trustwide ambition has been set to maintain a stable backlog of fewer than 250 letters, whilst also ensuring that no patient waits more than two weeks to receive their outcome letter.
Lower GI	• Key contributing specialty to the non compliant position • Low ranking specialty for 28D against national benchmarking data	• Specialty	• Q4	• There have been significant improvements in the LGI pathway – 1st OPA regularly taking place within one week of referral, Endoscopy wait times under 10 days. • The newly ratified pathway will continue to be adopted in practice throughout 25/26. • Both WHH and QEQM sites are reviewing their letter administrative process to improve letter turnaround time.

Integrated Improvement Plan (IIP)

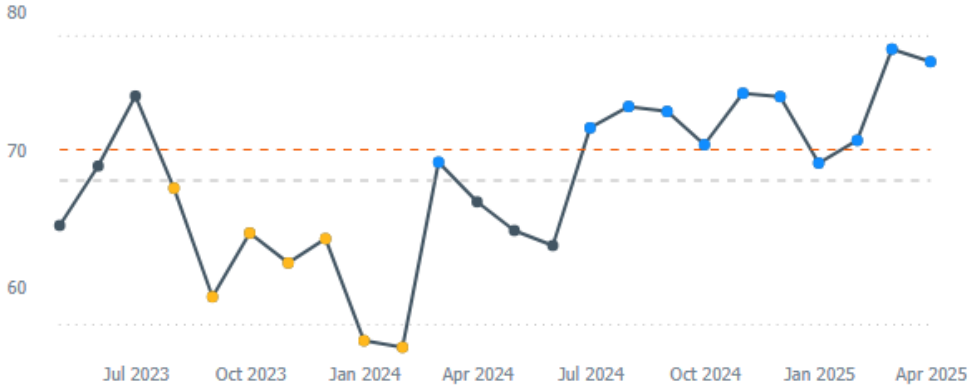
Cancer 62 Day Performance

Cancer 62d Combined Performance

Timescale	Value	SPC
May-24	64.1%	
Jun-24	63.0%	
Jul-24	71.6%	
Aug-24	73.2%	
Sep-24	72.8%	
Oct-24	70.4%	
Nov-24	74.1%	
Dec-24	73.9%	
Jan-25	69.0%	
Feb-25	70.7%	
Mar-25	77.3%	
Apr-25	76.4%	

XMR Run Chart

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



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/04/2025 the latest Cancer 62d Combined Performance performance is 76.4% against a static target of 70.0% (higher is better).

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

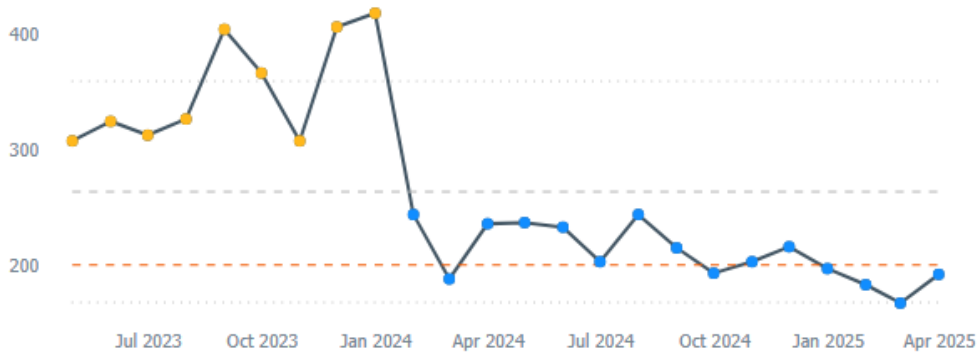
The biggest contributing factors are: 11 - Urological (70.9% , 23*), 07 - Lower GI (67.5% , 14*), 01 - Breast (82.1% , 13*). *Breaches

Cancer Over 62d on PTL

Timescale	Value	SPC
May-24	237	
Jun-24	233	
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	

XMR Run Chart

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



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/04/2025 the latest Cancer Over 62d on PTL performance is 192 against a static target of 200 (lower is better).

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

The biggest contributing factors are: 11 - Urological (70*), 07 - Lower GI (63*), 08 - Skin (15*). *Number

Integrated Improvement Plan (IIP)

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	• Successful recruitment across the clinical team within radiology will boost substantive capacity for CT and US biopsy capacity. • Visibility on vetting lead times now being discussed at escalation meetings.
Urology treatment capacity	• Limited consultant robotic capacity • Limited oncology capacity	• Urology	• Q2	• Rapid Access referrals increased for three consecutive months across January, February and March following the high profile prostate cancer case of Sir Chris Hoy. The number of patients on the prostate pathway has increase and, by nature of a two-month lag, in April we started to see the 62 day breach position increase for urology. • A recovery plan is in place and we anticipate a recovery of the position by end June, early July. • 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. • April was further challenged by Oncology capacity due to staff sickness. WLIs were implemented and the position is being closely monitored.
Surgical booking out times	• Elongated time between MDM and surgical treatment	• All surgical specialties	• Ongoing	• Close monitoring of booking out times for all surgical treatments across all specialties supported by 31D breach reviews • Cancer services are supporting specialties with reviewing the time from MDM to Decision to Treat discussions due to the impact on the 62d compliance standard
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.

Integrated Improvement Plan (IIP)

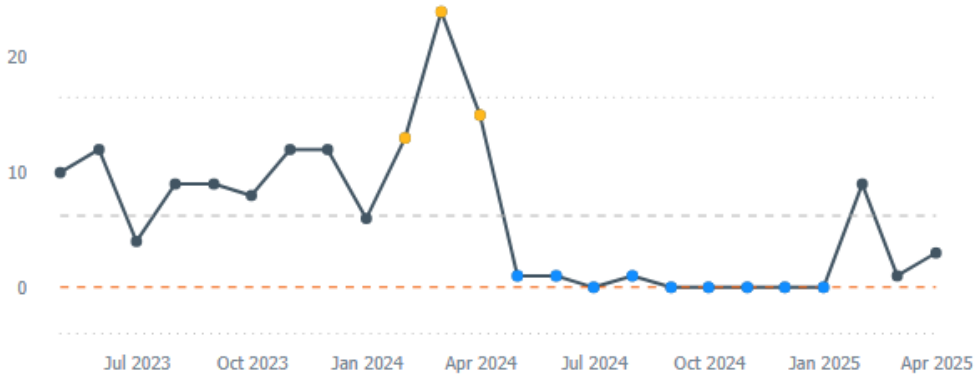
Referral to Treatment Waiting Times; 104 & 78 week waits

RTT 104w Breaches

Timescale	Value	SPC
May-24	1	
Jun-24	1	
Jul-24	0	
Aug-24	1	
Sep-24	0	
Oct-24	0	
Nov-24	0	
Dec-24	0	
Jan-25	0	
Feb-25	9	
Mar-25	1	
Apr-25	3	

XMR Run Chart

No Special Cause Flags



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/04/2025 the latest RTT 104w Breaches performance is 3 against a static target of 0 (lower is better).

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

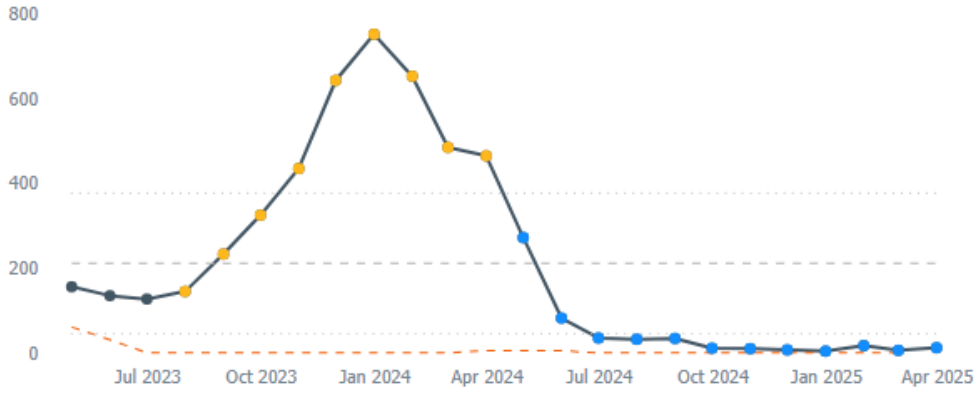
The biggest contributing factors are: 100 - GENERAL SURGERY (1*), 120 - EAR NOSE AND THROAT (1*), 215 - PAEDIATRIC EAR NOSE AND THROAT (1*). *Breaches

RTT 78w Breaches

Timescale	Value	SPC
May-24	272	
Jun-24	82	
Jul-24	35	
Aug-24	32	
Sep-24	34	
Oct-24	11	
Nov-24	10	
Dec-24	7	
Jan-25	4	
Feb-25	17	
Mar-25	6	
Apr-25	12	

XMR Run Chart

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



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

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

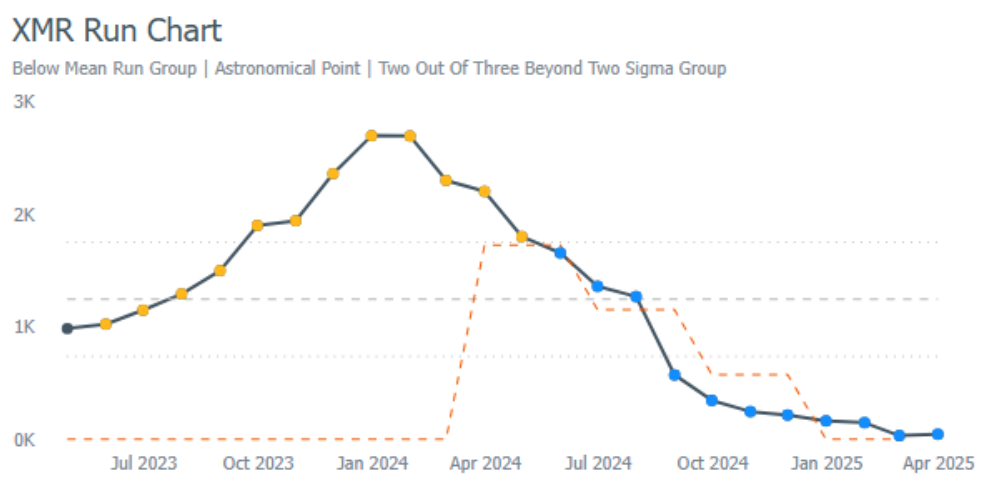
The biggest contributing factors are: 120 - EAR NOSE AND THROAT (3*), 100 - GENERAL SURGERY (3*), 130 - OPHTHALMOLOGY (2*). *Breaches

Integrated Improvement Plan (IIP)

Referral to Treatment Waiting Times; 65 week waits

RTT 65w Breaches

Timescale	Value	SPC
May-24	1,802	
Jun-24	1,656	
Jul-24	1,360	
Aug-24	1,269	
Sep-24	572	
Oct-24	346	
Nov-24	247	
Dec-24	216	
Jan-25	164	
Feb-25	148	
Mar-25	33	
Apr-25	45	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

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

The biggest contributing factors are: 120 - EAR NOSE AND THROAT (9*), 301 - GASTROENTEROLOGY (8*), 130 - OPHTHALMOLOGY (7*). *Breaches

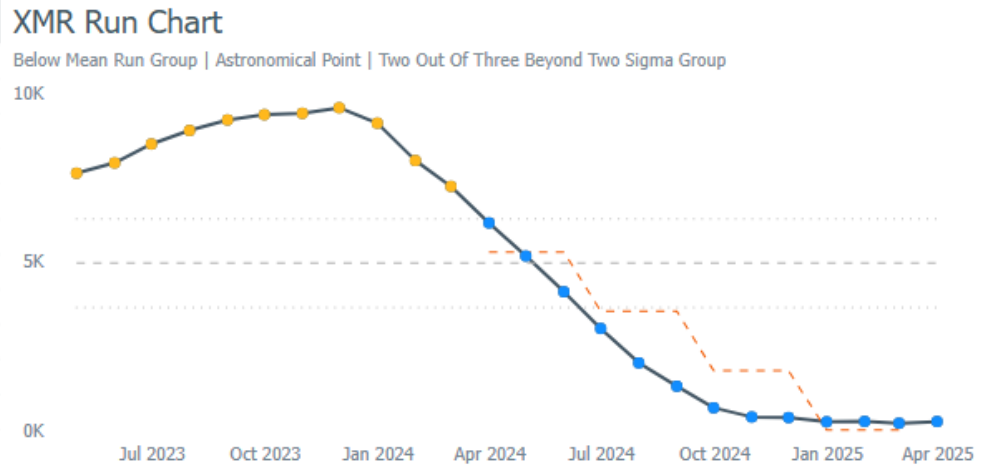
Drive to eradicate 65 week waits and sustain as well as reduce the level of 52 week waits to <1% of PTL from a baseline of 3.6%.	• Weekly clearance against trajectory monitored at Access with clear delivery plans for non-compliance.	• COO	• Ongoing	• Performance shared daily with all specialities, to ensure services are on track against trajectory.
	• Continued drive through daily oversight and management of risk cohort through care group PTL's and into Trust Access meeting.	• COO	• Ongoing	• Weekly Returns/Forecasts shared with ICB/Region – EKHUFT have exited Tier 2 Support for Elective Care.
	• Theatre programme to improve utilisation to 85% and drive clearance of backlog.	• Dir Planned Care Recovery	• Ongoing	• 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
	• All internal capacity being directed to key risk cohorts from dropped sessions	• MD - CCAS	• Ongoing	• Continual review of bookings to ensure patients are dated in chronological order and priority.
	• Independent Sector capacity aligned to support risk cohorts	• MD – CCAS	• Ongoing	• Ongoing

Integrated Improvement Plan (IIP)

Endoscopy Backlog; Overdue Surveillance and Routine Waits

Endoscopy Backlog

Timescale	Value	SPC
May-24	5,170	
Jun-24	4,108	
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	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

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

The biggest contributing factors are: OGD (111*), Dual (70*), Colon (63*). *Overdue Waiters

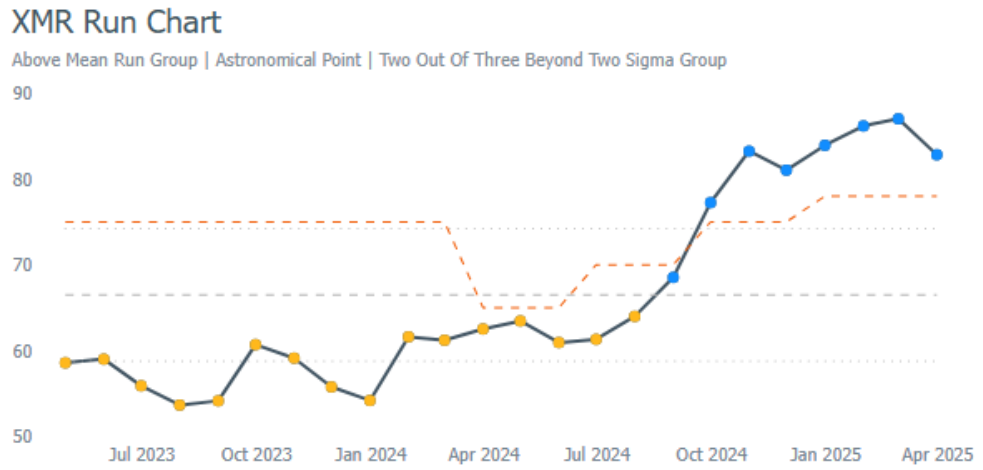
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Theatre utilisation and bookings	• Reception staff workforce review completed and additional staff required part of 25/26 business plans • Business planning for 25/26 to ensue ongoing sustainability.	• Endoscopy GM • HoOPs	• Ongoing	• Activity 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
Demand management	• Complex Polyp • GA Activity • WASP Triage	• Endoscopy GM • Clinical Lead • HoOPs	• Ongoing	• A business case developed, 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. • Assistance in analysing the WASP triage backlog to ensure compliance with endoscopy DM01 position
Alternative Diagnostics to support demand	• All three business cases approved to facilitate phase 2 of the Endoscopy recovery plan • Business case awaiting Executive review 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.

Integrated Improvement Plan (IIP)

Diagnostics; DM01 Compliance % Patients Waiting less then 6 Weeks

DM01 Compliance

Timescale	Value	SPC
May-24	63.5%	
Jun-24	60.9%	
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%	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/04/2025 the latest DM01 Compliance performance is 82.8% against a Trajectory target of 78.0% (higher is better).

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

The biggest contributing factors are: MRI (84.8% , 851*), CT (83.5% , 741*), Cardiac MRI (21.9% , 353*). *Breaches

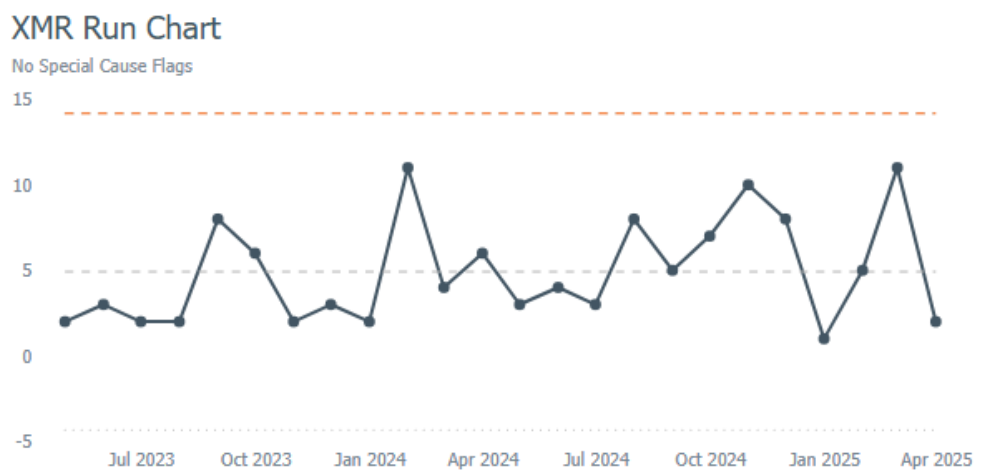
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Echocardiography Back log	• Ongoing review of capacity gap	• Cardiology GM • Cardiology Lead Clinical Scientist	• Ongoing	• Echo overall finished April at 78.1%. • Simple echo is at 95.8% April. • Non-achievement driven by complex echo however, waiting list continues to reduce for these modalities. Insourcing/outsourcing to be explored. • 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. • May is showing continued improvement with performance currently at the highest it has been for 2.5 years (81% at this point in the month).
Cardiac MRI Backlog	• Recruitment to vacant consultant posts.	• Cardiology GM	• March 2026	• Successful recruitment to two consultant posts which will provide additional capacity. First post will started in December however leaves in June for personal reasons. • Second to commence in June 2025 – goes on mat leave September 2025. • 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.

Integrated Improvement Plan (IIP)

Patient Falls with Moderate or Above Harm Recorded

Falls with Harm

Timescale	Value	SPC
May-24	3	
Jun-24	4	
Jul-24	3	
Aug-24	8	
Sep-24	5	
Oct-24	7	
Nov-24	10	
Dec-24	8	
Jan-25	1	
Feb-25	5	
Mar-25	11	
Apr-25	2	



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/04/2025 the latest Falls with Harm performance is 2 against a (6 Sigma Threshold) target of 14 (lower is better).

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

The biggest contributing factors are: QDEA - QEQM DEAL WARD (1*), QSTM - QEQM ST. MARGARETS 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 shows a drop to 2 for April.	• Trust Wide Improvement Plan (TWIP) re-designed for 25/26 focussing on learning from previous year and AARs undertaken. • Strengthening governance through the After Action Review (AAR) processes using SEIPS model to ensure detailed learning and targeting of actions.	Falls Lead/Care groups ADoN/ Falls Lead	June`25 June '25	• Trust Wide, multidisciplinary Improvement Plan approved at April FoCC. To be presented at tMay NMECfor final approval. • TWIP will be monitored, for quarterly progress on actions and impact, by the Falls Steering Group and FoCC. • AAR's being undertaken for all falls with harm and learning themed. • Themed learning assisted in defining actions for TWIP and for individual areas with action plans. • FoCIP findings to be included within all AARs. • Learning from AARs to be presented and shared through the Falls Steering Group.

Integrated Improvement Plan (IIP)

Falls with Harm; Actions Table

Falls with Harm (con't)

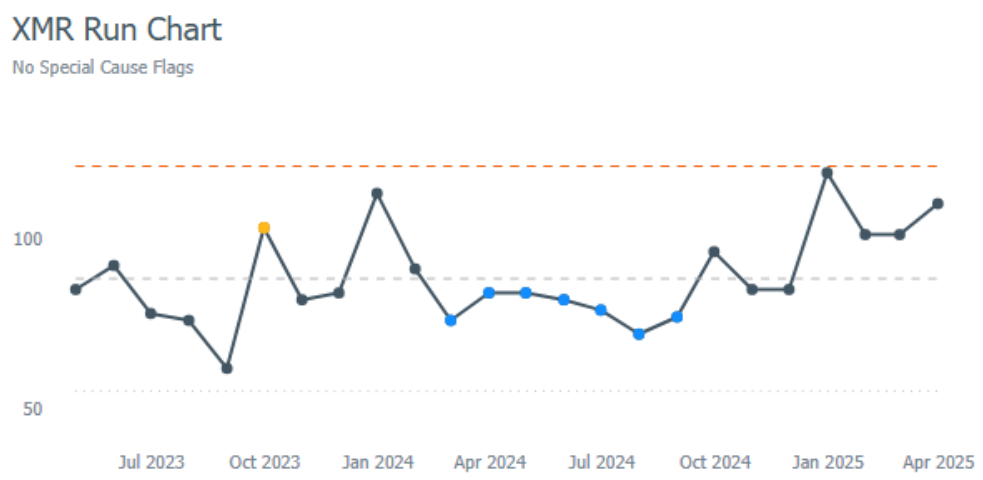
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
A consistent theme in audits and incidence data is that MFRACP risk assessments are incomplete or inaccurate. In addition, completed risk assessments are not always acted upon correctly. These issues lead to delayed Falls prevention strategies, delayed treatment strategies and a resulting increase in patient falls.	• To provide training and education on dynamic staff deployment risk assessment.	ADoN FoC/ADoN WDET.	July 2025	• To design and deliver a tabletop exercise for NIC to support the redeployment of staff across the ward/unit based on chnages in patient needs.
		Falls Lead	June 2025	• Training module designed to address the need for completion of the Multifactorial Risk Assessment Care Plan. To be added to ESR.
	• MHRA Trolley and Bed rail risk assessment education for completion as per alert to be provided.	Falls Lead/ADoN FoC	May 2025	• Learning and development team added trolley and bedrail training to ESR falls mandatory training package. Staff undertaking falls module in addition will complete trolley and bedrail training module. • There are curently issues with staff access and completion of the ESR training package. This is being addressed by the Learning and Development team with an expectation this will be resolved during June 2025.
	• 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. Date still pending.

Integrated Improvement Plan (IIP)

Pressure Ulcers; Hospital Associated

Pressure Ulcers

Timescale	Value	SPC
May-24	84	
Jun-24	82	
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	



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/04/2025 the latest Pressure Ulcers performance is 110 against a (6 Sigma Threshold) target of 121 (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
The Trust noted a rise in Pressure Ulcers in April 2025. With a specific increase in shear related damage and Unstageable pressure ulcers.	• Individual ward areas identified with high levels of pressure ulcers – meeting with Matrons to discuss how to address themes.	Tissue Lead Nurse/Matron	May 2025	• Tissue Viability Team holding bespoke training for individual areas for support. Joint working planned with manual Handling team for some areas.
	• Lead TVN to present a report at Fundamentals of Care Committee for discussion and local actions to be agreed with Care Group Leads.	TV lead/Care groups	May 2025	• For discussion at Fundamentals of Care committee on 20th May 2025.
	• To adapt the auditing of Slide sheets to correct usage rather than availability. To include on the ward education programme for areas of low compliance.	Manual Handling	June 2025	• Initial reviews involving triangulating data, demonstrate that wards with low slide sheet compliance are the highest reporters of patients with shear damage. First results of audit to be presented at Tissue Viability Steering Group in May 2025.
	• Manual Handling to provide equipment to aid staff with repositioning patients in bed.	Manual Handling	July 2025	• To be discussed at Tissue Viability Steering Group in May 2025. To produce some Trust wide communication on the use and supply of the Golman 'Turner'. To attach to the hoist and aid repositioning in bed.
	• 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	September 2025	• First meeting held to look at themes across the patient pathway. Work will be ongoing including reviewing the national guidance and looking at NICE guidance and various systems used across the network.

Integrated Improvement Plan (IIP)

Pressure Ulcers; Action Table

Pressure Ulcers (con't)

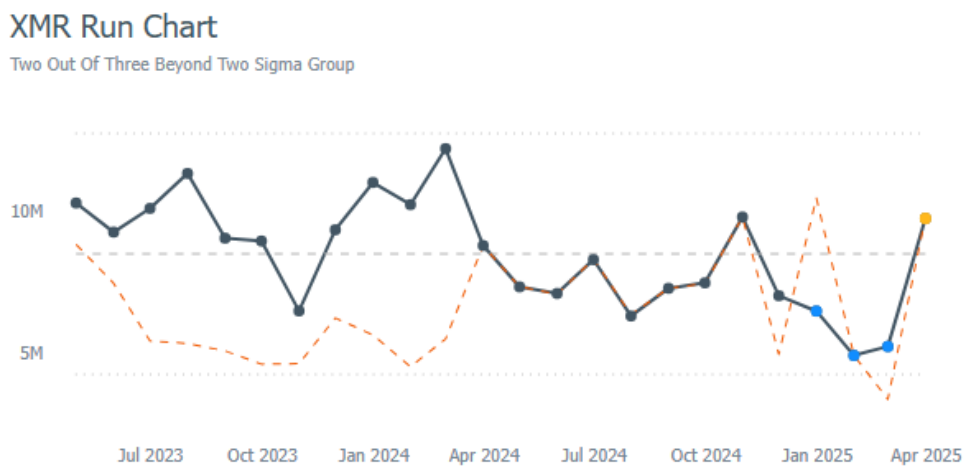
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Increased pressure damage noted due to long gaps in repositioning. Contributing to the development of unstageable and moderate harm pressure damage.	• To review current foam mattresses and tender for replacements to ensure all mattresses are of higher specification for higher risk patients. • To review data to drill down into themes and barriers for repositioning gaps. Attendance from specialist teams and clinical teams' representation.	Manual Handling & TV Lead TV lead/Care groups	June 2025 April 2025	• Tender and evaluation completed. Procurement are liaising with company on proposed changes with the evacuation straps on the new foam mattresses. • Barriers to implementing improvements have been analysed with the TV team and mitigations and actions included for priority in 2025/26. Actions and their impact will be monitored through Tissue Viability Steering Group.
An increased theme for April has been lack of escalation of pressure damage at first review resulting in deterioration.	• Focus on earlier reporting and escalation to avoid the development of deeper pressure damage. • To set up a working group with ED to improve pressure ulcer prevention and skin inspection from the start of admission.	Lead TVN Lead TVN	August 2025 August 2025	• To focus communications and education on the early reporting of category 1s and 2s. Mandatory training module will assist in the message of early reporting. • First working group to be set up. Initial communication sent out for availability.
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.	• To review pressure ulcer training with a view to produce a mandatory module. Moodle training being developed regarding end of bed risk assessments. • Trust Wide Improvement Plan (TWIP) to be reviewed to align with Patient Safety Incident Review Framework and Trust priorities. • Risk assessment documentation on admission and dynamic assessments during admission to be reviewed.	TV Lead TV lead/Care groups ADoN FoC	July 2025 April 2025 August 2025	• Tissue Viability now part of clinical induction from Feb 2025. Mandatory training has been agreed and Module to be agreed and launched in July 2025. • Developed transformative action plan for 2025/26. Agreed at FoC Committee in April 2025 and for support at NMEC in May. • Fundamentals of Care Lead Nurses to meet with Nurse consultant from Palliative care and WDET Lead regarding on admission risk assessments and dynamic risk assessments. This will also combine with the work that is taking place with the Sunrise team.
Delay obtaining appropriate support surface for vulnerable patients. Contributing to the increase in Unstageable pressure ulcers this month.	• To improve the trollies in ED to include a high specification mattress. • Training on accurate risk assessment will improve the compliance with pressure ulcer prevention strategies. Modules being developed for pressure ulcer mandatory training for all clinical staff.	AdoN FoCC ADoN FoC/ADoN WDET.	July 2025 July 2025	• Report on options compiled by procurement currently being reviewed. Trust has gone back out to tender to look for suitable alternative as the trialled trolley was not suitable for X-ray. To be discussed through the ED Trolley Working Group and progress presented at July TVSG. • Mandatory pressure ulcer training module agreed. Module to be agreed and launched in July 2025.

Integrated Improvement Plan (IIP)

Income & Expenditure Monthly Deficit (Group)

Deficit In Month Group (£)

Timescale	Value	SPC
May-24	7.3M	
Jun-24	7.1M	
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	



Understanding the Latest Performance

ALERT: Variation flag has changed from Improvement to Concern

For the month beginning 01/04/2025 the latest Deficit In Month Group (£) performance is 9.7M against a Trajectory target of 9.8M (lower is better).

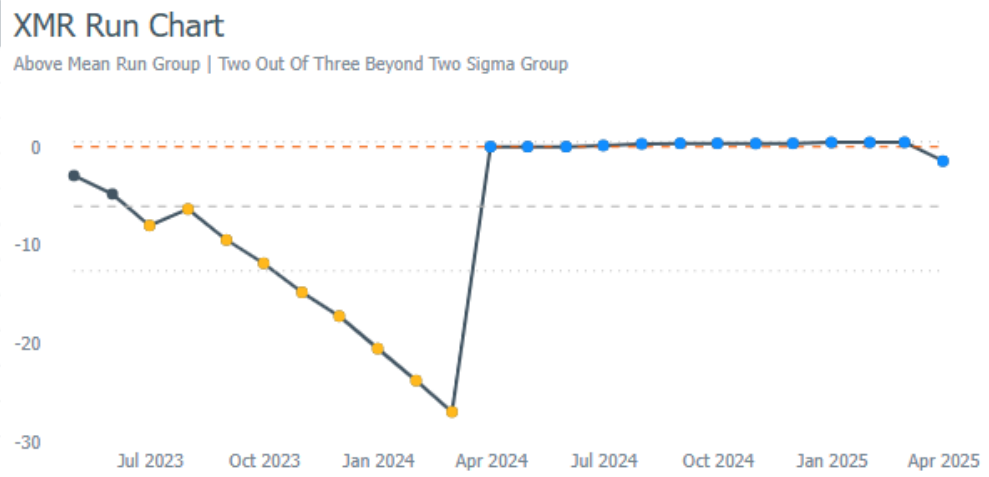
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Achievement of financial plan for 25/26	• Cash out CIP target of £80m is needed to support the agreed £62.4m deficit (Pre DSF) position as submitted on the 30th of April.	• Theme leads • PMO	• On-going	• As with other Trusts, work is ongoing with regards to agreeing budgets for the Care Groups and Corporate areas. A robust approach to aligning activity, workforce and financial budgets has been undertaken throughout the business planning process. Work on budget setting will be concluded by month 2 in readiness for reporting.

Integrated Improvement Plan (IIP)

Financial Efficiencies; YTD Variance

Efficiencies YTD Variance (£M)

Timescale	Value	SPC
May-24	0.0	
Jun-24	0.0	
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	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/04/2025 the latest Efficiencies YTD Variance (£M) performance is -1.5 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 £44.5m unadjusted • The £80m CIP plan will be transacted by month 2 allocating all of the CIP targets into the care group and corporate areas
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 forecasting in process of validation with Theme leads and Finance business partners.

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

Patients

Executive Summary:

Unplanned Care

- Overall four-hour compliance improved in April with performance across all types of department at 76.2% and Type 1 departments at 54.2%. Compliance in Type 1 departments has been above the mean of the two year period now for 12 months with performance consistently above 50%. We should consider recalculating control limits on the basis of this step change.
- Despite the improvements seen in four-hour compliance the total time patients are spending in our emergency departments appears to have stepped up since January with 21.7% of patients spending more than 12 hours in the department prior to admission, transfer or discharge home. This remains a significant challenge and focus for the Trust and system partners
- Ambulance handover performance remains strong with 92.6% of patients handed off to the Emergency Departments within 30 minutes.
- The number of patients in ED corridor >30 mins in April was at a similar level as the previous year, with 1,791 patients (60 per day) experiencing corridor care. There was a month on month reduction in time spent in corridors, with a reduction of 25% of total corridor hours compared to March 2025.
- An increase in patients >7 days on the RTS caseload was observed again in April to an average of 155 patients, a slight reduction on March 2025. Patients recorded as having No Criteria to Reside (NCTR) , and remaining in hospital at midnight was an average of 173 patients though out April, unchanged from March. Delayed discharges contributes to the increased LOS observed and challenges in flow through the three main sites.

Planned Care

- April performance was impacted by the Easter break and additional bank holidays, leading to a slight decline in key metrics. The Trust reported a modest deterioration in performance for both FDS (from 76.4% to 74.8%) and 62D (from 77.3% to 76.4%). However, 62D performance remains above the Trust's target trajectory. Encouragingly, post-Easter recovery has been swift, with continued improvements in the number of patients attending their first outpatient appointment (OPA) within 10 days.
- The RTT position deteriorated slightly throughout April with on-going challenges of late validations and complexity. The target for April was that zero patients should be waiting greater than 65 weeks which was revised due to late validation backlog entering the live waiting list. The end of April position was that there were 45 patients waiting greater than 65 weeks including 3 x 104 and 12 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 improved further in April to 80.3%. 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 deteriorated at the end of April to 82.87%. 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

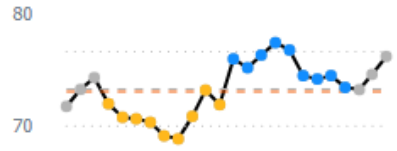
Domain	Nat	Flag	KPI	SPC	Ass...	Target	May-24	Jun-24	Jul-24	Aug-24	Sep-...	Oct-24	Nov-24	Dec-24	Jan-25	Feb-...	Mar-...	Apr-25
Patients	NAT		ED Compliance			73.0%	76.0%	75.2%	76.3%	77.4%	76.8%	74.4%	74.1%	74.4%	73.4%	73.2%	74.6%	76.2%
	IIP		Type 1 Compliance 4hrs			51.0%	53.2%	52.0%	54.7%	56.2%	56.5%	54.1%	53.7%	54.7%	51.0%	50.1%	51.4%	54.2%
	IIP		12 Hr Total Time in Department			19.7%	19.3%	19.3%	18.6%	18.5%	18.0%	18.7%	18.8%	19.4%	21.3%	20.7%	20.8%	21.7%
	NAT		12Hr Trolley Waits			0	1,227	1,189	1,085	1,033	1,017	1,171	1,121	1,326	1,385	1,177	1,327	1,256
	NAT		Ambulance Handovers within 30m			95.0%	92.6%	88.1%	87.7%	89.8%	88.6%	86.6%	90.0%	88.4%	88.2%	87.7%	90.5%	92.6%
	IIP		% Beds Occupied 14+			30.0%	30.8%	29.6%	30.0%	30.8%	34.3%	32.0%	28.2%	29.1%	33.9%	34.9%	35.4%	34.1%
	KEY		Super Stranded >21D			107	214	205	203	212	237	212	178	184	224	239	236	232
	NAT		Not Fit to Reside (pats/day)			100.0	170.9	172.4	180.8	189.7	197.4	195.5	157.8	155.3	165.7	171.0	172.9	173.0
	IIP		Cancer 28d Combined Performance			77.0%	70.2%	70.4%	72.6%	71.0%	69.9%	71.3%	71.8%	75.0%	66.5%	78.5%	76.4%	74.8%
	NAT		Cancer 31d Combined Performance			96.0%	96.0%	94.6%	96.1%	95.2%	95.2%	92.7%	94.3%	97.1%	92.8%	96.2%	97.2%	96.4%
	IIP		Cancer 62d Combined Performance			70.0%	64.1%	63.0%	71.6%	73.2%	72.8%	70.4%	74.1%	73.9%	69.0%	70.7%	77.3%	76.4%
	IIP		Cancer Over 62d on PTL			200	237	233	203	244	215	193	203	216	197	183	167	192
	KEY		Cancer Over 104d on PTL			0	36	42	39	54	50	36	40	33	40	44	46	34
	KEY		Cancer Rapid Access Perf			93.0%	94.9%	96.1%	93.4%	90.6%	92.7%	82.3%	88.1%	93.2%	96.7%	97.7%	94.0%	96.0%

Patients

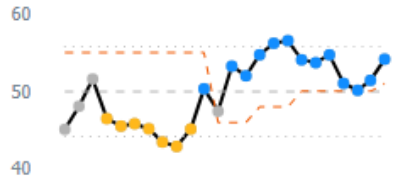
Domain	Nat	Flag	KPI	SPC	Ass...	Target	May-24	Jun-24	Jul-24	Aug-24	Sep-...	Oct-24	Nov-24	Dec-24	Jan-25	Feb-...	Mar-...	Apr-25
	NAT		RTT Incomplete Performance			49.6%	52.0%	51.0%	50.3%	50.8%	50.9%	50.5%	51.2%	52.0%	52.5%	52.8%	53.3%	54.0%
	NAT		RTT 1st OPA Performance			56.7%	58.9%	58.1%	57.5%	58.3%	57.8%	57.1%	57.5%	57.4%	58.3%	58.8%	60.4%	61.9%
	NAT		RTT 52w Performance			6.4%	6.5%	6.0%	5.6%	5.3%	4.3%	3.9%	3.6%	3.6%	3.5%	3.2%	2.8%	3.2%
	NAT		RTT Total Incomplete Pathways			89.3K	87.5K	85.8K	85.6K	88.1K	86.7K	86.0K	85.6K	83.0K	81.2K	81.3K	81.0K	83.1K
	NAT		RTT 52w Breaches			5,589	5,700	5,186	4,773	4,657	3,735	3,353	3,119	2,959	2,861	2,621	2,272	2,648
	IIP		RTT 65w Breaches				1,802	1,656	1,360	1,269	572	346	247	216	164	148	33	45
	IIP		RTT 78w Breaches				272	82	35	32	34	11	10	7	4	17	6	12
	IIP		RTT 104w Breaches			0	1	1	0	1	0	0	0	0	0	9	1	3
	IIP		Endoscopy Backlog				5,170	4,108	3,018	1,997	1,304	663	391	373	247	258	206	255
	IIP		DM01 Compliance			78.0%	63.5%	60.9%	61.3%	64.0%	68.5%	77.2%	83.3%	81.0%	83.9%	86.2%	87.0%	82.8%
	KEY		Theatre Session Opp.			25	40	33	40	51	39	44	35	45	36	39	29	30
	NAT		DNA Rate OP New			7.0%	6.9%	6.7%	7.1%	7.7%	7.7%	7.5%	7.6%	8.0%	7.6%	7.4%	7.3%	7.3%
	NAT		Theatre Uncapped Utilisation			85.0%	78.5%	79.9%	77.9%	79.2%	77.1%	77.7%	78.0%	76.7%	77.5%	76.6%	78.0%	80.3%

Patients

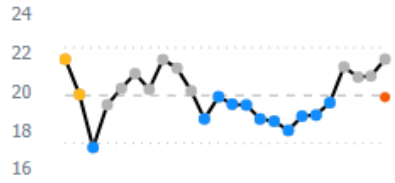
ED Compliance



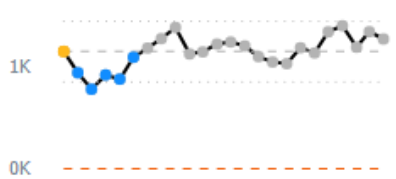
Type 1 Compliance 4hrs



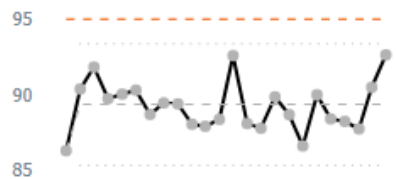
12 Hr Total Time in Department



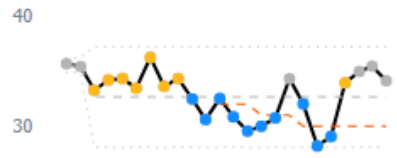
12Hr Trolley Waits



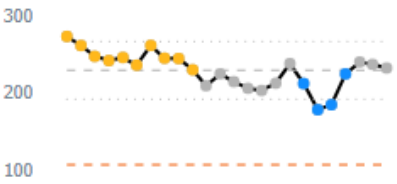
Ambulance Handovers within 30m



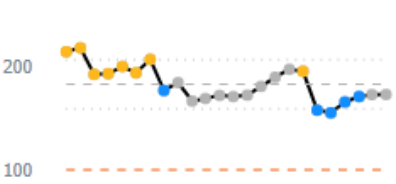
% Beds Occupied 14+



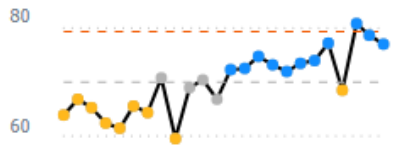
Super Stranded >21D



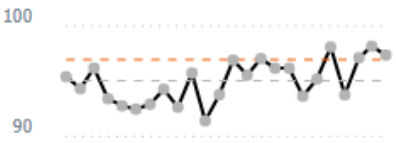
Not Fit to Reside (pats/day)



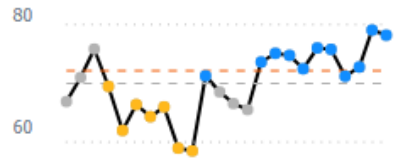
Cancer 28d Combined Performance



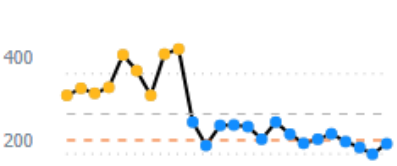
Cancer 31d Combined Performance



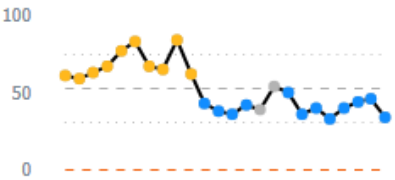
Cancer 62d Combined Performance



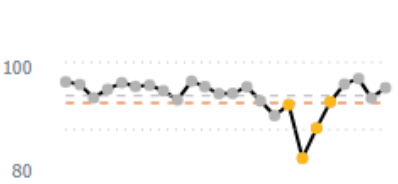
Cancer Over 62d on PTL



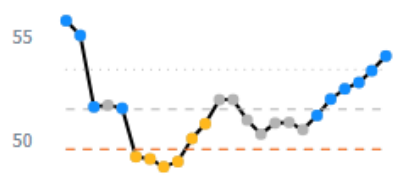
Cancer Over 104d on PTL



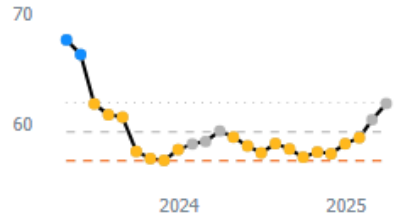
Cancer Rapid Access Perf



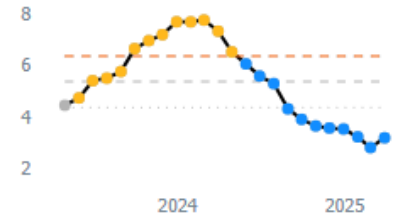
RTT Incomplete Performance



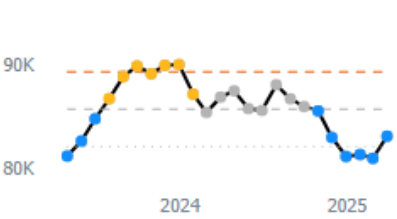
RTT 1st OPA Performance



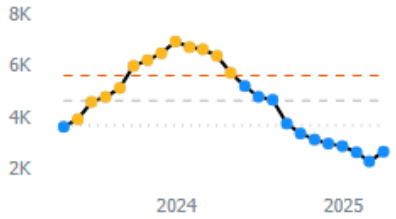
RTT 52w Performance



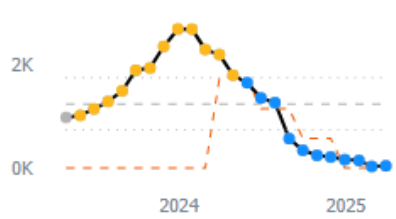
RTT Total Incomplete Pathways



RTT 52w Breaches

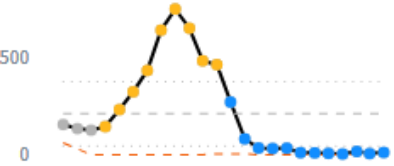


RTT 65w Breaches

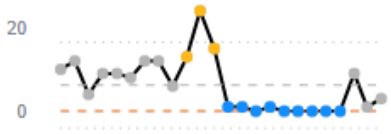


Patients

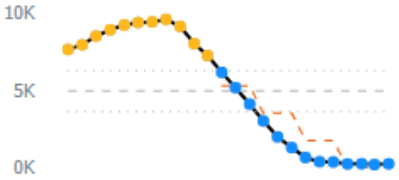
RTT 78w Breaches



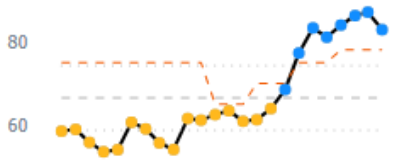
RTT 104w Breaches



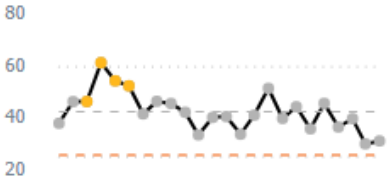
Endoscopy Backlog



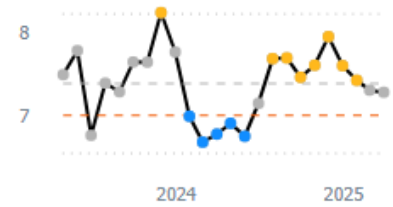
DM01 Compliance



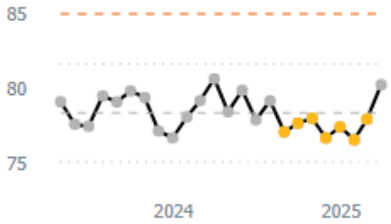
Theatre Session Opp.



DNA Rate OP New



Theatre Uncapped Utilisation



Quality and safety

Assurance

Variation

	P — Will consistently pass the target if nothing changes	? — Will not consistently pass or fail the target if nothing changes	F — Will consistently fail the target if nothing changes
H / L — Improving Variation (High or Low)		Duty of Candour - Verbal Duty of Candour - Written 15wd Safeguarding Adults Training	Complaint Response Overdue Incidents VTE Assessment Compliance
No Significant Change	FFT Satisfaction Level - Outpatient	Complaints Number Duty of Candour - Findings Falls with Harm FFT Satisfaction Level - Inpatient IPC: CDiff Infections IPC: EColi Infections IPC: Klebsiella 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
H / L — Concerning Variation (High or Low)		After Action Reviews (AARs) SHMI	

Quality and safety

Executive Summary:

Safeguarding :
Our overall training compliance as a Trust is 90.5% for Adult Safeguarding and 91.1 % for Children Safeguarding. Medical and dental staffing groups is 74.2% for safeguarding children and 77.1% for safeguarding adults Level 2 59.8% Level 3 this is below the required 85% compliance described in CR3733, Monitoring continues through the operational safeguarding group and care group performance review meetings; additional medical sessions have been put in place with the medical education team. The new safeguarding supervision model is now in place supported by the all-age safeguarding policy hybrid sessions are now in place in UEAM. Themes of safeguarding investigations include identification of self-neglect/neglect and continue to be safe discharge, formal assessment of capacity and supporting patients with complex behaviours.

Complaint Response:
The response within timescales KPI has been met for the fifth month. An issue with the IPR/Datix data collection has occurred and has been identified this month. The actual number of new complaints received is 118, this will be reflected in the monthly reporting to TMC and QSC. This issue will be resolved next month.

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 April had:
9 nationally reportable PSIIs are ongoing: 2 NEs, 1 medication incident identified through LfD, and 6 Maternity and Neonatal Safety Investigations (MNSI).
9 Local PSIIs including 1 new PSII commenced in February: 1 Perforated duodenal ulcer with peritonitis.

Never Events:
There were no new Never Events reported in April, however, a new NE was reported on StEIS 04/05/2025 (Fall from an unrestricted window) which has been presented at IRP and a PSII has been commenced. All windows are being checked to ensure that all window restrictors are in working order led by H&S lead. A Trust-wide safety alert was sent out to prompt staff to report any door locks and window restrictors that are not fully functional Current Never Event investigations are ongoing.

Duty of Candour:
In April, the findings component of DoC was 95.5% due to one being completed outside of the 10-day KPI (completed on day 11); however, the verbal and first written DoC were compliant with the KPIs.
As the DoC compliance process is now well embedded the twice-weekly meetings to improve compliance are no longer required. The expectation is that DoC continues to be actively managed, and 100% compliance is maintained through QGBP and Triumvirate escalation following the established process.
Monitoring and compliance will continue to be shared in the weekly report to executives to provide assurance.

Quality and safety

Executive Summary:

Overdue Incidents:
The number of overdue incidents reduced to 965 in April. A total of 634 incidents became overdue in April which has significantly reduced from 834 in March. 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) has been approved and circulated. 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 new weekly overdue and anomalies report is being created to be shared weekly, this aims to address all overdue incidents, actions, DoC compliance and LfPSE data quality issues.

InPhase:
The ongoing development and implementation encompass the following modules: Risk, Policies, CQC, Clinical Audit, Audit Oversight, NICE, and CAS. Persistent delays are affecting all these modules. Although all configuration meetings have taken place, the updates resulting from these meetings have either not been completed or have not met the required standards set by InPhase. We have been informed on several occasions that their servers were malfunctioning, which resulted in the loss of some configuration work. A newly designated consultant has been assigned to us, and we met for the first time on April 30 to discuss a resolution plan for each delayed application. The earliest opportunity to address these issues is scheduled for May 21, 2025, which should have coincided with the Go Live date for the Risk, NICE, Audit, CQC, and CAS applications. Due to the delays caused by InPhase, the original plan and timelines have been disregarded as they no longer align with the revised schedule. The Trust is currently working on a new plan in collaboration with InPhase.
A projection of risks has been mapped out and in view of the progress and delays by Inphase to date, we anticipate that it is likely that the Trust will not meet the March 2026 deadline and the Datix contract will need to be extended for a second year at a cost of approx. £45K. We are currently in negotiations with InPhase to agree that should this occur, they will incur the Datix licence fee for 2026.

Mixed Sex Breaches
118 breaches occurred in the month; this is a significant increase since last month and is monitored daily.
The reasons were:

- 48 patients were unable to be stepped down from critical care within the four-hour standard: 37 at WHH and 11 at QE.
- SDEC and SEAU at QEQM had a total of 67 breaches. This increase is owing to a change in reporting methodology; Patient pathways and remodelling of the environment are being reviewed.
- 1 patient on Rainbow ward requested to be with children of a similar age, but this could not be accommodated so they were cared for with own sex of mixed ages instead. This is the first time that paediatrics have identified a breach in line with national paediatric reporting criteria.

Quality and safety

Executive Summary:

Infection Prevention and Control:
C. diff infections and E. coli bloodstream infections finished below trajectory for 24/25 which is a great achievement for the Trust. However, the Trust exceeded the year-end thresholds for Klebsiella, Pseudomonas, and MSSA bacteraemia. The trajectories for 25/26 have not been set, however, the IPC team will drive towards a zero tolerance with avoidable infections. The focus will continue to be on improving environmental factors and compliance with IPC precautions, focusing on learning from post infection reviews. COVID-19 cases continue to be be observed at William Harvey Hospital, and there were no outbreaks across all sites.

Quality and safety

Domain	Nat	Flag	KPI	SPC	Ass...	Target	May-24	Jun-24	Jul-24	Aug-24	Sep-...	Oct-24	Nov-24	Dec-24	Jan-25	Feb-...	Mar-...	Apr-25
Quality	NAT		Patient Safety Incidents			2,307	1,979	1,846	2,040	1,864	1,889	2,108	2,079	2,001	2,176	1,963	1,975	2,173
	NAT		Patient Safety Incidents - Mod/Sev			64	27	46	38	37	33	48	39	37	40	62	53	56
	NAT		Never Events			0	0	1	0	2	2	1	0	0	0	0	0	0
	NAT		PSII - National			0	0	1	4	3	2	2	1	1	0	0	1	0
	NAT		PSII - Local			0	0	0	1	2	0	0	2	0	2	1	2	2
	NAT		After Action Reviews (AARs)			0	7	4	11	6	5	7	14	15	8	12	11	0
	NAT		AARs Overdue			0	51	52	45	27	23	24	26	25	35	37	42	39
	KEY		Overdue Incidents			0	1,406	1,557	1,164	724	688	659	734	757	974	1,202	1,160	965
	IIP		Falls with Harm			14	3	4	3	8	5	7	10	8	1	5	11	2
	NAT		Safeguarding Incidents			56	50	32	29	27	31	33	38	34	16	25	31	24
	NAT		Safeguarding Children Training			90.0%	93.6%	93.3%	92.3%	91.8%	91.2%	91.3%	91.5%	91.7%	91.7%	91.4%	90.9%	91.1%
	NAT		Safeguarding Adults Training			90.0%	93.5%	93.6%	93.0%	93.4%	92.7%	93.0%	93.1%	93.3%	93.3%	92.9%	92.5%	92.4%
	NAT		Duty of Candour - Findings			100%	81.3%	89.5%	91.7%	74.3%	94.6%	87.5%	100%	100%	100%	100%	100%	95.5%
	NAT		Duty of Candour - Written 15wd			100%	64.0%	64.3%	50.0%	82.1%	88.0%	96.4%	97.2%	100%	100%	96.0%	100%	100%
	NAT		Duty of Candour - Verbal			100%	78.3%	78.9%	85.7%	87.5%	100%	95.8%	97.1%	100%	100%	96.3%	100%	100%
	NAT		IPC: EColi Infections			13	11	16	14	13	16	9	9	13	14	12	10	13
	NAT		IPC: CDiff Infections			12	4	6	9	8	12	11	11	9	11	8	11	9
	NAT		IPC: Klebsiella Infections			7	7	7	9	7	11	5	6	9	6	5	9	5
	NAT		IPC: Pseudomonas Infections			2	2	4	5	2	4	2	7	4	5	1	2	0
	NAT		IPC: MRSA Infections			0	0	0	0	1	0	0	1	0	0	0	0	1
	NAT		IPC: MSSA Infections			6	7	5	8	6	8	5	2	7	9	11	13	5

Quality and safety

Domain	Nat	Flag	KPI	SPC	Ass...	Target	May-24	Jun-24	Jul-24	Aug-24	Sep-...	Oct-24	Nov-24	Dec-24	Jan-25	Feb-...	Mar-...	Apr-25
	KEY		HSMR			96.0	101.6	101.3	102.6	101.7	102.6	101.7	101.4	100.2				
	KEY		SHMI			1.070	1.051	1.126	1.133	1.131	1.140	1.140	1.142	1.127				
	IIP		Pressure Ulcers			121	84	82	79	72	77	96	85	85	119	101	101	110
	NAT		Mixed Sex Breaches			148	24	36	76	56	57	68	52	65	92	33	49	118
	KEY		Complaint Response			85.0%	4.4%	7.8%	16.2%	18.6%	31.6%	54.1%	71.4%	84.2%	86.1%	87.3%	86.0%	87.5%
	KEY		Complaints Number			127	105	77	92	87	90	85	83	94	117	99	97	117
	NAT		FFT Satisfaction Level - ED			90.0%	83.7%	83.8%	83.6%	87.5%	84.0%	83.0%	84.1%	85.1%	85.3%	82.1%	83.2%	84.0%
	NAT		FFT Satisfaction Level - Outpatient			90.0%	95.7%	95.7%	95.4%	95.6%	95.8%	95.3%	95.7%	95.8%	96.0%	95.7%	95.4%	95.7%
	NAT		FFT Satisfaction Level - Inpatient			90.0%	91.1%	90.5%	92.3%	91.0%	90.1%	88.9%	91.4%	90.8%	89.4%	88.4%	91.7%	92.3%
	NAT		VTE Assessment Compliance			95.0%	93.2%	93.4%	92.7%	93.5%	93.7%	94.2%	93.8%	92.7%	93.8%	94.5%	94.1%	94.3%
			NICE Compliance				8.6%	16.5%	25.2%	34.4%	50.0%	62.9%	63.4%	74.6%	83.1%	91.9%	98.5%	98.5%

Quality and safety

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Patient Safety Incident Response (PSIR) Framework: National and Local Patient Safety Incident Investigations (PSIIs)	• Terms of Reference (ToR) for the Learning Response Approval Panel (LRAP) have aligned with the NHS Oversight requirements. The draft ToR has been circulated for comments and will be finalised. • PSIR Plan commenced in January 2025 to align the refreshed plan with Quality Account timeframes (April 25 to March 26). • Patient safety training programme in place: PSIRF, Swarm, AAR, Incident Investigation, Engagement/Duty of Candour, Human Factors.	• Head of Patient Safety and Improvement	30/05/2025	• Weekly report to Executives includes details of PSIIs. • Training Needs Analysis in place. A review of training content is underway to further align with the National Patient Safety Syllabus. • Swarm and AAR training dates are available on ESR at 3 acute sites and Incident Investigation training dates are planned for June and July.
Two incidents were identified for local PSIIs in April 2025.	One paediatric Ligature Incident will be a multiagency investigation including; CAMHS, ICB, Safeguarding and Social care. The second PSII relates to a hospital-acquired pressure ulcer but is a complex case requiring KCHFT involvement. Both incidents were: • Presented at IRP. • DoC completed. • Investigation underway	• Head of Patient Safety and Improvement	02/10/2025	• Local learning shared at IRP and ToR being drafted.
The duty of Candour findings component was 95.5% compliant in April	One KCVH final DoC letter was completed outside of the 10-day timeframe but was completed on day 11. • Escalation process followed • NoK contacted by telephone and sent a letter detailing findings and outcome of the investigation	• Head of Patient Safety and Improvement	30/05/2025	As the DoC compliance process is now well embedded the twice-weekly meetings to improve compliance are no longer required. The expectation is that DoC continues to be actively managed, and compliance is maintained through QGBP and Triumvirate escalation following the established process. Monitoring and compliance will continue to be shared in the weekly report to executives to provide assurance.
IPC processes across all sites to focus on the reduction of avoidable infections. Thresholds for 25/26 not published, therefore, focus on zero tolerance	• 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.	IPC Team	31/05/2025	- 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
Continued mixed sex breaches	• An internal assurance review of theatre recovery and SAU areas to be completed.	• ADoN for FoCC/ADoN for CCASS	• May 2025	• Recommendation approved at FoC Committee to internally report theatres and to undertake further benchmarking for SEAU across the region. • To be presented at NMEC in May for final approval

Quality and safety

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Complaint Performance was below the standard we would expect	• Complainants are called at the start of the complaint and updated/advised of any delays. • Specific resource continues to be focussed on response reviewing within the complaints team, to drive quality and timeliness of responses. • Weekly reporting for care groups to identify breaching complaints and age of complaints. • An enhanced escalation process with the triumvirates to support responsive resolutions. • Fortnightly meetings with specialties to discuss progress with their complaints. • A programme of training for care group staff is ongoing; bite size sessions, concentrating on areas where improvement is required. • Targeted work on 90+ working day old complaints.	• Head of CPBS	• Ongoing in line with agreed trajectory for clearing the complaint breaches	• Trajectory set September 2024, to meet KPI - 85% of responses completed within agreed timescales, by end of December 2024. Trajectory achieved. • KPI met consistently since December 2024.
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). • Promotion of the carers leaflet and carers survey • Communication passport for people with hearing or visual impairments to be offered to patients on the wards. • Pilot 'What Matters to me' communication posters behind patient beds on each site.	• Patient Voice and Involvement team • Ward managers / QIWA team • Ward staff • Associate Directors of Nursing for SAGE and GM	• By end of May 2025 • June 2025 • By May 2025 • By June 2025	**ON TRACK**: first group of youth volunteers trained. Survey is now live. Youth volunteers will start to gather feedback from last week in May 2025. **ON TRACK:** Will promote during Carers Week 9-15 June. **DELAYED**: Waiting for final update to design by Comms team. **ON TRACK**: 'What Matters to Me' posters now being piloted. Wards at 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.

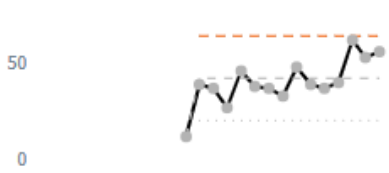
Quality and safety

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.
Limited use of telephone interpreters by ED (concerns that family are being used to interpret)	• Staff to be made aware of the importance of using interpreters, especially to gain consent, explain diagnosis and treatment.	• ED Managers with support from Trust interpreting lead	• By May 2025	• All staff were reminded about the availability of interpretation services. • Posters are displayed in clinical areas to prompt staff to offer these services when needed.
Long waits in ED after triage to be treated remain a source of patient dissatisfaction. Patients are not always kept updated on waiting times.	• Improve communication with patients in ED waiting for treatment but not waiting to be admitted (e.g. Patient information app at WHH)	• ED Matron and senior nurses	• By June 2025	• 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	• 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
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)	• Lead for Moving and Handling /Lead for Tissue Viability	• By April 2025	• Linet trollies had a further trial at QEQM. Awaiting final outcome.
	• 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.	• Assoc. Director of Patient Experience / DoNs of K&CH, QEQM and WHH and UEAM senior teams	• By September 2025	• Sleeper chair supplier visited. Charitable funding bid to be made to pilot at WHH.

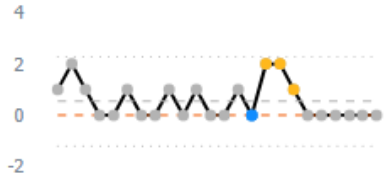
Quality and safety

Patient Safety Incidents

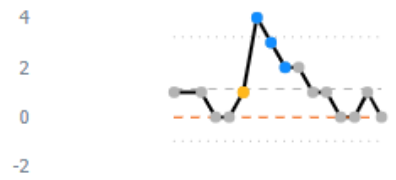
Patient Safety Incidents - Mod/Sev



Never Events

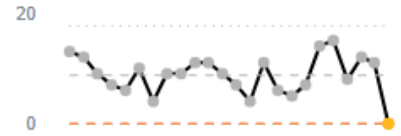


PSII - National

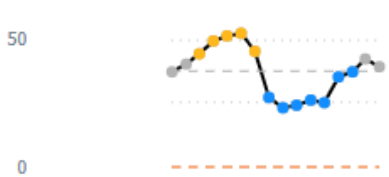


PSII - Local

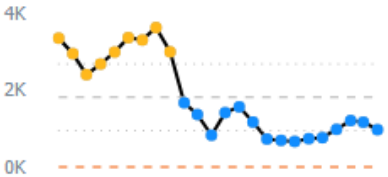
After Action Reviews (AARs)



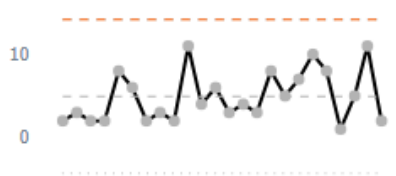
AARs Overdue



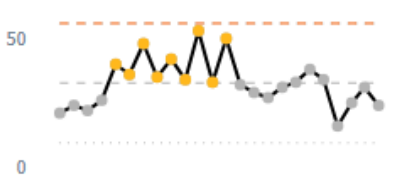
Overdue Incidents



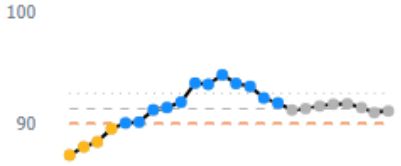
Falls with Harm



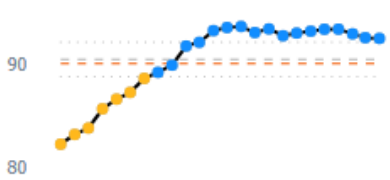
Safeguarding Incidents



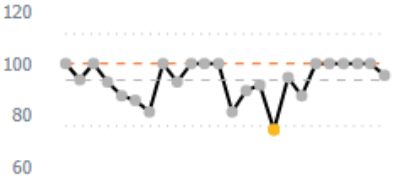
Safeguarding Children Training



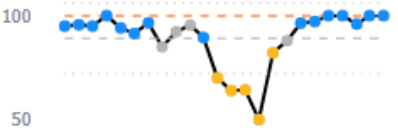
Safeguarding Adults Training



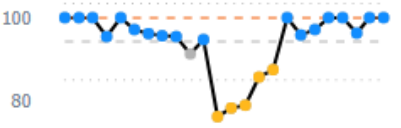
Duty of Candour - Findings



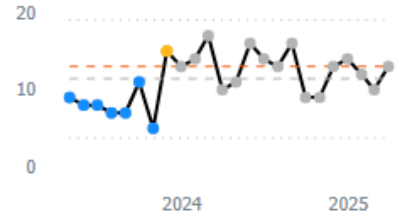
Duty of Candour - Written 15wd



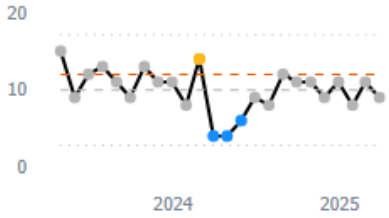
Duty of Candour - Verbal



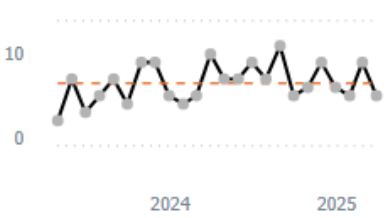
IPC: EColi Infections



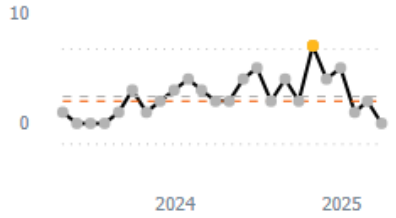
IPC: CDiff Infections



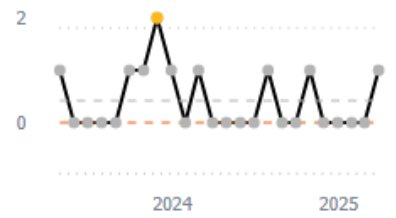
IPC: Klebsiella Infections



IPC: Pseudomonas Infections

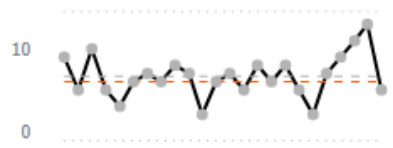


IPC: MRSA Infections

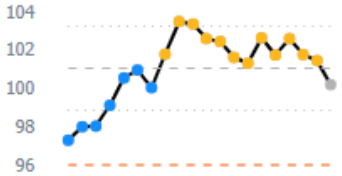


Quality and safety

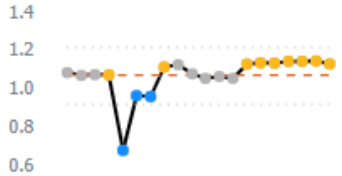
IPC: MSSA Infections



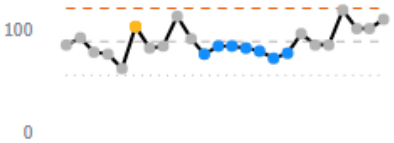
HSMR



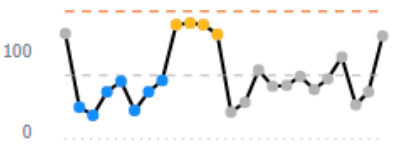
SHMI



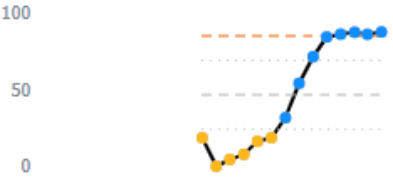
Pressure Ulcers



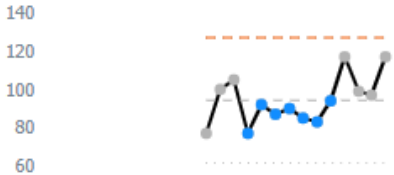
Mixed Sex Breaches



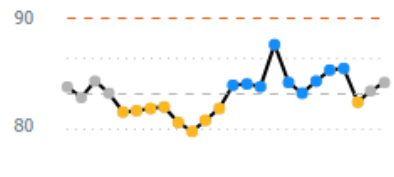
Complaint Response



Complaints Number

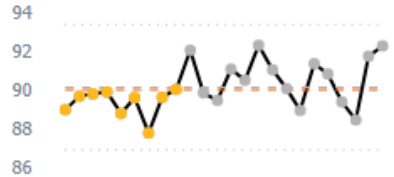


FFT Satisfaction Level - ED

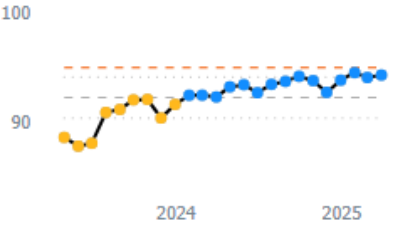


FFT Satisfaction Level - Outpatient

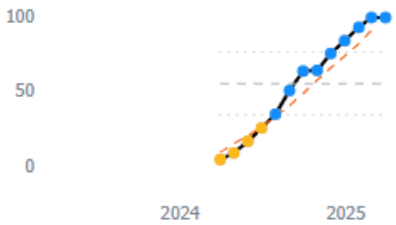
FFT Satisfaction Level - Inpatient



VTE Assessment Compliance



NICE Compliance



Quality and safety

Staff Type	Vacancy Rate Apr-25 (Target 10%)	Sickness Rate Apr-25 (Target 5%)	Safe Care Red Flags Apr-25
Registered Nursing & Midwifery	4.5%	5.01%	
Registered Nursing Associate	N/A	N/A	370
Health Care Support Worker	%	N/A	

Staff Type	Care Hours Per Patient Day (CHPPD) Apr-25	Avg Fill Rate Day Apr-25	Avg Fill Rate Night Apr-25
Registered Nursing & Midwifery	6.5	85%	91%
Registered Nursing Associate	0.1	100%	100%
Health Care Support Worker	3.1	84%	99%

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 April 2025 remain at an acceptable level overall. Roster management issues are being addressing to see supported improvement. St Lawrence was closed from mid-April to support the fire works programme, with reduced fill rates showing.

Several areas did work on amber shifts, as defined within our organisation. There were 3 red shifts; 1 in QEQM critical care, 1 in Kings D1 and 1 in St Margarets wards. Round table reviews have been undertaken to recognise real time escalation of shifts and to support learning. For the 1 shift whereby Critical Care was non-compliant to GPICS, staffing levels were supported by co-locating patients to enable a staff member to oversee more than one.

People

Assurance

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

People

Executive Summary:

Sickness absence rates are below the alerting threshold at 4.66%. This is the third successive month this have been the case after three months above the alerting threshold (5%) and appears primarily related to a steep reduction in the number of staff absent with coughs, colds and influenza (from 1034 in January to 457 in April). Coughs, colds and flu do, however, account for more sickness episodes than any other reason (457 episodes) followed by gastrointestinal problems (347 episodes). By contract, stress, anxiety and depression accounts for less that half of the episodes (228). This level remains blunted by the provision of face-to-face counselling and the development of a greater network of wellbeing advocacy and peer support. Conversations are ongoing around extending the service beyond July when the face-to-face service is due to come to a close.

Vacancy rate has increased to 9.2% from 8.9%, having remained below the 10% threshold for most of the last year. The highest vacancy rates are in the QEQM Care Group (9.6%), primarily driven by UEAM (19.1%), and the K&C Care Group (9.6%), which is primarily driven by vacancies across Stroke (17.6%). The lowest is across the DCB Care Group (6.8%). The new VCP process will impact vacancy rates moving forward, and vacancies will need to be carefully monitored to ensure patient safety and activity are not detrimentally affected.

Staff turnover remains at 7.8%, continuing the positive trend that has been observed across the last 2 years. It is the lowest it has been in over 2 years and remains on a positive trajectory. Nursing turnover has inflected upwards marginally to 7.3%. Whilst this is the first increase in almost 2 years, it remains well below the alerting threshold – but will be monitored closely Health Care Support Worker turnover has also inflected upwards quite sharply to 10.9% (from 8.1%). Premature turnover however, reduced to 12.5%, keeping overall rates low.

Appraisal compliance has remained above the Trust-level threshold (80%), currently standing at 81.1%. In the clinical Care Groups, rates are highest in WCYP (87.8%). DCB and K&C Care Groups are below the 80% threshold. Corporate appraisal compliance remains the lowest at 73.1%.

Statutory training compliance increased slightly more to 92.8%. This continues to exceed the Trust-level threshold (91%). All Care Groups are above 90% and although compliance for medical staff remains below the expected threshold, this has responded positively in-month and improved again to 85.2%. Compliancy is highest against the Equality and Diversity modules (95.9%) and lowest against Information Governance (89.6%).

People

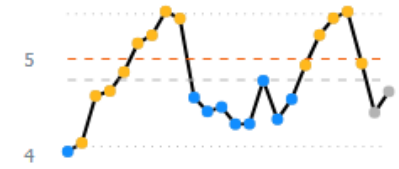
Domain	Nat	Flag	KPI	SPC	Ass...	Target	May-24	Jun-24	Jul-24	Aug-24	Sep-...	Oct-24	Nov-24	Dec-24	Jan-25	Feb-...	Mar-...	Apr-25
People	NAT		Sickness			5.0%	4.3%	4.3%	4.8%	4.4%	4.6%	4.9%	5.2%	5.4%	5.5%	5.0%	4.4%	4.7%
	NAT		Vacancy Rate			10.0%	8.7%	9.2%	8.7%	9.6%	8.7%	8.6%	8.7%	8.8%	9.0%	10.1%	8.9%	9.2%
	NAT		Staff Turnover Rate			10.0%	9.2%	9.2%	8.9%	8.9%	8.9%	8.8%	8.7%	8.4%	8.3%	8.2%	7.8%	7.8%
	NAT		Premature Turnover Rate			25.0%	15.0%	14.9%	15.2%	14.9%	14.8%	14.8%	14.4%	13.5%	13.5%	12.7%	12.1%	12.5%
	KEY		Appraisals Compliance			80.0%	74.7%	74.1%	75.0%	74.8%	77.9%	79.4%	80.3%	80.0%	81.4%	80.8%	80.5%	81.1%
	IIP		Staff Engagement Score			6.80	5.70	5.70	5.95	5.95	5.95	6.35	6.35	6.35	6.04	6.04	6.04	5.97
	KEY		Staff Advocacy Score			6.70	4.99	4.99	5.34	5.34	5.34	5.80	5.80	5.80	5.55	5.55	5.55	5.49
	NAT		Statutory Training			91.0%	92.4%	92.5%	92.2%	92.4%	92.2%	92.2%	92.4%	92.4%	92.5%	92.3%	92.4%	92.8%
	KEY		Infection Control Training			90.0%	93.2%	93.7%	93.4%	93.7%	93.5%	93.4%	93.3%	93.2%	93.1%	92.9%	92.8%	93.1%
	KEY		Hand Hygiene Training			85.0%	76.3%	76.8%	79.7%	79.2%	79.0%	79.1%	93.1%	92.9%	92.7%	91.7%	91.4%	91.7%
	KEY		Medical Job Planning Rate			90.0%	44.1%	37.0%	36.5%	33.3%	32.5%	30.3%	32.0%	27.9%	27.9%	32.1%	31.1%	30.5%

People

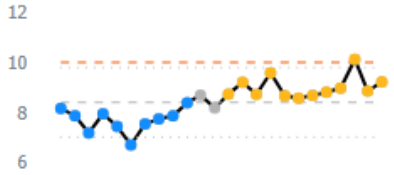
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Ensuring vacancy rate remains below the Trust threshold of 10%.	• Monthly monitoring of vacancies across Care Groups, ensuring that active recruitment is taking place. • Focus on hard to recruit areas and supporting new ways of working to reduce 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 10.1% following the recruitment of student midwives and other positive recruitment. The vacancy rate peaked at 15.2% in December 2024.
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	• 464 staff have accessed the service, with 1,321 counselling sessions delivered and clinically reliable change in 82.1% of staff. • New bid for funding being prepared with the 6-month extension due to expire in August 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% 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.
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 (**12.5%**) remains within the desired parameters (≤15%), although has increased slightly in the last two months.
Staff Engagement levels (5.95) 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 2024 staff survey, with the launch linked to the Culture & Leadership programme implementation.	Head of Staff Experience	• Mar 25	• The response rate to the National NHS Staff Survey is a marker of engagement in itself and acts as a precursor to the scores which are released in January '25. The Trust closed with one of the highest response rates in the country (63%), has achieved a majority response and the highest number of respondents in the Trusts' history. Priorities have been identified and actions initiated.
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 85.2%, which is the highest it has been in 4 years. All Care Groups are targeting improvement within medical staff compliance – with medical staff compliance lowest in the Corporate Care Group (74.0%).

People

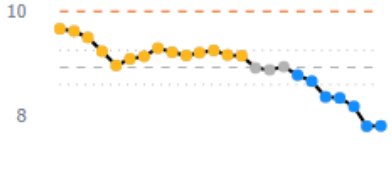
Sickness



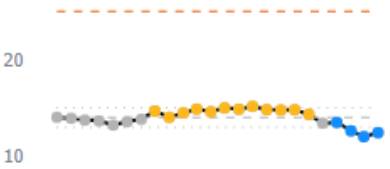
Vacancy Rate



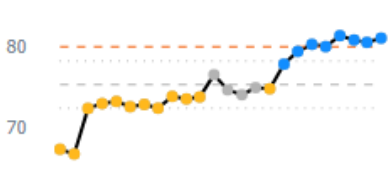
Staff Turnover Rate



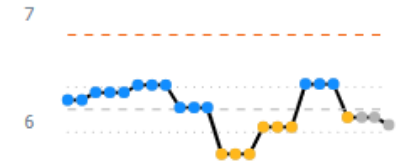
Premature Turnover Rate



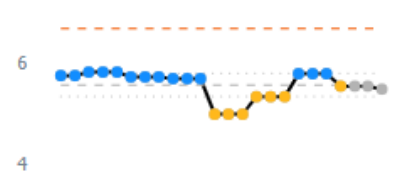
Appraisals Compliance



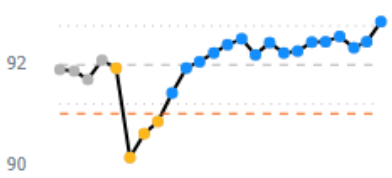
Staff Engagement Score



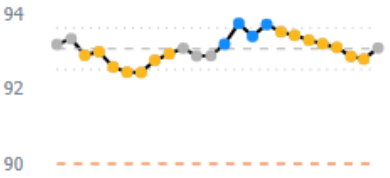
Staff Advocacy Score



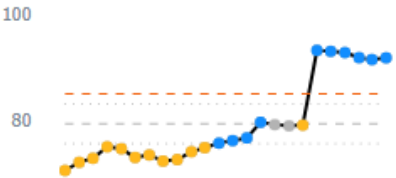
Statutory Training



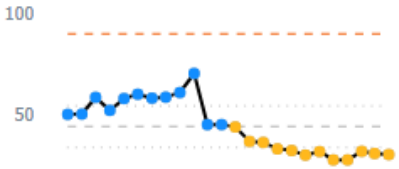
Infection Control Training



Hand Hygiene Training



Medical Job Planning Rate



2024 2025 2024 2025 2024 2025 2024 2025 2024 2025

Sustainability

Assurance

Variation

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

Sustainability

Executive Summary:

The Month 1 in month position achieved the Groups (Pre-deficit support) deficit of (£9.7m).

Income from patient care activity is £0.4m above plan, £0.2m variable chemotherapy and Cancer Alliance funding £0.08m above plan.

Other operating income is adverse to plan by £0.3m. Income for education and training was the largest (adverse) variance at £0.8m in month.

Employee expenses are £0.8m adverse to plan. Whilst substantive staff costs are breakeven, there are overspends of £0.7m in bank and £0.3m in agency mainly due to medical staffing usage.

Other operating expenses are £0.8m favourable to plan. There are three main areas of favourable performance in April. There is a minor underspend in drugs of £0.3m, a £0.3m underspend in purchase of healthcare usage and a £0.3m underspend in depreciation compared to plan.

As with other Trusts, work is ongoing with regards to agreeing budgets for the Care Groups and Corporate areas. A robust approach to aligning activity, workforce and financial budgets has been undertaken throughout the business planning process. Work on budget setting will be concluded by month 2 in readiness for reporting.

Sustainability

Domain	Nat	Flag	KPI	SPC	Ass...	Target	May-24	Jun-24	Jul-24	Aug-24	Sep-...	Oct-24	Nov-24	Dec-24	Jan-25	Feb-...	Mar-...	Apr-25
Sustainability	IIP		Deficit In Month Group (£)			9.8M	7.3M	7.1M	8.3M	6.3M	7.3M	7.5M	9.8M	7.0M	6.5M	4.9M	5.2M	9.7M
	KEY		Variance to Plan (£)			0K	5K	-28K	20K	53K	1K	-31K	1K	-2,070K	3,990K	-2K	240K	13,0...
	KEY		Premium Pay			10M	8.4M	7.9M	8.8M	8.9M	8.0M	8.6M	8.6M	8.0M	7.6M	8.3M	9.1M	8.7M
	KEY		WTE worked (Premium Pay)			1,232	1,019	968	1,031	1,049	1,017	996	967	975	964	1,072	1,108	1,040
	KEY		Total Pay Spend In Month			62M	51M	51M	51M	52M	51M	66M	54M	54M	53M	55M	49M	57M
	KEY		WTE worked (All Pay Spend)			10,380	10,103	9,984	10,049	10,048	10,105	10,138	10,096	10,144	10,110	10,2...	10,309	10,2...
	KEY		Efficiencies Green Schemes (£M)			40	5	4	11	15	16	20	25	28	35	40	45	0
	IIP		Efficiencies YTD Variance (£M)			0.0	0.0	0.0	0.1	0.3	0.3	0.3	0.3	0.3	0.4	0.4	0.5	-1.5

Sustainability

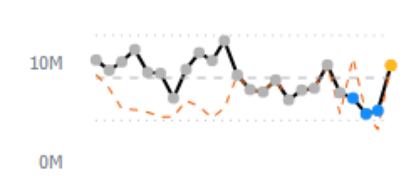
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
ID Medical finding it challenging to swap out high pay premium medical workers and/or negotiate alternative terms, such as becoming Direct Engagement (DE). Many of the high cost agency have been working with the Trust long term and embedded in 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	• The ID Medical Managed Service have now provided a 3x proposals to address our current high cost locums and overall agency spend. These are currently with the CMO for review and follow up meetings are to be arranged with the Care Group Managing Directors (June 2025). • Meetings have now been scheduled for May/June with Care Groups and ID to review current rates and implement plans to reduce these inline with the rate caps. • A restriction is now in place in relation to new standard placement bookings. Our DE throughput, currently at 91%. A plan is now being established to replace the remaining 8 locums, one of whom is due to leave shortly and two are on short-term contracts and one had decided to join the Trust substantively. • IDM are now to provide a detailed update at the weekly operational meeting to discuss activity, improvements/savings made and any challenges.
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 April, down 29% when compared to March 2025. Overall AfC agency hours continue to reduce (down 34% compared to March) with further restrictions applied and a number of agency staff migrating to the bank. • 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. Agency rates had been agreed for Maternity and likely to be in place until July 2025. • On the 1st March 2025 the Trust will be implemented a restriction on the use of agency staff for bands 2 and 3. • 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. Process maps have been redesigned and share with Care Groups to incorporate VCP approval. • Proposal sent to the CMO/DCMO to restrict agency usage for FY1 roles, a restriction has now been agreed an in place from the 19th May 2025.

Sustainability

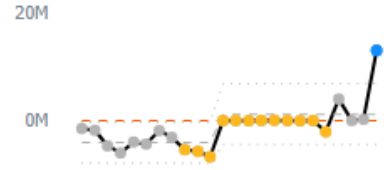
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Agency management across the South East NHS Region means disparity across Kent and Medway Trusts for Medical rates.	• Sign up to the Kent and Medway Collaborative Medical Rate Card • Areas above cap to work with IDM & South East Temp Staffing 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	• The rate card was approved by the board on the 11th September, it was agreed that the collaborative would keep the rate ceilings stable over the winter period. A project plan has now been established to improve our compliance against the step down rates. This is now with the CMO for review and awaiting sign-off. • Regular supplier Meetings have now been completed with support from the SETS programme team. • Meeting held with the SE collaborative, attended by the CMO to review our current medical bank rates and how these compare to other organisations in the region. A further regional board meeting is arranged for June 2025. • The ID Medical managed service has provided a report detailing all locums engaged at the Trust and their hourly rates in comparison to the applied ceiling caps. IDM to provide a plan to bring those above the cap in line with the rate framework, starting with those closest to the current cap. Proposal now with the CMO for review, meeting to be arranged with a view to implementing a new mandate around rates and extensions.

Sustainability

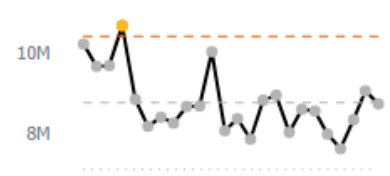
Deficit In Month Group (£)



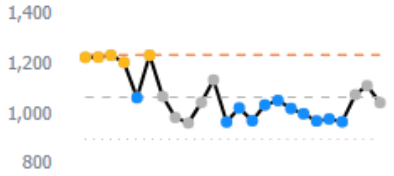
Variance to Plan (£)



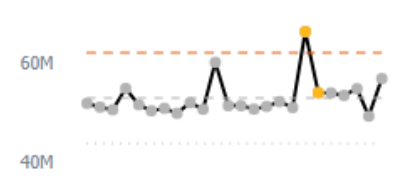
Premium Pay



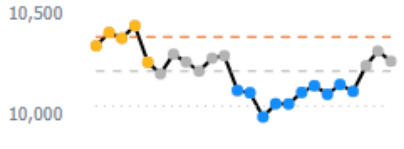
WTE worked (Premium Pay)



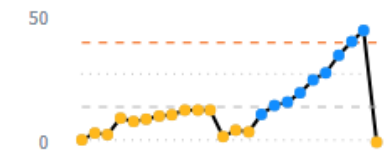
Total Pay Spend In Month



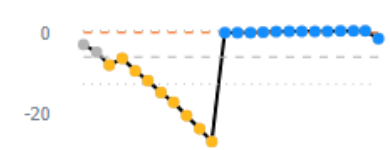
WTE worked (All Pay Spend)



Efficiencies Green Schemes (£M)



Efficiencies YTD Variance (£M)



Maternity

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

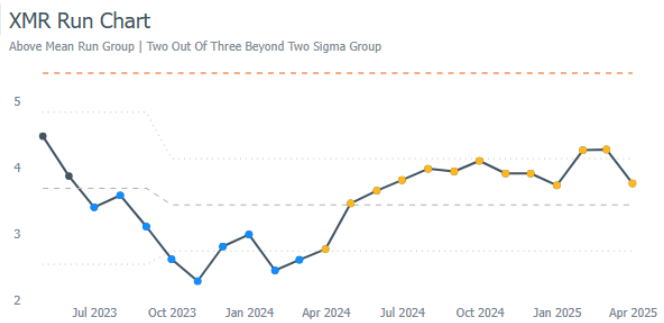
Maternity

Executive Summary:

Morbidity & Mortality | MBRRACE Ext Perinatal Rate 12m

MBRRACE Ext Perinatal Rate 12m

Timescale	Value	SPC
May-24	3.46	
Jun-24	3.65	
Jul-24	3.81	
Aug-24	3.98	
Sep-24	3.94	
Oct-24	4.10	
Nov-24	3.91	
Dec-24	3.91	
Jan-25	3.73	
Feb-25	4.26	
Mar-25	4.27	
Apr-25	3.76	



The extended perinatal rate remains consistently below the threshold of 5.42 per 1,000 births, with the April 12 month rolling rate reducing to below the upper threshold at 3.76 per 1,000 births. This rate includes both stillbirths and neonatal deaths.
In April, the neonatal death 12 month rate decreased below the MBRRACE average of 1.82 for the first time in 11 reporting periods, to 1.71. The service reported 0 neonatal deaths >24 weeks in month. The stillbirth rate also decreased in month, reducing to below the upper threshold from 2.39 in March to 2.05 in April. The stillbirth rate remains below the threshold of 3.61. The service reported 0 stillbirths in month.

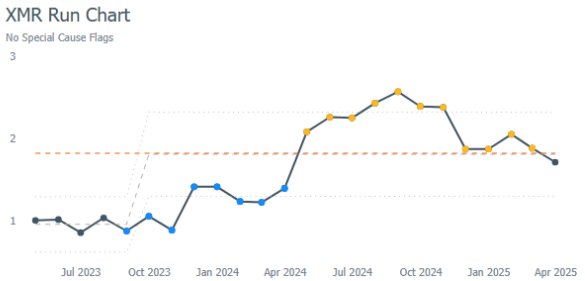
Metric Definition

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 NND Rate 12m

Timescale	Value	SPC
May-24	2.08	
Jun-24	2.26	
Jul-24	2.25	
Aug-24	2.43	
Sep-24	2.57	
Oct-24	2.39	
Nov-24	2.38	
Dec-24	1.87	
Jan-25	1.87	
Feb-25	2.05	
Mar-25	1.88	
Apr-25	1.71	



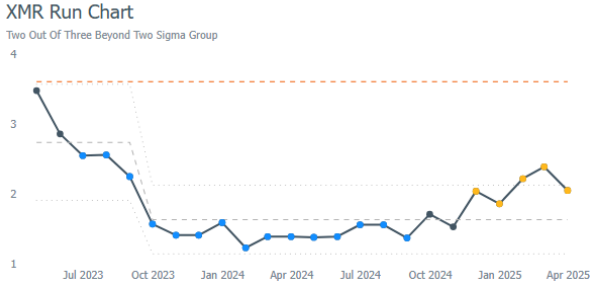
Metric Definition

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)

MBRRACE Stillbirth 12m Rate

Timescale	Value	SPC
May-24	1.38	
Jun-24	1.39	
Jul-24	1.56	
Aug-24	1.56	
Sep-24	1.37	
Oct-24	1.71	
Nov-24	1.53	
Dec-24	2.04	
Jan-25	1.86	
Feb-25	2.22	
Mar-25	2.39	
Apr-25	2.05	



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

Maternity

Executive Summary:
No new MNSI referrals made in April
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 as the location where mother sadly died. Therefore this MNSI investigation is not evident in the EKHUFT maternity scorecard - Investigation in progress
	Maternal death following collapse in community and admission to ITU.	- MNSI investigation in progress

Current open local PSSI's

	Case Summary	Progress
	ITU admission 4 days post caesarean section birth with suspected sepsis and ileus.	- Investigation in progress, draft report reviewed at peer panel review meeting
	Neonatal death at 24 weeks gestation	- Investigation in progress
	Intrauterine death at term	Final draft report awaiting Trust sign off following feedback from family.

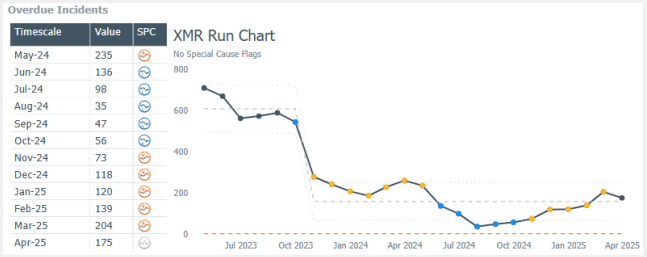
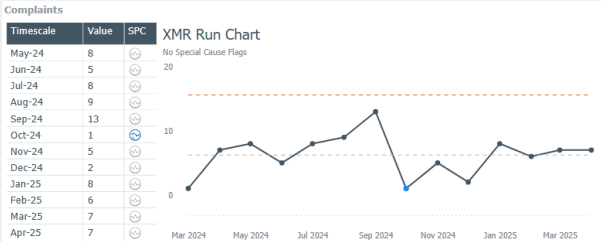
3 moderate /severe patient safety incident were reported in April under the following categories:

- Maternal Death (not reported on dashboard, as outside of MBRRACE definition due to being over 42 days from delivery) Declared PSII led by WHH Care Group.
- Failure to act on abnormal test results – AAR in process
- 3rd or 4th degree tear – re suturing required

Maternity: Metric Dashboard

Domain	Nat	Flag	KPI	SPC	Ass...	Target	May-24	Jun-24	Jul-24	Aug-24	Sep-...	Oct-24	Nov-24	Dec-24	Jan-25	Feb-...	Mar-...	Apr-25
Maternity	KEY		Mat Patient Safety Incidents Mod/Sev			7	1	2	2	2	1	0	3	2	5	5	7	3
	NAT		PSII - National (Maternity)			0	0	0	4	1	0	1	0	1	0	0	1	0
	NAT		PSII - Local (Maternity)			0	0	0	0	1	0	0	0	0	1	0	1	0
	KEY		Maternity Complaints			16	8	5	8	9	13	1	5	2	8	6	7	7
	KEY		Maternity Complaint Response			85.0%	20.0%	0.0%	42.9%	66.7%	50.0%	85.7%	100%	100%	100%	60.0%	80.0%	100%
	KEY		Extended Perinatal Mortality			5.87	3.46	3.65	3.81	3.98	3.94	4.10	3.91	3.91	3.73	4.26	4.27	3.76
	NAT		FFT Maternity Response Rate			15.0%	9.1%	12.1%	11.1%	10.7%	10.2%	12.2%	10.6%	9.8%	9.9%	12.6%	11.1%	8.5%
	NAT		FFT Maternity Recommended			90.0%	93.7%	95.2%	92.4%	88.4%	92.2%	95.6%	92.8%	90.4%	93.9%	91.2%	90.4%	90.6%
	NAT		FFT Maternity (IP) Recommended			90.0%	94.8%	95.3%	93.0%	89.3%	95.8%	97.1%	91.9%	94.7%	93.9%	94.9%	94.1%	97.8%
	KEY		WH Engagement Score			6.90	6.07	6.07	6.12	6.12	6.12	6.40	6.40	6.40	6.19	6.19	6.19	6.03

Maternity: Actions

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
FFT scores	• Review existing process in relation to the promotion of the FFT	• Patient Experience Team		There has been a decline in April to 8.5% from 11.1% in March. The 'go live' of EDNv2 is commencing 28th April where every EDN will have an individualised QR code for women / birthing people to scan prior to discharge - this will be for the birth and discharge from hospital elements of FFT. Women are able to opt-in to sharing their details should they wish to follow up with a conversation. 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 action owners with ongoing monitoring and 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		• Reduction of 29 overdue incidents with the number of maternity overdue incidents in April is 175 • Continued monitoring of incident management with increased surveillance and support. • Working hard to comply with corporate set trajectory to reduce overdue incidents to zero by August 2025 • Enhanced monitoring and focus on incident management via stop the clock meetings to be introduced in May 
Complaints		• Head of Governance		• Total of 7 maternity complaints received in April • Complainants offered option for LRM within primary complaint response • Complaint response rate increased in month to 100% 

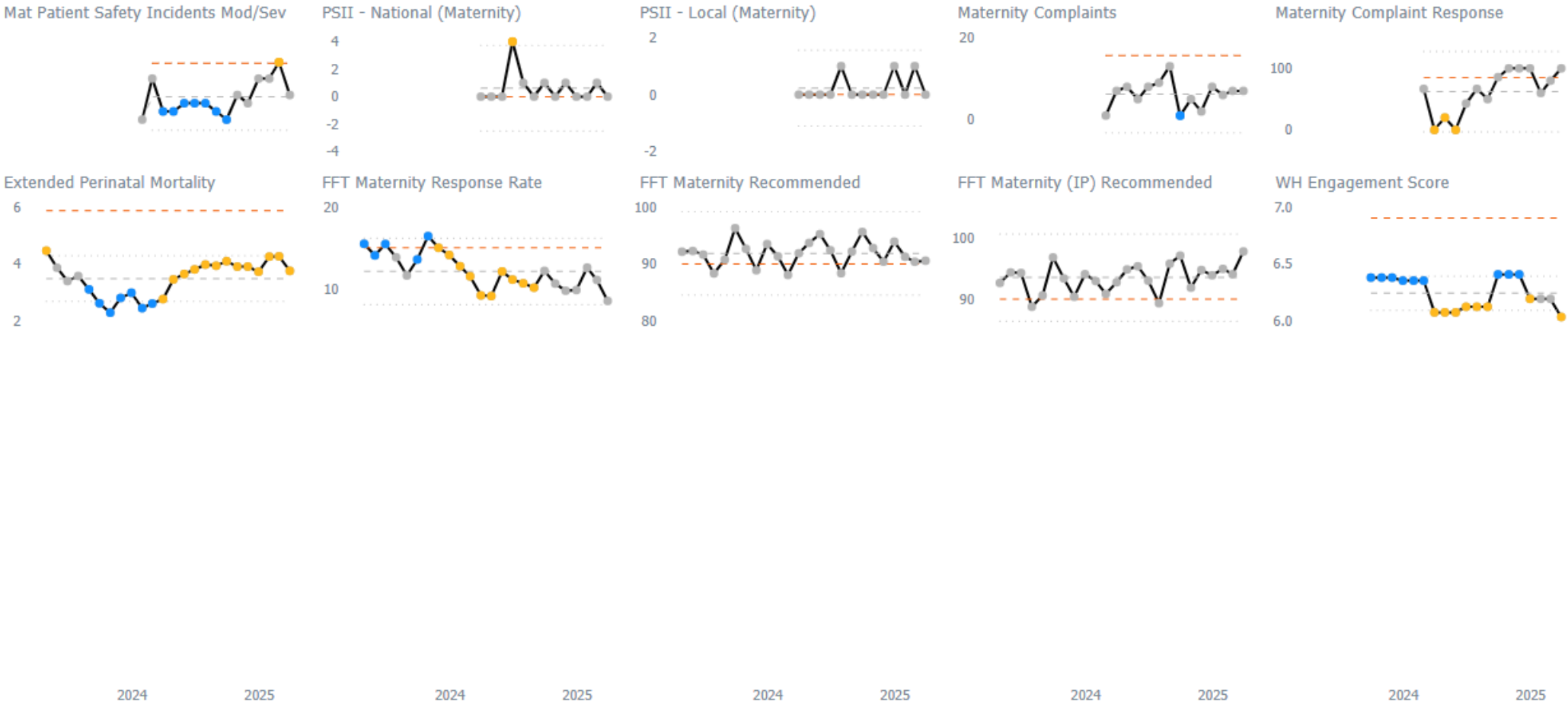
Overdue Incidents

Timescale	Value	SPC
May-24	235	
Jun-24	136	
Jul-24	98	
Aug-24	35	
Sep-24	47	
Oct-24	56	
Nov-24	73	
Dec-24	118	
Jan-25	120	
Feb-25	139	
Mar-25	204	
Apr-25	175	

Complaints

Timescale	Value	SPC
May-24	8	
Jun-24	5	
Jul-24	8	
Aug-24	9	
Sep-24	13	
Oct-24	1	
Nov-24	5	
Dec-24	2	
Jan-25	8	
Feb-25	6	
Mar-25	7	
Apr-25	7	

Maternity: Metric Run Charts



East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: M1 Finance Report

Meeting date: 5 June 2025

Board sponsor: Chief Finance Officer (CFO)

Paper Author: Director of Finance (DoF)

Appendices:

Appendix 1: M1 Finance Report

Executive summary:

Action required:	Information
Purpose of the Report:	The report is to update the Board on the financial performance for April 2025 (Month one).
Summary of key issues:	**The Finance Report**: In 25-26 the Trust has a planned gross deficit of £64.2m which is a reduction of £21.6m from the 24-25 deficit of £85.8m. The Trust has been allocated deficit support funding (DSF) of £57.6m in 25-26 reducing the planned deficit to £6.6m. By way of comparison, in 24-25 the Trust received £78.5m DSF reducing the planned deficit to £7.4m The Month 1 in month position achieved the Group's (Pre-deficit support) deficit plan of (£9.7m).

	Year to Date (YTD) Plan	YTD Actual	YTD Variance
£'000			
Patient care income	78,262	78,496	234
Other income	6,123	3,924	(2,199)
Employee Expenses	(60,525)	(61,448)	(922)
Other operating expenses	(32,988)	(30,431)	(2,557)
Non-operating expenses	(683)	(372)	311
Operating Surplus/Deficit	(9,811)	(9,831)	(20)
Technical adjustments	60	105	45
TECHNICALLY ADJUSTED SURPLUS/(DEFICIT) EXCLUDING DEFICIT SUPPORT	**(9,751)**	**(9,726)**	**25**

East Kent Hospitals University NHS Foundation Trust

	Income from patient care activity is £0.4m above plan, with £0.2m variable chemotherapy and Cancer Alliance funding £0.08m above plan. Other operating income is adverse to plan by £0.3m. Income for education and training was the largest (adverse) variance at £0.8m in month. Employee expenses are £0.8m adverse to plan. Whilst substantive staff costs are breakeven, there are overspends of £0.7m in bank and £0.3m in agency mainly due to medical staffing usage. Other operating expenses are £0.8m favourable to plan. There are three main areas of favourable performance in April. There is a minor underspend in drugs of £0.3m, a £0.3m underspend in purchase of healthcare usage and a £0.3m underspend in depreciation compared to plan. 2gether Support Solutions reported a M1 surplus of £0.1m, which is £0.16m below plan. Spencer Private Hospitals reported a M1 deficit of £0.02m, which is £0.05m below plan.
Key recommendations:	The Board of Directors is asked to review and **NOTE** the financial performance of Month 1.

Implications:

Links to Strategic Theme:	Having Healthy Finances by providing better, more effective patient care that makes resources go further. • Partnerships • Sustainability
Link to the Trust Risk Register:	**SRR 3664**: Failure to deliver the Trust financial plan for 25/26.
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 - 27 May 2025

We care

East Kent Hospitals University NHS Foundation Trust

Finance Performance Report 2025/26

April 2025

Chief Finance Officer
Angela van der Lem

We care

Group Summary
Month 1 (April) 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	71.551	72.055	0.504	-	-	-	1.750	1.310	(0.440)	(0.239)	(0.191)	0.048	73.062	73.174	0.112
NHS Income From Commissioners - Drugs	4.700	4.405	(0.295)	-	-	-	-	0.229	0.229	-	-	-	4.700	4.634	(0.066)
NHS Income From Commissioners - Devices	0.500	0.688	0.188	-	-	-	-	-	-	-	-	-	0.500	0.688	0.188
Other Income	5.293	4.980	(0.313)	14.028	12.318	(1.710)	0.005	0.003	(0.002)	(13.203)	(13.377)	(0.174)	6.123	3.924	(2.199)
Total Income	**82.044**	**82.127**	**0.083**	**14.028**	**12.318**	**(1.710)**	**1.755**	**1.542**	**(0.213)**	**(13.442)**	**(13.567)**	**(0.125)**	**84.385**	**82.420**	**(1.965)**
Substantive Staff (inc. Apprenticeship Levy)	(49.707)	(49.651)	0.056	(3.723)	(3.737)	(0.014)	(0.646)	(0.727)	(0.081)	0.060	0.062	0.002	(54.016)	(54.053)	(0.037)
Bank Staff	(4.039)	(4.715)	(0.676)	-	-	-	-	-	-	-	-	-	(4.039)	(4.715)	(0.676)
Agency/Contract	(2.223)	(2.449)	(0.226)	(0.179)	(0.189)	(0.010)	(0.068)	(0.042)	0.026	-	-	-	(2.470)	(2.680)	(0.210)
Total Employee Expenses	**(55.969)**	**(56.815)**	**(0.846)**	**(3.902)**	**(3.926)**	**(0.024)**	**(0.714)**	**(0.769)**	**(0.055)**	**0.060**	**0.062**	**0.002**	**(60.525)**	**(61.448)**	**(0.923)**
Drugs	(3.559)	(8.202)	(4.643)	-	(0.001)	(0.001)	(0.221)	(0.229)	(0.008)	0.204	0.187	(0.017)	(3.576)	(8.246)	(4.670)
Rechargeable Drugs	(5.127)	(0.275)	4.852	-	-	-	-	-	-	-	-	-	(5.127)	(0.275)	4.852
Rechargeable Devices	(0.500)	(0.688)	(0.188)	-	-	-	-	-	-	-	-	-	(0.500)	(0.688)	(0.188)
Supplies and Services - Clinical	(4.596)	(4.219)	0.377	(4.800)	(4.644)	0.156	(0.186)	(0.057)	0.129	0.106	0.023	(0.083)	(9.476)	(8.897)	0.579
Supplies and Services - General	(12.839)	(12.881)	(0.042)	(2.776)	(1.486)	1.290	(0.021)	(0.032)	(0.011)	12.594	12.885	0.291	(3.042)	(1.514)	1.528
Clinical negligence	(3.148)	(3.147)	0.001	-	-	-	-	-	-	-	0.000	0.000	(3.148)	(3.147)	0.001
Depreciation and Amortisation	(2.228)	(1.944)	0.284	(0.043)	(0.094)	(0.051)	(0.019)	(0.028)	(0.009)	-	0.000	0.000	(2.290)	(2.066)	0.224
Other non pay	(3.562)	(3.441)	0.121	(2.191)	(2.131)	0.060	(0.553)	(0.453)	0.100	0.477	0.427	(0.050)	(5.829)	(5.598)	0.231
Total Other Operating Expenses	**(35.559)**	**(34.798)**	**0.761**	**(9.810)**	**(8.356)**	**1.454**	**(1.000)**	**(0.799)**	**0.201**	**13.381**	**13.522**	**0.141**	**(32.988)**	**(30.431)**	**2.557**
Non Operating Expenses	(0.655)	(0.477)	0.178	(0.019)	0.100	0.119	(0.010)	0.005	0.015	0.001	(0.000)	(0.001)	(0.683)	(0.372)	0.311
Profit/Loss	**(10.139)**	**(9.962)**	**0.177**	**0.297**	**0.136**	**(0.161)**	**0.031**	**(0.021)**	**(0.052)**	**0.000**	**0.016**	**0.016**	**(9.811)**	**(9.831)**	**(0.020)**
Less Technical Adjustments	0.060	0.105	0.045	-	-	-	-	-	-	-	0.000	0.000	0.060	0.105	0.045
Technically Adjusted Profit/Loss	**(10.079)**	**(9.858)**	**0.221** **1**	**0.297**	**0.136**	**(0.161)** **2**	**0.031**	**(0.021)**	**(0.052)** **3**	**0.000**	**0.017**	**0.017** **4**	**(9.751)**	**(9.726)**	**0.025** **5**
Non Recurrent Deficit Support Revenue Allocation	8.468	8.468	-	-	-	-	-	-	-	-	-	-	8.468	8.468	-
Deficit Support Adjusted Profit/Loss	**(1.611)**	**(1.390)**	**0.221**	**0.297**	**0.136**	**(0.161)**	**0.031**	**(0.021)**	**(0.052)**	**0.000**	**0.017**	**0.017**	**(1.283)**	**(1.258)**	**0.025**

1. Trust:
The Trust has delivered against its plan submission for month 1. The Trust has been allocated non-recurrent Deficit Support Funding (DSF) totalling £57.6m for the year. This non-recurrent allocation reduces the Group planned deficit from £64.2m to £6.6m. Due to this allocation being non-recurrent in nature, the finance report will focus on the pre DSF deficit and show DSF being below the line enabling the focus to remain on the recurrent position. Excluding the Non-recurrent DSF allocation, the Trust's month 1 position is £0.03m favourable. The key drivers include:

- Income from patient care activity is £0.4m above plan, £0.2m variable chemotherapy and Cancer Alliance funding £0.08m above plan.
- Other operating income is adverse to plan by £0.3m. Income for education and training was the largest variance at £0.8m in month.
- Employee expenses are £0.8m adverse to plan. Whilst substantive staff costs are breakeven, there are overspends of £0.7m in bank and £0.3m in agency mainly due to medical staffing usage.
- Other operating expenses are £0.8m favourable to plan. There are three main areas of favourable performance in April. There is a minor underspend in drugs of £0.3m, a £0.3m underspend in purchase of healthcare usage and a £0.3m underspend in depreciation compared to plan.

2. 2gether Support Solutions
2gether Support Solutions reported a M1 surplus of £0.1m, which is £0.16m below plan.

3. Spencer Private Hospitals
Spencer Private Hospitals reported a M1 deficit of £0.02m, which is £0.05m below plan.

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

5. Group
The Month 1 deficit outturn of £1.3m is in line with the planned deficit.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Report on Journey to Exit National Oversight Framework 4 (NOF4) and Integrated Improvement Plan (IIP)**

Meeting date: **5 June 2025**

Board sponsor: **Chief Executive**

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

Appendices:

Appendix 1: IIP Q4 Transition RAG – agreed at external review

Executive summary:

Action required:	Discussion
Purpose of the Report:	This report has been provided to update the BoD at EKHUFT following the completion of the 2024/25 IIP and the external review with Integrated Care Board (ICB), South East (SE) Region and Recovery Support Programme (RSP) representatives to offer assurance based on evidence gathered to support the transition criteria set within the NHS England (NHSE) RSP NOF4.
Summary of key issues:	The IIP concluded at the end of March 2025. Of the 87 quarterly metrics set, 74 were met by the end of Q4. Seven metrics remained amber and six were red, confirming that these will support the improvement focus in 2025/26. Discussions around targeted support moving forwards are to take place. The external review took place on 28 April, where the panel reviewed the annual performance of each programme. Whilst not all areas of transition criteria were delivered, the SE Regional Director commended the organisation on the progress made throughout 2024/25, advising that whilst there remain some key areas of focus, these areas were identified and concerns shared, whilst the Trust continued to implement their improvement plans, giving confidence in the organisation. The key areas identified will not necessarily be a barrier to prevent exiting the RSP. The transition journey will be discussed at the next Oversight meeting in May. The following RAG ratings were discussed and agreed with the external review panel. The panel agreed that Leadership, Governance & Culture programme has evidenced transition criteria of a stable Executive Team and the development of the organisational Strategy. Whilst there was acknowledgement for the significant increase in engagement of the staff survey and the number of steps towards culture improvement, the panel agreed that here was still more to be done to fully achieve this area of transition criteria.

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	Urgent and Emergency Care (UEC) performance has made demonstrable improvement over 2024/25, however, the key metrics within the transition criteria were not met in their entirety. 12 hour waits and Length of Stay (LoS) will remain a key priority moving into 2025/26. The Planned Care programme has delivered its transition criteria in both Cancer performance and Diagnostics, which was commended by SE Regional Director. Whilst the organisation has seen a consistent reduction in its longest waiting patients, the transition criteria was not met and Referral to Treatment (RTT) processes and governance will remain a focus area moving forwards. The Finance Programme has delivered transition criteria by meeting the deficit plan, delivering Cost Improvement Programme (CIP) and putting in place robust grip and control measures. There was acknowledgement on how far the finance programme has come and the success in delivering the 2024/25 plan, but agreement remains outstanding on the medium-term plan. The organisation has completed an addendum and await further discussion with system partners to fully meet this transition criteria. Further work needs to be completed. The agreement of the medium-term financial plan remains a risk. The Programme Management Office (PMO) collated and reviewed 289 pieces of evidence to support the transition criteria required to exit NOF4.
Key recommendations:	The Board of Directors is invited to discuss and **NOTE** the Journey to Exit NOF4 and IIP report.

Implications:

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

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Assurance route:

Previously considered by:

Internal Exec Review Panel and RSP representatives
External Review Panel of ICB, SE Region and RSP representatives

Quarterly Evidence Review Progress to support transition – position agreed during Q4 external review

Based on 289 pieces of supporting evidence submitted and reviewed

NHS East Kent Hospitals University NHS Foundation Trust

	Transition Criteria	Suggested Evidence	Evidence Position RAG			
			Q1	Q2	Q3	Q4
Leadership, Culture & Governance						
1	A Stable Executive team with clear and robust organisation wide governance in place supported by an agreed board development programme	a) All Board and sub-board leadership and development programmes in place b) Evidence of Board oversight of regulatory actions with clear improvement plans, and use of BAF c) Evidence of progress against action plan for Well Led domains and GGI recommendations and delivery of CQC must dos (within capital restrictions)				
2	Demonstrable improvement in the culture of the whole organisation in particular the safeguarding and the safety culture, and effective engagement with the workforce.	a) No significant deterioration in quality b) Evidence of learning from statutory reviews c) Evidence of improved and effective engagement of staff, patients and wider stakeholders d) Evidence of ongoing delivery of maternity & neonatal improvement plan				
3	Development of organisation strategy for clinical pathways	a) Trust organisation strategy for clinical pathways or equivalent developed with effective clinical and stakeholder engagement and plan for implementation developed				
Urgent Care						
4	Consistent improvement in performance to deliver UEC type 1 to >50% and 12 hour waits to below 8%	a) Type 1 to exceed 50% sustainably b) 12 hours from arrival to be below 8% c) Sustainable removal of corridor care d) Compliance with NHSE Tiering requirements and governance				
5	Demonstrable quality, safety and operational improvements across the whole UEC pathway reducing the proportion of patients occupying beds with 14+length of stay.	a) Evidence of reduction of Length of Stay through improvements in simple and timely discharge b) Patients requiring emergency care or experiencing a deterioration in their condition receive timely, c) appropriate escalation and treatment c) Evidence of effective safety prioritisation and harm avoidance processes across UEC pathways that incorporates sustained learning from incidents				
Planned Care						
6	To deliver Zero 104 and 78 week waits with consistent reduction in overall PTL and 65 week waits in order to deliver zero by March 2025	a) Evidence of sustainable improvement in elective performance and waiting list management with reduction in overall PTL 65w consistently reducing against % of PTL b) Reduction in incidents of harm relating to diagnostics and/or treatment delays for patients waiting longer than standard waiting times or a result of being lost to follow up c) Compliance with NHSE Tiering requirements and governance				
7	To deliver Cancer Faster Diagnosis Standard (FDS) c77% and 62d combined performance c70% with consistent reduction in 62d backlog	a) Evidence of sustainable improvement in cancer performance with effective multidisciplinary team (MDT) arrangements and improved validation position of surveillance waiting list b) Embedded streamline pathway, aligning diagnostic and MDT capacity c) Reduction in total diagnostic PTL d) Tiering process monitoring, feedback and delivery				
8	Consistent trajectory towards DMO1 compliance c5% and endoscopy delivery plan agreed and delivered	a) Endoscopy recovery delivery plan with agreed trajectories and milestones delivered against b) Reduction in total diagnostic PTL and >6ww c)Reduction in incidents of harm relating to diagnostics and/or treatment delays for patients waiting longer than standard waiting times or a result of being lost to follow up d)At least 90% of CDC activity plans delivered. e) Trust delivering their portion of the Kent and Medway Integrated Care Board endoscopy plan				
Finance						
9	Delivery of 2024/25 plan inclusive of the CIP, income and expenditure plans	a) Financial position actuals submitted in monthly NHSE returns in line with plan. b) 2024/25 outturn position in line with plan. c) Improved levels of agency usage; at or towards national agency ceiling target. d) Delivery CIP programme agreed as part of 2024/25 annual plan e) Recurrent % of the 2024/25 CIP programme being greater than 67%				
10	Robust financial oversight, governance, and a strong financial control environment in place	a) 6 monthly review of PWC Grip and Control Actions b) Evidence that recommendations from PWC report have been adhered to c) Independent review of financial governance d) Appropriate attendance at finance & investment committees e) Evidence of staff engagement (e.g. Finance training attended by non-finance staff) f) Equality and Quality impact assessments developed for each cost improvement plan (CIP) linked to financial savings. g) Clear governance process for assessing and approving CIPs including clinical sign off h) Evidence of financial governance processes working in practice				
11	Agreement of a Medium-Term Financial Recovery Plan (FRP) with system / region and national partners and demonstrable progress towards delivery	a) Development of Medium-Term Financial Recovery Plan (FRP) with financial trajectories agreed with ICB & NHSE. b) Evidence FRP addresses key drivers of deficit as identified in PWC reports including workforce realignment/resizing c) Evidence of alignment with the ICS financial plans and of engagement and support from stakeholders (e.g finance committee papers/ minutes, documents used to engage Trust staff) d) Evidence Trust has internal capacity and capability in place to deliver FRP (e.g substantive internal finance leadership & resource) e) Evidence timely progress is being made on 2025/26 efficiency plan				

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Significant Risk Register Report**

Meeting date: **5 June 2025**

Board sponsor: **Chief Nursing and Midwifery Officer**

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

Appendices:

None

Executive summary:

Action required:	Assurance
Purpose of the Report:	This paper presents the current Significant Risk Report 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 documented review within the last four weeks. As of the 19 May 2025 when the Significant Risk Register was extracted there were 11 risks with associated overdue actions. There has been a slight decrease in actions being completed within the specified timeframe and/or an update provided to document the reason for the delay and where appropriate an extension. Monthly meetings continue with the executive leads for each significant risk (and their deputy/wider team as requested) to ensure regular oversight and scrutiny. For the July Significant Risk Report, forecasts will be provided for risks, including those with reduced residual risk scoring. The last Risk Review Group meeting was held on 19 May 2025. At this meeting, Strategic Development and Capital Planning (covering Estates, Health and Safety and Information Technology/Digital) and Corporate Medical presented deep dives.

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	Since the last Board report in April, five new risks have been approved. One further Trust-wide risk (residual risk rating 12) has been approved and there has been one escalation of an existing risk from a moderate to a high risk. Full details are in Section 4. There were two areas of escalation from the meeting as shown below: ➢ Continued review of overdue risks by Care Groups and Corporate Leads. ➢ Training Needs Assessment and rollout plan – the Head of Risk Management and Assurance was to provide an update on the Training Needs Analysis and a tiered rollout plan following piloting of the Fundamentals of Risk Management module. Due to lack of time in the meeting this information will be sent out to all members and attendees for comment to ensure approval of the next stages of training rollout following the pilot and evaluation. Planning for the implementation of InPhase continues. Several areas have been urgently escalated with the senior InPhase team due to a lack of functionality within the system, against the required specification. A technical meeting was held with the supplier on 21 May 2025 to go through solutions to the main issues that have been raised. We await further information from the suppliers about whether reporting concerns can be addressed. The current 4Risk/4Policy has been extended for a further three months from 1 July 2025.
Key recommendations:	The Board of Directors is asked to receive and **NOTE** the Significant Risk Report for assurance purposes and for visibility of key risks facing the organisation.

Implications:

Links to 'We Care' Strategic Objectives:	• Our patients • Our people • Our future • Our sustainability • Our quality and safety
Link to the Board Assurance Framework (BAF):	This paper provides an update on the significant risks to the Trust which align with the risks on the BAF.
Link to the Corporate Risk Register (CRR):	This paper provides an update on the significant risks (to be known as the 'significant risk report') to the Trust which replaces the 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

Assurance route:

Previously considered by: Trust Management Committee (TMC) on 7 May2025.

Reports are provided to the following Sub Committees:

- Finance and Performance Committee (monthly) – 27 May 2025
- Quality and Safety Committee (bi-monthly) – 20 May 2025
- People and Culture Committee (bi-monthly) – 13 May 2025
- Integrated Audit and Governance Committee (bi-monthly) 2 May 2025

It should be noted that as the Risk Register is a live document the supporting information was extracted on 19 May 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 19 May 2025. Deep dive presentations were provided by Strategic Direction and Capital Planning (including Estates, Health and Safety and Technology/Digital) and Corporate Medical. 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, 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 33 risks in total on the Significant Risk Report (up from 31 in the April Board report).

3.2 The residual risk scores of all risks reported in April remain the same.

3.3 There are overdue actions associated with 11 of the risks (marked in bold for clarity). These have been escalated for immediate attention with the Risk Owners and Delegates via the Risk Review Group and directly. They have also been escalated via the monthly meetings with the Responsible Executive Risk Owners.

3.4 The Significant Risk Register is summarised below:

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
1891	Corporate Operations **Accountable Executive: Chief Operating Officer (COO)**	Misalignment between Demand and Capacity across the Trust's urgent and emergency care pathway	Extreme (20)	⟺	Low (6)	Demand and capacity modelling to be confirmed by all systems partners for all P1 to P3 patients as part of the system wide better use of beds programme to inform 2526 redesign. Person Responsible: Interim Managing Director Due: 01 Jul 2025 Conduct a comprehensive review of current Emergency Department (ED processes and identify areas for improvement – focussing initially on the opportunity to reduce the number of patients spending 12+ hour in ED. Introduction of Clinical Decision Unit (CDU) at William Harvey Hospital (WHH) required by end of Jan 2025. Person Responsible: Interim Managing Director Due: 30 Jun 2025
3386	Care Group - Women's Health	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

	Accountable Executive: CNMO					testing is successful, then 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 Jun 2025 Attendance at quality board to communicate what staff can do to help mitigate the risk Person Responsible: Digital Lead Midwife Due: 31 Jul 2025
2406	Care Group - Diagnostics, Cancer and Buckland **Accountable Executive: Chief Partnerships & Strategy**	Delay to patient diagnosis from potential loss of Nuclear Medicine service at WHH	High (16)	⟺	Low (4)	Associated work is required to allow camera under NM to open on. discussed at Performance Review Meeting (PRM) on the 29/08/24 and awaiting update. This Administration of

	Officer (CPSO)					Radioactive Substances Advisory Committee (ARSAC) licence renewal to allow operational services to commence Additional work needed to remove handbasin and related service pipes to meet recent national guidelines. Approved by Infection, Prevention and Control (IPC) in Dec 2024. Approve by Care Group. Purchase Order (PO) to be raised and issued. Person Responsible: Chief Technologist Nuclear Medicine & Osteoporosis Due: 30 Jun 2025
3354	Queen Elizabeth Queen Mother Care Group **Accountable Executive: CPSO**	Clinical environment not fit for purpose in many areas	High (16)	⟺	Low (4)	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

						Person Responsible: Director of Nursing To be implemented by: 31 May 2025 Full review of this risk with details of areas of non-compliance and key actions to be completed. Person Responsible: Managing Director Due: 13 Jun 2025
3553	William Harvey Hospital Care Group **Accountable Executive: CPSO**	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 decant lab initially, to be implemented by end of financial year. Further lab replacements will then be reviewed once this is completed. Person Responsible: General Manager (GM) Due: 30 Apr 2026
2158	Care Group - Diagnostics, Cancer and Buckland **Accountable Executive: Chief Medical Officer (CMO)**	Risk of Patient harm and treatment due to unreported Accident & Emergency (A&E) chest xrays	High (16)	⟺	Low (4)	**External review to be undertaken by Regional Advisor. Meeting to be arranged with care group leaders to discuss outputs of report.** **Now have an AI algorithm ready for deployment that assigns high and low risk status to chest xrays. This has been extensively tested and a paper is due to come to Clinical**

						Executive Management Group (CEMG)/TMC in March to recommend immediate deployment. **Person Responsible: CMO** **To be implemented by: 31 Mar 2025**
678	Care Group - Diagnostics, Cancer and Buckland **Accountable Executive: CMO**	Insufficient Pharmacy support for the safe (and secure) use of medicines on wards	High (15)	⟺	Low (4)	**Review current working models to release clinical pharmacy time e.g. late nights, dispensary commitments.** **Workflow Standard Operating Procedure (SOP) has been drafted for clinical pharmacy staff.** **Reviews of staffing in GSM and ward cover is being completed to identify any opportunity to tweak model to release capacity.** **Person Responsible: Deputy Lead CS Pharmacist** **Due: 31 Mar 2025** Consider Full 7-day service from Pharmacy following action from Care Quality Commission (CQC) Must do. Due date amended to next year as still awaiting CQC case review by Business

						Case Scrutiny Group (BCSG). Person Responsible: Director of Pharmacy Due: 1 Apr 2026 **Start to recruit to GSB BC (assuming case is approved) submitted Oct 2024** **Person Responsible: Deputy Lead CS Pharmacist** **Due: 31 Jan 2025** Recruit to paeds case (once approved and presented to the BCSG). Awaiting date for BCSG still from Dec 2024 submission. Person Responsible: Deputy Lead CS Pharmacist Due: 01 Jun 2025 Request purchase of Sunrise medicines management app for the use by pharmacy staff with aim of improving processes on the system which have been impacted when switching to epma e.g. ordering and screening (Home function is required to improve MR process) Person Responsible: Rebecca Morgan Due: 30 Jun 2025
2796	Kent & Canterbury	There is a risk of delay in	High (15)	⟺	Low (6)	In the process of finalising the rolling

	and Royal Victoria Care Group **Accountable Executive: CPSO**	dialysis treatment due to high number of Renal Dialysis machines that are over 15 years old				replacement programme for dialysis machines across all of the dialysis units to ensure that there is a clearly shown sub-set within the Medical Devices Group (MDG) capital allocation that will be reviewed monthly at the Trust's Capital Investment Group Person Responsible: General Manager Due: 21 May 2025 Currently in the process of taking receipt of 51 machines, which will require commissioning and training across all dialysis units to be completed by the end of March 2025. Person Responsible: Renal Technical Manager Due: 21 May 2025 8 of the 51 machines are now in use in the unit. This risk will be monitored and updated as further machines are operational and this risk can then be de-escalated.
1831	Queen Elizabeth Queen	Privacy and dignity will be adversely affected when	High (15)	⟺	Low (6)	**Fortnightly QEQM Urgent Emergency Care (UEC) delivery Group set-up with a**

	Mother Care Group **Accountable Executive: CMNO**	patients are treated in non-care spaces				**wide range of improvement programmes to support improvements in flow across the site. This delivery group provides the governance oversight on local care group improvement schemes and reports through to Trust Emergency Care Delivery Group for overall oversight.** **Person Responsible: Deputy Head of Nursing** **To be implemented by: 31 Mar 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 we come out of winter. We are trying to highlight patients on Sunrise who are looked after in non-care areas or delayed in ambulance queues** **Person Responsible: Associate Medical Director** **To be implemented by: 31 Mar 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: Deputy Head of Nursing** **To be implemented by: 31 Mar 2025** **Fundamentals of care training to be completed by staff re privacy and dignity. Training remains ongoing.** **Person Responsible: Deputy Head of Nursing** **To be implemented by: 31 Mar 2025** **A proposal has been made and is being considered to utilise a corridor section for examination and checks on patients by putting a permanent curtain in place.** **Person Responsible: Deputy of Head of Nursing** **To be implemented by: 30 Apr 2025**
3556	William Harvey Hospital Care Group	Delays in delivery and personal care are resulting in an increased	High (15)		Low (6)	**Continued Implementation of the Emergency Floor Improvement plan which includes**

	Accountable Executive: CMNO	risk of pressure ulcers and falls occurring				**direct pathways such as right sizing Same Day Emergency Care (SDEC), Surgical Emergency Admissions Unit (SEAU) and Urgent Treatment Centre (UTC).** **Risk needs significant review and re-write to ensure actions are appropriate to the risk** **Person Responsible: Head of Operations To be implemented by: 31 Mar 2025**
3367	Corporate Medical **Accountable Executive: CMO**	Lack of timely review of diagnostic test results	High (15)	⟺	Low (6)	Developing a page on Sunrise for consultants to review all results that are allocated to them The focus needs to be on both the test results being accessible by the relevant clinicians but also on safety netting for critical results Person Responsible: Chief Clinical Information Officer Due: 30 Jun 2025
679	Care Group – Diagnostics, Cancer and Buckland **Accountable Executive: CMO**	Failure to supply, from Pharmacy, scheduled chemotherapy treatments to patients	Extreme (20)	⟺	High (15)	**Commence £250K of remedial work required. Work commencing on the plan to complete the refurbishment in Sept 2025.**

						Person Responsible: Interim Accountable Pharmacist **To be implemented by: 31 Dec 2024** **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).** **Person Responsible: CMO** **To be implemented by: 31 Mar 2025** Assurance of completion of AHU Airis Q action plan by the Accountable pharmacist/Estates/production manager. Action plan and document uploaded and in process via the refurbishment work planned. Person Responsible: Pharmacy Quality Assurance & Quality Control Lead To be implemented by: 27 Jul 2025 Create and appoint to a substantive Accountable pharmacist to replace current interim role Case for shared post with Medway NHS Foundation Trust (MFT) outlined following discussion with Regional Quality

						Assurance (QA) team that inspected the unit on 11/12 March as it being a viable option. MFT still committed to this which is 8D hosted at EKHUFT which they pay 50% of. Director of Pharmacy (DoP) to pursue this action. Person Responsible: DoP To be implemented by: 30 Sep 2025 Replacement of the unit with off-site licensed facility as part of the Integrated Care System (ICS) strategy and linked to the national aseptic review. Person Responsible: DoP To be implemented by: 30 Sep 2029
3557	Care Group – William Harvey **Accountable Executive: COO**	Increased length of stay for mental health patients awaiting inpatient community beds	High (16)	⟺	Moderate (9)	**No actions** **This risk is in the process of being rewritten with a separate risk for quality impact of increased wait**
1895	Care Group – Diagnostics, Cancer and Buckland **Accountable Executive: CMO**	Current CT and MRI reporting backlog presents a clinical risk due to potential delays in diagnosis and treatment	High (16)	⟺	Moderate (9)	**External review to be undertaken by Regional Advisor. Meeting to be arranged with care group leaders to discuss outputs of report. Corrections on the report were made on**

						16/01 – awaiting for final version of report. The report and corrections has been shared with the Exec Board and Senior Management Team of DCB. The report has been well received and actions laid out will form part of the plan to address the backlog 31/3/25. **Person Responsible: CMO** **To be implemented by: 31 Mar 2025**
1628	Care Group – William Harvey **Accountable Executive: CNMO**	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 ED Consultants in place for WHH and QEQM.** **Person Responsible: Consultant** **Due: 31 March 2025** **Advertise and recruit into Matron post. Use internal and external networks to promote role. Interim in place in meantime.** **Person Responsible: Associate Director of Nursing** **Due: 31 March 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), urology and skin work now being distributed according to the job plans of the consultants. Person Responsible: Head Biomedical Scientist Cellular Pathology To be implemented by: 31 Jul 2025 Kent & Medway Pathology Network (KMP)N Digital Histopathology & AI project to improve performance & resilience. The digital pathology project is on hold at Maidstone and Tunbridge Wells NHS Trust (MTW), but validation of reporting by digital image (as opposed to microscope image) is proceeding slowly at EKHUFT, with the breast pathologists about to enter phase 2 (live case dual

						reporting with digital image and microscope). Each pathologist will have to be validated for each sub-discipline they report before they can switch to digital reporting. AI roll out for assisted reporting can only follow after validation of digital reporting. Person Responsible: Head Biomedical Scientist Cellular Patholgy To be implemented by: 31 Dec 2026 Trust involved in discussions regarding a Kent & Medway Joint Venture. Trust to ensure areas of pressure are highlighted and worked up. Person Responsible: CMO To be implemented by: 01 Jul 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 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. 1.85 vacancies. One Whole Time Equivalent (WTE) to come to vacancy approval panel

						imminently. Work underway to ensure funding available for remaining 0.85 to be 1 WTE. Some vacancies on call rota due to restrictions in some individuals being able to do on call. Mitigated by locums. Additional business case being written to use the funding from Ockenden to appoint an additional obstetrician at QEQM. Person Responsible: Associate Medical Director Due: 31 Oct 2025
3384	Corporate – Strategic Development & Capital Planning **Accountable Executive: CPSO**	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: Director of Strategy & Business Development Due: 01 Sept 2025
2599	Corporate – Medical	There is a risk of inadequate medical staffing levels and skills	High (15)	⟺	Low (6)	Programmes to support career progression and attraction of consultant posts for

	Accountable Executive: CMO	mix to meet patients' needs				long term locums becoming substantive (i.e. Certificate of Eligibility of Specialist Registration (CESR)). Person Responsible: Head of People & Culture Services To be implemented by: 30 May 2025 Establishment review at WHH to determine the number of consultants required to run the service Person Responsible: CMO Due: 30 Jun 2025 To develop and implement a standard operation procedure for recruitment for hard to recruit posts Person Responsible: Head of People and Culture Services Due: 31 Oct 2025
3700	Corporate – Finance & Performance Management **Accountable Executive: Chief Finance Officer (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, Integrated Care Board (ICB) & NHSE Person Responsible: CFO Due: 31 July 2025
3701	Corporate – Nursing	Staff may experience physical and psychological	High (16)	⟺	Low (6)	Re-establish personal safety and restraint training as appropriate. Priority

	Accountable Executive: CNMO	harm as they are frequently subjected to verbal and physical abuse from patients exhibiting challenging behaviours				training for certain staff groups (tiers of training) and ongoing training for workforce. Person Responsible: Deputy Chief Nurse Due: 02 Jun 2025 Security service provision contract will form basis of specification for 2gether to tender the service. New security contractor will be appointed by end of May with the intent to mobilise by Aug 2025. The increase in provision to the ED departments is already in place and the majority of existing security officers have been upgraded to a higher SIA door supervisor level Person Responsible: Associate Director of Safety Due: 29 Aug 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 site responsibilities

						Person Responsible: Director of Nursing Due: 30 May 2025
1814	Corporate – Strategic Development & Capital Planning **Accountable Executive: 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 Person Responsible: Head of Infrastructure, Cyber and Frontline Services Due: 31 May 2025 Training needs analysis to be undertaken for IT staff in relation to cyber Person Responsible: Head of Infrastructure, Cyber and Frontline Services Due: 31 May 2025 Review and update current IT incident and cyber response plans Person Responsible: Head of Infrastructure, Cyber and Frontline Services Due: 30 Jun 2025 Review of all systems to include planned upgrades and patches are part of the departments/ trust annual cycle – to ensure adequate management and control Person Responsible: Head of IT Applications Due: 31 Jul 2025

						Servicing of Uninterruptible Power Supplies (UPS) within data centre Person Responsible: John Kelly Due: 30 Sept 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 Sept 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 Sept 2025 Annual servicing of air con within data centres Person Responsible: John Kelly Due: 31 Oct 2025 Review privileged access rights to key infrastructure systems (as per DocIT). Person Responsible:

						Head of Infrastructure, Cyber and Frontline Services Due: 31 Mar 2026 Review of external facing systems that currently do not support Multi-Factor Authentication (MFA) Person Responsible: Jon McKinlay Due: 31 Mar 2026
1350	Care Group – Diagnostics, Cancer and Buckland **Accountable Executive: CMO**	Failure to provide ward stock medicines in a timely fashion due to obsolescence of Pharmacy TWS Distribution robot	High (15)	⟺	Moderate (12)	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 1. Pursuing ITT – with no commitment just to get more detailed costings 2. meeting with automation companies re options 3. Engaging with care grp Tri's and CEMG on the options 4. Robot continues to go blind the extent of which reported via DCB PRMs Person Responsible: Chief Pharmacy Technician Due: 1 July 2025
3719	Care Group – Diagnostics, Cancer and Buckland	There is a risk of patient harm from availability, delays and	High (15)	⟺	Low (5)	**ARIA system failure to be included in local business continuity plans**

	Accountable Executive: CMO	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)				**Business continuity completed, sent to emergency planning for approval. Once approved can close action.** **Person Responsible: Clinical Matron** **To be implemented by: 31 Mar 2025** **New E-prescribing system to be procured and implemented across the Cancer Alliance.** **Person Responsible: Interim Head of Operations** **Due: 30 Apr 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)	**Executive team Risk Owner has changed to CSPO. Risk to be reviewed and actions updated.** **Person Responsible: CSPO** **Due: 31 Jan 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	Extreme (20)	⟺	Low (4)	Recommendation to Executive to pilot removing two additional beds on three wards – decision pending Paper presented to CEMG but no decision made thus far. Review in one month. Person Responsible: CNMO Due: 30 Jun 2025

						Undertake Trust-wide, a bed space measurement review (to be supported by Directors of Nursing on each site). Plan to be agreed as to the process for doing this Person Responsible: Associate Chief Nurse Due: 30 Jun 2025
3725	Corporate Services **Accountable Executive: Chief Executive Officer (CEO)**	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. Person Responsible: Director of Corporate Governance Due: 30 May 2025
3782	Corporate – Operations **Accountable Executive: COO**	Overdue Appointments for Patients on the Diabetes and Endocrine Outpatients Patient Tracking List (PTL)	Extreme (20)	⟺	16	**Additional Clinics to clear the backlog, which can be supported by the nurse and the consultant completing the validation but will need additional resource.** **Person Responsible: Head of Operations To be implemented by: 30 Apr 2025** Procure additional Administration to Validate PTL to make sure that data is correct and clear any duplicates.

						Person Responsible: Head of Operations Due: 07 Jul 2025 Remove a consultant from the ward to support with a second line of Validation by a Clinician to understand if any harm has come to patients and identify patients to be focused on and if any patients would be suitable to be discharged Person Responsible: Head of Operations Due: 14 Jul 2025 Letter to long waiters to understand if they still need a follow up and if not discharge supported by the additional admin team member Person Responsible: Head of Operations Due: 01 Sept 2025
3764	Care Group - Women's Health **Accountable Executive: CNMO**	Lack of infrastructure to enable training provision to meet national requirements	High (16)		Low (4)	Identify space within the organisation to enable assurance that the maternity training requirements can be delivered to meet NHSE and Maternity Incentive Scheme (MIS) national standards Canterbury College being reviewed currently as an alternative location Person Responsible:

						Head of Operations Due: 30 Jun 2025 Business case for extension of the lease at St Pauls. Not required as yet until alternative space identified. Person Responsible: Head of Operations Due: 31 May 2025
3803	Care Group – Diagnostics, Cancer and Buckland **Accountable Executive: CSPO**	Risk of total failure of DartOCM	Extreme (20)	NEW	Moderate (8)	Project plan in place – Trust IT, Path IT and KMPN Programme Management Office (PMO) team supporting to deliver Tactical solution by 01 Dec 2025. Person Responsible: General Manager Pathology Due: 01 Dec 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)	NEW	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 Sept 2025 Approval required of a workforce plan that has been submitted for 2025/26 increasing the service by 1x Band 6, 2x Band 5, 1x Band 4 posts via EKHUFT business case and an additional 2x Band 7

						posts through the Community Diagnostic Centre business case Person Responsible: General Manager Due: 30 Sept 2025 Triumvirate to liaise with COO to discuss the service and liaise with the Integrated Care Board (ICB). Person Responsible: Managing Director Due: 30 Sept 2025 Insourcing extended for 6 months Person Responsible: General Manager Due: 30 Nov 2025
3799	Care Group – William Harvey **Accountable Executive: COO**	Insufficient capacity to deliver gastro OPA in a timely manner	High (15)	NEW	Very Low (2)	**Continuation of ID Medical gastro clinics being held at the weekend until end of March 2025. Person Responsible: General Manager Due: 30 Apr 2025**

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

	Residual Risk Score				
Care Group	**15**	**16**	**20**	**25**	**Total**
CCASS CG		1			1
DCB CG	3	4	3		10
K&C CG	1				1
QEQM CG	1	2			3
WHH CG	2	2			4
WCYP CG		3			3
Corporate Medical	2				2

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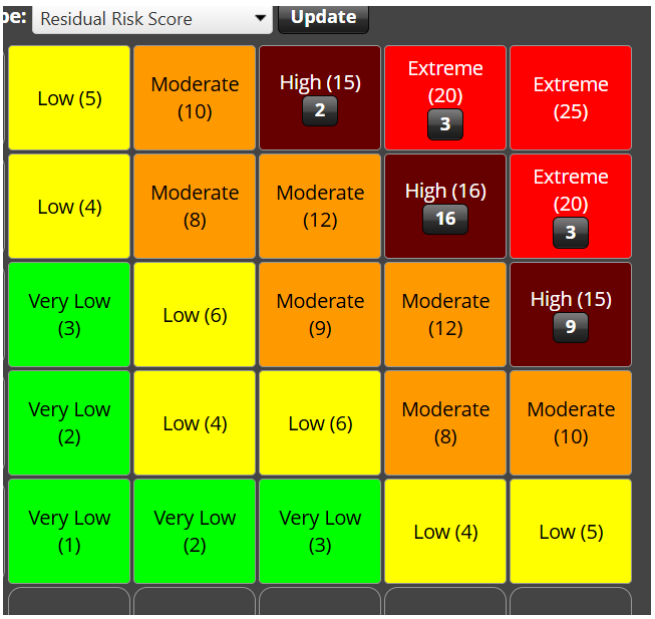
Corporate Nursing	1	1			2
Corporate Operations		1	2		3
Corporate Strategic Development	1	1			2
Corporate Finance			1		1
Corporate Services		1			1
Corporate People and Culture	0				0
TOTAL	**11**	**16**	**6**	**0**	**33**
CHANGE SINCE LAST REPORT	**+2**	**+2**	**-1**	**0**	**+3**



4. Changes since the last report

4.1 New risks or escalations to the Significant Risk Report since last report

- Due to known risk of lack of capital funding to adequately maintain the estate it is not always possible to comply fully with Health Technical Memoranda (HTM) and Health Building Notes (HBN) standards which enable effective infection prevention control measures including cleaning and ventilation (risk ref: 3810). Corporate Nursing. Residual risk rating 16 (high). Approved May Risk Review Group. To be noted this is not on the above summary table yet as only just approved via May Risk Review Group.

- 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 (risk ref: 3789.QEQM Care Group. Residual risk rating 16 (high). Approved April Risk Review Group.

- Risk of total failure of DartOCM (risk ref: 3803). DCB Care Group. Residual risk rating 20 (extreme). Approved April Risk Review Group.

- Insufficient capacity to deliver gastro OPA in a timely manner, therefore a risk to Referral To Treatment [RTT] (risk ref: 3799). WHH Care Group. Residual risk rating 16 (high). Approved April Risk Review Group.

- Inability to reach agreement on Health Care Support Workers (HCSW) backpay with Unions which could result in a precedent-setting Tribunal claim or industrial action, (risk ref: 3787). Corporate People and Culture. Residual risk rating 15

(high). To be noted this is not on the above summary table yet as only just approved via May Risk Review Group.

A Trust wide risk was presented with further discussion ongoing as to whether it met the criteria of a significant risk.

- Information Technology - Trust may not be able to make the most of the opportunities that Digital, Data and Technology (DDaT) provides (risk ref: 3769). Strategic Development, Capital Planning and Estates. Proposed residual risk rating 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. This includes those patients with infections, immunocompromised, challenging behaviours, learning disabilities, end of life and other requirements. (risk ref: 3811). Corporate Nursing. Residual risk rating 12 (moderate).

4.3 Escalations from the Significant Risk Report

- Failure to address poor organisational culture (risk ref: 1679). Corporate People and Culture. Previous residual risk rating 9 (moderate) increased to 16 (high).

4.4 De-escalations from the Significant Risk Report

- Staff attendance at resus training (risk ref: 3727). CCAS Care Group. Residual risk rating decreased from 20 (extreme) to 12 (moderate) on 9 April 2025.

5. Escalations from Risk Review Group

5.1 There were two areas of escalation from the meeting:

- All overdue actions to be reviewed and updates provided by Risk Owners and Delegate Risk Owners.

- Training Needs Assessment and rollout plan – the Head of Risk Management and Assurance provided an update on Risk Management Training Needs Analysis and a tiered rollout plan following piloting of the Fundamentals of Risk Management module with the Quality Governance Business Partners. Due to lack of time in the meeting this information will be sent out to all members and attendees for comment to ensure approval of the next stages of training rollout following the pilot and evaluation.

6. Corporate Risk Management Infrastructure

6.1 Project planning for the implementation of InPhase continues. Several areas have been urgently escalated with the senior InPhase team due to a lack of functionality within the system, against the required specification. A meeting was held with the supplier on 30 April 2025 covering feedback and concerns on User Acceptance Testing and on 21 May 2025 to go through reporting solutions. The current 4Risk/4Policy was extended for a further three months from 1 July 2025.

7. Conclusion

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

End.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Board Assurance Framework (BAF)**

Meeting date: **5 June 2025**

Board sponsor: **Director of Corporate Governance**

Paper Author: **Director of Corporate Governance**

Appendices:

Appendix 1: BAF

Executive summary:

Action required:	Information
Purpose of the Report:	A Board Assurance Framework (BAF) is the Trust's structured system that helps it oversee and understand how well key risks to achieving its strategic objectives are being managed, and where assurance (evidence) exists that controls are effective. It is presented quarterly and supports EKHUFT's board of directors to understand and manage the risks to achieving the Trust's strategic objectives by: • **Identify risks**: The BAF helps the board understand the risks to achieving its strategic goals. • **Identify assurance gaps**: the BAF helps the board identify areas where assurance is insufficient or missing. • **Identify areas for improvement**: the BAF helps the board identify areas where controls and assurances can be improved. • **Improve governance**: the BAF helps the board and management consider how to secure assurance in a way that promotes good governance and accountability.
Summary of key issues:	EKHUFT's Board Assurance Framework or BAF is a key part of the Trust's strategic risk management process. It is overseen by the Board and Integrated Audit and Governance Committee (IAGC) as a whole and by each Board committee in respect of its allocated strategic risks. The use of the BAF, closely aligned with the Strategic Risk Register (SRR), is now embedded in the Trust's assurance and risk management processes. The Trust's BAF is a living document. It has been designed to allocate risks to each relevant Board committee in line with EKHUFT's 'We Care' strategic objectives: • Our patients • Our people • Our future • Our sustainability • Our quality and safety EKHUFT's BAF has taken on an increasingly vital role in its assurance processes.

	The BAF – and specific risks allocated to each Committee – now form the framework for their work and agendas. The report identifies the Trust's BAF risks with reference to each Committee in the paper. In addition, the Paper confirms the risk rating as endorsed by the IAGC. Changes since the last review of the BAF by the IAGC in May, the following changes have been made: 1. The FPC has agreed inclusion of a digital/cyber risk: *Cyber security and data loss: Failure to prioritise cyber resilience through the implementation of up-to-date cyber security controls, training, surveillance, risk management, business continuity and recovery planning increases the risk of a major cyber event causing data loss, key system failure, and prolonged disruption to services impacting patients and staff.* 2. We have updated BAF Risk Ref: BAFSQC003: From: *There is a risk that the trust won't improve the experience of women and their families following the Independent Investigation into East Kent Maternity Services.* To: *There is a risk that the trust won't continue to improve the experience of women and their families following the actions taken in response to the Independent Investigation into East Kent Maternity Services and other reviews.*
Key recommendations:	The Board of Directors is asked to review and **NOTE** the status of the Principle Risks in the BAF.

Implications:

Links to Strategic Theme:	This report aims to support the following 'We care' Strategic Objectives; • Our patients • Our people • Our future • Our sustainability Our quality and safety
Link to the Board Assurance Framework (BAF):	The entirety of the BAF is appended.
Link to the Corporate Risk Register (CRR):	The SRR is linked to the BAF.
Resource:	No
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

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	• Health and Safety Executive
Subsidiary:	n/a

Assurance route:

The BAF is overseen by the IAGC and the specific BAF risks are considered and presented at each respective Committee.

East Kent Hospitals University NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK (BAF)

May 2025

Glossary of terms

Board Assurance Framework (BAF) – A tool for the Board corporately to assure itself about successful delivery of the organisation's strategic objectives.

Inherent Risk – The risk that an activity would pose if no controls or other mitigating factors were in place

Risk – Risk is the combination of the probability of an event and its consequence. Consequences can range from positive to negative.

Residual Risk – The risk that remains after controls are considered.

Risk Appetite – The amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time.

Risk Tolerance – Reflects the boundaries within which the executive management are willing to allow the day-to-day risk profile of the Trust to fluctuate.

Target Risk – The desired risk level over a period of time after risk actions have been implemented.

Controls – How the risk is being managed

Assurance – The evidence that controls are effective

RISK MATRIX						
Impact	5. Extreme	5. L	10. M	15. H	20. E	25. E
	4. Significant	4. L	8. M	12. M	16. H	20. E
	3. Moderate	3.V L	6. L	9. M	12. M	15. H
	2. Low	2. VL	4. L	6. L	8. M	10. M
	1. Negligible	1. VL	2. VL	3. VL	4. L	5. L
		1. Rare	2. Unlikely	3. Possible	4. Likely	5. Almost certain
		Likelihood				

E	Extreme Risk
H	High Risk
M	Moderate Risk
L	Low Risk
VL	Very Low Risk

Strategic Theme	Principle Risk	Oversight Committee	Inherent Risk Score	Current Risk Score	Change ↑↓↔	Target Risk Score	Target Date
Quality and Safety	**Ref: BAF QSC 001** Failure to (i) meet quality standards for clinical care; (ii) continuously improve care quality and safety; and/or (iii) engage patients and carers in that care, could result in patient harm, impaired outcomes, and poor experience for both patients and staff.	Quality & Safety Committee (Q&SC)	20	16	↔	12	
	Ref: BAF QSC 002 Failure to identify harm and involve patients and their families in their care and investigations, and use opportunities to embed a culture of safety and learn from when things don't go well and share best practice across the organisation	Quality & Safety Committee (Q&SC)	20	20	↔	12	
	Ref: BAF SQC 003 There is a risk that the trust won't continue to improve the experience of women and their families following the actions taken in response to the Independent Investigation into East Kent Maternity Services and other reviews.	Quality & Safety Committee (Q&SC)	20	15	↓	6	
Patients	**Ref: BAF QSC 004** There is a risk we fail to meet our statutory and regulatory requirements resulting in regulatory action, harm to patients and staff and damage to our reputation.	Quality & Safety Committee (Q&SC)	16	16	↔	9	
	Ref: BAF FPC 001 Due to significant waiting lists, in part, as a legacy of the Covid-19 pandemic, and misalignment between demand and capacity in certain specialties, there is a risk that the Trust is not able to deliver the constitutional standards within National timeframes which could result in harm, poorer outcomes and experience for our patients.	Finance & Performance Committee (FPC)	20	16	↓	12	
	Ref: BAF FPC 002 Due to constraints and sub-optimal patient pathways, the Trust is not able to deliver timely and responsive services, both elective and non-elective, sustainably increase activity levels to reduce waiting lists, while at the same time managing future surges in seasonal viruses.	Finance & Performance Committee (FPC)	20	16	↔	12	
	Ref: BAF FPC 003 We are unable to address or mitigate effectively infrastructure and safety system risks due to insufficient capital funding impacting on patient and staff safety, continuity of clinical service delivery, regulatory compliance and reputation.	Finance & Performance Committee (FPC)	20	20	↔	12	
	Ref: BAF FPC 007 Failure to prioritise cyber resilience through the implementation of up-to-date cyber security controls, training, surveillance, risk management, business continuity and recovery planning increases the risk of a major cyber event causing data loss, key system failure, and prolonged disruption to services impacting patients and staff.	Finance & Performance Committee (FPC)	20	16		12	
People	**Ref: BAF PCC 001** A failure to recruit and retain staff could lead to: the quality and quantity of healthcare being impaired; pressure on existing staff and decreased resilience, health & wellbeing and staff morale; over-reliance on agency staffing at high cost/premiums and potential impairment in service quality; and loss of the Trust's reputation as an employer of choice.	People & Culture Committee (P&CC)	20	20	↔	9	
	Ref: BAF PCC 002 A failure to develop and maintain our culture in line with the Trust values and the NHS people promise which includes: being compassionate and inclusive, recognition and reward, having a voice that counts, health, safety & wellbeing of staff, working flexibly, supporting learning & development, promoting equality, diversity & inclusivity and fostering a team culture. The absence of which could result in; harm to staff; an inability to recruit and retain staff; a workforce which does not reflect Trust and NHS values; and poorer service delivery.	People & Culture Committee (P&CC)	20	20	↔	12	
	Ref: BAF PCC 003 Failure to maintain a coherent and co-ordinated structure and approach to succession planning, organisational development and leadership development may jeopardise: the development of robust clinical and non-clinical leadership to support service delivery and change; the Trust becoming a clinically-led organisation; staff being supported in their career development and to maintain competencies and training attendance; staff retention; and the Trust being a "well-led" organisation under the CQC domain	People & Culture Committee (P&CC)	20	20	↔	12	
Partnerships	**Ref: BAF FPC 004** We are unable to deliver the strategic intentions of the trust due to the lack of a trust strategy that would support and enable the delivery of sustainable services and the future viability of the organisation.	Finance & Performance Committee (FPC)	16	16	↔	8	
	Ref: BAF FPC 005 We are unable to foster and maintain effective collaborative working relationships with Health and Care Partnership, System and regional partner organisations and regulatory bodies to deliver on common aims and objectives.	Finance & Performance Committee (FPC)	16	12	↔	8	
Our Sustainability	**Ref: BAF FPC 006** There is a risk that the Trust, as part of the Kent and Medway ICS, is unable to deliver the scale of financial improvement required to achieve breakeven or better within the funding allocation that has been set over a 3-year period. This would lead to regulatory action and/or limits on our ability to invest in strategic priorities/provide high quality services for patients.	Finance & Performance Committee (FPC)	25	25	↔	16	