Board of Directors meeting in Public

15 October 2025, 9 to 11am

Kent Community Health NHS Foundation Trust Offices, Meeting rooms 6 and 7, Trinity House, 110 – 120 Upper Pemberton, Eureka Park, Ashford, Kent TN25 4AZ

Agenda and Papers

Trust Board Meeting in Public

Wednesday 15 October 2025, 9am to 11am, Meeting rooms 6 and 7, KCHFT offices, 110 – 120 Upper Pemberton, Eureka Park, Ashford, TN25 4AZ

Key: DL: Diligent Reference, FA- For Approval, FD - For Discussion, FN – For Noting

DL	Description	FOR	Format	Lead	Time
1.	Welcome and apologies	FN	Verbal	Trust Chair	09.00
2.	Declarations of Interest	FN	Verbal	Trust Chair/All	
Board reflection items					
3.	Patient Story	FD	Verbal	Chief Nursing Officer	09.05
Standing items					
4.	Minutes from the meeting of 16 July 2025	FA	Paper	Trust Chair	09.20
5.	Action log and matters arising	FA	Paper	Trust Chair	09.25
6.	Chair's report (incl. Board Effectiveness Survey report)	FN	Paper	Trust Chair	09.30
7.	Chief Executive's report	FN	Paper	Chief Executive	09.35
Strategy and system reports					
8.	We CARE Strategy – breakthrough objectives progress report	FD	Paper	Chief Medical Officer	09.40
9.	Board assurance framework	FA	Paper	Interim Trust Secretary	09.50
Assurance					
10.	Audit and Risk Committee Chair's assurance report – meeting held on 6 October 2025	FN	Paper	Audit and Risk Committee Chair	09.55
11.	Finance, Business and Investment Committee Chair's assurance report – meetings held on 23 July and 29 September 2025	FN	Paper	Finance, Business and Investment Committee Chair	
12.		FN	Paper		

	Quality Committee Chair's assurance report – meeting held on 4 September 2025 Learning from Deaths report (published externally)			Quality Committee Chair	
13.	People Committee Chair's assurance report – meeting held on 21 August 2025	FN	Paper	People Committee Chair	
Performance					
14.	Integrated performance report	FD	Paper	Chief Finance Officer and Executive Directors	10.05
15.	Workforce Race Equality Standard, and Workforce Disability Equality Standard report	FN	Paper	Chief People Officer	10.25
Governance and compliance					
16.	Standing Financial Instructions and Scheme of Delegation	FA	Paper	Chief Finance Officer	10.30
17.	Medical appraisal and validation report	FA	Paper	Chief Medical Officer	10.40
18.	Infection Prevention and Control Board Assurance Framework	FA	Paper	Chief Nursing Officer	10.45
Closing items					
19.	Any other items of business previously notified to the Board	FD	Verbal	Trust Chair	10.50
20.	Evaluation of the meeting	FD	Verbal	Trust Chair	
21.	Questions relating to the agenda items from Governors and public	FD	Verbal	Trust Chair	
Date and venue of next meeting					
21 January 2026: Meeting rooms 6 and 7, KCHFT offices, 110 – 120 Upper Pemberton, Eureka Park, Ashford, TN25 4AZ					

Members:		
John Goulston	JG	Trust Chair
Olu Odeniyi	OO	Non-Executive Director
MaryAnn Ferreux	MAF	Non-Executive Director
Kim Lowe	KL	Non-Executive Director (Deputy Trust Chair)
Dr Razia Shariff	RS	Non-Executive Director (Senior Independent Director)
Karen Taylor	KT	Non-Executive Director
Faham Sinan-Katamba	FSK	Associate Non-Executive Director
Andy Brooks	AB	Associate Non-Executive Director
Mairead McCormick	MM	Chief Executive
Pauline Butterworth	PB	Chief Operating Officer and Deputy Chief Executive
Dr Sarah Phillips	SP	Chief Medical Officer
Caroline Bates	CB	Chief Nursing Officer
Gordon Flack	GF	Chief Finance Officer
Victoria Robinson-Collins	VRC	Chief People Officer
Rachel Dalton	RD	Chief Allied Health Professional Officer (CAHPO)
Ali Carruth	AC	Executive Director for Prevention, Inequalities, and Children’s Services
In attendance:		
Gina Baines	GB	Assistant Trust Secretary
Tony Saroy	TS	Trust Secretary for KMPT and Interim Trust Secretary for KCHFT
Julia Rogers	JR	Director of Communications and Engagement
Apologies:		

Trust Board Meeting in Public

UNCONFIRMED Minutes of the Trust Board Meeting in Public, held on Wednesday 16 July 2025 Meeting rooms 6 and 7, Trinity House, Eureka Park, Ashford, Kent TN25 4AZ

Present
John Goulston - Trust Chair (Chair)
Caroline Bates - Chief Nursing Officer
Andy Brooks - Associate Non-Executive Director (non-voting)
Pauline Butterworth - Deputy Chief Executive and Chief Operating Officer
Ali Carruth - Executive Director of Health Inequalities and Prevention (non-voting)
Rachel Dalton - Chief Allied Health Professional Officer (non-voting)
Dr MaryAnn Ferreux - Non-Executive Director
Gordon Flack - Chief Finance Officer
Kim Lowe - Non-Executive Director
Mairead McCormick - Chief Executive Officer
Olu Odeniyi - Non-Executive Director
Dr Sarah Phillips - Chief Medical Officer
Victoria Robinson-Collins - Chief People Officer
Dr Razia Shariff - Non-Executive Director
Faham Sinan-Katamba - Associate Non-Executive Director (non-voting)
Karen Taylor - Non-Executive Director

In attendance
Gina Baines - Assistant Trust Secretary and Committee Secretary (minute taker)
Peter Dean - Freedom to Speak Up Guardian Service
Jackie Green – Patient Story
Sheilagh McCrossan – Professional Lead and Head of East Kent Respiratory Service
Tony Saroy - Interim Director of Governance
Julia Rogers - Director of Communications and Engagement

16/07/98	**Patient story**
	The Board welcomed Jackie Green to the meeting to share her experience of the support that she had received from the East Kent Respiratory Service (EKRS) and in particular the impact of her attendance at the respiratory symptom management and anxiety group. Sheilagh McCrossan also joined the meeting to represent the service.
	Jackie described her experience of septic bronchial pneumonia which had resulted in an admission to an intensive therapy unit (ITU), an

experience which had left her traumatised and very aware of her own mortality. She described how her engagement with the EKRS had supported her through her rehabilitation both physically, mentally and emotionally, particularly around anxiety management. The supported exercises, education and counselling had helped her to rebuild her life and she was now able to give back to others by volunteering with the service.

Sheilagh McCrossan explained that patients as volunteers were an important element of the anxiety management programme. Having patients there to share their personal experiences was important to others who were going through similar experiences.

The Board **NOTED** the patient story.

16/07/99 Welcome and apologies for absence

John Goulston welcomed everyone to the meeting of the Public Board meeting of the Kent Community Health NHS Foundation Trust (the Trust) Board.

There were no apologies.

The meeting was quorate.

16/07/100 Declarations of interest

Karen Taylor highlighted that her interest with The Prince's Trust should be updated to reflect the charity's new name, The King's Trust. The register would be updated accordingly.

16/07/101 Minutes of the Board meeting in public held on 16 April 2025

The minutes were read for accuracy.

The following amendment was made.

16/04/26 Patient Story Podiatric Team **–** paragraph 2 – change 'one of the nurses' to 'one of the podiatrists'.

The Board **AGREED** the minutes of its meeting held on 16 April 2025 as an accurate record, subject to the amendment.

16/07/102 Action log and matters arising from the Board meeting in public held on 16 April 2025

1707/16 Integrated performance report (regarding training on interpreting the report to be offered as part of the induction of the new Board

members) – Tony Saroy would take the action and schedule a new date. Action open.
16/10/11 An update on the independent inquiry into the issues raised by the David Fuller case – The report had now been published and a date for the report to come to the Board would be agreed. Action not due.

All other actions were closed.

16/07/103 Chair's report

John Goulston presented his verbal report to the Board for noting.

The Board noted that Caroline Bruce, non-executive director had resigned as of 31 May 2025. The recruitment process was underway to appoint her replacement. This would result in a vacancy on the Board for the time being. To maintain a non-executive majority on the Board, one executive director would be invited to temporarily give up their voting right. Mairead McCormick confirmed that she would be discussing this with the executive directors and she would nominate an individual shortly.
Action – Mairead McCormick

John Goulston highlighted that following a request from NHS England and the Department of Health and Social Care for applications to the latest vanguard programme to deliver neighbourhood services, the Trust would put submit an application.

The Board **NOTED** the Chair's report

16/07/104 Chief executive's report

Mairead McCormick presented the report to the Board for noting.

In response to a question from Andy Brooks as to how the Trust would ensure it continued to focus on the right priorities and have the capacity to do so, Mairead McCormick responded that it would be essential to remain focused on the We Care strategy and the key priorities that had been identified for the year head and were under constant review. As to capacity, the resource to support the Trust's strategic direction would also be under ongoing review.

In response to a question from Olu Odeniyi as to whether being an integrated health organisation was part of the Trust's future, Mairead McCormick indicated that the Trust had a big role to play in such a development. For the time being, the Trust would work in partnership with other system partners in delivering a full range of community services including prevention and proactive care.

In response to a question from Karen Taylor as to the schedule for expanding the Home First service into West Kent, Pauline Butterworth

explained that the Trust was in discussion with the integrated care board (ICB) for additional capacity funding.

Returning to the challenge of keeping colleagues well-informed of the complex changes that were taking place within the Trust, Kim Lowe questioned whether there was any evaluation taking place to understand how people felt. Victoria Robinson-Collins responded that the governors, the staff networks and organisational development business partners were well-placed to monitor how staff were feeling. All change schemes included an equity impact assessment which provided valuable information on the potential impact of changes to colleagues. The Trust also looked to the Staff Partnership Forum for its endorsement of any change programme and agreement that process was being followed correctly.

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

16/07/105 Board assurance framework

Tony Saroy presented the report to the Board for approval.

The Board was asked to agree the changes to the risks on the board assurance framework in principle as not all the committees had had time to review them in detail. As the BAF continued to be a live document, risk ratings would change. This meant that some risks would be reformulated by the executive and presented back to the committees for further scrutiny before coming to the Board. It was proposed that some risks could be removed as their ratings had now fallen to within the Board's risk tolerance, but this needed to be tested by members before agreement. It was acknowledged that this stepped outside the usual governance arrangements but would not occur in the future. Three, rather than two risks had changed their scores. This included risk BAF 001 (strategic objective: putting communities first) which had been considered by the Quality Committee who had supported its movement downwards to a risk rating of 12 high.

In response to a question from Karen Taylor as to whether this was the right time to be removing BAF003 (strategic objective: a great place to work) bearing in mind the changes that were underway with the integration of colleagues under the new community services contract, Tony Saroy explained that the current risk was within the Board's risk tolerance. He anticipated that a revised risk would be re-included on the BAF once it had been reformulated and its risk scoring re-evaluated.

Kim Lowe indicated that she was happy with the interim measure but would like to see the timeline for agreeing the Board's current risk position. It was suggested that a development session on the Board's risk appetite be scheduled before September in order that the Board could agree its risk position, ahead of the refresh of the BAF. Tony Saroy would lead on arranging a date.

Action – Tony Saroy

The Board **APPROVED** the proposed removal of the specified risks in principle and **ENDORSED** the board assurance framework.

16/07/106 Audit and Risk Committee chair's assurance report for the meeting held on 16 June 2025

Karen Taylor presented the report to the Board for assurance.

The Board **RECEIVED** the Audit and Risk Committee chair's assurance report and **NOTED** its assurance.

16/07/107 Finance, Business and Investment Committee chair's assurance report meeting held on 30 May 2025

Olu Odeniyi presented the report to the Board for assurance.

The Board **RECEIVED** the Finance, Business and Investment Committee chair's assurance report and **NOTED** its assurance.

16/07/108 Quality Committee chair's assurance reports for the meetings held on

- **01 May 2025**
- **3 July 2025**
- **including the Learning from Deaths report (published externally)**

MaryAnne Ferreux presented the reports to the Board for assurance.

The Board **RECEIVED** the Quality Committee chair's assurance reports and **NOTED** their assurance.

16/07/109 People Committee chair's assurance reports for the meetings held on

- **22 April 2025**
- **25 June 2025**

Kim Lowe presented the reports to the Board for assurance.

The Board **RECEIVED** the People Committee chair's assurance reports and **NOTED** their assurance.

16/07/110 Charitable Funds Committee chair's assurance report for the meeting held on 2 July 2025

Razia Shariff presented the report to the Board for assurance.

The Board **RECEIVED** the Charitable Funds Committee chair's assurance report and **NOTED** its assurance.

16/07/111 Integrated performance report

Gordon Flack presented the report to the Board for assurance.

The Board noted that the access target for diagnostic appointments in the audiology service still had its challenges. This was due to a training need for clinicians. As this training was completed, it was expected that the six-week target for referral would improve. Separately, the Trust continued to perform well in its access waiting times for non-consultant services. Considerable improvement work had been done in this area which had enabled services to meet their targets and set themselves stretch targets.

Andy Brooks questioned whether the Trust had considered combining services such as the cardiac rehab and pulmonary rehab services to help improve the patient experience around waiting times. Pauline Butterworth responded that this had not been considered. However, the pulmonary rehab service had made significant improvements around the time to assess through more effective triaging of GP referrals and this was improving the patient experience.

In response to a question from Oly Odeniyi as to whether there were any areas of greater risk or improvement for services as the system moved towards a provider collaborative model, Mairead McCormick suggested services that were reliant on a small number of whole-time equivalents were more fragile and therefore at greater risk. To mitigate this, there was the potential to strengthen these services under the new community services contract. She was optimistic that the model would provide considerable opportunity for improvement.

Kim Lowe questioned whether there was any data available which would show where patients had been referred to mental health services from a community service and vice versa. Mairead McCormick responded this data was being pulled together to support a workshop on this theme and she hoped that it would be available to share with the Board in time.

The Board **RECEIVED** the integrated performance report and **NOTED** its assurance.

16/07/112 Safer staffing report

Caroline Bates presented the report to the Board for assurance.

The report had been received at the Quality Committee on 1 May 2025 and the People Committee on 25 June 2025. Both committees had endorsed the recommendations and proposal within the paper and taken assurance.

The Board **RECEIVED** the safer staffing report and **NOTED** its assurance.

16/07/113 Freedom to Speak Up report

Peter Dean joined the meeting to present the report to the Board for assurance.

The Board noted that there had been one red concern reported around patient safety which had been escalated. Management issues were the leading theme and included four reports relating to bullying and harassment. The new service was pleased to report that concerns were responded to positively by the senior management team and no detriment had been reported. The implementation of the service had been well-received by colleagues.

Karen Taylor added that as the Freedom to Speak Up non-executive director champion she had regular calls with the service. The feedback the service was receiving suggested that colleagues were aware of it and how to access its support and her own enquiries during service visits confirmed this to be so.

Razia Shariff suggested that the Staff Council and staff networks were well-placed to explore issues of bullying in clinical services to inform and change behaviours. Victoria Robinson-Collins thanked the new service for its responsiveness and the work it was doing to support colleagues and resolve the issues that were raised.

The Board **RECEIVED** the Freedom to Speak Up report and **NOTED** its assurance.

16/07/114 We CARE Strategy – breakthrough objectives report

Sarah Phillips presented the report to the Board for noting.

MaryAnn Ferreux questioned whether the breakthrough objectives for year three now incorporated the ambitions of the recently published NHS 10-Year Plan. Sarah Phillips reflected that this had been discussed by the Quality Committee earlier in the month. She suggested that although there was a strong alignment between the breakthrough objectives and the NHS 10-Year Plan, she would like to have the opportunity to set out how the two were aligned. Any gaps that were identified would be incorporated into the next year's priorities. She would be happy to bring her report to the Board.
Action – Sarah Phillips

Razia Shariff highlighted that there was a wider discussion to be had around aligning the We Care strategy with the IPR and the BAF. She would like to see the BAF reflecting the wider risks for the Trust in relation to the NHS 10-Year Plan, system changes and the changing financial

landscape. It was agreed that a discussion would take place outside of the meeting with Sarah Phillips and Tony Saroy.
Action – Tony Saroy

The Committee **NOTED** the We CARE Strategy and **APPROVED** the breakthrough objectives.

16/07/115 Equality Delivery System (EDS) report

Ali Carruth presented the report to the Board for approval.

MaryAnn Ferreux questioned how long it would take the Trust to achieve compliance with all the EDS objectives, particularly in progressing towards an 'Excelling' rating across assessed domains. Ali Carruth explained that the Health Inequalities Team was dedicated to reducing health inequalities for patients and staff and improving equitable access for all patients to all the Trust's services at pace, and she offered to set a target timeline to achieve compliance with the objectives. Victoria Robinson-Collins added that the Equity, Diversity and Inclusion action plan for colleagues included some timescales which her team were working towards.
Action – Ali Carruth

The Board **APPROVED** the Equality Delivery System report.

16/07/116 Public Sector Equality Duty (PSED)

Ali Carruth presented the report to the Board for approval.

The Board noted the Trust's commitment to being an inclusive employer and providing inclusive care to its patients. The Trust's strategy and the Trust's compliance with the workforce race equality standard, the workforce disability equality standard and the workforce sexual orientation equality standard all underpinned the Duty as did the Trust's Nobody Left Behind strategy and action plan and the improvement that was being seen in reducing the gender pay gap within the organisation.

In response to a question from Olu Odeniyi as to whether there were some mandated champions, Victoria Robinson-Collins explained that there were national champions. Within the Trust, there were the staff networks, the inclusion ambassadors and the Nobody Left Behind ambassadors.

The Board **APPROVED** the Public Sector Equality Duty.

16/07/117 Approval and ratification of terms of reference of committees

Tony Saroy presented the report to the Board for approval.

The Board **APPROVED** and **RATIFIED** the Committees' terms of reference.

16/07/118 Clinical Care and Quality annual reports - infection prevention and control and declaration

Caroline Bates presented the report to the Board for noting.

The Board **NOTED** the Clinical Care and Quality annual reports - infection prevention and control and declaration.

16/07/119 Clinical Care and Quality annual reports – safeguarding

Caroline Bates presented the report to the Board for noting.

The Board **NOTED** the Clinical Care and Quality annual reports – safeguarding.

16/07/120 Research Report

Rachel Dalton presented the report to the Board for noting.

The Board **NOTED** the Research Report.

16/07/121 Any other items of business previously notified to the chair

There was no other business.

16/07/122 Questions from the governors and public

There were no questions.

16/07/123 Date and time of next meeting

15 October 2025; Meeting rooms 6 and 7, Kent Community Health NHS Foundation Trust offices, Trinity House, 110 – 120 Upper Pemberton, Eureka Park, Ashford, Kent TN25 4AZ and on MS Teams

The meeting finished at 10.52am.

Action Log of Trust Board Part One meetings

Monitoring Open, Pending and Closed Actions

Actions Due in October 2025

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Due Date	Comments	Status
17/07/2024	17/07/16	Integrated performance report	Training on interpreting the integrated performance report to be offered as part of the induction of the new Board members	Tony Saroy	15/10/2025	Following the postponement of the Making Data Count session at the 21 May 2025 Board Development session, a new date is being scheduled.	**Overdue**
16/07/2025	16/07/103	Chair’s report	To record which executive director will temporarily become non-voting until a new non-executive director has been appointed	Mairead McCorm-ick	15/10/2025	The non-voting executive director will be Victoria Robinson-Collins, Chief People Officer.	**Propose Close**
16/07/2025	16/07/105	Board assurance framework	Schedule the board development session on risk appetite before September 2025	Tony Saroy	15/10/2025	Two dates (in November and December) have been proposed to NHS Providers and a response is awaited regarding availability to deliver the session.	**Overdue**

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Due Date	Comments	Status
16/07/2025	16/07/114	We CARE strategy – breakthrough objectives report	Provide a report to the Board which shows how the breakthrough objectives align with the NHS 10-Year Plan.	Sarah Phillips	15/10/2025	Verbal update to supplement item 8 – We Care Strategy: Breakthrough objectives progress report	**In progress**
16/07/2025	16/07/114	We CARE strategy	Discussion outside of the meeting between Razia Shariff, Sarah Phillips and Tony Saroy around developing the board assurance framework to reflect the wider risks for the Trust	Tony Saroy	15/10/2025	The Audit and Risk Committee was updated on 6 October 2025 that the Trust's risk management framework and updated board assurance framework will be brought to the respective meetings in January 2026. Trust Secretariat will work with board members in the interim.	**In progress**
16/07/2025	16/07/115	Equality Delivery System (EDS) report	Set a target timeline for the Trust to achieve compliance with all Equality Delivery System (EDS) objectives, with a focus on progressing towards an 'Excelling'	Ali Carruth	15/10/2025	It is acknowledged that achieving full compliance with all EDS objectives is a long-term commitment, particularly in areas involving workforce	**Propose Close**

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Due Date	Comments	Status
			rating across assessed domains			and cultural transformation. However, to demonstrate progress under Domain One (Patients and Services), the three services assessed in 2024/25 will be reassessed in July 2026. These services will be supported through tailored improvement plans and quarterly follow-ups, enabling them to self-assess and update their grading in line with EDS expectations. For Domains Two and Three, which focus on workforce-related outcomes, the Trust is already assessed as being “excelling.” While there are a few	

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Due Date	Comments	Status
						areas identified for improvement, these are captured within our other mandatory Equality, Diversity and Inclusion (EDI) reports, which are submitted to the Board annually. In addition, there is active engagement with colleagues in the Health Inequalities team to clarify the future direction of national reporting. There is currently some uncertainty regarding whether Domains Two and Three will remain reportable, given that their content is already covered in other mandated submissions to NHS England.	

Actions Pending (not due)

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Due/ Revised Date	Comments	Status
16/07/2025	16/10/11	An update on the independent inquiry into the issues raised by the David Fuller case	Schedule a report to the Board following the published Phase Two of the David Fuller inquiry.	Caroline Bates	21/01/2026	The report has now been published and a date for the report to come to the Board will be agreed and the forward plan updated accordingly. The report will be presented at the January Public Board meeting.	Not Due

Closed at Last Meeting or Completed Between Meetings

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Closed Date	Comments	Status
16/04/2025	16/04/31	Chief executive's report	Schedule the We Care strategy 2025/26 breakthrough objectives to come to the July Public Board meeting for formal approval	Sarah Phillips	16/07/2025	We Care Strategy and breakthrough objectives are on the agenda for July Public Board meeting for formal approval.	Closed

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Closed Date	Comments	Status
16/04/2025	16/04/32	Board assurance framework	Schedule the refreshed 2025/26 board assurance framework to come to the July Public Board meeting	Tony Saroy	16/07/2025	The board assurance framework is scheduled for the July Public Board meeting.	**Closed**

Key
Overdue – **Bold Red** Not Due – **Bold Bright Blue** In Progress – **Bold Vibrant Orange** Propose Close/Closed – **Bold Vivid Green**

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**15 October 2025**
Title	**Chair's Report**
Author	**John Goulston, Trust Chair**
Presenter	**John Goulston, Trust Chair**
Purpose	**For noting**

1. Introduction

In my role as Trust Chair, I present this report focusing on key matters of significance.

2. Fit and Proper Persons Test

The Board is asked to acknowledge that the Trust submitted its annual Fit and Proper Persons Test compliance to NHS England on the 27 June 2025.

3. Annual General Meeting (AGM) / Annual Members Meeting (AMM)

The Trust held its AGM / AMM on the 17 September 2025, which was well attended by staff, governors and members of the public, it included an overview of the Trust's operational and financial performance for 2024/25 and a look ahead to 2025/26, with a number of questions and comments received from attendees.

4. Kent & Medway system and national activity

This has been a relatively quiet period for the system and the national team, whilst providers focus on their operational performance and financial sustainability. The recent Chair's and Chief executives network focused on the system-financial position, with a range of measures proposed to support the system-wide position.

I had the pleasure of attending the We Care Conference which was an opportunity for staff to highlight the excellent work being carried out to enhance the delivery of care and patient experience.

The inaugural meeting of the Kent Community Health Foundation Trust (KCHFT) and Medway Community Health (MCH) Integration Board was held, which represented a positive first step.

A joint meeting was held with Kent and Medway NHS and Social Care Partnership Trust to explore those areas where collaborative working could be developed to support a holistic approach to physical and mental health, to improve patient outcomes.

5. Board Self-Assessment

Recently the Board undertook a self-assessment of its performance against the Care Quality Commission's Key Line of Enquiries. Appended to my Chair's report is a paper setting out the results of the self-assessment and a Board development session will be held to agree the next steps and associated actions.

6. Trust Chair and NED visits

Since the last Board meeting, the following visits having taken place.

Where	Who
August 2025	
Podiatry, West Kent Service	John Goulston
Health Inequalities Team	Karen Taylor, Razia Shariff and Olu Odeniyi
North Kent Children's Community Nursing	Faham Sinan Katamba
September 2025	
Edenbridge Memorial Centre	Kim Lowe

BOARD SELF-ASSESSMENT RESULTS REPORT 2024/25

1. Introduction

The NHS Well-Led guidance, issued by the healthcare regulator NHS England, recommends that an annual self-assessment exercise is carried out by Boards of Directors of NHS organisations. In line with this guidance, the Trust Board has completed its review and the results are enclosed for Board discussion. The well-led framework is structured around eight key lines of enquiry (KLOEs) and Board members have been asked to undertake a self-assessment around these KLOE.

The NHS Well-Led guidance has been renewed from April 2024 however, updated guidance on developmental reviews and self-assessments has yet to be issued; therefore, all questions are based on previous guidance, and future self-assessments will reflect the updated guidance once this has been issued.

2. Administration of the self-assessment

Board members were asked to provide a rating between strongly disagree to strongly agree for each question (1 = strongly disagree, 5 = strongly agree). The results have been analysed by averaging the scores for each KLOE and cross referenced with the NHSE well led rating framework. The results are laid out in the Appendix to this report. Where responses scored 3 or less, respondents were requested to provide some further information; all comments have been noted by the Chair, and actions will be developed at the next Board Development session to address any areas for improvement.

13 Board members responded of which seven were non-executives and six executives.

3. Summary of responses

Overall, the rating and comments received from Board members demonstrated a positive response to the Board's function and performance. A majority of Board members scored four or five across all the KLOEs, with additional positive comments made regarding the Board's processes for managing risks, issues and performance and in relation to good governance, with several comments attributing this to implementation of a new senior governance team.

Areas for improvement were identified as follows:

1. KLOE 8 (robust systems and processes for learning, continuous improvement and innovation) was the well-led area with the lowest score. Comments focused on a requirement for additional consideration of quality / continuous improvement, and the method by which the Board is informed of improvements resulting from learning.

2. KLOE 6 (appropriate and accurate information) also score below average, with comments highlighting a need for further oversight of cyber security and artificial intelligence at a Board level, as well as there being areas for improvement in terms of information quality.

3. The induction and development of Board members requires further strengthening.

4. Although initial improvements have been delivered, further work is required to improve the Board Assurance Framework, with a focus on understanding, risk appetite, and the totality of the risk profile.

4. Next steps

A session will be held at the next Board Development session in November 2025 to enable the Board, as a unitary body, to agree a series of actions to address those areas where a lower score was received, either in totality, or from two or more Board members. The agreed actions will be reported to the next Public Board meeting as part of the Chair’s report.

APPENDIX

Key Line of Enquiry (KLOE)		Board's View 24/25 (Average scoring)	Risk Rating
KLOE 1	Is there the leadership capacity and capability to deliver high quality, sustainable care?	3.7	
KLOE 2	Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?	4.2	
KLOE 3	Is there a culture of high quality, sustainable care?	4.1	
KLOE 4	Are there clear responsibilities, roles and systems of accountability to support good governance and management?	4,2	
KLOE 5	Are there clear and effective processes for managing risks, issues and performance?	4.1	
KLOE 6	Is appropriate and accurate information being effectively processed, challenged and acted on?	3.7	
KLOE 7	Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?	4.3	
KLOE 8	Are there robust systems and processes for learning, continuous improvement and innovation?	3.5	
Additional question	Board operation/administration/governance	3.9	

Key:

4 score – Green

3-4 score - Amber Green

2-3 score - Amber Red

1-2 score - Red

Risk rating	Definition	Evidence
Green	Meets or exceeds expectations	Many elements of good practice and no major omissions.
Amber-green	Partially meets expectations, but confident in management's capacity to deliver green performance within a reasonable timeframe	Some elements of good practice, some minor omissions and robust action plans to address perceived gaps with proven track record of delivery.
Amber-red	Partially meets expectations, but with some concerns on capacity to deliver within a reasonable timeframe	Some elements of good practice, has no major omissions. Action plans to address perceived gaps are in early stage of development with limited evidence of track record of delivery.
Red	Does not meet expectations	Major omission in governance identified. Significant volume of action plans required with concerns regarding management's capacity to deliver.

Chief Executive's report – October 2025

This report highlights key updates since our last public Board report in July.

National, regional and local updates

National recognition as a top 10 community trust

I'm really proud to report that Kent Community Health NHS Foundation Trust has been ranked seventh nationally among 61 community trusts in the new NHS Oversight Framework league tables.

This places us in segment one, the highest performance category, reflecting our consistent delivery of high-quality, community-based care. This recognition is a testament to the dedication of our teams and our commitment to proactive, preventative care in neighbourhoods. While this is a significant achievement, we remain focused on continuous improvement and partnership working to meet the evolving needs of our communities.

While it's a moment to be proud of – it's also one to approach with humility. Rankings are updated every quarter and reflect relative performance across the NHS, so they can and do change. We received a personal thank you message from the Secretary of State for Health and Social Care Wes Streeting, which we were able to share with our teams.

Pride in our multi-cultural workforce

Recent weeks have seen heightened community tensions related to immigration and national identity, including the appearance of St George's flags in public spaces, some of which have been linked to protest activity. While we respect the right to peaceful expression, we are deeply concerned by the language and behaviour observed at some of these events.

We recognise the impact this may be having on our workforce and communities, particularly our global majority colleagues and their families, who have been disproportionately affected. As an organisation, we are proud of our diverse and inclusive workforce and are committed to standing against all forms of discrimination. We continue to offer support to colleagues and reaffirm our zero-tolerance approach to racism and abuse in any form and have published an open letter, along with other Kent and Medway NHS organisations, on our website.

Five-year planning requirement

In line with the NHS 10-Year Plan published in July, NHS England has introduced a new five-year planning framework for all providers and systems, covering the period 2026/27 to 2030/31. This marks a shift away from annual cycles toward a rolling, integrated planning model that supports long-term transformation.

KCHFT, as a provider, is expected to develop credible, joined-up plans that align strategic and operational priorities, demonstrate financial sustainability, and triangulate workforce, activity, quality, and finance. The framework emphasises bottom-up planning, co-designed

with local communities and partners, and encourages continuous iteration to reflect changing needs, innovations, and system pressures. This approach is intended to embed the three major shifts outlined in the 10-Year Plan.

New wave of foundation trusts and integrated health organisations

The invitation to bid to become one of the first wave of NHS foundation trusts and also expressions of interest in becoming integrated health organisations is expected this autumn. We need to take some time to look at what more this means for KCHFT, alongside our partners, but, as a segment one performer, we are in strong position.

System changes

It has been confirmed that Paul Bentley will be stepping down from his role as Chief Executive of NHS Kent and Medway ICB this autumn. I would like to take this opportunity to thank Paul for his support. Adam Doyle has been appointed as the new Chief Executive Officer for NHS Kent and Medway ICB and will be joining on 15 October 2025.

Anne Eden, South East Regional Director, has announced her decision to step down next year after more than a decade in the role. I would like to extend my thanks to Anne for her support and wish her success in her future endeavours.

System finance

The financial pressures across Kent and Medway continues to mount. Conversations are ongoing between region and the integrated care board to understand what system partners are doing to recover the position and to deliver their plan. KCHFT’s contribution has been significant, and we continue to have strong vacancy control procedures in place. We are also leading on one of the biggest system opportunities that is reviewing intermediate care and the better use of beds. This will be one of the levers that will contribute to the left shift from hospital to community.

Responding to the government reorganisation consultation

We welcomed the opportunity to contribute to the Local Government Reorganisation proposals for Kent and Medway. As a key partner in delivering integrated health and social care, we support reforms that strengthen local governance and improve service delivery. Our response emphasises the importance of aligning local authority boundaries with health and care partnership (HCP) areas to reduce fragmentation and enhance collaboration. This alignment supports more effective joint planning, improves patient outcomes, and enables more equitable, community-based care. We remain committed to working with local partners to shape a system that is responsive, inclusive and sustainable.

We care strategy performance

Data to support our progress against our breakthrough objectives can be seen in our Integrated Performance Report (IPR) and our We Care strategy report included in the Board papers.

Putting communities first

Transform community services

From 27 October 2025, KCHFT will begin delivery of new five-year contracts as lead provider for adult and children's community services across Kent and Medway, awarded by the NHS Kent and Medway Integrated Care Board. Working in partnership with HCRG Care Group and Medway Community Healthcare (MCH), we will use our collective expertise to improve care across the county. Children's specialist services will transfer to KCHFT from EKHUFT and Medway NHS Foundation Trust, while some services, such as pulmonary rehabilitation and podiatry in north Kent, will transfer to HCRG. A KCHFT-led Transformation and Improvement Group, reporting into the Contract Management Committee, will co-produce a system-wide transformation plan by March 2026, ensuring services are designed around population needs, aligned with the NHS 10-Year Plan and shaped by meaningful engagement with patients, staff, and communities.

Develop our partnerships

We have now submitted our strategic case to NHS England to signal our intention to bring KCHFT and MCH together as one NHS foundation trust. This strategic exploration is focused on strengthening community services across Kent and Medway, improving resilience, and unlocking opportunities for innovation and shared learning. Work has now started on developing a detailed business case.

During the past couple of months, we've been talking to staff and partners about what this means for them. I was very grateful to MCH's Managing Director Martin Riley and other members of the Executive Team for joining our September staff We Care conference to talk about our shared vision and answer any questions people have. I will be doing the same for MCH colleagues later in the year. A summary version of the strategic case can be read in appendix 1 and also more detail can be found at www.kmstrongertogether.nhs.uk

Embedding neighbourhood health

East Kent named national pilot

We are proud to share that east Kent has been selected by NHS England as one of the national Neighbourhood Health Pioneer sites, recognising our leadership in delivering joined-up, community-based care. This designation places us at the forefront of the Government's 10-Year Health Plan, which aims to transform how people are supported to live well at home. As part of the programme, Folkestone, Hythe and Romney Marsh was chosen as the area to co-design the teams with residents and partners. These teams will bring together GPs, nurses, social workers, mental health professionals, and voluntary organisations to work as one, with shared goals and information. This is a significant opportunity to accelerate our progress and share learning across the system, ensuring care is more coordinated, personalised, and accessible for those with complex needs.

Sustainable care

Financial position

At the midpoint of the financial year, we remain on target to breakeven, however there are substantial savings still to be found with our £22m cost improvement target. We still rely heavily on non-recurrent savings, which makes up £13million. This will require a major restructure in our transformational work around the new models of care to deliver recurrent benefits.

Improve productivity

We are renewing our focus on productivity and in particular patient-initiated follow-ups, using learning from the redesign of pathways within MSK. When compared against the baseline of 2019/20, the trust has a productivity increase of 1.83% at month five.

Corporate services review

NHS trusts across the country, including those in Kent and Medway, have also been asked to reduce corporate budgets back to 18/19 levels. Corporate costs are monitored monthly by the national team to track progress.

As part of our community services review and our ongoing partnership work, we are progressing with our work to look at how corporate services within our own organisation and across the system, can work better together. We already share some posts with our mental health partners with the newly-named Kent and Medway Mental Health NHS Trust (formally KMPT). We also require a transitional fund to support our progression with Medway community health to become one provider.

Small changes: big impact – new campaign to reduce waste

We have more than 40 suggestions to our trust campaign aimed at reducing not only physical waste but also wasteful processes, as part of our sustainable care ambition.

Small changes: big impact aims to encourage colleagues and teams to examine what the wasteful processes are in their service or team and to make the – often small – changes needed to reduce waste and give more time back to clinicians and patient care.

Automation update

We continued to make significant strides in embedding robotic process automation (RPA) to improve efficiency, reduce manual workload and enhance service delivery.

We now have 229 active working bots, with 74 working in clinical services and teams/operational divisions, 44 bots developed for the Kent and Medway Integrated Care Board, demonstrating our collaborative approach across the system and a further 175 in the pipeline. The programme has delivered 82,587 hours of time saving, with 21,763 of these hours in operational divisions supporting frontline services.

Recent additions include Pharm002, supporting timely medication ordering in community hospitals, especially at weekends, saving around 100 hours a month. Another new bot is

streamlining volunteer onboarding by automatically capturing and processing expressions of interest, saving 70 hours a year.

Better patient experience

Transform intermediate care

We are progressing plans to expand our Home First model. Initially focused in east Kent, we will now begin the strategic development required to extend this model. This expansion is a key component of our ambition to deliver more integrated, person-centred care that supports timely discharge and recovery at home.

Temporary pause to inpatient services at Faversham

Following the temporary pause of inpatient services at Faversham Cottage Hospital in late June due to critically low staffing levels, particularly in leadership roles, the trust has worked intensively to recruit to safety-critical posts. To date, six new staff members have been appointed specifically to Faversham, with further interviews ongoing. While the target for reopening is December 2025, this remains subject to safe and sustainable staffing.

During the closure, staff have been redeployed to neighbouring services, and KCHFT has actively engaged the local community through a public meeting and ongoing community survey. We continue to prioritise patient safety and transparency and will only reopen the ward once we are confident in our ability to deliver high-quality care consistently. I would personally like to thank the Faversham team for their professionalism and flexibility. To ensure patients and the public understand our rationale, we have also taken part in a number of media interviews, including the BBC politics show.

Thanet health hub nears completion

The £10 million Thanet Community Health Hub remains on track to open in early November 2025, with services moving in on a phased basis. St Peter's Surgery will relocate to the hub at the beginning of November, followed by Kent Community Health NHS Foundation Trust services — including podiatry, physiotherapy, and community nursing — throughout the month. The community diagnostics centre will have a staggered start, with some services operational before Christmas. Voluntary sector partners are expected to join early in the new year, ensuring a fully integrated model of care by spring 2026. Patients and service users are being kept informed throughout the transition, with a strong emphasis on accessibility, travel planning, and community involvement via the Citizens' Panel.

A great place to work

Staff engagement: Supporting our people during times of change

I'd like to acknowledge the significant amount of change and the impact this is having on our workforce. We continue to maintain our monthly engagement webinars with staff in July, August and September, with our conference in September also focusing on our efforts to support staff. I have also attended our Staff Council. The impact of uncertainly cannot be underestimated and this has played out in the responses we have seen to our recent

engagement, as well as our pulse survey results. As an executive team, we are making concerted efforts to provide clarity where we can and supporting our leaders to lead with compassion.

Build our improvement culture

As we grow our improvement culture, we are looking from moving from a project-management type approach, to developing a learning lab among our corporate teams. As part of this work, the executive team has reviewed its approach to service visits to tailor it to a more coaching for improvement approach.

A new way to tackle unacceptable behaviour

Our new *Managing unacceptable behaviour policy* aims to tackle unacceptable behaviour towards staff from patients, their relatives, friends, carers or members of the public. Prompted by concerning data – over 15 per cent of colleagues experienced abuse last year, with many incidents going unreported – it introduces a clear policy and sanctions framework to protect staff and uphold a safe and respectful care environment. The new system includes verbal warnings, behaviour agreements, **yellow cards** as formal warnings and **red cards** for the most severe cases, which may result in exclusion from services. A dedicated sanctions panel will oversee decisions, ensuring fairness and consistency. This launch marks a significant step in safeguarding staff wellbeing and reinforcing the trust's zero-tolerance stance on abuse.

Celebrating long service milestones

In October, we proudly celebrated our long service awards, honouring over 150 dedicated colleagues. For the first time since the awards began, one individual marked an incredible milestone of 50 years of service. Together, attendees at the event represented more than 3,300 years of combined commitment to the NHS.

Colleagues recognised for learning achievements

Our 'Celebrating you' event recognised more than 130 colleagues who successfully completed a formal qualification between September 2024 and July 2025. Each colleague was proudly presented with a certificate and badge to mark their achievement. Today, we're supporting 341 colleagues across 70 learning programmes at KCHFT – ranging from entry-level courses to Master's degrees – helping them grow, develop and thrive in their NHS careers.

Retaining platinum for staff health and wellbeing

KCHFT has retained **platinum status** for staff health and wellbeing, reflecting our continued investment in creating a supportive and inclusive workplace. Recruitment remains strong, with targeted campaigns for community nursing roles at the new Thanet hub and inclusive practices such as job carving and working interviews gaining national recognition.

Launch of flu vaccination campaign

The trust's annual flu vaccination campaign launched on Wednesday, 1 October. Seasonal flu remains a significant winter pressure, with last year's vaccination programme estimated to have prevented between 96,000 and 120,000 hospitalisations nationally, in spite of less than 37 per cent of staff having received their vaccination. This year, we have clinics for staff

across Kent, East Sussex and London. Staff can also choose to have their vaccination at a local pharmacy and claim the expense back.

This report represents just a section of the huge amount of work going on to support our ambitions.

A huge thank you to all colleagues.

Mairead McCormick
Chief Executive October 2025

Why we believe our two organisations should unite for stronger community care and what this means for you – **our patients, staff and our communities**

Stronger together

A new chapter for community health in Kent and Medway

Helping people in Kent and Medway to lead their best and healthiest lives is at the heart of everything we do.

It's this shared purpose — and the shared challenges we face — that have led Kent Community Health NHS Foundation Trust (KCHFT) and Medway Community Healthcare (MCH), to explore becoming one organisation.

Our communities are changing. People are living longer, often with more complex health needs. Yet access to care can vary depending on where you live, and long waits for some services persist. At the same time, we face growing pressures from financial constraints and workforce shortages.

Rather than face these challenges alone, KCHFT and MCH, which is a community interest company (CIC), are choosing to unite — not as a takeover, but as a partnership of equals. Together, we believe we can build a stronger, more resilient organisation that delivers better care, closer to home.

What does this mean for you?

For patients and communities:

- **better access** to care, especially in areas with limited access to services
- **more consistent services** across Kent and Medway
- **stronger neighbourhood teams** delivering care closer to home.
- **improved health outcomes** through better use of data and joined-up care.

For staff:

- **more career opportunities** and training
- **fairer pay and conditions,** especially for MCH staff, who would have the stability and funding of an NHS trust, which isn't always guaranteed as part of a CIC
- **stronger support** for wellbeing and inclusion
- **a shared culture** that values both NHS and CIC strengths.

For all:

- **more efficient use of resources**
- **a stronger voice** for community services in system planning
- **better digital systems** and estates planning
- **improved financial sustainability.**

We're still in the early stages of discussion and are committed to working with our staff, patients, communities and partners to explore all options. Our preferred approach is for MCH to join KCHFT as part of the NHS family, through a transfer of services and staff.

Together — in whatever form we take — we will continue working with our health and care partners to deliver the best possible services for our communities.

Let's build something better and stronger for our communities together.

Mairead McCormick

Chief Executive,
Kent Community Health NHS Foundation Trust

Martin Riley

Managing Director,
Medway Community Healthcare

About this document

This document sets out why we believe Kent Community Health NHS Foundation Trust and Medway Community Healthcare should come together as one organisation.

It's a summary version of a larger technical strategic outline case, which sets out why we think we need to do things differently and what we think the benefits are.

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4 Who are we?
5 Why do we need to do things differently?
6 What are the benefits?
9 What people have already told us
11 What next?
11 Your voice and how to give your views
12 Frequently asked questions

Your voice matters

Let us know what you think

Whether you're a member of staff, a patient, or one of our valued partners — we want to hear from you. Your feedback will help shape how services are delivered and how we work together. Find out how on page11.

Who are we?

Both organisations are deeply rooted in their communities and share a commitment to high-quality, compassionate care.

Category	Medway Community Healthcare (MCH)	Kent Community Health NHS Foundation Trust (KCHFT)
Organisation type	Community interest company (CIC) 99% of staff are shareholders in the organisation and an elected members forum ensures that the voices of staff and shareholders are heard at meetings of the Board and its committees.	NHS trust All staff are members of the Foundation Trust with elected public and staff governors acting as ambassadors for the organisation and providing a public and staff voice.
Established	2011	2011
Mission	Lead the way in excellent healthcare	Empower adults and children to live well, be the best employer, and work with our partners as one
Values	Caring and compassionate, deliver quality and value, work in partnership	Compassionate, aspirational, responsive, excellence
Funding	£80million	£325 million
Workforce (WTE)	1,500 staff	5,300 staff
CQC Rating	Good	Outstanding
Strategy	- Deliver care closer to home - Provide flexible, efficient services - Respect dignity and privacy	- Putting communities first - Better patient experience - Great place to work - Sustainable care
Services	More than 40 community services in Medway and surrounding areas	More than 70 services in Kent, Medway, East Sussex, London
Governance	Independent Board with CIC accountability	NHS Trust Board with public accountability

Why do we need to do things differently?

Like many parts of the NHS, we are under pressure:

More people need care

The population is growing and ageing. By 2040, the number of people aged 65+ in Kent and Medway is expected to rise by more than 40 per cent.

Workforce pressures

Recruiting and retaining staff is increasingly difficult, especially in community nursing.

Services are fragmented

Different providers, systems and standards can lead to delays, duplication, and confusion for patients.

Financial constraints

Both organisations are operating at breakeven, but face ongoing savings targets of 3 to 6 per cent of turnover.

Health inequalities are widening

People in deprived areas live more than a decade less in good health than those in more affluent areas.

The NHS nationally is also shifting towards neighbourhood-based care, where services are more local, joined-up, and focused on prevention. This merger supports that direction.

We believe this merger will help make care more joined-up, easier to access and better suited to the needs of local people.

Our two organisations believe uniting will make us stronger to face these challenges and build services fit for the future.

What are the benefits?

This merger is about building a stronger, more joined-up community health service for everyone in Kent and Medway. It will bring real benefits for patients, staff, and the wider health and care system.

For patients and communities:

We know that where you live can affect the care you receive. Our goal is to change that — so everyone can access high-quality care, no matter their postcode.

Here's what the merger will help us deliver:

Better access to care:
Especially in underserved areas like coastal and rural communities, where health needs are often greatest.

More consistent services:
We'll reduce variation in how services are delivered across Kent and Medway, so patients get the same high standard of care wherever they live.

Stronger neighbourhood teams:
Services will be more local, more joined-up, and better tailored to the needs of each community.

Improved health outcomes:
By using data more effectively, we can target support where it's needed most and help people stay well for longer.

Less repetition:
Patients won't have to repeat their story multiple times — services will be better connected and easier to navigate.

Focus on prevention:
We'll invest more in keeping people well, not just treating illness.

We'll still deliver care in the same places, with the same dedicated teams — but over time, services will become more integrated and responsive.

For staff:

We know change can bring uncertainty, especially for those in corporate or support roles. But this merger is also a chance to create a better, more supportive working environment for everyone.

Here's what it means for you:

More career opportunities:

A larger organisation means more roles, more training, and more chances to grow.

Fairer pay and conditions:

Especially for MCH staff, who would have the stability and funding of an NHS trust, which isn't always guaranteed as part of a CIC. TUPE protections apply — your terms and conditions will be honoured.

Stronger support for wellbeing and inclusion:

You'll be part of a wider network with more resources and a shared commitment to staff wellbeing.

A shared culture:

We're bringing together the best of both organisations — the innovation and agility of a CIC, and the stability and scale of the NHS. Together, we'll build a shared culture that captures the best of both organisations.

More resilient teams:

By pooling resources, we can reduce pressure on individuals and improve work-life balance.

We're committed to open communication, early clarity on roles, and involving you in shaping the future.

For the wider system:

This merger supports the ambitions of the Kent and Medway Integrated Care System and national NHS priorities.

It will help us:

Use resources more efficiently:

Reducing duplication and making every penny of public money count.

Plan better:

With a single organisation, we can take a more strategic approach to estates, digital systems, and workforce planning.

Strengthen our voice:

A unified community provider will have more influence in system-wide decisions and planning.

Improve financial sustainability:

By streamlining services and sharing infrastructure, we can deliver better care within our means.

What will change?

Patients will still see the same teams in the same places — but behind the scenes, we'll be working more closely together. Over time, services will become more joined-up, with early focus on:

- integrated frailty pathways and urgent community response
- children's therapies
- virtual wards and discharge-to-assess
- rehabilitation, end-of-life care, and long-term condition management.

We'll also invest in digital tools and automation to improve patient experience and free up staff time for care.

What have we heard so far about our plans?

We know that any change of this scale must be shaped by the people it affects most — our patients, staff, partners, and local communities. That's why we've made listening a priority from the very beginning.

How are we engaging?

We want to make sure voices are heard and feedback is acted on. So far, this has included:

- staff webinars and briefings
- stakeholder letters to local authorities, MPs, NHS partners, and voluntary organisations
- media statements and updates on our websites and social media
- meetings with councillors and scrutiny committees
- drop-in sessions and FAQs for staff.

This is just the start — and we'll continue to listen and involve people throughout the process.

What people are telling us

Our commissioner for adult and children's community services, NHS Kent and Medway Integrated Care Board, has expressed strong support for the merger. They highlighted the importance of: Equitable access to care, simplified governance and a more resilient and capable community provider.

Our partners have been supportive, recognising the potential benefits for local people. However, they've been clear that local services and funding must be protected.

Transparency and accountability are essential. We've committed to maintaining a strong local presence and continuing to report to local scrutiny bodies.

Feedback from staff has been generally positive, with many seeing the merger as a natural next step.

- MCH staff welcomed the opportunity for greater career stability, access to NHS benefits.
- KCHFT staff valued the potential for improved patient experience, shared learning, and stronger collaboration.

At the same time, we've heard concerns — particularly around:

- job security, especially in corporate and support roles
- cultural integration between an NHS trust and a community interest company.

In response, we've created a dedicated people and culture workstream and tailored engagement plans to support staff through the transition.

"It makes complete sense that as Medway is in Kent, we have one organisation serving the whole of the region."
- MCH staff member

"From a patient's perspective this would be good news for the sharing of good practice and resource."
- KCHFT staff member

"It makes sense to join the communities — we have such close borders and yet are subject to a 'postcode lottery' by remaining separated."
- KCHFT staff member

"It would be much more seamless and less confusing for our patients. Being joined up would allow ideas and ways of working to be better shared."
- MCH staff member

So, what next?

July 2025

In July 2025 a more detailed strategic case for change was approved by both organisations' boards. This outlines the rationale and high-level benefits of the merger.

Now until February 2026

Continued planning and engagement with staff, patients, and local communities. A full business case is being developed and is due for submission in February 2026.

March 2026

As MCH is a community interest company (CIC), there will be an advisory vote of MCH shareholders.

July 2026

NHS challenge meeting with both Boards' organisations.

September 2026

Merger is officially approved by MCH and KCHFT's Boards. NHS England formally approve.

By October 2026

The merger is planned to be completed, with the goal of ensuring the new organisation is ready to deliver safe, effective care from day one.

Your voice matters

Our communities and colleagues will be involved throughout this process. Your feedback will help shape how services are delivered. There will be opportunities to ask questions, share concerns and help make the new organisation work for everyone.

How you can give your views:

There are many ways in which you can give us your views. You can:

find out more information on our website
www.kmstrongertogether.nhs.uk

give your views through a survey
https://surveys.kentcht.nhs.uk/s/HXRKK7

email us at
kchft.comms@nhs.net

write to us at
Communications and Engagement Team
Kent Community Health
NHS Foundation Trust
Trinity House
110-120 Upper Pemberton
Eureka Park, Ashford
Kent, TN25 4AZ

Frequently asked questions

What other options were considered?

We didn't jump straight to a merger. A full options appraisal was carried out, including:

- a strategic partnership
- integration of corporate and support services
- a full merger (the preferred option)
- a merger with local acute trusts.

Each option was assessed for its impact on patients, staff, and financial sustainability. The full merger scored highest across all areas — offering the greatest benefits with manageable risks.

How will it affect my care?

You should see very little change to your care. You'll continue to see the same professionals in your community or at home. Over time, we hope you'll benefit from:

- even better-quality care
- more advanced technology
- shorter waits and more support between appointments.

Will it reduce waiting times?

Yes, that's the aim. Currently, waiting times vary across Kent and Medway due to different local contracts. As part of the new community services contract and merger, we're reviewing care pathways to:

- standardise services
- learn from teams who've successfully reduced waits
- improve access and consistency across the county.

Is this a merger or a takeover?

While MCH staff and services will transfer to KCHFT, this is not a takeover. We're merging as partners — combining the best of both organisations to tackle shared challenges and improve care.

Who decided on this change?

The choice to work together has been made independently by the two Boards at KCHFT and MCH.

This decision is supported by our commissioning partners and local authorities and will need to be agreed by NHS England.

Is this just to save money?

No. While financial sustainability is important, the primary driver is improving care.

This merger will:

- strengthen services
- make us more resilient
- help us deliver better care for patients.

What will a single, larger organisation offer that the existing separate trusts cannot?

A larger organisation brings:

- greater buying power
- easier recruitment and retention
- more efficient service delivery
- a stronger voice for community services
- faster learning and innovation across teams.

What happens to my data?

Your data remains secure and confidential. Initially, both organisations will keep separate systems, but over time we'll bring them together.

Will this merger mean I will have to reapply for my job if I am a Medway member of staff?

TUPE protections apply and we will be transferring colleagues to KCHFT on their current terms and conditions. There is no blanket requirement to reapply for roles.

I am worried our culture and identity will be lost when we merge

Preserving the strengths of both organisations is a priority. We'll be looking at the best of both cultures to shape a new identity for our colleagues. The transformation required to deliver sustainable services for our communities means change is inevitable and we must adapt and shape our organisation together so it is fit for purpose.

What would happen if the two organisations stayed as they are?

We'd miss the opportunity to combine resources, strengthen services and avoid future financial challenges.

For MCH, remaining a small organisation would make it harder to meet rising demand and financial pressures without affecting services. This merger is a proactive step to protect and grow community care.

Will all the policies, procedures and digital systems change overnight?

No. We'll continue using current systems and policies. Any changes will be carefully planned and only made where they benefit staff and patients.

Will there be a disruption to care?

Maintaining high-quality care is our top priority. The merger work will happen behind the scenes while services continue as usual.

Alternative formats

If you need communication support or would like this in an alternative format, please contact the KCHFT Communications and Engagement Team.

Phone:
0300 790 0506

Email:
kchft.comms@nhs.net

Web:
www.kentcht.nhs.uk

Write:
Communications and Engagement Team
Kent Community Health NHS Foundation Trust,
Trinity House
110-120 Upper Pemberton
Eureka Park
Ashford
Kent, TN25 4AZ

Stronger together

We Care Strategy Progress Report

This report updates the Board on progress against the We Care Strategy's four ambitions and outlines the status of six corporate projects and seven breakthrough objectives for 2025/26.

Meeting:	Board Meeting - Part 1 (Public)
Date of meeting:	15 October 2025
Agenda item no:	Item 8
Report title:	We Care Strategy Progress Report
Executive sponsor(s):	Sarah Phillips, Chief Medical Officer
Report author(s):	Natalie Parkinson, Associate Director Business Development and Service Improvement
Action this paper is for:	Discussion
Public/non-public	Public

Executive summary

Overview of paper:
To provide the Board with a mid-year update (Year 3 of the 2023–2028 strategy) on progress against high-level milestones across four strategic ambitions, six corporate projects, and seven breakthrough objectives. It highlights key successes and areas of concern, with further details available in the report.

Strategic Ambitions Overview

- Putting Communities First – All milestones on track; no issues to report.
- Better Patient Experience –
  Success: Community Paediatrics reduced 52-week waits from 398 to zero (target met by Oct 2025) through nurse-led assessments, revised triage, streamlined pathways, and web-based support.
  Concern: Intermediate Care transformation project delayed due to unresolved ICB funding and bed closure agreements.
- Great Place to Work – All milestones on track; no issues to report.
- Sustainable Care –
  Concern: Clinical Productivity project delayed due to complexity, resource demands, and system dependencies.
  Linked objective to reduce documentation time by 20 percent by March 2026, is behind schedule due to Windows 11 upgrade issues affecting voice recognition rollout.

- Governance and Improvement Culture
  Governance is aligned with relevant Board committees.
  The Improvement Board fosters continuous improvement through data-driven decision-making, structured problem-solving (A3 thinking), and sharing of successful practices.

Items of concern to be brought to the Board's attention:
The Intermediate Care Transformation Project is currently off track due to delays in securing agreement from the Integrated Care Board (ICB) on key elements, including the temporary closure of certain community hospital beds and funding for the Home First initiative. Discussions with ICB executives are ongoing to resolve these issues and determine the next steps.

The Clinical Productivity Project is currently off track due to its complexity, high resource demands, and dependencies on wider system and external factors. These challenges have made it difficult to demonstrate measurable impact. A detailed paper outlining the contributing issues and proposed actions was submitted to the Finance, Business and Investment Committee on 1 October 2025 for review and oversight.

The breakthrough objective to reduce clinician documentation time by 20 per cent by March 2026 experienced delays due to technical issues arising from the Windows 11 upgrade, which affected voice recognition functionality. Implementation has now resumed and is being rolled out across 51 teams, including Kent School Health, Adult Speech & Language Therapy, and Podiatry.

Significant improvements in matters that were previously an area of concern:
Community Paediatrics have successfully reduced the number of children waiting over 52 weeks for assessment from 398 to zero by October 2025.
Improvements have been driven by:

- Nurse-led assessments
- Revised triage and prioritisation
- Streamlined clinical pathways
- Web-based support for families
- Use of ADOS form to reduce report writing time
- Positive cultural shift: "safe to fail" approach enabled rapid testing and learning.

The organisation is actively spreading successful innovations across services. The ADOS form, which helped streamline clinical reporting in Community Paediatrics, is now being adopted in Children's Therapies. Additionally, the voice recognition and progress notes initiative—initially tested in Community Nursing—has re-commenced after earlier delays and is being rolled out to 51 teams, including Kent School Health, Adult Speech & Language Therapy, and Podiatry.

Items of excellence:
A strengthened improvement culture through the Improvement Board, which:

- Facilitates data-driven decision-making.
- Promotes structured problem-solving using A3 thinking.
- Encourages safe-to-fail experimentation.
- Supports cross-team learning and idea generation (e.g., digital champions).

The strategy's ambitions are clearly mapped to specific board committees. This ensures each committee maintains focused oversight and is accountable for progress within its remit.
The mid-year review of the We Care Strategy (Year 3) shows that the majority of strategic ambitions, corporate projects, and breakthrough objectives are progressing well, with governance structures effectively supporting delivery. A standout achievement is the elimination of 52-week waits in Community Paediatrics, with successful practices now being adopted across other services. However, three areas require attention: the Intermediate Care Transformation Project is off track due to unresolved ICB agreements; the Clinical Productivity Project faces challenges related to complexity and system dependencies; and the linked breakthrough objective to reduce documentation time has experienced delays due to technical issues, though implementation has now resumed.

The corporate projects and breakthrough objectives not highlighted in the report are provided in a separate appendices which Board members can access in the BoardEffect library.

Report history / meetings this item has been considered at and outcome

Thie report was presented at the executive team meeting on 7 October 2025 for discussion.

Recommendation(s)

The Board is asked to **discuss** the report.

Link to CQC domain				
☑ **Safe**	☑ **Effective**	☑ **Caring**	☑ **Responsive**	☑ **Well-led**

Assurance level	Significant

Implications		
Links to BAF risks / Corporate Risk Register	☐ BAF	☐ CRR
Equality, diversity and inclusion	No	
Legal and regulatory	No	

Executive sponsors sign off

Name and designation:
Sarah Phillips, Chief Medical Officer

Date: 07 October 2025

We care strategy: Progress report | October 2025

Year three, mid-year position

This report provides an update to Board on the progress against our five-year We care strategy 2023-2028 and our strategic direction for 2025/26 (Year three), detailing progress in meeting the high-level milestones for each ambition constituent parts and highlighting corporate projects and breakthrough objectives where there have been successful changes and where there are items of concern. The corporate projects and breakthrough objectives not highlighted in the report, are provided in separate appendices.

Our We Care Strategy, shown in figure one below, includes four ambitions – to make KCHFT a great place to work, to put our communities first, to improve patient experience and to deliver sustainable care. The focus for 2025/26 is to deliver six corporate projects and seven breakthrough objectives, across three strategic initiatives. The majority of the projects and objectives are on track against their milestone plans. Exceptions to this are transforming intermediate care, reviewing clinical productivity and the linked objective to reduce administration by 20% where there are items of concern. There is one objective spotlighted as a key success this report. That is the community paediatrics team work to reduce the number of people waiting over 52 weeks to be seen to zero by October 2025.

We care strategy: Year 3

	Putting communities first	Better patient experience	Great place to work	Sustainable care
Ambitions (5 years)	*Everyone has the same opportunity to lead a healthy life, no matter where they live.*	*We focus on what matters to the patient, so they get the right care, right place, right time.*	*Our colleagues are valued, feel heard and make changes easily to deliver better care*	*We will live within our means to deliver outstanding care*
Strategic initiatives (1 - 3 years)	Transform community services		Grow our culture for collaboration	Improve productivity
Corporate projects (0 to 18 months)	**Develop our partnerships** **Embedding neighbourhood health**	**Transform intermediate care**	**Build our improvement culture**	**Review clinical productivity** **Review corporate functions**
Enablers	A fit for purpose estate | Effective digital change			
Targets	**Achieve less than a 1% gap in missed appointment rates between most & least deprived**	**87% of patients wait less than their service-specific waiting times, by March 2027**	**Increase staff engagement and staff morale scores by 0.2 compared with March 2023**	**Staff spend less time on administration processes by March 2027**
Breakthrough objectives (2025/26)	**PC1a:** Reduce the missed appointment rate for patients from the most deprived localities to below 4% by March 2026 **PC1b:** Reduce the missed appointment rate for patients from Asian or Asian British, Black or Black British, Mixed and any other white ethnic group by 25% by March 2026	**BP1a:** 92% of people are seen within 12 weeks, by March 2026. **BP1b:** Reduce the number of children waiting more than 52 weeks for our Community Paediatrics Service from 398 to 0 by October 2025.	**GP1a:** Support colleagues' health and wellbeing during a period of significant change so they continue to learn and grow.	**SC1a:** Reduce clinician time spent on documenting care by 20% by March 2027 **SC1b:** Reduce waste by eliminating processes that don't add value by March 2027.

Figure 1: We care strategy

Governance is provided by the Improvement Board for breakthrough objectives and the Executive team for corporate projects. Both are aligned to the relevant Board committee – Putting Communities First and Better Patient Experience aligned to Quality

Committee, Great Place to Work aligned to People Committee and Sustainable Care to the Finance, Business and Investment Committee.

The Improvement Board, which supports the delivery of the breakthrough objectives provides the opportunity for sharing learning about improvement activities and approaches. It continues to support the shift to a culture, where continuous improvement is part of the fabric of everything we do and provides the opportunity for:

- in depth discussion, insights and learning with a focus on development of metrics, data insights and possible tests of change
- focusing on 2 of the ambitions in alternate meetings, allowing individuals to share their work in detail.
- information/data and small tests of change providing data for decision-making, what to prioritise and how to know we are making a difference
- evidence of more sophisticated use of data e.g. waiting times forecasting
- use of ‘A3 thinking’ as a structured approach to problem-solving
- generating ideas for further improvement projects e.g. digital champions

Each of the ambitions have high level milestone plans, detailed below in figures two through five. Those areas where there have been key successes, or where there are areas of concern, are detailed in the following sections.

Ambition One – Putting Communities First. All milestones on track. Nothing to highlight to the Board.

		2025						2026									
		Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct
Strategic Initiative: Transform community services.	Corporate Projects: Develop our partnerships – MCH Acquisition	Boards approve SOC		NHSE agree move to FBC					FBC to NHSE	MCH vote				NHSE Challenge		Boards & Governors approve NHSE grants risk rating	Merge
	Embedding neighbourhood health – testing integration	Develop relationships, analysis of data & plan workshop.		Finalise and PLAN tests of change	PDSAs			Evaluate – review learning, scale and spread successes.									
Target: Achieve less than 1% gap in missed appointment rates between most and least deprived	Breakthroughs: Reduce missed appointment - most deprived localities &	Workshops 1 thru 5 held PLAN, DO, STUDY,ACT & SPREAD							Decision point for next steps – has the target been met, what next.								
	Reduce missed appointments for Asian or Asian British, Black or Black British, Mixed and any other white ethnic group	Power BI dashboards created. Targeted QI coaching with 5 focus teams		Imp. board focus		Imp. board focus		Imp. board focus		Imp. board focus							

Key: Completed | On track | Off track | Not started

Figure 2: Ambition one – high level milestone plan

we care

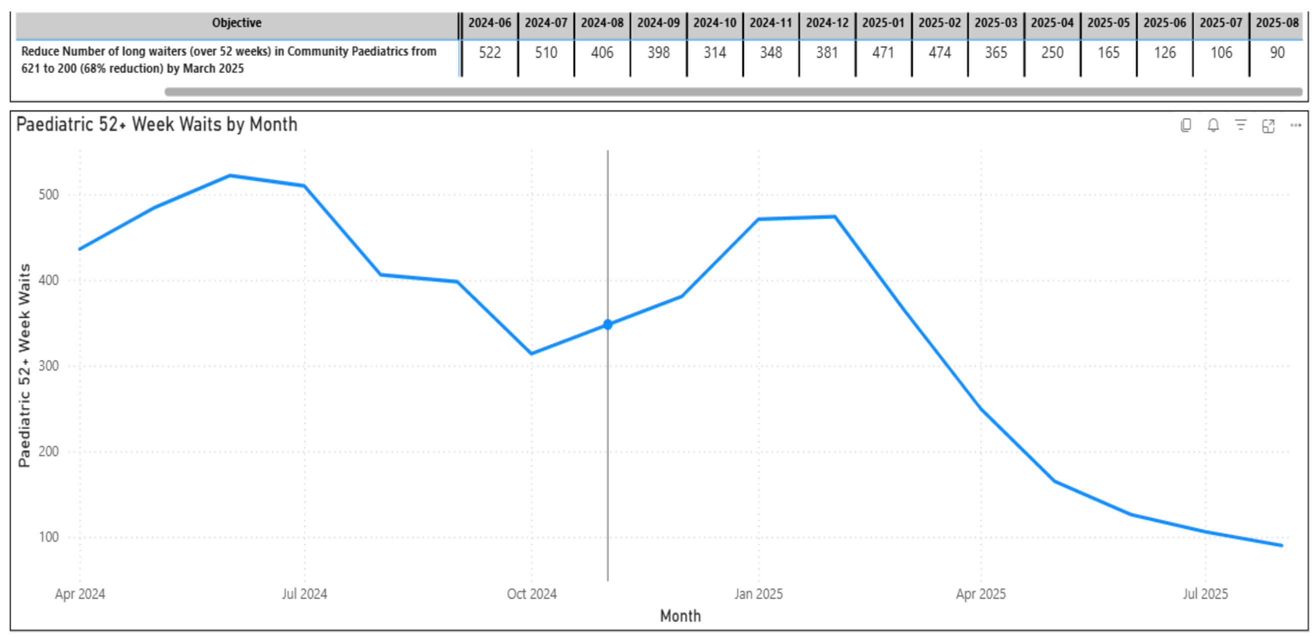
Ambition Two – Better patient experience. Majority of milestones on track. Highlights related to the significant shift in waiting times for community paediatrics, and concerns regarding the work within the transforming intermediate care corporate project, both detailed below.

		2025					2026									
	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct
Strategic Initiative: Transform community services. Corporate Projects: Transforming Intermediate Care - Perfect Ward	Outline Business Case for tests of change (toc): Perfect Ward Home First Home First Plus Colocation		Local toc - implement	PDSAs		Mid point evaluation	Agree continuation of pilot									
			Organisational toc - ICB approval	Align workforce (inc. recruitment and redeployment)		Training / upskilling										
Transforming Intermediate Care - Home First West Kent	HCP-led multi agency agreement of pilot clinical and workforce model		Options for non-funded pathway	Implement non-funded options												
Target: 87% of patients wait less than their service specific waiting times by March 2027. Breakthroughs: 92% of people are seen within 12 weeks, by March 2026		Specific pathways reviews including triage and forms		Development of Standard Operating Procedures (SOP)			Increase emphasis on patient experience metrics									
Reduce the number of children waiting more than 52 weeks for our Community Paediatrics Service from 398 to 0 by October 2025	Collation and analysis of data for initial assessments and first to follow up		Imp. board focus		Imp. board focus		Imp. board focus		Imp. board focus							

Key: Completed (purple); On track (green); Off track (orange); Not started (blue)

Figure 3: Ambition two – high level milestone plan

Breakthrough objective to reduce the number of children waiting more than 52 weeks for our community paediatrics from 398 to zero by October 2025. The team is on track to meet its target of zero by October, as illustrated in figure two below.



Objective	2024-06	2024-07	2024-08	2024-09	2024-10	2024-11	2024-12	2025-01	2025-02	2025-03	2025-04	2025-05	2025-06	2025-07	2025-08
Reduce Number of long waiters (over 52 weeks) in Community Paediatrics from 621 to 200 (68% reduction) by March 2025	522	510	406	398	314	348	381	471	474	365	250	165	126	106	90

Figure 2 – reduction in people waiting longer than 52 weeks

Back in April 2024 the team recognised the negative impact the waiting times were having on young people, their families and the staff in the service. People and their families were having to wait up to 71 weeks to have their initial assessments, resulting in symptoms exacerbating, behavioural issues escalating, frustrations at not understanding a child's needs without a formal assessment, access extra support or be prescribed medication. From a staff perspective, they were stressed and burned out. Throughout 2024 and the first half of 2025, the team met and agreed a number of things they wanted to try to see if they could reduce the waiting list and improve staff experience at work. Some changes didn't work e.g. Tortus ambient voice technology and some did. Those things that have worked include nurse led assessments for children referred for behavioural concerns, revised triage procedures, clinical prioritisation, validation of waiting lists, streamlining of clinical pathways and the introduction of web-based support for children and families waiting. Learning from the introduction of the ADOS form is also now being applied to all clinical reports with the aim of reducing clinical report writing. This has already shown successes with autism diagnostic waits which has resulted in seeing one extra family per week.

Crucial to the resulting improvements was the culture of safe to fail and allowing the team to fail safe and fail fast.

- Some of the successes the teams have introduced are now being spread to the other teams: the ADOS form is now being implemented in children's therapies.
- TORTUS was widely used in Primary care settings where templates were well suited to use cases and brevity of consultation. In other healthcare settings some users felt that consultations were over-summarised, with key details missing. In community paediatrics, there were specific use cases such as initial assessments for under-five's which required detailed documentation.
- A co-ordinated system approach has been crucial to the reduction in waits specifically for children referred for autism and ADHD assessments, whereby offering support in the community or with other paediatric services has shown benefits to ensure that referrals are made only once persistent and pervasive concerns are demonstrated. This allows early intervention to be in place to support the child and family and builds a better profile of the child's needs should referral be indicated.

Items of concern

The corporate project to transform intermediate care, which includes home first and the perfect ward is not on track. This is owing to delays with the ICB agreeing to some of the requirements regarding temporary closure of some community hospital beds and the funding for home first not being agreed. This has been discussed with the ICB executive. It was agreed that while there is no immediate resolution to the issue, that we will work together to agree next steps. In parallel there is ongoing exploration and development of pathway improvements and elements of the Perfect Ward project that can be delivered within existing resources, albeit these are limited.

Ambition Three – Great Place to Work. All milestones are on track. Nothing to highlight to the Board.

		2025						2026									
		Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct
Strategic Initiative: Grow our culture for collaboration	**Corporate Projects:** **Build Our Improvement Culture**			**Development of Rapid Improvement (RI) Events and Improvement training.**		**Implementation of RI workshops and workplan for identified teams.** **Further development of QI advisor coaching proficiencies**		**Delivery of new QI training course, daily improvement training & coaching activities**									
Target: Increase staff engagement and staff morale scores by 0.2 compared with March 2023.	**Breakthroughs:** **Support colleagues health and wellbeing during a period of significant change so they continue to learn and grow**		**Baseline data collection – 9 bespoke questions across 8 teams**		**Commence new interventions. PDSA format where appropriate.**												
			Imp. board focus		**Imp. board focus**		**Imp. board focus**		**Imp. board focus**								

Key: Completed (purple) On track (green) Off track (red) Not started (blue)

Figure 4: Ambition three – high level milestone plan

Ambition Four – Sustainable Care. Majority of milestones on track. Item of concern regarding the work within the review clinical productivity corporate project, detailed below.

		2025						2026									
		Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct
Strategic Initiative: Improve Productivity	Corporate Projects: Review clinical productivity	Baseline activities			Voice Recording relaunch 3 services			Continued Scale and spread									
		Phase 1 Job Planning			Phase 2 Job Planning			Phase 3 job planning									
		Rio Development (Rio redesign for services)									Patient Flow & Clinical Pathway workstream						
		Baseline activities			Clinic structures to Rio config												
	Review corporate services	Schemes under development															
			Consultations														
					Implement changes												
Target: Staff spend less time on administration processes by March 2027	Breakthroughs: Reduce clinical time spent on documenting care by 20% by March 2027	Launch of little change, big impact campaign			Voice Recording relaunch 3 services												
	Reduce waste by eliminating processes that don't add value by March 2027	Imp. board spotlight		waste reduction suggestions process development	Imp. board spotlight		Imp. board spotlight		Imp. board spotlight								

Key: Completed On track Off track Not started

Figure 5: Ambition four – high level milestone plan

Items of concern

The corporate project to review clinical productivity, is not on track. The project's primary objective is to optimise the clinical workforce by reducing administration burden, thereby freeing up time for direct patient care and enabling potential financial efficiencies. This is balanced with a commitment to maintaining and improving staff experience, measured through increased opportunities for breaks and reduced instances of working beyond scheduled hours. The programme predominantly targets five key service areas identified through multi-dimensional data analysis: Community Paediatrics, Children's Therapies, Podiatry, Adult Speech and Language Therapy, Community Neuro-Rehab Team and Community Rehab Team Adults identified through data analysis. The factors contributing to the slower progress to demonstrate impact include programme complexity, resource intensity, system dependencies, external factors and measurement limitations. A detailed paper which includes more information on these contributory factors and actions being taken to address has been presented to the FBI committee on 1st October. A significant element is the reconfiguration of Rio to optimise clinical templates which is underway in multiple services and the introduction and implementation of non-medical job planning with phase 1 completed.

Linked to the clinical productivity work is the breakthrough objective which aims to reduce the clinician time spent on documenting care by 20% by March 2026. There have been delays to rolling out the voice recognition and progress notes initiative, first tested successfully in the community nursing teams, owing to complications relating to Windows 11 upgrade and the impact on the functionality. The implementation more widely has now re-commenced, and the plan is for all teams (51) where the initiative is appropriate to start in the next six months. Currently Kent School Health, adult speech and language therapy and podiatry are implementing.

All of the corporate project highlight reports and breakthrough objectives projects on a page are provided in the appendices in addition to more details on those not highlighted in this report as key successes or items of concern.

Conclusion

Significant progress has been made overall, and the deployment of the strategy using a "true north" approach is supporting us to spread and embed improvement methods in the organisation. The breadth and complexity of the work being done is evident in the areas where less progress has been made, but this report also highlights the important learning this provides.

Front Sheet – Board Assurance Framework

This paper outlines the Trust's approach to the current risk environment, fostering a proactive approach to risk management and organisational resilience.

Meeting:	Board Meeting - Part 1 (Public)
Date of meeting:	15 October 2025
Agenda item no:	Item 9
Report title:	Board Assurance Framework (BAF)
Executive sponsor(s):	Tony Saroy, Interim Trust Secretary
Report author(s):	Claire Hayler, Risk and Incident Manager
Action this paper is for:	Approval
Public/non-public	Public

Executive summary

Overview of paper
This paper provides an update to the Board in relation to the Board Assurance Framework (BAF).

The BAF presents the key information regarding the principal risks faced by the Trust in meeting its strategic ambitions. It provides the Board with clear and comprehensive information about the:

- main risks to achieving the Trust's strategic objectives,
- controls, assurance, and oversight of these risks, and
- Strategic Risk Owners (SROs) and actions being undertaken to mitigate the risk to the extent that the Board deems tolerable.

The committee receives a regular update on the BAF risks, controls and mitigations that fall within the committee's remit. There are currently six strategic risks on the BAF, as outlined in **Appendix 1**.

The BAF is currently receiving a refresh to reflect the 2025/26 breakthrough objectives with new risks being formulated.

Items of concern to be brought to the Board's attention:
None

Significant improvements in matters that were previously an area of concern:
None

Items of excellence:
The BAF continues to be visible; it is presented at various forums including Board committees. Actions, assurance levels and controls in place are regularly refreshed to ensure they are fit for purpose.

Report history / meetings this item has been considered at and outcome

The BAF was last presented to the following committees:

- Audit and Risk Committee Meeting 6 October 2025
- Finance and Business Investment Committee 29 September 2025
- Quality Committee 4 September 2025
- People Committee 21 August 2025
- Executive Team on 7 October 2025

Recommendation(s)

The Board is asked to receive the BAF as attached at **Appendix 1** and

- **Approve** the report

Link to CQC domain				
☑ **Safe**	☑ **Effective**	☑ **Caring**	☑ **Responsive**	☑ **Well-led**

Assurance level	Reasonable

Implications		
Links to BAF risks / Corporate Risk Register	☑ BAF	☑ CRR
Equality, diversity and inclusion	No	
Legal and regulatory	Yes (provide a brief sentence describing the issue) The wider risk management process delivers the requirements under KLOE5 of the Well-led framework.	

Executive sponsors sign off

Name and designation:
Tony Saroy, Interim Trust Secretary

Date: 07 October 2025

The Board Assurance Framework

The BAF was last presented to the Board in July 2025. This report reflects further updates on risks since July 2025, following discussions with the Executive Team.

New Risks:

No new risks have been added since the BAF was presented to the Board in July 2025.

Risk Movement:

BAF 001 - Putting Communities First (Current score remains 12 high):
Waiting to embed even though the target rating is the same as the milestone, the new risk score has been achieved at the target milestone and been at that for one whole quarter with the recommendation to be removed, however, the Board may wish for this to remain on the BAF because there are two outstanding actions. Three completed actions have been removed and no longer have a material impact on the direction of the risk.

BAF 002 - A Great Place to Work (current score 12 medium):
Three completed actions have been removed and no longer have a material impact on the direction of the risk.

BAF 003 - A Great Place to Work:
The Board approved the removal at its meeting 16 July 2025 subject to approval by the People Committee. The People Committee approved the removal at its meeting 21 August 2025.

BAF 004 - Sustainable Care (Current score 8 medium):

There was a recommendation that the Board approved the risk was removed subject to approval by the FBI 23 July 2025. The FBI reviewed the risk and although approved the reduced risk rating they did not approve removal of risk from the BAF.

BAF 005 - Sustainable Care

There was a recommendation that the Board approved the risk was removed subject to approval by the FBI 23 July 2025. The FBI reviewed the risk at a more granular level but did not formally approve the removal of risk from BAF.

BAF 010 - Sustainable Care

Following discussion at its meeting 29 September 2025, the Finance and Business Investment (FBI) Committee agreed that BAF010 should be reworded to reflect the current financial pressures, the potential impact on transformation, and the risk of increased system controls. In addition, a review of the associated risk rating would be undertaken.

Appendix 1: Board Assurance Framework: *Last updated on 19 September 2025*

Definitions:

Initial Rating: The risk rating at the time of identification

Current Rating: Risk remaining with current controls in place. This is reviewed monthly and should decrease as actions take effect.

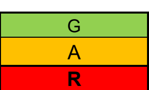
Target Date: Month end by which all actions should be completed

Target Rating: The risk can be removed from the BAF (and if appropriate onto the directorate risk register) once this score is achieved.

Triangulation Data: Is this detailed in Integrated Performance Review (IPR), Corporate Projects or Breakthrough Objectives

Action status key:

Actions completed	G
On track but not yet delivered	A
Actions overdue	R



Ambitions: Putting communities first/Better patient experience/A great place to work/Sustainable care

Strategic Goal	ID	Opened	SRO	Assuring committee	Risk Description (Simple Explanation of the Risk)	Initial score C	Initial score L	Initial score Rating	Controls Description	Top Five Assurances	Gaps in Assurance	Current score C	Current score L	Current score Rating		Target milestone C	Target milestone L	Target milestone Rating
Putting Communities First	BAF001	06.06.2023	Pauline Butterworth	Quality Committee	**If** demand for services subject to the 12 week RTA internal standard continues at current levels and **if** we cannot increase commissioned capacity for services, **then** we will not be able to achieve our target of reducing the number of people who wait more than twelve weeks to be seen, **resulting** in negative impacts on patient outcomes, increased complaints, negative impacts on staff morale and possible wider system impacts.	4	5	20	• Divisional monitoring of RTA reporting to Executive Performance reviews and Highlight Assurance reports to Quality Committee; • Harm Review process in place for services with 52 week waiting times challenges; • Engagement with System-led transformation programme for services with long waits associated with CYP SEND and Adult Neurodevelopmental needs. • Collaboration with Provider partners on developing new models of care. • Acute Provider Collaborative have agreed Dental GA as a priority to reduce waiting times. Patient tracking list group established and ongoing.	• Executive Performance Reviews monitor RTA performance across all services. • Divisional Governance Groups have focus on services requiring targeted support for improvement. • KCHFT Improvement Board oversight of breakthrough objectives. • Established the Trustwide Clinical Productivity Group. • Harm review process in place for people waiting for over 52 weeks.	Adequate controls and assurance in place	4	3	12 H		4	3	12 H
A Great Place to Work	BAF002	06.06.2023	Victoria Robinson-Collins	People Committee	**If** staff do not feel involved and engaged with the strategic objectives, **then** they may not support the changes required to services **resulting in** inability to deliver the trust strategy.	3	5	15	• Use of staff networks, health and wellbeing champions, NLB ambassadors, staff governors and Staff Side to support engagement. • Webinars led by Board SROs for each strategy ambition to engage with colleagues. • Use of We Care conferences to engage and test out ambitions and breakthrough objectives. • Use of Executive Team visits and We Care visits to test understanding and direction of travel and level of cascade about the strategy. • Appraisal and objective setting.	• Staff survey engagement score • Pulse survey engagement score, staff FFT scores • Level of attendance and feedback at we care conferences, other engagement events • Number of You said, we did examples of listening and acting on feedback and analysis of engagement on flo with blogs, webinars • Analysis of themes from visit and engagement reports.	Adequate controls and assurance in place	3	4	12 M		3	3	9
	BAF004	06.06.2023	s and Gordon Flack	Quality Committee	**If** the Trust's clinical systems are not efficient and user friendly, **then** staff time will be spent on activities that do not add value to patients **resulting in** reduced time for safe, effective patient care and a negative impact on staff morale.	4	4	16	• Chief Executive /director level discussions with supplier • Rio governance group and clinical champions • Automation steering group chaired by Chief Financial Officer and Chief Medical Officer.	• Use of automation and programme to reduce inputs and tolerate more risk • Increased frequency of new system releases and added modules • Snap staff surveys of system usability. • Establishment of the Improvement Board.	Adequate controls and assurance in place	4	2	8		4	2	8

Planned Actions and Milestones

BAF001:

Actions to reduce risk	Owner	Target Completion (end)	Status	Triangulation Data
Clinical productivity Group to identify opportunities to reduce waiting times.	Rachel Dalton	December 2025	A	
Engagement with East Kent Hospital University Foundation Trust to create more theatre spaces (*new action)*	Mark Johnstone	October 2025	A	

BAF001 - Current Score

Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
16	16	16	16	16	16	16	16	16	12	12	12	12

BAF002:

Actions to reduce risk	Owner	Target Completion (end)	Status	Triangulation Data
Deliver core elements of EDI action plan	Victoria Robinson-Collins	March 2026	A	

BAF002 - Current Score

Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
12	12	12	12	12	12	12	12	12	12	12	12	12

BAF004:

Actions to reduce risk	Owner	Target Completion (end)	Status	Triangulation Data
~~Review new modules for enhancing the Rio system.~~ Implementation of new models improving experience of staff using RIO	Gordon Flack	~~December 2025~~ July 2025	A	

Current Rating: Risk remaining with current controls in place. This is reviewed monthly and should decrease as actions take effect.

Target Date: Month end by which all actions should be completed

Target Rating: The risk can be removed from the BAF (and if appropriate onto the directorate risk register) once this score is achieved.

Triangulation Data: Is this detailed in Integrated Performance Review (IPR), Corporate Projects or Breakthrough Objectives

Actions overdue: R

Ambitions: Putting communities first/Better patient experience/A great place to work/Sustainable care

Strategic Goal	ID	Opened	SRO	Assuring committee	Risk Description (Simple Explanation of the Risk)	Initial score C	L	Rating	Controls Description	Top Five Assurances	Gaps in Assurance	Current score C	L	Rating		Target milestone C	L	Rating
Sustainable Care			Sarah Phillips															
Sustainable Care	BAF005	06.06.2023	Sarah Phillips and Gordon Flack	Finance Business and Investment Committee	**If** the current funding constraints continue, **then** KCHFT may be unable to complete estates transformation ambitions, **resulting in** inability to reduce emissions by 80% and failure to reduce poor quality estate by 100%.	4	4	16	• Representation on system capital group and CFOs overseeing distribution of resources • Capital steering group • Estates and services steering Group • Financial Business and Investment committee • ICB Sustainability Group.	• Capital reports to Board and FBI • Reporting of emissions on budget statements and in summary finance report • Reports on estates utilisation to estates and services committee • Returns collated on backlog maintenance	Adequate controls and assurance in place	4	3	12 H		4	2	8
Better Patient Experience	BAF006	06.06.2023	Pauline Butterworth	Board	If system stakeholders do not support Kent Community Health NHS Foundation Trust ambitions, then we may not be able to deliver or implement the new models of care which could result in KCHFT not achieving targets, continuing with models of care which do not meet the needs of our populations and resources not being used to their maximum.	4	4	16	• KCHFT CEO is SRO for System transformation group for Social Care, Primary Care and Community Collaborative. • Full engagement with HCP Boards and associated PLACE based transformation workstreams including INT Pilots. • KCHFT Deputy CEO is now SRO for system Better Use of beds.	• KCHFT Improvement Board oversight of delivery of Breakthrough Objectives. • Oversight of transformation impact through UCDBs. • Provider Collaborative work taking place in East Kent to test new models of care. • Each HCP has a board where improvement work would be shared with system partners. • We have representation at each HCP INT steering group.	Adequate controls and assurance in place	4	3	12 H		4	2	8
	BAF010	06.06.2023	Executive Team	...Investment Committee	**If** the system deficit results in lack of investment in new models of care, **then** we will not have the resource to deliver the strategy, **resulting in** continued poor system performance, workforce pressures and poor patient outcomes.	5	4	20	• System CEOs and CFOs groups overseeing performance • Financial recovery plan for the system • Better Care Fund monitoring group	• System FRP has better use of beds as a significant improvement scheme requiring new models of care • Provider collaboratives to drive the changes • Dashboards on discharge delays and scale of opportunity.	Adequate controls and assurance in place	4	3	12 H		4	2	8

Planned Actions and Milestones

BAF004 - Current Score

Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
12	12	12	12	12	12	12	12	12	12	12	8	8

BAF005:

Actions to reduce risk	Owner	Target Completion (end)	Status	Triangulation Data
Adaption Plan to manage impacts of climate change	Gordon Flack	~~June 2025~~ July 2025	A	
Green travel plan implementation including lower cost low emissions lease car scheme	Gordon Flack	~~May 2025~~ July 2025	A	

BAF005 - Current Score

Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
12	12	12	12	12	12	12	12	12	12	12	12	12

BAF006:

Actions to reduce risk	Owner	Target Completion (end)	Status	Triangulation Data
To implement the test of change for both bedded and out of hospital pathways to ensure patients get home as soon as possible.	Rachel Dalton	October 2025	A	
Support Kent and Medway ICB to progress with the publication of a case for change for community hospitals and engagement with patients, public, staff and wider stakeholders.	Rachel Dalton	December 2025	A	

BAF006 - Current Score

Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
12	12	12	12	12	12	12	12	12	12	12	12	12

BAF010:

Actions to reduce risk	Owner	Target Completion (end)	Status	Triangulation Data
Integration of short term services with social services under KCHFT lead provider model	Pauline Butterworth	November 2025	A	
Confirmation of ongoing funding arrangements for Intermediate Care pilots	Pauline Butterworth	July 2025	A	

Current Rating: Risk remaining with current controls in place. This is reviewed monthly and should decrease as actions take effect.

Actions overdue | R

Target Date: Month end by which all actions should be completed

Target Rating: The risk can be removed from the BAF (and if appropriate onto the directorate risk register) once this score is achieved.

Triangulation Data: Is this detailed in Integrated Performance Review (IPR), Corporate Projects or Breakthrough Objectives

Ambitions: Putting communities first/Better patient experience/A great place to work/Sustainable care

						Initial score						Current score				Target milestone			
Strategic Goal	ID	Opened	SRO	Assuring committee	Risk Description (Simple Explanation of the Risk)	C	L	Rating	Controls Description	Top Five Assurances	Gaps in Assurance	C	L	Rating		C	L	Rating	Planned Actions and Milestones
Sustainable Care				Finance Business and															

BAF010 - Current Score

Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
12	12	12	12	12	12	12	12	12	12	12	12	12

Front sheet – Committee chairs' assurance reports

The reports which follow provide a summary to the Board of the discussions that took place at its sub-committees since the last Public Board meeting in July 2025

Meeting:	Board Meeting - Part 1 (Public)
Date of meeting:	15 October 2025
Agenda item no:	Items 10, 11, 12, 13
Report title:	Committee chairs' assurance reports
Executive sponsor(s):	John Goulston, Chair
Report author(s):	Gina Baines, Assistant Trust Secretary / Committee Secretary Liz Crossley, Corporate Governance Officer
Action this paper is for:	Noting
Public/non-public	Public

Executive summary

The purpose of this report is to provide an update to the Board on the following Committee meetings:

- Audit and Risk Committee meeting held on:
  - 6 October 2025
- Finance Business and Investment Committee meeting held on:
  - 23 July 2025
  - 29 September 2025
- Quality Committee meeting held on:
  - 4 September 2025
  - Learning from Deaths Report (published externally)
- People Committee meeting held on:
  - 21 August 2025

The meetings were called and convened in accordance with the Committees' terms of Reference and were quorate.

The Board is asked to receive and note the Committee Chairs' reports for assurance.

Report history / meetings this item has been considered at and outcome

Recommendation(s)
The Board is asked to • **Note** the reports

Link to CQC domain				
☑ **Safe**	☑ **Effective**	☑ **Caring**	☑ **Responsive**	☑ **Well-led**

Assurance level	Significant

Implications		
Links to BAF risks / Corporate Risk Register	☐ BAF	☐ CRR
Equality, diversity and inclusion	No	
Legal and regulatory	No	

Executive sponsors sign off
Name and designation: John Goulston, Trust Chair Executive Sponsor:
Date: 08 October 2025

AUDIT AND RISK COMMITTEE CHAIR'S ASSURANCE REPORT

This report is founded on the Audit and Risk Committee meeting held on 6 October 2025

Agenda items

- Issues from Quality Committee / Finance, Business and Investment Committee / People Committee / Charitable Funds Committee / Council of Governors
- Board assurance framework (BAF)
- Corporate risk register report (CRR)
- Internal audit progress report
- Local counter fraud progress report
- External audit report
- Health, Safety and Emergency Preparedness group chair's assurance report
- Combined governance report: Cyber security report, data integrity annual report, information governance annual report
- Legal report
- Chief Finance Officer's report
- Single tender waivers and retrospective requisitions report
- Losses and special payments including debt write off assurance report
- Standing Financial Instructions and Scheme of Delegation
- Development and management of procedural documents – for approval

Agenda item	Assurance and key points to note	Assure/ Alert/ Advise
Matters arising	The Committee noted that the Trust is producing its climate adaptation plan and that a first draft should be ready to share with the Committee before its next meeting in early January 2026. An update was also received on the security arrangements at the Folkestone Walk In Centre. The Security Team from East Kent Hospitals University NHS Foundation Trust has met with the Trust to discuss security going forward. The current arrangement will continue but staff are being reminded to raise any concerns through incident reporting.	Advise
Risk management	Board assurance framework and corporate risk register report The Committee received the BAF and discussed BAF001 and BAF002 and were advised that they would remain on the BAF as the wording was under review to -make them more precise in relation to the Trust's risk management framework. The Committee was pleased to hear that arrangements were underway for NHS Providers to provide a seminar to the Board on risk appetite. The Committee and the Board would be receiving the Trust's risk management framework for approval in January 2026	Assure
Internal controls – 3rd party	Internal audit progress report The Committee was updated on progress with the internal auditors' annual plan of audits across the Trust. Good progress is being made and the auditors are on track with the plan. On recent internal audit reports that have been published in 2024/25, good levels of assurance have been received but there is one with limited assurance on the Estates backlog maintenance audit which prompted some discussion by the Committee. Many of the issues highlighted in the audit are outside of the Trust's control as sites are owned by third party landlords. This limits the extent to which the Trust can improve compliance across the estate. However, an estates dashboard is being used to track compliance and monitor progress against all the issues which are within the Trust's gift to resolve.	Alert

	The auditors have undertaken an audit on the Trust's learning from the report into the issues raised by the Fuller inquiry. The final report from the auditors is yet to be finalised but will be shared with the Committee at its next meeting. Local counter fraud progress report The Committee received assurance on the Anti-Crime Progress Report audit based on activity carried out against the agreed Counter Fraud work-plan undertaken in line with the Government Counter Fraud Functional Standards (GFS). Of note to the Committee was the new Failure to Prevent Fraud Offence; a new corporate offence which came into effect on 1 September 2025. The full report was shared with the Committee, and it was noted that the Trust has a solid foundation for fraud prevention. The executive continues to enhance its fraud prevention framework to meet the legislative requirements and is working on further policy integration, staff awareness and leadership communication to strengthen its position. The Committee acknowledged the executive responsibility for this. External audit report A preliminary outline of the timetable for the 2025/26 external audit was received and this will be confirmed in more detail in the New Year.	Assure Assure
Internal assurances	Health, Safety and Emergency Preparedness group chair's assurance report The Committee received good assurance. There are no new concerns to raise to the Board this month. Combined governance report: Cyber security report The Committee received a comprehensive report on the Trust's current readiness status and there was much discussion about the work that is underway to protect the organisation from cyber-attacks, particularly in light of the incidents in the private sector that have been reported widely in the media. The Committee noted that there is an ongoing/ever-changing landscape of risks, and mitigations are in place.	Assure Assure

	The Trust’s digital service boundary increases, both independently, but also jointly through convergence, collaboration and joint working with other organisations. This means that the Trust’s cyber-attack surface is increasing. The Trust recognises this and is evolving risk mitigation strategies to protect its services. The latest audit report concluded that the overall risk to the Trust across all five cyber assurance framework (CAF) objectives is very low and that the overall confidence level of the independent assessment was high. <u>Data integrity annual report</u> Services continue to provide a high completeness of NHS number and ethnicity data and Power BI is being used to further enrich reporting and collaborate with services. As the Board is aware, there was a recent incident regarding the accuracy of the activity data that had been submitted for the Virtual Ward services. This was discussed by the Committee and the Committee was assured that the Trust had taken the appropriate action once the issue had been identified. <u>Information governance annual report</u> A comprehensive report was provided which gave the Committee good assurance. The Trust continues to achieve a high level of compliance with the Data Security and Protection Toolkit. <u>Legal report</u> The Committee received the report for assurance. There is nothing to escalate to the Board this month.	Assure Assure Assure
Financial reporting and controls	<u>Chief Finance Officer’s report</u> As has been reported elsewhere to the Board, the system deficit remains a risk to the Trust. <u>Single tender waivers and retrospective requisitions report</u> The Committee is pleased to report that the number of single tender waivers and retrospective requisitions continues in a downward direction.	Assure

	Losses and special payments including debt write off assurance report The Committee received the report for assurance and no concerns were raised. Standing Financial Instructions and Scheme of Delegation – for approval and recommended to the Board for approval The Committee noted the amendments that had been made and recommend the updated standing financial instructions and scheme of delegation to the Board for approval.	Assure Advise
Committee business	Development and management of procedural documents The Committee approved the policy.	Alert

Karen Taylor
Chair, Audit and Risk Committee
6 October 2025

FINANCE, BUSINESS AND INVESTMENT COMMITTEE CHAIR'S ASSURANCE REPORT

This report is based on the Finance, Business and Investment Committee meeting held on 23 July 2025

Agenda items

- Board Assurance Framework (BAF) and Corporate Risk Register (CRR)
- Kent and Medway System Financial Position – Month 2
- Community Services Contract Negotiations
- Estates Update and Green Plan
- Community Hospitals Transformation – Intermediate Care Model
- Finance Report – Month 3 and Cost Improvement Programme (CIP)
- Business Development and Service Improvement Report
- Treasury Management Policy
- Forward Plan

Agenda item	Assurance and key points to note	Assure/alert/advise the Board
Board Assurance Framework (BAF) and Corporate Risk Register (CRR)	The Committee agreed to reduce the risk scores for BAF004 (clinical systems) and BAF005 (sustainability planning) following updates and assurances received below.	**Assure:** Risk ratings adjusted in line with improved controls.
Kent and Medway System Financial Position	It was noted that there continued to be a challenging financial context across the Kent and Medway Integrated Care System with approximately £200 million in high-risk savings, including over	**Alert:** Financial constraints at system level poses a risk to the Trust's resources.

Agenda item	Assurance and key points to note	Assure/alert/advise the Board
	£100 million in unidentified savings (Kent and Medway ICB public board meeting, 1 July). The Integrated Care Board is required to deliver significant reductions in running costs, system partners are working collectively to manage this.	
Community Services Contract Negotiations	The Committee was reasonably confident with the progress made. Some risks remain, but steps are in place to manage them, including a written confirmation from the ICB to provide financial reassurance while final contract details are being finalised.	**Assure:** Reasonable confidence in managing residual risks.
Estates Update and Green Plan	Strong performance noted in compliance and maintenance. The Green Plan was approved and will be published by 31 July. Estates optimisation will be explicitly referenced.	**Assure:** The Committee was assured by progress and strategic alignment.
Community Hospitals Transformation	The Committee approved the two-site model for tests of change. Legal and reputational risks were acknowledged, and the matter may be escalated to the Board.	**Advise:** Board to be briefed on political and legal sensitivities.
Finance Report – Month 3 and CIP	The Trust reported a small surplus and strong financial metrics. CIP delivery was slightly below target, with a high proportion of non-recurrent savings.	**Assure:** Financial position remains sound; CIP delivery to be monitored.

Olu Odeniyi
Chair, Finance Business and Investment Committee
23 July 2025

FINANCE, BUSINESS AND INVESTMENT COMMITTEE CHAIR'S ASSURANCE REPORT

This report is based on the Finance, Business and Investment Committee meeting held on 29 September 2025

Agenda items
• Board Assurance Framework (BAF) and Corporate Risk Register (CRR) • Kent and Medway System Financial Position • Community Services Contract Mobilisation • Digital Plan • Investment and Cash Review Update • Budget Setting Framework • Finance Report – Month 5 • Productivity Report • Business Development and Service Improvement Report • Health Visiting Contract Update • Forward Plan

Agenda item	Key points to note	Assure/alert/advise the Board
Board Assurance Framework (BAF) and Corporate Risk Register (CRR)	Following an update and discussion on the system finance position, it was agreed BAF010 rewording should be revised to reflect current financial pressures and system constraints. It was also agreed to review its risk	**Advise**

Agenda item	Key points to note	Assure/alert/advise the Board
	rating. BAF004 was discussed for potential reassignment to FBI from the Quality Committee.	
Kent and Medway System Financial Position	The system-wide deficit and a risk-adjusted forecast outturn was noted. Regulatory action and loss of deficit support funding was highlighted. Although the Trust remains in a strong position, it is under pressure to achieve a stretch surplus target to support system finance.	**Alert:** System financial fragility may impact Trust transformation plans.
Community Services (CS) Contract Mobilisation	CS contracts have been signed with Medway Community Health and HCRG. Transfer of Undertakings (Protection of Employment) transfers are progressing well and due diligence is underway for the subsequent proposed merger.	**Advise:**
Digital Plan	A comprehensive update was presented on the digital plan to 28/29. The plan aligns with national priorities and includes integration work across EMIS, Rio and Sunrise Altera systems and has been approved virtually following further Non-Executive Director review of the full detailed plan. Formation of a multidisciplinary group of Digital Champions will be critical in supporting delivery and adoption of the plan.	**Assure:**
Investment and Cash Review Update	The Trust continues to report a strong cash position. System partners are experiencing pressure; emergency support applications are underway.	**Assure:**
Budget Setting Framework	The budget setting timetable and methodology was approved as the Trust begins formal medium-term financial planning moving from an annual planning cycle to a 5-year rolling plan. The approach Provides clear visibility of budget changes to 2026/27 by cost centre and account code.	**Advise:**

Agenda item	Key points to note	Assure/alert/advise the Board
	The plan will be presented to board for approval in December before NHS England full planning submission in the same month and detailed budgets will be agreed in March.	
Finance Report – Month 5	The Trust reported a year-to-date surplus of £203k. Year-end forecast is breakeven in-line with the plan for the year. 18 per cent of CIP target remains unidentified and 60 per cent is forecast to be non-recurrent yielding an amber RAG (red, amber, green) rating. All other financial performance indicators are RAG rated as green.	**Advise:**
Productivity Report	The Committee noted a 4.2 per cent increase in productivity from 2019/20 to 2024/25, but a 2 per cent drop compared to last year (still 1.8 per cent increase from 2019/20). Multiple workstreams are underway. KCHFT developed a productivity measure ahead of national guidance as noted by NHSE.	**Advise:**
Business Development and Service Improvement Report	Collaborative bids for the Integrated Musculoskeletal service tender are progressing across all areas. A private provider may also bid.	**Assure:**
Health Visiting Contract Update	The Committee noted progress with KCC towards a direct award. Workforce planning is underway to support the new model.	**Advise:**

Olu Odeniyi
Chair, Finance Business and Investment Committee
7 October 2025

QUALITY COMMITTEE CHAIR'S ASSURANCE REPORT

This report is founded on the Quality Committee meeting held on 4 September 2025.

Agenda items

- Improvement project – Earlier pharmacy support for patients discharged from acute hospitals in East Kent
- Board assurance framework
- Quality risk report
- Infection prevention and control board assurance framework
- Quality report
- Quality deep dive
- Community hospitals
- Community nursing
- Learning from Experience Council chair's assurance report
- Patient Safety and Clinical Risk Group chair's assurance report (including the patient safety incident response report)
- Dental Services harm reviews
- Health Inequalities quarterly report
- Learning from Deaths report (quarter four 2024/25)
- Quality Priorities progress report
- Forward plan

Agenda item	Assurance and key points to note	Assure/alert/advise the Board
Improvement project – Earlier pharmacy support for patients discharged from acute hospitals in east Kent	The Integrated Pharmacy Team (IPT) has focussed on introducing interventions that can improve the self-management of medicines by patients at the point when they return home after a stay in an acute hospital. The team wanted to receive referrals straight from the acute hospitals, when a patient was discharged, so that the pharmacists could assess the patient's medication, and identify any interventions needed. This compliments the work being undertaken by community and primary care pharmacists and reduces the risk of harm at a point in the patient journey when patients may make mistakes when managing their medicines. This in turn could have an impact on their recovery or result in a readmission to hospital. Patients and colleagues in the acute trusts have welcomed the outcomes from this improvement project. Initial interest from the acute hospitals was slow but through word of mouth this gathered momentum and since completing the project the team has exceeded its target. Further work to build on these results is planned They have developed working relationships with primary care network (PCN) pharmacy teams and attend multiple multidisciplinary team (MDT) meetings and are collaborating closely to ensure the patient's needs and safety come first. The IPT only works in east Kent, but the team would like to see the service extend into other parts of the county so that all Kent patients can benefit.	Advise
Board assurance framework (Quality risks)	The Committee received the report and noted its assurances.	Assure
Quality risk report	The Committee received and discussed the new quality risk report, with particular focus on high-rated risks and ongoing monitoring arrangements	Assure
Infection Prevention and Control Board Assurance Framework	The Committee received the report and noted its assurances.	Assure
Quality report	The Committee received the report and noted its assurances.	Assure

Agenda item	Assurance and key points to note	Assure/alert/advise the Board
Quality deep dive: Community hospitals	The Committee noted the challenges to both recruiting to clinical posts in the community hospitals and the work underway to improve the culture in some of the teams. It was also noted that this work is ongoing and being actively supported by senior leaders. Despite the challenges, the process of introducing the new safer staffing model has had a positive impact on staff engagement. Improvements were beginning to be seen in reshaping the care that was delivered to patients, rostering and team culture across several wards.	Alert
Quality deep dive: Community nursing	The Committee received a summary of the capacity and demand programme, established in 2023 in response to rising service pressures and staff reports of high stress levels. Clinical workstreams are in place to improve delivery of daily insulin, end of life care and caseload management. Non-clinical workstreams are focused on variable working patterns, voice notes for documentation, and strengthening professional leadership to support staff wellbeing, recruitment and retention, while reducing administrative burden. Lessons learnt from recent incidents, including insulin medication errors, are being used to improve clinical leadership, competency and training. Vulnerable teams have been identified and are receiving targeted support around leadership and culture change. The Committee also received an update on the *Not in a Day's Work* (NIADW) programme. While earlier engagement led to improvements in staff feedback and survey results, concerns around bullying and harassment persist and further work is required. The next round of engagement sessions has been completed across all community nursing teams, with action plans in place or being developed.	Alert
Learning from Experience Council chair's assurance report	The Learning from Experience Council continues to do valuable work in the engagement arena to provide assurance to the Committee that patient/service user experience has been considered in the delivery of services. The feedback from patients and service users is invaluable in shaping our services and the	Assure

Agenda item	Assurance and key points to note	Assure/alert/advise the Board
	Committee has been considering whether there is a role for the patient voice at committee meetings.	
Patient Safety and Clinical Risk Group chair's assurance report including the patient safety incident response report.	The Patient Safety and Clinical Risk Group chair's assurance report was received, and its assurances were noted.	Assure
Dental Services harm reviews	The Committee continues to monitor the risk that the Dental Service has been carrying around the lack of access to theatre space to undertake paediatric dental procedures under general anaesthetic. Despite great heroic efforts by the dental team to find a solution to the issue, there has been no significant movement on reducing the waiting times since the service last reported to the Committee in May 2025. Some non-recurrent funding has been identified by the integrated care board (ICB) which the team has identified could be used for Sunday surgery. In principle, the team believe this would have a positive impact on reducing the waiting list but would be dependent on the availability of staff at the Trust and at the acute sites.	Alert
Health Inequalities quarterly report	The Trust will be working in partnership with Kent and Medway NHS and Social Care Partnership Trust (KMPT). The initial work will be on identifying the cohort of patients that is common to both organisations, with particular focus on those with mental health illnesses and who are experiencing homelessness. Further joint working will include training and access to different forums.	Assure
Learning from Deaths	The Committee received the report for assurance. Areas of good practice and learning continue to be identified. Of those deaths in the community hospitals and community that were reviewed by the Trust in quarter four, none were judged more likely than not to have been due to problems in care.	Assure

Agenda item	Assurance and key points to note	Assure/alert/advise the Board
	Regarding support for colleagues who care for patients with learning disabilities or who are autistic at end of life, the Trust has rolled out the Oliver McGowan training on learning disability and autism which is mandatory for all colleagues. This training provides a starting point for increasing confidence, but it was recognised that more work needed to be done to embed the learning into practice. The Trust would be working with KMPT to support staff.	

Dr MaryAnn Ferreux, Non-executive Director
Chair, Quality Committee
4 September 2025

PEOPLE COMMITTEE CHAIR'S ASSURANCE REPORT

This report is founded on the People Committee meeting held on 21 August 2025

Agenda items

- LGBTQIA+ Network presentation
- Updates on legislation/regulations/national changes and impacts
- System update regarding workforce implications
- Operational Workforce Report
- Workforce performance report, including board assurance framework and corporate risk register
- Significant employee relations report
- Staff Engagement quarter one report and national people Pulse survey results
- Workforce Disability Equality Standards and Workforce Race Equality Standards Reports
- Assessing Impact of Investment, Leadership Development Programmes (annual report)
- Medical Revalidation Report

Agenda item	**Assurance and key points to note**	**Assure/ Alert/ Advise**
LGBTQI+ Network presentation	The Committee welcomed a presentation from the LGBTQI+ Staff Network, which highlighted achievements and emerging concerns. The network shared that over 685 colleagues had attended awareness training since February 2023.	Assure

Agenda item	Assurance and key points to note	Assure/ Alert/ Advise
	Concerns were raised about the wellbeing of gender non-conforming colleagues, due to the recent Supreme Court ruling which decided that the term “sex” in the Equality Act refers to biological sex. The ruling has increased anxiety among gender non-conforming colleagues, especially those in administrative roles, who are already navigating uncertainty linked to wider workforce pressures. The Committee acknowledged the emotional toll of these intersecting challenges and recognised the importance of psychological safety and inclusive leadership. A proposal to include pronouns on staff ID badges was discussed.	
Updates on legislation/regulations/national changes and impacts	The Committee received an update on the workforce implications relating to the recently published NHS 10-Year Plan. Key themes were recruitment, retention, digital transformation and leadership development. KCHFT remains the only Trust in Kent and Medway actively supporting clinical apprenticeships. Colleagues noted the absence of a direct link with social care in the national plan and the need for system-level coordination to aid benefits realisation.	Advise
System workforce update	A business case for a system-wide recruitment service is being developed with the proposal that this be hosted by KCHFT as lead provider. Work is ongoing to align People and Organisational Development policies across Kent and Medway organisations. The Committee noted the importance of clarity and consistency to support colleagues through change.	Assure
Operational workforce report, including Board Assurance Framework (BAF) and Corporate Risk Register (CRR)	The Committee received an update on staffing pressures across community nursing, specialist services and community hospitals. A new escalation process will be introduced to trigger formal reviews for teams in prolonged business continuity. Financial constraints resulting in an urgent change to a new equipment provider and resultant delays are contributing to increased stress and clinical risk. The safer staffing consultation has caused anxiety among healthcare support workers due to the proposed skill mix changes, with recruitment underway to address registered nursing gaps.	Alert

Agenda item	Assurance and key points to note	Assure/ Alert/ Advise
	The Committee noted the Board's approval to remove the risk 003 regarding workforce supply from the BAF, following sustained improvement. Two new risks were added to the CRR: the national decision to remove Level 7 apprenticeship funding and the potential for industrial action linked to national pay decisions. The apprenticeship risk will be clarified to understand which clinical apprenticeships remain funded and ensure accurate risk representation.	
Significant employee relations report	The Committee received assurance on significant employee relations cases, including on the handling of sexual misconduct investigations. A rise in reported sexual misconduct cases was noted following the introduction of mandatory training, indicating improved awareness, which was welcomed as a positive development to ensure appropriate action can be taken. Monitoring will continue to assess any correlation with protected characteristics.	Assure
Staff engagement and People Pulse survey	The Committee received an update on staff engagement and the April 2025 National Pulse Survey. Engagement activity was wide-ranging and well received, with colleagues describing change as "exciting" and "improvement focused." Team meetings and one-to-ones were highlighted as the most valued forms of communication. The Committee noted strong alignment with the Trust's values. Key themes included psychological safety, transparent communication and leadership confidence during change. Concerns were raised about digital exclusion, inconsistent one-to-ones and the accessibility of counselling services. The Committee supported proposals to develop peer support networks, standardised meeting patterns and creating a set of "principles of change" to guide managers. Continued focus on local teams addressing staff survey results through a continuous improvement lens was encouraged. Staff Council was being used as an engagement tool and the committee requested updates on this way of working as it matures.	Assure

Agenda item	Assurance and key points to note	Assure/ Alert/ Advise
Workforce Disability Equality Standards (WDES) and Workforce Race Equality Standards (WRES) Reports	The Committee approved the WRES and WDES reports, which are embedded within the Trust's "Nobody Left Behind" framework. The disciplinary likelihood ratio for non-white colleagues has improved to 1.10, down from 1.8 in previous years, and compares favourably across the system. Due to small numbers, WDES disciplinary data is not published, though no significant concerns were reported. A one-page summary outlining six key ambitions is in development to support wider visibility, which will include priorities for the year ahead The Committee welcomed the Trust's coordinated and transparent approach, noting it as a model others are keen to follow.	Assure
Leadership Development Programmes	The Committee received assurance on the evaluation of the Trust's structured leadership programmes. Initial feedback showed strong Net Promoter Scores, with most cohorts exceeding the benchmark for excellence. Improvements are underway in the health and wellbeing module following lower scores in two cohorts. Participants reported increased confidence, improved team dynamics and service delivery, with 16 per cent moving into new roles. A new process will be introduced to assess prior development before accepting nominations. Uptake in high-pressure areas will be reviewed to ensure equitable access. Staff survey results will be used as a barometer of success and effectiveness of this investment	Assure
Medical Revalidation Report	The Committee received assurance that the Trust continues to meet General Medical Council and NHS England requirements. Appraiser capacity is being strengthened, with improved engagement in feedback processes and mentoring support for new appraisers.	Assure

Kim Lowe
Chair, People Committee
21 August 2025

Front Sheet – Integrated Performance Report

This paper gives an overview of performance against a number of national, contractual and internal key performance indicators.

Meeting:	Board Meeting - Part 1 (Public)
Date of meeting:	15 October 2025
Agenda item no:	Item 14
Report title:	Integrated Performance Report
Executive sponsor(s):	Gordon Flack, Chief Finance Officer
Report author(s):	Nick Plummer, Associate Director – System and Analytics
Action this paper is for:	Discussion
Public/non-public	Public

Executive summary

Overview of paper

The Integrated Performance Report is produced to give an overview of performance against a number of national, contractual and internal key performance indicators. This report is presented with the use of Statistical Process Control (SPC) charts which highlight statistically significant changes.

In month performance against target:

The following table is a summary of the position against target:

	This month		Previous Month	Trend
Targets	43		41	
Met	25	58%	22	
Marginally Off Target	9	21%	10	
Missed	9	21%	9	

For this report, **25** of the **43** KPIs (3 **more** than last month) are meeting or exceeding target for the month (58 per cent). These movements are:

KPIs 2.5a Inpatient Care Hours per patient day (CHPPD) – Registered staff and **2.5b Inpatient Care Hours per patient day (CHPPD) – Unregistered staff** are new to the report (both green)

KPI 2.2 Community Medication Errors per 1000 WTE, KPI 2.3 Rate of Injurious falls per 1000 Occupied Bed Days, 2.4 Pressure Ulcers Lapses in Care and **KPI 3.3 Turnover** have all moved from marginally off target last month (amber) to on target (green) this month.

These 5 positive shifts have been offset by **KPI 1.3 Health Visiting Antenatal Visits, KPI 4.3 Staff Bank Spend per cent of Pay (Clinical) and KPI 4.6 Bed Occupancy (per cent)** moving from to on target (green) last month to marginally off target this month (amber)

9 KPIs are marginally off target (amber) and a further **9** are significantly off target (red - same as last month).

Of the red KPIs, there are only 2 KPIs that are also in special cause variation (declining), which are KPI 3.3 Sickness Rate (Stress and Anxiety) and KPI 4.9 Average Acute Daily No Criteria to Reside (NCTR) - East Kent. The remaining red KPIs are currently experiencing either common cause variation or special cause variation (improving).

Variation and Assurance:

32.6 per cent (14) of the KPIs are in special cause variation (improving) with only 4 (9.3per cent) in special cause variation (declining) and the remaining 25 (58.1per cent) in normal variation:

KPI 1.2 health checks is in special cause variation (declining) but still consistently meeting target at 100.3 per cent, KPI 2.15 Friends and Family - per cent who would recommend KCHFT is in special cause variation (declining) but still consistently meeting target, 3.2 Sickness Rate (Stress and Anxiety) has performed near the upper control limit for 4 consecutive months (showing a negative shift) and KPI 4.9 Average Acute Daily No Longer Fit to Reside (NCTR) – East Kent has is experiencing an 8 month period above the mean.

In terms of assurance there are 5 KPIs consistently missing target. KPI 2.12 AHP Access Waiting Times – however in special cause variation (improving), KPI 2.14 Average Length of Community Hospital Inpatient Stay, KPI 3.2 Sickness (Stress), KPI 4.7 No Criteria to Reside in a Community Hospital bed and KPI 4.9 Average Acute Daily No Criteria to Reside (East Kent) both in special cause variation (declining)

Putting Communities First	Variation/Assurance	Consistently Hitting Target	Hit and Miss target	Consistently Missing Target	Trend
	Improving Special Cause Variation	0	2	0	
	Normal Variation	1	5	0	
	Deteriorating Special Cause Variation	1	0	0	
	Trend				

Better Patient Experience	Variation/Assurance	Consistently Hitting Target	Hit and Miss target	Consistently Missing Target	Trend
	Improving Special Cause Variation	5	1	1	
	Normal Variation	1	8	1	
	Deteriorating Special Cause Variation	1	0	0	
	Trend				

Great Place to Work	Variation/Assurance	Consistently Hitting Target	Hit and Miss target	Consistently Missing Target	Trend
	Improving Special Cause Variation	1	2	0	
	Normal Variation	1	2	0	
	Deteriorating Special Cause Variation	0	0	1	
	Trend				

Sustainable Services	Variation/Assurance	Consistently Hitting Target	Hit and Miss target	Consistently Missing Target	Trend
	Improving Special Cause Variation	0	2	0	
	Normal Variation	1	4	1	
	Deteriorating Special Cause Variation	0	0	1	
	Trend				

Performance Vs National Benchmarks (where available):

We are currently adverse to the benchmark in only four KPIs: KPI 2.1 Inpatient Medication Errors per 1,000 bed days (3.1 against 2.8 benchmark), KPI 2.8 2-Hour Crisis Response (85.5 per cent against the benchmark of 86.0 per cent), KPI 2.14 Community Hospital Mean Length of Stay (30.4 days against the benchmark of 29.2 days) and 3.3 Turnover (13.78 per cent against the benchmark of 10.18 per cent).

Items of concern to be brought to the Board's attention:

While KPI 1.2 Health Checks (100.3 per cent) is ahead of trajectory, performance has seen a gradual decline with special cause variation below the mean. Requires continued monitoring and underlying causes and trends analysed to prevent further deterioration.

Significant improvements in matters that were previously an area of concern:

KPI 2.12 AHP Access Waits within 12 weeks continues to show an upward trajectory, with the last 10 months above the mean. This has been facilitated through 12 of 19 services showing an improvement and an average service improvement of 4.5 per cent compared to the same period last year, with some more significant improvements in certain services in the same period:

MSK Physio +32.5per cent, Pulmonary Rehab +21.2per cent, Community Neuro Rehab +17.5per cent, Continence +9.7per cent, West Kent Falls +8.7per cent, and Kent Children's Therapies +8.0per cent.

We have 11 services meeting the 2025/26 92 per cent WeCare target. (of the 19 services measured)

Items of excellence:

The Trust is consistently exceeding trajectory with a key prevention metrics (KPI 1.1 Stop Smoking Quits at 106.7 per cent) and have achieved 102.7 per cent of our activity plan for the year to date (KPI 4.5)

We are performing significantly and consistently better than national benchmarks for KPI 2.6a Adults DNA rate (2.1per cent against 4.0per cent benchmark) and KPI 3.6 Mandatory Training (97.4per cent against 92.7 per cent benchmark).

Additionally, we are showing an 0.1 per cent surplus with our income and expenditure (KPI 4.1), have delivered 98.8 per cent of our year-to-date CIP plan (KPI 4.4), and continue to deliver >80per cent of Urgent Community Responses within 2 hours (KPI 2.8) with demand having increased by >25per cent for the last quarter compared to the same period the previous year.

Report history / meetings this item has been considered at and outcome

This report was shared at the executive team meeting on 07 October 2025.

Recommendation(s)

The Board is asked to

- **Discuss** the report

Link to CQC domain				
☑ **Safe**	☑ **Effective**	☑ **Caring**	☑ **Responsive**	☑ **Well-led**

Assurance level	Reasonable

Implications		
Links to BAF risks / Corporate Risk Register	☐ BAF	☐ CRR
Equality, diversity and inclusion	Yes (provide a brief sentence describing the issue) Ethnicity Appointment from Shortlisting disparity in favour of white candidates White any other background, Mixed, and Asian/Asian British and Black/Black British groups have statistically significantly	

	higher rates of DNAs compared to the White British group in Adult Services. White any other background, Mixed, and Other ethnic groups have statistical significantly higher rates of DNAs compared to the White British group in children services
Legal and regulatory	No

Executive sponsors sign off
Name and designation: Gordon Flack, Chief Finance Officer
Date: 07 October 2025

Integrated Performance Report

2025/26 Month 5 report

October 2025

Overall CQC Rating – Outstanding (July 2019)

Domain	Rating
Safe	Good
Effective	Outstanding
Caring	Outstanding
Responsive	Good
Well-led	Good

Service	Date	Rating
Community health services for adults	2 September 2014	Good
Community health services for children, young people and families	2 September 2014	Good
Community dental services	24 July 2019	Good
Community health inpatient services	2 September 2014	Good
Community end of life care	24 July 2019	Good
Community urgent care services	24 July 2019	Outstanding
Community health sexual health services	24 July 2019	Outstanding

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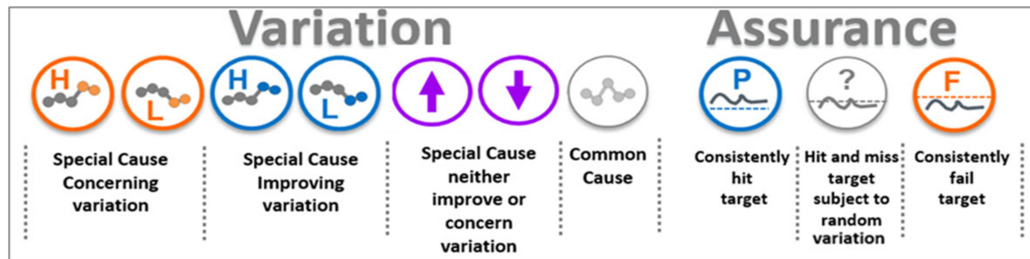
Pages 34-38 – Workforce EDI Summary
Pages 39-40 – Appendix 1 (RTA by Service)



Executive Summary

National Oversight Framework (as at 24th September 2025 – Q1)

Our overall segment is segment **1**, with an average metric score of **1.87 (out of 4)**. This places us **27th out of 205** nationally and **3rd of 28** in the south east region.
For individual domains and metrics we are:

Access to Services (3.15)
Percentage of people waiting over 52 weeks for community services score – 2.43
Annual change in number of children and young people accessing NHS-funded MH services score – 3.87

Note – the Annual change in number of children and young people accessing NHS-funded MH services score metric has been affected by a change in guidance on inclusion of MH diagnostic pathway in national data. The national team have been made aware of this impact on our metric score and we are awaiting feedback.

Effectiveness and Experience of Care (1.71)
Percentage of Urgent Community Response patients seen within two hours score 1.71

Patient Safety (1.1)
NHS Staff Survey - raising concerns sub-score score – 1.1

People and Workforce (1.75)
Sickness absence rate score - 1.85
NHS staff survey engagement theme score - 1.65

Finance and Productivity (1.17)
Planned surplus/deficit score - 1
Relative difference in costs score – 1.35

Executive Summary

Summary

For this report, 25 of the 43 KPIs (three more than last month) are meeting or exceeding target for the month (58%), while 9 KPIs are marginally off target (amber) and a further 9 are further off target (same as the last report). Of the red KPIs, there are only 2 KPIs that are also in special cause variation (declining), which are KPI 3.3 Sickness Rate (Stress and Anxiety) and KPI 4.9 Average Acute Daily No Criteria to Reside (NCTR) - East Kent. The remaining red KPIs are currently experiencing either common cause variation or special cause variation (improving).

	This month		Previous Month	Trend
Targets	43		41	
Met	25	58%	22	
Marginally Off Target	9	21%	10	
Missed	9	21%	9	

Variation

There are 14 metrics with special cause variation (improving), with highlights being sustained improving performance for KPIs 1.3 Health Visiting – Antenatal, 1.4 School Health Year R and Year 6 Height and Weight Screening, 2.5a Inpatient Care Hours Per Patient Day (CHPPD) - Registered Staff, 2.6a Adults DNA Rate, 2.8 % 2 Hour Urgent Community Responses Met, 2.9 MIU 4hr Target, 2.10 Consultant Led 18 week RTT %, 2.11 Consultant-Led RTT Waiting List Size, 2.12 AHP (Non-Consultant Led) Access Waiting Times (12 week target), 3.4 Turnover (Voluntary), 3.6 Mandatory Training, 3.7 Vacancy Rate, 4.2 External Agency Spend % of Pay (Clinical) and 4.8 Average Acute Daily No Criteria to Reside (NCTR) - West Kent.

Putting Communities First

VARIATION \ ASSURANCE	Consistently Hit Target	Hit and Miss Target subject to random variation	Consistently Fail Target
Special Cause Variation (improving)		KPI 1.3 Health Visiting - Antenatal Visits undertaken KPI 1.4 (N) School Health - Year R and Year 6 Children Screened for Height and Weight	
Common Cause Variation	KPI 1.5 Admissions Avoidance (2 Hour Crisis Responses)	KPI 1.1 Stop Smoking - 4 week Quitters KPI 1.6 (N) Percentage of child BCG vaccinations given within 28 days KPI 1.7 (N) Looked After Children - Initial assessments completed within 28 days KPI 1.8 (N) Looked After Children - Review assessments completed within timescale KPI 1.9 (N) Education and Health Care Plan (EHCP) - Completed within 6 weeks	
Special Cause Variation (declining)	KPI 1.2 Health Checks Carried Out		

Better Patient Experience

VARIATION \ ASSURANCE	Consistently Hit Target	Hit and Miss Target subject to random variation	Consistently Fail Target
Special Cause Variation (improving)	KPI 2.6a ADULTS DNA Rate: DNAs as a % of total activity KPI 2.8 (N) % 2 Hour Urgent Community Responses Met KPI 2.9 (N) Total Time in MIUs/UTCs: Less than 4 hours KPI 2.10 (N) Consultant Led 18 Week RTT - Incomplete Pathways KPI 2.11 (N) Consultant Led 18 Week RTT - Waiting List Size (>18 weeks)	KPI 2.5a Inpatient Care Hours Per Patient Day (CHPPD) - Registered Staff	KPI 2.12 AHP (Non-Consultant Led) Access Waiting Times (12 week target)
Common Cause Variation	KPI 2.7 Non-Urgent Response Times Met (%)	KPI 2.1 Inpatient Medication Errors Per 1000 bed days KPI 2.2 Community Medication Errors Per 1000 WTE KPI 2.3 Rate of Injurous Falls per 1000 Occupied Bed Days KPI 2.4 Pressure Ulcers - Lapses in Care KPI 2.5b Inpatient Care Hours Per Patient Day (CHPPD) - Unregistered Staff KPI 2.6b CYP DNA/WNB Rate: DNAs as a % of total activity KPI 2.13 (N) Access to GUM: within 48 hours KPI 2.16 (N) 6 Week Diagnostics (DM01)	KPI 2.14 Average Length of Community Hospital Inpatient Stay (Mean)
Special Cause Variation (declining)	KPI 2.15 (N) Friends and Family - % Patients who would Recommend KCHFT		

A Great Place to Work

VARIATION \ ASSURANCE	Consistently Hit Target	Hit and Miss Target subject to random variation	Consistently Fail Target
Special Cause Variation (improving)	KPI 3.6 Mandatory Training: Combined Compliance Rate	KPI 3.4 Turnover (Voluntary) KPI 3.7 Gross Vacancy Factor (% of the budgeted WTE unfilled)	
Common Cause Variation	KPI 3.5 Stability (% workforce who have been with the trust for >=12mo)	KPI 3.1 Sickness Rate KPI 3.3 Turnover (ALL)	
Special Cause Variation (declining)			KPI 3.2 Sickness Rate (Stress and Anxiety)

Sustainable Care

VARIATION \ ASSURANCE	Consistently Hit Target	Hit and Miss Target subject to random variation	Consistently Fail Target
Special Cause Variation (improving)		KPI 4.2 External Agency spend % of Pay (Clinical) KPI 4.8 Average Acute Daily No Criteria to Reside (NCTR) - West Kent	
Common Cause Variation	KPI 4.5 Community Activity: YTD as % of YTD Plan	KPI 4.1 Income & Expenditure - Surplus (%) KPI 4.3 Staff Bank spend % of Pay (Clinical) KPI 4.4 Cost Improvement Plans (CIP) Achieved against Plan (%) KPI 4.6 Bed Occupancy: Occupied Bed Days as a % of available bed days	KPI 4.7 No Criteria to Reside in a Community Hospital bed as a % of Occupied Bed Days
Special Cause Variation (declining)			KPI 4.9 Average Acute Daily No Criteria to Reside (NCTR) - East Kent

Executive Summary

Benchmarking

Benchmarks are available to give national context to KCHFT performance. The trust are performing **favourably** in KPIs, 2.2 Community Medication Errors per 1000 WTE, KPI 2.3 Rate of Injurous Falls per 1,000 Occupied Bed Days, 2.6a DNA rates for Adults, 2.6b DNA/Was Not Brought for CYP services, 3.1 Sickness Rate, 3.6 Mandatory Training, 3.7 Vacancy Rate, KPI 4.2 External Agency spend % of Pay (Clinical), KPI 4.3 Staff Bank spend % of Pay (Clinical), 4.4 CIP, and 4.6 Bed Occupancy.

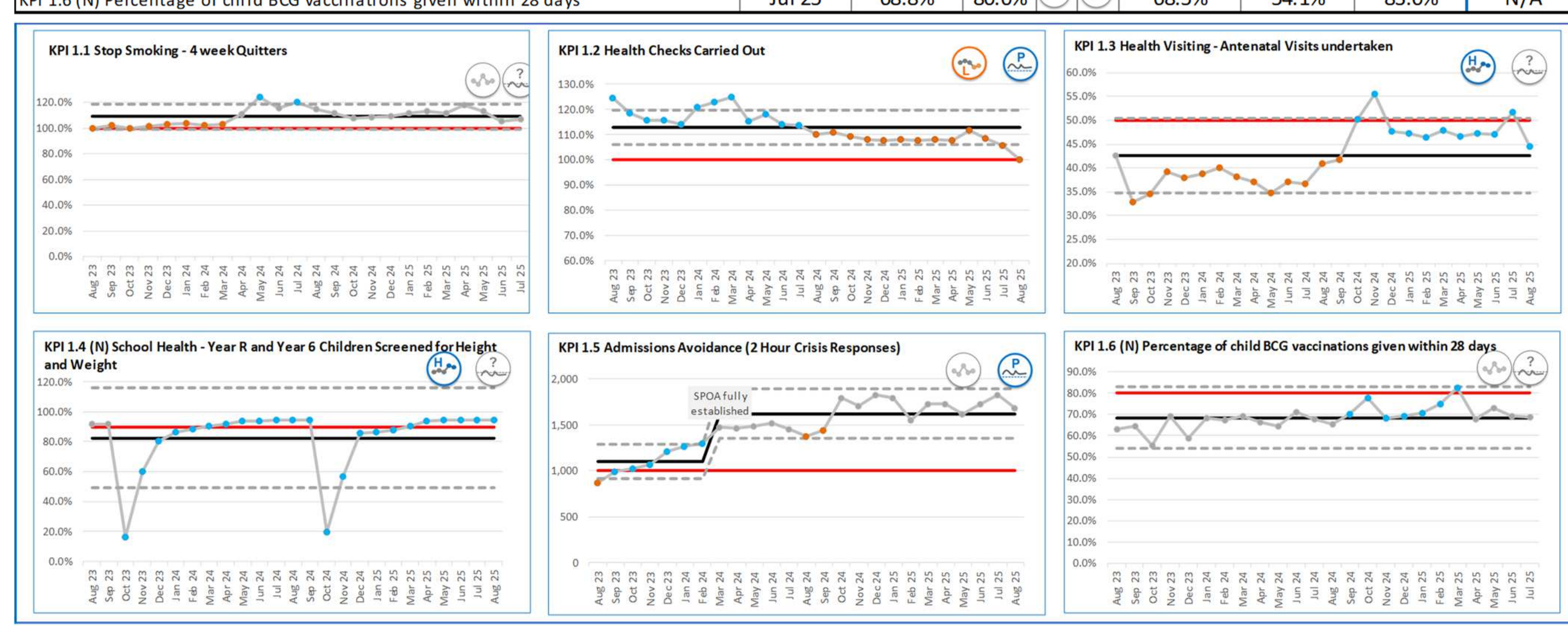
We are currently **adverse** to the benchmark in only four KPIs: KPI 2.1 Inpatient Medication Errors per 1,000 bed days (3.1 against 2.8 benchmark), KPI 2.8 2-Hour Crisis Response (85.5% against the benchmark of 86.0%), KPI 2.14 Community Hospital Mean Length of Stay (30.4 days against the benchmark of 29.2 days) and 3.3 Turnover (13.78% against the benchmark of 10.18%).

National Targets

Indicator	Detail	2025/26 Target	2025/26 Actual (YTD)
National targets	KPI 1.4 School Health - YrR and Yr6 Height and Weight Screening	90%	94.6%
	KPI 1.6 Child BCG Vaccinations given within 28 days	80%	69.7%
	KPI 1.7 Looked After Children Initial Health Assessments	85%	24.9%
	KPI 2.7 2-Hour Urgent Community Response	80%	86.8%
	KPI 2.8 Total Time in MIU/UTCs: Less than 4 hours	95%	99.8%
	KPI 2.9 Consultant Led 18 Week RTT - Incomplete Pathways	92%	99.9%
	KPI 2.12 Access to GUM within 48 hours	100%	100%
	KPI 2.15 6 week Diagnostic Tests (DM01)	95%	79.6%

Putting Communities First

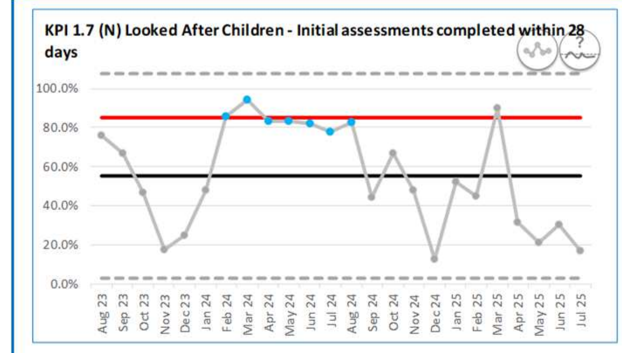
KPI (Variation: Special Cause Concerning variation; Special Cause Improving variation; Special Cause neither improve or concern variation; Common Cause. Assurance: Consistently hit target; Hit and miss target subject to random variation; Consistently fail target)	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit	Benchmark
KPI 1.1 Stop Smoking - 4 week Quitters	Jul 25	106.7%	100.0%			108.8%	99.1%	118.5%	N/A
KPI 1.2 Health Checks Carried Out	Aug 25	100.3%	100.0%			112.9%	106.0%	119.7%	N/A
KPI 1.3 Health Visiting - Antenatal Visits undertaken	Aug 25	44.6%	50.0%			42.6%	34.8%	50.4%	N/A
KPI 1.4 (N) School Health - Year R and Year 6 Children Screened for Height and Weight	Aug 25	94.6%	90.0%			82.6%	49.1%	116.2%	N/A
KPI 1.5 Admissions Avoidance (2 Hour Crisis Responses)	Aug 25	1684	1000			1624	1355	1893	N/A
KPI 1.6 (N) Percentage of child BCG vaccinations given within 28 days	Jul 25	68.8%	80.0%			68.5%	54.1%	83.0%	N/A

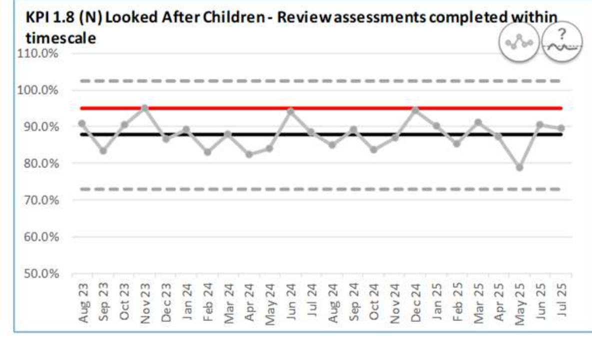


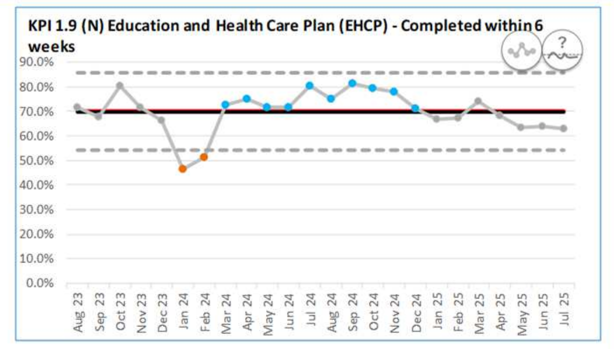
Putting Communities First

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit	Benchmark
KPI 1.7 (N) Looked After Children - Initial assessments completed within 28 days	Jul 25	16.7%	85.0%		?	55.3%	2.7%	107.8%	N/A
KPI 1.8 (N) Looked After Children - Review assessments completed within timescale	Jul 25	89.6%	95.0%		?	87.8%	73.0%	102.6%	N/A
KPI 1.9 (N) Education and Health Care Plan (EHCP) - Completed within 6 weeks	Jul 25	63.1%	70.0%		?	69.9%	54.1%	85.8%	N/A

Variation: Special Cause Concerning variation; Special Cause Improving variation; Special Cause neither improve or concern variation; Common Cause. Assurance: Consistently hit target; Hit and miss target subject to random variation; Consistently fail target.







Putting Communities First Summary

Focus for Improvement Work

KPI 1.3 Health Visiting – Antenatal Visits Undertaken is in special cause variation (improving), showing a sustained level of performance above the mean as a result of the remedial actions implemented by the service. However, the month 5 position has dipped to 44.6% against the 50% target level. While this is likely due to the school holidays, it will be closely monitored. The overall coverage for antenatal (receiving an antenatal contact by the health visiting service OR antenatal information letter) is at 98.0% in month 5 (target 98%)

Although staffing levels remain a challenge (particularly within some of the North/West districts), as a result of the actions being taken as part of the Health Visiting Strategy 2022-2025, turnover rates are a continued downward trajectory which is helping sustain operational metric performance.

KPI 1.6 Percentage of BCG vaccinations given within 28 days is common cause variation and stable, although below the target level (68.8% against target of 80%)

In North Kent, the data shows 72.9% were vaccinated within 28 days and 81.3% vaccinated overall. In East Kent the rates are 65.8% within 28 days and 81.2% vaccinated overall.

The BCG referral process has been successfully automated since August 2024. Service continues to explore other areas that may benefit from automation.

Stable Metrics

KPIs 1.1 Stop Smoking Quits, 1.5 Admissions Avoided and KPI 1.9 EHCP Compliance are showing common cause variation with no current areas of concern.

Putting Communities First Summary

Other variation for highlighting

KPI 1.2 Health Checks Carried out is showing some special cause variation with 43 months marginally below the mean, although this is not a concern. Performance for M5 is 0.3% above the trajectory which is a downturn on previous performance where we had consistently been between 5-10% above trajectory.

KPIs 1.4 School Health Screening is showing special cause variation (improving) as the service has continued to improved and exceeded the 90% school year target at 94.6%

KPI 1.7 Looked After Children Initial Health Assessments - The Looked After Children's (LAC) service is currently operating a wait list for Initial Health Assessments (IHAs), which is because of increased demand mainly due to Unaccompanied Asylum Seeker Children. The service performance in M4 has declined slightly on the previous month to 16.7%. The ICB are cited on the performance against the statutory time frames.

It has been identified that EKHUFT have capacity within their LAC clinics, and it has been agreed that this capacity will be utilised to support the reduction of the waiting lists, and this has resulted in a decrease in the waiting list from 86 children in August to 56 children as of the 26th September 2025.

The service has built trajectory with the increased capacity the service will be compliant with statutory time frames in January 2026, if the referral numbers remain at the current level.

KPI 1.8 Looked After Children Review Health Assessments are at 89.6% in M4 (within expected timeframe), with all children now having been seen. There were 6 non attributable breeches 3 appointment cancelled by carer, 1 late request,1 WNB and 1 delayed due to hospital admission.

Better Patient Experience

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit	Benchmark
KPI 2.1 Inpatient Medication Errors Per 1000 bed days	Aug 25	3.1	2.8			2.9	0.3	5.6	2.8
KPI 2.2 Community Medication Errors Per 1000 WTE	Aug 25	6.8	8.0			7.9	2.3	13.5	14.6
KPI 2.3 Rate of Injurous Falls per 1000 Occupied Bed Days	Aug 25	1.17	1.50			1.45	-0.39	3.30	1.35
KPI 2.4 Pressure Ulcers - Lapses in Care	Aug 25	1	1			2	-3	7	N/A
KPI 2.5a Inpatient Care Hours Per Patient Day (CHPPD) - Registered Staff	Aug 25	4.3	3.5	H	?	3.2	2.8	3.6	N/A
KPI 2.5b Inpatient Care Hours Per Patient Day (CHPPD) - Unregistered Staff	Aug 25	4.6	4.5			4.9	3.5	6.3	N/A

Variation: Special Cause Concerning variation; Special Cause Improving variation; Special Cause neither improve or concern variation; Common Cause
Assurance: Consistently hit target; Hit and miss target subject to random variation; Consistently fail target

KPI 2.1 Inpatient Medication Errors Per 1000 bed days

KPI 2.2 Community Medication Errors Per 1000 WTE

KPI 2.3 Rate of Injurous Falls per 1000 Occupied Bed Days

KPI 2.4 Pressure Ulcers - Lapses in Care

KPI 2.5a Inpatient Care Hours Per Patient Day (CHPPD) - Registered Staff

KPI 2.5b Inpatient Care Hours Per Patient Day (CHPPD) - Unregistered Staff

Better Patient Experience

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit	Benchmark
KPI 2.6a ADULTS DNA Rate: DNAs as a % of total activity	Aug 25	2.1%	3.0%			2.4%	2.1%	2.6%	4.0%
KPI 2.6b CYP DNA/WNB Rate: DNAs as a % of total activity	Aug 25	6.8%	6.5%			7.2%	6.1%	8.3%	7.4%
KPI 2.7 Non-Urgent Response Times Met (%)	Aug 25	82.3%	80.0%			83.7%	80.7%	86.6%	N/A
KPI 2.8 (N) % 2 Hour Urgent Community Responses Met	Aug 25	85.5%	80.0%			83.5%	80.2%	86.8%	86.0%
KPI 2.9 (N) Total Time in MIUs/UTCs: Less than 4 hours	Aug 25	99.7%	95.0%			99.5%	99.0%	99.9%	N/A
KPI 2.10 (N) Consultant Led 18 Week RTT - Incomplete Pathways	Aug 25	99.9%	92.0%			99.8%	99.4%	100.2%	N/A

KPI 2.6a ADULTS DNA Rate: DNAs as a % of total activity

KPI 2.6b CYP DNA/WNB Rate: DNAs as a % of total activity

KPI 2.7 Non-Urgent Response Times Met (%)

KPI 2.8 (N) % 2 Hour Urgent Community Responses Met

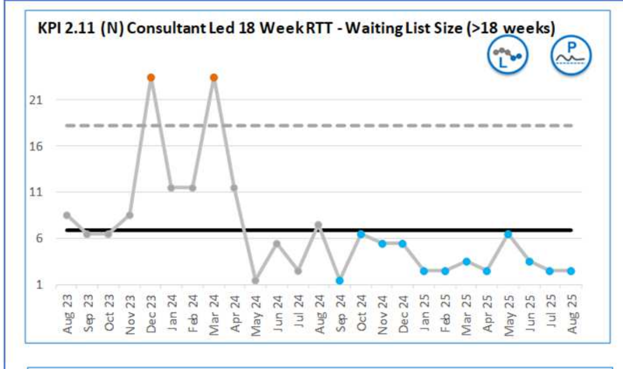
KPI 2.9 (N) Total Time in MIUs/UTCs: Less than 4 hours

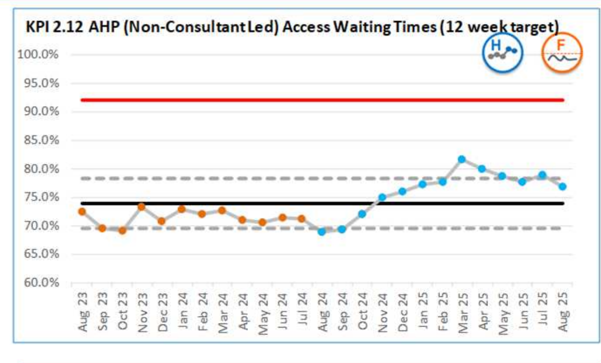
KPI 2.10 (N) Consultant Led 18 Week RTT - Incomplete Pathways

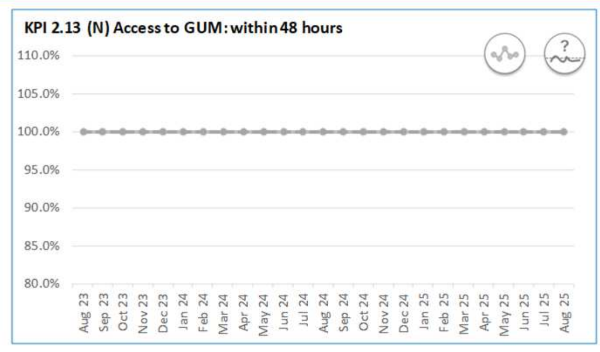
Better Patient Experience

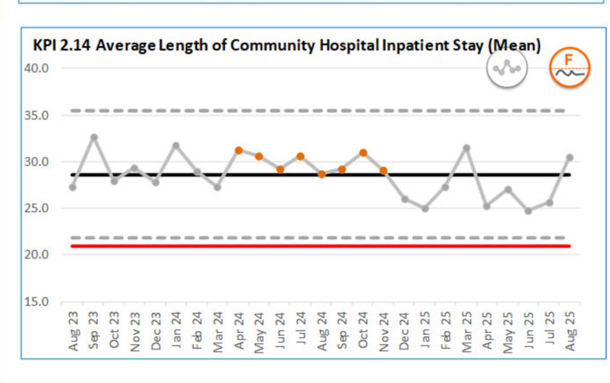
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit	Benchmark
KPI 2.11 (N) Consultant Led 18 Week RTT - Waiting List Size (>18 weeks)	Aug 25	2	100	Special Cause Improving variation (L)	Consistently hit target (P)	6	-5	18	N/A
KPI 2.12 AHP (Non-Consultant Led) Access Waiting Times (12 week target)	Aug 25	76.8%	92.0%	Special Cause Improving variation (H)	Consistently fail target (F)	73.8%	69.5%	78.2%	N/A
KPI 2.13 (N) Access to GUM: within 48 hours	Aug 25	100.0%	100.0%	Common Cause	Hit and miss target subject to random variation (?)	100.0%	100.0%	100.0%	N/A
KPI 2.14 Average Length of Community Hospital Inpatient Stay (Mean)	Aug 25	30.4	21.0	Common Cause	Consistently fail target (F)	28.7	21.8	35.5	29.2
KPI 2.15 (N) Friends and Family - % Patients who would Recommend KCHFT	Aug 25	97.1%	95.0%	Special Cause Concerning variation (L)	Consistently hit target (P)	97.3%	96.2%	98.3%	N/A
KPI 2.16 (N) 6 Week Diagnostics (DM01)	Aug 25	82.9%	95.0%	Common Cause	Hit and miss target subject to random variation (?)	91.2%	78.7%	103.8%	N/A

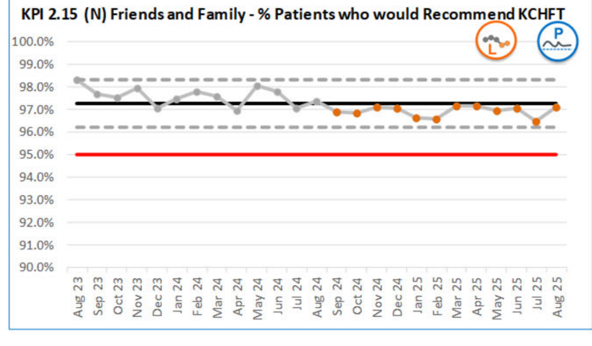
Variation key: Special Cause Concerning variation; Special Cause Improving variation; Special Cause neither improve or concern variation; Common Cause. Assurance key: Consistently hit target; Hit and miss target subject to random variation; Consistently fail target.

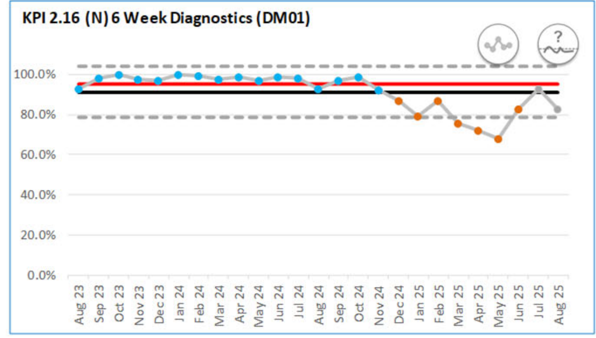












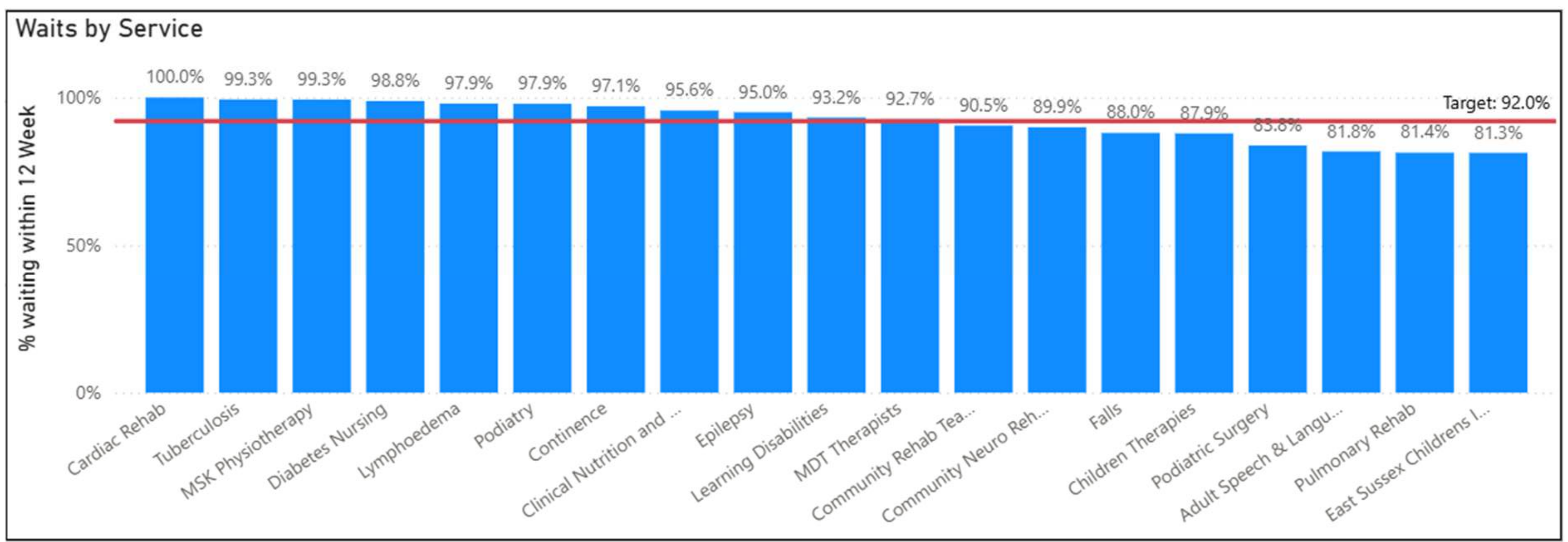
Better Patient Experience Summary

Focus for Improvement Work

KPI 2.6a Adults DNA Rate continues to show special cause variation (improving), predominantly as a result of ongoing targeted improvement work such as use of digital functions such as SMS reminders. This will be further enhanced through the implementation of the NHS App into 2026-27

KPI 2.12 AHP Access Waits within 12 Weeks (%) remains in special cause variation (improving) following a positive performance shift. This metric is a current breakthrough objective (BP1a), with improvement plans ongoing for services to meet the minimum We Care standard: *Services to work towards achieving 92% and above.*

The overall position at service level as at 25th September is 92.9%. This excludes Community Paediatrics which is subject to separate reporting oversight under BP1b (see slide 16). Of the 19 services, 11 are achieving 92%.



Better Patient Experience Summary

Kent Community Health
NHS Foundation Trust

Current Situation – Patient Tracking and wait times

A review the Breakthrough objectives has changed the 12 week KPI to 92% for all services except, Community Paediatrics, by 31st March 2026. The overall target is 92% of first appointments are within the 12 week waiting time to be achieved by 31st March 2026. Current reports show 11 out of 19 services are within target with remaining services within 10% of target. Many services particularly children's services have variation ins activity throughout the year and we are coming out of the summer holidays with staff returning to normal rotas and increasing patient demand.

The Breakthrough Objectives are monitored and supported through the Trust Improvement Board with BP1a and BP1b supported via the Patient Tracker List (PTL) working group which includes Business Managers and Heads of Service. This meets monthly and monitors progress against target. Each service produces an A3 mapping activity against target, risks and obstacles and projections. The group mutually supports learning from successful initiative. Plans are being developed for online learning on the use of PTL for some services.

Focus on specific services continues; Children's Therapies (87.9%) activity has dropped recently due to annual leave and sickness which is now improving; Learning Disabilities (93.2%) has dropped due to data errors which have been corrected, Podiatric Surgery (83.8%) dropped and is improving again due to annual leave in the summer and predicting 93% by October; ASLT (81.8%) is running with vacancies and maternity leave. East Sussex Children's IT&E have pockets of exceeding the 92% target and underachieving in other areas. This is being managed by moving staff with some retraining. They bare predicting an improvement. The 92% RTA target remains with the expectation that improvement will continue; Focus and support is also given to services which have always managed to achieve the 92%+ target. Forward planning and using trajectories should be able to predict when there will be pressure on waiting lists and action can be taken in advance.

The PTL working group is also looking a first to follow up ratios to see if achieving the first appointment targets is at the expense of the follow up appointments. So far early indications is that they are not but further analysis is required to cover all services.

PIFU has been successful in some services in managing demand and test of change on MSK Physiotherapy and Podiatry has shown significant improvement in waiting time s by managing demand. PIFU is being actively developed in other services where it is appropriate.

Better Patient Experience Summary

Current Situation – Patient Tracking and wait times

The key recent areas of learning are;

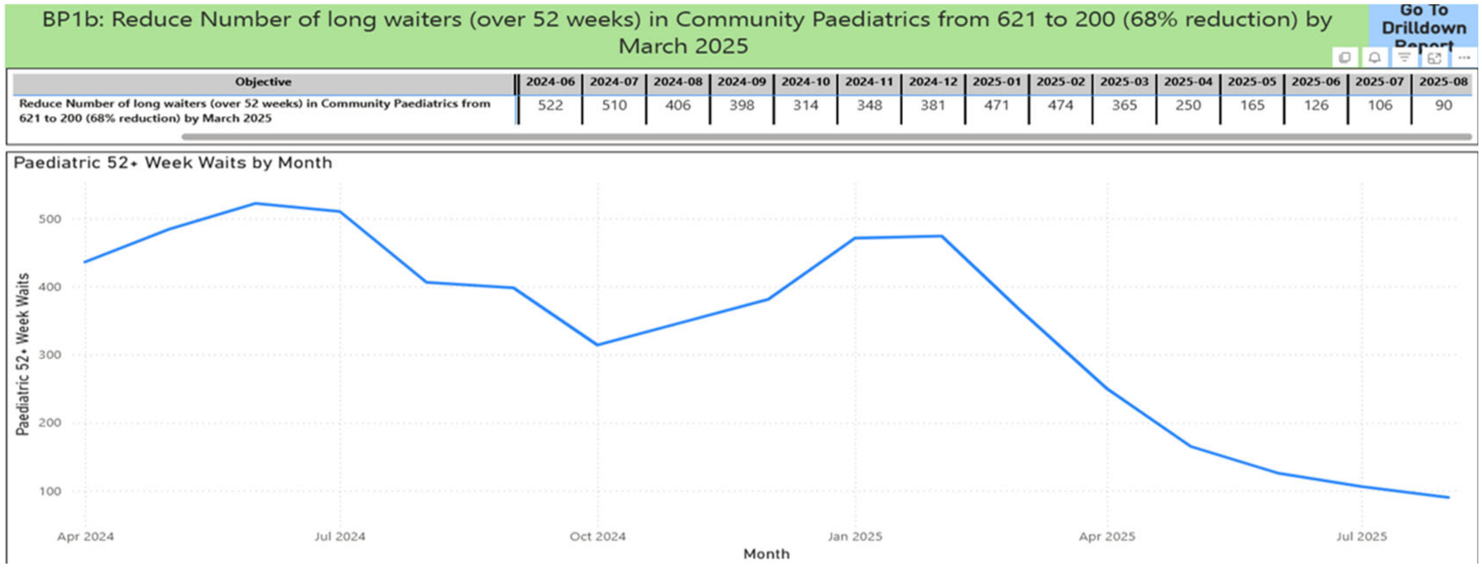
- Continued monthly PTL review meetings to share learning and provide progress on service initiatives and action plans and review progress against objective targets.
- Audit of the use of and roll out of PIFU in suitable services.
- Review and revision of Trust Access Policy against new National Guidance on managing RTT waits in Elective Care.
- Development of on-line internal training on waiting times and PTL for new and existing staff
- Introduction of a community demand/capacity model with job plans being agreed in all services

Better Patient Experience Summary

Community Paediatrics – BP1b

The service focus had been to reduce the number of long waiters (52+weeks) with an improvement trajectory (We Care Breakthrough metric BP1b) target to reduce number of children waiting over 52 weeks to 200 by end of March 2025 which was achieved at the end of May 2025. A new trajectory had been set with the aim to reduce the number of children over 52 weeks to 0 by 31st October 2025. The service remains on track to meet this target. However, there may be a small number just over 52 weeks in November due to WNB/parent cancellations.

The service continues to monitor the number of initial assessment slots available on a weekly basis flexing capacity to meet demand.



BP1b: Reduce Number of long waiters (over 52 weeks) in Community Paediatrics from 621 to 200 (68% reduction) by March 2025

Objective	2024-06	2024-07	2024-08	2024-09	2024-10	2024-11	2024-12	2025-01	2025-02	2025-03	2025-04	2025-05	2025-06	2025-07	2025-08
Reduce Number of long waiters (over 52 weeks) in Community Paediatrics from 621 to 200 (68% reduction) by March 2025	522	510	406	398	314	348	381	471	474	365	250	165	126	106	90

Better Patient Experience Summary

KPI 2.5a Inpatient Care Hours Per Patient Day Care Hours Per Patient Day (CHPPD) - Registered Staff and
KPI 2.5b Inpatient Care Hours Per Patient Day Care Hours Per Patient Day (CHPPD) - Unregistered Staff

Both metrics are above target for the month, with 2.5a (Registered Staff) showing special cause variation (improving) with a significant upward trajectory and the last 3 months above the upper control limit. The combined CHPPD is 8.91 for month 5 (for future reports KPIs 2.5a and 2.5b will be combined into a single metric), which is common cause variation (although the last 8 months have shown an increase).

The increase in CHPPD for registered nurses (RNs) is in line with us increasing our RNs from 2 per day and 2 per night shift to 3 RNs per day on all the wards and 3 RNs per night in all but 4 wards (at Westview and Tonbridge where there are 2 wards on the same site). The below are the fill rates for each hospital.

Aug-25	Registered Staff			Unregistered Staff			Combined CHPPD
	Shift Fill Rate	Planned Hours	Actual Hours	Shift Fill Rate	Planned Hours	Actual Hours	
Victoria Hospital, Deal	99%	2201	2176	80%	2954	2365	8.32
Faversham Cottage Hospital	Closed						
Westview Hospital	92%	1923	1763	114%	1583	1801	8.03
Westbrook House	101%	2192	2216	136%	2767	3768	12.37
QVMH, Herne Bay	107%	2196	2354	100%	1766	1769	9.00
Whitstable & Tankerton Hospital	108%	1956	2117	127%	1887	2394	9.92
Hawkhurst Hospital	98%	2260	2215	107%	2407	2582	7.49
Tonbridge NOF	97%	1808	1749	97%	1744	1696	8.81
Tonbridge Stroke	92%	1984	1833	84%	2449	2060	11.68
ALL Sites	98%	18502	18205	104%	18945	19783	8.91

Victoria Hospital, Deal and Tonbridge Stroke wards planned unregistered staff hours are showing as underfilled, this is due to the ongoing work to align staffing ratios as recommended by the safer staffing report. Both wards have had the correct numbers of staff per shift. Westbrook House and Whitstable & Tankerton Hospital had an increase in patients who required 1:1 enhanced therapeutic observations and care (ETOC) during this period, resulting in showing over 100% fill rates.

Better Patient Experience Summary

Stable Metrics

The following KPIs are all in common cause variation, and either consistently meeting target or subject to random variation.

KPI 2.1 Inpatient Medication Errors Per 1000 bed days, KPI 2.2 Community Medication Errors Per 1000 WTE, KPI 2.3 Rate of Injurous Falls per 1000 Occupied Bed Days, KPI 2.4 Pressure Ulcers - Lapses in Care, KPI 2.6b CYP DNA/WNB Rate: DNAs as a % of total activity, KPIs 2.7 Non Urgent Response Times, and KPI 2.13 (N) Access to GUM: within 48 hours.

KPI 2.14 Average Length of Community Hospital Inpatient Stay (Mean) is in normal variation, however is generally at an elevated level (30.4 days in month 5) and above the target of 21 days. This target is an average as we would expect some rehabilitation placements (such as stroke) to be longer and targeted intervention to facilitate discharge home to be shorter. LOS continues to be impacted by the level of No Criteria To Reside patients within our beds, with the primary driver of these being the availability of social care packages and flow (see page 27 for more detail).

As stated previously, the length of stay has been impacted by the temporary closure of Faversham Cottage which traditionally has had the shortest length of stay and continues to be closely monitored. Additional current challenges include: an increase in the volume of bariatric need, and subsequently complex patients. Extended waits for CHC assessments and outcomes have also been escalated to the ICB.

Other variation for highlighting

2.8 (N) % 2 Hour Urgent Community Responses Met is showing special cause variation (improving), performing above target at 85.5% and continuing to meet target regularly, while **KPI 2.9 (N) Total Time in MIUs/UTCs: Less than 4 hours** is also showing some slight special cause variation (improving) and at 99.7%

KPI 2.10 (N) Consultant Led 18 Week RTT - Incomplete Pathways and **KPI 2.11 (N) Consultant Led 18 Week RTT - Waiting List Size (>18 weeks)** are showing special cause variation (improving) with sustained good performance

Better Patient Experience Summary

Other variation for highlighting

KPI 2.15 (N) Friends and Family - % Patients who would Recommend KCHFT is showing slight special cause variation (declining) following a shift below the mean and is at 97.1% in month 5. However the target level of 95% continues to be achieved consistently.

Response rates continue to be low in some teams, which is affecting the overall levels (and confidence) in the feedback we are receiving. We are working with those services to improve their survey completion rates, by adopting or improving their digital methods (SMS, email, QR codes). Where services have poor FFT responses, this is being highlighted to the teams and providing help to identify where improvements can be made.

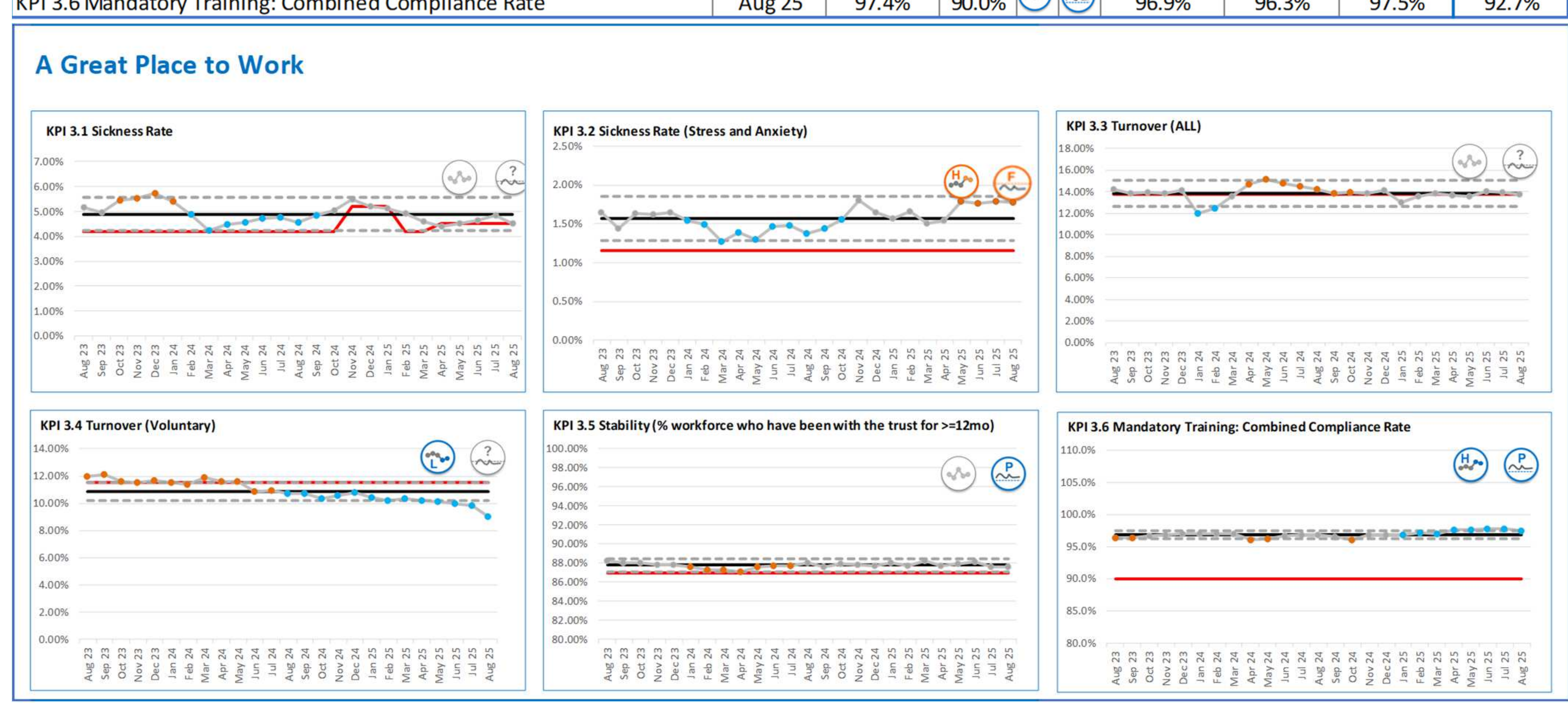
KPI 2.16 6 Week Diagnostics is below the NHSE 95% target compliance, although performance has dipped this month to 82.9%. Due to reduced capacity outside of the services control (Jury Service and maternity leave). There is a requirement of new fit hearing aids need to be fitted with four weeks of diagnosis which had a further impact on capacity.

August Data showed 486 still waiting with 66 breaching, 0 waiting over 12 weeks, longest wait 8.43, average wait 5.71 weeks. 100% of babies were booked with in time frame. Extra resource has been identified for October, and this will support the clearing of the 66 children breaching, resulting in DMO1 recovering by November 2025.

A Great Place to Work

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit	Benchmark
KPI 3.1 Sickness Rate	Aug 25	4.53%	4.52%			4.90%	4.25%	5.55%	5.53%
KPI 3.2 Sickness Rate (Stress and Anxiety)	Aug 25	1.77%	1.15%			1.56%	1.28%	1.85%	N/A
KPI 3.3 Turnover (ALL)	Aug 25	13.78%	13.78%			13.85%	12.67%	15.02%	10.18%
KPI 3.4 Turnover (Voluntary)	Aug 25	9.04%	11.50%			10.87%	10.23%	11.51%	N/A
KPI 3.5 Stability (% workforce who have been with the trust for >=12mo)	Aug 25	87.64%	87.00%			87.77%	87.12%	88.42%	N/A
KPI 3.6 Mandatory Training: Combined Compliance Rate	Aug 25	97.4%	90.0%			96.9%	96.3%	97.5%	92.7%

Variation: Special Cause Concerning variation; Special Cause Improving variation; Special Cause neither improve or concern variation; Common Cause. Assurance: Consistently hit target; Hit and miss target subject to random variation; Consistently fail target.



A Great Place to Work

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit	Benchmark
KPI 3.7 Gross Vacancy Factor (% of the budgeted WTE unfilled)	Aug 25	3.71%	6.00%			6.18%	4.90%	7.46%	4.42%

A Great Place to Work Summary

Focus for Improvement Work

KPI 3.1 Sickness Absence (4.53% in month 5) remains a focus for the Breakthrough objective as a watch metric, with an aim to consistently keep levels to below the revised 4.52% target. The absence level for this month is in common cause variation although marginally above the target level for the month, remaining below the national benchmark of 5.53%. Levels of Stress absence decreased slightly and sit at 1.77%, remaining above target and in special cause variation (declining).

Dedicated resource in the employee relations team provides dedicated support to assist managers with sickness absence management. Additionally, our dedicated therapy role assists with workplace adjustments provision, to reduce sickness and aid swift returns to work where possible. The People team continue to flex to support fragile teams to hold sickness discussions and enable leaders to provide clinical care as part of several measures whilst in business continuity.

In relation to stress absence, several conditions fall into this category and individuals who report this type of sickness are regularly reviewed by the ER team and People & OD Business Partners to ensure all are being managed appropriately and sensitively in line with policy. It is evident that a combination of personal stress factors and workplace contributors, including specific organisational change activity or matters relating to employee relations, are key drivers.

KPI 3.3 Turnover (All), at 13.78%, is showing a decrease this month and is in common cause variation, moving just below the mean. It has also now reached target level (13.78%). A number of organisational factors including ongoing change, TUPE transfer etc are driving this. However, **KPI 3.4 Turnover (Voluntary)** is a breakthrough objective watch metric and continues to show special cause variation (improving), with 13 months consecutively below the mean and performing below the 11.5% target at 9.04%.

Stable Metrics

Stability (KPI 3.5) remains in common cause variation with little month to month variation and no concerns about failing to meet target.

A Great Place to Work Summary

Other variation for highlighting

Mandatory Training (KPI 3.6) continues to perform strongly at 97.4 (target 90%) showing a period of special cause variation (improving) with the last 8 months above the mean.

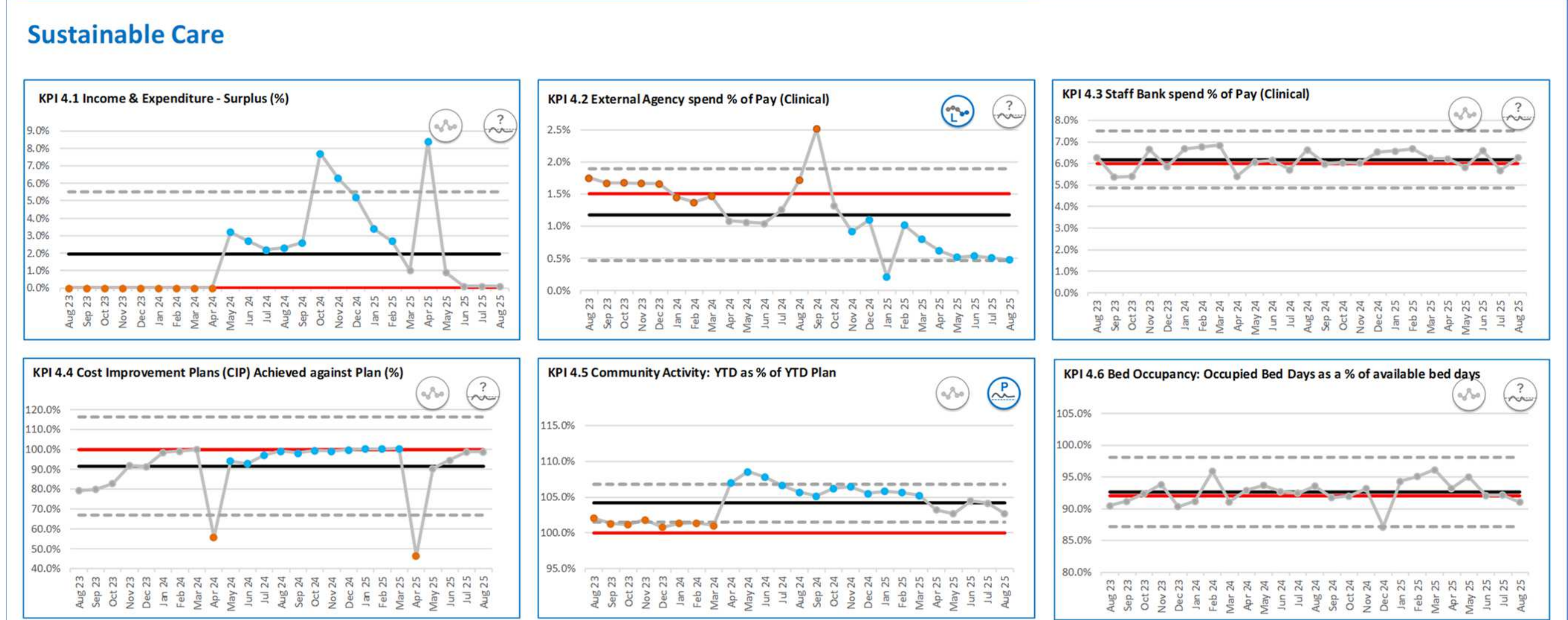
Vacancy Rate (KPI 3.7) is now in special cause variation (improving) as it is showing a shift below the lower control limit in months 1-5. Contracted WTE reduced by 3 WTE to 4,386 in post in August which includes 10 posts funded by capital projects. Vacancies increased to 169 in August (from 161 in July) which was 3.7% of the budgeted establishment. Budgeted establishment increased by 5 WTE from July.

Sustainable Care

Variation: Special Cause Concerning variation; Special Cause Improving variation; Special Cause neither improve or concern variation; Common Cause

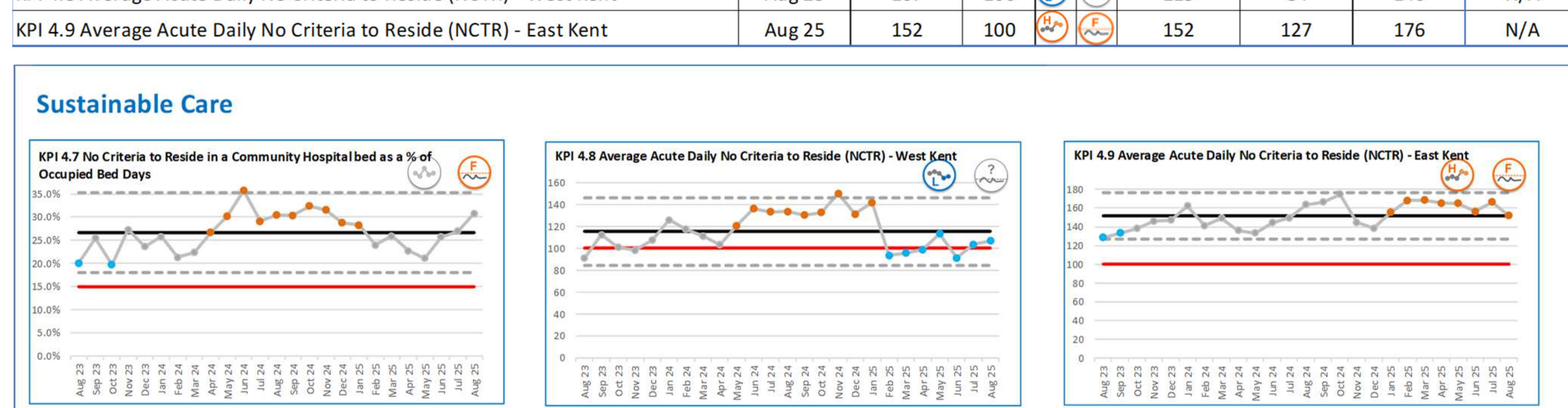
Assurance: Consistently hit target; Hit and miss target subject to random variation; Consistently fail target

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit	Benchmark
KPI 4.1 Income & Expenditure - Surplus (%)	Aug 25	0.1%	0.0%			2.0%	-1.6%	5.5%	N/A
KPI 4.2 External Agency spend % of Pay (Clinical)	Aug 25	0.5%	1.5%			1.2%	0.5%	1.9%	2.1%
KPI 4.3 Staff Bank spend % of Pay (Clinical)	Aug 25	6.3%	6.0%			6.2%	4.9%	7.5%	6.5%
KPI 4.4 Cost Improvement Plans (CIP) Achieved against Plan (%)	Aug 25	98.8%	100.0%			91.6%	67.0%	116.2%	70.7%
KPI 4.5 Community Activity: YTD as % of YTD Plan	Aug 25	102.7%	100.0%			104.2%	101.5%	106.8%	N/A
KPI 4.6 Bed Occupancy: Occupied Bed Days as a % of available bed days	Aug 25	91.0%	92.0%			92.6%	87.1%	98.1%	90.9%



Sustainable Care

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit	Benchmark
KPI 4.7 No Criteria to Reside in a Community Hospital bed as a % of Occupied Bed Days	Aug 25	30.8%	15.0%			26.7%	18.0%	35.3%	N/A
KPI 4.8 Average Acute Daily No Criteria to Reside (NCTR) - West Kent	Aug 25	107	100			115	84	146	N/A
KPI 4.9 Average Acute Daily No Criteria to Reside (NCTR) - East Kent	Aug 25	152	100			152	127	176	N/A



Sustainable Care Summary

Focus for Improvement Work

KPI 4.7 Community No Criteria to Reside (NCTR) is in common cause variation at 30.8% and remains above target level (15%). The east Kent position continues to impact the KCHFT NCTR rate (33.4% compared to 27.9% in west Kent). The NCTR position is largely driven by pressures within social care for packages of care and residential / nursing home placement. There are a small number of Continuing Health Care patients, however delays to DST assessments and decision making is significant.

Additional ad-hoc review of current and impending NCTR patients and twice weekly flow huddles take place to support timely flow and escalation. Flow Matron now attends weekly Transfer of Care Escalation call to escalate delays with KCC and support to expedite delays. Consideration to alternative placement whilst awaiting CHC assessments is also being reviewed. 5 core improvement workstreams are under development with oversight via the internal Flow Improvement Plan and the Flow Operational lead.

An Internal flow improvement plan is in place to focus upon internal operational process efficiencies. In order to provide sustainable improvements to NCTR a test of change business case had been agreed at Trust Board, however implementation has been postponed whilst further discussions are undertaken with the ICB. This is associated to the impact of the temporary Faversham hospital closure. Improvement to length of stay will be tested through the Perfect Ward pilot, implementation pending review of investment.

Sustainable Care Summary

Stable Metrics

KPIs 4.1 Income and Expenditure Surplus - The Trust is in a surplus position of £203k to the end of August once adjusted for £15k of depreciation on donated assets. The surplus position is comprised of underspends on pay and depreciation / interest of £1,188k and £164k respectively partly offset by a an overspend on non-pay of £883k and an under recovery on income of £266k)

4.3 Staff Bank Spend % of Pay (clinical) and 4.6 Bed Occupancy are in common cause variation with little month to month change. However they don't provide full assurance of meeting target given the process control limits are above the target level.

KPI 4.4 CIP is in common cause variation, having achieved CIP savings of £9,095k to the end of August against a plan of £9,208k which is £113k (1.2%) behind target. Of the YTD savings achieved, £6,868k (75%) has been delivered on a non-recurrent basis.

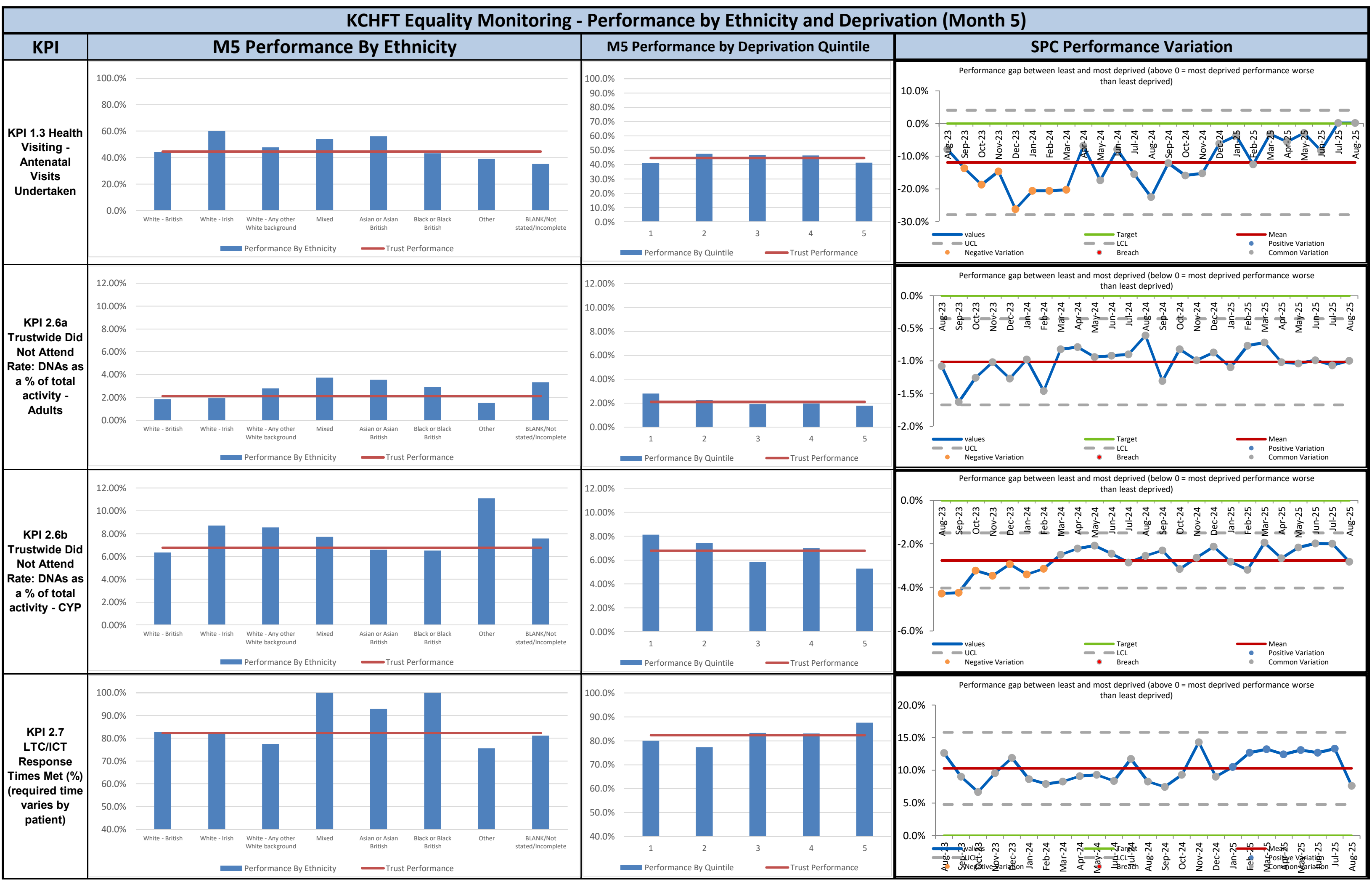
Other variation for highlighting

KPI 4.2 External Agency Spend % of Pay (Clinical) is in special cause variation (improving) following a positive shift below the mean, standing at 0.5% for the month. Of the overall temporary staffing usage in August, £68k related to external agency. The agency ceiling for the month was £176k meaning costs were £108k below the maximum

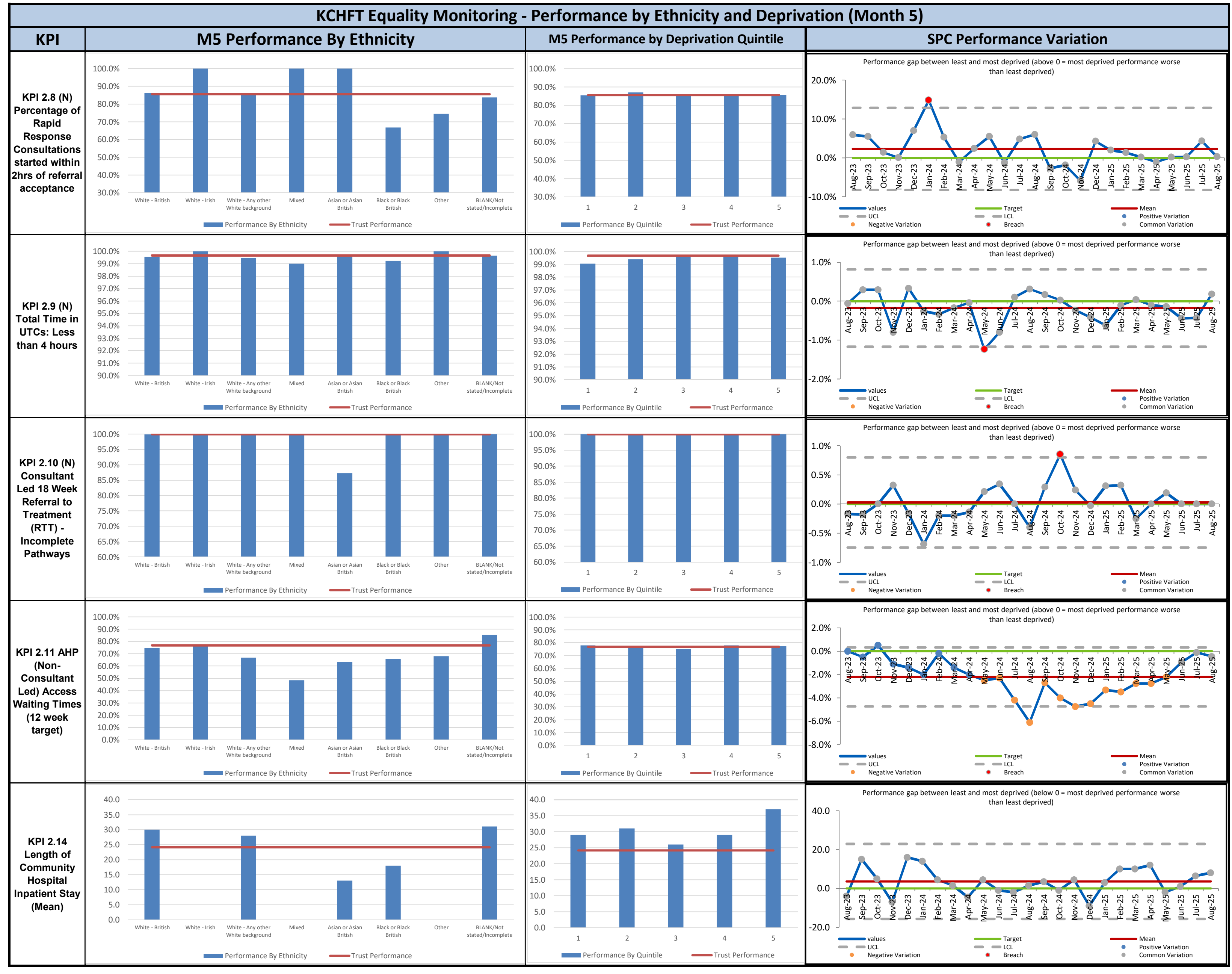
KPI 4.5 Activity levels are in a positive position against the 25/26 plan at 102.7%

KPI 4.9 Acute No Criteria To Reside East Kent is in special cause variation (declining) following an elevated period for the last 8 months and remain above target. We are working with the acute trust and the HCP to improve the integrated discharge function through a series of improvement weeks. **4.8 Acute No Criteria To Reside West Kent is showing** special cause variation (improving) with a sustained improvement period, although still marginally above target.

KCHFT Equality Monitoring - Performance by Ethnicity and Deprivation (Month 5)																		
	KPI 1.3 Health Visiting - Antenatal Visits Undertaken		KPI 2.6a Trustwide Did Not Attend Rate: DNAs as a % of total activity - Adults		KPI 2.6b Trustwide Did Not Attend Rate: DNAs as a % of total activity - CYP		KPI 2.7 LTC/ICT Response Times Met (%) (required time varies by patient)		KPI 2.8 (N) Percentage of Rapid Response Consultations started within 2hrs of referral acceptance		KPI 2.9 (N) Total Time in UTCs: Less than 4 hours		KPI 2.10 (N) Consultant Led 18 Week Referral to Treatment (RTT) - Incomplete Pathways		KPI 2.11 AHP (Non-Consultant Led) Access Waiting Times (12 week target)		KPI 2.14 Length of Community Hospital Inpatient Stay (Mean)	
Trust Performance	44.6%		2.1%		6.8%		82.3%		85.5%		99.7%		99.9%		76.8%		24.1	
Target	50.0%		3.0%		6.5%		80.0%		80.0%		95.0%		92.0%		92.0%		21.0	
Performance by Ethnicity																		
	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	Days	No.
White - British	44.2%	806	1.83%	95270	6.35%	25199	82.7%	1611	86.2%	1248	99.5%	10844	99.9%	1457	74.6%	10064	30.0	117
White - Irish	60.0%	5	1.92%	798	8.70%	125	81.8%	11	100.0%	15	100.0%	13	100.0%	8	77.1%	70	N/A	0
White - Any other White background	47.6%	103	2.77%	1895	8.53%	2022	77.4%	31	85.2%	27	99.5%	361	100.0%	79	66.7%	555	28.0	1
Mixed	53.9%	39	3.73%	528	7.71%	1957	100.0%	5	100.0%	3	99.0%	99	100.0%	27	48.3%	306	N/A	0
Asian or Asian British	56.0%	116	3.53%	1233	6.57%	1897	92.9%	14	100.0%	7	99.6%	452	87.2%	33	63.3%	286	13.0	1
Black or Black British	43.1%	58	2.92%	881	6.51%	1488	100.0%	8	66.7%	3	99.2%	263	100.0%	8	65.5%	232	18.0	1
Other	38.9%	18	1.52%	2864	11.09%	611	75.6%	45	74.4%	43	100.0%	19	100.0%	20	68.0%	25	N/A	0
BLANK/Not stated/Incomplete	35.3%	156	3.31%	19949	7.56%	4024	81.1%	583	83.6%	348	99.6%	267	100.0%	1932	85.3%	4579	31.0	19
% Completeness	**88.0%**	**1301**	**83.8%**	**123418**	**89.2%**	**37323**	**74.7%**	**2308**	**79.5%**	**1694**	**97.8%**	**12318**	**45.8%**	**3564**	**71.6%**	**16117**	**86.3%**	**139**
Performance by Deprivation Quintile																		
	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	Days	No.
Quintile 1 - Most Deprived	41.0%	251	2.79%	18634	8.10%	7660	79.9%	324	85.4%	171	99.0%	1943	100.0%	455	77.8%	2371	29.0	14
Quintile 2	47.4%	249	2.26%	23468	7.41%	7751	77.3%	414	87.0%	285	99.4%	2555	100.0%	629	76.6%	2877	31.0	20
Quintile 3	46.6%	365	1.93%	31476	5.80%	9464	83.3%	633	85.0%	440	99.6%	3062	100.0%	917	75.0%	4112	26.0	35
Quintile 4	46.3%	244	1.96%	29699	6.98%	7170	83.0%	587	85.0%	412	99.6%	2518	99.9%	825	77.8%	3797	29.0	45
Quintile 5 - Least Deprived	41.2%	170	1.79%	19479	5.28%	4530	87.5%	345	85.7%	384	99.5%	1416	100.0%	636	77.3%	2828	37.0	24



KCHFT Equality Monitoring - Performance by Ethnicity and Deprivation (Month 5)
KPI
M5 Performance By Ethnicity
M5 Performance by Deprivation Quintile
SPC Performance Variation
KPI 1.3 Health Visiting - Antenatal Visits Undertaken
KPI 2.6a Trustwide Did Not Attend Rate: DNAs as a % of total activity - Adults
KPI 2.6b Trustwide Did Not Attend Rate: DNAs as a % of total activity - CYP
KPI 2.7 LTC/ICT Response Times Met (%) (required time varies by patient)
White - British
White - Irish
White - Any other White background
Mixed
Asian or Asian British
Black or Black British
Other
BLANK/Not stated/Incomplete
Performance By Ethnicity
Trust Performance
Performance By Quintile
Performance gap between least and most deprived (above 0 = most deprived performance worse than least deprived)
Performance gap between least and most deprived (below 0 = most deprived performance worse than least deprived)
values
Target
Mean
UCL
LCL
Positive Variation
Negative Variation
Breach
Common Variation


KCHFT Equality Monitoring - Performance by Ethnicity and Deprivation (Month 5)
KPI
M5 Performance By Ethnicity
M5 Performance by Deprivation Quintile
SPC Performance Variation
KPI 2.8 (N) Percentage of Rapid Response Consultations started within 2hrs of referral acceptance
KPI 2.9 (N) Total Time in UTCs: Less than 4 hours
KPI 2.10 (N) Consultant Led 18 Week Referral to Treatment (RTT) - Incomplete Pathways
KPI 2.11 AHP (Non-Consultant Led) Access Waiting Times (12 week target)
KPI 2.14 Length of Community Hospital Inpatient Stay (Mean)
White - British
White - Irish
White - Any other White background
Mixed
Asian or Asian British
Black or Black British
Other
BLANK/Not stated/Incomplete
Performance By Ethnicity
Trust Performance
Performance By Quintile
Performance gap between least and most deprived (above 0 = most deprived performance worse than least deprived)
Performance gap between least and most deprived (below 0 = most deprived performance worse than least deprived)
values
UCL
Negative Variation
Target
LCL
Breach
Mean
Positive Variation
Common Variation

Population Equality Summary

KCHFT measures equity by ethnic group and deprivation against 8 key KPIs

Ethnicity Analysis

The proportion of activity which does not have an ethnic group assigned and the small numbers of people in some of the ethnic groupings makes it challenging to assess if there is inequity. The monthly ethnicity reporting rate is now at over 80% and meaningful analysis is possible against a number of the indicators.

Five KPIs have sufficient data for ethnic group:

KPI 1.3 Health Visiting – There were **significantly fewer** antenatal visits undertaken within 14 days for White British compared to Asian/Asian British babies.

KPI 2.6a DNA Rate Adults – White any other, Mixed, Asian/Asian British and Black/Black British patients had **significantly higher** DNA rates compared to White British patients. DNA rates for patients with an ethnic background of Other were **significantly lower** than White British**.**

KPI 2.6b DNA Rate Children – DNA rates for children with White Irish, White any other, Mixed or Other ethnic backgrounds were **significantly higher** compared to White British children.

KPI 2.9 UTC 4 Hour Wait – 97.8% of patients waited in UTCs for less than 4 hours. There were **no statistically significant** differences in this metric between ethnic groups.

KPI 2.11 AHP Access waiting time – The 12 week access target was met for a **significantly lower proportion** of patients with White any other, Mixed, Asian/Asian British, and Black/Black British ethnicity compared to White British.

Population Equality Summary

Deprivation Analysis

KPI 1.3 Health Visiting – There were no statistically significant differences between deprivation quintiles in the proportion of antenatal visits undertaken by 14 days.

KPI 2.6a DNA Rate Adults & 2.6b Children – The DNA rates for people living in the two most deprived quintiles were **significantly higher** than those from quintiles 3 to 5. The variation by month in the difference in DNA rates for people living in the most and least deprived remained within common cause variation limits.

KPI 2.7 LTC/ITC response times met – The proportion of people having their LTC/ITC response times met was significantly lower in those living in the two most deprived quintiles compared to the least deprived quintile. The SPC chart shows the variation in the difference in the % response times met between people living in the least and most deprived areas stayed within common cause variation limits.

KPI 2.8 Rapid Response Consultations – There were **no statistically significant** differences between deprivation quintiles in the proportion of consultations that started within 2 hours.

KPI 2.9 & 2.10 – There were **no statistically significant** differences in KPI 2.8 and 2.9 attainment by deprivation quintile. The monthly variation was within common cause variation limits.

KPI 2.11 AHP Access Waits – A **significantly lower proportion** of patients in quintile 3 met the 12 week access target compared to quintiles 1 and 4. The SPC chart shows that the gap between the most and least deprived quintiles was within common cause variation limits.

KPI 2.14 Mean Length of Community Hospital Inpatient Stay (LOS) – The difference in mean LOS between the most and least deprived quintiles stayed within common cause variation limits, which were very wide due to the small number of people in each category.

Workforce EDI Metrics

Summary

For this report, 3 of the 6 EDI metrics are meeting or exceeding target for the month (50%), while 1 metric is marginally off target (amber) and a further 2 are further off target. Of the red KPIs, there is one KPI that is also in special cause variation (declining) which is Relative Likelihood of white staff being appointed from shortlisting compared to BAME staff. The remaining 5 KPIs are all currently experiencing special cause variation (improving).

	This month		Previous Month	Trend
Targets	6		6	
Met	3	50%	3	
Marginally Off Target	1	17%	1	
Missed	2	33%	2	

Variation

There is one red KPI; % BAME Representation – Non-Clinical Band 8a+ Roles, which is off target but showing special cause variation (improving).

There are a further 4 metrics with special cause variation (improving), with those being Disability Declaration Rate, BAME Voluntary Turnover Rate, Relative Likelihood of non-disabled staff being appointed from shortlisting compared to disabled staff and Relative likelihood of BAME staff entering the formal disciplinary process compared to white staff.

Workforce EDI Dashboard

EDI Dashboard

VARIATION / ASSURANCE	Consisently Hit Target (P)	Hit and Miss Target subject to random variation (?)	Consistently Fail Target (F)
Special Cause Variation (improving) (H, L)	Relative Likelihood of non-disabled staff being appointed from shortlisting compared to disabled staff		Disability Declaration Rates % % BAME Representation - Non-Clinical Band 8a+ roles BAME Voluntary Turnover Rate % Relative Likelihood of BAME staff entering the formal discplinary process compared to white staff
Common Cause Variation			
Special Cause Variation (declining) (H, L)			Relative Likelihood of white staff being appointed from shortlisting compared to BAME staff

Workforce EDI Dashboard

The EDI Dashboard is provided to support the ambitions of the Nobody Left Behind Project.
Explanations of the graphs are as follows:

Disability Declaration Rate: This metric shows the percentage of the trust's total headcount who have declared a disability through the ESR system

% BAME Representation – Non-Clinical Band 8a+ Roles: This metric shows the percentage of staff in non-clinical roles, at a pay band of Band 8a and above, who have declared a BAME ethnicity within ESR.

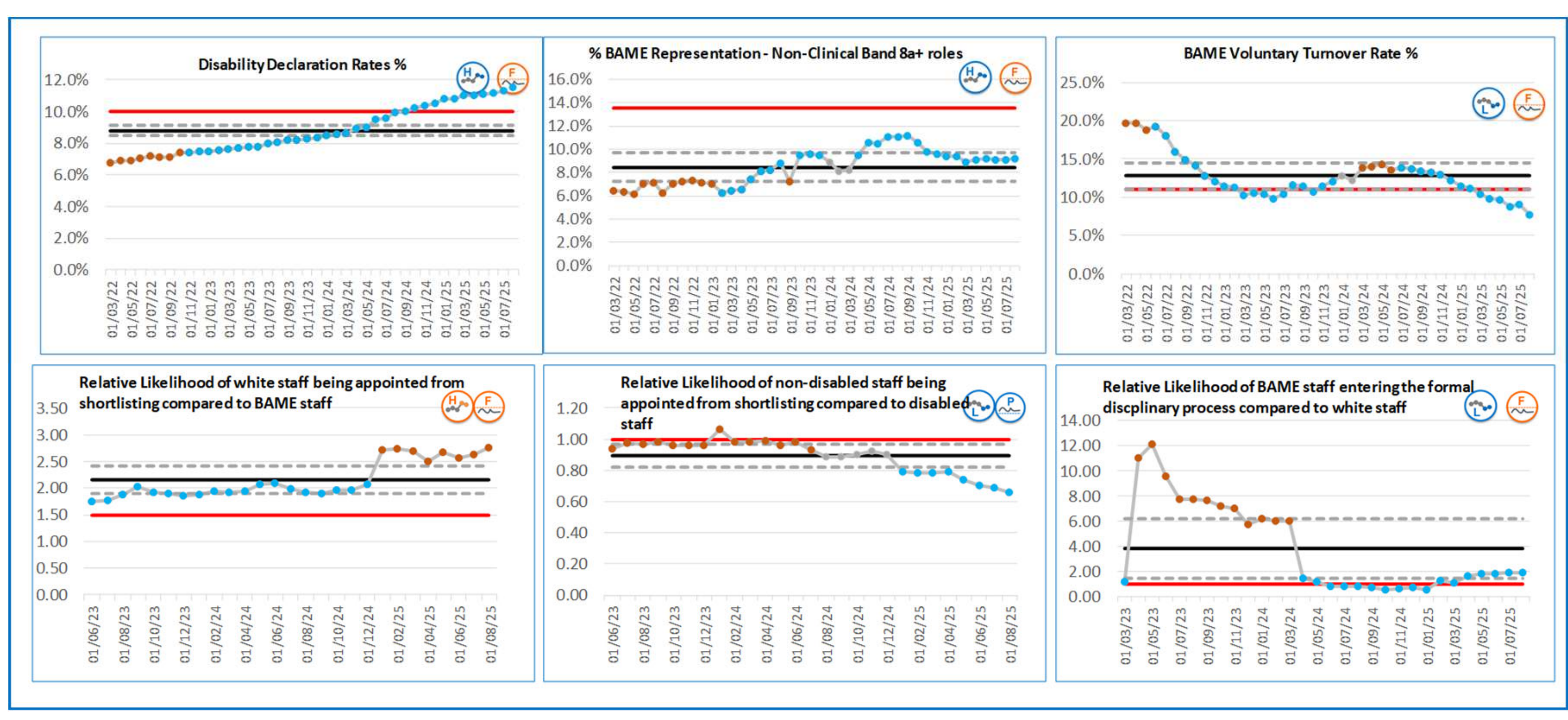
BAME voluntary Turnover Rate %: This metric shows the voluntary turnover rate for BAME colleagues. The metric is calculated by counting the number of BAME colleagues who left the trust for a voluntary reason over the last 12 months and dividing this by the average BAME headcount over that 12 month period.

Relative Likelihood of white staff being appointed from shortlisting compared to BAME staff: This shows the relative likelihood of white applicants being appointed from shortlisting compared to BAME applicants. A figure above 1 indicates that white candidates are more likely than BAME candidates to be appointed from shortlisting.

Relative Likelihood of non-disabled staff being appointed from shortlisting compared to disabled staff: This shows the relative likelihood of non-disabled applicants being appointed from shortlisting compared to disabled applicants. A figure above 1 indicates that non-disabled candidates are more likely than disabled candidates to be appointed from shortlisting.

Relative likelihood of BAME staff entering the formal disciplinary process compared to white staff: This shows the relative likelihood of BAME staff entering the formal disciplinaries compare to white staff. A value above 1 indicates that BAME staff are more likely to enter formal disciplinary proceedings than white staff

Workforce EDI Dashboard



Workforce EDI Dashboard

Disability Declaration Rates %
Disability Declaration Rates % - 11.5% [0.2% positive change month / month]

%BAME Representation – Non-Clinical Band 8a+ roles
% BAME Representation - Non-Clinical Band 8a+ roles – 9.2% [0.1% positive change month / month]

BAME Voluntary Turnover Rate % (2023-24 target, BAME voluntary turnover rate = White voluntary turnover rate)
BAME Voluntary Turnover Rate % - BAME Voluntary Turnover Headcount/BAME Average Headcount = 7.8% [1.2% improvement (decrease) month / month, positive]

Relative Likelihood of white staff being appointed from shortlisting compared to BAME staff
Relative Likelihood of White staff being appointed from shortlisting compared to BAME staff = 2.75 [0.13 point worsening month / month]

Relative Likelihood of non-disabled staff being appointed from shortlisting compared to disabled staff
Relative Likelihood of Non-Disabled Staff being appointed from shortlisting compared to Disabled staff = 0.66 [0.03 point change in favour of interviewees with disabilities]

Relative likelihood of BAME staff entering the formal disciplinary process compared to white staff
Relative Likelihood of BAME Staff entering formal disciplinary process compared to White staff = 1.90 [0.01 point improvement month / month]

Appendix 1: RTA By Service

Clinical Nutrition and Dietetics

Diabetes

Epilepsy

Cardiac Rehab

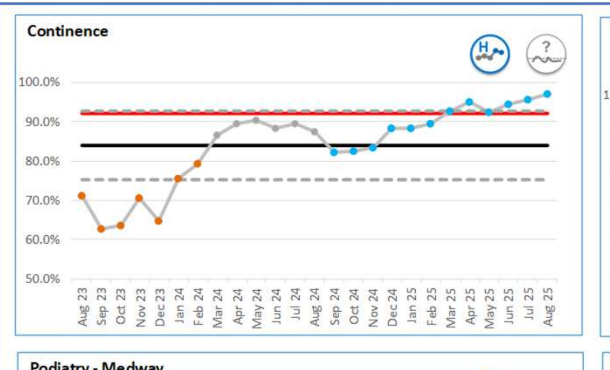
Pulmonary Rehab

Adult Speech and Language Therapy

Lymphoedema

West Kent Falls

Community Neuro Rehab Team


Continence
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
Aug 23
Sep 23
Oct 23
Nov 23
Dec 23
Jan 24
Feb 24
Mar 24
Apr 24
May 24
Jun 24
Jul 24
Aug 24
Sep 24
Oct 24
Nov 24
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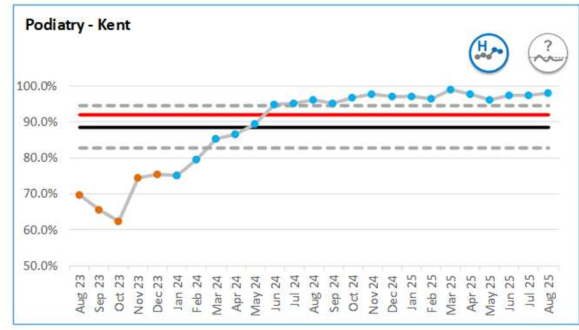
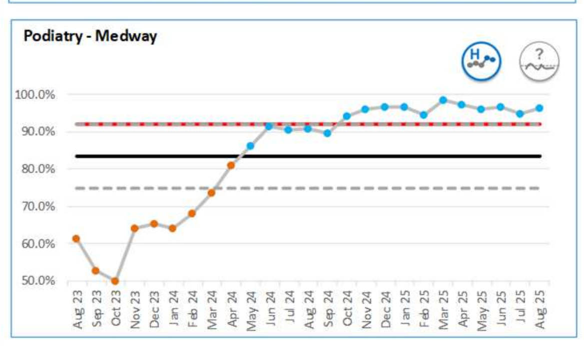
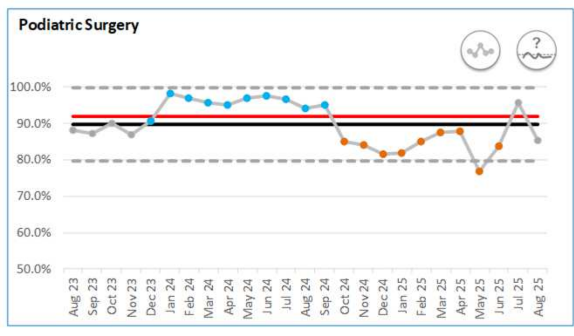
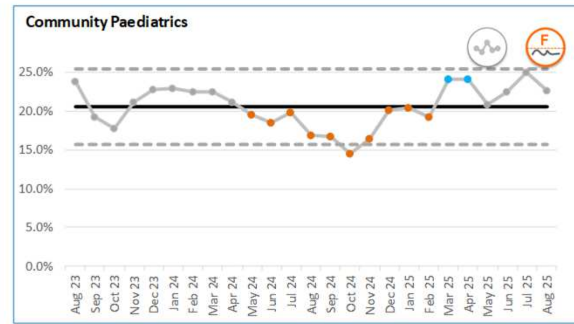
Jan 25
Feb 25
Mar 25
Apr 25
May 25
Jun 25
Jul 25
Aug 25

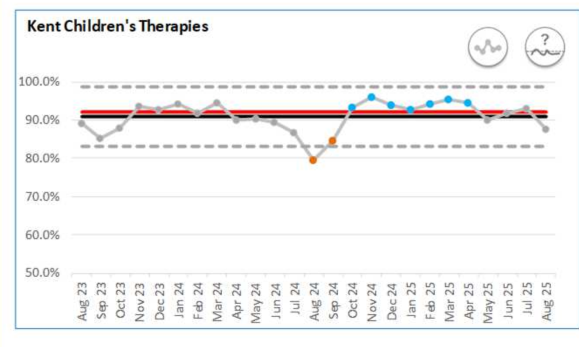
MSK Physio

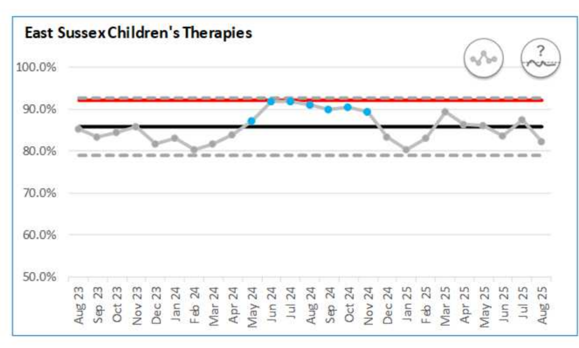

Podiatry - Kent

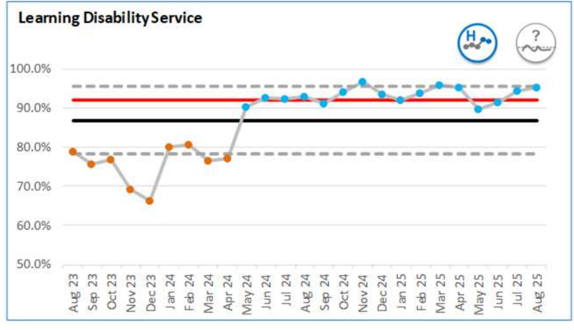

Podiatry - Medway

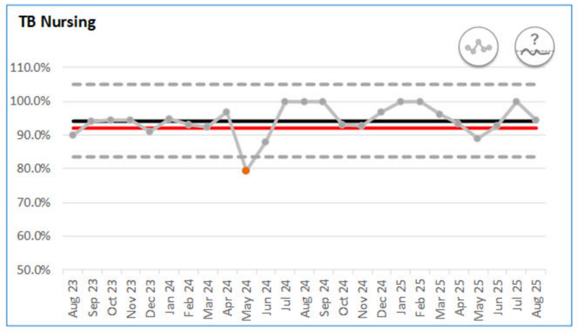

Podiatric Surgery


Community Paediatrics


Kent Children's Therapies


East Sussex Children's Therapies


Learning Disability Service


TB Nursing

Front Sheet – Workforce Race Equality Standard and Workforce Disability Equality Standard report 2025

This paper outlines the journey and findings of the Workforce Race and Disability Equality Standard returns for the year 2024/25.

Meeting:	Board Meeting - Part 1 (Public)
Date of meeting:	15 October 2025
Agenda item no:	Item 15
Report title:	Workforce Race Equality Standard and Workforce Disability Equality Standard report
Executive sponsor(s):	Victoria Robinson-Collins, Chief People Officer
Report author(s):	Hasan Reza, Head of Workforce Equity, Diversity, Inclusion, Health & Wellbeing
Action this paper is for:	Noting
Public/non-public	Public

Executive summary
Overview of paper Per the public sector equality duty and related legislation KCHFT is required to submitted returns as part of the annual Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data collections by the 31 May. Thereafter KCHFT is required to develop a dedicated report for each standard providing analysis and narrative for the individual metrics alongside a proposed plan of action to address inequities realised therein. The underlying data, reports and action plans have to various committees and groups as outlined beneath where they have been reviewed in-depth and approved. They will now be uploaded to our public website before the 31 October 2025 national deadline. **Items of concern to be brought to the Board's attention:** As outlined to Board members in May 2025 there are areas in both reports where the Trust has either slipped year on year or has further work that will support improvement. Plans to address these have been incorporated into the action plans that were approved at August's People Committee and make up our wider Nobody Left Behind Action Plan (our internal, central point of information for all EDI actions). The EDIH&Wb team will support the Executive Team in ensuring we are true and honest in our own reflections of the areas that we need to continue to progress. Of major concern was the high levels of discrimination and unwanted behaviour from members of the public being reported by

colleagues. The team has been involved in the development of the Trust's new managing unacceptable behaviours policy which we hope will address these experiences and enable colleagues to ensure they do not have to tolerate said behaviours. We will be supporting colleagues to ensure they feel able to access the support and systems created as a result of this new policy and not tolerate what they have previously seen as "part of the job". However, we are also cognisant that local, national and international events have a significant impact on the experience of our colleagues and are not factors that the Trust or we as a team have any influence over. As a result, we may not see a decrease in reported incidents via Staff Survey results – which has to date been our primary port of data collection for these findings – but we are hopeful that we can evidence a greater level of reports coming through the new managing unacceptable behaviours policy and evidence the issuances of both yellow and red cards. Unfortunately, August 2024 and September 2025 are poignant reminders of how challenging the discourse remains and how much of this is in turn felt by our workforce.

Significant improvements in matters that were previously an area of concern:

These were also outlined in previous reports bought to the aforementioned committees and the Board earlier in the year but, in summary, there has been a particularly positive improvement in the belief of our progression and promotion processes being fair for the first time since 2018.

Items of excellence:

Our workforce remains an example of true diversity excelling against the local population demographics both for ethnicity and disability. We continue to see an increase in disability declaration every month, indicative of the culture change that has occurred at KCHFT. Our Chief People Officer, Head of EDIH&Wb and colleagues are clear in the ambitions we have to be an anchor organisation within Kent for inclusion and diversity.

Report history / meetings this item has been considered at and outcome

The data which forms submission 1 of the WRES / WDES annual process was presented to the Executive Team and then Board in April and May 2025. After this was signed off, reports and action plans were produced that were consulted on with our Staff Networks, Health and Wellbeing Champions, People Directorate colleagues and other key stakeholders. Once these reports and action plans were finalised, they were sent for approval first to the Executive Team in July / August 2025 followed by the People Committee in August 2025. This submission to the Board is now the final step prior to publication on our public website which will ensure our compliance with the public sector equality duty (PSED) mandate.

Board members can access the full reports and action plans in the BoardEffect library.

The EDIH&Wb team would like to thank all partners who have supported in the production, review and development of these reports and action plans. The annual WRES and WDES process provides significant assurance to us and the key stakeholders we support, such as our Staff Networks, that the KCHFT Executive and Board take matters of equity, diversity, inclusion, health and wellbeing seriously and give them the utmost priority.

Recommendation(s)
The Board is asked to • **Note** the report

Link to CQC domain				
☑ **Safe**	☐ **Effective**	☑ **Caring**	☑ **Responsive**	☑ **Well-led**

Assurance level	Significant

Implications		
Links to BAF risks / Corporate Risk Register	☑ BAF	☐ CRR
Equality, diversity and inclusion	Yes (provide a brief sentence describing the issue) Compliance with PSED and Equality legalisation	
Legal and regulatory	Please choose: Yes or No Compliance with PSED and Equality legalisation	

Executive sponsors sign off
Name and designation: Victoria Robinson-Collins, Chief People Officer
Date: 16 September 2025

Standing Financial Instructions and Scheme of Delegation

The Standing Financial Instructions (SFIs) and Scheme of Delegation (see Appendix 1) were reviewed at the October 2025 Audit and Risk Committee for oversight prior to going to the Board for final approval on 16 October 2025.

Meeting:	Board Meeting - Part 1 (Public)
Date of meeting:	15 October 2025
Agenda item no:	Item 16
Report title:	Standing Financial Instructions and Scheme of Delegation
Executive sponsor(s):	Gordon Flack, Chief Finance Officer
Report author(s):	Gordon Flack, Chief Finance Officer
Action this paper is for:	Approval
Public/non-public	Public

Executive summary

Overview of paper

The Standing Financial Instructions (SFIs) and Scheme of Delegation (see Appendix 1) are reviewed annually and were presented to the Audit and Risk Committee for oversight prior to going to the Board for final approval on 16 October 2025.

The amendments made to the SFIs and Scheme of Delegation since the Board's last approval in October 2024, are presented in Appendix 2, and Appendix 3 respectively.

The amendments to the SFIs in the main follow updates required in response to the introduction of the Procurement Act 2023, and other procurement guidance.

The one change to the Scheme of Delegation is an update in the narrative and approvals limits (for capital schemes up to £999,999) to align with the current process which has been in operation and followed by the Integrated Management Meeting since its introduction during last financial year.

Board members can access the Standing Financial Instructions and the Scheme of Delegation (referenced as Appendix 1) in the BoardEffect library. Appendix 2 and 3 are the supporting papers and are included in the boardpack.

Items of concern to be brought to the Board's attention: None

Significant improvements in matters that were previously an area of concern: N/a

Items of excellence: N/a

Report history / meetings this item has been considered at and outcome
SFIs and Scheme of Delegation were presented at the Audit and Risk Committee on 06 October 2025 for oversight prior to Board approval.

Recommendation(s)
The Board is asked to **APPROVE** the report.

Link to CQC domain				
☐ **Safe**	☐ **Effective**	☐ **Caring**	☐ **Responsive**	☑ **Well-led**

Assurance level	Significant

Implications		
Links to BAF risks / Corporate Risk Register	☐ BAF	☐ CRR
Equality, diversity and inclusion	No	
Legal and regulatory	Yes (provide a brief sentence describing the issue) NHS mandated guidance for SFIs and Scheme of Delegation to be in place and regularly reviewed.	

Executive sponsors sign off
Name and designation: Gordon Flack, Chief Finance Officer
Date: 06 October 2025

Change	Section	Details of Change	Previous Text	Revised Text
1	Tendering and Contracting - 7.1	Narrative updated to align with current terminology and guidance	7.1 - The procedure for making all contracts by or on behalf of the Trust shall comply with the SOs and these SFIs.	7.1 - The procedure for making all contracts by or on behalf of the Trust shall comply with the SOs and these SFIs. The Trust will also comply with the Cabinet Office spend controls, and any other national instructions where applicable, and endeavour to use only accredited framework providers approved by NHS England with consideration for Activity-Based Income percentages (ABI) charged.
2	Tendering and Contracting - 7.2	Narrative updated to align with current terminology and guidance	7.2 - The procurement regulations (2015 to 2023) and The Provider Selection Regime prescribe the procedures for awarding all forms of contracts and shall have effect as if incorporated in the SOs and these SFIs.	7.2 - The Procurement Regulations 2024, the Procurement Act 2023, and The Provider Selection Regime prescribe the procedures for awarding all forms of contracts and shall have effect as if incorporated in the SOs and these SFIs.
3	Tendering and Contracting - 7.8.7	Word "consultants" replaced by "supplier".	7.8.7 - when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;	7.8.7 - when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging a different supplier for the new task would be inappropriate;
4	Tendering and Contracting - 7.9	Word "consultant" replaced by "supplier".	7.9 - The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure (see 7.8.7 above).	7.9 - The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a supplier originally appointed through a competitive procedure (see 7.8.7 above).
5	Tendering and Contracting - 7.9.15	Narrative updated to add further guide	7.9.15 - where the trust needs to buy original manufacturer's parts e.g. for dental equipment and we can't reasonably run a procurement as there is potentially only one provider	7.9.15 - where the trust needs to buy original manufacturer's parts e.g. for dental equipment and are unable to run a reasonable procurement process as there is potentially only one provider or the manufacturer can supply the products at a significantly better price than alternative third-party sources.
6	Tendering and Contracting - 7.9.16	Section added to provide additional criteria when a requirement for a Single Tender Waiver will be deemed exempt.		7.9.16 - where there is intra-NHS Trust spend and this is either covered by the Provider Selection Regime or is a horizontal arrangement in the Procurement Act 2023. The Horizontal Arrangement exemption is set out in paragraph 3 of Schedule 2 to the Procurement Act 2023. It provides an exemption from the procurement rules for "horizontal arrangements" between two contracting authorities which have been entered to achieve common objectives related to the authorities' public functions, and entered solely in the public interest, in which no more than 20% of activities under the arrangement are to be carried out for purposes other than those relating to the authorities' public functions.
7	Tendering and Contracting - 7.11	Narrative updated to align with current terminology and guidance	7.11 - In line with the Department of Health and Social Care procurement transparency guidance, the Trust shall ensure that all contract opportunities with a contract value of £30,000 and over are advertised on the national Contracts Finder portal and the Government's Find a Tender service. For contract opportunities with a contract value under £30,000, the Trust shall ensure fair and adequate competition by selecting a sufficient number of suppliers, and in no case less than 2 suppliers for evaluation, having regard to their capacity to supply the goods or materials or to undertake the services or works required. In circumstances where only one bid is received, this will be deemed acceptable if the appropriate processes have been adhered i.e. the contract opportunity was advertised to more than one supplier and the bid is evidenced as representing value for money.	7.11 - In line with the Procurement Act 2023, the Trust shall ensure that all contract opportunities with a contract value above the current threshold of £139,688 (1st January 2024 to 21st December 2025) for goods and services is advertised on the Government's central digital platform (Find a Tender service). This value is adjusted every 2 years for inflationary and currency fluctuations etc, and there are higher values to be considered for capital works and light touch services. The value is fully inclusive of VAT. The Trust's Procurement team will provide further advice on values in accordance with the latest guidance as and when required. When assessing for contract opportunities with a contract value over £10,000, the Trust shall ensure fair and adequate competition by selecting a sufficient number of suppliers, and in no case less than 2 suppliers for evaluation, having regard to their capacity to supply the goods or materials or to undertake the services or works required. The Trust will publish the relevant award notice for contracts over £12,000. In circumstances where only one bid is received, this will be deemed acceptable if the appropriate processes have been adhered i.e. the contract opportunity was advertised to more than one supplier and the bid is evidenced as representing value for money or if multiple suppliers have been given an opportunity to submit a proposal.

Change	Section	Details of Change	Previous Text	Revised Text
8	Tendering and Contracting - 7.12.1.1	Additional reference now made to the Modern Day Slavery Act 2015	7.12.1.1 - Suppliers awarded contracts shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person and shall act in accordance with the law and for the avoidance of doubt this includes all relevant employment legislation and guidance and the Bribery Act 2010.	7.12.1.1 - Suppliers awarded contracts shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person and shall act in accordance with the law and for the avoidance of doubt this includes all relevant employment legislation and guidance, and the Bribery Act 2010, and the Modern Day Slavery Act 2015.
9	Tendering and Contracting - 7.15.1	Reference to Procurement Team updated to add further guide	7.15.1 - If for any reason the designated Officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive or his Nominated Officer.	7.15.1 - If for any reason the Procurement Team and other designated Officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive or his Nominated Officer.
10	Tendering and Contracting - 7.18.1	Narrative updated to add further guide	7.18.1 - Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed £10,000 but not £50,000. Also see section 7.11 with regards to advertising contract opportunities in excess of £30,000.	7.18.1 - Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed £10,000 but not £50,000. Also see section 7.11 with regards to publishing contract award notices above £12,000.
11	Non-pay expenditure - 10.7.5.12	Reference to credit card records added	10.7.5.12 - petty cash records are maintained in a form as determined by the Chief Finance Officer.	10.7.5.12 - petty cash, and credit card records are maintained in a form as determined by the Chief Finance Officer.
12	Stores and Receipt of Goods - 14.8	Narrative updated to add further guide	14.8 - For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note and ensure that the goods have been received before accepting the recharge.	14.8 - For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note and ensure that the goods have been received. Any goods not received or received in a damaged condition should be notified to NHS Supply Chain immediately.
13	Information Technology - 16.5	Narrative updated to add further guide	16.5 - The Chief Finance Officer shall ensure that contracts for computer services for financial applications with another health service body or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes. Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.	16.5 - The Chief Finance Officer shall ensure that contracts for computer services for financial applications with another health service body or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage and detail the arrangements around exit from the contract. The contract should also ensure rights of access for audit purposes. Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

Change	Section	Details of Change	Previous Text		Revised Text	
1	Capital Investment	Narrative and approvals updated to align with current practice	Capital Scheme Approval Limits (on receipt of a business case approved by Head of Service);		Capital Scheme Approval Limits (on receipt of a business case approved by Head of Service);	
			- Up to £100,000	Integrated Management Team	- Estates or Digital schemes - up to £100,000	Director of Estates or Director of Digital and Analytics, and noted at Integrated Management Team
			- up to £999,999	Capital Steering Group	- All other minor schemes and equipment purchases - up to £100,000	Integrated Management Team
					- All capital schemes – from £100,001 to £999,999	Integrated Management Team (with technical and advisory oversight from Capital Steering Group)

Front Sheet – Medical appraisal and revalidation annual report for appraisal year 2024/2025

This report provides a summary of the policies and systems in place within Kent Community NHS Foundation Trust (KCHFT) to meet the requirements of medical revalidation.

Meeting:	Board Meeting - Part 1 (Public)
Date of meeting:	15 October 2025
Agenda item no:	Item 17
Report title:	Medical appraisal and revalidation annual report for appraisal year 2024/25
Executive sponsor(s):	Sarah Phillips, Chief Medical Officer
Report author(s):	Dr Sati Lall, Associate Medical Director
Action this paper is for:	Approval
Public/non-public	Public

Executive summary

Overview of paper:
This report provides a summary of the policies and systems in place within Kent Community NHS Foundation Trust (KCHFT) to meet the requirements of medical revalidation.

The purpose of this annual report is to provide assurance to the Board and is mandated by NHS England.

Items of excellence:
There has been an increase in trained active appraisers in 2024/25 from 10 to 13. A further one has been recruited and trained, taking the number of active appraisers from 10 to 14 for the appraisal period 2024/25. Qualitative feedback from doctors on the quality of the appraisals is excellent, with no negative comments received this year.

A new appraiser mentoring scheme has been introduced. In addition, an appraisal for appraisers is undertaken by the Lead Appraiser.

We have also increased the number of Structured Service Feedback Forms (SSFF) from 65 percent return to 89.1 percent. The supports a robust appraisal to ensure Scope of Practice and concerns are discussed.

Report history / meetings this item has been considered at and outcome
The report was approved at People committee in August 2025.

Recommendation(s)
The Board is asked to: • **note** the annual report, this will be shared with the higher-level responsible officer and to consider any needs/resources required. *This is included in the boardpack* • **approve** the "NHS England Designated Body Annual Board Report and Statement of Compliance, Annex A", confirming that the organisation, as a designated body, follows the relevant regulations. *Board members should access this document in the BoardEffect library.*

Link to CQC domain				
☑ **Safe**	☐ **Effective**	☐ **Caring**	☐ **Responsive**	☑ **Well-led**

Assurance level	Significant

Implications		
Links to BAF risks / Corporate Risk Register	☐ BAF	☐ CRR
Equality, diversity and inclusion	No	
Legal and regulatory	No	

Executive sponsors sign off
Name and designation: Sarah Phillips, Chief Medical Officer
Date: 03 October 2025

MEDICAL APPRAISAL AND REVALIDATION ANNUAL REPORT FOR APPRAISAL YEAR 2024/25

Situation

Doctors must be registered with a licence to practise with the General Medical Council (GMC) to practise medicine in the UK. Medical revalidation was introduced in December 2012 and is the process by which the GMC confirms the continuation of a doctor's licence to practise in the UK. Its purpose is to give assurance that licensed doctors are up to date and fit to practise and it aims to improve the quality of care provided to patients, improve patient safety and increase public trust and confidence in the medical system.

The purpose of this paper is to provide assurance to the board regarding the policies and systems in place within Kent Community Health NHS Foundation Trust (KCHFT) to meet these requirements. An annual board report is mandated by NHS England.

Background

Provider organisations have a statutory duty to support their responsible officers in discharging their duties under the Responsible Officer Regulations and it is expected that provider boards will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

The key roles are the responsible officer (RO) and the lead appraiser. Both roles are set out in detail in KCHFT’s policies. The Chief Medical Officer (CMO) is the responsible officer and is accountable for the quality assurance of the revalidation appraisal and governance processes, making recommendations to the GMC regarding a doctor’s revalidation. Dr Sarah Phillips has been the RO for KCHFT since June 2017. The lead appraiser is responsible for the appraisal processes across the trust, ensuring that it reflects best current practice and meets all legislative requirements, working with KCHFT medical appraisers to ensure the appraisals are of a high quality. The current lead appraiser is Dr Satvinder Lall. Since August 2017 support has been provided by a Band 4 Appraisal and Revalidation administrator. This has evolved into the role of Medical Education and Medical Directorate Governance Administrator (which incorporates the function of Director of Medical Education (DME). The appraisal system, FourteenFish, has been in place since April 2019 and will continue.

The Trust has the following policies in support of the revalidation system.

- Medical Appraisal and Revalidation Policy KCHFT HR043, ratified in March 2021 has been reviewed and is awaiting ratification. A structured service feedback form has been included to help doctors bring relevant organisational information into the appraisal discussion and align with NHS England Guidance.

All policies have had an equality impact assessment which has provided assurance that inequality/equality issues have been considered and addressed.

Assessment

1. Appraisers

During the appraisal year 2024/25, KCHFT has 13 active trained appraisers. There is 1 new appraiser who has not undertaken appraisal yet. The appraisal administrator and appraisal lead meet regularly and actively seek new appraisers. The Lead Appraiser therefore gives assurance that there are sufficient trained medical appraisers within the organisation.

The Lead Appraiser and Responsible Officer attend NHS England's regional responsible officer and appraisal leads network meetings to keep up to date. The lead appraiser is also responsible for ensuring that the appraisers have appropriate training, support and supervision. The annual appraiser refresher training update took place on 11/10/2024 for this appraisal year.

2. Appraisal and Revalidation Performance Data

There were 52 doctors with a prescribed connection to GMC Connect at the end of the appraisal year 2024/2025. Due to movement of doctors in and out of the Trust however, during this year meant that 46 appraisals were due during the period of the appraisal year and all were completed.

The aim of the appraisal and the associated appraisal documentation went through two iterations as a result of Covid (Appraisal 2020 and Appraisal 2022). These were as per the recommendations of the GMC, British Medical Association (BMA) and Academy of Medical Royal Colleges.

There has been an update to the domains of Good Medical Practice (Good Medical Practice 2024) which will be reflected in the appraisal documentation (provided to KCHFT by Fourteenfish).

In the appraisal year 2024-2025, there were two agreed delayed appraisals due new starters.

There were 7 general practitioners (GPs) or other doctors working for KCHFT during the 2024-2025 appraisal year who do not have a prescribed connection to KCHFT (2 in sexual health, 2 in the frailty team and 3 in paediatrics. There are no concerns with their performance and we have written to their ROs in line with the *'Information flows to support medical governance and responsible officer statutory function'*

3. Quality Assurance

The quality assurance processes are as follows:

For the appraisal portfolio:

- The RO or Lead Appraiser reviews appraisal outputs as they are received to provide assurance that the personal development plan (PDP), summary and sign offs are complete and to an appropriate standard
- The RO reviews appraisal outputs to provide assurance that complaints or other key items identified pre-appraisal as needing discussion during the appraisal are included in the appraisal outputs.
- A 'Structured Service Feedback Form' (SSFF) is required to be included in the appraisal evidence. This allows for triangulation of input from both the clinical director and operational manager to the appraisal discussion. It summarises any areas of good practice or areas for development and adds assurance that all information is available to the appraiser. In the 2024-2025 appraisal year 89.1 per cent of SSFF's have been completed in a timely way. This has increased from 65 per cent in 2023-2024. The appraisal team continue to remind doctors to complete this and include the information in the supporting information of the appraisal.
- The lead appraiser assesses the quality of a proportion of the appraisal outputs (two per appraiser) using the PROGRESS tool

For the individual appraiser:

- Each appraiser is asked to complete a form recording their reflection on appropriate continuing professional development.
- An annual record of the appraiser's attendance at appraisal workshops is kept. We expect attendance at a minimum of one workshop annually.
- Feedback from doctors on their appraisal – each doctor is asked to complete feedback after their appraisal has taken place. The lead appraiser views each response to identify any serious concerns needing action. They are assessed annually and fed back to the RO and each appraiser.
- Each appraiser will have an appraisal for their appraiser role and the PROGRESS tool will be utilised to support this discussion (new for 2025/26)

For the organisation:

- We carry out an audit of all incomplete or missed appraisals (defined as more than three months late) within KCHFT. There were zero in the period of 2024/2025.

- There is an annual review of lessons learned from any significant events regarding the appraisal processes. During the last appraisal year there have not been any 'never events' or SUI involving doctors.

- All of our doctors are aware of the Patient Safety Incident Reporting Framework (PSIRF). Doctors identify and report incidents, lead transparent communication

with patients/families (Duty of Candour), and actively participate in system-focused learning reviews.

4. Access, security and confidentiality

The RO team keeps information from appraisals electronically in a secure site that can only be accessed by the RO and the team which includes the lead appraiser, Medical Appraisal & Revalidation Administrator and the RO's EA.

5. Revalidation Recommendations to the GMC 2024/2025

During the year the RO made eight revalidation recommendations. Two deferrals have been made.

Doctors due to revalidate are discussed in a multidisciplinary revalidation meeting chaired by the responsible officer, with an employee liaison /human resources representative, the appraisal administrator and the lead appraiser.

6. NHS England Appraisal Reporting

KCHFT is required to take part in NHS England's Annual Organisational Audit, as attached

7. Recruitment and engagement background checks

There is an agreement with the RO in relation to references for doctors, that if the reference contains no issues of concern the recruitment team process it and no formal approval from managers is needed.
If there is an issue in the reference, the reference is forwarded to the recruiting manager for approval.

In April 2013, new regulations came into force requiring ROs to assure themselves that the doctors they are responsible for have the appropriate level of language competency to enable them to practise safely. KCHFT has a document 'Procedure for testing English language competency for medical staff in KCHFT' (May 2014) to ensure that the RO fulfils their statutory duties around this. This procedure is designed to meet these regulations.

Since the start of the 2016/17 appraisal year employment of locum doctors has been provided through the staff bank. KCHFT only uses locums from Framework Agencies, providing a higher level of assurance around background checks.

8. Monitoring Performance

The RO is sent information on all complaints, DATIX reports, escalations/concerns from the patient safety team. This is aligned to PSIRF. Feedback also comes through Mortality Review Meetings. Serious concerns over a doctor's performance are escalated by the clinical director or head of service to the RO and managed in line with 'Responding to Concerns' or 'Maintaining High Professional Standards' (MHPS) policies. Any relevant Royal College or governance reviews, Care Quality Commission reports are fed back to individual doctors. The responsible officer identifies any issues

arising from this information and ensures that the designated body takes steps to address such issues. Advice is taken from GMC employer liaison advisers, Practitioner Performance Advice, local expert resources, specialty and Royal College advisers where appropriate.

9. Responding to Concerns and Remediation

KCHFT has two polices relevant to this:

- Responding to Concerns regarding Clinical Practice of Doctors and Dentists Policy, KCHFT HR054 ratified in January 2019. This replaces the Supporting Doctors in Difficulty Policy KCHFT HR044.
- People Management - Maintaining High Professional Standards KCHFT HR027 ratified in July 2017.

In the appraisal year 2024/25, concerns have arisen about two doctors which required Practitioner Performance Advice .

10. Risk and Issues

These are:

- As a result of integrated working within the system, we have growing numbers of doctors working part time for KCHFT but who are connected with a different organisation and RO. It is the responsibility of all doctors to include evidence covering their whole scope of practice in their medical appraisal with their designate body. For doctors who have a designated body that is not KCHFT, we have recommended that they use the Structured Service Feedback Form to provide this evidence to their appraiser.

Corrective Actions, Improvement Plan and Next Steps

We have reminded all doctors working within KCHFT who are connected to other designated bodies that their appraisal should include supporting information about their work for us and reminded them that it is their responsibility to take this to their appraisal. We shall continue to monitor the completion of the SSFF form in the new appraisal year.

Recommendations

The Board is asked to accept this annual report, noting that it will be shared, along with the annual audit, with the higher-level responsible officer and to consider any needs/resources required.

We ask the Board to approve the “NHS England Designated Body Annual Board Report and Statement of Compliance, Annex A”, confirming that the organisation, as a designated body, follows the relevant regulations.

Following this, we ask the Chair of the Board of Directors to sign the NHS England Illustrative Designated Body Annual Board Report and Statement of Compliance and return this to Dr Sarah Phillips to forward to NHS England.

Dr Sarah Phillips	**and**	**Dr Satvinder K Lall**
Medical Director		**Lead Appraiser**

Infection Prevention and Control Board Assurance Framework

This paper provides assurance to the Board regarding compliance with the statutory and regulatory requirements of the Health and Social Care Act 2008: code of practice on the prevention and control of infections.

Meeting:	Board Meeting - Part 1 (Public)
Date of meeting:	15 October 2025
Agenda item no:	Item 18
Report title:	Infection Prevention and Control Board Assurance Framework
Executive sponsor(s):	Caroline Bates, Chief Nursing Officer
Report author(s):	Jacqui Griffin, Assistant Director Infection Prevention Control
Action this paper is for:	Approval
Public/non-public	Public

Executive summary

Overview of paper

This report provides assurance to the Board regarding Kent Community Health NHS Foundation Trust's compliance with national infection prevention and control (IPC) standards. It is a dynamic document reviewed quarterly or sooner if guidance changes. The framework supports self-assessment against the National Infection Prevention and Control Manual, the Health and Social Care Act 2008: Code of Practice, and UK Health Security Agency (UKHSA) guidance. It outlines current performance, identifies risks, and details mitigation strategies to ensure patient safety and regulatory compliance. The Trust is currently compliant with 139 out of 150 key lines of enquiry, partially compliant with 7, and 4 are not applicable.

Items of concern to be brought to the Board's attention:

Several areas remain partially compliant and require attention. These include the absence of a dedicated Authorised Person for water safety, gaps in MRSA screening compliance, and lack of dedicated antimicrobial stewardship training at induction. Additionally, there is a need for improved processes in dental procurement to ensure devices can be appropriately sterilised. These gaps are being actively managed through targeted actions such as monthly Water Safety Group meetings, enhanced scrutiny of MRSA screening, and development of e-learning packages for antimicrobial stewardship.

Significant improvements in matters that were previously an area of concern:

A previously identified concern regarding assurance from NHS Property Services and Private Finance Initiative (PFI) contractors about cleaning standards has been resolved. The issue was removed from the gap analysis following improvements in cleaning practices and auditing. The Estates and Facilities Compliance Officer now conducts efficacy audits, and complaints are addressed promptly, indicating substantial progress in this area.

Items of excellence:

The Trust demonstrates strong performance in several areas, including 99% compliance with mandatory IPC training and 98% hand hygiene compliance across all staff. There is also robust governance with IPC being a standing item on the Quality Committee agenda and bi-annual reporting to the Board. The IPC systems are well-aligned with national standards, and there are no significant risks to patients or staff from an IPC perspective. The IPC team have devised a new environmental audit tool based on the IPC standard precautions and have completed all Quarter 1 audits and are on track to complete all Quarter 2 audits

Board members can access the full infection prevention and control board assurance framework in the BoardEffect library.

Report history / meetings this item has been considered at and outcome

The Quality Committee received the infection prevention and control board assurance framework on 4 September 2025 and noted its assurances.

Recommendation(s)

The Board is asked to
- **Note** the report

Link to CQC domain				
☑ **Safe**	☑ **Effective**	☑ **Caring**	☑ **Responsive**	☑ **Well-led**

Assurance level	Significant

Implications		
Links to BAF risks / Corporate Risk Register	☑ BAF	☐ CRR
Equality, diversity and inclusion	No	
Legal and regulatory	Yes (provide a brief sentence describing the issue)	

	CQC compliance with Health and Social Care Act 2008: code of practice on the prevention and control of infections

Executive sponsors sign off
Name and designation: Caroline Bates, Chief Nursing Officer
Date: 06 October 2025

Infection Prevention and Control Board Assurance Framework Summary

Organisation: Kent Community Health NHS Foundation Trust
Reporting Period: April 2025-September 2025.
Prepared by: Jacqui Griffin
Role: Assistant Director Infection Prevention Control.
Date of Report: 6 October 2025

Executive Summary

This paper provides assurance to the Board regarding compliance with national infection prevention and control standards. It is a working document that is reviewed and updated quarterly and earlier if there are changes to guidance or within the Trust that affects the organisation's compliance with the Health and Social Care Act 2008: Code of practice on the prevention and control of infections. It provides a structured self-assessment tool for healthcare organisations to evaluate their compliance with their statutory and regulatory requirements. It outlines current performance against the National Infection Prevention and Control Manual (NIPCM), the Health and Social Care Act 2008: Code of Practice, and UKHSA guidance. The report identifies key risks, mitigation strategies, and areas for improvement to ensure patient safety and regulatory compliance.

The Trust is compliant with 139 out of 150 key lines of enquiry, and partially compliant with 7. There are 4 that are not applicable for the organisation.

1. Purpose of the IPC Board Assurance Framework

The IPC Board Assurance Framework (BAF) is a working document that is reviewed and updated quarterly and earlier if there are changes to guidance or within the Trust that affects the organisation's compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections. It provides a structured self-assessment tool for healthcare organisations to evaluate their compliance with:

- The National Infection Prevention and Control Manual (NIPCM)
- The Health and Social Care Act 2008: Code of Practice
- Guidance from the UK Health Security Agency (UKHSA)

2. Core Objectives

- Assess current IPC measures and identify gaps in assurance
- Identify risks associated with infectious agents.
- Establish a systematic framework of mitigation measures to reduce those risks.

- Ensure that infection prevention and control practices are evidence-based and aligned with national standards

3. Structure and Use

- The framework is built around the 10 criteria set out in the Health and Social Care Act 2008 Code of Practice.
- It supports continuous improvement by helping organisations monitor, evaluate, and enhance their IPC systems.
- It is designed to be flexible and responsive, especially in the face of emerging threats like COVID-19

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4. Governance and Leadership

- **Director of Infection Prevention and Control (DIPC):** Caroline Bates, Chief Nursing Officer.
- **Board Oversight:** IPC is a standing item on the Quality Committee agenda and is presented to Board bi-annually.
- **IPC Strategy:** This is a Kent and Medway system IPC strategy, reviewed annually and aligned with national guidance.
- **IPC Annual Work and Improvement Plan**: Written annually and reviewed quarterly or earlier as required. This is aligned to the strategy and includes work streams, and an IPC BAF action plan.
- **Staff Training:** 99% compliance with mandatory IPC training across all staff. 98% hand hygiene across all staff and 78% compliance for FFP3 mask fit testing for eligible clinical staff. Monitored at a team level at the Infection Prevention Control Governance (IPCG) group.

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5. Compliance with NIPCM and Code of Practice

The below table demonstrates the compliance criterion, that the Trust needs to be able to demonstrate and the compliance level KCHFT is currently at. There is a total of 150 key lines of enquiry of which the Trust is compliant with 139, and partially compliant with 7. There are 4 not applicable for the organisation.

Compliance criterion	What the registered provider will need to demonstrate	KCHFT compliance
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them	Partially compliant
2	Provide and maintain a clean and appropriate environment in managed	Partially compliant

	premises that facilitates the prevention and control of infections	
3	Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	Partially compliant
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.	Partially compliant
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	Compliant
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	Partially compliant
7	Provide or secure adequate isolation facilities.	Compliant
8	Secure adequate access to laboratory support as appropriate	Partially compliant
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.	Compliant
10	Providers have a system in place to manage the occupational health needs of staff in relation to infection.	Compliant

6. Mitigation for partially compliant key lines of enquiry.

Below are the main areas that the Trust is partially compliant with including the mitigations that have been put in place to ensure risk to patients is low:

Compliance criterion	**Line number**	**Gaps in Assurance**	**Mitigation/ Actions**
1	12	The Trust does not currently have an Authorised Person (AP) for water safety.	The Trust is utilising the expertise of the Authorised Engineer (AE) for water safety to support the gap in

			house. The Water Safety Group meetings are being held monthly for closer monitoring with the AE(W) in attendance at each meeting.
1	30	Lack of assurance from NHS Property Services (NHSPS) and PFI (private finance initiative) facilities contractors of cleaning standard, compliance and auditing.	The PFI builds are listed on the organisational risk register. In response, the Facilities team continues to provide additional cleaning support as required to mitigate associated risks. The Associate Director for Facilities is actively collaborating with PFI facilities contractors to enhance cleaning standards and strengthen the service level agreement. This partnership is yielding positive outcomes. To ensure ongoing assurance, the Estates and Facilities Compliance Officer conducts regular efficacy audits on buildings maintained by external contractors. These audits provide an independent assessment of cleaning performance. Furthermore, any concerns raised through IPC audits or service-level complaints regarding

			cleaning are promptly addressed by the Compliance Officer, with demonstrable improvements observed.
2	63	The current dental procurement process lacks sufficient safeguards to ensure compatibility with Integrated Healthcare Sterile Services (IHSS) re-processing capabilities. As a result, there have been instances where medical equipment was acquired that cannot be re-processed and is therefore unusable. While this issue does not present a direct risk to patient safety, it does constitute a financial risk for the organisation due to the loss incurred on non-utilisable devices.	Medical, devices that cannot be processed by IHSS are not used in patient care. IPC are working closely with dental to devise a process whereby the purchase of all medical devices for dental are aligned to the non-dental procurement of medical devices. Manufacturers must complete pre-acquisition questionnaire detailing their recommended re-processing. IHSS agree that they can re-process the device and only devices that can be re-processed by IHSS will be purchased.
3 and 6	74 and 107	There is not dedicated training for Antimicrobial Stewardship at induction	The Antimicrobial Stewardship lead in conjunction with the lead pharmacist is investigating e-learning packages that can be sourced and implemented in the Trust. This is an action from the Antimicrobial Stewardship group and regularly monitored at these meetings.

4	88	Use of target leaflets to support the importance of appropriate use of antimicrobials	Resources can be accessed via UKHSA. The antimicrobial stewardship group are looking at having a generic leaflet on safe and correct use of antibiotics.
8	124	MRSA screening compliance for admission to inpatient units remains below 95%.	The IPC team continue to identify patients that need to be screened and highlight these to the wards. The AD for community hospitals, and the lead matron provide monthly scrutiny of this with the matrons. They are working closely with the matrons to establish challenges to screening, good practice and embedding processes. This is monitored at the bi-monthly Infection Prevention and Control Governance group meetings, at the Patient Safety Clinical Risk group and is included in the IPC bi-monthly quality committee slides.

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7. Improvement Plan

The IPC Board Assurance Framework is reflected in the IPC annual work and improvement plan which includes a designated action plan for working towards full compliance with the IPC BAF.

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8. Conclusion

IPC systems are robust and aligned with national standards. Overall, the Trust has good compliance with the Health and Social Care act 2008: code of practice on the prevention and control of Infections. There are no significant risks to patients or staff from an IPC perspective.