

Board of Directors (BoD) Open meeting - Tuesday 28 July 2026

Tuesday 28 July 2026, 01:30PM - 05:10PM

to be held by Microsoft Teams



Agenda

OPENING/STANDING ITEMS

01:30PM - 01:31PM 26/44
1 min
Welcome and Apologies for Absence

To Note *Interim Chair*
Verbal

01:31PM - 01:32PM 26/45
1 min
Confirmation of Quoracy

To Note *Interim Chair*
Verbal

01:32PM - 01:33PM 26/46
1 min
Declaration of Interests

To Note *Interim Chair*
 26-46 - BoD register of interests July 2026.pdf (3 pages)

01:33PM - 01:35PM 26/47
2 min
Minutes of Previous Meeting held on 4 June 2026

Approval *Interim Chair*
 26-47 - Unconfirmed BoD 04.06.26 Open Minutes.pdf (21 pages)

01:35PM - 01:37PM 26/48
2 min
Board of Directors Decision outside the Board

To Note *Interim Chair*
 • **Reconfiguration of Acute Stroke Services - Capital Costs**
 26-48 - Decision outside cycle Acute Stroke Reconfiguration Capital Costs.pdf (2 pages)

01:37PM - 01:40PM 26/49
3 min
Matters Arising from the Minutes on 4 June 2026

Approval *Interim Chair*
 26-49 - Front Sheet Open BoD Action Log.pdf (7 pages)

Quality and Safety - Patients

01:40PM - 02:10PM

30 min

26/50

Patient Story

Information

Chief Nursing and Midwifery Officer (CNMO)

 26-50.1 - Front sheet Patient Story Board July 2026.pdf (2 pages)

 26-50.2 - App 1 Meg's Story July 2026 (002).pdf (3 pages)

REGULATORY AND GOVERNANCE

02:10PM - 02:15PM

5 min

26/51

Interim Chair's Report

Information

Interim Chair

 26-51 - Interim Chair Report to Board 28 Jul 2026 vFinal.pdf (6 pages)

02:15PM - 02:20PM

5 min

26/52

Acting Chief Executive Officer's (CEO's) Report

Discussion

Acting CEO

 26-52 - Acting CEO Report Board 28 July 2026 FINAL(DH).pdf (6 pages)

02:20PM - 02:25PM

5 min

26/53

Trust Strategy 2026-2035

To Note

Acting CEO/Chief Strategy and Partnerships Officer (CSPO)

Verbal

02:25PM - 02:35PM

10 min

26/54

Systems and Place Updates: System Working

Discussion

Interim Chair / Acting CEO

- The Provider Alliance Update and Neighbourhood Collaboratives / NHS Kent and Medway System Governance and Joint Committee Alignment: Joint Committee Board

 26-54.1 - Front sheet EKHUFT System Working Jul 2026.pdf (2 pages)

 26-54.2 - App 1 The Provider Alliance.pdf (11 pages)

 26-54.3 - App 2 JC Board Report Paper Extract.pdf (10 pages)

02:35PM - 02:50PM

15 min

26/55

Learning from Investigations

Approval

Acting CEO / Chief People Officer (CPO)

 26-55.1 - BoD Front Sheet Anaesthetics Reviews July 26 V2.pdf (3 pages)

 26-55.2 - App 1 East Kent Anaesthetics Report VF.pdf (57 pages)

 26-55.3 - App 2 EKHUFT Raising Concerns FINAL report post review.pdf (15 pages)

Sustainability

02:50PM - 03:05PM

26/56

15 min

Performance and Finance Reporting:

Assurance

Executive Directors

26/56.1

Integrated Performance Report (IPR)

Discussion

CSPO/Executive Directors

 26-56.1.1 - BoD Front Sheet_V16_Jun IPR_260526_v2.pdf (5 pages)

 26-56.1.2 - Board IPR_v7.0_Jun26_FINAL.pdf (56 pages)

26/56.2

Month 2 Finance Report

Information

Chief Finance Officer (CFO)

 26-56.2.1 - Finance Report front sheet Board M2 2026-27.pdf (2 pages)

 26-56.2.2 - App 1 M2 2026-27 Finance Report Summarised.pdf (6 pages)

03:05PM - 03:10PM

5 min

26/57

Finance and Performance Committee (FPC) - Chair Assurance Reports

Assurance

FPC Non-Executive Director (NED) Member on behalf of Chair FPC - Robert Musgrove

 26-57.1 - FPC Assurance Report 9 June 2026 FINAL.pdf (4 pages)

 26-57.2 - FPC Assurance Report 30 June 2026 FINAL.pdf (4 pages)

03:10PM - 03:15PM

5 min

26/58

Charitable Funds Committee (CFC) - Chair Assurance Report

Assurance

CFC NED Member on behalf of Chair CFC - Ffion Griffith

 26-58 - CFC Assurance Report 28.07.2026.pdf (2 pages)

03:15PM - 03:25PM

10 min

TEA/COFFEE BREAK (10 MINS)

Quality and Safety - Patients - Partnerships - Sustainability

03:25PM - 03:35PM

10 min

26/59

Significant Risk Register Report

Assurance

CNMO

 26-59 - BoD Significant Risk Report 28 July 2026 final.pdf (46 pages)

Quality and Safety - Patients

03:35PM - 03:45PM

10 min

26/60

Maternity and Neonatal Board Chair's Report

Assurance

CNMO/DoM

 26-60 - BoD Maternity Summary 28.7.26.pdf (6 pages)

03:45PM - 04:20PM

26/61

35 min

2025/26 Annual Reports

Approval

26/61.1

Infection Prevention and Control Annual Report April 2025 - March 2026 (10 min)

Approval

CNMO

-  26-61.1.1 - BoD front sheet DIPC Annual Report 25-26.pdf (2 pages)
-  26-61.1.2 - App 1 DIPC Annual Report 25-26 final.pdf (24 pages)

26/61.2

Safeguarding Annual Report April 2025 - March 2026 (10 min)

Approval

CNMO

-  26-61.2.1 - Safeguarding Annual Report.pdf (3 pages)
-  26-61.2.2 - App 1 Annual Safeguarding Report for Board.pdf (52 pages)

26/61.3

Complaints, Patient Advice and Liaison Service (PALS) and Compliments Annual Report 2025-26 (5 mins)

Approval

CNMO

-  26-61.3.1 - Board Front Sheet CPBS Annual Report 2025-26.pdf (3 pages)
-  26-61.3.2 - App 1 FINAL CPBS Annual Report 2025-26 08.05.26.pdf (21 pages)

26/61.4

Research and Innovation (R&I) Board Report 2026 (10 mins)

Discussion

Acting Chief Medical Officer (CMO)/Director of R&I

-  26-61.4 - R&I Board Report 2026.pdf (9 pages)

04:20PM - 04:25PM
5 min

26/62

Care Quality Commission (CQC) Update Report

Assurance

CNMO

-  26-62.1 - CQC Report BoD July 26 Final approved SH.pdf (14 pages)
-  26-62.2 - App 1 CQC W&CA Update June 2026.pdf (2 pages)

04:25PM - 04:30PM
5 min

26/63

Quality and Safety Committee (Q&SC) - Chair Assurance Report

Assurance

Chair Q&SC - Dr Andrew Catto

-  26-63 - QSC Chair's Report Final 180526 to July 26 BoD.pdf (5 pages)

People

04:30PM - 04:35PM
5 min

26/64

Guardian of Safe Working Hours (GoSWH): Quarterly Report and Annual Report 2025

Information

CPO / Guardians of Safe Working

-  26-64.1 - GoSW Q1 Report (Jan-26 - Mar-26) BoD.pdf (10 pages)
-

04:35PM - 04:40PM
5 min

26/65
Progress on Implementation of the NHS England (NHSE) Resident Doctor 10 Point Plan

Assurance CPO
 26-65 - 10 Point Plan Report july 2026.pdf (5 pages)

04:40PM - 04:45PM
5 min

26/66
Nursing Band 5 Job Evaluation Role Review

Approval Chief People Officer (CPO)/CNMO
 26-66.1 - Trust Board Band 5 JD review Jul 26.pdf (4 pages)
 26-66.2 - App 1 Nursing Band 5 JD review Jul 26.pdf (7 pages)

04:45PM - 04:50PM
5 min

26/67
People and Culture Committee (P&CC) - Chair Assurance Report

Assurance Chair P&CC - Ffion Griffith
Equality, Diversity and Inclusion (EDI) (EDI is now a standing item on this committee/board meeting as part of NHSE Equality Delivery System and so EDI can be considered in all meetings and key decisions. Please discuss and consider how this meeting/decision may impact EDI and record this e.g. have an adverse or positive impact on staff or patients with protected characteristics e.g. race, age, disability etc.)
 26-67 - PCC Chair's Report July 2026 Final.pdf (4 pages)

04:50PM - 04:55PM
5 min

26/68
Integrated Audit and Governance Committee (IAGC) - Chair Assurance Report

Assurance Interim Chair IAGC - Dr Andrew Catto
 26-68 - IAGC Chair Assurance Board Report 23.06.26 FINAL.pdf (3 pages)

CLOSING MATTERS

04:55PM - 05:00PM
5 min

26/69
Any Other Business

Discussion All
Verbal

05:00PM - 05:10PM
10 min

26/70
Questions from the Public

Discussion All
Verbal

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

Date of Next Meeting: Thursday 1 October 2026

REGISTER OF DIRECTOR INTERESTS – 2026/27 FROM JULY 2026

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
BLISSETT, NORMAN	Chief People Officer	Director and sole shareholder of Gallanach Enterprises Ltd (1) (3)	20 January 2025
CATTO, ANDREW	Non-Executive Director	Group Chief Executive Officer, Integrated Care 24 (IC24) (1) (including Director of Cleo Systems 24 Ltd, Brightdoc 24 Limited, Idental Care 24 Ltd.) Board Member of east Kent Health and Care Partnership (HCP) (1) Director of Transforming Primary Care (1)	1 November 2022 (Second term)
FLETCHER, TRACEY	Chief Executive	None	4 April 2022
GIBBS, DAN	Chief Operating Officer	Equity holder in Ignite Data Ltd. (2) Director in Common, Spencer Private Hospitals (SPH) Board (1)	7 February 2025
GRIFFITH, FFION	Non-Executive Director	Director of R National Realisations. Charity entered into administration November 2024, wind-up in progress, expected to conclude by 30/11/2026. No active governance role; retained as Director pending completion of administration process (1) (4)	1 May 2025 (First term)
HAYES, SARAH	Chief Nursing and Midwifery Officer	Charity Trustee, The 1930s Fund for Nurses (Charity) (4)	18 September 2023
HOLDEN, DES	Chief Medical Officer	International Advisor, Public Intelligence (Denmark) (5) (2018) Advisor/Non-Executive Director, South East Health Technology Alliance (4) (2017) Visiting Professor, Clinical and Experimental Medicine, University of Surrey (5) (2023 to 2026)	2 January 2024

REGISTER OF DIRECTOR INTERESTS – 2026/27 FROM JULY 2026

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
HOLLAND, CHRISTOPHER	Non-Executive Director Associate Non-Executive Director	Director of South London Critical Care Ltd (1) Shareholder in South London Critical Care Ltd (2) Dean of Kent and Medway Medical School, a collaboration between Canterbury Christ Church University and the University of Kent (4) South London Critical Care solely contracts with BMI The Blackheath Hospital for Critical Care services (5)	17 April 2026 13 December 2019 (Third Term (First one year extension))
MUSGROVE, ROBERT	Non-Executive Director	Employee of IBM UK Ltd (1) Non-Executive Director In-Common, 2gether Support Solutions (1)	1 May 2025 (First term)
OIRSCHOT, RICHARD	Non-Executive Director	Non-Executive Director, Puma Alpha VCT plc (July 2019) (1) Director, R Oirschot Limited (August 2010) (3) Trustee, Camber Memorial Hall (June 2016) (4)	1 March 2023 (First term)
OLASODE, OLU	Interim Chair Senior Independent Director (SID)/Non-Executive Director	Executive Chairman, TL First Group (started 9 May 2020) (3) Chairman, Governance and Leadership Academy UK (started 11 September 2018) (1) Non-Executive Director, Priory Care Group (started 1 June 2022) (1) Independent Chair of Audit and Governance, London Borough of Croydon (started 1 October 2021) (4)	23 April 2026 1 April 2021 (Second term)
OTITE, DOROTHY	Director of Corporate Governance	Founder of BoardCore™ - governance consultancy and governance infrastructure development (2) (currently not trading) Independent Panel Member (IPM) for Public Appointments (5) Member of Empowering People of Colour (EPOC) – not for profit peer network supporting senior executives from global majority backgrounds with board and trustee opportunities (5)	1 June 2026

REGISTER OF DIRECTOR INTERESTS – 2026/27 FROM JULY 2026

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
PHIPPS, BELINDA	Interim Non-Executive Director	To be advised	23 July 2026 (Interim – Three Months)
PROSSER, SPENCER	Interim Non-Executive Director	To be advised	23 July 2026 (Interim – Three Months)
STEVENS, BEN	Chief Strategy and Partnerships Officer	None	1 June 2023 (substantive) (20 March 2023 interim)
van der LEM, ANGELA	Chief Finance Officer	Board Member, NHS Commercial Solutions Management Board (1)	6 November 2024

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

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

Categories:

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

**UNCONFIRMED MINUTES OF THE ONE HUNDRED AND FIFTIETH
MEETING OF THE BOARD OF DIRECTORS (BoD)
THURSDAY 4 JUNE 2026 AT 1.00 PM
HELD IN SEMINAR ROOMS 1 & 2, BUCKLAND HOSPITAL,
COOMBE VALLEY ROAD, DOVER, CT17 0HD
AND BY MICROSOFT TEAMS**

PRESENT:

Dr O Olasode	Interim Trust Chair (Chair)/Nominations and Remuneration Committee (NRC) Chair	OO
Mr N Blissett	Chief People Officer (CPO)	NB
Dr A Catto	Non-Executive Director (NED)/Quality and Safety Committee (Q&SC) Chair/Integrated Audit and Governance Committee (IAGC) Member/ NRC Member	AC
Mr D Gibbs	Chief Operating Officer (COO)	DG
Ms F Griffith	NED/NRC Member/People and Culture Committee (P&CC) Member/ NED Maternity Safety Champion	FG
Ms S Hayes	Chief Nursing and Midwifery Officer (CNMO)	SH
Dr D Holden	Acting Chief Executive Officer (CEO)	DH
Dr H Mackie	Acting Chief Medical Officer (CMO)	HM
Mr R Musgrove	NED/Finance and Performance Committee (FPC) Member/ NRC Member/NED In-Common (2gether Support Solutions (2gether))RM	
Mr R Oirschot	NED/FPC Chair/Charitable Funds Committee (CFC) Member/ IAGC Member/NRC Member	RO
Professor C Holland	NED/Senior Independent Director (SID)/NRC Member/P&CC Member/Q&SC Member	CH
Mr B Stevens	Chief Strategy and Partnerships Officer (CSPO)	BS
Ms A van der Lem	Chief Finance Officer (CFO)	AvdL

ATTENDEES:

Ms C Hinson	Organisational Development Manager (Staff Story) (<i>minute number 26/025</i>)	CH
Ms S Pease	Director of Midwifery (DoM) and Gynaecology Nursing (<i>minute number 26/033</i>) (<i>joined by Teams</i>)	SP
Ms C McDonald	Intensive Recovery Programme (IRP) Programme Director	CMcD
Staff Member	Critical Care Outreach Lead Nurse – Trust Sepsis Lead Nurse (Staff Story) (<i>minute number 26/025</i>)	
Mrs D Otite	Director of Corporate Governance (DCG) (non-voting Board member)	DO
Ms Z Woodward	Associate Medical Director (Women's Services) (<i>minute number 26/033</i>) (<i>joined by Teams</i>)	ZW

IN ATTENDANCE:

Miss S Robson	Board Support Secretary (BSS) (Minutes)	SR

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

Ms M Bonney	Governor
Ms M Low	Governor
Mrs B Mayall	Lead Governor
Ms C Heggie	Member of the public
Ms S Landers	Member of Staff
Ms A Moore	Member of the public
Mr T Norton	Member of the public
Mrs C Sykes	Member of the public
Mr M Taylor	Member of the public
Ms K Thornberg	Member of the public
Mrs M Warburton	Member of the public
Mrs L Williams	Member of Staff
Mr R Yates	County Councillor for Cliftonville, Kent County Council

MINUTE NO.		ACTION
26/020	INTERIM CHAIR'S WELCOME AND APOLOGIES FOR ABSENCE The Interim Chair opened the meeting, welcomed everyone present, noting attendance of Mrs D Otite, the Trust's DCG, and noted apologies received from the following: • Ms T Fletcher (TF), Chief Executive (CE).	
26/021	CONFIRMATION OF QUORACY The Interim Chair NOTED and confirmed the meeting was quorate.	
26/022	DECLARATION OF INTERESTS The Interim Chair NOTED there were no additional interests declared.	
26/023	MINUTES OF THE PREVIOUS MEETING HELD ON 2 APRIL 2026 DECISION: The Board of Directors APPROVED the minutes of the previous meeting held on 2 April 2026 as an accurate record.	
26/024	MATTERS ARISING FROM THE MINUTES ON 2 APRIL 2026 Action B/46/25 – Analysis of equity of cancer diagnosis in younger people The report presented was noted on the analysis of equity of cancer diagnosis in younger people, the findings indicating no evidence of later diagnosis in this cohort, and AGREED the closure of this action. The outstanding actions were noted for ongoing monitoring, including continued engagement with system partners and stakeholders regarding social care capacity, and the independent stillbirth review report for presentation of progress updates at future meetings. The Board of Directors NOTED the action log, NOTED the updates on actions, actions for future meetings, verbal updates noted above, APPROVED the one action recommended for closure, and the one action noted above AGREED for closure.	
26/025	STAFF STORY: TEAM ENGAGEMENT AND DEVELOPMENT (TED) The Board received a staff story presentation on the TED programme sharing a practical case study of implementation. Noting TED, an evidence based engagement tool, widely adopted across the Trust, designed to enable teams to identify issues, take ownership of improvements and strengthen team culture and performance. The TED tool had been applied within the small Critical Care Outreach teams to gain deeper insight into staff experience, particularly where national survey data was limited. The initial survey resulted in identifying key areas for improvement, including valuing individuals, celebrating success and strengthening team engagement. Targeted interventions were implemented, such as recognition initiatives, structured team engagement activities, and the introduction of forums (e.g. 'Fix It Friday') to promote open discussion and collaborative problem solving.	

The use of TED supported driving measurable improvements in team engagement scores fostering a more open, supportive and inclusive culture, which in turn contributed to improved psychological safety and patient care. It was emphasised engaged and supported staff were better able to deliver safe, high quality care, particularly for vulnerable patients.

The NEDs queried the practical application of the tool, including ease of implementation, availability of resources, and the need for facilitation support in some areas. The CPO highlighted whilst many teams had successfully adopted TED independently, further work was planned to target areas of lower engagement and support teams that might require additional guidance. The Board noted the importance of follow-up surveys to track progress and ensure improvements were sustained over time.

ACTION: Circulate to Board members a briefing overview of the TED programme.

CPO

The Board of Directors discussed the Staff Story and:

- **NOTED** the establishment of the Culture and Inclusion service and its strategic role in leadership development;
- **RECOGNISED** the success of the TED tool programme and how this supported the National Staff Survey (NSS) work and staff engagement;
- **SUPPORTED** the planned expansion of TED 2026, ensuring continued investment in engagement, compassionate and inclusive leadership;
- **WELCOMED** the staff story as a lived example of programme impact, reinforcing the Board's commitment to culture and inclusion.

26/026 INTERIM CHAIR'S REPORT

The Interim Chair highlighted the following key points:

- Trust faced continued significant challenges across quality, operational performance, finance, workforce and governance, alongside need to restore confidence and stability following period of organisational disruption;
- Important Trust maintained focus on patients, staff and communities, recognising continued professionalism of Trust staff, and organisation beginning to stabilise with renewed clarity and direction;
- Serious current regulatory position, including additional licence conditions by NHS England (NHSE), and Trust's responsibility to respond with pace, discipline and clear accountability;
- Welcomed system partner support noting clear ownership of recovery and delivery remained with the Trust, requiring a strong, unified Board approach focused on translating priorities into tangible actions and delivery at pace.

The NEDs reflected on the need to strengthen governance, leadership capability, assurance arrangements, and to maintain a coherent focus across quality, performance, finance and culture as interdependent priorities. Noting key areas of ongoing oversight, included Urgent and Emergency Care (UEC) recovery, patient flow and discharge, deteriorating performance in cancer and diagnostics, and continued attention to patient safety concerns.

The Board discussed and noted the immediate priorities for the next 90 days, including restoring Board stability and governance grip, delivering single integrated recovery and delivery framework with clear ownership and milestones, progressing leadership capacity reviews and senior recruitment, and strengthening alignment with NHSE, the Integrated Care Board (ICB) and wider system partners. Actions

arising from external reviews and regulatory requirements would be progressed through a structured Section 111 assurance framework with regular reporting.

The Board supported future longer term focus on delivering sustained operational and financial recovery, progressing Trust's strategic agenda, and embedding improvements in culture, leadership and staff experience. It was also important the Board maintain strong oversight, transparent assurance and demonstrable improvement in care and outcomes critical to rebuilding confidence.

The Board of Directors **NOTED** the Interim Chair's report.

26/027 **LEARNING FROM INVESTIGATION**

The Acting CEO provided a verbal update highlighting the following key issues:

- Learning from recent investigations relating to anaesthetic services, particularly introduction of third tier out of hours cover model at William Harvey Hospital (WHH). Originally implemented in response to concerns from trainee doctors regarding workload pressures and stress, aimed at strengthening resilience and safety;
- Significant challenges experienced in recruiting to this rota, resulting in ongoing staffing gaps, increased pressure on existing staff and concerns regarding service sustainability and risk;
- These issues led to escalation through internal discussions and governance routes, culminating in formal investigations examining both specific concerns raised by anaesthetic staff and wider organisational learning, including how Board received assurance of services under pressure;
- Investigations also considered whether there was any evidence of patient harm associated with identified issues;
- Confirmed investigation reports now completed, in process of being fed back to anaesthetic teams who had raised the concerns;
- Wider engagement process with anaesthetic workforce planned, with dissemination of findings and actions scheduled for early July. Report to be presented to next meeting at end of July.

ACTION: Complete feedback and engagement with clinical teams, ensuring transparency and shared understanding of findings and planned actions ahead of presenting full investigation reports formally to July 2026 Open Board meeting for discussion and scrutiny.

CPO/
Acting
CMO

The Board of Directors **NOTED** the verbal update on Learning from Investigation.

26/028 **ACTING CHIEF EXECUTIVE OFFICER'S (CEO's) REPORT**

The Acting CEO highlighted the following key issues:

- Some areas of progress in respect of performance and key priorities. Trust remained below required standards in a number of areas, particularly cancer pathways and diagnostics, where capacity and workforce constraints continued to impact timely access and performance;
- Previous improvements achieved through additional 'sprint' resources not sustained, with work ongoing to address underlying pathway and capacity challenges, including potential cross system solutions to improve patient access and equity;
- Improvement shown in UEC performance, including sustained reduction in corridor care, excess waiting times, and progress in reducing length of stay (LoS) and numbers of patients with no criteria to reside (NCTR);

- Trust not where it needed to be, further work required to eliminate the use of all non-designated care spaces and to sustain improvements in patient flow.

The NEDs raised concern about the continued challenges in diagnostics and cancer performance, recognising these as critical constraints affecting wider elective and operational recovery. The Acting CEO reported a focused recovery programme in place, targeting workforce stabilisation, improved utilisation, and expansion of diagnostic capacity, and sustained improvement depended on addressing structural capacity gaps.

The Acting CEO highlighted developments included the opening of the Thanet Community Health Hub, beginning to support outpatient capacity and provide more accessible, community based services, alongside clinical innovations. The Trust had appointed a substantive Director of Midwifery and Gynaecology Nursing.

The NEDs emphasised the need to accelerate improvements at pace and traction in delivery, noting further action planning and additional meetings would be required to ensure progress against key priorities. The Board welcomed the appointment of the IRP Programme Director, as well as the support being provided through the IRP national programme, with a clear expectation of developing a single, coherent recovery plan owned by the Trust.

The Board of Directors **NOTED** the Acting CEO's report.

26/029

CARE QUALITY COMMISSION (CQC) QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL (QEQM) UEC – INSPECTION UPDATE

The CNMO highlighted the following key issues:

- Multiple CQC inspections took place between January and May 2026, including initial QEQM Emergency Department (ED) inspection resulting in a Letter of Intent and requirement for urgent action plan;
- Comprehensive action plan developed and submitted ahead of required deadline, weekly reporting in place to both the CQC and Board, supported by a dedicated programme management approach;
- Subsequent inspections, including re-inspection in May, identified clear improvements. Positive feedback provided about strengthened medical and nursing leadership, effective multidisciplinary working, improved collaboration across QEQM and WHH, and evidence of compassionate patient care despite sustained operational pressures;
- Inspection process had been intense for frontline teams, with positive results galvanising staff and accelerating improvement work, particularly in relation to patient flow and reduction of corridor care.

The NEDs emphasised a number of areas for improvement remained. These included key ongoing issues including patient flow and delays in admission, consistency of observations, use of escalation processes, medicines management, adherence to clinical guidelines, and utilisation of specialist services. The CNMO confirmed these had been incorporated in the action plan, expanded to include additional actions following the May inspection, with the majority either completed or in progress and subject to continued oversight.

The NEDs highlighted significant challenge with medical workforce capacity, particularly at registrar level, with gaps impacting delivery against required standards for senior cover. The Acting CMO commented work was ongoing to strengthen recruitment, reduce reliance on temporary staffing, and develop a

sustainable pipeline of medical staff whilst improving attractiveness as a training environment.

ACTION: Present update report to future Board meeting on progress continuing to deliver action plan, including completion of outstanding actions and embedding of sustainable improvements.

CNMO

The Board of Directors received and **NOTED** the assurances regarding post inspection activity and arrangements for ongoing assurance and oversight of QEQM action plan.

26/030 **PERFORMANCE AND FINANCE REPORTING:**

26/030.1 **INTEGRATED PERFORMANCE REPORT (IPR)**

The Executive team highlighted the following key performance against metrics reported in the IPR for month of April 2026, noting this also tracked progress against the Integrated Improvement Plan (IIP) milestones:

- Operational performance
 - Improving performance in UEC, including increase in 4-hour performance and sustained reductions in LoS over 24 hours;
 - System flow remained significant risk, particularly in relation to discharge delays and patients NCTR;
 - Corridor care reduced with range of operational and cultural changes embedded, ongoing occurrences in non-care spaces and heightened risk during periods of high demand. Assurance improvements now embedded as business as usual, remained a continued risk of deterioration, particularly ahead of winter pressures;
 - Planned care mixed performance, overall activity exceeding plan, deterioration in Referral to Treatment (RTT) and long wait performance in some specialties, notably areas with limited mutual aid options;
 - Cancer and diagnostic performance key risks, with delays driven primarily by workforce and capacity constraints across diagnostic pathways. Actions underway to strengthen productivity, increase capacity, and utilise external support, with oversight through formal recovery boards and national programmes.
- Quality and Safety (Q&S)
- Patients
 - Significant progress reducing overdue incidents and strengthening governance grip, challenges remained in sustaining timeliness of investigations under the new framework;
 - Continued risks in relation to mixed sex accommodation breaches, infection control (notably E. coli), and impact of flow constraints on patient safety;
 - Mortality indicators assurance no specific areas of avoidable harm identified with continued vigilance and targeted improvement, particularly for frail patients remained a priority.
- People
 - Workforce metrics showed improvement in sickness absence and turnover, with vacancy levels remaining high in key areas;
 - Staff engagement declined, presenting ongoing cultural and retention risk.
- Financial performance

- Trust in line with plan at Month 1, with underlying pressures relating to workforce costs and delivery of Cost Improvement Programme (CIP), requiring continued focus and external support.

The NEDs raised the anticipated impact of the Mutually Agreed Resignation Scheme (MARS) on staff turnover and requested a deeper analysis of workforce data, including vacancy impacts and trends across staff groups.

ACTION: Provide progress update to Board on the further work to address workforce gaps, including analysis of vacancies, turnover trends and medical job planning at team level. Also provide findings of additional analysis on workforce metrics and vacancy impacts to better inform financial and operational decisions.

CPO

The Board of Directors **NOTED** the metrics reported in the April 2026 IPR.

26/030.2 MONTH 1 (M1) FINANCE REPORT

The CFO reported on the following key issues:

- Trust delivered its planned financial position at start of 2026/27, reporting a £4.6m deficit before Deficit Support Funding (DSF), broadly in line with plan, equating to a net £1.7m deficit after £2.9m DSF;
- Early indications Month 2 reported on plan, providing some initial assurance on delivery against the financial trajectory;
- Delivery £35m DSF allocation remained contingent on continued achievement of financial plan, could be withdrawn if performance deteriorated, reinforcing importance sustained financial grip throughout year;
- Trust strengthening delivery through enhanced oversight and support, including weekly system level challenge and appointment of an external strategic delivery partner to accelerate productivity and transformation;
- Assurance resources and capability now in place to support delivery, pace of implementation and decision making critical.

The NEDs highlighted significant scale of the financial challenge, particularly requirement to deliver £76m CIP savings in-year, emphasising this was a substantial stretching target following substantial savings delivered in previous years. The CFO reported the Trust was targeting £90m of identified opportunities to mitigate delivery risk and ensure sufficient headroom.

The NEDs recognised the importance that achieving financial recovery be aligned with improvements in operational performance and quality, with a clear focus on productivity gains and reducing waste. Particular emphasis was placed on workforce costs as a key driver of the financial position, highlighting temporary staffing as an early priority area, building on reductions achieved in previous year. Noting Month 1 CIP delivery of £3.7m below the £4.6m target, indicating early delivery risk that would require close monitoring and mitigation.

The Board acknowledged its responsibility in playing an active role in supporting timely decisions where required and ensuring governance processes did not delay necessary actions.

The CFO commented the broader multi-year financial sustainability trajectory, with DSF reducing over future years, requiring fundamental changes to Trust's cost base and service delivery model. Detailed work underway to analyse productivity and cost variation at specialty level to inform targeted improvement actions.

ACTION: Present regular update reports to Board and FPC to track delivery of the CIP, maintaining over programmed pipeline of savings, sustained focus on workforce cost control, particularly temporary staffing, and ongoing detailed productivity analysis informing transformation plans.

CFO

The Board of Directors **NOTED** the financial performance of Month 1.

26/030.3 **2026/27 CAPITAL PLAN UPDATE**

The CSPO reported on the following key issues:

- Trust planning to deliver a significantly increased capital programme, rising from £75.5m in 2025/26 to £85.2m in 2026/27, with a further £8m secured through the Estates Safety Fund (ESF), bringing total programme to approximately £93m;
- Largest capital programme undertaken to date, reflecting successful bids for national funding across key areas including maternity, Same Day Emergency Care (SDEC), diagnostics, UEC, and critical estate infrastructure schemes.

The NEDs welcomed success securing additional funding, particularly for high priority estate safety schemes, recognising the benefits of investment in addressing backlog maintenance, infrastructure risks and ageing equipment, as well as supporting clinical capacity and patient experience. It was acknowledged, compared to previous year, programme less reliant on large individual schemes and instead comprised broader range of projects, including equipment replacement such as CT and MRI scanners, supporting more manageable delivery.

The NEDs raised concern about significant delivery challenge associated with scale of programme and sought assurance regarding organisational capacity to deliver and the need to avoid back-end loading of expenditure. It was highlighted ongoing strategic risk relating to scale of unmet capital need, noting Trust continued to face substantial backlog maintenance and infrastructure requirements, estimated at a much higher level than current funding allowed, and requested continued visibility of this risk and potential mitigation options.

The NEDs also focused on the relative lack of dedicated digital capital funding within the plan. Whilst recognising national ambitions around digital transformation, noting specific funding streams had yet to be confirmed. The Board emphasised the importance of clearly articulating digital investment opportunities, including 'invest to save' schemes, through Trust's recovery and financial planning processes to strengthen future funding cases.

The CSPO commented programme had started positively, with early year capital expenditure broadly in line with plan, with governance and oversight arrangements, including monitoring of national approvals and development of mitigation plans for potential slippage, in place.

ACTION: Present update report to future Board meeting on progress with backlog maintenance and infrastructure risk, including updated cost assessments and options. Ensure continued monitoring and manageable execution of programme delivery and phasing.

CSPO

DECISION: The Board of Directors **APPROVED** the acceptance of £12.2m additional capital funding (over the next three financial years) awarded by the NHSE ESF, noting benefits, risks and mitigations outlined in the report.

26/031 SIGNIFICANT RISK REGISTER (SRR) REPORT

The CNMO highlighted the following key elements from the SRR providing oversight of all risks rated 15 and above:

- Oversight of Trust's highest rated risks regularly reviewed progress against mitigating actions challenged through Executive-led governance structures, including the Risk Review Group and Board Committees;
- Currently 39 risks on register, five new risks, three escalations, five de-escalations and three closures, reflecting positive ongoing movement and active management of risk profile.

The NEDs highlighted concern regarding the presence of 12 risks with overdue actions, emphasising that whilst not all actions within these risks were overdue, and this position required attention and improvement. The CNMO provided assurance these had been escalated to risk owners and accountable Executives, with strengthened oversight arrangements in place including monthly Executive review meetings and increased scrutiny through the Risk Review Group.

The Board discussed and considered examples of key risks and associated mitigations, including pharmacy related risks affected by external constraints. Also workforce challenges relating to senior medical capacity where recruitment progress was improving, and ongoing work to strengthen processes for management and follow-up of diagnostic test results to reduce potential patient harm. Noting some risks were complex and would remain open whilst longer-term solutions were implemented, with progress being made in areas such as radiology and pathology.

The NEDs highlighted the importance of clearly defining timelines for completion of actions and improving clarity in reporting, particularly where actions had been completed but risks remained open. The CNMO reported additional assurance through the internal audit work examining new processes for managing unexpected test results, which would be incorporated into the audit programme.

ACTION: Strengthen focus on addressing overdue actions, ensuring clear timelines for completion recorded and monitored.

CNMO

ACTION: Incorporate internal audit findings providing additional assurance on risk controls, particularly in relation to diagnostic test result management.

CNMO

The Board of Directors **NOTED** the SRR report for assurance purposes and for visibility of key risks facing the organisation.

26/032 BOARD ASSURANCE FRAMEWORK (BAF)

The DCG highlighted the following key elements:

- BAF redesigned as a standalone document strengthening its role as primary tool for understanding and managing the Trust's strategic risks;
- Revised BAF realigned to Trust's emerging strategic objectives, structured around core themes (Quality and Safety, Patients, People, Partnerships and Sustainability), with risks mapped to Board Committees to improve oversight and governance.

The Board acknowledged the revised BAF represented an initial reset, with further development required to ensure risks were appropriately defined, scored and supported by clear controls, mitigations and sources of assurance. It emphasised

the current stage was focused on validating whether the right risks had been identified, including identifying any gaps or areas requiring amendment, ahead of detailed scoring and assurance work.

The NEDs supported direction of travel, noting importance of aligning BAF more closely with current organisational priorities and risk appetite. It was agreed further more detailed consideration of risk appetite and prioritisation would be undertaken separately to enable a more robust and meaningful assessment of strategic risks. It was highlighted the need for a consistent methodology in assessing inherent, current and residual risk. The DCG provided assurance this would be developed through IAGC and reflected across Board Committees.

The DCG commented the intention of the BAF as a 'live' document being embedded within routine governance rather than static report, supported by more frequent review cycles given current organisational context. The Board confirmed agreement that risks and associated scores should evolve over time as mitigating actions were implemented, with regular updates feeding through Board Committee structures to the Board.

ACTION: Ensure Executive leads further develop the BAF by populating controls, mitigations, assurance routes and risk scoring.

DCG

ACTION: Undertake a dedicated session with the Board to consider its risk appetite and prioritisation.

DCG

The Board of Directors reviewed, discussed and **NOTED** revised BAF risks, would be a direct reference to where each risk scored according to Board's Risk Appetite, and Executives would provide input to score the risks according to the:

- inherent or initial;
- current; and
- residual or target.

26/033

MATERNITY AND NEONATAL ASSURANCE BOARD (MNAB) CHAIR'S REPORT

The DoM and Gynaecology Nursing highlighted the following key points:

- Clinical Negligence Scheme for Trusts (CNST) Compliance:
 - Maternity and neonatal services continued demonstrating strong performance across key safety, quality, governance and patient experience measures, with full compliance achieved against CNST safety actions and Year 7 of the Maternity Incentive Scheme (MIS).
- Perinatal Quality Oversight Model (PQOM):
 - High levels of clinical safety, including 100% compliance with 1:1 care in labour and supernumerary co-ordinator status;
 - Neonatal deaths remained below national thresholds;
 - Patient experience assurance, with high satisfaction rates across antenatal, intrapartum, postnatal and neonatal care, although areas for improvement remained around communication, triage waiting times and postnatal care;
 - Training compliance remained strong overall, with fetal monitoring, Practical Obstetric Multi-Professional Training (PROMPT) and newborn life support meeting or approaching required standards. Some workforce

groups remained slightly below target and training capacity constraints persisted following loss of estate capacity.

- Maternity and Neonatal Improvement Programme (MNIP):
 - Workforce recruitment improving, significant progress in midwifery recruitment and strong pipeline of applicants, challenges remained in maternity support worker vacancies and training provision. Wider system issues affecting workforce, including changes to bank rates, and need to maintain constructive engagement with staff;
 - Estates and service development issues, including delays to antenatal education provision, completion of CQC environmental actions and reconfiguration of WHH triage area, expected to be resolved later in year.
- Avoiding Term Admissions into Neonatal Units (ATAIN):
 - Transitional Care (TC)/ATAIN process mapping day: project plan and Terms of Reference (ToR) agreed.
- Saving Babies Lives (SBL):
 - Total compliance assessed at 99%, quarterly meetings with ICB ongoing for support and oversight of implementation.
- Maternity and Neonatal Patient Safety Incident Response Framework (PSIRF) Plan:
 - Plan presented and agreed at March 2026 MNAB, with development of the project plan underway.
- Antenatal and Newborn Screening (ANNB)
 - Improvement in newborn blood spot avoidable repeat rate now 3%, 70% of women receiving screening results by 10+ weeks, and focus on current limited genetic counselling resource due to staff leavers.
- Matters to escalate to Board
 - External independent review of intrauterine deaths underway, expected completion shortly, early learning already informed actions to improve awareness of reduced foetal movements, access to care and triage responsiveness.

The NEDs raised concern about the ongoing stillbirth rate, which remained above the national threshold (4.11 vs 3.50), with four cases reported in March resulting in a Maternity Outcomes Signal System (MOSS) trigger and prompting immediate internal review and escalation.

The NEDs emphasised the importance of transparent assurance in respect of the external independent review of intrauterine deaths, and agreed in addition to internal reporting, the external reviewers should present their findings directly to the Board once review complete.

The NEDs acknowledged progress of MNIP, including strengthened leadership, reduced neonatal deaths, improved compliance with safety metrics and clearance of patient safety backlogs. It was noted the ongoing enhanced oversight arrangements and regulatory engagement. The DoM and Gynaecology Nursing provided reassurance that governance processes, audit activity and safety monitoring remained robust, although service would remain under enhanced oversight given current performance concerns.

ACTION: Present to Board on completion the external stillbirth review including the findings and any recommendations.

CNMO

The Board of Directors **NOTED** the MNAB Chair's Assurance Report.

26/034 **ASSURANCE REPORT: ANNUAL RESEARCH AND INNOVATION (R&I) PORTFOLIO PERFORMANCE AND STRATEGIC OUTLOOK**

The Board of Directors noted this item had been deferred to the next meeting due to unforeseen circumstances, Director of R&I unable to attend owing to an urgent personal matter.

26/035 **ACTING CHIEF MEDICAL OFFICER'S (CMO'S) REPORT: ANNUAL ORGANISATIONAL AUDIT (AOA)**

The Acting CMO highlighted the following key points:

- Assurance on compliance with medical appraisal and revalidation requirements, part of Trust's statutory responsibilities as a designated body;
- Overall appraisal compliance remained strong and consistent at approximately 88–90%, with sustained performance across the year and continued increase in number of doctors connected to Trust;
- Responsible Officer's Advisory Group (ROAG) continued to oversee revalidation process, reviewing doctors three months ahead of their revalidation dates.

The Board acknowledged around 70% of revalidation recommendations were positive, with a relatively high deferral rate (circa 27–30%) primarily attributed to insufficient supporting evidence, particularly completion of 360-degree feedback from patients and colleagues. Recognising proportion of deferrals also reflected appropriate practice where doctors were new to the organisation and required further time before revalidation, consistent with General Medical Council (GMC) guidance. The Acting CMO reported actions already taken to address deferrals, including changes to required multi-source feedback earlier in appraisal cycle (year three) to ensure readiness for revalidation, alongside strengthened induction processes to better support newly appointed doctors. She commented there had been one instance of non-engagement during the period, subsequently resolved following intervention.

The Board took assurance appraisal quality and governance arrangements remained robust, with clear processes in place for monitoring compliance, identifying gaps and supporting improvement. Noting report also contributed to the wider NHSE assurance framework and informing the forthcoming Statement of Compliance submission.

The Board of Directors **NOTED** the content of the Acting CMO's: AOA report and the Annual Revalidation information provided.

26/036 **CERVICAL SCREENING ANNUAL REPORT 2025/26**

The Acting CMO highlighted the following key elements:

- Trust delivering safe and effective cervical screening and colposcopy service with good overall performance against national standards;
- Activity supported by comprehensive workforce, approximately 17 clinics per week;
- Key performance indicators related to timeliness of results and follow-up treatment continued showing strong and improving performance over time, with slight shortfall against the 100% timeliness standard in one quarter.

The NEDs raised the notable reduction in referral volumes, 13.3% decrease in cytology referrals in the most recent period, representing first significant fall after

several years of growth. It was noted whilst volumes remained historically high, expressed concern as to whether this reflected reduced uptake of screening or potential access issues. The Acting CMO reported a multi-agency task group established to investigate the underlying causes, including possible health inequalities, access to GP appointments, smear testing, and demographic changes. It was highlighted the importance of understanding whether wider factors, such as Human papillomavirus (HPV) vaccination uptake, might be influencing referral patterns.

The NEDs highlighted the risks relating to ageing equipment and facilities, including failures of colposcopy equipment during the year and need for replacement of essential devices such as colposcopes and diathermy machines. Noting these issues had not yet impacted performance, it was recognised this was a growing risk to service sustainability. The Acting CMO confirmed a business case underway for replacement with Executive support.

The NEDs raised the benefit of exploring opportunities to improve access and service delivery, including consideration of alternative models such as community based provision or mobile services. It was acknowledged clinical requirements might limit feasibility of some approaches. It was also noted need to review screening services more broadly alongside other service line reviews, given legacy nature of commissioning arrangements and the importance of ensuring services remained accessible and effective.

The Board commended the quality focused approach and strong engagement of the clinical team, noting positive assurance from national oversight. It was agreed further analysis of referral trends and access issues would be brought back to the Board once the task group had completed its work.

ACTION: Investigate and provide update report to a future Board meeting on the causes of reduced referrals, including access, inequalities and screening uptake. Also review cervical screening services within the wider context of screening provision, service line reviews, considering any opportunities to improve accessibility based on findings.

Acting
CMO

ACTION: Progress capital planning business case for replacement of ageing equipment and report update to future Board meeting on progress of procuring new equipment.

Acting
CMO

The Board of Directors received and **NOTED** the Cervical Screening Annual Report 2025/26 and the issues detailed.

26/037

PATIENT VOICE AND INVOLVEMENT (PV&I) ANNUAL REPORT 2025/26

The CNMO highlighted the following key elements:

- Significant progress made by a small but impactful team in strengthening patient engagement, feedback and co-production across the Trust;
- Scale of activity undertaken, including over 256,000 Friends and Family Test (FFT) responses with more than 57,000 free text comments themed. Alongside expanded use of surveys, improved accessible information, and enhanced outreach to local communities, particularly those experiencing health inequalities;
- Patient stories presented to Board, engagement with diverse groups, including homeless people, deaf communities and ethnic minority populations, improving organisation's understanding of patient experience and informed service development;

- Assurance robust processes in place to analyse and act on feedback, including development of theming tools, “You said, we did” approaches, and targeted engagement programmes such as cancer listening events, which had led to tangible service improvements;
- Strong responsiveness of service, including a 100% response rate to Care Opinion posts, and ongoing partnership working with voluntary and community sector organisations to extend reach and impact.

The Board welcomed strengthening participation arrangements, over 40 Participation Partners recruited, increasingly embedded in key Committees, supporting governance, ensuring patient voice directly informed decision making.

The NEDs queried opportunities to further enhance efficiency and impact, particularly the potential use of digital tools and AI-enabled analytics to support theming of large volumes of free text feedback, recognising current processes were resource intensive. Encouraging continued exploration of these approaches to support the team and improve timeliness of insight generation.

The Board commended the progress achieved, emphasising need to maintain momentum and accelerate delivery, ensuring patient voice activity continued to translate into measurable improvements in care and experience.

The CNMO reported a new Experience of Care Strategy was being co-designed and would be presented to the Board later in the year.

ACTION: Continue development of Experience of Care Strategy for consideration by the Board at a future meeting.

CNMO

ACTION: Explore use of AI/digital solutions to support feedback analysis.

CNMO

DECISION: The Board of Directors **NOTED** progress on delivering the Patient Voice and Involvement Strategy and **APPROVED** the Patient Voice and Involvement Annual Report 2025/26.

26/038 PEOPLE AND CULTURE STRATEGY

The Board of Directors received and **NOTED** the verbal progress update report from the CPO on the development of the People and Culture Strategy and that this would be presented to the People and Culture Committee and then the Board.

26/039 BOARD COMMITTEE – CHAIR ASSURANCE REPORTS

26/039.1 NOMINATIONS AND REMUNERATION COMMITTEE (NRC) – CHAIR ASSURANCE REPORT

The Interim Chair/NRC Chair reported on the following key issues:

- Remained significant pressures on Board capacity, particularly due to NED vacancies, with potential associated risks in respect of quoracy and leadership of key Board Committees. This included IAGC and FPC;
- Urgent actions being progressed around recruitment and interim mitigation arrangements to maintain effective governance and support forthcoming statutory responsibilities, including approval of annual accounts and annual documentation;
- Wider strategic workforce risks related to leadership capacity and succession planning, with limited ‘ready now’ successors for a number of Executive roles. Risk to be explicitly reflected in Trust’s BAF, further work

required to accelerate succession planning and leadership development across the organisation, including consideration of CEO succession;

- Approval of acting arrangements for Acting CEO and Acting CMO, agreement on NED recruitment priorities (focussing on IAGC and FPC around financial expertise), support for initiatives to strengthen Board diversity and future pipeline (e.g. Empowering People of Colour (EPOC) Fellowship Programme).

Board members acknowledged progress strengthening leadership and governance processes, including development of an Executive Team Development Programme, implementation of Board 360-degree feedback approach, and continuation of appraisal processes aligned to Fit and Proper Person Test (FPPT) requirements. Work to complete outstanding FPPT submissions and governance compliance requirements underway, expedited to meet statutory deadlines.

The Board emphasised the importance of accelerating key areas of work, particularly Executive and Board development priorities, ensuring timely delivery of governance actions and maintaining stability during a period of organisational pressure and transition.

The Board of Directors **NOTED** the 7 April and 19 May 2026 NRC Chair assurance reports.

26/039.2 **QUALITY AND SAFETY COMMITTEE (Q&SC) – CHAIR ASSURANCE REPORT**

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

- Breadth of scrutiny undertaken at March meeting, particularly focussing on UEC, quality governance and patient safety risks;
- Detailed deep dive into Emergency Department (ED) performance, highlighting ongoing pressures including misalignment of demand and capacity, long patient waits (including over 24 hours), and risks associated with overcrowding and corridor care;
- Received assurance of range of mitigating actions in progress, including delivery of UEC workstream, implementation of 'pool model' to improve patient flow, and continued ambition to eliminate corridor care and strengthen fundamentals of care (FoC);
- Quality governance and patient safety remained under close review and monitoring, including Prevention of Future Deaths (PFD) notice raising concerns about completeness and consistency of medical records, hindering coroner investigation. Matter of concern with ongoing monitoring;
- Continued scrutinisation of incident management (including backlog reduction), Duty of Candour (DoC) compliance, and learning from incidents and deaths. Evidence of improving engagement in structured judgement reviews (SJRs) and mortality processes, alongside continued analysis of mortality indicators such as Standard Hospital Mortality Indicator (SHMI).

The Board discussed ongoing challenges within patient pathways affecting patient experience and outcomes, including the non-Referral to Treatment (RTT) backlog, clarified as continuing to widen that required a substantive solution supported by a business case. Mental health service pressures continued, including long waits for beds impacting both patients and staff. Recruitment of additional registered mental health nurses being progressed, noted as a positive step, although wider system challenges and issues such as violence and aggression remained.

The NEDs noted learning from complaints and patient feedback, including 23% increased complaints largely associated with ED waits, and importance of early

engagement through Patient Advice and Liaison Service (PALS) and clinician involvement to improve patient experience and early resolution. Additional concerns raised regarding patient behaviour and its impact on staff and other patients, noting further partner system level discussions planned to address this.

The Board acknowledged areas of good practice, including comprehensive 'Never Events' annual review demonstrating alignment with national profiles, focus on learning rather than blame, as well as strong audit outcomes in areas such as stroke care. The Board received assurance Q&SC continued to provide robust oversight, with a strong focus on triangulating data, learning and improvement, whilst recognising need to sustain pace and focus in key risk areas.

The Board of Directors **NOTED** the 24 March 2026 Q&SC Chair assurance report.

26/039.3 **FINANCE AND PERFORMANCE COMMITTEE (FPC) – CHAIR ASSURANCE REPORT**

The FPC Chair reported on the following key issues:

- Assurance provided in respect of financial performance, CIP delivery, capital investment and operational performance risks;
- Trust achieved its revised year-end financial position, delivering £60m of savings, forecast deficit of approximately £49m, representing significant achievement without adverse impact on core performance;
- Delivery of 2026/27 CIP remained key risk, with ambitious targets (c.£76m) and substantial gap between identified opportunities and risk adjusted deliverable savings;
- Business case approved appointing strategic delivery partner to support CIP, achievement required sustained focus and structural change;
- Progress around eliminating corridor care, with positive system working across partners, recognising further progress dependent on support from system partners, particularly local authority services.

The NEDs emphasised the wider financial and operational risks, including reliance on CIP delivery to maintain cash stability, increasing pressure from workforce reduction requirements (including need for a detailed plan to deliver c.730 Whole Time Equivalent (WTE) reductions), and the impact of financial recovery on quality of care. Noting these risks reflected in the SRR and BAF, with a clear need for integrated planning across finance, workforce and quality.

The Board received assurance on capital delivery, noting strong performance in delivering a record capital programme, whilst acknowledging ongoing risks relating to the scale of the estates backlog (c.£240m) and the need for improved forward planning to avoid late in year spending concentration. The NEDs highlighted fire safety was a significant and ongoing risk, with audit findings identifying areas requiring remedial action, agreement continued oversight and more comprehensive reporting was required.

In relation to operational performance, the Board noted mixed progress, including improvements in RTT performance following targeted recovery actions and sustained gains in UEC, although performance remained below national standards in several areas, including cancer and diagnostics.

The Board noted positive ongoing scrutiny of its subsidiaries and partnership arrangements, including budgets for 2gether and Spencer Private Hospitals (SPH), with approvals either escalated to Board or agreed subject to further assurance on governance, transparency and financial viability.

The Board sought assurance on deliverability of the savings plans and discharge performance (including patients NCTR, recognising both internal progress and continued dependency on system partners. It was acknowledged that whilst internal improvements had been made, system wide collaboration remained critical to achieving sustainable performance improvements.

ACTION: Develop a detailed and integrated workforce reduction plan aligned to financial and quality objectives.

CPO

ACTION: Progress estates and fire safety improvement plans, providing regular reporting updates to FPC and the Board.

CSPO

The Board of Directors **NOTED** the 31 March and 24 April 2026 FPC Chair assurance reports.

26/039.4 PEOPLE AND CULTURE COMMITTEE (P&CC) – CHAIR ASSURANCE REPORT

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

- Committee's refreshed approach to assurance and oversight under new Chair leadership. Strengthening focus on triangulating workforce data at Care Group level and undertake more targeted deep dives aligned to BAF priorities, to better identify areas of organisational pressure, risk and opportunity. This revised approach supported by early positive examples, including detailed Care Group deep dive bringing together multiple sources of people data providing clearer insight;
- Positive performance in key workforce indicators, including reduction in sickness absence to below target and improvements within Occupational Health (particularly reducing referral waiting times and improving staff wellbeing support);
- Assurance of strengthened recruitment controls and governance processes, including vacancy management and Quality Impact Assessments (QIAs);
- Ongoing challenges, including below target appraisal compliance and need to strengthen appraisal quality as a key component of organisational culture and leadership.

The NEDs raised concern with focussed discussion around workforce transformation and delivery of the Pay CIP, where P&CC had only received partial assurance. There was also concerns regarding the pace and effectiveness of workforce reduction plans, including the need to better understand drivers of pay expenditure and ensure sufficient grip and delivery confidence. It was agreed further work was required to develop a clearer, more coherent and accelerated plan aligned to financial and operational objectives.

The Board highlighted progress to address ongoing complexity within the medical establishment review, including challenges in rota design, workforce utilisation and cultural barriers to change. Assurance was provided the programme was progressing, it was emphasised the need to accelerate this work to realise benefits in workforce efficiency, staff experience and patient care.

The NEDs highlighted the importance of aligning governance frameworks, including closer integration between the SRR and BAF in providing more coherent view of workforce risks and mitigation. Broader cultural priorities also endorsed, including strengthening leadership and organisational culture, noting P&CC formally approving a prioritised approach to cultural improvement.

The NEDs raised an emerging risk relating to sexual safety at work, noting forthcoming legislative changes that would significantly raise expectations on employers. It was agreed this area required further consideration and to be brought back to P&CC and Board to ensure appropriate actions and assurances in place.

ACTION: Bring forward report on sexual safety at work in advance of legislative changes presenting to P&CC, and provide an update to the Board.

CPO

The Board of Directors **NOTED** the 11 May 2026 P&CC Chair assurance report.

26/039.5

INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC) – INTERIM CHAIR ASSURANCE REPORT

- **STANDING FINANCIAL INSTRUCTIONS (SFIs) AND SCHEME OF DELEGATION (SoD)**
- **SAFETY, FIRE AND STATUTORY COMPLIANCE UPDATE REPORT**
- **IAGC TERMS OF REFERENCE (ToR)**

The Interim IAGC Chair reported on the following key issues:

- Progress made strengthening governance frameworks and internal controls, whilst number of areas continued to require focus, including delivery of management actions, cultural aspects of Freedom to Speak Up (FTSU), and risks associated with financial recovery and system dependencies;
- Continued oversight of BAF, supported by further development, including alignment with Board Committee 'deep dive' arrangements to strengthen ownership and scrutiny of key risks;
- Provision of limited assurance overall from internal audit, specifically in areas such as FTSU receiving partial assurance, further work required to embed a culture where staff felt confident to raise concerns;
- Limited assurance also provided by counter fraud in respect of fraud risk arrangements with improvements required in outcomes and timeliness, although compliance in declarations of interest improved significantly;
- Positive external audit assurance provided, work on track with annual audit, highlighting Value for Money opinion expected to identify weaknesses in financial arrangements;
- Assurance received in respect of financial governance and reporting, approval of Internal Audit Plan, External Audit Plan and Going Concern assessment;
- Review of the draft 2025/26 Annual Accounts Annual Report, Annual Governance Statement and Quality Account, assurance provided these annual documents on track for submission within the required deadlines.

The NEDs raised the Safety, Fire and Statutory Compliance report, with particular focus in the report presented for careful noting given its legal and regulatory significance. Whilst overall compliance levels had improved (c.91–92%), this remained below the 95% target, with ongoing risks relating to fire safety, backlog maintenance, and estates compliance. It was emphasised the seriousness of these statutory responsibilities and supported the need for continued detailed oversight and reporting in this area.

The Board noted the strengthened control and governance arrangements through proposed updates to the SFIs and SoD, including tighter approval thresholds and improved clarity. The Committee undertook its annual review of its ToR, confirming these as presented for approval and these continued to be fit for purpose.

DECISION: The Board of Directors:

- **NOTED** the 1 May 2026 Interim IAGC Chair assurance report;
- **APPROVED** the SFIs and SoD;
- **CAREFULLY NOTED** the Safety, Fire and Statutory Compliance Update Report;
- **APPROVED** the IAGC ToR.

26/039.6 KENT AND MEDWAY PATHOLOGY NETWORK (KMPN) ASSURANCE REPORT

The CSPO emphasised the following key issues:

- Continued progress in development of the pathology Joint Venture (JV) across the system;
- Programme progressing through agreed phased approach, Phase 2 (single management and governance) now largely complete, work beginning to transition towards Phase 3, delivering fully integrated single service JV by April 2027;
- Governance arrangements strengthened through establishment of Joint Committee with delegated authority and supporting sub-structures, accelerated progress and improved decision-making across partner organisations;
- Maidstone and Tunbridge Wells NHS Trust would continue as host organisation for next two years, with a future decision to be taken on long term hosting arrangements.

The NEDs acknowledged the scale and complexity of work required in next phase, particularly transition of staff, employment models, and budgets into the JV structure, alongside delivery of significant transformation and modernisation programme, including digital systems, equipment harmonisation and service consolidation.

The NEDs raised the broader system learning from the KMPN programme, noting whilst valuable insights had been gained (particularly regarding importance of joint governance, delegated authority and external expertise) there was currently limited formal capture of this learning. It was agreed this represented an opportunity to strengthen organisational and system capability for future service transformation initiatives and that mechanisms to capture and share learning should be explored through the Joint Committee

The NEDs noted progress was strong, whilst some delivery risks remained, including delays to certain actions and dependencies related to wider system financial pressures, and that continued oversight through the joint governance structure was essential.

ACTION: Raise at the Joint Committee the need to develop a more formal approach to capturing and sharing system learning from the KMPN programme.

The Board of Directors **NOTED** the KMPN assurance report and via the Joint Committee mechanism, continued to provide support to ensure the successful development of the KMPN Joint Venture.

CSPO

26/040 ANY OTHER BUSINESS

There were no other items of business raised.

The Interim Chair formally thanked the Executive, NEDs, and colleagues across the Trust, for their continued professionalism, commitment and significant additional

effort and hard work supporting the organisation during a period of increased activity and pressure. He also recognised flexibility shown by Board members accommodating additional meetings to maintain pace of delivery against key priorities.

26/041

QUESTIONS FROM THE PUBLIC

The Interim Chair reported the following questions submitted, which would be responded to by the appropriate Board member:

- Ms C Dolling submitted questions on behalf of the Sands and Tommy's Joint Policy Unit related to elements in maternity services:
 - Oversight of maternity, neonatal services, overview of key data sources;
 - Mortality and other perinatal outcomes;
 - Staff and patient experience;
 - Learning from reviews and investigations.
- The CNMO confirmed she had met with Ms Dolling and addressed and discussed the questions raised.
- Mr K Green submitted a question asking when the Patient Portal (past the date) would be fully completed, implemented and available for patient use? Highlighting the importance that information provided on Trust's website was up to date and current.
- The CSPO responded, reporting Trust developed its own patient portal, which had been in operational use for a number of years. Functionality of this was continually evolving. Portal now integrated with NHS App, a real positive step forward, and Trust among first Trusts to be live in this App. Now dedicated inpatient and outpatient appointments, with 56% of letters now digital by default (moving into the digital space). Apologised for Trust website not being frequently updated and listing current information and services available on the portal, and the IT team would ensure this was updated.
Mr Green had subsequently been in liaison with the IT team, and cancer and ophthalmology had now been added to the portal and the NHS App, the Trust continued to work on other areas.

ACTION: Update website information relating to the Patient Portal, keeping digital platform developments under review and ensure any updates are reflected on the Trust's website.

CSPO

- Mr R Yates (County Councillor for Cliftonville) submitted question Why there was no provision of air conditioning at Accident & Emergency (A&E) waiting room? Particularly in light of recent hot weather experienced.
- The CSPO responded reporting whilst it was not air conditioning in the sense that people would understand it, what was in place was a ventilation system in the waiting room that provided cooling of essential plant provision. This came under stress with the very high temperatures, Estates team adjusted the temperature set points to try and improve the local environment. It was recognised this provided challenge within the environment and Trust would continue to work on how could be improved.
- Ms K Thornberg submitted a question asking going forward and looking to the future, if Trust had a plan to involve patients and people more in order to improve and make a difference to patient health care and services within the organisation?

- The CNMO responded highlighting the 2025/26 Patient Voice and Involvement Report presented earlier in the meeting. The Trust agreed a Patient Voice Involvement Strategy in 2022, part of this included establishing a patient voice involvement team, also discussed earlier in supporting delivery of the strategy. The Trust co-designing an Experience of Care Strategy that would reflect an inclusive approach to improving the experience of care for patients, their families, carers and local communities (due to be presented in October 2026). The Patient Experience and Involvement team also supported services in making improvements based on feedback, involving patients and other stakeholders in finding solutions. Noting this started with patients, carers and families having a seat at the table when feedback discussed and improvements identified and prioritised. A detailed briefing would be provided direct to Ms Thornberg.
- Dr R Hallam submitted a question related to Trust's engagement with Palantir in respect of providing the 'Cancer 360' module FDP.
- The CSPO responded reporting at the current time Trust was not planning to implement the Cancer 360 module.

The Interim Chair closed the meeting at 4.25 pm.

Date of next meeting: Tuesday 28 July 2026

REPORT TO BOARD OF DIRECTORS (BoD)

BOARD OF DIRECTORS DECISION OUTSIDE THE BOARD

Report title: RECONFIGURATION OF ACUTE STROKE SERVICES – CAPITAL COSTS

Meeting date: 28 JULY 2026

Board sponsor: BEN STEVENS, CHIEF STRATEGY & PARTNERSHIPS OFFICER (CSPO)

Paper Author: STROKE PROGRAMME MANAGER/NICKY BENTLEY, DIRECTOR OF STRATEGY AND BUSINESS DEVELOPMENT

Appendices:

None

Executive summary:

Action required:	To Note
Purpose of the Report:	The Board of Directors were asked to approve the increased capital element of the final cost of the Stroke Hyper Acute Stroke Unit (HASU) build from 2gether Support Solutions' (2gether) P23 partner. Approval required to enable 2gether to sign the contract with IHP (the P23 partner) within the period during which the price to be held.
Summary of key issues:	Summary providing an update on the final costs received from the appointed P23 partner (IHP) in relation to the Stroke HASU build at the William Harvey Hospital (WHH). The stroke HASU business case approved by the Board in November 2025, pending the final RIBA 4 costings from the P23 provider. The final costing information now been received by 2gether with the cost being £3.65m higher than the value included within the business case. As this additional cost exceeded the 10% threshold, at which business cases required to seek further formal approval, additional sum required approval by the Board.
Key recommendations:	Board of Directors to NOTE approval of the £3.65m increased capital costs to enable the contract for the delivery of the Stroke HASU at WHH to be progressed.

Implications:

Links to Strategic Theme:	Sustainability – Financial governance to support financial sustainability.
Link to the Trust Risk Register:	N/A



Resource:	- Capital. Additional capital for 2027/28 and 2028/29 – this can be accommodated within the Trust's 5-year capital plan. 2gether. Confirmation required that the capital resource is available to sign the contract. - Project team – if the capital increase is not approved, additional resource (both human resource and capital resource) to undertake a full reset.
Legal and regulatory:	No
Subsidiary:	Yes - 2gether deliver the capital build of the Stroke HASU on behalf of the Trust.

Assurance route:

FPC – 9 June 2026
BoD – June 2026



REPORT TO BOARD OF DIRECTORS (BoD)

Report title: Matters Arising from the Minutes on 4 June 2026

Meeting date: 28 July 2026

Board sponsor: Dr Olu Olasode, Interim Chair

Paper Author: Board Support Secretary

Appendices:

None

Executive summary:

Action required:	Approval
Purpose of the Report:	The Board is required to be updated on progress of open actions and to approve the closing of implemented actions.
Summary of key issues:	An open action log is maintained of all actions arising or pending from each of the previous meetings of the BoDs. This is to ensure actions are followed through and implemented within the agreed timescales. The Board is asked to note the updates on the action log.
Key recommendations:	The Board of Directors is asked to: 1) NOTE the updates on actions, actions for future meetings, verbal updates on actions to be provided; and 2) APPROVE the seven actions recommended for closure.

Implications:

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

Assurance route:

Previously considered by: None

MATTERS ARISING FROM THE MINUTES ON 4 JUNE 2026
1. Purpose of the report

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

2. Background

- 2.1. An open action log is maintained of all actions arising or pending from each of the previous meetings of the BoDs. This is to ensure actions are followed through and implemented within the agreed timescales.
- 2.2. The Board is asked to note the updates on the action log as noted below:

Action No.	Action summary	Target date	Action owner	Status	Latest Progress Note (to include the date of the meeting the action was closed)
B/41/25	Progress engagement with local Councillors regarding social care capacity, as well as raising social care pressures with MPs and at Integrated Care System (ICS) level.	Apr-26/ Jun-26/ Jul-26	Acting Chief Executive Officer (CEO)	Open	02.04.26 - Trust continued to engage and raise at ICS level issues around social care capacity for progressing to support discharging patients from hospital.
B/47/25 B/11/26	Present independent stillbirth review report at a future Board meeting when completed. Present to Board on completion the external stillbirth review including the findings and any recommendations.	Apr-26/ Jun-26/ Jul-26	Chief Nursing and Midwifery Officer (CNMO)	Open	02.04.26 - External independent review now expected for completion in May 2026. 28.07.26 - Verbal update to be provided by CNMO at 28.07.26 Board meeting.
B/01/26	Circulate to Board members a briefing overview of the Team Engagement and Development (TED) programme.	Jul-26	Chief People Officer (CPO)	To Close	E-mail circulated to Board members with briefing overview of the TED programme (sent 22.06.26). Action for agreement for closure at 28.07.26 Board meeting.
B/02/26	Learning from Investigation: Complete feedback and engagement with clinical teams, ensuring transparency and shared understanding of findings and planned actions	Jul-26	CPO/Acting Chief Medical Officer (CMO)	To Close	Report presented to Open Board meeting on 28.07.26. Action for agreement for closure at 28.07.26 Board meeting.

Action No.	Action summary	Target date	Action owner	Status	Latest Progress Note (to include the date of the meeting the action was closed)
	ahead of presenting full investigation reports formally to July 2026 Open Board meeting for discussion and scrutiny.				
B/03/26	Present update report to future Board meeting on progress continuing to deliver action plan, including completion of outstanding actions and embedding of sustainable improvements.	Oct-26	CNMO	Open	Item for October 2026 BoD meeting.
B/04/26	Provide progress update to Board on the further work to address workforce gaps, including analysis of vacancies, turnover trends and medical job planning at team level. Also provide findings of additional analysis on workforce metrics and vacancy impacts to better inform financial and operational decisions.	Jul-26	CPO	Open	28.07.28 - Verbal update to be provided at 28.07.26 Board meeting, and progress update provided in People & Culture Committee (P&CC) Chair Assurance Report from P&CC meeting held on 21.07.26.
B/05/26	Present regular update reports to Board and Finance and Performance Committee (FPC) to track delivery of the Cost Improvement Programme (CIP), maintaining over programmed pipeline of savings, sustained focus on workforce cost control, particularly temporary staffing, and ongoing detailed productivity analysis informing	Jul-26	Chief Finance Officer (CFO)	To Close	CIP Governance and Oversight In train on a rolling basis. FPC receives detailed monthly reporting on financial position including CIP and Board will receive finance reports monthly. For Board awareness: - CIP planning is subject to a robust weekly Check and Challenge process, with progress and key issues reported to the System Finance Improvement Director (external/independent scrutiny). - CIP delivery against plan is monitored through weekly finance meetings, with any areas requiring Executive intervention escalated

Action No.	Action summary	Target date	Action owner	Status	Latest Progress Note (to include the date of the meeting the action was closed)
	transformation plans.				accordingly. Schemes that are materially deviating from plan are reviewed with the relevant Executive Sponsor and discussed at the weekly Financial Turnaround Session, and a standing agenda item of the Executive Management Team. - Progress against CIP targets is also reported to the weekly Finance Recovery Board, which in turn provides assurance to the monthly FPC. Reporting covers performance against savings targets across all areas, including pay expenditure (substantive, bank and agency staffing) and Productivity initiatives. - As noted in the June FPC paper, delivery of Productivity opportunities will be further strengthened through the establishment of a new Clinical and Operational Productivity Board reporting into FPC. Action for agreement for closure at 28.07.26 Board meeting.
B/06/26	Present update report to future Board meeting on progress with backlog maintenance and infrastructure risk, including updated cost assessments and options. Ensure continued monitoring and manageable execution of programme delivery and phasing.	Oct-26	Chief Strategy and Partnerships Officer (CSPO)	Open	Item for October 2026 BoD meeting.
B/07/26	Strengthen focus on addressing overdue actions, ensuring clear timelines for completion recorded and monitored.	Jul-26	CNMO	To Close	Focussed work undertaken addressing overdue actions, resulting in reduction from 43 to three. Progress update provided in Significant Risk Register report presented at 28.07.26 Board meeting. Action for agreement for closure at 28.07.26 Board meeting.
B/08/26	Incorporate internal audit findings providing additional	Jul-26	CNMO	To Close	Update provided in Significant Risk Register report presented at 28.07.26 Board meeting. Action for agreement for

Action No.	Action summary	Target date	Action owner	Status	Latest Progress Note (to include the date of the meeting the action was closed)
	assurance on risk controls, particularly in relation to diagnostic test result management.				closure at 28.07.26 Board meeting.
B/09/26	Ensure Executive leads further develop the Board Assurance Framework (BAF) by populating controls, mitigations, assurance routes and risk scoring.	Jul-26	Director of Corporate Governance (DCG)	Open	This is in progress with Executive leads. The draft BAF will be presented to the Sub-committees during the June/July meeting cycle for discussion.
B/10/26	Undertake a dedicated session with the Board to consider its risk appetite and prioritisation.	Jul-26	DCG	To Close	Dedicated 2 hour session for Board discussion of the Trust's Risk Appetite included on agenda for 02.07.26 BoD Strategic Session. Action for agreement for closure at 28.07.26 Board meeting.
B/12/26	Investigate and provide update report to a future Board meeting on the causes of reduced referrals, including access, inequalities and screening uptake. Also review cervical screening services within the wider context of screening provision, service line reviews, considering any opportunities to improve accessibility based on findings.	Oct-26	Acting CMO	Open	Item for October 2026 BoD meeting.
B/13/26	Progress capital planning business case for replacement of ageing equipment and report update to future Board meeting on progress of procuring new equipment.	Oct-26	Acting CMO	Open	Item for October 2026 BoD meeting.

Action No.	Action summary	Target date	Action owner	Status	Latest Progress Note (to include the date of the meeting the action was closed)
B/14/26	Continue development of Experience of Care Strategy for consideration by the Board at a future meeting.	Oct-26	CNMO	Open	Item for October 2026 BoD meeting.
B/15/26	Explore use of AI/digital solutions to support feedback analysis.	Jul-26	CNMO	To Close	Utilising a free AI tool developed by NHS England (NHSE) and Imperial college has been previously discussed with the Information team, who raised concern about the possibility of valuable insight being missed without humans reviewing comments. There is limited comments humans can review (within the team resources available) and the use of AI will support analysing Trust-wide comments much more effectively, assisting with identifying areas for focus and any trends. We have an automated solution identified, which is open source and has been developed within the NHS (not the Imperial Tool). The Information Department is working with the IT Department to pursue the solution in accordance with governance and cybersecurity standards. The solution should allow us to recategorise all Friends and Family Test (FFT) that has been received since the new platform was implemented. Aim for solution to be implemented by end of July. Action for agreement for closure at 28.07.26 Board meeting.
B/16/26	Develop a detailed and integrated workforce reduction plan aligned to financial and quality objectives.	Jul-26	CPO	Open	28.07.28 - Verbal update to be provided at 28.07.26 Board meeting, and progress update provided in P&CC Chair Assurance Report from P&CC meeting held on 21.07.26.
B/17/26	Progress estates and fire safety improvement plans, providing regular reporting updates to FPC and the Board.	Oct-26	CSPO	Open	Progress update report to be presented to August FPC meeting. Further progress update report to be presented to 1 October Board meeting.

Action No.	Action summary	Target date	Action owner	Status	Latest Progress Note (to include the date of the meeting the action was closed)
B/18/26	Bring forward report on sexual safety at work in advance of legislative changes presenting to P&CC, and provide an update to the Board.	Jul-26	CPO	Open	28.07.28 - Verbal update to be provided at 28.07.26 Board meeting.
B/19/26	Raise at the Joint Committee the need to develop a more formal approach to capturing and sharing system learning from the Kent and Medway Pathology Network (KMPN) programme.	Jul-26	CSPO	Open	28.07.28 - Verbal update to be provided at 28.07.26 Board meeting,
B/20/26	Update website information relating to the Patient Portal, keeping digital platform developments under review and ensure any updates are reflected on the Trust's website.	Jul-26	CSPO	Open	28.07.28 - Verbal update to be provided at 28.07.26 Board meeting,

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: Patient Story for the Board

Meeting date: 28 July 2026

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

Paper Author: Julie Yanni, Deputy Chief Nurse - Safeguarding, Vulnerable Patients and Patient Experience

Appendices:

Appendix 1: Meg's story

Executive summary:

Action required:	Information
Purpose of the Report:	The purpose of this patient story is to bring the patient's voice directly into Board level discussions and decision making. This patient story relates to the experiences of Meg who gave birth to a pre-term baby (Callum) in our maternity services. After a brief spell on the Neonatal Intensive Care Unit (NICU), Callum and the family spent a number of weeks on the Special Care Baby Unit (SCBU).
Summary of key issues:	Getting a mother's (and by association the family's) care right at the beginning of a new life can help provide that family with the best possible start to a new life chapter for all concerned. Arguably this is never more important than when birthing plans go awry. The unexpected events leading to Callum's birth and subsequent hospital stay could have been one that impacted the family in a lifelong negative way. In this case the opposite was true. Meg's story highlights how exceptional skilled clinical care from a high functioning multi-disciplinary team coupled with kind, compassionate and safe care enabled this mother and her family to feel cared for and supported at a very difficult time. Importantly, this story demonstrates the impact of staff behaviour and culture and the role this plays in providing a great patient experience. A great deal of attention was paid to discharge planning, ensuring that the parents as well as Callum were ready to take their next steps. Baby Callum has not required further admissions and the family have continued to grow and thrive since discharge. Appendix 1 sets out Meg's story.
Key recommendations:	The Board of Directors are asked to RECEIVE the report and hear Meg's story.

Implications:

Links to 'We Care' Strategic Objectives:	• Quality and Safety • Patients
Link to the Trust Risk Register:	None
Resource:	No
Legal and regulatory:	The Trust must comply with the Care Quality Commission (CQC) Regulations. The Equality Act 2010 and the public sector equality duty under the Act require NHS organisations to demonstrate due regard to people with protected characteristics in the provision of healthcare. The Carers Act 2024.
Subsidiary:	No

Assurance route:

Previously considered by: Not applicable - Patient/family stories come direct to the Board.

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Meg's story

1. Introduction

- 1.1 Meg is a new mum to Baby Callum. Callum's dad and Meg's husband is Pete. Meg is also a nurse. She trained locally, qualifying in 2013. She has worked in paediatrics ever since. Her current role is Paediatric Advanced Clinical Practitioner.
- 1.2 Meg was 33 weeks pregnant and at work at Kent & Canterbury Hospital (K&C). Up until then she had an uneventful pregnancy. Meg felt uncomfortable with some abdominal "pressure". Supported by the Director of Nursing, Meg went to the Early Baby Unit at K&C. They were unable to accommodate her as her pregnancy was beyond 16 weeks so she returned to Dolphin Ward where her pain became intermittent. Supported again by her Director of Nursing, Meg telephoned the maternity triage service but was unable to get through. Her husband collected her and she went to the William Harvey Hospital (WHH).

2. Events of March 2026

- 2.1. On arrival at the unit, even though the staff were not expecting her, she was warmly received. She was quickly assessed and Meg describes a lot of activity at this time but staff were calm which helped with her anxiety. At one point the baby's heart rate dropped. The emergency buzzer was activated and Meg remembers hearing the words "woman in pre-term labour." She says there was then a room full of people including an anaesthetist and Consultant Gynaecologist. Her consent was sought for an internal examination and she was found to be 2-3cm dilated.
- 2.2. The next 12 hours or so were a hive of activity as Meg's labour commenced. She had to have a number of interventions including steroid and magnesium infusions. "I could see the Neonatal Intensive Care Unit (NICU) team outside my room." Despite all of this, Meg repeatedly talks about how calm everyone was. She was included in the decision making every step of the way and as much as possible was supported with her birth plan. "Nothing was said to me in an alarming fashion." Little things made a difference, the fan provided, the sandwiches, choices over pain relief. Meg felt her privacy and dignity were maintained throughout.
- 2.3. Meg feeling she was supported throughout with her choices was really important to her. For example, she didn't want to give birth on her back so staff tried to support with this by helping her on to her side. This was difficult due to all the monitoring. When it was inevitable Meg needed to be on her back to safely deliver, she was supported to do so. Two midwives held her hand, when she said "I can't do this" they said "you can, you are".
- 2.4. When Callum was delivered, he was placed on her chest. The team gave her as much time as possible, she didn't feel rushed and therefore experienced that all important skin to skin contact with her little boy as he was welcomed to the world. The cord was cut and Callum was taken to NICU. Pete was invited to accompany Callum but chose to stay with Meg. They went to NICU together to see their baby 20 minutes later.

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- 2.5 Callum remained in hospital for a total of three weeks. He was stepped down from NICU within three hours but spent the remainder of the time in Special Care Baby Unit (SCBU). Callum's problem was mostly a feeding issue. Meg says every nurse throughout their stay was "lovely and I'm probably their worst nightmare (being a paediatric nurse)". She felt that they really took an interest in her and the family. Meg described the medical team as being very present. The Consultant was "very present" and "really gentle and kind to me." She said he described everything twice. He spoke to me using medical language and then explained to my husband in layman's terms.
- 2.6 Meg and Pete were keen to understand how long Callum would need to be in hospital. Meg felt that they weren't fobbed off with answers. They were told it is likely to be your gestation date +/- two weeks which is exactly what happened.
- 2.7. Meg felt really cared for. She was expressing milk, there was a cupboard full of food she could help herself to. The space is tiny in SCBU but Meg describes how she was enabled to have privacy, screens were offered and staff though always present were "good at not looking at you" which afforded Meg, Callum and Pete privacy. Meg says that the Matron (Tracy Twyman) was very present on the unit. She offered lunch vouchers to Meg for the restaurant. It wasn't clear whether this was available to all as the other mothers did not appear to have been offered this.
- 2.8 After five days, Meg was discharged from Folkestone Ward which meant she would be going home without Callum. "I burst into tears." with discharge of Meg imminent, staff in words and actions continued to wrap their arms around her and support her with this difficult transition. A nurse said to her "I will pick him up if he cries, phone anytime" Callum stayed connected with his parents, even with the physical distance. By the time Meg got home on the day of discharge, she had received a photo of Callum saying "night mum." When Meg awoke in the morning photos of his night were there waiting for her with messages written in Callum's voice.
- 2.9 If Callum was going to be moved, Meg was always informed so she would always know where to find him. She said the staff were really good at thinking of all the things that would upset me.
- 2.10. Meg described how thorough discharge planning was to support a good outcome when Callum went home. This included feeding, safe sleep. Meg didn't feel rushed. The Nasogastric (NG) tube was removed and Meg was supported with breast feeding. Meg was very grateful that they were given time.
- 2.11. Meg was particularly pleased that one of the nurses "Kayleigh" was her student a year before. She was particularly delighted to know she had taught someone who was clearly an outstanding nurse.
- 2.12. When the time to go home was imminent, the clinical team sought feedback of the family's experience. She was also prepared for the future and signposted to psychological support as there may be anxiety if Meg and Pete decide to expand their family.

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- 2.13. Since discharge, the family have settled well. Callum is thriving and has not needed to be readmitted.

3. Conclusion

- 3.1. The unexpected events leading to Callum's birth and subsequent hospital stay could have been one that impacted the family in a lifelong negative way. Meg's story highlights how exceptional skilled clinical care from a high functioning multi-disciplinary team coupled with kindness and compassion enabled this mother and family to feel supported and cared for at a very difficult time. The themes coming through are consistent; choices (no decision taken without me), consent, support, exceptional examples of kindness and compassion, privacy and dignity felt even when the physical environment did not enable this, truly patient centred care, pre-empting what mattered to Meg, the little things, trust, engagement, and preparation for a safe discharge.

4. Recommendation

The Board of Directors are asked to receive the report and to hear Meg's story.

INTERIM CHAIR'S REPORT

Introduction

Since my last report in June, the Trust has continued to stabilise its leadership and governance arrangements while maintaining its focus on the quality and safety of care, staff experience, operational recovery and financial sustainability.

The Trust remains subject to additional licence conditions under Section 111 of the Health and Social Care Act 2012 and to Enforcement Undertakings accepted under Section 106 of the same Act, and is one of a small number of trusts nationally within NHS England's Intensive Recovery Programme (IRP). The Board does not underestimate the seriousness of this position. The Undertakings reflect serious and sustained concerns about the quality and safety of care, the experience of our staff, and the effectiveness of Board leadership – concerns that this Board owns and is taking intensified action to address.

A significant part of our discussions this afternoon will focus on the mechanism through which we will demonstrate to patients, staff, governors and our regulators that care is becoming safer, that staff are being heard, and that the Board is leading that change with the necessary pace. Today's meeting will table consolidated evidence of ownership, collective leadership and delivery.

I again want to thank colleagues across the Trust for their professionalism, compassion and continued focus on patients during a demanding and uncertain period.

Governance, leadership and regulatory oversight

The Board's response spans five connected areas: governance and stability; quality and safety; finance and performance; people and culture; and strategy and transformation. Since June, the Board has strengthened the foundations on which that response rests: a review of the Board's risk appetite and the Board Assurance Framework has commenced; committee-to-Board assurance routes and Board reporting are being redesigned; a Director of Corporate Governance is in post on a fixed term basis; and the Board has commenced an externally supported development programme focused on assurance, scrutiny and collective leadership.

The appointment of two fixed-term Non-Executive Directors have been confirmed with one more to be confirmed shortly to address quoracy and strengthen Board capacity and capability in the near term, and I warmly welcome them to the Board. Recruitment of a substantive Chair and further substantive Non-Executive Directors is underway through the Council of Governors, with interviews planned for September 2026, and the route to recruiting a substantive Chief Executive has been confirmed and is being progressed.

The 2025/26 Fit and Proper Person Test process has been completed for Board members, and the annual declaration was submitted to NHS England by the 30 June deadline. Annual Board member appraisals have also been completed.

The Board continues to operate as a unitary Board: executive colleagues remain responsible for implementation and delivery, Non-Executive Directors bring independent scrutiny and challenge,



and we take and own our decisions collectively, with collective accountability for the Trust's performance.

Strengthening the relationship between the Council of Governors and the Board of Directors

The Council of Governors met on 23 July, and I am grateful to governors for their continued engagement, challenge and support during this period. The Council's statutory role, including in the appointment of the substantive Chair and Non-Executive Directors through its Nominations and Remuneration Committee, is central to restoring stable, credible Board leadership, and the Board is committed to supporting governors to discharge it well.

At the meeting, the Council considered practical steps to strengthen its relationship with the Board and support governors in discharging their statutory responsibilities.

Two initiatives are being progressed:

1. **Informal sessions with the Chair:** regular informal meetings have been arranged from September to support open dialogue, mutual understanding and timely engagement between formal Council meetings.
2. **Joint Council and Board strategic session:** a joint session is being planned for autumn or winter 2026/27 and is intended to become at least an annual feature of the governance calendar.

These arrangements will not alter the distinct statutory responsibilities of the Board and Council. They are intended to strengthen trust, information flow and the Council's ability to hold the Non-Executive Directors to account for the performance of the Board.

Board Strategic Session

On 2 July, the Board held a Strategic Session at which we were joined by Professor Sir Jonathan Montgomery, NHS England South East Regional Chair; Anne Eden, NHS England South East Regional Director; and Angela McNab, Interim Chair, and Adam Doyle, Chief Executive, of NHS Kent and Medway Integrated Care Board. The session provided an important opportunity for open and honest dialogue on the Trust's position across governance and leadership, quality and safety, people and culture, operational performance and finance, and the period ahead, including where the Trust needs support from regional and system partners. The Board welcomed the challenge brought by colleagues.

This was one of three additional Board sessions held since the June oversight meeting — on 24 June, 2 July and 10 July — reflecting the pace at which the Board is testing and sharpening its improvement response. The sessions also considered the Trust's risk appetite and the prioritisation of immediate actions to deliver the improvements needed for patients, staff and the Trust. This discipline will be reflected in the priorities and recovery framework being considered today and in the detailed delivery plans to be agreed in September.



Quality, operational performance and patient experience

The Board continues to see meaningful improvement in urgent and emergency care. Corridor care has been eliminated at the Queen Elizabeth the Queen Mother Hospital since March and at the William Harvey Hospital since early June, and performance on the longest Emergency Department waits has improved substantially. The Board's focus is now on sustaining this position through winter and reducing the use of other non-care spaces. These improvements matter because they bear directly on patient safety, dignity and mortality, and the Board is monitoring that relationship closely.

The Board is equally clear about where performance is not yet where it must be. Cancer performance and diagnostic access — particularly radiology — remain under significant pressure; long waits for planned care remain a concern; and delayed discharge continues to constrain patient flow, requiring sustained work with system partners. These areas are subject to detailed oversight through the Integrated Performance Report and the Finance and Performance Committee, and form central strands of the Trust's improvement programme. The Board will also continue to scrutinise mortality indicators, recent Never Events, and maternity and neonatal improvement.

Anaesthetic Service Review

The Board will consider the reports arising from the reviews of anaesthetic services and the associated raising-concerns process. It will continue to seek assurance that the findings have been addressed transparently, that the actions are sufficiently clear and measurable, and that learning is translated into safer care, stronger clinical leadership and a culture in which concerns are raised and acted upon promptly.

I want to acknowledge the staff who raised concerns and who contributed to these reviews. Speaking up takes courage, and the test of this organisation is that those who do so are heard, respected and see action and change follow. The Board's decision to consider these reports in public reflects its commitment to transparency and to learning openly.

People, culture and leadership capability

I reiterate that the experience of our staff is fundamental to the Trust's recovery, and the Board has been honest with itself about what the most recent National Staff Survey said: staff engagement fell, and experience deteriorated across the majority of measures. The Board does not regard this as survey data to be noted; it is the clearest signal of the leadership and cultural change required.

Work is underway to refresh the Trust's culture programme around three priority outcomes (advocacy, compassionate culture, and fair access to development) focusing on the things that evidence shows move them: compassionate leadership, team climate, and growth. A strengthened staff experience governance model will ensure the Board hears from staff continuously, not annually, and the findings of the review of speaking up will be translated into visible action. The Raising Concerns report on today's agenda is part of that commitment.



We continue to approach leadership and culture issues fairly, thoughtfully and compassionately, while recognising that the organisation cannot wait for perfect conditions before necessary action is taken.

Strategy, partnership and financial sustainability

The Board remains committed to developing a clear longer-term strategy for the Trust, rooted in the needs of the communities of East Kent and informed by clinical priorities, partnership working and the changing expectations of the NHS. The development of the Trust Strategy 2026-2035 provides an important opportunity to set a coherent direction for services, workforce, estates, digital capability and partnership delivery.

At the time of writing, the Trust was consulting with NHS England and Kent and Medway Integrated Care Board (ICB) on the strategy in advance of sign-off by the Board. Subject to that engagement, the Board expects to approve and publish the Trust Strategy 2026–2035 in the early autumn, with an organisational clinical strategy, developed through clinical leadership, to follow as one of the Trust's formal commitments to NHS England.

Today's agenda also includes an update on system working and the developing Kent and Medway Provider Alliance, which will be an increasingly important vehicle for addressing challenges, including diagnostics, discharge and financial sustainability, that no single organisation can resolve alone.

The condition of the Trust's estate remains a significant strategic risk, and the Board will continue to make the case, with system and national partners, for a credible route to addressing the Trust's critical infrastructure needs.

I continue regular engagement with the NHS England South East Regional Chair and Regional Director, the leadership of NHS Kent and Medway ICB, fellow provider chairs and other regional partners. These discussions are focused on maintaining alignment, securing practical support and ensuring that external input strengthens rather than displaces the Trust's own accountability for recovery.

National Context

On 20 July 2026, following the appointment of the Rt Hon Andy Burnham MP as Prime Minister, the Rt Hon Yvette Cooper MP was appointed Secretary of State for Health and Social Care. Both bring prior ministerial experience of the Department of Health. The detailed implications for NHS policy and delivery will become clearer over the coming months. The Board will be kept informed, through NHS England and the Integrated Care Board, on any implications for national priorities, planning assumptions and the oversight arrangements described below, and the Executive will assess and report any consequences for the Trust's improvement programme.

NHS Oversight Framework 2026/27

NHS England published the NHS Oversight Framework 2026/27 on 11 June. The refreshed framework reinforces the need for clear trajectories, reliable evidence, early escalation and



demonstrable improvement across quality, access, workforce, leadership and finance. The Trust remains in Segment 4 and is one of five organisations receiving support through the Intensive Recovery Programme. This reflects the seriousness of the challenge and the expectation that improvement will be delivered with ownership, pace and urgency.

NHS England Medium-Term Planning Framework

NHS England's Medium-Term Planning Framework (delivering change together, 2026/27 to 2028/29) sets out an expectation that provider productivity measures will be published monthly and incorporated into the Oversight Framework. It also confirms a continuing shift toward a structured, digital-first urgent and emergency care model, and closer alignment between the Oversight Framework and Care Quality Commission (CQC) assessments of provider capability. This has direct relevance to our own productivity, Urgent and Emergency Care (UEC) and quality agendas, and I have asked that the Executive keep the Board sighted on national timelines as they firm up.

Regional Matters

The Trust continues to work closely with NHS England and NHS Kent and Medway ICB through the current oversight and intensive recovery arrangements.

On 17 July, the Trust submitted a detailed supplementary response bringing together the Section 111 conditions, Enforcement Undertakings, IRP domains and the issues raised during the 2 July Board visit. It sets out the evidence NHS England should expect at the agreed evidence points, providing a coherent and cumulative basis for oversight and public accountability. The Board remains grateful for the support provided by the Director of the Intensive Recovery Programme in helping to ensure that recovery actions against the identified challenges remain focused and are delivered at pace.

The Board continues to welcome constructive external support and scrutiny. It is equally clear that the Trust must own its recovery and be assessed against the evidence of delivery at the agreed milestones.

Immediate Priorities

The Board's immediate priorities are to adopt a shared statement of the causes of the Trust's challenges, informed by the Intensive Recovery Programme diagnostic, and to agree a focused set of improvement priorities with named senior responsible owners. The Board will then approve detailed delivery plans, an integrated Board scorecard and strengthened assurance routes for inclusion in the Integrated Improvement Plan to be submitted to NHS England by 30 September. In parallel, the Trust will continue to deliver against its key operational and financial commitments.

Conclusion

This remains a challenging period for the Trust, and the Board is under no illusion about the scale of what must change. But the Board enters the period ahead with one integrated improvement framework, clear priorities, named ownership, and agreed milestones against which NHS England, the ICB, our governors and the public will see progress. The test of this work is not the



quality of our plans but whether care becomes measurably safer, access to treatment improves, staff feel the difference, and confidence in the Trust is restored. My ambition, shared across the Board, remains that East Kent comes through its current difficulties and becomes an excellent provider of healthcare for the people of East Kent.

Patients, staff, governors, regulators and partners need to continue to see a Board that is focused, disciplined and united in its purpose — and one that welcomes scrutiny of whether it is making a difference.

I would again like to thank all staff and Board colleagues for their continued professionalism, commitment and compassion during a demanding period for the Trust.

May I remind everyone there will be the Annual Members Meeting (AMM) on Thursday 3 September 2026 in Seminar Rooms 1 & 2 at Buckland Hospital, Dover (arrival 4.30 pm for meeting starting at 5.00 pm).

Olu Olasode

July 2026



REPORT TO BOARD OF DIRECTORS (BoD)

Report title: Acting Chief Executive Officer's (CEO's) Report

Meeting date: 28 July 2026

Board sponsor: Des Holden, Acting Chief Executive Officer (CEO)

Paper Author: Des Holden, Acting Chief Executive Officer (CEO)

Appendices:

N/A

Executive summary:

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

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Trust Risk Register:	The report links to the corporate and strategic risk registers.
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: N/A



ACTING CHIEF EXECUTIVE OFFICER'S (CEO'S) REPORT

1. PURPOSE OF THE REPORT

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

2. INTERNAL UPDATE

2.1 Performance update

A more comprehensive update on access and performance will be made by relevant executives in the Integrated Performance section of the Board. However, Urgent and Emergency Care performance remains significantly improved compared with earlier in the year, although combined all type UEC 4hr performance was 0.9% worse in June than May. Performance against the 12hr standard also worsened slightly with 17% of arrivals spending more than 12hr in the department, performance had been tracking broadly in line with May until week commencing 22 June, when a period of extreme heat resulted in operational pressures across both sites and the introduction of Red Heat Health Alert escalation arrangements.

Despite this, the Trust has sustained significant reductions in excess hours spent by patients in Emergency Departments. Excess hours for non-admitted patients remain approximately half the historic average, demonstrating the continued impact of flow improvement initiatives and front-door pathway changes. Ambulance handover and waiting times also continue to improve.

Patient flow remains the principal constraint, with No Criteria to Reside (NCTR) at 180, above trajectory. However, improvements in length of stay continue to be seen across Pathway 0 and Pathway 3 cohorts, supported by the introduction of strengthened daily review processes at all sites from April as part of the Eliminating Corridor Care programme. Patients with lengths of stay greater than 14 days have reduced significantly, alongside reductions in NCTR-related delays, indicating that enhanced review and discharge arrangements are having a positive effect.

A comprehensive Rapid Improvement Programme, aligned to the GIRFT Corridor Care Improvement Guide, has supported the objective to deliver the elimination of corridor care. Stopping the provision of care in locations which are not normally bedded is an area of focus in the next phase of improvement, which includes continuing to improve patient flow, reducing unnecessary Emergency Department demand through alternative pathways for assessment and treatment, expanding Same Day Emergency Care (SDEC) capacity, strengthening frailty services and working closely with system partners to improve discharge and community



capacity. Sustained system-wide action remains critical to achieving constitutional standards and driving down, and eliminating corridor care.

Cancer performance remained challenged throughout June, with both Faster Diagnosis Standard (FDS) and 62-day performance continuing below national expectations. The primary driver of underperformance continues to be diagnostic delay rather than treatment capacity. These delays are resulting in patients reaching multidisciplinary team review later in their pathways and subsequently breaching cancer standards. We are a partner in the Kent and Medway Pathology Network, and in addition have agreed with other providers in Kent and Medway (K&M), and with our commissioners, that as well as improvements within our own gift to make, an acute provider collaborative approach to diagnostic imaging across K&M will be progressed. The trust reports fortnightly on internal progress in this area of performance to Regional oversight. The Trust continues to perform strongly against the 31-day treatment standard, achieving 97.2% in June, demonstrating that treatment capacity remains largely sufficient once a decision to treat has been made.

At the end of Quarter 1, the Trust is behind plan for elective activity delivery.

Across the quarter, the Trust delivered fewer first outpatient appointments, and fewer inpatient spells, and day cases than had been planned.

RTT performance remains marginally ahead of plan at 56.1% against a trajectory of 54.7%; however, this position reflects recovery activity undertaken during late 2025/26, giving a stronger starting position than had been anticipated when the trajectories were originally set, rather than current-year delivery. Work is underway to ensure the performance standards are met, and timely actions taken to achieve our performance objectives in full in year.

The Trust continues to prioritise productivity improvement, increasing elective activity in line with what is expected this year for Trust performance and reduction of long waits to support achievement of RTT standards and delivery of the Operating Plan.

3. OTHER AREAS TO NOTE

3.1 Intensive Recovery Programme

I am pleased to report that Catherine McDonald has joined the Trust as our Director of Intensive Recovery. Catherine brings a great deal of experience and is helping us determine priorities for improvement, in partnership with our regulators and commissioners, and move forward as a leadership team.

3.2 External investigation following concerns raised by anaesthetists

I draw attention to two reports which were commissioned externally and appear in the agenda of this meeting. Following concerns raised by colleagues we commissioned two external reports, one about safety of staffing arrangements, in



particular in relation to a third tier of anaesthetic staffing at William Harvey Hospital, and a second on how concerns are raised, and heard within our hospitals.

3.3 Trust Strategy

Development of the Trust's Strategy is now in its final stages, with ongoing discussions taking place with both the Integrated Care Board and NHS England. The strategy has been a long time in production, and has therefore needed to take account of the local system realisation of the ambitions of the NHS 10-year plan and should be seen as the Trust's commitment to working collaboratively across Kent and Medway to improve outcomes for patients. The Board has actively engaged with the ICB through its provider alliance and acute collaboratives, and supports the ambition of structuring future care at primary, neighbourhood, intermediate and acute hospital levels.

The Trust continues to play an active role within the Kent and Medway Provider Alliance, (as mentioned in respect to pathology and diagnostics, but in all other areas of work) and it is important that our strategic priorities align closely with the wider ambitions and objectives of the Kent and Medway health and care system. Finalisation of the strategy will provide a clear framework for organisational improvement and delivery over the coming years.

3.4 Care Quality Commission Inspection of William Harvey Hospital Emergency Department

The Care Quality Commission (CQC) has rated the urgent and emergency care service at William Harvey Hospital as Requires Improvement following an unannounced inspection undertaken in February 2026. The service was rated Good in three of the five domains (for Caring, Effective and Well-Led), and Requires Improvement for Safe and Responsive, resulting in an overall rating of Requires Improvement.

The report is an accurate reflection of the significant pressures experienced within urgent and emergency care during the winter period, including the impact of overcrowding and corridor care. This is something everyone in the Trust has recognised as unacceptable as we are clear it has a significant impact on patients' care, safety, privacy and dignity. As noted earlier, the Trust has worked alongside NHS England, the Integrated Care Board and system partners to eliminate corridor care and improve patient flow across our hospitals.

The report also recognises the positive safety culture within the department and highlights improvements in leadership, effectiveness and compassionate care. The Trust remains fully committed to continuing this improvement journey for patients and staff.

3.5 Independent National Maternity and Neonatal Services Investigation

Baroness Amos has published the final report of the independent national maternity and neonatal services investigation, alongside individual reports for the



twelve NHS trusts selected to participate in the review, including East Kent Hospitals. The publication follows the review of maternity services nationally and has been accompanied by a set of immediate actions for systems issued by NHS England.

We recognise and sincerely apologise for the devastating and enduring impact that failures in our maternity service have had on families. Whilst the report identifies important improvements made since the publication of Dr Bill Kirkup's Reading the Signals report in 2022, it also highlights concerns raised by families and staff which we acknowledge fully.

We remain committed to delivering sustained improvement in maternity and neonatal care and will ensure the learning and recommendations arising from the review are incorporated into our ongoing improvement programme. Progress against these actions will continue to be reported openly through our Trust Board.

3.6 Digital Innovation and Artificial Intelligence Pilot

East Kent Hospitals has become the first NHS Trust to pilot an artificial intelligence tool designed to help clinicians identify infections at an earlier stage and support timely treatment.

The technology, known as MEMORI, is currently being trialled on the Harvey Ward at the Kent and Canterbury Hospital and analyses routine clinical information to generate an individual infection risk score for patients.

The pilot has been developed through a partnership with UK health technology company Sanome and has been co-designed with Trust clinical teams before being integrated into the Sunrise electronic patient record system.

By helping clinicians identify deteriorating patients sooner, the tool has the potential to improve outcomes and reduce the risk of serious complications such as sepsis. The initiative supports the ambitions set out in the NHS 10-Year Plan to increase the use of digital technology and artificial intelligence in patient care.

3.7 National Recognition for Diabetes Team

I am delighted that our Diabetes Specialist Nursing team has been recognised nationally after being named Inpatient Diabetes Specialist Nurses of the Year at the Diabetes Nursing Awards.

The award recognises teams that make a significant contribution to improving care for patients living with diabetes through education, clinical leadership and improved patient outcomes. Our team was recognised for its work transforming inpatient diabetes care across the Trust in response to rates of diabetes-related harm, including hospital-acquired diabetic ketoacidosis (DKA) and hyperosmolar hyperglycaemic state (HHS) and I would like to congratulate them on this well-deserved achievement.



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



REPORT TO BOARD OF DIRECTORS (BoD)

Report title: The Provider Alliance Update

Meeting date: 28 July 2026

Board sponsors: Dr Olu Olasode, Interim Chair
Des Holden, Acting Chief Executive Officer (CEO)

Paper Author: Dorothy Otite, Director of Corporate Governance

Appendices:

Appendix 1: Kent & Medway Acute Provider Alliance and Acute and Neighbourhood Collaboratives

Appendix 2: NHS Kent & Medway System Governance and Joint Committee Alignment: Joint Committee Board Report

Executive summary:

Action required:	Discussion
Purpose of the Report:	The report sets out: 1) Acute Provider Alliance – Appendix 1 sets out the structure and work programme of joint working arrangements across the system and then lists these out using the bullet points below: • Structure of system joint working arrangements and Provider Alliance • Multi-neighbourhood footprints • Priorities identified for the Acute Collaborative • Priorities for the Neighbourhood Collaborative • Commissioner work plan 2) Joint Committee Report – The report in Appendix 2 reflects the outcome of the Joint Committee discussion, confirming areas of agreement and setting out clear expectations for the next phase of delivery. It is designed to be issued to all Boards as a consistent account of system direction, supported by coordinated phasing of discussions across organisations.
Summary of key issues:	The papers have been shared with all CEOs and Chairs for discussion with the Board.
Key recommendations:	The Board of Directors is asked to: - DISCUSS the contents of the report; - NOTE the outcome of the Joint Committee discussion; - CONFIRM continued support for the agreed direction of travel; and - CONSIDER the implications for the Trust, particularly in relation



	to collaboration, clinical model development, leadership capacity and financial sustainability.

Implications:

Links to Strategic Theme:	Partnerships
Link to the Trust Risk Register:	Y BAF FPC 005: There is a risk that the significant financial pressures, operational challenges, and competing priorities of all organisations within our System could impact on collaborative relationships with partners.
Resource:	N
Legal and regulatory:	Y
Subsidiary:	N

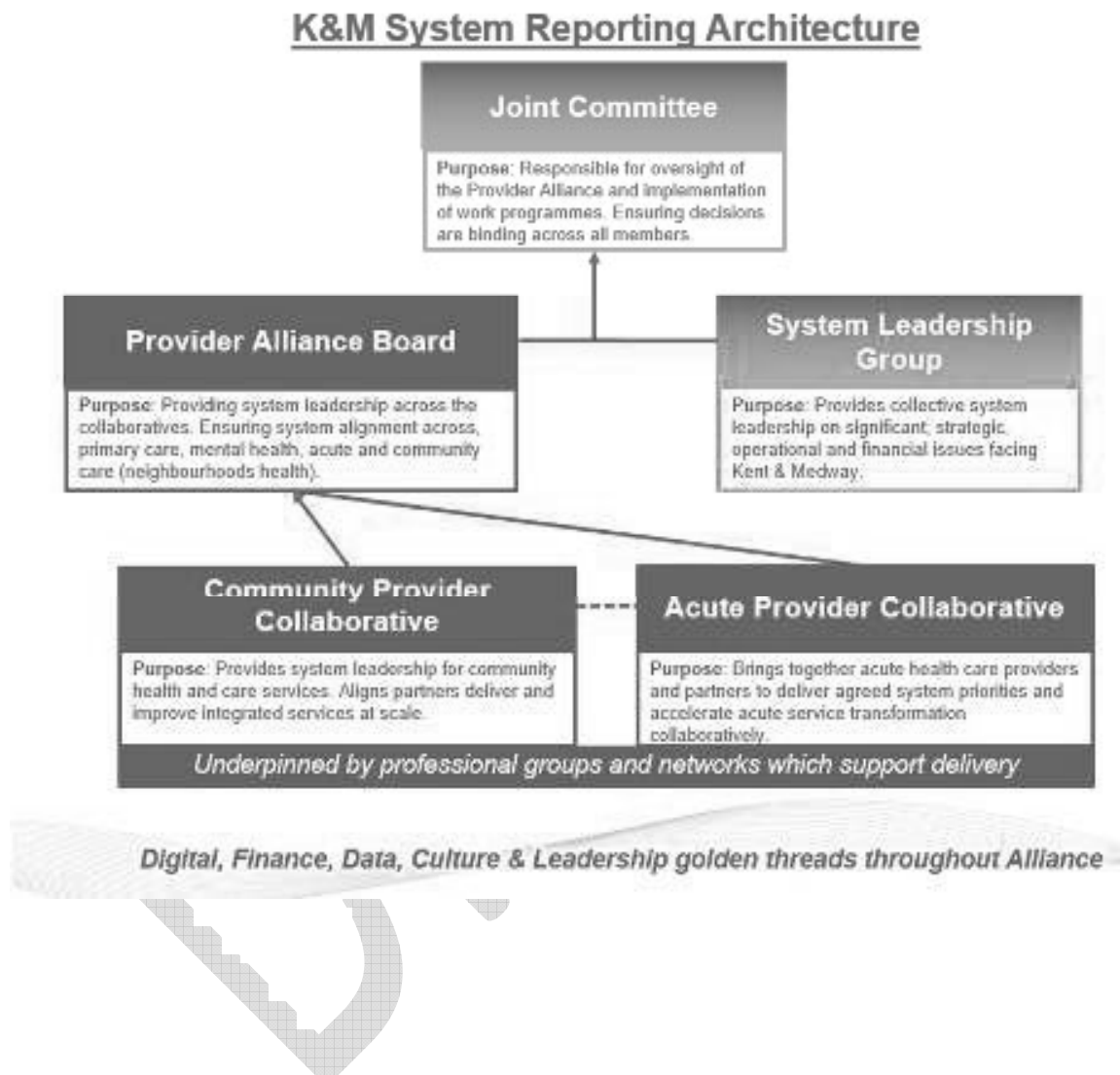
Assurance route:

Previously considered by: N/A

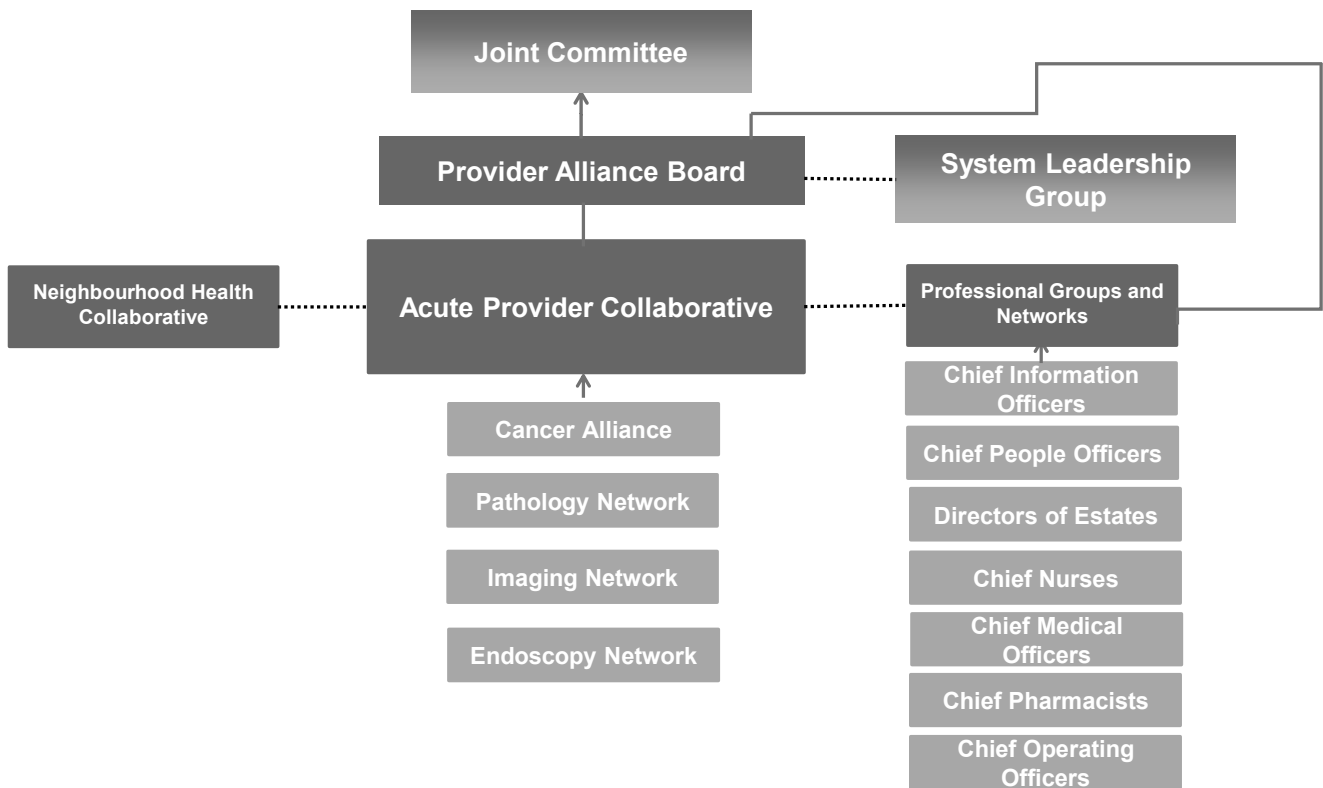


Appendix A

Alliance Structure (high level)

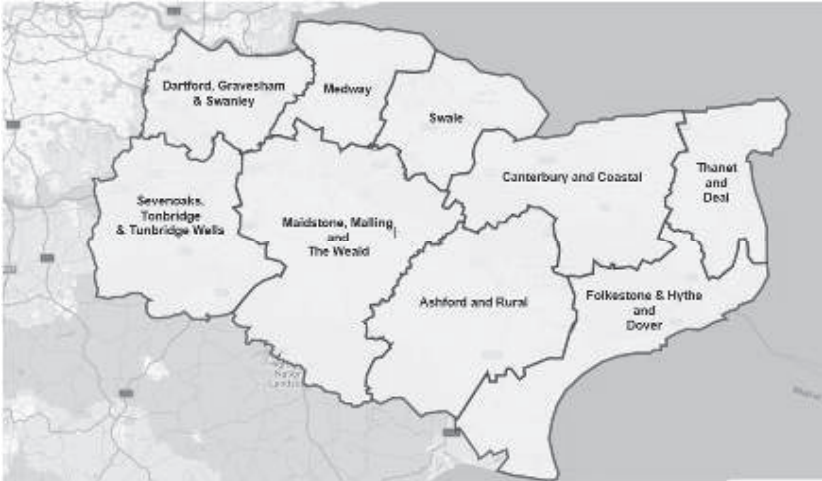


K&M Acute Provider Collaborative



Multi-Neighbourhood Footprints

In Kent and Medway, **nine multi-neighbourhood footprints have been agreed each ranging from 109,000 to 339,000 residents**. These are designed to be large enough to enable collaboration, yet local enough to maintain a strong sense of place and identity, providing the right balance for effective joint planning and delivery. Each footprint brings together several single neighbourhoods to strengthen integration across health, care, and community services, support shared workforce planning, and align resources around local population needs.



	Multi-Neighbourhood Footprints	Population Count
1.	Dartford, Gravesham & Swanley	c.297,955
2.	Medway	c.338,780
3.	Swale	c.109,030
4.	Canterbury and Coastal	c.221,200
5.	Thanet and Deal	c.205,020
6.	Dover, Folkestone Hythe	c.180,890
7.	Ashford and Rural	c.216,000
8.	Maidstone, Maidstone and The Weald	c.297,990
9.	Sevenoaks, Tonbridge & Tunbridge Wells	c.241,660

Acute Provider Collaborative Programme Areas FY26/27

The Acute Provider Board met on 17 April to propose a set of Phase Two (26/27) programmes for consideration by the System Leadership Group and Provider Alliance.

Through a scoring and prioritisation process the following areas have been identified as the highest priorities for collective action to be taken forward by the Acute Provider Collaborative with **delivery during FY26/27:**

1. Referral Management, (min 10 specialties to inc. gastro, T&O/MSK, ophthalmology, ENT, neurology)
2. Reducing long Waiters and equitable access – working towards single PTL/s
3. Radiology – immediate focus with a view to consolidation or single management
4. Reduction in use of independent sector and repatriation from out of Kent providers
5. Cancer centre, oncology & chemotherapy
6. Gynae oncology service plan to address urgent sustainability issues, (EKHUFT & MTW)
7. Establishing a hospital flow improvement collaborative to work together on national best practice guidance for: ED; eliminating corridor care; first 72 hours of care; discharge. (NB subject to avoiding duplication with nationally mandated activity through special measures programmes.)

Acute Provider Collaborative Programme Areas FY26/27

In addition, work will be initiated during FY26/27 to address priorities that have a significantly longer lead in time to implementation as a consequence of requirements for: significant analytical preparation and complex business case development; formal consultation; capital investment and approval; major changes in commissioning plans. It is proposed that this work is initiated in relation to:

1. Fragile Services
2. Centres of Excellence
3. Maternity Services
4. Specialist Paediatrics & Children's Surgery
5. Utilisation and disposition of acute facilities

Other areas prioritised for collective action being taken forward by other groups.

In working through the prioritisation we identified a number of priorities for action which are being taken forward by other groups currently, (or we recommend are done so). In each case we need to agree whether these programmes report: i) directly into the Provider Alliance; ii) into the Acute Provider Collaborative; iii) into the System Leadership Group; or iv) are a commissioner-led piece of work. Where the programme of work does not report into the APC, the acute providers will work collaboratively with the relevant SRO to agree how the APC can engage effectively in the work.

- Frailty and Care of the Elderly – being led by the Neighbourhood Health Collaborative
- Medicines Optimisation – ?? being led by Chief Pharmacists group
- Dermatology – to be commissioner led for service reconfiguration
- Neuro-rehab - to be commissioner led due to differential provision
- Digital – ?? being led by the CDIO group
- Corporate Support and Back Office – ?? to report directly into the Provider Alliance

The Acute Provider Collaborative will ensure that both focus and resource is allocated to support delivery of areas to be taken forward by others. In particular, clinical expertise and alignment to neighbourhoods will ensure that services that form part of the 'left shift' will be identified and transitioned when ready.

Neighbourhood Collaborative Plan

26/27

Programmes	Plan	Process to adoption	Lead	Key Dependencies	Timeframe/National Requirements	Outputs	Provider Resource
Virtual Ward	Agreed model of care to be adopted K&M wide Agreed financial and workforce modelling Agreed timeframe for full implementation	Neighbourhood Collaborative	Neighbourhood Collaborative	- Acute Care / ED / SDEC - SPOA programme - SECAMB - UCR - Primary Care - Digital Professional Group - Acute and Primary Care Collaborative - Single Neighbourhood SN) - Multi-neighbourhood MN) - VCSE	Delivery to be in line with national requirements and agreed model of care Full mobilisation by Oct 2026 (Q3)	- Consistent VW model of care across K&M digitally enabled - Standardisation of clinical pathways and clinical governance agreed - Monitoring PNG 10 11+for each of the following: - Attendance Avoidance - Admission avoidance increase - Early supported discharge improves - ROI calculations	Transformational team resource agreed: - Digital Lead - BI Lead - Finance lead - Clinical and Cultural Leadership to embed the neighbourhood models
Single Point of Access	Agreed model of care to be adopted K&M wide Agreed financial and workforce modelling Agreed timeframe for full implementation	Neighbourhood Collaborative	Neighbourhood Collaborative	Acute and Primary Care Collaboratives: - SECAMB - UCR - VW - SDEC - SN - MN - VCSE	Delivery to be in line with national requirements and agreed model of care– full mobilisation by October 2026 (Q3)	- Consistent SPOA model of care across K&M - Digitally enabled - Standardisation of clinical pathways and clinical governance agreed - Monitoring of PNG 10 & 11+ for each of the following: - Attendance avoidance - Admission avoidance - Early supported discharge - ROI calculations	Transformational team resource agreed: - COOs - Digital Lead - BI Lead - Finance Lead - Clinical and cultural leadership to embed the neighbourhood models
Urgent Community Response	Agreed model of care to be adopted K&M wide Agreed financial and workforce modelling Agreed timeframe for full implementation	Neighbourhood Collaborative	Neighbourhood Collaborative	Acute and Primary Care Collaboratives - SECAMB - VW - SDEC - SNH - MNH - SPOA - VCSE	Delivery to in line with national requirements and agreed model of care EK WK – mobilised by Q3 D,G,S and M&S uplift in Q3 / full mobilisation by Q4.	- Consistent UCR model of care across K&M - Digitally enabled - Standardisation of clinical pathways and clinical governance agreed - Monitoring of PNG 10 & 11+ for each of the following - Attendance avoidance - Admission avoidance - Early supported discharge - ROI calculations	Transformational team resource agreed: - COOs - Digital Lead - BI lead - Finance lead - Clinical and cultural leadership to embed the neighbourhood models

Neighbourhood Collaborative Plan 26/27

Programmes	Plan	Process to adoption	Lead	Key Dependencies	Timeframe/National Requirements	Outputs	Provider Resource
Home First (HF)	Agreed model of care to be adopted K&M wide Agreed financial and workforce modelling Agreed timeframe for full implementation	Neighbourhood Collaborative	Neighbourhood Collaborative	Acute IDT Teams Transfer of Care Hubs Local Authority Adult Social Care Community Hospital and Nursing Teams K&M Medicines Optimisation Teams UCR Single Neighbourhood SN) Multi-neighbourhood MN) Primary Care Acute and Primary Care Collaborative VCSE Patients / Families and Carers	Delivery to be in line with National Hospital Discharge and Community Support Guidance and agreed model of care Full mobilisation by Oct 2026 (Q3)	Consistent HF model of care across K&M Standardisation of clinical pathways and clinical governance agreed Monitoring PNG 10 & 11+ for each of the following: Early supported discharge improves No criteria to reside reductions for P1 Length of Stay reduction for P1 30-day Re-admission Avoidance ROI calculations	Transformational team resource agreed COOs Digital Lead BI Lead Finance lead Clinical and Cultural Leadership to embed the neighbourhood models and improved discharge and flow
Perfect Ward (PW)	Agreed model of care to be piloted across Kent Agreed financial and workforce modelling Agreed timeframe for full implementation	Neighbourhood Collaborative	Neighbourhood Collaborative	Acute IDT Teams Transfer of Care Hubs Local Authority Adult Social Care Community Hospital and Nursing Teams UCR SN MN Acute and Primary Care Collaboratives VCSE, incl Hospices and Palliative Care Patients / Families and Carers	Delivery to be in line with National Hospital Discharge and Community Support Guidance and agreed model of care EK WK mobilised in Q1 DGS and Swale full mobilisation by Oct 2026 (Q3)	Consistent PW model of care across K&M Standardisation of clinical pathways and clinical governance agreed Monitoring PNG 10 & 11+for each of the following: Early supported discharge improves No criteria to reside reductions for P2 Length of Stay reduction for P2 30-day Re-admission Avoidance ROI calculations	Transformational team resource agreed COOs Digital Lead BI Lead Finance lead Clinical and Cultural Leadership to embed the neighbourhood models and improved discharge and flow

Commissioner Work Plan – System Leadership Group 22nd May

1. INTRODUCTION

We are resetting our role to become a high-performing strategic commissioning organisation, focused on improving population outcomes, tackling inequalities and securing value for money. This represents a deliberate shift away from transactional commissioning and fragmented oversight, towards a model where the ICB sets clear system expectations, aligns resources to agreed models of care, and holds the system to account for delivery.

This reset underpins recovery in performance and finance, while creating the conditions for long-term transformation. We will commission services across the four layers of care we have defined for the system, primary care, single neighbourhoods, intermediate/multi-neighbourhoods and acute.

We are now preparing our commissioning intentions for 2027/28, which will be shared in the coming weeks before being finalised in the autumn. We will also now have a three-year commissioning strategy, which has been specifically requested of integrated care boards by NHSE Chief Executive Jim Mackey, please see attached current version. This incorporates the 3 year shift to strategic commissioning and what it means in practice.

Our commissioning strategy describes our plan for the next three years, using annual commissioning intentions to set expectations and ambition for radical change – it is clinically-led.

In order to progress, it has been agreed that will categorise our commissioning schemes/activities, based on the following, to support with alignment to our strategy to facilitate us moving forward:

- Category A – Schemes/activities developed pre-October prior to the ICB reset)
- Category B – Schemes/activities introduced post October post the start of the ICB reset
- Category C – Schemes/activities introduced from now, in line with Commissioning Strategy

By April 2027, the ICB will be operating as a strategic commissioning organisation – with MDTs embedded as the primary decision-making mechanism, supported by real-time data, an equipped workforce and governance integrated into corporate cycles.

2. COMMISSIONER WORKPLAN

Our commissioning strategy describes our plan for the next three years, using annual commissioning intentions to set expectations and ambition for radical change – it is clinically-led.

The process/timescale for our commissioning intentions is as follows:

- Engage on our draft Commissioning Strategy and priorities 20th May–17th June)
- Produce a draft set of commissioning intentions for approval at our July Board
- Carry out engagement with public, providers and partners over summer
- Schedule discussions with Alliance and Collaboratives to discuss draft intentions
- Produce a final set of commissioning intentions for approval at our September Board

- Communicate formally with Providers/Alliance/Collaboratives by 30th September

Kent and Medway providers will deliver through a Provider Alliance comprising two formal Collaboratives for Neighbourhood Health and Acute. We will support primary care to play a fuller role in these collaboratives by working across the ICB at scale.

We are in the process of aligning our functions to deliver through four Commissioning Multidisciplinary Teams. They will provide the enabling way of working where clinical, finance, contracting, procurement, involvement, quality and risk, business intelligence, health inequalities/population health and commissioning expertise come together around defined population groups, pathways and areas of spend.

We have embedded clinicians within each of our Commissioning Multi-Disciplinary Teams for Urgent and Emergency Care, Elective Care, Primary Care/Community and Neighbourhood and Mental Health/Learning Disabilities and Autism. Our strategic commissioning will only deliver impact if it is underpinned by strong and visible clinical leadership. It needs to be at centre of how priorities are set, services are designed and outcomes are delivered. Commissioning Multi-Disciplinary Teams are starting to come together now and will be formally set-up by 1st July, with the launch of our new organisation.

In order to progress, it has been agreed that will categorise our commissioning schemes/activities, based on the following, to support with alignment to our strategy to facilitate us moving forward:

- Category A – Schemes/activities developed pre-October prior to the ICB reset)
- Category B – Schemes/activities introduced post October post the start of the ICB reset)
- Category C – Schemes/activities introduced from now, in line with Commissioning Strategy

Category A – longstanding commissioning exercise being brought to a head or closing. Pre-empt ICB reset Schemes/activities developed pre-October 2025

- UTC Review – being recast and reset to reflect new system architecture.
- Community Beds work – being incorporated into future work on discharge model and closed down.
- Childrens and all age Mental Health services transfer to KMMH from NELFT (Final review of Q1 2026/27 before process deemed complete
- Community Services reprocurement – Transformation funding for 2025/26 and 2026/27 still to be agreed

Category B – Ongoing commissioning projects initiated during transition phase Schemes/activities introduced post October 2025)

- Implement Single Neighbourhood Health as the core neighbourhood delivery model for management of escalation in complex populations, utilising the Patient Need Groups risk stratification tool, agreed footprints and partnering within a multi-neighbourhood health model to deliver at scale. 2026/27)
- Create multi-neighbourhood service model to partner SNH delivery for the complex care cohort and to reduce attendances and admissions at ED. Requires CV to Community Contract (Q1 2026/27
- NOUS reprocurement agreed by Commissioning Sub-Group May 2026
- Commission new models of ADHD and autism assessment starting initially in 2026/27 and expanding from 2027/28 if successful)

Category C – to be done via ‘new method’ Schemes/activities introduced from now)

- BCF Review Q1 2026/27
- UTC Review new approach)
- Action plan for General Practice responding to the NAPC review of GP services (Q1 2026/27)
- Improving utilisation of clinical services in community pharmacy to manage demand plan developed in 2026/27
- Create a unified model of intermediate care Standardise models for Virtual Wards, Urgent Community Response and remote monitoring from current variable picture 2026-27 with implementation into 2027-28). Undertake a parallel review of future community bed requirements.
- Transfer of care hub model standardised as part of a revised discharge blueprint for the system. Designed in 2026/27 and implemented in 2027/28. Matched with a full review of P3 capacity joint with Council Partners to ensure type and volume of provision fits need review starts 2026/27 and implemented 2027/28
- Commission elective community services at scale from 2027/28) and increase diagnostic access through additional straight-to-test pathways 2027/28 and optimising use of Community Diagnostic Centres 2027/28) rather than non-NHS capacity. Decommission fragmented services where previous historic commissioning not based on need and variation does not address specific population need. Commission new models of MSK and dermatology services to reduce demand flowing into acute settings 2027/28 and 2028/29)
- Commission scaled multidisciplinary pathways across maternal medicine and pelvic health 2027/28
- Develop Acute Centres of Excellence and realign outpatient capacity, including new to follow-up appointment ratios and Patient Initiated Follow Up 2026/27 through to 2028/29). Start with T+O and endoscopy, rolling out to wider specialities. SPOA established 2026/27 and expanded over period to 2028/29.
- Agree a plan to adopt a single system waiting list approach (2026/27 and implement in stages through 2027-2029 linked to SPOA rollout.
- Identify outpatient specialities for ‘left shift’ and in support of SNH with a design phase 2026) informing gradual rollout.
- Co-design and develop a consistent system-wide maternity and women’s health model following a review of maternity services in 2026 (2027/28 and 2028/29
- Redesign acute mental health urgent and emergency pathways to reduce ED reliance, improve flow, and minimise length of stay and out-of-area placements ensuring that East Kent and Medway are supported by a MH CAC model that retains the best of current voluntary sector input 2027/28)
- Standardise and integrate mental health pathways at scale, including Children & Young People to Adult transitions beginning in 2026/27 and through to 2028/29), crisis (from 2026/27), step-up and step-down pathways including commissioning of a revised model 2026/27 initially consolidated in 2027/28), and placement pathways S117, LDA (starting in 2026/27 and expanding in 2027/28 .

3. REQUIRED OUTCOMES AND NEXT STEPS

- Discuss and endorse direction with Commissioning Strategy and Work Plan
- Discuss and agree approach for proactive Provider engagement with commissioning intentions

4. SUPPORTING DOCUMENTATION

Commissioning Strategy for Kent and Medway attached.

Report to	NHS System Leadership Group
Meeting date	26 June 2026
Report Title	System Governance and Joint Committee Alignment: Joint Committee Board Report
Key question	Is the System Leadership Group content with the proposed approach to issuing a consistent Joint Committee update to all Boards, including the phasing and supporting arrangements?
Executive Lead	Adam Doyle, Chief Executive Officer, NHS Kent and Medway
Author	Adam Doyle, Chief Executive Officer, NHS Kent and Medway

Which of the organisation s strategic objectives does the report support:	
☐ Commission the right services each year	☐ To ensure financial sustainability over three years
☒ Lead strategy and ensure commissioning levers deliver impact	☐ Develop into a high-performing Commissioning Organisation
☐ Renew our culture for long-term sustainability	

Recommendation (outcome / action requested):
Meeting action required: ☒ Seek assurance ☐ Decision/approval required ☐ For noting/information Recommendation(s) to the Meeting: The Meeting is asked to: NOTE the contents of this report SUPPORT the approach to co-ordinated circulation across partner organisations NOTE the proposed phasing, with the ICB Company Secretary working with partner organisation Company Secretaries and Director of Communications to support messaging and consistency of communications

Executive summary:
This paper presents the draft Board report summarising the outcome of the Joint Committee discussion on system transformation, care models and commissioning architecture, for onward consideration by the ICB Board and partner provider Boards.

The intention is to provide a single, consistent system narrative following Joint Committee, ensuring alignment across organisations on the agreed direction of travel and expectations for delivery.

The ICB Company Secretary is working with Company Secretaries across partner organisations to agree the phasing of Board discussions, ensuring coordinated timing and alignment of governance processes. The Director of Communications will support the approach to ensure clarity and consistency of messaging.

The System Leadership Group is invited to note the proposed approach and provide assurance that it is appropriate.

Proposed next steps:

- Finalise the Board report following SLG feedback
- Agree phasing and timing of Board presentations with partner Company Secretaries
- Support coordinated communication and messaging across organisations
- Issue report to all Boards in line with agreed approach

Governance pathway to date:

Meeting name:	Date:	Outcome:
N/A		

Contact for further information

Adam Doyle, adam.doyle5@nhs.net

COMPLIANCE NOTES:

Equality, health inequalities, and quality impact assessment

If this report is presented for decision/approval, please complete:

Has an assessment been undertaken?

- ☐ Yes (please attach the action plan as an appendix to this paper)
- ☒ No/Not applicable (please indicate why an assessment was not required)

An Equality and Health Inequalities and Quality Impact Assessment has not been undertaken as this paper is a strategic update on agreed system direction and proposed Board reporting, and does not introduce any direct changes to services, access or delivery.

Conflicts of Interest

COMPLIANCE NOTES:

Are there any conflicts associated with authors or reporting officers?

☐ Yes ☒ No

If yes, please confirm how the conflict has been managed.

FOI Status

Is this report disclosable under FOI?

☒ Yes ☐ No

If no, please specify why:

Financial Implications

Are there financial implications associated with this report?

☐ Yes ☒ No

If yes, please describe:

Legal Implications

Are there legal implications associated with this report?

☐ Yes ☒ No

If yes, please describe:

Quality and Safety Implications

Are there quality or safety implications associated with this report?

☐ Yes ☒ No

If yes, please describe:

Patient and Public Engagement

Are there patient and public engagement implications associated with this report?

☐ Yes ☒ No

If yes, please describe. If no, please specify why:

There are no patient and public engagement implications as this paper communicates an agreed system position and approach to Board reporting; any future service changes arising from this work will be subject to appropriate engagement.

SYSTEM GOVERNANCE AND JOINT COMMITTEE ALIGNMENT: JOINT COMMITTEE BOARD REPORT

1. INTRODUCTION

This paper presents the draft Board report summarising the outcome of the Joint Committee discussion on system transformation, care models and commissioning architecture. It is intended for onward consideration by the ICB Board and partner provider Boards, providing a single, consistent system narrative and ensuring alignment on the agreed direction of travel and expectations for delivery.

2. STRATEGIC ALIGNMENT

This report supports delivery of the agreed system transformation programme, including the move to a more integrated, population-based model of care, strengthened provider alliances and the transition to strategic commissioning. It enables a consistent understanding across Boards, supporting collective leadership, coordinated decision-making and alignment to system priorities, including improved outcomes, reduced inequalities and financial sustainability.

3. JOINT COMMITTEE BOARD REPORT

The attached report reflects the outcome of the Joint Committee discussion, confirming areas of agreement and setting out clear expectations for the next phase of delivery. It is designed to be issued to all Boards as a consistent account of system direction, supported by coordinated phasing of discussions across organisations. The ICB Company Secretary is working with Company Secretaries across partner organisations to agree the timing and sequencing of Board consideration, with support from the Director of Communications to ensure clarity and consistency of messaging.

4. KEY RISKS, MITIGATIONS, AND CONTROLS

There is a risk that, without a coordinated approach, differing timing or interpretation of the Joint Committee outcomes across organisations could lead to inconsistency in understanding, messaging or organisational response. This is being mitigated through a structured, system-wide approach led by the ICB Company Secretary in collaboration with partner Company Secretaries to align Board cycles and phasing. In addition, communications support will ensure consistent messaging and narrative across organisations, reducing the risk of misalignment and supporting collective ownership of the agreed direction.

5. OTHER CONSIDERATIONS

There are no other considerations relevant to this report.

6. REQUIRED OUTCOMES AND NEXT STEPS

The Meeting is asked to:

- **NOTE** the proposed Board report content following Joint Committee
- **SUPPORT** the approach to coordinated circulation across partner organisations
- **NOTE** the proposed phasing, with the ICB Company Secretary working with partner organisation Company Secretaries and Director of Communications to support messaging and consistency of communications

7. SUPPORTING DOCUMENTATION

There are no supporting documents relevant to this report.

Appendices:

Appendix 1: Joint Committee Board Report

NHS Kent and Medway Joint Committee
System Transformation, Care Models and Commissioning Architecture
Report for Noting – Following Joint Committee Discussion

1. Purpose

- 1.1. This paper brings together the previously circulated system architecture and care model proposals and provides an update following discussion at the Joint Committee.
- 1.2. The purpose of this report is to confirm the areas of agreement reached, clarify the expectations arising from that discussion, and provide a consistent system narrative for consideration by the ICB Board and partner provider Boards.
- 1.3. The Joint Committee confirmed that there is now a shared understanding of both the direction of travel and the scale of change required across Kent and Medway.

2. Context and Rationale for Change

- 2.1. The context set out in the original paper remains unchanged. The system continues to operate under sustained financial, operational and workforce pressure, with variation in access and outcomes and a delivery model that remains overly reliant on hospital-based care.
- 2.2. The Joint Committee explicitly confirmed that:
 - The current model has reached its limits and is no longer sustainable
 - Incremental change will not deliver the scale of improvement required
 - A more fundamental shift in how care is organised and delivered is necessary
- 2.3. There was a clear and consistent articulation from provider organisations that their current models are both clinically and financially unsustainable in their present form. This was recognised collectively as a critical driver for change across the system.

3. The System Model: Four Layers of Care

- 3.1. The Joint Committee confirmed agreement with the four-layer model of care as the organising framework for the system:
 - Primary care
 - Neighbourhood care
 - Intermediate care at scale
 - Acute care
- 3.2. there was strong support for this structure as the right foundation for future delivery. However, the discussion emphasised that the models within these

layers must remain deliberately fluid and adaptive, rather than fixed end-states.

3.3. The Committee recognised that:

- The overall framework is now clear and widely understood
- Clinical models within each layer are at varying stages of development
- Further clinically led work is required to define how care will be delivered in practice

3.4. Importantly, the discussion highlighted that stronger clinical leadership across the health and care economy is now essential to progress this work. The scale of change required cannot be delivered solely through organisational or managerial leadership. It will require:

- Visible and credible clinical leadership at system level
- Greater alignment of clinical leaders across organisations and care settings
- Clinically led design and ownership of future service models

3.5. It was therefore agreed that strengthening clinical leadership capacity and coherence across Kent and Medway is a critical enabler of the next phase, alongside the continued development of detailed clinical models, particularly within acute care.

4. Implications for System Architecture

4.1. The system architecture described in the original paper, with neighbourhoods as the core unit of delivery supported by alliance-based working, was supported by the Joint Committee.

4.2. The discussion reinforced the expectation that:

- Organisations will operate within a clearly defined system framework
- Decision-making will be taken at the appropriate level with shared accountability
- Behaviour will shift from organisational optimisation to system-wide outcomes

4.3. There was a clear acknowledgement that this represents not only a structural change but a significant shift in leadership behaviour across the system.

5. Provider Alliances and Delivery Expectations

5.1. The Joint Committee confirmed the central role of provider alliances in leading delivery and transformation across the system.

5.2. There was a clear and consistent view that acute providers will need to work significantly more closely together, particularly in relation to:

- Clinical service lines
 - Workforce utilisation
 - Cost management
 - Productivity and efficiency
- 5.3. This shift will require strong and aligned clinical leadership across acute providers, ensuring that decisions on service configuration and delivery are clinically led, evidence-based and collectively owned.
- 5.4. The Committee agreed that the Neighbourhood Health Alliance must now accelerate its development and delivery role at pace.
- 5.5. In particular, it will need to move quickly to a position where it is:
- Clinically led, with clear models of care
 - Operationally effective at scale
 - Financially accountable for delivery
- 5.6. This again reinforces the requirement for consistent clinical leadership within and across neighbourhoods, bringing together primary, community and specialist expertise.

6. Strategic Commissioning and Commissioning Intentions

- 6.1. The Joint Committee reaffirmed support for the transition to strategic commissioning, with commissioning intentions as the primary mechanism for translating strategy into delivery.
- 6.2. The discussion also clarified more explicitly how the ICB's role will evolve in practice.
- 6.3. There was a clear expectation that the commissioning function will be increasingly focused on securing the best possible value from contracts and ensuring that every pound spent delivers demonstrable benefit for population outcomes. This represents a shift towards a more rigorous and outcomes-focused approach to commissioning, with greater scrutiny of value, productivity and impact.
- 6.4. It was recognised within the discussion that this approach may create individual organisational pressures for providers, particularly where existing contracts, cost bases or service configurations are not aligned to the emerging model.
- 6.5. However, there was a clear and shared view that these challenges must not be addressed in isolation. Instead, they will need to be worked through collectively across the system, with the provider alliances acting as the primary mechanism for resolving these issues.
- 6.6. This reinforces the expectation that:

- Financial and contractual challenges will be overtly addressed at a provider and system level
 - Providers will work together through alliance arrangements to redesign services and manage consequences
 - Commissioning and provider collaboration will be essential to ensure a coherent transition to the new model
- 6.7. The Committee also emphasised that this transition must be managed in a way that maintains delivery grip during 2026/27.

7. Financial Context and System Imperative

- 7.1. A central theme of the discussion was the scale of the system's financial challenge.
- 7.2. The Joint Committee agreed that the system financial position is now paramount in shaping decisions and priorities. This reinforces the need for:
- Rapid progress on productivity and efficiency
 - Alignment between financial plans and clinical models
 - Collective ownership of financial sustainability across organisations
- 7.3. The clinical and quality outcomes and financial context was recognised as a major driver of urgency in implementing the new model.

8. Governance and System Leadership

- 8.1. The Joint Committee confirmed agreement with the proposed governance arrangements, including the role of the Joint Committee as the primary forum for system-level decision making and accountability. There was explicit agreement that:
- A formal report will be produced following each Joint Committee meeting
 - This report will be shared with all partner Boards in public
 - This will provide a single, consistent narrative of system decisions and progress
- 8.2. This paper constitutes part of that agreed reporting approach.

9. Organisational Development and Leadership

- 9.1. The discussion reinforced that delivery of the model will require a step change in leadership capability, relationships and behaviours across the system.
- 9.2. The Joint Committee supported the proposed organisational development approach, recognising that:

- Building trust and collective leadership is essential to success
- Leadership behaviour must align with system expectations
- Clinical leadership must be strengthened alongside managerial leadership, with a clearer and more consistent voice for clinicians in system decision-making and service design
- This programme is a core enabler of transformation rather than a supporting activity

10. Key Risks and Focus for the Next Phase

10.1. The risks outlined in the original paper were endorsed, with particular emphasis on:

- The pace of clinical model development
- Clarity of accountability for delivery
- The ability of organisations to operate collectively

10.2. The Joint Committee was clear that progress over the next six months will depend on maintaining clarity of direction, strengthening system leadership and ensuring that delivery is not compromised during the transition.

11. Conclusion

11.1. The Joint Committee discussion confirmed that Kent and Medway has reached a clear point of alignment on its future model. There is now:

- Agreement on the overall structure and direction of travel
- A shared recognition that the current model is unsustainable
- Clear expectations for greater collaboration, particularly within acute services
- A requirement to accelerate neighbourhood delivery
- A clear need to strengthen clinical leadership across the system
- A collective understanding that financial sustainability is central to all decisions

11.2. The focus now moves from agreement to delivery, with pace, discipline and collective leadership critical to success.

12. Recommendation

12.1. The ICB Board and partner provider Boards are asked to:

- Note the outcome of the Joint Committee discussion
- Confirm their continued support for the agreed direction of travel
- Consider the implications for their organisations, particularly in relation to collaboration, clinical model development, leadership capacity and financial sustainability

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: Learning from Investigations

Meeting date: 28 July 2026

Board sponsor: Norman Blissett, Chief People Officer (CPO)/Dr Helen Mackie, Acting Chief Medical Officer (CMO)

Paper Author: Norman Blissett, CPO/Acting CMO

Appendices:

Appendix 1: Carnall Farrar – Review of Critical Care and Anaesthetics Services (CCAS)
Appendix 2: Helen Buckingham – Review of Systems and Processes for Raising Concerns

Executive summary:

Action required:	Approval
Purpose of the Report:	To summarise outcomes and next steps of the investigations and review in Anaesthetics.
Summary of key issues:	A number of concerns were raised by staff in the anaesthetics service relating to behaviours, management of patient safety concerns and the impact of medical rota gaps. One investigation and two reviews were commissioned to address the concerns raised. These are summarised below, along with next steps. - Investigation into concerns raised about conduct and behaviours. The investigation has concluded no further action to be taken. - The Carnall Farrar review examined the leadership, workforce, governance and operational effectiveness of anaesthetic and critical care services across East Kent Hospitals University NHS Foundation Trust's three acute sites (William Harvey Hospital(WHH), Queen Elizabeth the Queen Mother Hospital (QEQM) and Kent & Canterbury Hospital (K&C). The review was commissioned following formal concerns raised in September 2025 and used workforce data, demand and capacity analysis, job plans, rotas, Datix reports and extensive stakeholder interviews. The review found that services are under significant strain due to consultant vacancies, rota gaps and uneven skill mix. Variation in workforce models was identified at between sites, with limited cross-site working and a lack of formal Trust-wide planning, resulting in siloed services and missed opportunities to share expertise and capacity.



Cultural and leadership challenges compound these issues. Staff across all sites reported feeling unheard and unsupported despite raising repeated concerns. Governance processes exist, but recommendations are not consistently implemented and feedback loops are weak.

The Datix review identified repeated staffing-related incidents, almost all relating to out-of-hours anaesthetic cover, with evidence of delays to emergency surgery, maternity epidurals and critical procedures. Incidents were often managed individually rather than as a theme, escalation to the risk register was slow, investigations lacked depth, and feedback to reporters was limited, restricting organisational learning. Harm was identified in 16% of incidents raised, which were predominantly from the WHH.

The report made recommendations to review clinical leadership to develop a more collective leadership structures with greater clarity of site, department and Trust-wide roles, development of anaesthetic and critical care workforce strategy, standardisation of consultant job planning, improved workforce planning and strengthened governance processes

3. A review of the Trust's policies and processes on raising concerns was commissioned from Helen Buckingham.

This independent review assessed the effectiveness of systems for raising concerns at East Kent Hospitals and the Board's ability to triangulate these with other data. While multiple routes exist, their effectiveness is undermined by a longstanding culture of low psychological safety, inconsistent follow-through, leadership instability, and weak informal management practices. Confidence in speaking up remains fragile, despite recent improvements including strengthened People and Culture capacity, an external Freedom to Speak Up (FTSU) service, and better Board reporting. Board triangulation has improved but remains constrained by data gaps, volume, and limited synthesis. Seven recommendations focus on culture, leadership, data, and governance.

The recommendations are as follows:

- i. Build staff confidence – Acknowledge cultural issues openly, demonstrate that speaking up is encouraged, and ensure visible, appropriate consequences for poor behaviour, with clear feedback to staff.
- ii. Strengthen quality governance – Ensure a clear line of sight from Board to care groups, with consistent discussion, ownership, and feedback on themes arising from concerns.
- iii. Improve staff engagement – Clarify and strengthen staff networks and forums so they effectively escalate concerns and influence senior leadership.



	iv. <u>Strengthen line management</u> – Improve appraisal coverage, management visibility, and leadership capability, with greater emphasis on accountability for management behaviours. v. <u>Improve data and reporting</u> – Provide clearer, more thematic and benchmarked data to support effective triangulation, including better use and feedback from Datix and FTSU data. vi. <u>Embed Board-level triangulation</u> – Make triangulation a consistent, structured Board practice, supported by improved data literacy and clarity on escalation thresholds. vii. <u>Review leadership capacity</u> – Assess whether executive and medical leadership capacity is sufficient, particularly to address medical leadership gaps and siloed working. 4. Meeting held with Anaesthetists at the beginning of July 2026 where the investigations and review in Anaesthetics were shared and discussed. 5. Next Steps An action plan for next steps has been developed which captures all the key recommendations from the investigations and reports.
Key recommendations:	Board members are invited to discuss and APPROVE the outcomes and next steps proposed.

Implications:

Links to Strategic Themes:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Trust Risk Register:	1679 - There is a risk of failure to address poor organisational culture.
Resource:	N
Legal and regulatory:	Y – there are employment law and regulatory risks – specifically relating to recent interventions by NHS England (NHSE) and Care Quality Commission (CQC).
Subsidiary:	N

Assurance route:

N/A



Review of Critical Care and Anaesthetic Services

East Kent Hospitals University NHS Foundation Trust

Draft report for feedback

March 2026

Disclaimer

This report has been prepared by Carnall Farrar for East Kent Hospitals University NHS Foundation Trust ("the Trust") solely for the purpose of conducting a service review of anaesthetics and critical care services. The report is based on information, data, and documentation provided by the Trust, supplemented by stakeholder interviews and publicly available information current as of 5/3/26.

Limitations of Scope and Liability:

This review represents an independent assessment based on the information available during the review period. Carnall Farrar makes no representation or warranty as to the completeness or accuracy of information provided by third parties, including the Trust, its staff, or other stakeholders.

This review does not constitute an audit, assurance engagement, compliance review, or provision of legal advice.

It was not within the scope of this engagement to:

- Review the configuration of services
- Validate rota requirements or model demand and capacity
- Investigate staff performance or organisational culture issues

The findings, analysis, and recommendations contained in this report are based on the specific terms of reference agreed with the Trust and should not be relied upon for any other purpose or by any party other than the Trust without Carnall Farrar's prior written consent.

This report does not constitute legal, regulatory, or professional advice on specific courses of action. Any decisions regarding the implementation of recommendations remain the sole responsibility of the Trust's management and governance bodies.

Carnall Farrar is under no obligation to update this report for events or circumstances arising after the date of publication, and expressly disclaims any responsibility to do so.

Data and Information:

While reasonable efforts have been made to verify data accuracy, Carnall Farrar accepts no liability for errors or omissions in source data provided by the Trust or third parties. Analysis is based on data available at the time of review and may not reflect subsequent changes.

Incident reports and governance documentation referenced in this review have been analysed for patterns and systemic issues. Individual case details have been anonymised where appropriate, but the Trust remains responsible for ensuring compliance with data protection requirements in any further use or distribution of this report.

Stakeholder Views:

This report includes perspectives gathered through confidential stakeholder interviews. These views represent individual opinions and experiences at the time of interview and may not reflect the views of the Trust or other stakeholders. Carnall Farrar has sought to present a balanced assessment but cannot verify all subjective accounts.

Distribution and Use:

This report is intended solely for use by the Trust's Board, executive team, and relevant governance committees. Third parties who obtain access to this report do so at their own risk and Carnall Farrar accepts no duty of care to such parties.

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Glossary

Abbreviation	Term
EKHUFT	East Kent Hospitals University NHS Foundation Trust
WHH	William Harvey Hospital
K&CH	Kent & Canterbury Hospital
PA	Programmed Activity <i>(The standard unit used in NHS consultant job planning to measure clinical and non-clinical work time)</i>
DCC	Direct Clinical Care <i>(One of the two main categories of PAs in NHS consultant job plans, involving patient facing clinical work and associated clinical administration)</i>
SPA	Supporting Professional Activities <i>(One of the two main categories of Programmed Activities (PAs) in NHS consultant job plans allocated for non-patient-facing work such as continuing professional development, job planning and appraisals)</i>

1. Executive summary

Executive summary

Introduction and methodology

East Kent Hospitals University NHS Foundation Trust (EKHUFT or Trust) commissioned a review of anaesthetic and critical care services across its three acute sites: William Harvey Hospital (WHH), Queen Elizabeth the Queen Mother Hospital (QEQM), and Kent & Canterbury Hospital (K&CH).

This review was initiated following concerns raised in September 2025 regarding service functioning, leadership effectiveness, and working relationships. It aims to establish a common understanding of challenges affecting operational effectiveness and develop recommendations for improvement.

Carnall Farrar conducted this review over an eight week period using a mixed-methods approach including analysis of workforce data, procedure volumes, job plans, rotas, Datix reports, policies, and procedures. Stakeholder interviews were facilitated with Trust executives, Care Group and clinical managers and other clinical leaders.

Key findings

- **Workforce:** There are workforce challenges on each site, driven by recruitment challenges at all levels, against a backdrop of high variation in job plans, and on call arrangements. There are structural weaknesses in how out of hours cover is provided, and these combined with rota gaps create a clinical risk and place significant pressure on staff. Cross site working is limited.
- **People and culture:** Misalignment exists in the Trust regarding service direction, standardisation, and working practices, creating challenges for decision-making and leadership recruitment. Frontline staff across all sites reported feeling unheard and unsupported, with concerns repeatedly raised but not visibly addressed. Site-based identities are also stronger than Trust-wide professional unity, limiting cross-site collaboration and support.
- **Governance:** While governance structures exist, stakeholders reported that recommendations are not consistently implemented and incident reports receive limited feedback. The three sites operate as largely independent entities with minimal standardisation, creating variation in practice and complicating training and cross-site working. No systematic mechanisms exist for Trust-wide capacity coordination or sharing of specialist expertise
- **Leadership and management:** Stakeholders described unclear delegation of authority, with operational leaders uncertain about decision-making scope. Portfolio breadth for some senior roles limits specialty-specific engagement. Previous site-level administrative authority has been centralised, reducing local flexibility to respond to operational challenges.

Recommendations address both site-based challenges and the broader leadership and management of anaesthetic services

Trust level actions

- Set out leadership arrangements for anaesthetics at site level and in cross cutting roles
- Institute a collective leadership structure for anaesthetics and critical care, the Care Group leadership and management arrangements to support this, and the organisational development needed to support it to deliver effective management and leadership
- Review consultant job plans to align to service requirements and reduce variation in practice between sites
- Develop a workforce strategy for anaesthetics and critical care, leveraging the benefits of being a multi-site Trust to create attractive posts on all sites through the effective use of cross-site working
- Align service offer for anaesthetics and critical care by site with the Trust's overarching clinical strategy
- Review Datix process to ensure it is driving improvement in quality and safety of care

WHH specific recommendations

- Map out-of-hours demand to establish pressure points
- Identify opportunities to moderate or redistribute demand to make more effective use of capacity, and steps needed to enable this
- Identify opportunities to increase capacity, resilience or depth of cover out-of-hours in the short, medium and longer term

QEQM specific recommendations

- Map existing workforce capacity and capability across consultant, and non-consultant resident doctors
- Align on what workforce can deliver each component of activity, and the level of supervision required to achieve this
- Establish recruitment requirement and delivery trajectory

K&CH specific recommendations

- Start the process of separating critical care and anaesthetic responsibilities out-of-hours, setting out an agreed trajectory to full separation
- Increase depth of on call cover out-of-hours

2. Context and methodology

A review of anaesthetic and critical care was commissioned for EKHUFT to understand challenges and align on recommendations to improve the service

Review purpose

The EKHUFT commissioned a review of anaesthetic and critical care services to establish how services are led and delivered across three sites, understand challenges with working relationships, and develop recommendations for improvement, including an assessment of incident reporting and investigation processes in relation to specific incidents raised concerning anaesthetic staffing levels

Relevant context to the review

**Service context**

- EKHUFT is a large multi-site teaching Trust serving approximately 700,000 people across East Kent from three acute sites WHH, QEQM and K&CH
- Anaesthetic and critical care sits within one of three non site-based Care Groups at EKHUFT, with triumvirate and clinical leadership at each site
- Anaesthetic services are delivered 24/7 from all three sites with WHH and QEQM providing maternity services, level 3 critical care, and full emergency departments

**Challenges and concerns**

- Concerns have been raised about the depth of out-of-hours anaesthetic cover, particularly at WHH. An additional on-call tier was partially implemented but there have been staffing challenges.
- Datix reports documented safety concerns across the sites. Questions were raised about how Datix reports were investigated and actioned.
- Clinicians raised concerns about leadership effectiveness, the extent of clinical engagement in management decision-making processes, and challenges in working relationships.

**Initiation of the review**

- In September 2025, formal concerns were raised with the EKHUFT Chair about the functioning of the anaesthetic service and its leadership
- These concerns, subsequently documented in writing, covered leadership effectiveness across all three sites and decision-making processes
- EKHUFT commissioned this independent review to establish a single version of the truth about how services are being led and delivered, and to develop recommendations to support more effective service delivery

A mixed-methods approach was used to review anaesthetic services, including quantitative analysis and stakeholder engagement

Overview of approach

The review was conducted over an eight-week period and involved data analysis, a desktop review of policies and reports, and individual and group interviews. Throughout the review, a range of stakeholders were engaged across sites, roles, and specialties to ensure a balanced and comprehensive understanding of the service challenges. A set of recommendations to address the challenges and opportunities to improve care delivery, management and leadership were then developed.



Desktop review

Review of:

- 31 Datix reports between February and August 2025
- Rotas and job plans
- Policies and procedures



Quantitative analysis

Analysis of:

- Procedure volumes
- Workforce establishment and costs
- Demand and capacity modelling



Interviews

19 interviews with:

- Trust executives
- Management staff
- Consultants and speciality doctors

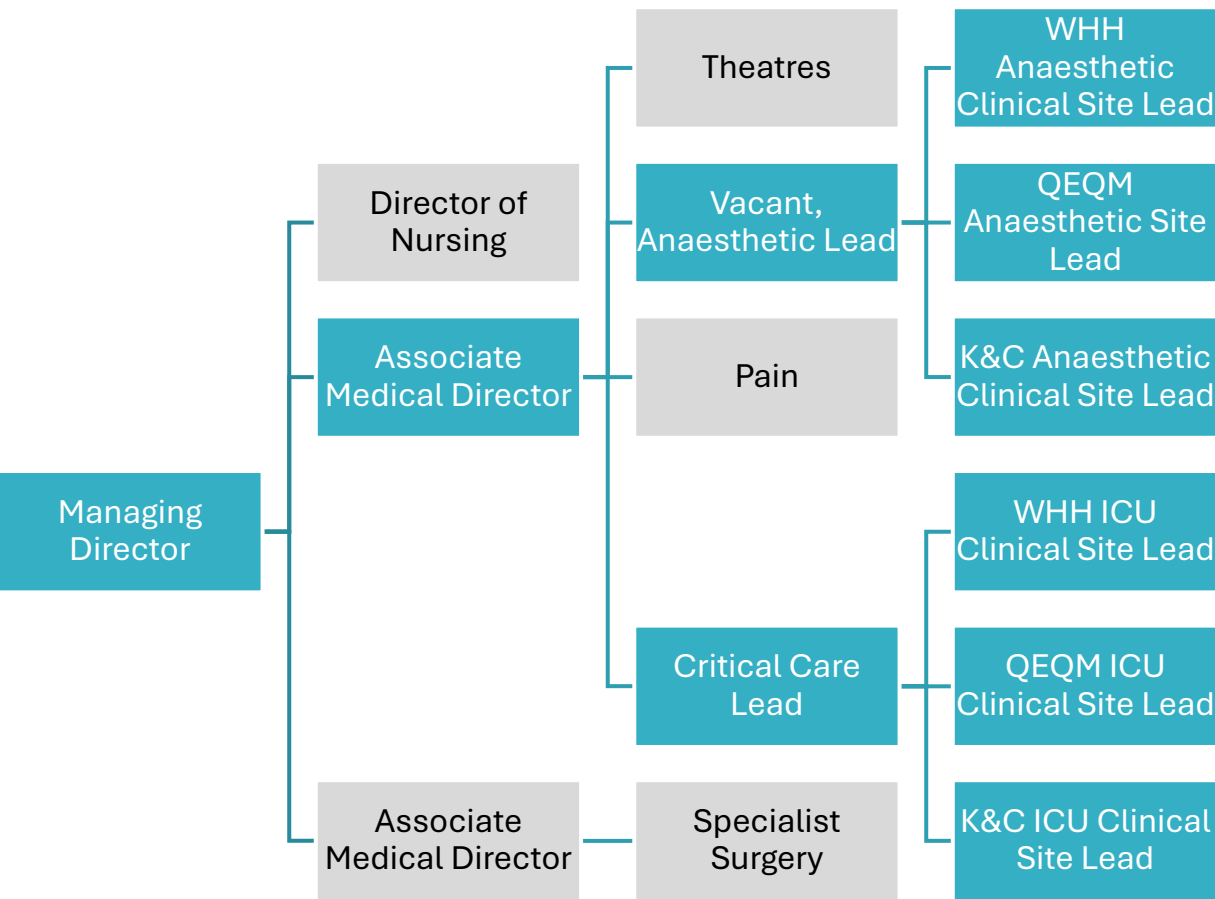
3. Overview of services

Anaesthetic and critical care leadership is distributed across the Trust, specialty, and site levels with key vacancies in strategic coordination roles

- The managing director provides executive oversight for the division, supported by two Associate Medical Directors and a Director of Nursing . This branches into specialty-based leadership roles covering key service areas which provide clinical and strategic direction across the Trust
- Site-based clinical leadership is organised around the three acute hospitals, with dedicated anaesthetic and critical care leads at each location. This site-based structure recognises the operational reality of delivering services across three geographically distinct locations, each with its own clinical teams, facilities, and local patient populations
- A key vacancy currently exists for the Trust-wide Anaesthetic Lead position, which sits between the Associate Medical Directors and the three site-based Anaesthetic Clinical Leads. The Trust-wide Anaesthetic Lead role would typically provide strategic direction and coordination for anaesthetic services across all three sites. Many of these responsibilities have been absorbed by the Associate Medical Director.

Leadership structure of CCASS*

Cross-site leadership positions



WHH is a large district general hospital serving a diverse and complex population

Hospital profile

- Large district general hospital in Ashford
- Ashford's population grew 12.5% between 2011 and 2021, the fastest growth rate in Kent
- 88% white, median age 41.9, with a mixed urban-rural character (63% urban, 37% rural)
- Life expectancy is 83 and 80 years for women and men respectively
- Moderate but rising deprivation levels
- Level 2 trauma unit, part of the SELKaM Trauma Network
- 24/7 Primary PCI service
- Regional specialist centre for head and neck cancer surgery and colorectal cancer
- Obstetric service (3000 - 3500 deliveries annually; majority caesarean or assisted delivery)



Critical Care

- 24-bed space intensive care unit
- Dedicated 24/7 consultant and 3 resident clinician cover

Theatre provision

- 8 main theatres
- 1 obstetric theatre
- 3-day case theatres

Surgical services

- Gynaecology
- ENT (including head and neck cancer)
- Trauma surgery
- Ophthalmology
- Colorectal (including cancer)
- Breast surgery

QEQM is a district general hospital serving a deprived and elderly population

Hospital profile

- District general hospital serving Thanet population
- Population grew modestly by 4.8% between 2011 and 202, below regional and national averages
- 93% white, median age 45.2, with only 58.1% of working-age residents, a notably older population than the other catchments. Life expectancy is 82 and 77 years for women and men respectively
- Thanet is consistently the most deprived local authority in Kent
- Emergency department providing acute care for East Kent coastal communities
- Trauma primarily frailty-related injuries and falls in elderly population
- Obstetric service, 2,500 - 3,000 deliveries annually, majority caesarean or assisted delivery



Critical Care

- 9-bed space intensive care unit
- Dedicated 24/7 consultant and 2 resident doctor cover

Theatre provision

- 6 main operating theatres (elective and emergency)
- 3 day surgery theatres
- Obstetric theatre

Surgical services

- General surgery
- Ophthalmology
- Endoscopy

K&CH is a leading vascular and urology centre delivering specialist elective surgical services

Hospital profile

- Elective surgical centre in Canterbury
- Population grew 4.2% between 2011 and 2021, from ~151,100 to ~157,400 Office for National Statistics
- 89% white, median age 41.9, life expectancy of 83 and 79 years for women and men respectively and – broadly in line with national averages
- Canterbury has become more deprived compared to other local authorities between 2019 and 2025
- Trust hub for vascular and urology services (all East Kent cases)
- Elective Orthopaedic Centre
- Specialist tertiary surgical services



Critical Care

- 6-bed critical care and 4-bed high dependency unit
- 24/7 consultant and 1 resident doctor cover shared with anaesthetics

Theatre provision

- 7 main operating theatres
- Interventional radiology theatre
- Elective Orthopaedic centre
- Ophthalmology suite

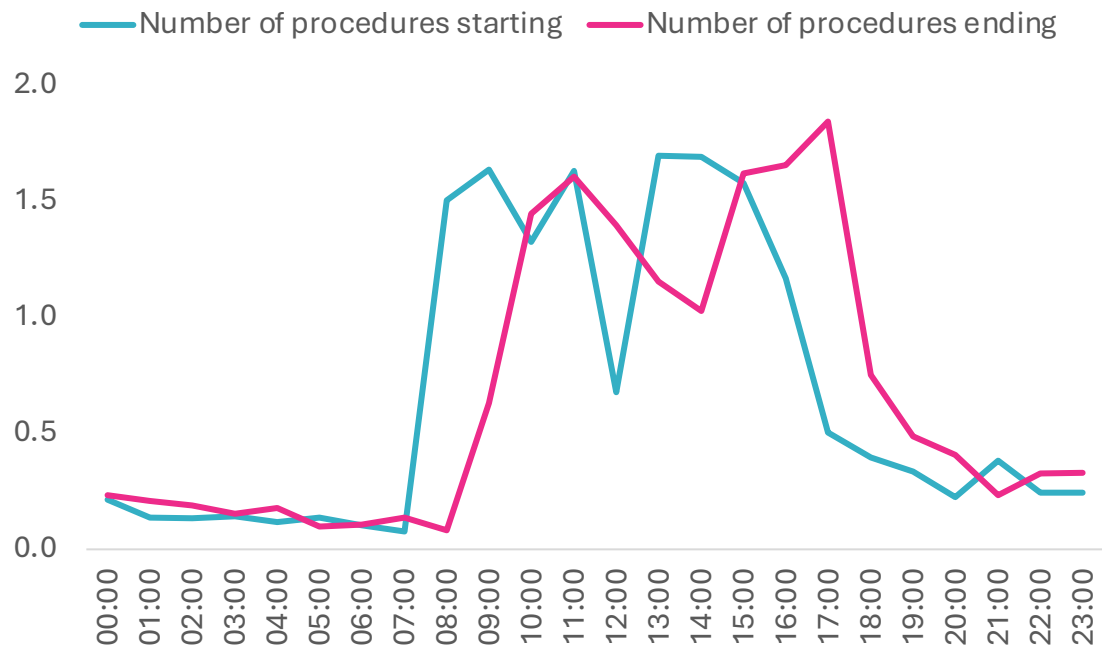
Surgical services

- Vascular surgery
- Urology
- Elective orthopaedics
- Dental and maxillofacial surgery
- ENT
- General surgery (including paediatrics)
- Ophthalmology
- Interventional radiology

Emergency surgical demand at WHH extends beyond standard working hours, with significant out-of-hours activity requiring anaesthetic cover

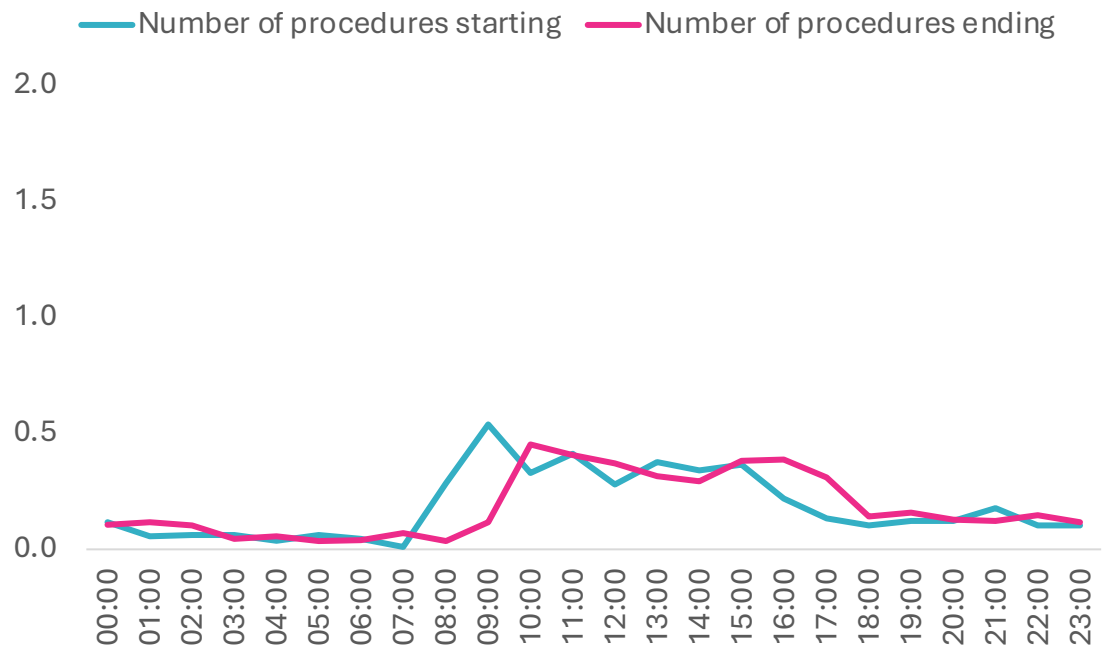
Time at which emergency cases occur during the week

Daily mean between 01/04/2025 and 31/12/2025; procedures recorded as emergency/trauma on Theatreman



Time at which emergency cases occur during the weekend

Daily mean between 01/04/2025 and 31/12/2025; procedures recorded as emergency/trauma on Theatreman

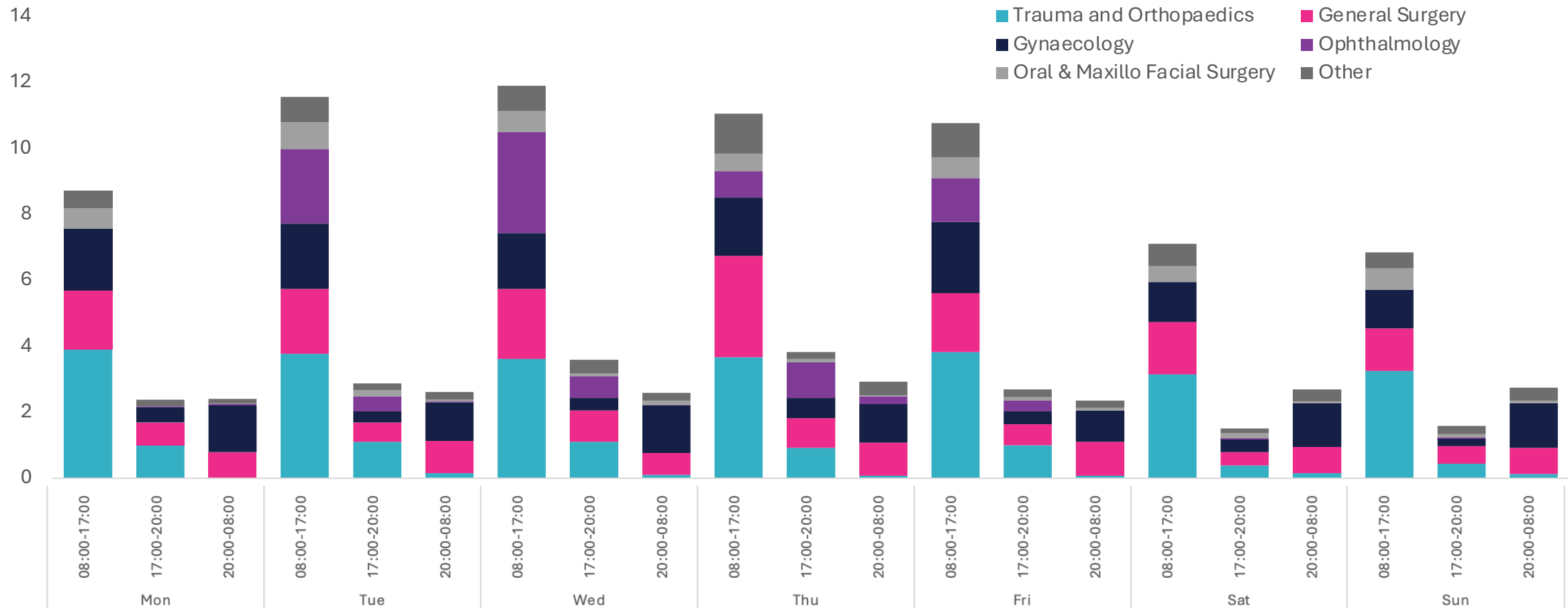


Weekday emergency surgical volume is substantially higher than at weekends, with peaks approaching four times greater during core hours. However, the overall shape of demand is broadly similar across both: a morning rise, sustained afternoon activity, and a persistent evening tail extending beyond 20:00, indicating that the pattern of out-of-hours pressure is consistent regardless of day type.

Emergency and trauma theatre demand at WHH peaks midweek, driven predominantly by General Surgery and Trauma & Orthopaedics

Distribution of theatre demand by specialty

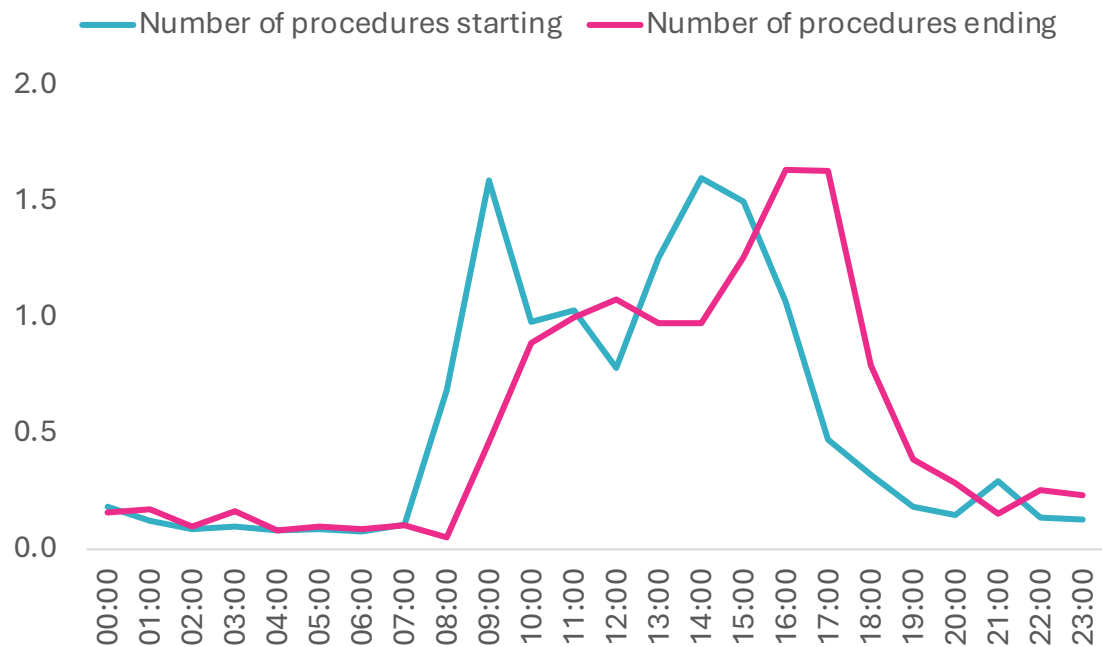
Daily mean procedures performed, stratified by time out of theatre, between 01/04/2025 and 31/12/2025; procedures recorded as emergency/trauma on Theatreman



Emergency theatre activity at QEQM concentrates between 08:00–17:00, with minimal out-of-hours operating at weekends

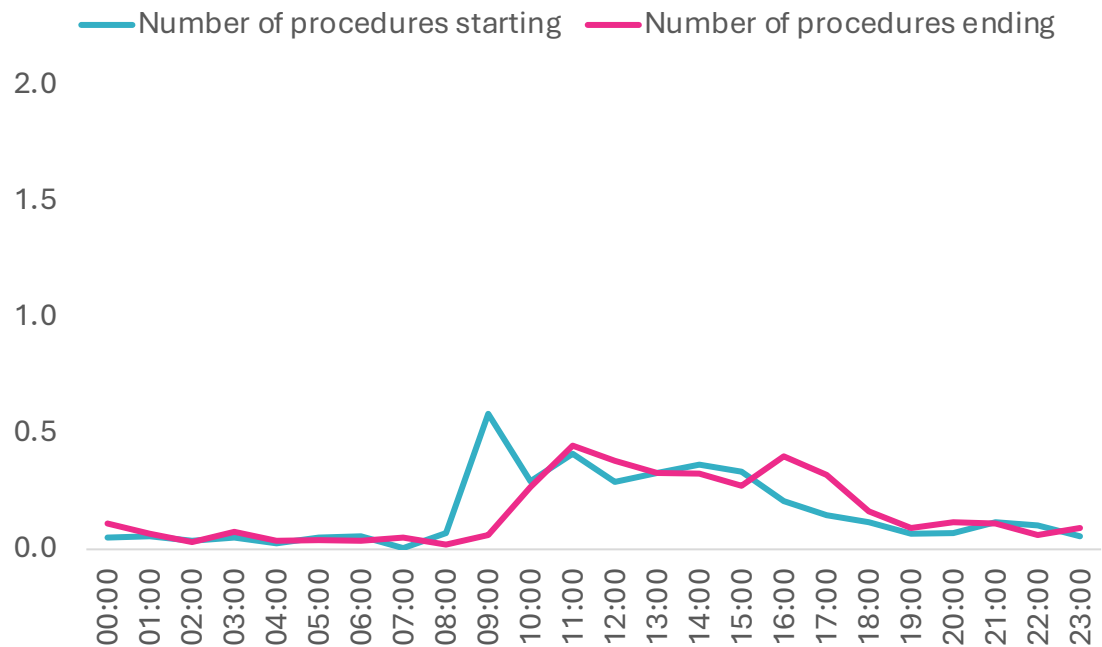
Time at which emergency cases occur during the week

Daily mean between 01/04/2025 and 31/12/2025; procedures recorded as emergency/trauma on Theatreman



Time at which emergency cases occur during the weekend

Daily mean between 01/04/2025 and 31/12/2025; procedures recorded as emergency/trauma on Theatreman

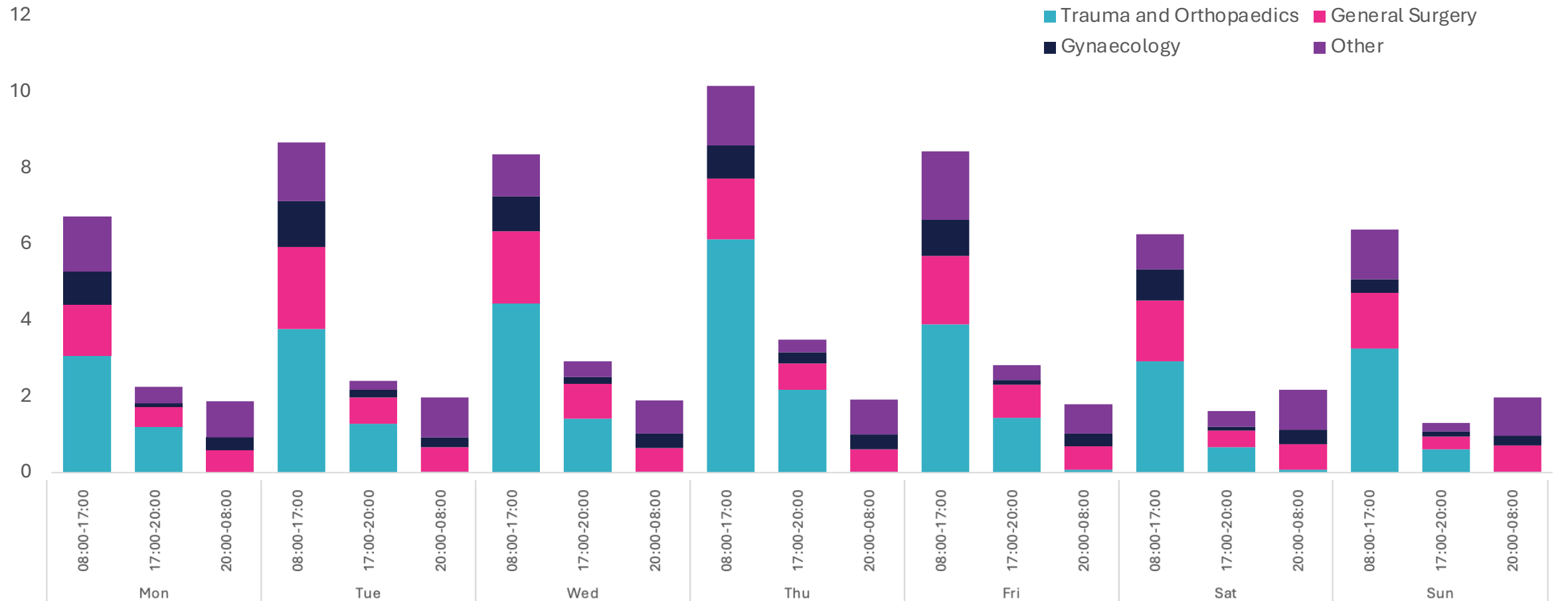


Weekday emergency surgical volume at QEQM rises gradually through the day before waning into the evening. Weekend volumes are substantially lower, with a flatter and more distributed profile across the day. The evening tail on both profiles appears more limited than at WHH, though some activity is visible through to 23:00.

Emergency operating at QEQM is largely confined to daytime hours, driven by General Surgery and Trauma & Orthopaedics

Distribution of theatre demand by specialty

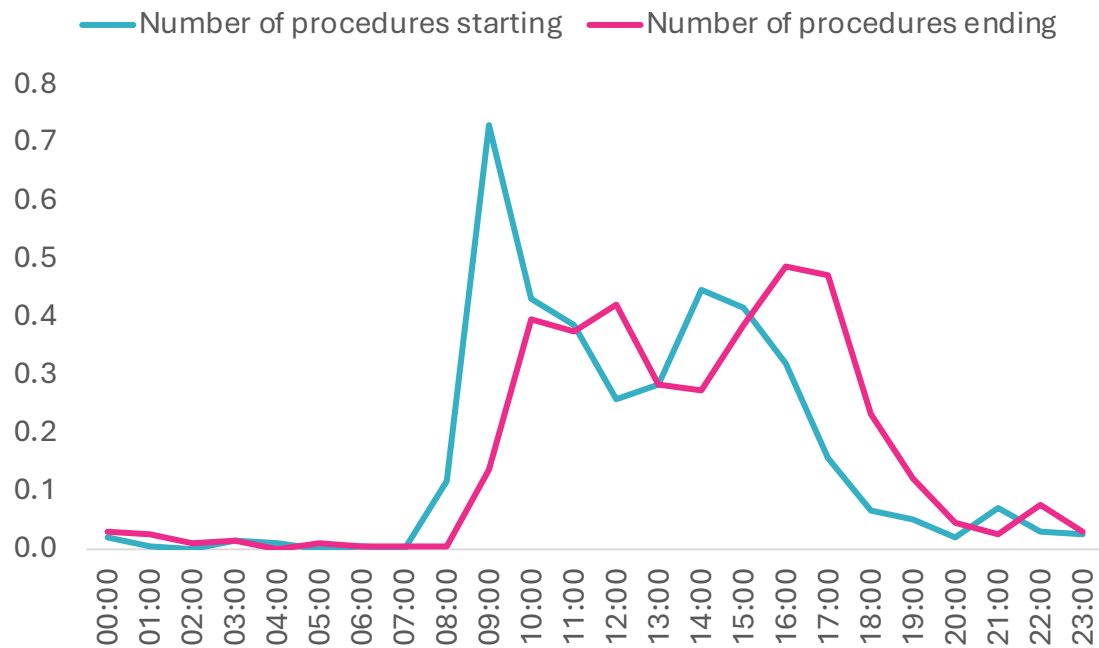
Daily mean procedures performed, stratified by time out of theatre, between 01/04/2025 and 31/12/2025; procedures recorded as emergency/trauma on Theatreman



K&CH has the lowest emergency theatre volume of the three sites, with weekend activity less than half of weekday levels

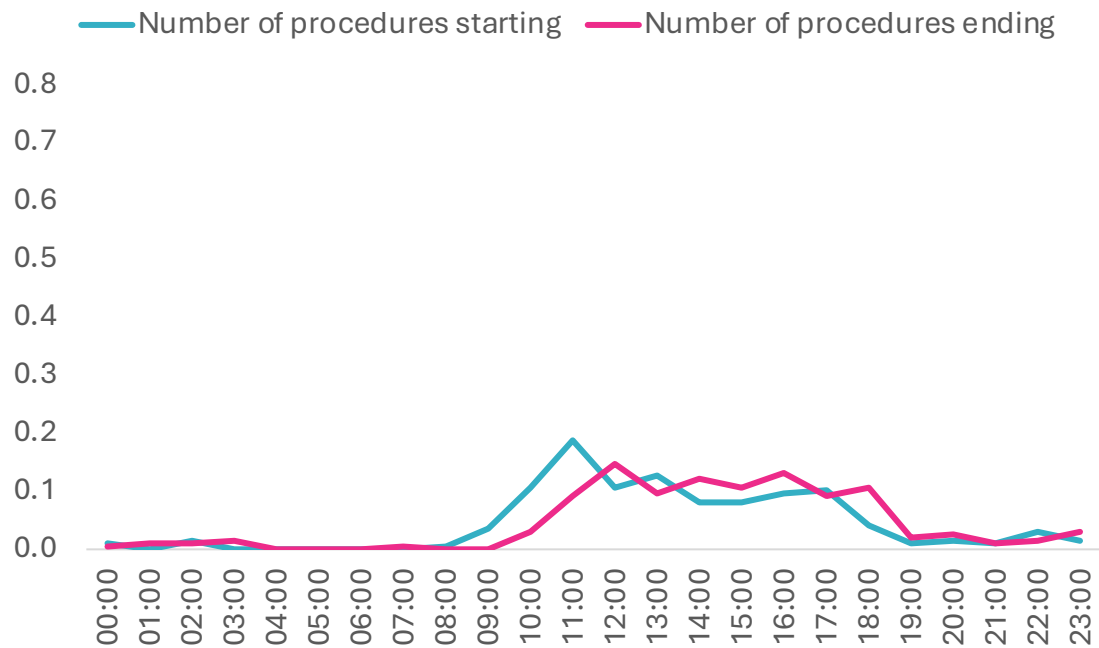
Time at which emergency cases occur during the week

Daily mean between 01/04/2025 and 31/12/2025; procedures recorded as emergency/trauma on Theatreman



Time at which emergency cases occur during the weekend

Daily mean between 01/04/2025 and 31/12/2025; procedures recorded as emergency/trauma on Theatreman

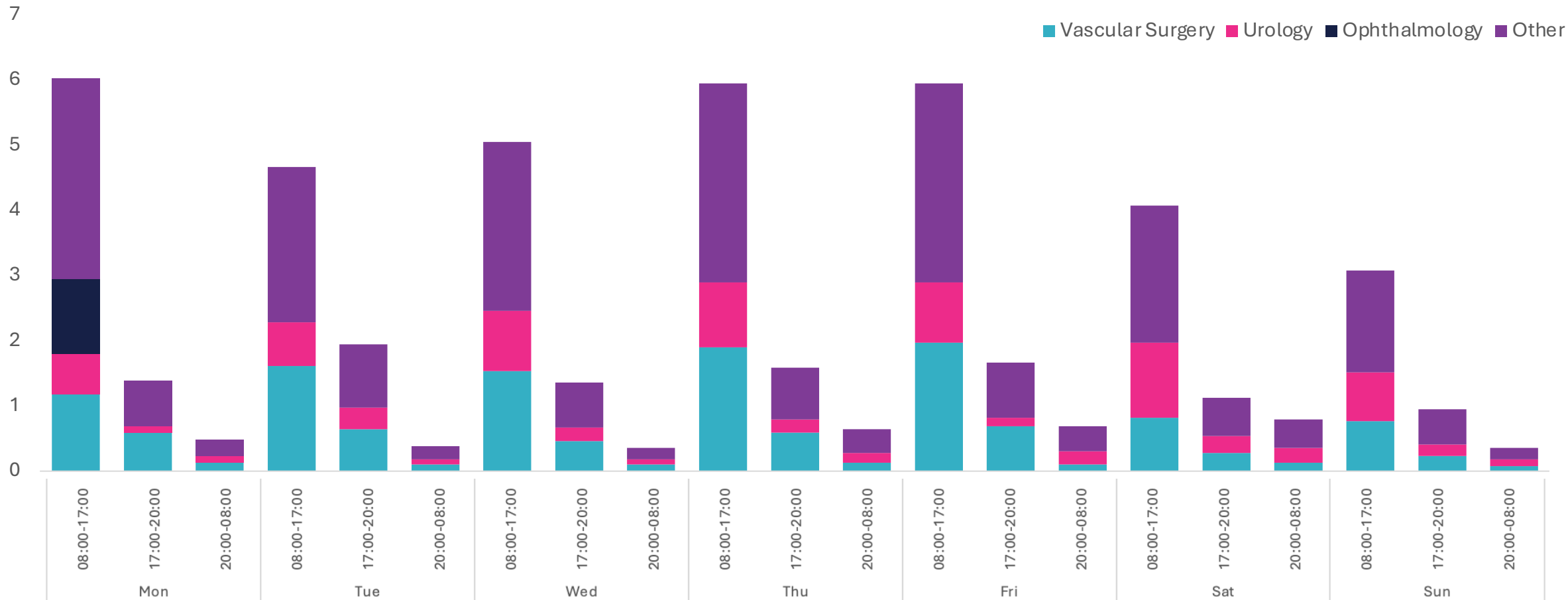


K&CH has the lowest emergency surgical volumes of the three sites, with weekday activity rising through the morning before waning into the evening. Weekend volumes are less than half of weekday levels, with a flatter and more distributed profile across the day.

Emergency theatre demand at K&CH is driven by vascular surgery and urology

Distribution of theatre demand by specialty

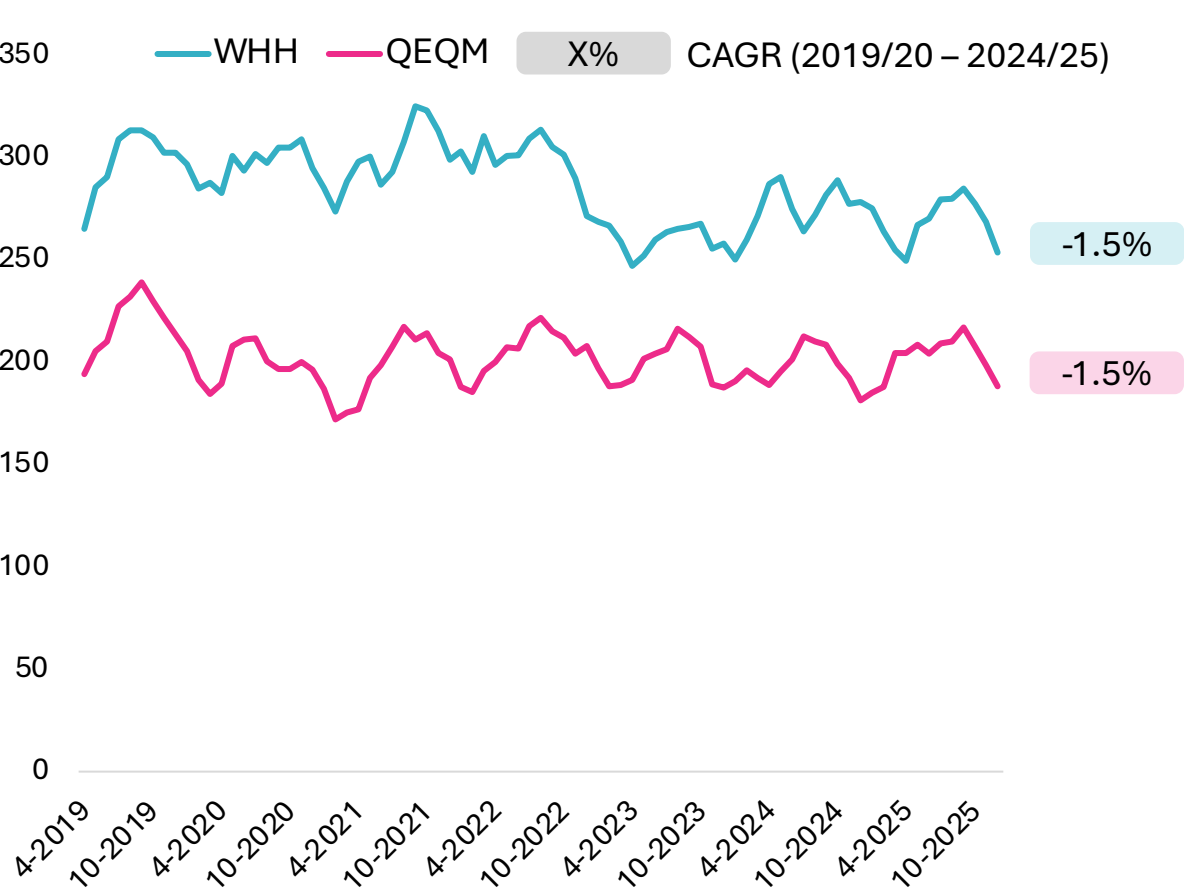
Daily mean procedures performed, stratified by time out of theatre, between 01/04/2025 and 31/12/2025; procedures recorded as emergency/trauma on Theatreman



Although overall deliveries have decreased over the past five years, both hospitals have experienced a shift away from spontaneous delivery

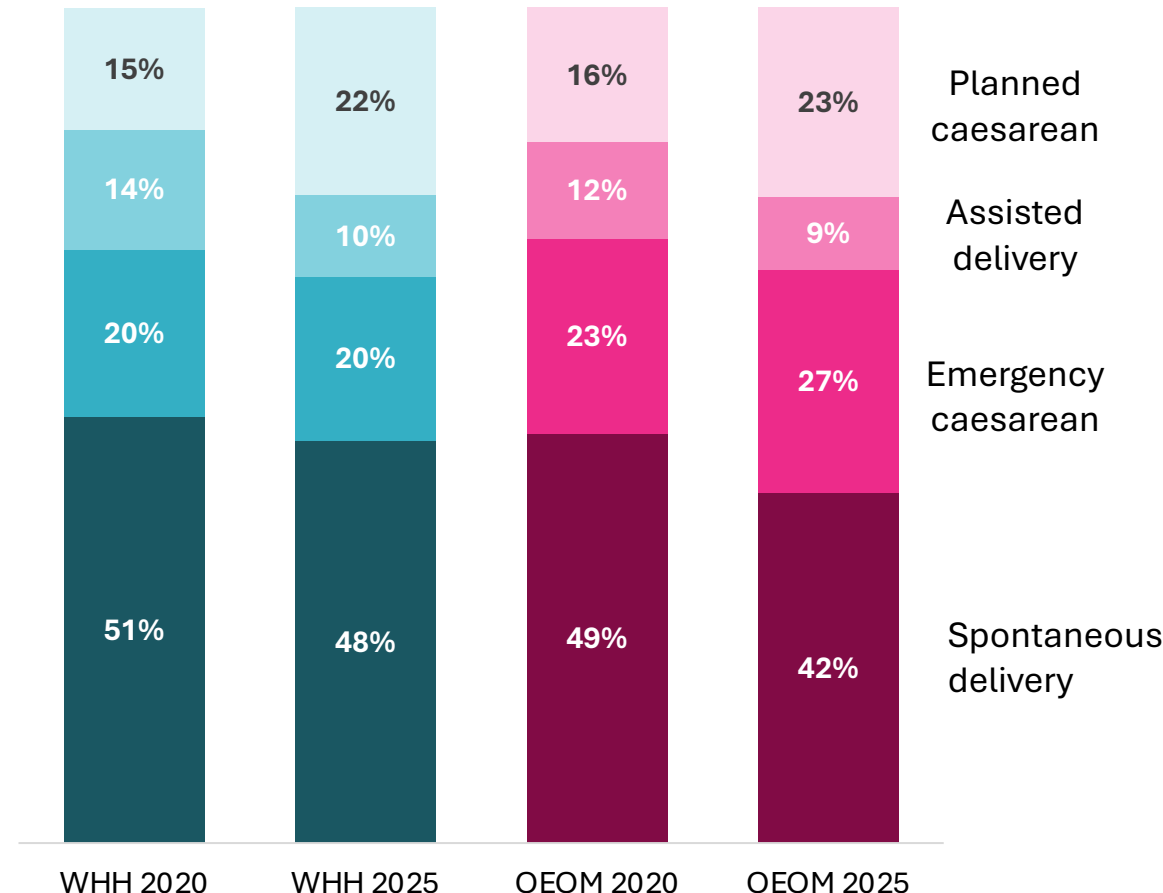
Total deliveries by hospital

Three-month rolling average, 2019 - 2025



Split of delivery type by hospital

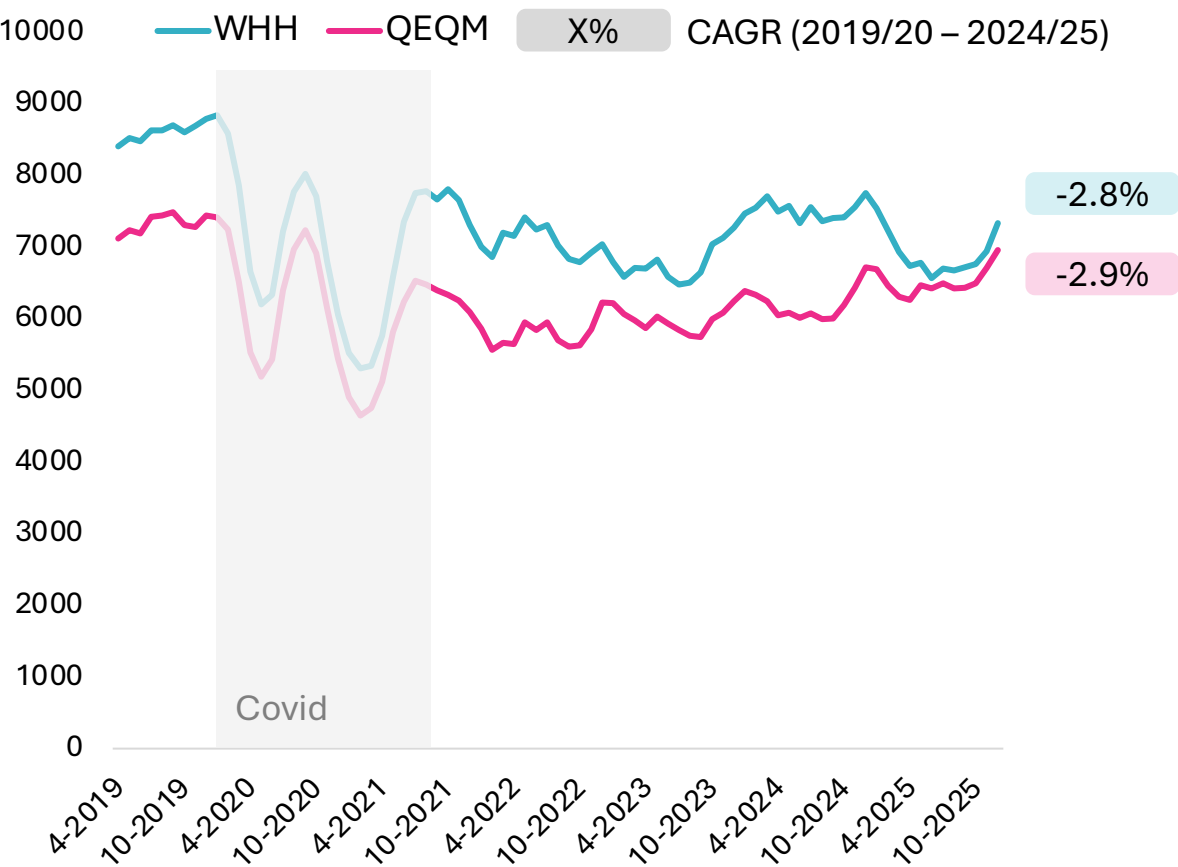
Proportion of delivery type by hospital, 2020 compared to 2025



Type 1 ED attendances, which are more likely to need anaesthetic input, remain below pre-pandemic levels

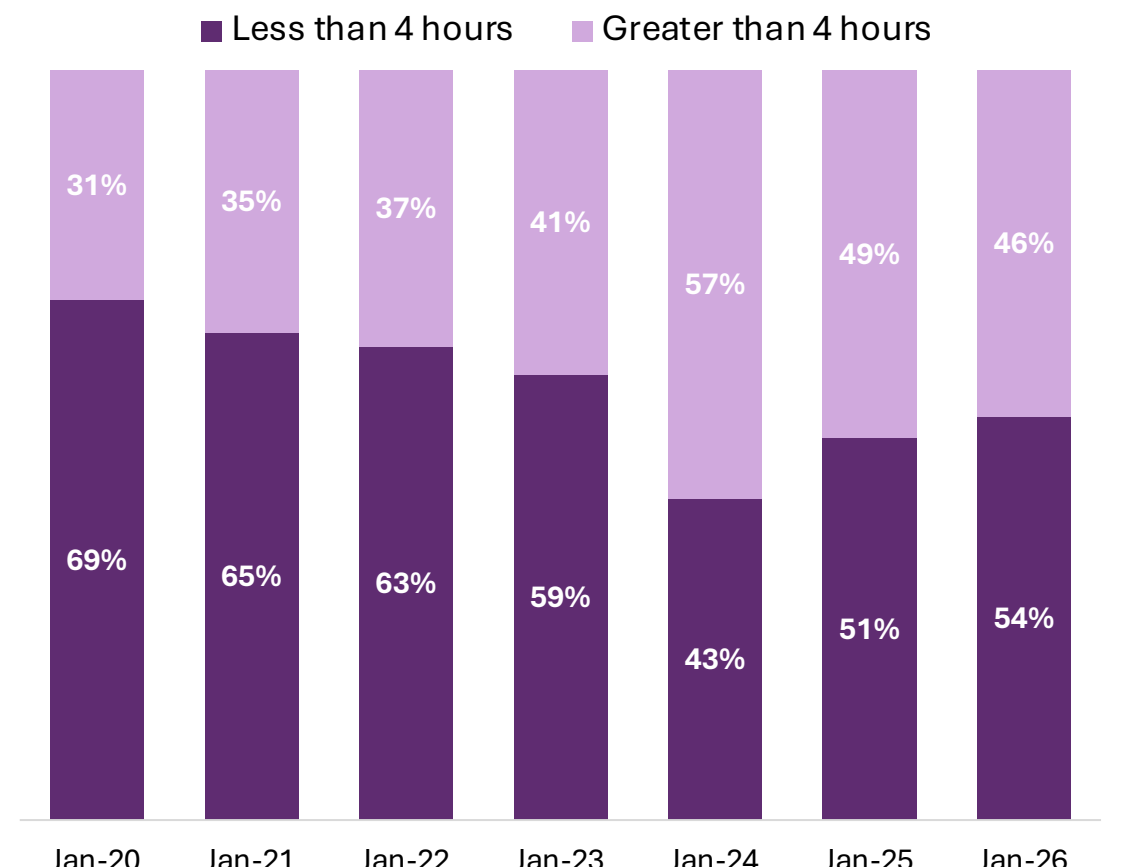
Total ED attendances by hospital

Three-month average of type 1 ED attendances, 2019 - 2025



Proportion of ED attendances seen within 4 hours

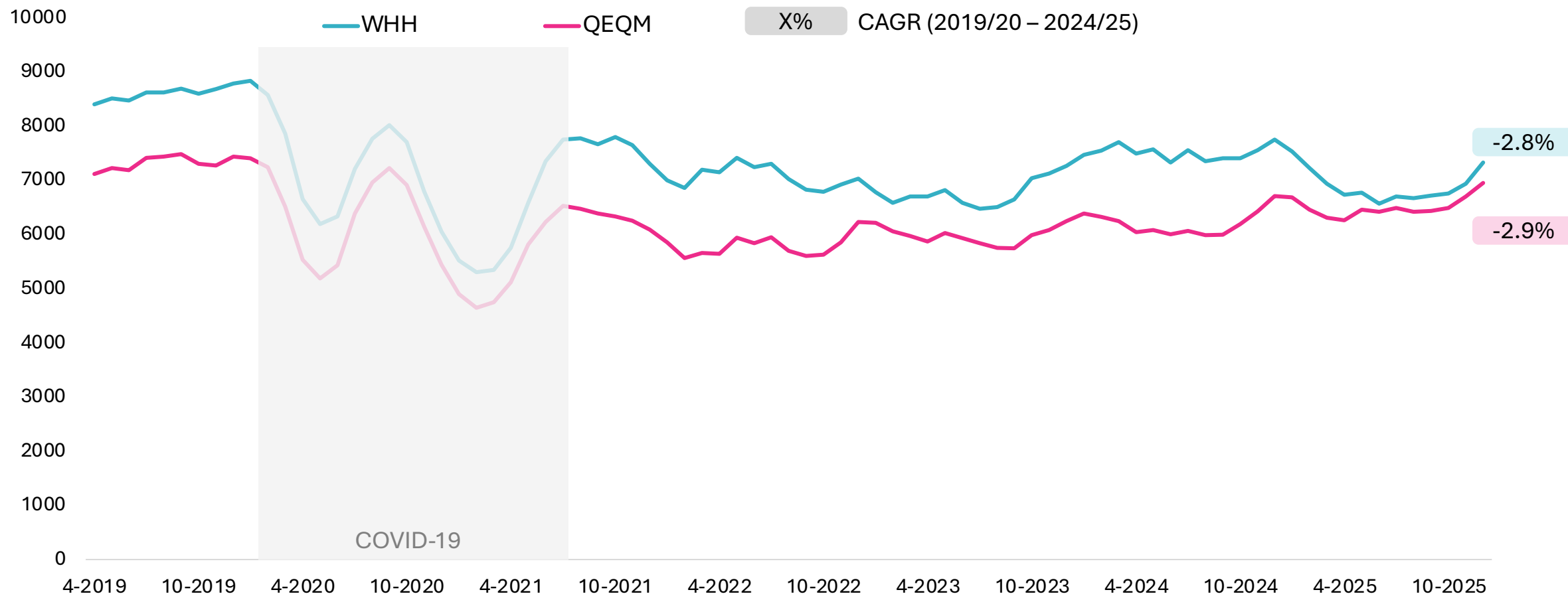
Type 1 ED attendances in East Kent, 2020 - 2026



Type 1 ED attendances, which are more likely to need anaesthetic input, remain below pre-pandemic levels

Total ED attendances by hospital

Three-month average of type 1 ED attendances, 2019 - 2025



4. Current state challenges and opportunities for improvement

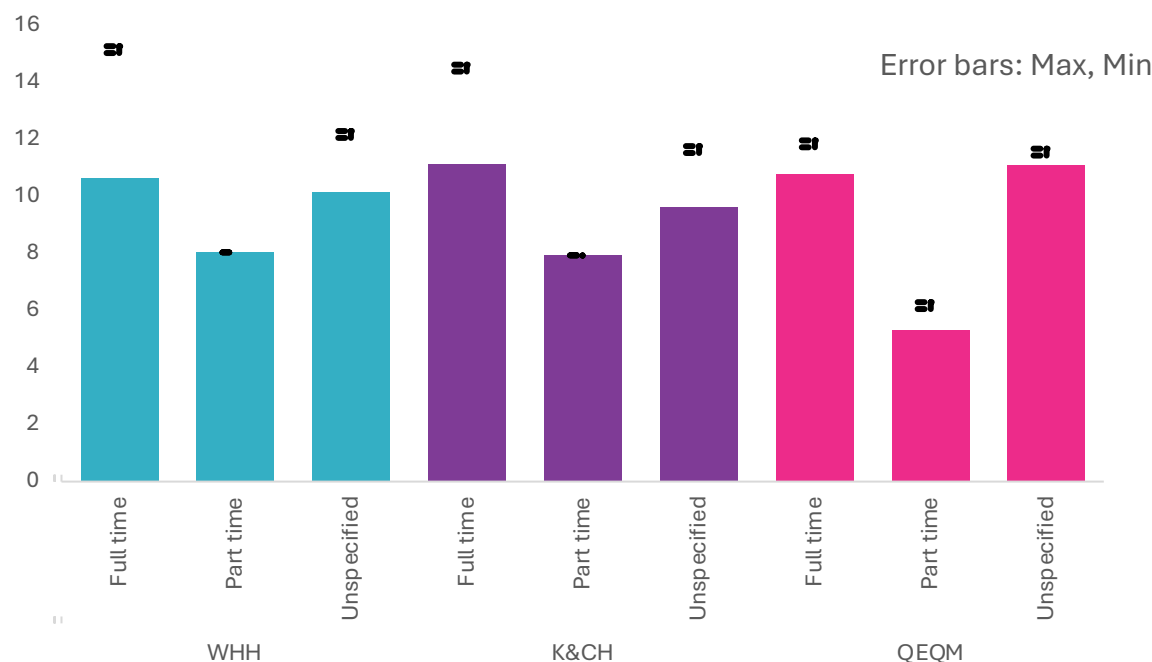
4.1 Current state: workforce and capacity



Consultants at WHH have the greatest variation in PAs in their job plans

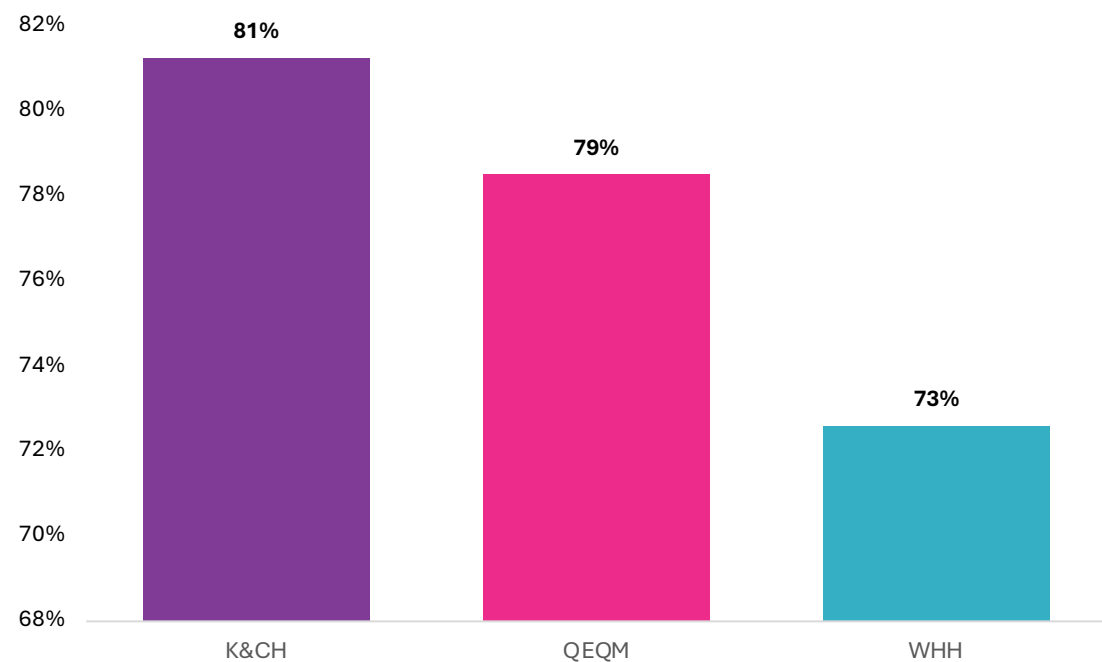
Mean number of PAs in job plans

Financial year 2025-26; Consultants and Locum Consultants



% of PAs as DCC

Financial year 2025-26; Consultants and Locum Consultants

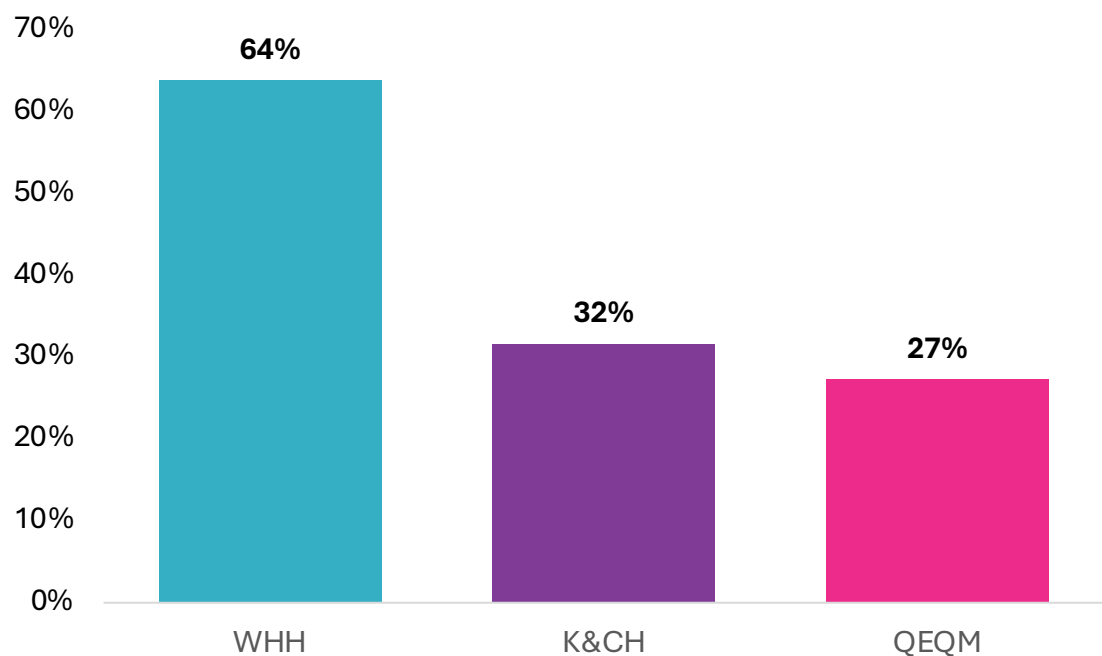


- Consultants at WHH deliver the lowest proportion of DCC relative to total PAs across the three sites and have the greatest variation in PAs per as per their job plans
- Some high PA rates reflect a pattern of remuneration in PA for additional responsibility rather than a time commitment

Based on the review of job plans, consultants at WHH deliver the lowest proportion of direct care to supporting activities

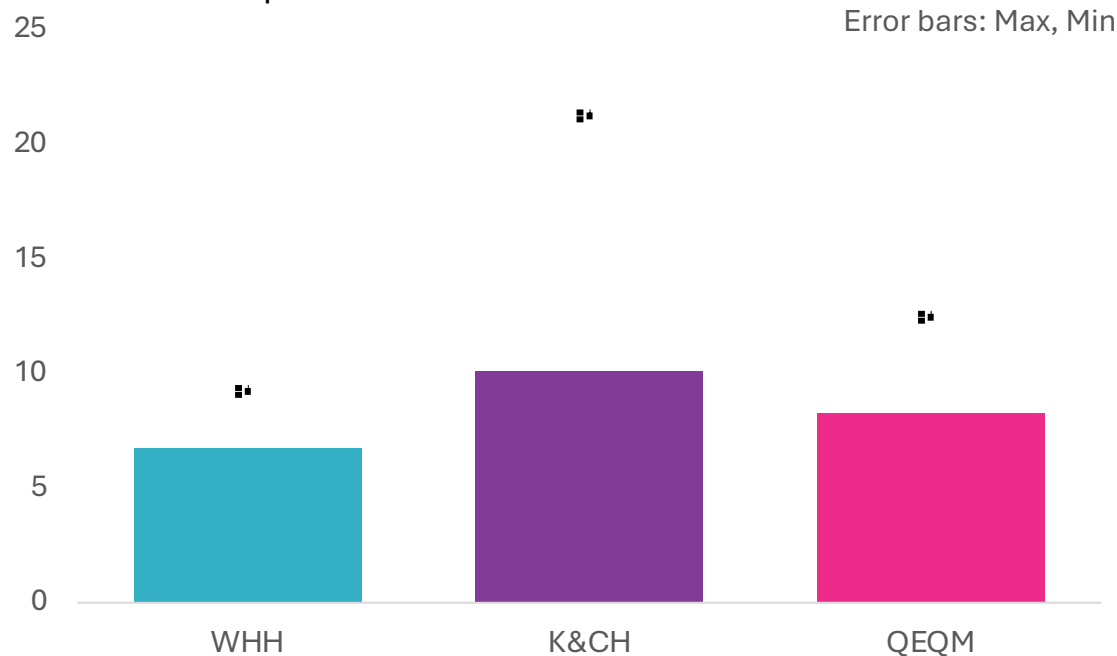
Proportion of consultants who deliver under 8:2 DCC to SPA ratio

Financial year 2025-26; Consultants and Locum Consultants



Average DCC:SPA Ratio

Financial year 2025-26; Consultants and Locum Consultants, number of DCC per 2 SPA

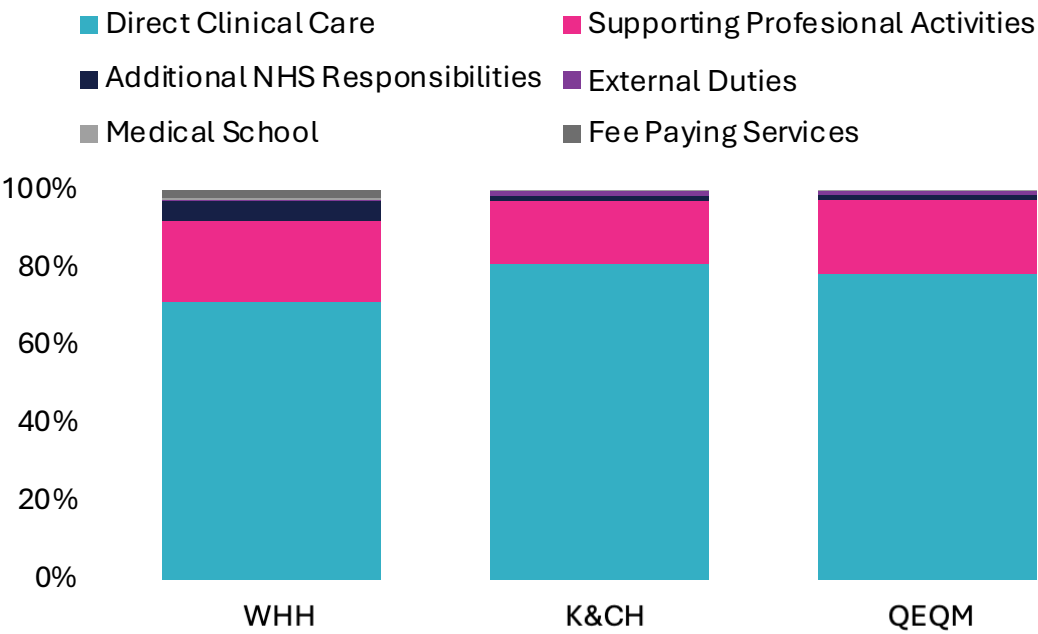


- A substantially larger share of consultants at WHH operate below the 8:2 DCC to SPA ratio benchmark compared to K&CH and QEQM, indicating consultants at WHH allocate a greater share of their job plans to supporting professional activities rather than direct patient-facing work.

Consultants at WHH take on more management and leadership responsibilities in place of clinical work according to job plans

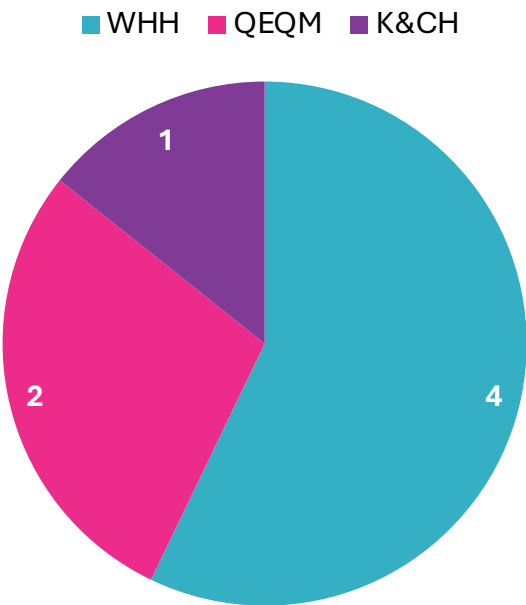
Distribution of consultant PAs

Financial year 2025-26; Consultants and Locum Consultants



Number of consultants in Trust roles

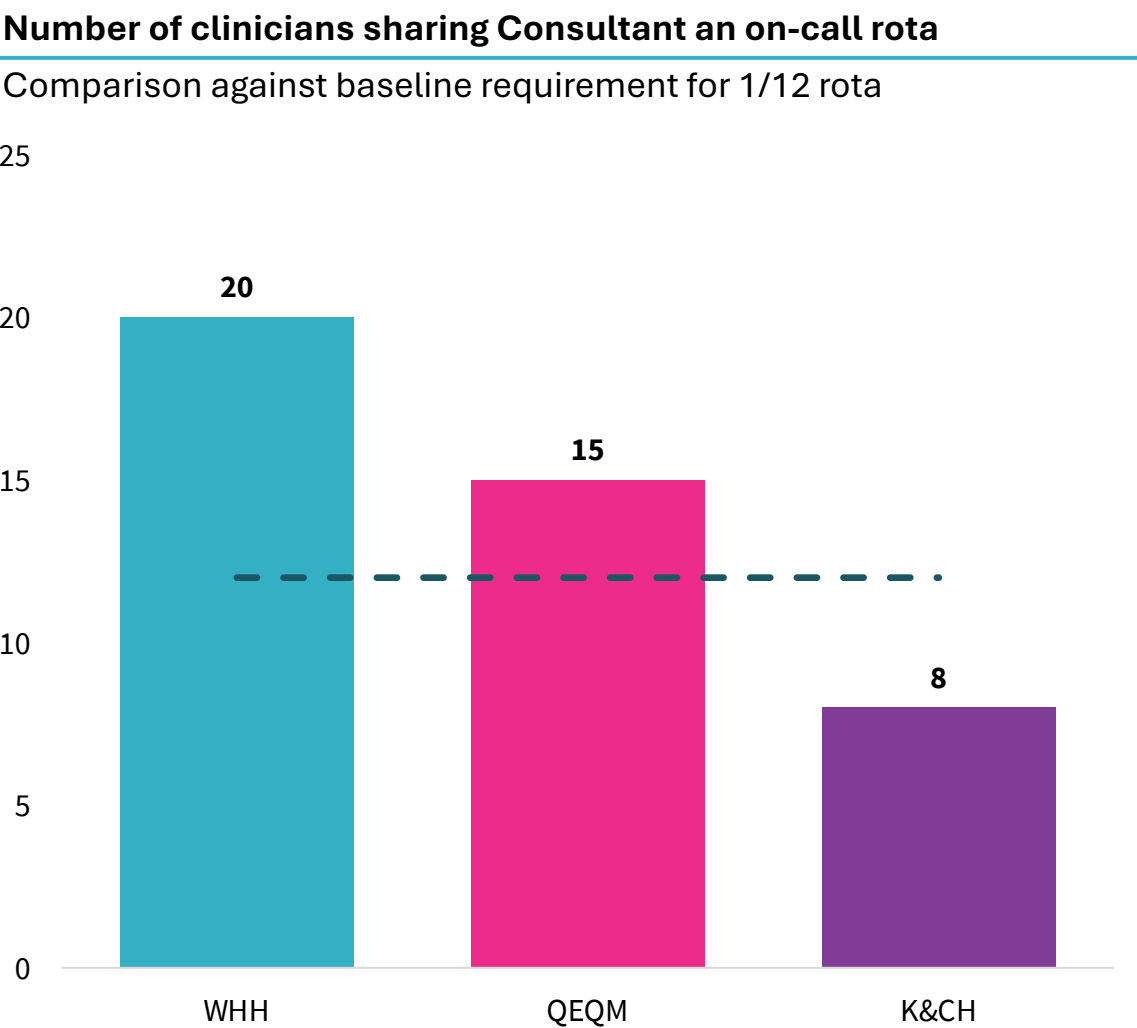
Financial year 2025-26; Consultants and Locum Consultants



- Consultants at WHH hold the majority of Trust-wide leadership roles, with four out of seven positions concentrated at this site, while consultants at K&CH and QEQM hold one and two respectively.
- This uneven distribution of leadership responsibilities across sites, combined with WHH's larger share of 'Additional NHS Responsibilities', means WHH consultants balance direct clinical delivery with disproportionate organisational and strategic commitments compared to their colleagues at K&CH and QEQM.

All sites maintain 1:12 on-call frequency despite differing consultant numbers and service portfolios

- All sites base their anaesthetics on-call rotas on a 1:12 on-call frequency, implying rotas require a minimum of 12 consultants to deliver without gaps
- WHH's broader service portfolio including obstetrics, trauma, and emergency services is supported a larger consultant cohort, with some consultants participating in on-call at lower frequencies (as low as 1:36)
- QEQM offers a moderate service range including obstetrics and trauma with a rota size above the minimum 12, though the site has historically been challenging to recruit to
- K&CH runs a shared ITU/anaesthetics on-call model with a narrower service range, but this shared arrangement has created significant recruitment challenges
- K&CH currently receives support from WHH consultants to fill gaps in the on-call rota

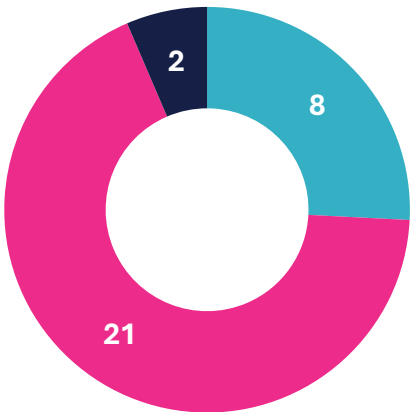


Weeknight and weekend commitments vary both by site, and within site-based teams

On-call and weekend elective work at WHH

Financial year 2025-26; Consultants

- Weekend Trauma/Elective
- On-Call/CEPOD
- None

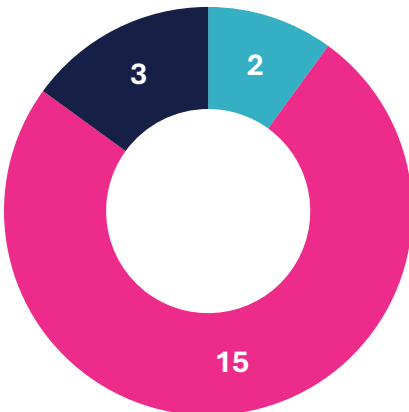


Both the CEPOD and trauma services operate year-round on a seven-day basis. The CEPOD service requires 3.25 PAs of consultant time each day, whilst trauma demands 2.5.

On-call and weekend elective work at QEQM

Financial year 2025-26; Consultants

- Weekend Trauma/Elective
- On-Call/CEPOD
- None

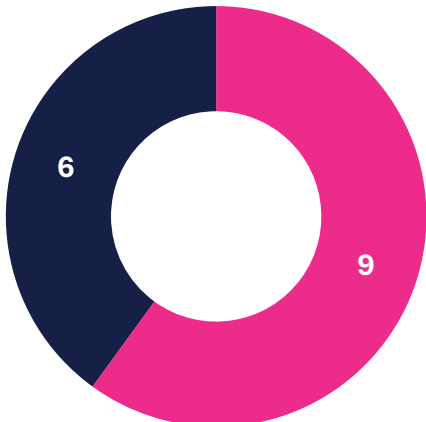


The emergency CEPOD and trauma services both operate 52 weeks a year, seven days a week, each requiring 2.5 PAs per day.

On-call and weekend elective work at K&CH

Financial year 2025-26; Consultants

- On-Call/Predictable/Unpredictable
- None



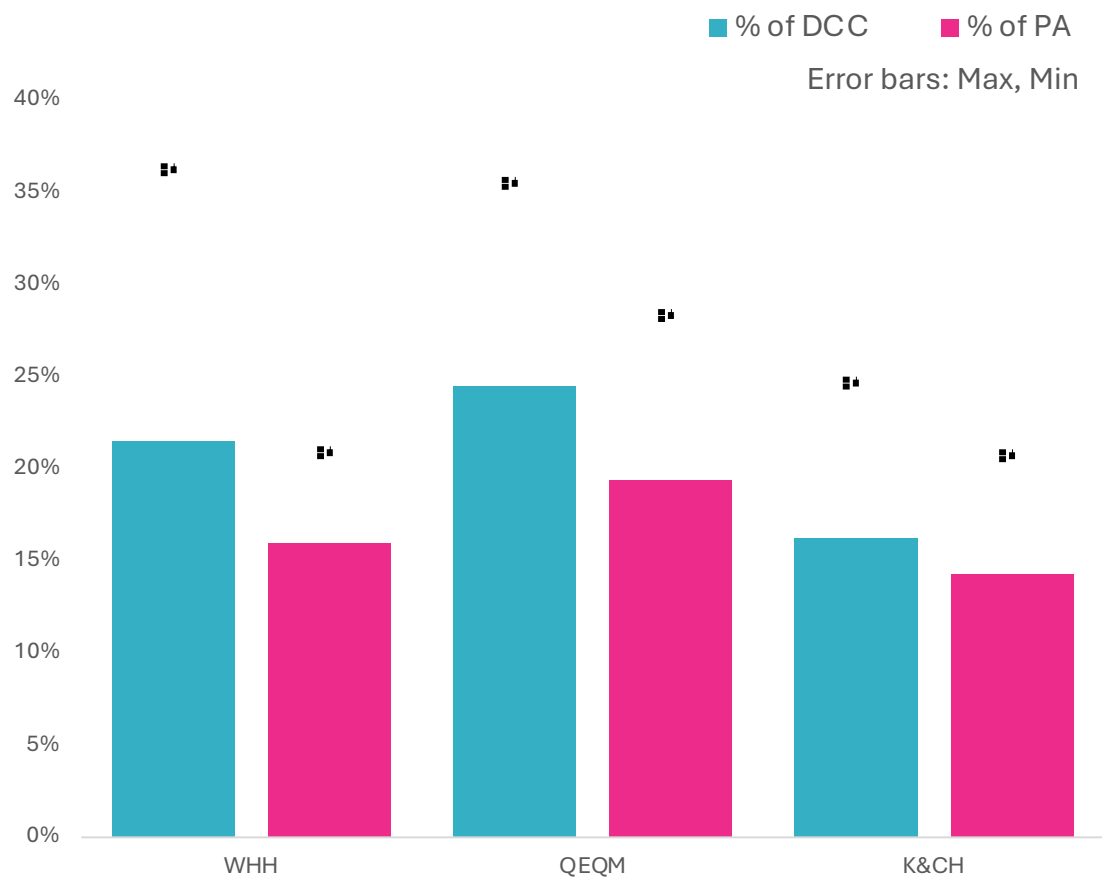
The emergency CEPOD service operates 52 weeks a year, seven days a week, requiring 2.5 PAs per day.

Consultants who work on-call do not work weekend trauma/elective and vice versa.
1 consultant from WHH cover's the on-call anaesthetic rota at K&CH

On-call activity accounts for 12-20% of consultant DCCs across sites, with varying compositions reflecting site-based needs

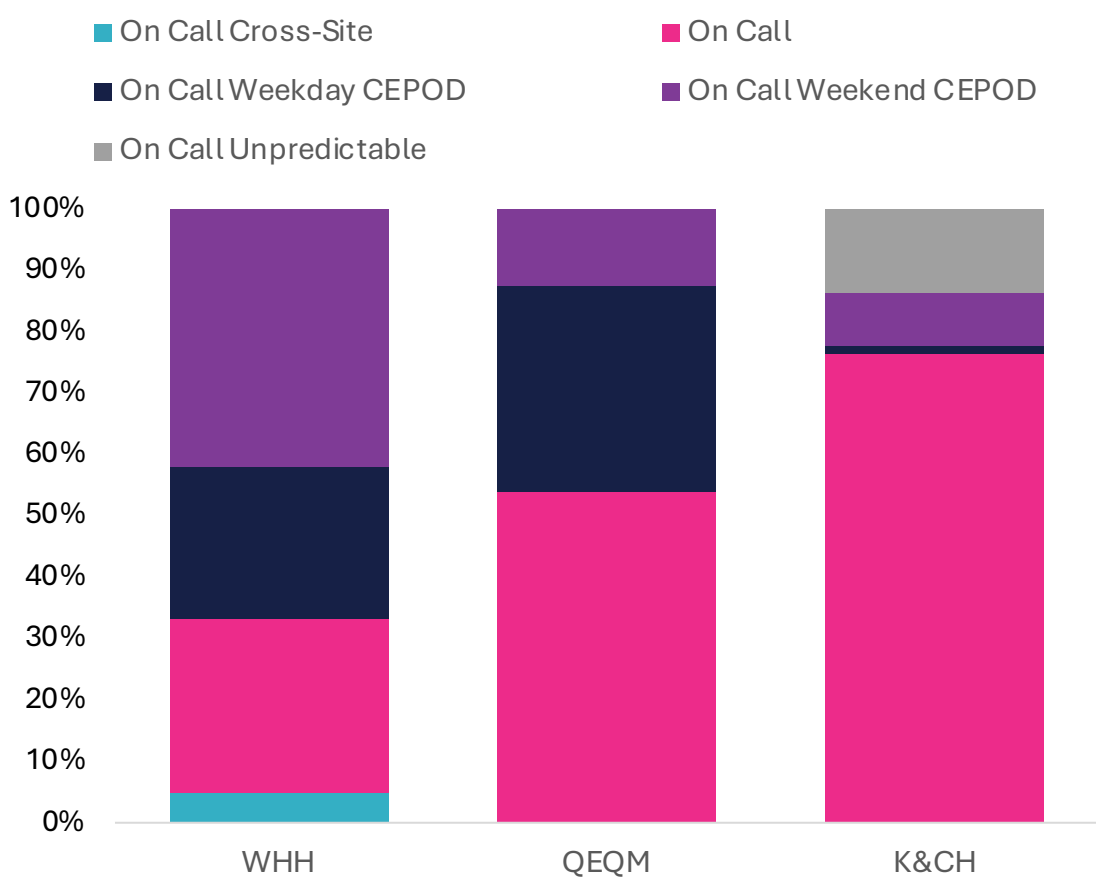
Mean on-call PAs as a proportion of all DCCs/PAs

Financial year 2025-26; Consultants working on-call



Composition of on-call commitments

Financial year 2025-26; Consultants working on-call

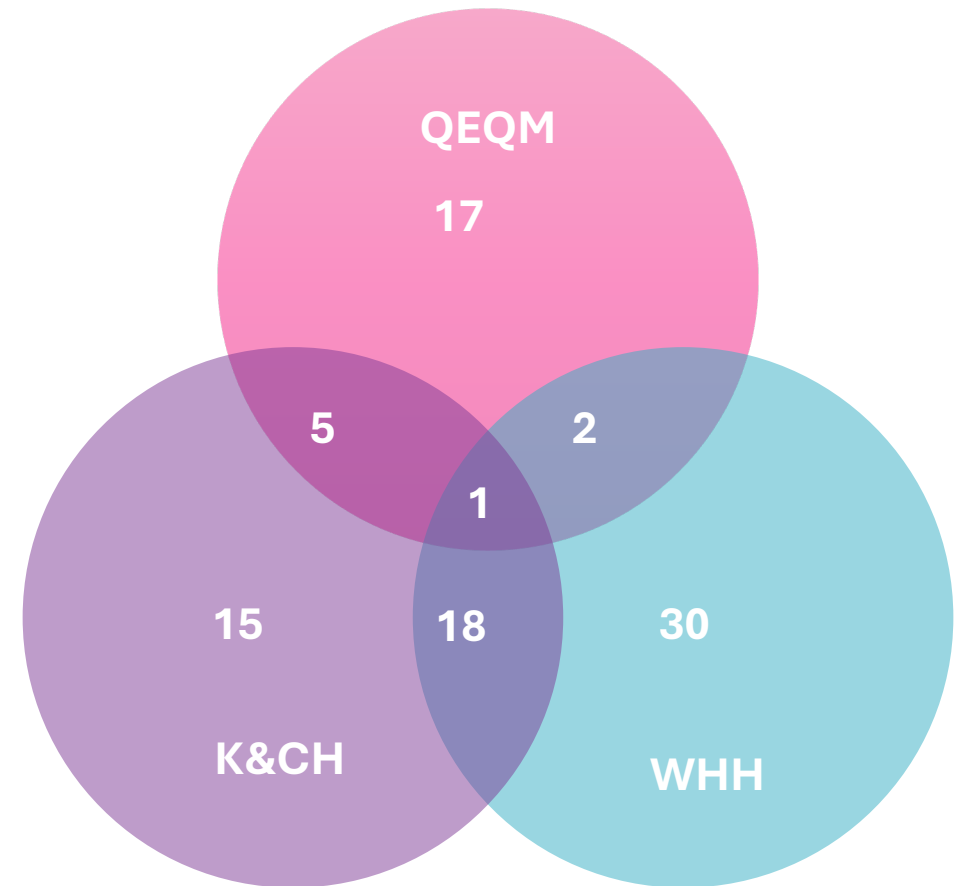


Cross-site working depends entirely on legacy arrangements with no formal rota arrangements or Trust-wide capacity view

- 88 Consultants work across anaesthetics and ITU services at EKHUFT
- 62 Consultants (70%) work exclusively at a single site, with only 1 Consultant working across all three hospitals
- 22 Consultants (25%) provide coverage across two sites, but QEQM has notably limited Consultant overlap with other sites – only 2 Consultants work between QEQM and WHH, and 5 between QEQM and K&CH, compared to 13 Consultants working across WHH and K&CH
- QEQM's relative isolation means it has minimal ability to draw on Consultant expertise from the other two sites, creating vulnerability during capacity pressures or when specialist skills are needed
- The workforce distribution is heavily siloed, limiting the Trust's ability to respond dynamically to variations in clinical demand or capacity pressures across sites
- Single-site concentration means Consultant expertise and specialist capabilities are not readily accessible Trust-wide, creating operational constraints for service delivery
- The workforce distribution reflects where Consultants are planned to deliver direct clinical care and does not capture non-clinical activities such as research or management responsibilities

Distribution of anaesthetic and ITU Consultants by site

DCCs planned as per Patchwork Job Plans; financial year 2025/26; Substantive and Locum Consultants



Workforce shortages, skill mix challenges, and static infrastructure are reportedly impacting service delivery

Analysis of workforce data, job plans, and stakeholder interviews identifies five challenges affecting anaesthetic and critical care service delivery across the Trust. These are explored in detail in the following pages of this section of the report.

Recruitment and vacancies	Critical posts are unfilled at Trust and site level, including the Trust-wide anaesthetic lead and key clinical posts at all three sites. Persistent vacancies across multiple posts, sites and levels are reflective of wider organisational factors impacting recruitment.
Skill mix and grade	The workforce deficit created by hard to recruit consultant vacancies is being filled with other grades, creating a potential clinical risk where there are skills deficits. Staff also raised concerns about the supervision of non-autonomous clinicians.
Out-of-hours cover	Concerns have been raised about the challenges of out-of-hours provision at all three sites. Staff are required to cover multiple clinical areas simultaneously with no standardised escalation pathways or formal backup arrangements across the Trust when demand exceeds the capacity of the on-call team
Rota gaps	A business case for a third-tier of anaesthetic cover at WHH was approved in April 2024 but remains only partially implemented as recruitment has been challenging. There is no systematic approach to addressing gaps in the rota and the clinical challenges these create
Infrastructure and capacity	QEQM's ITU capacity has remained unchanged despite growing demand from population growth and redirected emergency workload following K&C's ED closure. Non-clinical transfers are being driven by lack of capacity rather than clinical need and reduce the availability of anaesthetic cover across other services.

Consultant vacancies persist while lower grades are overfilled against establishment

Vacancy rate across ITU and anaesthetics

Workforce data provided Jan-2026

Site	Grade	Establishment	WTE	Vacancies	Vacancy Rate
K&CH	Consultant	24.4	17.1	-7.3	-30%
	SAS/Specialty Doctor	7.2	8.6	+1.4	+20%
	Resident Doctor	9.0	7.9	-1.1	-12%
QEQM	Consultant	27.7	22.5	-5.2	-19%
	SAS/Specialty Doctor	13.6	18.8	+5.3	+39%
	Resident Doctor	20.0	22.1	+2.1	+10%
WHH	Consultant	42.2	44.4	+2.2	+5%
	SAS/Specialty Doctor	4.7	6.9	+2.2	+46%
	Resident Doctor	42.9	37.7	-5.2	-12%

- Workforce data across ITU and anaesthetics reveals significant grade mix imbalances at all three sites. Consultant vacancies remain high at K&C (30%) and QEQM (19%), while SAS/Specialty Doctor positions are overfilled at QEQM and WHH, suggesting lower grades are being used to fill consultant-level gaps.
- This mismatch between planned and actual workforce composition creates operational risk, particularly in emergency and out-of-hours scenarios where appropriate skill mix is critical for patient safety.

Skill mix challenges and supervision concerns compound the impact of vacancies

The impact of consultant vacancies is compounded by skill mix challenges and concerns about supervision arrangements. Workforce data indicates lower grades are filling consultant-level gaps, while staff have raised concerns about oversight for non-autonomous clinicians.

Skill mix gaps across sites

- Workforce data shows consultant vacancies at K&CH (30%) and QEQM (19%) are being offset by overfilling at SAS/Specialty Doctor level, meaning lower grades are covering roles designed for Consultants
- At WHH, the second-tier on-call may be filled by trainees rotating through anaesthetics, who may lack specialist skills for scenarios including difficult airway management, obstetric emergencies, trauma, and paediatric emergencies. This increases reliance on the consultant, who may already be managing competing clinical demands across theatres, ED and labour ward

Concerns by staff about supervision arrangements

- Stakeholders reported concerns that non-autonomous clinicians are in some cases performing solo clinical work without the supervision arrangements that Royal College guidance requires
- Staff reported that these concerns have been raised with senior leadership but have not been visibly addressed or resolved
- Several interviewees expressed the view that these issues may be contributing to recruitment difficulties, as prospective candidates may be deterred by perceived standards of professional practice

Out-of-hours provision for anaesthetics lack resilience and face sustainability challenges

Each site is experiencing challenges with service delivery out of hours given the range of areas that require anaesthetic or critical care input. Demands can exceed both the capacity and capability of rostered staff,

WHH

- Separate on call for ICU, with good depth of cover. Potential for gaps in airway skills requiring anaesthetic support, including for some transfers
- Obstetrics requires dedicated anaesthetic capacity
- Third resident tier was agreed and funded c. 2 years ago but recruitment gaps persist, meaning there are insufficient resident doctors in post to provide three tiers out of hours, creating rota gaps which cannot be filled.
- Single consultant on call for anaesthetics with no formal backup arrangements

K&CH

- Single consultant covering anaesthetics and critical care OOH – a model which is difficult to recruit to
- One resident doctor for the site, across all areas
- Vascular and urology centre – while emergency activity volumes are lower than other sites, some cases are complex and lengthy, occupying staff for considerable periods.
- Insufficient capacity to deliver thrombectomy service at present

QEQM

- 9-bed ITU relies on cross-site consultant support from WHH to deliver a dedicated critical care rota, supported by 2 resident doctors
- Some reliance on anaesthetics when there are skills gaps
- Vacancies create additional pressures for cover arrangements.

QEQM's 9-bed ITU capacity has remained unchanged whilst Thanet population grows and K&CH emergency workload is absorbed

Demand drivers increasing

- Following the closure of Kent & Canterbury ED, emergency workload has been redirected to QEQM and WHH
- Major housing developments are underway in the region and Thanet is experiencing a demographic shift towards younger people
- QEQM facilitate approximately 2500 deliveries of which around 55% are Caesarean sections

Static capacity unchanged

- There are 9 ITU/HDU beds at QEQM and capacity has remained unchanged since K&CH ED closure
- Current infrastructure was designed for previous population baseline
- No expansion planned despite stakeholders reporting predicted demand growth

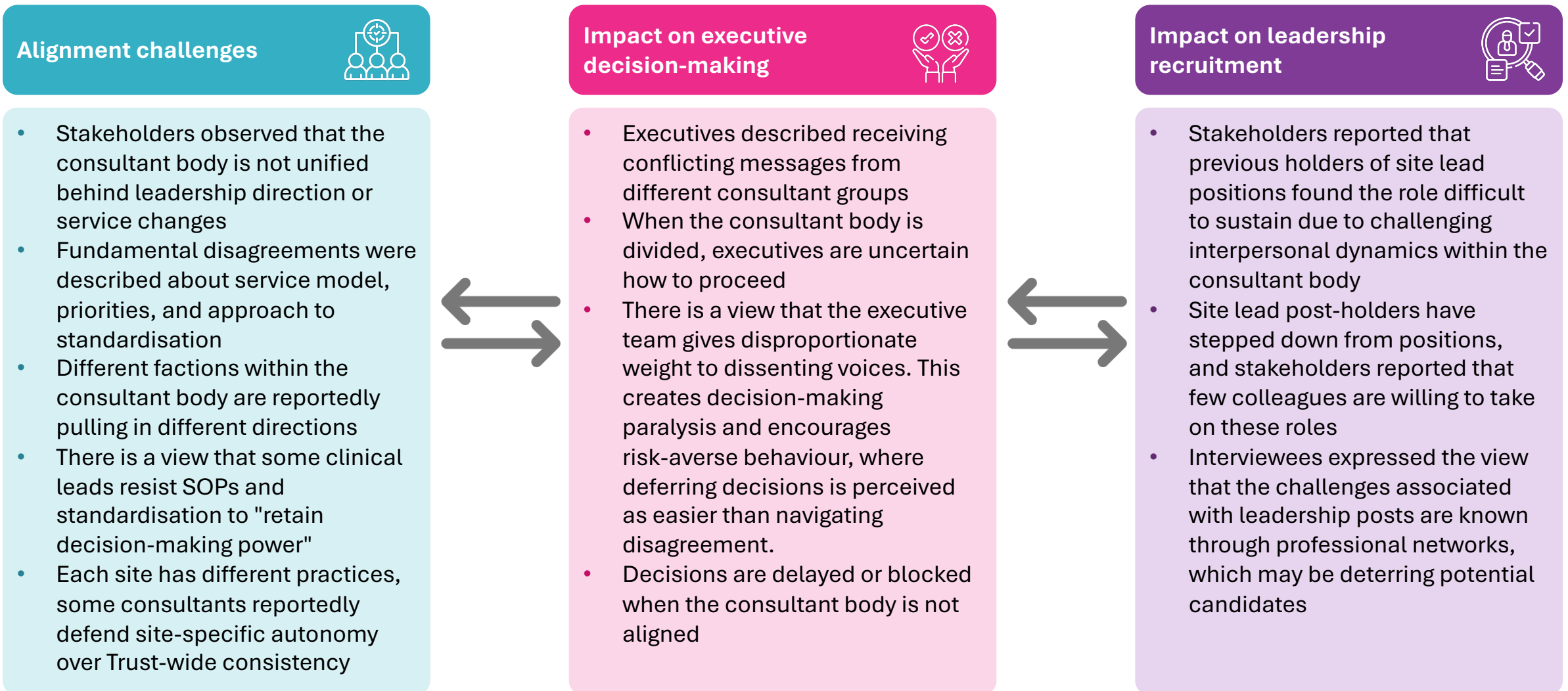
Consequences and pressures

- Non-clinical transfers are driven by capacity rather than clinical need, removing an anaesthetist from site for several hours and creating a coverage gap
- There is no dedicated transfer service and transfers are managed ad-hoc by whoever is on duty
- Longer waits for ITU admission affect theatre scheduling and emergency admissions
- The Trust has demonstrated the ability to invest in ITU capacity, with WHH recently expanding to 24 beds. A similar assessment of QEQM's capacity requirements against projected demand has not been undertaken

4.2 Current state: people and culture



Disagreement amongst consultants makes it difficult for the executive team to enact change and fill leadership posts



Frontline staff reported feeling unheard, unsupported and isolated

WHH

- Staff are operating under unsafe out-of-hours model with concerns repeatedly raised but model remains unchanged
- Despite having recently expanded ITU to 24 beds, the outcomes of the Kirkup report and funding for a third-tier, staffing model and support have not kept pace with demand
- Staff reported that safety concerns about managing simultaneous emergencies have been raised but not addressed

K&CH

- Staff feel patient acuity is underappreciated because site does not have an ED; there is a perception that without ED, complexity of work (vascular, urology, elective orthopaedics, 10-bed ITU) is not recognised
- Stakeholders reported that specialist and complex work is undervalued compared to emergency/trauma work at other sites. This contributes to a sense that K&CH's contribution to the Trust is not properly understood

QEQM

- Staff described feeling isolated from the rest of the Trust, with a smaller team operating with less visibility and support
- Geographic and cultural distance from other sites was reported as contributing to a sense of being deprioritised in Trust-wide decisions

Trust-wide

- Across all three sites, staff reported repeatedly raising concerns without seeing action or change
- Staff described a gap between frontline concerns reaching senior decision-makers and those concerns translating into tangible outcomes, leading to a perception that clinical expertise is not valued in decision-making

4.3 Current state: governance

Governance meetings occur and concerns documented, but stakeholders described recommendations as not being routinely implemented

Input

- Frontline concerns raised
- Datix reports submitted
- Safety concerns registered

Governance

- Monthly Care Group meetings occur
- Clinical leadership forums exist
- Board reporting happens

Output

- Decisions are not consistently communicated
- Recommendations not being routinely implemented

The governance gap



- According to a staff member: *"People raise issues, and whilst there is awareness about them, there is little engagement"*
- Governance meetings are described by staff as "box-ticking" rather than genuine problem-solving
- When concerns do reach senior level, they don't appear to result in visible action or change

Datix management disconnected



- Staff described incident reports as going into a "black hole," with no feedback provided to reporters on investigation outcomes or actions taken
- Staff reported no visible evidence of learning from incidents being translated into change
- This absence of feedback and visible action is reportedly eroding confidence in the reporting system

Executive-clinical communication breakdown



- Frontline staff expressed a need for immediate solutions, whilst executives were described as working in longer planning cycles and managing multiple competing priorities
- Staff reported uncertainty about clear routes for frontline concerns to reach decision-makers with authority to act
- Stakeholders expressed concern that efforts to drive change through existing channels may not result in timely action

The three sites reportedly operate as independent departments, failing to capture the benefits of being a single Trust

Site-based identities are stronger than Trust-wide professional unity, where WHH, QEQM and K&CH operate as separate entities with minimal integration. Staff identify as "WHH anaesthetist" or "Margate ITU" rather than "East Kent anaesthetist". Cross-site collaboration depends on individual long-standing relationships, not systematic structures. This means when individuals with cross-site relationships leave, connections break.

Site-based identity



- Staff reported that there is a lack of comradery and support between sites; success at one site is perceived as a threat to others
- Competition reportedly exists between sites for limited resources
- Staff felt that sites are advocating for themselves rather than Trust-wide optimisation
- Staff reflected that there is no obvious Trust-wide perspective on anaesthetics from clinical and executive levels

Resistance to standardisation



- Each site operates differently with varying clinical practices and protocols
- Clinical leads reportedly resist standard operating procedures and Trust-wide protocols, there is a view this stems from a desire to retain power
- Staff felt that professional autonomy is prioritised over standardisation whereby site-specific practices are seen as identity rather than unwarranted variation
- Standardisation is perceived by staff as bureaucracy and a threat to autonomy rather than an enhancement of safety and efficiency

Consequences of fragmentation



- According to staff, inconsistent care quality exists across sites and shifts depending on location and who is on duty
- Stakeholders described increased risk during and cross-site handovers due to the inconsistency between sites
- Training juniors is reportedly complicated since they must learn three different ways of working
- Staff working across sites are reportedly frustrated by a lack of coordination

Cross-site working reportedly relies on legacy arrangements with no formal rota arrangements or Trust-wide capacity view

Cross-site arrangements



- Staff described cross-site working as largely a remnant of historic arrangements, with cross-site sessions now the exception rather than the norm
- There are reportedly minimal formal cross-site rota arrangements or job-planned sessions, with the most consultants based exclusively at a single site
- Some stakeholders reported an expectation that anaesthetists would work across sites; however, they described this as not being consistently reflected in practice

Trust-wide capacity view



- Despite centralised structures being in place, there is limited evidence of a Trust-wide approach to workforce coordination
- Each site reportedly operates as if independent organisation rather than part of integrated Trust
- Stakeholders reflected that each site manages staffing and capacity in isolation and that there are challenges with flexibly moving staff to where clinical need is greatest on any given day
- Staff felt that opportunities for efficiency are lost through lack of coordination

Distribution of specialist skills



- According to stakeholders, specialist skills are concentrated at one site, not systematically available Trust-wide or aligned with patient
- Duplication of effort reportedly occurs with each site solving the same skill-mix problems independently
- Stakeholders felt that patients may not access best available expertise within Trust depending on which site they attend
- Staff observed that no systematic sharing of clinical innovations or service improvements occurs

Rota coupling at K&CH



- ITU consultant out-of-hours cover is integrated with anaesthetic rota
- According to stakeholders, contemporary consultants want either ITU or anaesthetics, not both
- Staff observed that the current model relies on older generation of consultants who trained across both and are willing to work flexibly, however many of these consultants are approaching retirement
- Consultants highly skilled in complex anaesthetics but less interested in ITU are reportedly not attracted to working at K&CH

4.4 Current state: management and leadership



Stakeholders reported that decision-making authority needs clarification to enable effective operational leadership

Unclear delegation of authority



- Senior operational and clinical roles exist but stakeholders described a lack of clearly defined remits of responsibility
- Feedback highlighted ambiguity about which decisions require escalation versus which can be made at the senior operational level
- Leaders expressed uncertainty about the scope of their authority to act

Unmanageable portfolio breadth



- Stakeholders noted that some senior roles span extraordinarily broad portfolios across multiple specialties and service lines
- According to feedback, portfolio breadth limits deep engagement with specific service areas and impedes specialty-specific decision-making
- The Trust-wide anaesthetic lead position has been vacant for over a year, resulting in reported gaps in strategic clinical leadership

Loss of site-level operational authority



- Stakeholders reported that previously, site administrators had delegated authority and deep knowledge of local staff, skills, and circumstances
- The current multi-layered structure was described as requiring issues to be escalated through multiple management layers
- According to feedback, site administrators now carry minimal authority, reducing flexibility and timely problem resolution

Stakeholders described operational bottlenecks and delays in addressing day-to-day issues due to limited decision-making authority. They reported reduced agility in responding to changing circumstances. Frontline staff expressed the perception that senior leaders are disconnected and ineffective. Concerns were raised about decreased staff morale and operational efficiency as a result of these decision-making authority gaps causing a breakdown in trust between frontline clinicians and management.

Administrative restructuring has reportedly reduced operational flexibility and impacted workplace culture

Loss of local flexibility and responsiveness



- Stakeholders described how the previous administrative structure allowed departments to organise themselves around local needs and staff circumstances
- The current centralised approach was reported as being more rigid and less responsive to site-specific realities
- Feedback highlighted that centralised functions have become disconnected from the distinct characteristics and needs of individual sites

Challenges with centralised rostering



- Stakeholders reported that daily staff allocations are frequently inaccurate, requiring constant reactive adjustments
- The rigidity of centralised rostering was described as preventing timely problem-solving even when solutions are apparent to those on the ground
- Staff expressed frustration about constantly managing staffing challenges without seeing improvements

Changes in collaborative workplace culture



- Stakeholders described a previous "give and take" culture where staff willingly stayed late, worked weekends, or covered gaps to support colleagues
- This informal flexibility was reported to have diminished as the formal system became less accommodating
- Staff perception is that informal arrangements and goodwill cannot be relied upon when the formal system is inflexible, leading to more protective behaviours

Lack of alignment on priorities



- There are different perceptions between groups of clinicians on the challenges faced by anaesthetic services on each site
- Care group leadership is viewed by many as remote and disconnected
- Management structures within the Care Group are not geared to delivering service level changes in collaboration with clinical teams

Stakeholders highlighted that sites would benefit from greater strategic integration and coordination

Lack of strategic clarity and planning



- Staff reported the absence of a multi-year workforce plan despite ongoing vacancy challenges
- Stakeholders described uncertainty about the service model and how the three sites should function together
- Feedback indicated that a longstanding capacity decision regarding QEQM (9 beds versus growing demand) has remained unresolved for several years
- Management was described as operating with reactive week-by-week locum booking rather than strategic recruitment planning
- Stakeholders expressed that there is no clear communicated vision for what the service should look like in 3 years

Limited cross-site coordination and collaboration



- Stakeholders reported that sites operate with minimal coordination between them
- Workforce data indicated that 70% of consultants work exclusively at a single site, with limited cross-site sessional working or emergency backup arrangements; cross site working is heavily associated with the Elective Orthopaedic centre
- Stakeholders noted there is no established forum or mechanism for site leads to coordinate with each other
- Where meetings do exist, attendance was reported as compromised by scheduling conflicts with consultants' job plans

Clinicians feel unsupported in driving clinically rational strategy and creating change



- Clinical staff reported identifying clinically necessary improvements but lacking authority to implement them
- Stakeholders expressed that clinical expertise and operational knowledge are not consistently translated into decision-making and action
- Clinical leaders described being held accountable for service outcomes whilst not being empowered to make changes needed for improvement
- This disconnect between responsibility and authority was reported to create frustration and disengagement amongst clinical staff

5. Review of Datix reports

Datix reports submitted over a six-month period reveal gaps in investigation quality, response implementation, and governance oversight

Incident pattern

- The 31 reports reviewed were concentrated at WHH (30 incidents) and K&CH (1 incident), with no incidents reported at QEQM
- Reports were all linked to anaesthetic staffing capacity constraints during out-of-hours periods
- Reports were generated in relation to events that occurred across clinical areas including anaesthetic rooms, labour ward, operating theatres, ED resus, and ITU

Patient and staff impact

- 68% of incidents documented specific delays or potential compromises to patient care, including emergency surgery delays, cancelled epidurals, and postponed critical procedures
- 42% of incidents had no recorded harm assessment, and 39% showed harm ratings downgraded during investigation despite clinical descriptions suggesting greater severity
- Staff documented psychological burden including stress and fear for patient safety, with no documented welfare follow-up in investigation records

Investigation and response

- 71% of incidents received standardised responses with no incident-specific learning, and set out commitments to address issues rather than completed actions, and these are not evidenced
- The first incident took 127 days to close, during which 17 further incidents were reported
- While the majority of incidents have not resulted in harm, 16% do report harm; careful investigation is needed to ensure causes are accurately identified.
- There is no evidence of consideration of a wider range of mitigating actions to reduce the risk posed by gaps in anaesthetic cover.

Governance

- Risk register escalation occurred only after 29 incidents had taken place
- Only 1 incident received PSIRF review out of 30 related incidents sharing similar staffing-related root causes
- No evidence of systematic feedback to incident reporters on outcomes or actions taken
- The treatment of incidents as individual events rather than a thematic cluster may limit organisational learning and recognition of systemic patterns

Two thirds of reports reviewed documented specific delays, with actual or potential compromise to patient care

The range of documented impacts indicates that staffing constraints can affect multiple points in patient pathways:

- Of 31 Datix reports reviewed, 20 cite incidents where patients experienced delays that either compromised care or had the potential to do so
- 4 state that whilst no patient was harmed, a near-miss had taken place
- 7 document risk to patients and staffing gaps without a specific patient related concern
- There are multiple causes of delay, sometimes simultaneously , and the causes of delay in specific cases require detailed investigation to ensure accurate attribution

Reported compromises to the epidural service in maternity	Redacted to protect patient confidentiality
Delays reported for emergency surgery	Redacted to protect patient confidentiality
Delays reported for diagnostic and therapeutic procedures	Redacted to protect patient confidentiality
Reported closures or compromises to the service	Redacted to protect patient confidentiality

6. Recommendation and actions

Recommendations address both site-based challenges and the broader leadership and management of anaesthetic services

Trust level actions

- Set out leadership arrangements for anaesthetics at site level and in cross cutting roles
- Institute a collective leadership structure for anaesthetics and critical care, the Care Group leadership and management arrangements to support this, and the organisational development needed to support it to deliver effective management and leadership
- Review consultant job plans to align to service requirements and reduce variation in practice between sites
- Develop a workforce strategy for anaesthetics and critical care, leveraging the benefits of being a multi-site Trust to create attractive posts on all sites through the effective use of cross-site working
- Align service offer for anaesthetics and critical care by site with the Trust's overarching clinical strategy
- Review Datix process to ensure it is driving improvement in quality and safety of care

WHH specific recommendations

- Map out-of-hours demand to establish pressure points
- Identify opportunities to moderate or redistribute demand to make more effective use of capacity, and steps needed to enable this
- Identify opportunities to increase capacity, resilience or depth of cover out-of-hours in the short, medium and longer term

QEQM specific recommendations

- Map existing workforce capacity and capability across consultant, and non-consultant resident doctors
- Align on what workforce can deliver each component of activity, and the level of supervision required to achieve this
- Establish recruitment requirement and delivery trajectory

K&CH specific recommendations

- Start the process of separating critical care and anaesthetic responsibilities out-of-hours, setting out an agreed trajectory to full separation
- Increase depth of on call cover out-of-hours

Actions 1 to 3 — Staffing

Addressing the challenges facing services on each site will require collective leadership and alignment on priorities for the short and medium term together with a longer-term strategy for services that aligns with the strategic priorities of the Trust. To deliver this we recommend the following actions:

1

To address staffing gaps at WHH and the potential for demand exceeding capacity to deliver services out-of-hours:

- a. Map existing workforce available to deliver care across anaesthetics and critical care and gaps against the expected model of care
- b. Identify any opportunities to shift activity from out-of-hours to planned sessions
- c. Identify opportunities to re-align activities across clinical teams, and the training requirements to enable this
- d. Align on short-term solutions and trajectory to the optimal staffing model

2

To address staffing challenges at K&CH and the viability of continued single consultant cover across anaesthetics and critical care:

- a. Establish two consultant cover with either one intensivist and one anaesthetist, or a first on and second on consultant anaesthetist, with the long-term aim of rota separation

3

To address staffing challenges at QEQM:

- a. Review current workforce capacity and capability, mapping this to existing in hours and out of hours requirements to establish a clear, granular understanding of who can undertake each activity, and any supervision required
- b. Set a trajectory for ICU capacity increases to address non-clinical transfers

Actions 4 and 5 — Management, leadership and strategy

4 Redesign management and leadership arrangements

An overhaul of management and leadership arrangements for anaesthesia, maintaining close coordination with Intensive Care services and sites:

- a. Review of the leadership roles that are required in anaesthetics and critical care both by site and as cross-cutting functions. Cross cutting roles would be for those functions that require coordination between sites e.g. rota master, lead for pre-operative assessment, college tutor, setting out clear role descriptions for each including the time commitment expected
- b. Establish a collective leadership group tasked with delivery of the service. In the short-term, leadership of this group would rotate on a six-monthly basis, with additional time allocated to one individual, and with an identified deputy who would then rotate into the lead role
- c. Aligning management by site, and with a single coordinating role to support the effective delivery of clinical leadership
- d. External sponsorship to the group, providing check and challenge and ensuring agreed ways of working are adhered to.

5 Develop a strategy for anaesthetics and intensive care

Develop a strategy for anaesthetic and intensive care services that aligns with the overall strategy of the Trust and addresses issues of service fragility and workforce succession planning, likely availability of staff and the requirement to deliver services within a financial envelope.

Actions 6 and 7 — Workforce plan and consultant job plans

6 Develop a tactical workforce plan

Development of a tactical workforce plan to address the needs of the Trust over the next 12 months

- a. Rapid review of existing demand and capacity work to ensure there is an accurate description of the services provided by the anaesthetic department by site and time of day.
- b. Map potential options for meeting these commitments from within the existing staff pool, and the assumptions and trade-offs created by each of these options, including where existing arrangements such as frequency of on call require review to meet the needs of both staff and service
- c. Align on tactical priorities and a timescale for resolution of any temporary arrangements, and align working arrangements accordingly

7 Harmonise consultant job plans

A harmonisation of consultant job plans across sites to ensure consistency

- a. Develop a model job plan for anaesthetics, setting out balance of elective and emergency commitments, cross-site working and the delivery of departmental responsibilities
- b. Review existing job plans against this model as part of a team job planning exercise to ensure there is transparency and consistency across the Trust.
- c. Agree longer term changes to job plans

Review of Systems and Processes for Raising Concerns

East Kent Hospitals University NHS Foundation Trust

Report prepared by Helen Buckingham, February 2026

1. Executive Summary

- 1.1 This report sets out the findings of a review of the effectiveness of the systems and processes for raising concerns within East Kent Hospitals University NHS Foundation Trust, commissioned following correspondence from consultants in the Critical Care, Anaesthetics, and Surgery Directorate in October 2025. The report also considers the Board's approach to triangulating such concerns with other organisational data to identify patterns and ensure appropriate action is taken.
- 1.2 The methodology underpinning this review included a desktop analysis of relevant policies and procedures, scrutiny of Board and Committee papers (specifically the Quality Committee and People and Culture Committee), and interviews and group discussions with Board members and other key staff.
- 1.3 Findings indicate that while the Trust has established a range of routes through which staff can raise concerns, the effectiveness of these systems depends to a very great extent on organisational culture. The current culture described by staff interviewed during this review is not conducive to psychological safety and to encouraging staff to raise concerns in the confidence that they will be addressed fully and fairly. It should be noted that the number of staff interviewed was very small in the context of the total size of the Trust's workforce, and it is possible that views are not fully representative. However, staff interviewees were consistent in their responses, and the views expressed triangulated with other sources such as staff survey feedback and the Trust's own measures of staff advocacy and engagement.
- 1.4 In respect of Board oversight, the report highlights the efforts being made by Board members to triangulate staff concerns with a broader spectrum of data—such as incident reports, patient feedback, and performance metrics—to identify recurring issues and respond proactively. However, this is compromised by limitations in data completeness, and by the sheer volume of data presented to the Board.
- 1.5 The report sets out seven recommendations, summarised here:
 - Building staff confidence
 - Ensuring consistent implementation of quality governance
 - Improving engagement with staff networks
 - Strengthening line management

- Improving data and reporting, including reviewing the 'user-friendliness' of the Datix system
- Further embed board-level triangulation practice
- Review leadership capacity, particularly medical leadership

2. Introduction

2.1. In October 2025 a number of consultants in the Critical Care, Anaesthetics and Surgery Directorate at East Kent University Hospitals NHS Foundation Trust wrote to the Chair of the Trust raising a number of concerns relating to the management of their services. The specific concerns raised by the consultants are being addressed by the Trust through a range of appropriate routes. However, the Trust wished to commission a piece of work addressing two higher level questions:

- whether the systems and processes in place for staff to raise concerns within the Trust are working effectively; and
- how the Board triangulate issues raised by staff with other data to identify patterns and ensure that appropriate action is taken.

2.2. This report addresses those questions.

3. Methodology

3.1. The findings and recommendations set out in this report are drawn from:

- A desktop review of relevant policies and procedures
- A desktop review of a cycle of Board and relevant Committee papers (Quality Committee, People and Culture Committee)
- Interviews and group discussions with relevant Board members and other staff:
 - Chief Medical Officer
 - Chief People Officer
 - Chief Nursing Officer
 - Chair of Quality Committee
 - Chair of People and Culture Committee
 - Director of Quality Governance
 - Freedom to Speak Up Guardians
 - Representatives of consultants raising concerns
 - Representatives of the wider consultant body
 - Union representatives on behalf of the wider staff body

3.2 It should be noted that the number of staff interviewed was very small in the context of the total size of the Trust's workforce, and it is possible that views are not fully representative. However, staff interviewees were consistent in their responses, and the views expressed triangulated with other sources

such as staff survey feedback and the Trust's own measures of staff advocacy and engagement.

4. Are the Processes in Place for Staff to Raise Concerns Working Effectively?

4.1. Interviews explored several different systems and processes for staff to raise concerns including:

- Datix/risk management system
- Line management
- Freedom to Speak Up
- Direct approaches to senior management and Board members

4.2. Overall, the processes for staff to raise concerns are not working as effectively as they should be. While there are some signs of improvement over the past 12-18 months, the use of both formal and informal systems for raising concerns remain fragile and inconsistent. Multiple interviewees expressed that the Trust is on an improvement journey but has not yet reached a point where staff have full confidence in raising concerns and seeing action taken. Some interviewees were more pessimistic, stating that they had no confidence about concerns being acted upon, even in response to reports such as this one. The obstacles to effective management of concerns are more cultural than structural, although there appear to be some practical issues with the Datix system which are discussed further below.

4.3. The last 12-18 months have seen some improvements, including the procurement of the external Guardian service, strengthening of the HR and People and Culture team, and better formal reporting on employee relations cases, tribunals, disciplinaries, and grievances beginning around March 2025. There is growing evidence of concerns being escalated and addressed, though this is still developing, and crucially, the feedback loop to staff is not yet operating consistently. Executive leadership under the current acting CEO and Chief Medical Officer is viewed as higher calibre and more proactive about identifying and addressing issues.

5. Key Findings

5.1. Cultural and Historical Context

5.1.1. The ineffectiveness of concern-raising processes stems from a combination of long-standing cultural issues, capacity and capability gaps in key leadership and support functions, executive instability, and insufficient follow-through on concerns that are raised. These factors have created a vicious cycle where staff believe raising concerns is at best pointless and at worse that it is not safe to speak up, leading to further underreporting and embedding of problematic behaviours.

5.1.2. Cultural problems are estimated to go back at least 10-15 years. There is a longstanding culture of failure to address poor behaviour. The combination of low geographic mobility and job insecurity has created pockets where poor performance persists unchallenged.

5.1.3. Past organisational culture was reported to tend to 'sweep issues under the carpet' rather than taking formal action, though there are indications this is changing with new leadership. Previous HR team weaknesses, including being risk-averse and failing to address poor performance, have contributed to a lack of confidence. Geographic isolation in Kent contributes to low staff turnover, meaning that poor performance and bad behaviours can become entrenched in silos and pockets.

5.2. Historical Weaknesses in HR and People Function

5.2.1. The HR team was described as historically fairly poor. Risk aversion in the employee relations team meant that issues were left unaddressed rather than tackled formally. An interim Chief People Officer made significant changes in the HR department and began to address the culture of inaction.

The new Chief People Officer, who started on a part time basis in January 2025, becoming full time in March 2025, represents a positive change but is still working to address inherited challenges. Until March 2025, the board did not receive regular reporting on employee relations cases, disciplinary actions, or grievances, limiting oversight of patterns and themes.

5.3. Executive Turnover and Instability

5.3.1. The Trust has experienced significant executive churn, with the Quality Committee chair noting they are on their third Chief Nurse and third Chief Medical Officer. There have been three Chief Executive Officers in ten years, and the current Chief Executive is on an extended leave of absence, with the Chief Medical Officer acting up into the role. This instability has created cynicism among middle and senior management who have seen many leaders come and go without lasting change. The lack of continuity has made it difficult to build trust and demonstrate that raising concerns will lead to meaningful action.

5.4. Capacity and Capability Gaps

5.4.1. Interviewees indicated that managers are sometimes complicit in maintaining problematic cultures. Several interviewees described a 'nepotistic' culture, where access to development opportunities and career progression is dependent on 'fitting in' and on the patronage of individuals rather than on merit.

5.4.2. Leadership development has been insufficient, with managers promoted based on clinical or technical expertise rather than management ability. While leadership training programmes have been introduced for middle managers, there is scepticism about whether training alone changes behaviour, particularly for those who have operated with impunity. Several

interviewees expressed some concerns relating to the level of clinical leadership capability and the various levels of professional registration among consultants. Site-based medical directors are not well-known or visible to board members. The Trust-wide medical leadership was described as extremely thin and stretched, so that however good the individuals in role may be, it is simply not possible for them to have an effective focus on the full range of operational and strategic issues for medical staff across the Trust. Care group leadership quality is described as mixed, with some who are very good and others who are simply not up to the role.

5.5. Lack of Consequences for Poor Behaviour

5.5.1. Board members have expressed frustration about wanting to see evidence of people being held to account for serious issues like bullying, harassment, or racism, but such examples are rare. While some disciplinary processes are reportedly underway, there is insufficient assurance that appropriate action is taken, up to and including exiting individuals from the organisation due to poor behaviour. The visible lack of consequences for poor behaviour reinforces staff perceptions that speaking up is pointless. Previous leadership reportedly moved problematic individuals aside or ignored issues rather than formally addressing them. Redacted due to person identifiable information.

5.6. Fear of retribution

5.6.1. A number of interviewees stated that they had seen colleagues inhibited from raising concerns through a fear that they would be “targeted” as a result. This might manifest as a disproportionate focus on an individual’s annual leave or job planning, being disadvantaged in rostering, not being made aware of opportunities for development, or even referral to the GMC.

In two separate interviews interviewees gave examples where consultants who had raised concerns found themselves under investigation. In at least one case the individual was told that one of their direct reports who had raised a concern was themselves being investigated for behaviour which was ‘not in line with Trust values’. This triangulates with a comment made by an individual in a separate interview who described the ‘Trust values being used as a threat’.

5.7. Inconsistent Processes

5.7.1. There appears to be a closing down of concerns quite low down in the organisation. Interviewees indicated that there have been incidences where staff have been actively encouraged not to speak up, not to ‘rock the boat’, or told that problems are insoluble due to budget constraints. This has been by their peers as much as by more senior staff. The quality of formal structures for raising concerns is reported to vary considerably. Nursing appears to have more established structures for raising concerns, but the picture across the organisation is mixed, and certainly some interviewees suggested that there are inconsistencies within nursing too. Historically, there has been a lack of regular forums such as consultant congresses or

advisory committees where medical staff could raise concerns directly with senior leadership. While attempts have been made to establish such meetings, they have not been consistently maintained or well-attended.

- 5.7.2. Interactions with HR staff in relation to concerns raised about individuals was reported as variable. Some interviewees who were also managers gave examples of being told to tell a member of staff that they were under investigation but without being given any details of the complaint or the form the investigation would take.

5.8. Staff Survey Evidence

- 5.8.1. Interviewees reflected that staff survey results over at least five years consistently show poor feedback about people feeling confident to speak up and believing that action would be taken if they did. One interviewee noted that staff tell the Trust that raising concerns does not lead to action, describing this as a general feeling particularly among rank and file staff outside of doctors, and especially among administrative staff who see issues but view raising them as futile. The most recent staff survey shows Trust results consistently below average including on questions specifically relating to raising concerns. The IPR report to the December Board showed that staff engagement and staff advocacy both to show considerable variation and to be at considerable risk of failing to achieve the targets set by the Trust.

5.9. Freedom to Speak Up Service Challenges

- 5.9.1. The internal Freedom to Speak Up service effectively collapsed in early 2024. For approximately three weeks in the summer of 2024, no member of the FTSU team was at work. During 2024, the Trust had no FTSU reports at all. An external Guardian service was procured and began operations in March 2025. 81 people from across the organisation have raised issues with the service between March and September 2025, indicating that there is awareness and use being made of the new service. However, this timeframe is too short to demonstrate sustained effectiveness, and staff confidence in using the service remains uncertain due to historical experiences. The Guardian service are making significant efforts to raise awareness of and confidence in the service, and some interviewees who had interacted with the new service reported a positive experience.

5.10. Barriers to Informal Concern-Raising

- 5.10.1. Beyond formal systems, informal mechanisms for raising concerns are weak. Appraisal rates have historically been below 80 percent and only recently reached target levels before dropping again to 74.5 percent. If staff are not receiving regular appraisals, they are likely not having one-to-one conversations where concerns can be raised informally. Some interviewees expressed a view that historically many managers have been promoted based on their technical expertise rather than management capability and not been provided with adequate management or leadership training to address this. Non-Executive Directors indicated that on site visits they had found that some staff did not know who their line manager was, had never

seen them, or were unaware of senior management and executives in their care groups. Conversely, some staff interviewed had never experienced a site visit from NEDs. This situation is reported to have improved but remains patchy across the organisation.

- 5.10.2. The Trust has a number of staff fora in place which could act as a route for staff to raise concerns. These include Trust wide networks as well as care group and professional group meetings. However, feedback from interviewees suggests that these fora are variable in the way they operate, clinical staff in particular find it hard to release time to attend meetings and there is not always personal attendance by or a clear escalation route to senior leaders.

5.11. Complexity and Crowded Operational Radar

- 5.11.1. The Trust is large and complex with significant operational pressures and financial challenges, coupled with long standing and high profile concerns relating to the quality of some services. The radar screen for leadership is described as extremely crowded, making it challenging to maintain focus on all areas simultaneously. There may be insufficient executive bandwidth to deal with the volume of issues requiring attention. In this context, there is a risk that corners of the organisation can harbour serious problems that only emerge when something goes significantly wrong. Interviewees referenced paediatric audiology as an example of this. The organisation operates across multiple sites with different cultures, adding to complexity. Several interviewees referenced the silo-ed cultures existing across sites and between teams. Some interviewees stated that the relationship between clinical and non-clinical managerial staff had deteriorated in recent years.

5.12. System and Process Issues

- 5.12.1. Broadly speaking the policies and processes in place are, on paper, adequate. However, there are implementation issues. The collapse of the internal Freedom to Speak Up service left the Trust with reduced mechanisms to track, theme, or respond to concerns for most of 2024. Reporting to the board on employee relations matters was absent until March 2025, creating a blind spot for pattern identification. Staff awareness of available policies and processes is reported to be low, with many not instinctively referring to policies when issues arise, and some interviewees gave examples of staff being actively discouraged from reporting incidents and risks. The transition from central to divisional management of incidents has raised questions about whether there is sufficient bandwidth in care groups to manage the volume of work effectively.
- 5.12.2. The Datix system was described by several interviewees as 'clunky'. It can take some time to complete a Datix report, with multiple boxes to be completed before a report can be submitted and several interviewees stated that there is apparently no facility to start a report and save it for later completion, although this may be a training issue. In addition, those who submit reports via Datix report that they get little if any feedback on actions taken as a result, and that many reports are closed with no further action or explanation. Some interviewees described pressure to close Datix reports

down and to minimise the numbers escalated for further investigation, although the Quality Governance team reflect that the backlog of open Datix reports contradicts this. Interviewees stated that as a result, they were less likely to raise a concern via Datix than to do so informally, or not at all. This, together with the cultural issues identified above, would result in an underreporting of risks and missed opportunities to identify themes for improvement.

- 5.12.3. A consistent theme throughout interviews was that where staff do raise concerns, the feedback loop does not work effectively. That applies at the individual level – that is, the individual raising an issue is not informed about the outcome and actions taken as a result – and collectively, that there is not effective regular feedback either through care group channels, despite the systems put in place by Quality Governance teams, or other mechanisms to engage staff of the themes arising from concerns raised and actions taken. Staff do not therefore see that raising concerns leads to appropriate action.

6. Does the Board Triangulate Feedback from Staff with Data from Other Sources Effectively?

6.1. Summary Assessment

- 6.1.1. The board's ability to triangulate feedback from staff with other data sources has improved significantly but remains a work in progress. While better data and reporting structures have been established over the past 2-3 years, challenges remain around data volume, granularity, thematic analysis, and the board's collective capability to use data effectively for triangulation. Individual board members, particularly the Quality Committee chair, describe good practice in triangulation, but it is not clear that this is consistently embedded across the full board.

6.2. Evidence of Triangulation Activity at Committee level

- 6.2.1. The Quality Committee chair has actively changed committee functioning to bring frontline teams in, providing opportunities to question them directly and giving staff a voice. Specific examples include bringing renal dialysis teams in to discuss aging machines and water purification plant issues, enabling direct engagement with staff concerns. Safeguarding teams have presented on mental health service challenges around training and staffing. The committee has bounced back papers that lacked sufficient quantitative data, such as virtual wards reporting, demanding more rigorous analysis. Site visits and NED-Governor visits are used to test what is heard in formal meetings, for example visiting theatres after concerns about holes in wraps were raised at committee.
- 6.2.2. The People and Culture Committee receives data analysed by department to identify hotspots and areas performing well. Staff networks provide regular input, with staff representatives coming to the People and Culture Committee every six months. However, some interviewees felt that networks were

discouraged from raising issues or concerns which did not fit with Trust priorities. A Staff Congress has been established since April 2024 with representatives from all staff groups. Employee relations reporting, which was absent before March 2025, now includes disciplinarys, grievances, and tribunal activity by department.

6.3. Governor Engagement

- 6.3.1. Committee chairs noted that Governors are encouraged to speak up at board committees, contrary to traditional practice of silent observation. A governor with lived experience of renal dialysis contributed valuable insight during discussions about renal services. Governors are explicitly asked for their views, for example on annual complaint reports, to provide constituency perspectives. Long-serving governors who regularly walk around Trust sites bring soft intelligence to committee meetings.

6.4. Qualitative and Quantitative Data Reported to Board

- 6.4.1. The Integrated Performance Report has been significantly improved using Statistical Process Control charts but is a lengthy document and there is a risk of readers being overwhelmed by detail, which is discussed further below.
- 6.4.2. Strategic risks from the Board Assurance Framework are owned by respective subcommittees, and agendas are structured around the BAF for better governance. The BAF itself seeks to reflect risks balanced across a range of dimensions including quality and workforce, but it isn't immediately obvious from Board minutes or from interviews with Board members that the relationships between risks in different dimensions are explored.

7. Gaps and Challenges in Triangulation

7.1. Data Volume and Presentation

- 7.1.1. Board papers can be 400-500 pages, creating information overload. Despite valiant attempts to provide concise executive summaries, there is a tendency for authors to present a significant amount of detailed data, rather than highlighting key issues for board attention. Board members find it difficult to see the wood for the trees when reports have limited synthesis. The IPR includes substantial sections on both quality and workforce issues, but there is little connection between the two, and analysis has something of a tendency to focus on numbers (e.g. of incidents) rather than themes – there is some discussion of themes but this tends to be buried deep in the report rather than drawn out in the summary. Board members acknowledged that it is difficult to find the time to read the full set of papers thoroughly and with discernment, and they are reliant on the lead directors for reports to highlight relevant issues.

7.2. Limited Data

- 7.2.1. The collapse of Freedom to Speak Up services in 2024 means there is no data for that entire year, limiting trend analysis. Only six months of data from the new external service is available, which is insufficient to demonstrate sustained patterns. The absence of historical employee relations reporting before March 2025 means there is no baseline for comparison. This lack of longitudinal data makes it difficult to demonstrate improvement or identify emerging trends.
- 7.2.2. Looking wider than the FTSU service, as discussed above staff confidence in raising concerns has been undermined by years of cultural issues, lack of visible consequences for poor behaviour, weak HR support, and executive instability. While formal systems are in place, there are clear limitations in how well they are used, and informal mechanisms for raising concerns remain underdeveloped, with gaps in line management engagement and insufficient leadership capability in some areas. This means that it is highly likely that data which is coming to the Board either directly or via committees relating to risks and concerns raised by staff is incomplete. Benchmarking against other trusts is limited, making it difficult to contextualize the Trust's position.

7.3. Board Capability Questions

- 7.3.1. When asked if the board uses and reflects on data to make decisions, one interviewee described it as a development journey. Board culture around data literacy and challenge appears to be developing but is not yet fully mature. There is recognition that the board does not yet have a clear and consistent narrative about quality and safety that would demonstrate effective synthesis of data.

7.4. Specific Issues Not Surfacing Through Data

- 7.4.1. The concerns in the Critical Care, Anaesthetics and Specialist Surgery care group that led to the consultant letter to the Chair did not surface through board-level data and triangulation. Board members were largely not aware of concerns in that care group before the letter was sent. The issues came to the Acting Chief Executive's attention through a range of channels including informal communications rather than through consistent formal reporting mechanisms. Each one was addressed as an individual issue as it arose, and it is with hindsight that the issues have been connected to raise a question about the wider underlying issues. This raises questions about whether the board's data sources are sufficient to identify concerns in all areas of the organisation, particularly those that do not generate high volumes of incidents or complaints. Desktop review of a recent set of People and Culture Committee papers suggests that the care group had a high level of FTSU cases and open ER cases than other care groups, but as the data is presented as absolute numbers rather than ratios (e.g. rates per 100 staff members) it is not clear whether the figures are high in relative terms. Review of the Quality Committee papers for the same period did not show any significant patterns of risks or incidents relating to the care group – though as noted above, it is possible that these are under-reported.

7.5. Executive-Board Information Flow

- 7.5.1. There is evidence of a cultural view that non-executives do not need to know about operational issues, even when they have governance implications. Executives were reportedly trying to deal with the anaesthetics concerns as a day-to-day operational matter rather than escalating to the board. This suggests a boundary question about what constitutes a board-level concern versus an operational matter. Of course, this is always something of a grey area, and the distinction often lies not so much in the nature of any one issue as the pattern across a range of issues which serves as an indicator of deeper concern. The absence of visibility at board level for certain types of concerns suggests data gaps, inadequate escalation protocols, or both.
- 7.5.2. Below the Board level, interviewees working in central functions within the Trust were able to describe a clear Trust wide process in line with PSIRF guidance whereby the patient safety team triages incidents and clinical teams present to a panel to discuss learning and agree issues which require escalation for further investigation. In addition, it was reported that key themes are presented at the monthly Trust Management Committee attended by care group triumvirate leads, and that each care group has aligned quality governance resources. However, staff interviewees could not describe consistently and confidently how concerns or themes which arise from concerns raised are addressed within care groups or the Trust as a whole, which suggests that these processes are not fully embedded within care groups and the cascade of information is not working effectively. The Board may be taking reassurance from the existence of systems and processes, rather than seeking assurance by testing how effectively the processes are operating. There is acknowledgement from the interviewees working in central functions that there is variability in maturity across the care groups – it is less clear how visible that variability is to the Board.

8. Emerging Good Practice

8.1. Individual Board Member Curiosity

- 8.1.1. One board member explicitly described themselves as curious and interested in understanding why things are the way they are, particularly interested in extremes of performance both good and bad. This curiosity drives informal triangulation through following up on briefings from the CEO and Chief Medical Officer. The Quality Committee chair actively uses committee minutes to test and follow-up on issues over time, such as tracking IPC issues with holes in wraps and then visiting theatres to validate what was heard in committee.

8.2. Developing Structures

- 8.2.1. The establishment of a Staff Congress provides a new formal channel for staff voice to reach the board level. Staff networks providing regular reports offers another triangulation source, assuming that the networks are operating effectively, although as noted earlier in this report, that appears not

to be consistently the case. The bimonthly quality governance report provides data on metrics such as open incidents, enabling tracking over time. Division of open incidents by care group allows identification of which areas may be struggling with capacity to manage incident loads, although this is of course dependent on incidents being reported appropriately.

8.3. Collaboration with Quality Governance

- 8.3.1. One interviewee gave an example of work they had done with their Care Group Governance team to make it easier for teams to report incidents and near misses, and thematically analyse them. They strengthened reporting structures so that incident data could be captured consistently, themes identified, and analysis used to support service improvement, presenting feedback in a monthly governance meeting.
- 8.3.2. The interviewee reported that following these improvements, colleagues appeared more willing to report incidents and near misses through established governance channels. Increased reporting of this nature is widely recognised as a key indicator of a developing safety culture, demonstrating improved psychological safety, staff confidence in reporting mechanisms, and organisational learning.

9. Conclusions

- 9.1.1. East Kent Hospitals University NHS Foundation Trust is on an improvement journey regarding systems and processes for raising concerns, but this journey is fragile and incomplete. The Trust has made important progress over the past 12-18 months with new executive leadership, a strengthened People and Culture team, an external Freedom to Speak Up service, and better data flows to the board. However, significant challenges remain and the staff interviewed during this review appeared to have little visibility on many of the changes to date.
- 9.1.2. Notwithstanding the concerns set out in this report, senior leaders interviewed reflected that they were regularly contacted by staff wishing to raise concerns, and indeed all the staff interviewed during this review were extremely candid and open with their reflections. This suggests that staff are not irredeemably disengaged and there is a desire to see and support improvements in processes.
- 9.1.3. The board's ability to triangulate data has improved but is still developing. Better data is now available, but challenges remain around volume, synthesis, thematic analysis, and the consistent application of triangulation approaches across the full board. The fact that significant concerns in one care group did not surface through board-level data and triangulation indicates that further work is needed to ensure all areas of the organisation are adequately visible.

- 9.1.4. The current trajectory is cautiously positive, but sustained focus on organisational culture, continued investment in capability building, and demonstrable consequences for poor behaviour will be essential to complete the journey and establish genuine confidence among staff that raising concerns is safe, worthwhile, and will lead to meaningful action.

10. Recommendations for the Trust

10.1. Building Staff Confidence

- 10.1.1. The Trust is putting in place a new People and Culture strategy. In launching and implementing this, it will be important for staff to see that leaders in the Trust acknowledge the issues with the current culture and are prepared to take action to address them, at every level from Board to ward. The strategy rightly places emphasis on kindness and compassionate leadership. It will be important to emphasise that this is not 'soft' and that taking action to address poor behaviour falls clearly within this approach.
- 10.1.2. The Trust leadership needs to demonstrate visibly that staff are encouraged to raise concerns and that raising concerns leads to **appropriate** action and consequences. While individual cases must remain confidential, staff need to see that the organisation is serious about addressing poor behaviour. The handling of 'tit for tat' reporting of concerns should be handled sensitively.
- 10.1.3. The strategy already references the need to ensure better communication on the processes for resolving concerns. In particular, effective communication about how concerns will be handled and clear 'closing the loop' feedback on actions taken as a result of concerns being raised would help build confidence. The Trust may wish to consider sharing this report, or a summary version of it, with staff groups as a manifestation of the commitment to transparency and to addressing concerns as set out in the strategy.

10.2. Quality governance

- 10.2.1. The Trust should ensure that there is a clear line of sight from the Board via its Committees to and from care groups, and that themes which arise from all routes for staff to raise concerns are discussed consistently within care groups, so that the Board can be assured that staff are able to see that concerns are taken seriously and that actions agreed are both fed back to and owned by staff and leaders at all levels. This review has not sought to review the Trust's structures to support quality governance in detail, but evidence from interviews would suggest that there needs to be a greater focus from senior leaders on ensuring that the wider staff body understands and is actively engaged with quality governance systems.

10.3. Staff engagement

- 10.3.1. The Trust should map the various fora and networks which exist to enable effective engagement with and support to staff and ensure that there are

clear communication lines between these groups and senior leadership. The agenda for the groups should be clearly set by the groups themselves, reflecting issues which are of importance to staff, although it should of course also be possible for senior leaders to request discussion and feedback on issues which have been identified as important for the Trust as a whole.

10.4. Strengthening Line Management

- 10.4.1. Informal concern-raising mechanisms depend on effective line management relationships. The Trust should prioritize achieving and maintaining high appraisal rates, ensure all staff know who their line manager is and see them regularly, continue leadership development programs with realistic expectations about behaviour change, and consider making some leadership training mandatory rather than voluntary, particularly for those in new management roles.

10.5. Improving Data and Reporting

- 10.5.1. The board and committees need data that enables effective triangulation. This requires papers that synthesize key messages rather than provide exhaustive detail. In particular at Committee level and within care groups, there should be regular enhanced thematic analysis identifying patterns and hotspots, development of benchmarking data to contextualize the Trust's position, and more granular breakdown by care group and department to identify where patterns exist and to ensure that lower-visibility specialties and services do not become blind spots. There should be clear tracking of actions taken in response to concerns. Building on the recent improvements, continued development of Freedom to Speak Up reporting to focus on analysis and actionable learning rather than just quantitative metrics will add real value.
- 10.5.2. With regards to the Datix system, the Trust should review the way the system operates and the training offered to staff to ensure that it is easier to submit reports and that staff raising concerns receive appropriate feedback when they do, both individually and through thematic reports which are shared effectively through care groups. In addition, there needs to be a very clear message from senior leaders that staff should never be told not to use the system to raise concerns. If there is evidence that the system is being used to raise concerns inappropriately that should be addressed via training.

10.6. Embedding Board-Level Triangulation

- 10.6.1. While individual board members demonstrate good triangulation practice, this should be embedded across the board through structured approaches to triangulation at board and committee level, clarity about what types of concerns should be escalated to board attention, regular discussion of how different data sources relate to each other, continued use of staff networks, governors, and frontline staff input at board level, and board development to strengthen collective data literacy and analytical skills.

- 10.6.2. The Board may also wish to consider building a focus on ‘problem-sensing’ into future Board and organisational development activity. Further information on this can be found in the [NHS Providers Guide to Good Governance](#) in the NHS and via the [THIS Institute](#) in Cambridge. This describes problem-sensing behaviours as those which “actively seeking out weaknesses in systems relating to quality and safety, typically using multiple techniques and sources of organisational intelligence...[and] data or other forms of organisational intelligence that offer challenge, disrupting any incipient risk of complacency.”

10.7. Leadership capacity

- 10.7.1. The Trust should honestly assess whether there is sufficient executive bandwidth to address the volume of issues requiring attention, considering whether additional executive or senior leadership capacity is needed in key areas, in particular medical leadership. Alongside this, further action is required to ensure that site-based leadership is visible, effective, and accountable, and that actions taken are consistent across sites, with shared learning to address the current perceptions of silo-ed working which persist despite the relatively new care group structure.

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: Integrated Performance Report (IPR)

Meeting date: 28 July 2026

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

Paper Author: Ben Stevens, Chief Strategy & Partnerships Officer

Appendices:

APPENDIX 1: Integrated Performance Report - June 2026

Executive summary:

Action required:	Discussion
Purpose of the Report:	The report provides the monthly update on Operational Performance, Quality & Safety, Workforce, Financial & Maternity organisational metrics. The metrics are directly linked to the Strategic and Annual objectives. The reported metrics are derived from: 1. Statutory reporting 2. Executive agreed key metrics The IPR is ordered into the following strategic themes: • Patients, incorporating operational performance metrics. • Quality and Safety (Q&S), incorporating Q&S metrics and • People, incorporating people, leadership & culture metrics. • Sustainability, Incorporating finance and efficiency metrics • Maternity, incorporating maternity specific metrics for quality and safety, Friends and Family Test (FFT) and engagement.
Summary of key issues:	Key performance points for June (reported month): Patients Urgent & Emergency Care (UEC) • 4-hour performance was 75.3% in June, down 0.9 percentage points from May. Type 1 performance was 56.4%, down 0.7 percentage points. The proportion of patients spending more than 12 hours in Emergency Department (ED) increased to 17.0%, partly reflecting pressures during the late-June heatwave, although excess hours for non-admitted patients continued to reduce and are now around half the historic mean. • No Criteria to Reside (NCTR) remains above trajectory at 180, indicating ongoing flow and discharge challenges. However, length of stay has reduced on Pathways 0 and 3, with daily reviews in place



	since April, and patients staying more than 14 days have reduced significantly. - The Trust successfully eliminated corridor care by the end of June 2026 through its Getting it Right First Time (GIRFT-aligned) Rapid Improvement Plan, with ongoing monitoring embedded through daily SitRep reporting. Ambulance waiting times continue to improve. Planned Care: Referral to Treatment (RTT) - Elective activity delivery is behind plan at the end of Q1, with underperformance across all key points of delivery, including 4,396 fewer new outpatient appointments, 414 fewer inpatient spells and 276 fewer day cases than planned. The shortfall is driven by delayed productivity improvements, non-delivery of planned capacity schemes, and delivery of only 45% of planned Waiting List Initiative (WLI) activity. - RTT performance remains slightly ahead of plan at 56.1% (vs 54.7%), largely reflecting recovery activity undertaken in late 2025/26. However, performance has begun to decline and is now below the July trajectory, creating a significant risk to delivery of the 67% year-end RTT target. The current forecast is 59.7%, which would result in the full contractual penalty being applied. - Long waits continue to deteriorate, with 2,462 patients waiting over 52 weeks and 166 waiting over 65 weeks. Recovery plans have been developed for Executive approval, including delivery of delayed capacity schemes, increased Waiting List Initiative (WLI) activity, improved theatre utilisation, and optimisation of outpatient clinic capacity and clinical triage pathways. Diagnostics - DM01 performance has maintained performance at 55.2% but remains well below standard, with CT, MRI and non-obstetric ultrasound as key constraints. - Targeted recovery actions underway, including MRI capacity options and insourcing to support ultrasound recovery. - Delivery is being strengthened through Chief Operating Officer (COO-led) oversight and formal recovery governance to accelerate improvement. Cancer 28-day Faster Diagnosis Standard (FDS) achieved 67.3% in June, the third consecutive month below 70% and significantly below the 80% national target. Performance continues to be constrained by prolonged diagnostic turnaround times, with radiology reporting averaging 25 days and Upper and Lower Gastrointestinal (GI) pathways exceeding 30 days from request to report. 62-day performance declined to 69.0% in June, also the third consecutive month below 70% and well below the 80% year-end target. Delays in diagnostics continue to result in patients reaching Multi-disciplinary Team (MDT) review later in their pathways, particularly within Lower GI services.



- Long waits remain elevated, with 324 patients waiting more than 62 days, predominantly within the Lower GI pathway. Endoscopy turnaround times continue to exceed 20 days, while Upper and Lower GI CT diagnostics exceed 30 days. Despite these diagnostic constraints, 31-day performance remains strong at 97.2%, demonstrating sufficient treatment capacity once a decision to treat has been made.

Quality

- **Patient Safety Investigations:** At the end of June, 58 learning responses remained open, including 17 nationally reportable investigations (Four Never Events, four Learning from Deaths cases and nine Maternity and Newborn Safety Investigations (MNSI) investigations). Executive oversight has been strengthened through twice-weekly review meetings to support timely completion.
- **Moderate, Severe and Death Harm:** The validated June position was 78 moderate harm, four severe harm and six death-related incidents, above normal variation, with pressures primarily associated with tissue viability, recognised procedural complications and obstetric incidents.
- **Overdue Incidents:** The number of overdue incidents increased from 415 to 459, although 108 are subject to agreed extended investigation timeframes. Enhanced governance arrangements, weekly reporting and targeted support for incident handlers remain in place to drive recovery.
- **Duty of Candour:** Compliance remained high in June at 96.2% verbal, 96.3% written and 100% findings, with delays limited to a small number of cases requiring translation support.
- **Overdue After Action Reviews (AARs) (Patient Safety Incident Response Framework (PSIRF) Learning Responses):** Fourteen AARs were overdue at month end, although progress continues with 13 completed during June. Weekly executive oversight and twice-weekly review meetings remain in place, with the Trust on track to eliminate overdue learning responses by August 2026.
- **Never Events:** One Never Event was reported in June relating to a retained foreign object following a colonoscopy procedure. No common themes have been identified with previous Never Events and learning actions are being monitored through established governance processes.
- **Mixed Sex Accommodation Breaches:** There were 58 breaches in June, predominantly within Critical Care. Review work has confirmed compliance with reporting requirements, with patient flow pressures identified as the main cause and further work underway to standardise reporting across the Trust.
- **Safeguarding:** Compliance with safeguarding training remains above the national 85% standard, with strong governance and supervision arrangements in place. Administrative capacity and data quality challenges continue to present risks, with mitigating actions underway.



- **Infection Prevention and Control:** All reportable healthcare-associated infections remained below threshold in June, with continued focus on reducing *C. difficile* and *E. coli* infections, antimicrobial stewardship, catheter care and hydration initiatives.

People

- **Sickness absence:** Rates have risen to 5.1%, driven by a sustained and non-seasonal increase in stress, anxiety and depression following the withdrawal of counselling services. Psychological absence is now the most significant wellbeing risk, particularly in Women's, Children's & Young People, and above threshold in William Harvey Hospital (WHH), Kent & Canterbury Hospital Royal Victoria Hospital (KCRVH) and Critical Care, Anaesthetics and Specialist Surgery (CCASS).
- **Vacancies:** Vacancy rate has reduced to 9.2%, remaining below threshold. Gaps remain concentrated in Alternative Provision Specialist (APST) and Bands 3-4, with notable pressure in Same Day Emergency Care (SDEC) at WHH. Care group variation persists, signalling a structural recruitment challenge rather than a temporary fluctuation.
- **Turnover:** Turnover has fallen to 6.0%, the lowest in Trust history. While positive, extremely low movement may mask latent retention risk, particularly in Band 5 roles and Women's Services, where leavers align with national concerns highlighted in the Amos report.
- **Workforce productivity:** Appraisal compliance has dropped to 69.3%, the lowest in 12 months, with concentrated backlogs in Nursing & Midwifery and Admin & Clerical. Operational pressure continues to constrain recovery.
- **Staff engagement:** Engagement remains below the national average, though progress continues across leadership development, team engagement, corridor care and behavioural interventions. Planning for the 2026 NHS Staff Survey is underway, with incentives agreed and an 11-week fieldwork plan designed to strengthen confidence and maximise participation.

Sustainability

- **Financial position:** The Trust achieved an in-month surplus of £0.1m in month 3 (£0.3m ahead of plan), Year to Date (YTD) the position is £3.1m (£0.4m ahead of plan). The Group achieved an in-month surplus of £0.1m; £8k favourable to plan. YTD the position for the Group is £2.5m deficit; £23k favourable to plan.
- **Income:** Trust income is ahead of plan YTD by £3.2m, reflecting an increase in block income from the specialised commissioning contract, additional variable NHS England (NHSE) income, prior year income and non-recurrent gains within other operating income.
- **Cost pressures:** Pay costs are above plan, primarily due to under-delivery in Pay savings. Pay reduced in in month 3 compared to month 2.
- **Efficiency delivery:** Cost Improvement Programme (CIP) continued to under-deliver in month, with a £3.3m under delivery YTD (£13.0m



	delivery against a £16.3m target). CIP shortfall has been mitigated by technical adjustments and income overperformance. £82.8m of CIP schemes have been identified, against the submitted financial plan CIP target of £75.9m. Work continues to accelerate delivery of CIP schemes currently phased to commence later in the year. • Overall risk: Delivery of recurrent savings and control of workforce costs remain key to maintaining financial grip and delivering the in-year financial plan. Maternity • Perinatal outcomes: The extended perinatal rate is significantly above the normal range at 5.75 per 1,000 births, and above the threshold of 5.42 (set at the average of our comparable Trusts). This rate includes both stillbirths and neonatal deaths. • Neonatal outcomes: Neonatal mortality remains below the MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK - target, indicating sustained performance in this element of care. • Safety incidents: Moderate–severe incidents remain elevated for a sustained period, highlighting ongoing patient safety risks and the need for continued improvement focus.
Key recommendations:	The Board of Directors is asked to CONSIDER and DISCUSS the metrics reported in the Integrated Performance Report.

Implications:

Links to Strategic Theme:	This report aims to support: • Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Trust Risk Register:	N
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

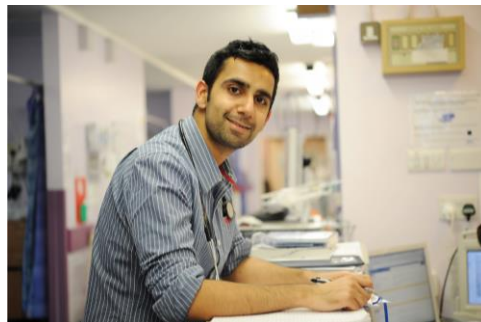
Assurance route:

Previously considered by: Finance and Performance Committee (30 June 2026), Quality and Safety Committee (14 July 2026), and People and Culture Committee (21 July 2026)



Integrated Performance Report

JUNE 2026



Integrated Performance Report

Statistical Process Control

The Trust's IPR forms the summary view of Performance against the organisations five strategic themes; Patients, Quality & Safety, People, Partnerships and Sustainability. It also collocates the metrics which are intrinsic to our Integrated Improvement Plan and monitors progress against the quarterly milestones which will enable the organisations exit from National Oversight Framework 4 and Tier 1 monitoring. To do this is uses Statistical Process Control to assess performance.

What is statistical process control (SPC)?

Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in doing so, guides us to take the most appropriate action.

Our Trust Integrated Performance Report incorporates the use of SPC Charts to identify common cause and special cause variations and uses NHS Improvement SPC icons to provide an aggregated view of how each KPI is performing with statistical rigor.

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

Key Facts about an SPC Chart

A minimum of 15-20 data points are needed for a statistical process control chart to have meaningful insight. 99% of all data will fall between the lower and upper confidence levels.

If data point falls outside these levels, an investigation would be triggered.

It contains two types of trend variation: Special Cause (**Concerns** or **Improvement**) and Common Cause (i.e. no significant change).

Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Variation icons: **orange** indicates concerning **special cause variation** requiring action; **blue** indicates where improvement appears to lie, and **grey** indicates no significant change (**common cause variation**).

Assurance icons: **Blue** indicates that you would consistently expect to achieve a target. **Orange** indicates that you would consistently expect to miss the target. A **grey** icon tells you that sometimes the target will be met and sometimes missed due to random variation – in a RAG report this indicator would flip between red and green.

The colours used for data points in the dashboard (tabular view) represent the position of each KPI from an SPC (Variation) perspective. The colours are based on statistically significant movement. The key is as follows:

Statistically significant
improving variation

Statistically significant
variation of concern

No significant change

Patients

Key Performance Indicator (KPI) Assurances

M



KPI's Statistically Improving

KPI's Indicating Concern



Consistently failing the target

Will consistently fail the target if nothing changes.



Inconsistent performance

Will not consistently pass or fail the target if nothing changes.



Consistently passing the target

Will consistently pass the target if nothing changes.



No set target

No set target.

Failing Metrics	SPC Range
12Hr Trolley Waits	
No Criteria To Reside (pats/day)	
RTT 52w Breaches	
RTT 65w Breaches	
Super Stranded >21D	
Theatre Capped Utilisation	
Theatre Uncapped Utilisation	
Cancer Over 104d on PTL	

Common Cause Metrics	SPC Range
RTT Incomplete Performance	
% Beds Occupied 14+	
Ambulance Handovers within 30m	
Cancer 28d Combined Performance	
Cancer 31d Combined Performance	
RTT 104w Breaches	
RTT 78w Breaches	
Theatre Session Opp.	
Cancer 62d Combined Performance	
Cancer Over 62d on PTL	
Cancer Rapid Access Perf	

Passing Metrics	SPC Range
Outpatient DNA Rate	
DM01 Compliance	

Metrics	SPC Range
12 Hr Total Time in Department	
RTT 1st OPA Performance	
ED Compliance	
RTT 52w Performance	
Type 1 Compliance 4hrs	
Endoscopy Backlog	
RTT Total Incomplete Pathways	

Understanding the Data

The columns indicate the level of assurance that performance will deliver the expected standard (target) . In order to achieve a "P" the target must be performing better than its respective confidence interval, as this indicates the performance standard will be maintained within natural variation.

Key Performance Indicator (KPI)

XMR Run Chart

Ranges

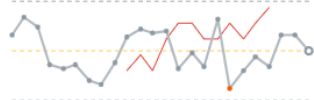
ED Compliance

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M | Jun 26

75.3%

Num: 21K
Denom: 27K



UCL: 78.3%
Mean: 75.2%
LCL: 72.2%
Targ:



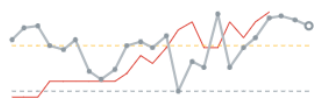
Type 1 Compliance 4hrs

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M_00093_Major_Comp
Updated: 14/07/2026 11:40

M | Jun 26

56.4%

Num: 8K
Denom: 14K



UCL: 59.6%
Mean: 54.2%
LCL: 48.8%
Targ:



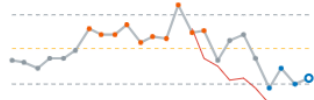
12 Hr Total Time in Department

FILTER: TOTAL
RP07218
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Updated: 14/07/2026 06:14

M | Jun 26

17.0%

Num: 2K
Denom: 14K



UCL: 22.5%
Mean: 19.5%
LCL: 16.5%
Targ:



12Hr Trolley Waits

FILTER: TOTAL
RP07218
M_00384_Trolley_Waits
Updated: 14/07/2026 12:45

M | Jun 26

1,059



UCL: 1,419
Mean: 1,162
LCL: 905
Targ: 0



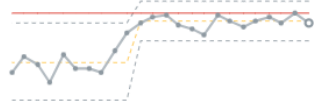
Ambulance Handovers within 30m

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Updated: 14/07/2026 09:44

M | Jun 26

93.9%

Num: 5K
Denom: 5K



UCL: 96.4%
Mean: 94.0%
LCL: 91.6%
Targ: 95.0%



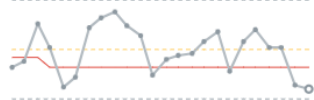
% Beds Occupied 14+

FILTER: TOTAL
RP07218
M_01141_Beds_Occupied_14plus
Updated: 14/07/2026 08:55

M | Jun 26

28.0%

Num: 8K
Denom: 30K



UCL: 36.5%
Mean: 31.7%
LCL: 26.9%
Targ: 30.0%



Key Performance Indicator (KPI)

XMR Run Chart

Ranges

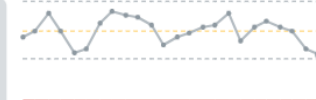
Super Stranded >21D

FILTER: TOTAL
RP07218
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Updated: 14/07/2026 11:07

M | Jun 26

177

Num: 5K
Denom: 30



UCL: 254
Mean: 212
LCL: 169
Targ: 107



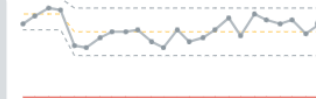
No Criteria To Reside (pats/day)

FILTER: TOTAL
RP07218
M_01184_Not_F2R
Updated: 14/07/2026 11:55

M | Jun 26

179.7

Num: 5K
Denom: 30



UCL: 196.7
Mean: 171.6
LCL: 146.5
Targ: 100.0



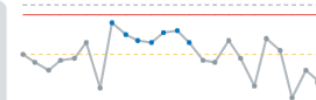
Cancer 28d Combined Performance

FILTER: TOTAL
RP07218
M_00897
Updated: 14/07/2026 08:40

M | Jun 26

67.3%

Num: 3K
Denom: 4K



UCL: 81.6%
Mean: 72.4%
LCL: 63.2%
Targ: 80.0%



Cancer 31d Combined Performance

FILTER: TOTAL
RP07218
M_01391
Updated: 14/07/2026 08:23

M | Jun 26

97.1%

Num: 635
Denom: 654



UCL: 99.5%
Mean: 95.9%
LCL: 92.3%
Targ: 96.0%



Cancer 62d Combined Performance

FILTER: TOTAL
RP07218
M_01390
Updated: 14/07/2026 08:35

M | Jun 26

69.0%

Num: 312.5
Denom: 453



UCL: 80.0%
Mean: 71.6%
LCL: 63.2%
Targ: 80.0%

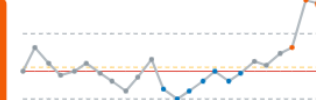


Cancer Over 62d on PTL

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M_00725
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M | Jun 26

324



UCL: 271
Mean: 210
LCL: 150
Targ: 200

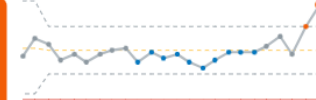


Cancer Over 104d on PTL

FILTER: TOTAL
RP07218
M_00715
Updated: 14/07/2026 08:41

M | Jun 26

84



UCL: 64
Mean: 44
LCL: 23
Targ: 0



Patients

Scorecard View

Referral to Treatment Waiting Times, Diagnostics & Productivity Measures

Key Performance Indicator (KPI)

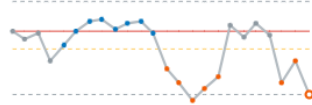
XMR Run Chart

Ranges

Cancer Rapid Access Perf

FILTER: TOTAL
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Updated: 14/07/2026 08:43

M | Jun 26
70.0%
Num: 3K
Denom: 5K

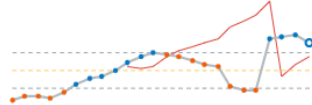


UCL: 103.7%
Mean: 86.8%
LCL: 70.0%
Targ: 93.0%

RTT Incomplete Performance

FILTER: TOTAL
RP07218
M_01304_Incompletes
Updated: 14/07/2026 13:26

M | Jun 26
56.1%
Num: 46K
Denom: 82K

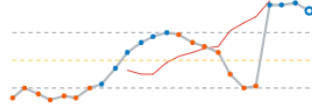


UCL: 55.1%
Mean: 53.3%
LCL: 51.6%
Targ: 54.7%

RTT 1st OPA Performance

FILTER: TOTAL
RP07218
M_01304_Incompletes_New_OP
Updated: 14/07/2026 13:26

M | Jun 26
66.2%
Num: 33K
Denom: 50K

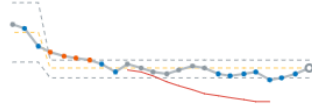


UCL: 64.0%
Mean: 61.2%
LCL: 58.5%
Targ:

RTT 52w Performance

FILTER: TOTAL
RP07218
M_01304_Incompletes_52_Perf
Updated: 14/07/2026 13:26

M | Jun 26
3.0%
Num: 2K
Denom: 82K

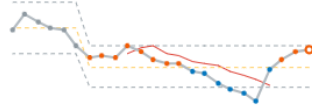


UCL: 3.5%
Mean: 3.0%
LCL: 2.4%
Targ:

RTT Total Incomplete Pathways

FILTER: TOTAL
RP07218
M_01304_Total_Pathways
Updated: 14/07/2026 13:26

M | Jun 26
82.4K

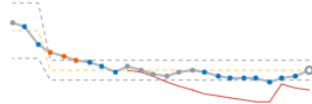


UCL: 82.8K
Mean: 79.6K
LCL: 76.4K
Targ:

RTT 52w Breaches

FILTER: TOTAL
RP07218
M_01304_RTT_52w
Updated: 14/07/2026 13:26

M | Jun 26
2,462



UCL: 2,877
Mean: 2,392
LCL: 1,907
Targ: 1,383

RTT 65w Breaches

FILTER: TOTAL
RP07218
M_01304_RTT_65w
Updated: 14/07/2026 13:26

M | Jun 26
166



UCL: 207
Mean: 117
LCL: 26
Targ: 0

Key Performance Indicator (KPI)

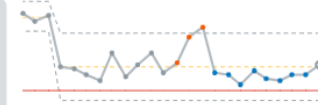
XMR Run Chart

Ranges

RTT 78w Breaches

FILTER: TOTAL
RP07218
M_01304_RTT_78w
Updated: 14/07/2026 13:26

M | Jun 26
12



UCL: 26
Mean: 10
LCL: -5
Targ: 0

RTT 104w Breaches

FILTER: TOTAL
RP07218
M_01304_RTT_104w
Updated: 14/07/2026 13:26

M | Jun 26
4



UCL: 8
Mean: 3
LCL: -3
Targ: 0

Endoscopy Backlog

FILTER: TOTAL
RP07218
M_01063_Endo_BL
Updated: 14/07/2026 07:32

M | Jun 26
400

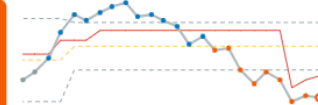


UCL: 555
Mean: 393
LCL: 231
Targ:

DM01 Compliance

FILTER: TOTAL
RP07218
M_00190_DM01_Compliance
Updated: 14/07/2026 12:15

M | Jun 26
55.2%
Num: 21K
Denom: 37K



UCL: 80.9%
Mean: 72.8%
LCL: 64.7%
Targ: 62.8%

Theatre Session Opp.

FILTER: TOTAL
RP07218
M_00148_Theatres_Utilisation
Updated: 14/07/2026 09:50

M | Jun 26
39

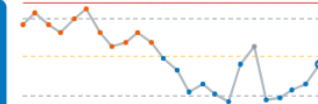


UCL: 54
Mean: 36
LCL: 19
Targ: 25

Outpatient DNA Rate

FILTER: TOTAL
RP07218
M_00185_DNA_OP_v4_ALL
Updated: 14/07/2026 08:43

M | Jun 26
6.0%
Num: 5K
Denom: 91K



UCL: 6.8%
Mean: 6.1%
LCL: 5.4%
Targ: 7.0%

Theatre Uncapped Utilisation

FILTER: TOTAL
RP07218
M_00718_Theatre_Act_Utilisation
Updated: 13/07/2026 13:52

M | Jun 26
80.6%
Num: 188K
Denom: 233K



UCL: 82.2%
Mean: 79.3%
LCL: 76.4%
Targ: 85.0%

Urgent and Emergency Care

- Combined 4 Hour performance in June was 75.3%, a reduction of 0.9pp on May's performance.
- 4 Hour Type 1 performance was 56.4%, a reduction of 0.7pp on May.
- The proportion of patients experiencing more than 12 hours in the Emergency Departments increased in June to 17.0% of type 1 arrivals. This was tracking at a similar rate to May (16.4%) until wc 22nd June, where sites were impacted by the heatwave, with sites commencing 'Red Heat Health Alert' daily check-in meetings, with performance reducing over the last week of the month.
- Excess hours spent by patients in ED reduced significantly over recent weeks, for non-admitted patients the excess hours are half the historic mean.
- NCTR remains at 180 which is above trajectory, LOS has reduced on pathway 0 and 3 currently with daily review at all sites from beginning of April as part of Eliminating Corridor Care.
- Patients over 14 days los has significantly reduced in correlation to the No Criteria to Reside (NCTR) length of stay (LoS) reductions
- A Rapid Improvement Plan for the Elimination of Corridor Care has been developed in line with the GIRFT Corridor Care Improvement Guide (March 2026). This programme of work has eliminated Corridor Care by the end of June 2026.
- Patients spending over 45 minutes in a visible corridor location on any given day are to be reported within the UEC Daily Sitrep.
- Ambulance waiting waits continue to improve.

Planned Care

Planned Activity

- At the end of Quarter 1 (June 2026), East Kent Hospitals NHS Trust is behind plan for elective/planned care activity delivery against the 2026/27 Operating Plan, creating a significant risk to achievement of year-end RTT performance targets and exposing the Trust to potential contractual income penalties.
- The Trust delivered fewer activities than planned across all key points of delivery, including: 4,396 fewer new outpatient appointments, 414 fewer inpatient spells, 276 fewer day cases, 264 fewer follow-up attendances with procedures, The activity deficit is principally driven by: Under-delivery of productivity improvements – only 2,893 activity gains achieved against a plan of 3,958, leaving a shortfall of 1,065 activities. Key weaknesses include theatre utilisation, which is significantly below target resulting in -159 procedures against plan. The remaining productivity shortfall relates to planned schemes that have not been delivered or delayed. Delays and non-delivery of approved capacity schemes – several planned workforce, insourcing and outsourcing initiatives have not been implemented as expected resulting in an activity shortfall of -1,038, 3Reduced Waiting List Initiative (WLI) activity – only 45% of planned WLI activity was delivered in Q1, creating a shortfall of -3,247 activities.

RTT Incomplete Performance (18 Weeks)

- Although RTT performance at Month 3 remains slightly ahead of plan (56.1% versus 54.7%), this is largely due to recovery activity undertaken in late 2025/26 and an increased denominator due to an larger than planned waiting list size linked to the activity underperformance. Incomplete RTT Performance has already started to decline and is now below the July trajectory, indicating a growing risk that the Trust will miss its year-end 67% RTT target. The contract includes penalties of £2.8m per percentage point below target, capped at £19.8m.
- The current year end Incomplete RTT performance forecast is that the Trust will fall significantly short at 59.7%. This will result in the Trust incurring the full £19.8m income penalty. The consequences for patients include longer waits for outpatient assessment and treatment, increased risk of clinical deterioration while waiting, more patients breaching national waiting-time standards, and additional pressure on urgent and emergency care services.

Planned Care – RTT (Cont.)

- A series of recovery options have been drafted for Executive approval to recover the activity deficit and meet the end of year RTT Incomplete Performance target of 67%. This includes delivery of the planned schemes, reprofiled to reflect delays in implementation as well as a series of additional recovery initiatives that Care Groups are working on which include delivering Waiting List Initiative Activity in line with the revised tapered plans previously submitted. WLI delivered activity is at 45% of planned levels at the end of Q1 and has had the biggest impact on the activity shortfall. Although the majority of productivity standards are being achieved in line with the Operating Plan, Theatre Utilisation remains behind plan. If the Trust was to mandate the use of the Expected Theatre Time i.e. without override and booked to 110% of available session time to offset cancellations and DNAs, then it is estimated that performance would improve to above 85% (peer average 81%). Furthermore, an increase in First Outpatient Clinic templates by 10% or a minimum of one patient to offset DNA/Late cancellations would support recovery of the first outpatient activity deficit and/or, replace face to face appointments with clinical triage sessions that would allow for more patients to be reviewed virtually.
- Long Waits – There was a further increase in the number of patients waiting greater than 52 weeks for treatment to 2,462 and an increase in the number of patients waiting greater than 65 weeks to 166.

Diagnostics DM01

- The DM01 position has maintained performance at 55.2% as at the end of June. CT, MRI and Non-Obstetric Ultrasound remain key areas of concern.
- For MRI recovery 3 options have been proposed with impacts and key calculations detailed for each.
- Business case approval has been sought for targeted insourcing to support Non Obstetric Ultrasound performance recovery
- Further recovery plans have been initiated with progress monitored via the weekly COO led DM01 Recovery Board with progress reported to the Finance and Performance Meeting.

Cancer

- At the end of June 2025, the Trust achieved 67.3% against the 28-day Faster Diagnosis Standard (FDS). This marks the third consecutive month that performance has remained below 70% and leaves the Trust significantly short of the in-year national target set at 80%. The primary challenge continues to be prolonged diagnostic turnaround times across most modalities. In June, the average request-to-report time for radiological diagnostics increased to 25 days, while turnaround times for Upper and Lower GI pathways exceeded 30 days.
- Performance against the 62-day standard closed June at 69.0%, marking the third consecutive month of performance below 70% and remaining significantly below the year-end national target of 80%. As with the Faster Diagnosis Standard, underperformance is primarily driven by extended diagnostic turnaround times, resulting in patients reaching Multidisciplinary Team (MDT) review later in their pathway. Despite these challenges, the Trust continues to perform strongly against the 31-day standard, achieving 97.2% in June, demonstrating that treatment capacity remains sufficient for most tumour sites once a decision to treat has been made.
- The number of patients waiting longer than 62 days remains elevated at 324, with the Lower GI pathway accounting for the majority of breaches. Endoscopy turnaround times continue to exceed 20 days, while Lower and Upper GI CT diagnostics are exceeding 30 days from request to report. Consequently, most Lower GI patients who are not discharged following their first outpatient appointment or subsequent endoscopy are now breaching the 62-day standard. The breach backlog stood at 324 at the end of June, compared with fewer than 200 patients for the majority of 2025, highlighting the growing impact of diagnostic delays on pathway performance.

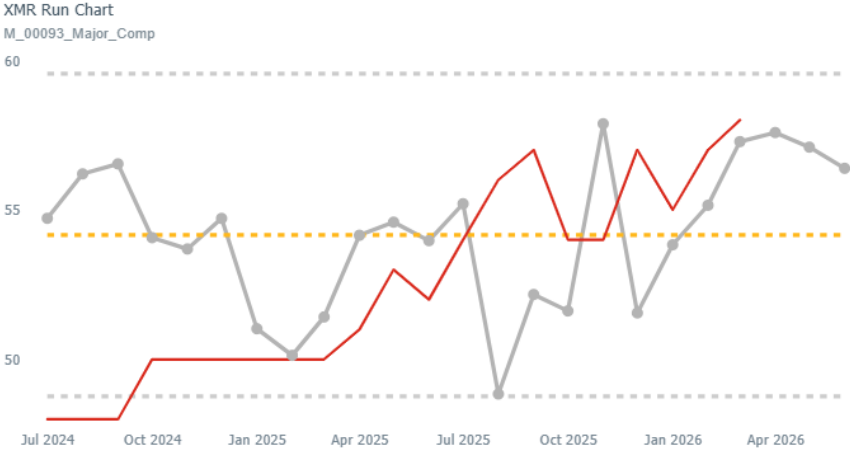
Patients

Urgent & Emergency Care

Type 1 Emergency Department; Four Hour Compliance

M | Jun 26
56.4%
Num: 8K
Denom: 14K

Timescale	Value	Target	Num	Denom
M Jul-25	☹️ 55.2%	54.0%	7,085	12.8K
M Aug-25	☹️ 48.8%	56.0%	5,919	12.1K
M Sep-25	☹️ 52.2%	57.0%	6,453	12.4K
M Oct-25	☹️ 51.6%	54.0%	6,799	13.2K
M Nov-25	☹️ 57.9%	54.0%	7,654	13.2K
M Dec-25	☹️ 51.6%	57.0%	7,230	14.0K
M Jan-26	☹️ 53.8%	55.0%	7,197	13.4K
M Feb-26	☹️ 55.2%	57.0%	6,898	12.5K
M Mar-26	☹️ 57.3%	58.0%	8,634	15.1K
M Apr-26	☹️ 57.6%		7,679	13.3K
M May-26	☹️ 57.1%		8,041	14.1K
M Jun-26	☹️ 56.4%		7,922	14.0K



-  Common cause variation
Common cause - no significant change.
-  No set target
No set target.
-  Commentary

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGRESS UPDATE
Type 1 Position	Working across the acute sites to improve patient pathways to decompress the ED's through streaming and daily rhythm for the sites.	Dep COO/UEC OPS	Q1 to Q4	Performance of 56.4% for type 1 slightly decreased in June. The Eliminating Corridor Care action plan reporting from March 2026 commencing 01/04/26 with system partners to improve the waiting times for patients in ED.
Attendance Avoidance	Review of frailty patients attending ED is underway with partners for KCHFT to develop a new frailty assessment unit/model pre-ED.		Q1 to Q4	The SDEC capital builds will be completed August to September 2026 at QEQM and WHH respectively with the development of clinical models. Options are currently being considered for a suitable location.
Safe and Effective ED	Standards and quality indicators will be reviewed on both of the hot sites to ensure timely delivery of patient care within the constraints of the Department. Pull flow model from AMU and the wards at both sites	CMO CNO and ADON	Q1 to Q4 Q1 to Q4	Internal professional standards are one of five themes of the Eliminating Corridor Action Plan with a quarter 1 focus in 2026/27. A new way of working and model is being developed and trialled currently.
Admission Avoidance	Front door alternatives to ED: SDEC capital plans are due for completion from August to September at WHH and QEQM with a steering group and workstream MDT approach, recants agreed upon completion. Direct pathways for patients to SDEC to be developed.	SiteTri & Dep COO/UEC OPS	Q1 to Q4	Patient flow and pathways for emergency patients will be considered and reviewed as part of the Emergency Village capital development at WHH and QEQM, August and September 26.

Patients

Urgent & Emergency Care

12 Hour Total Time in Emergency Department

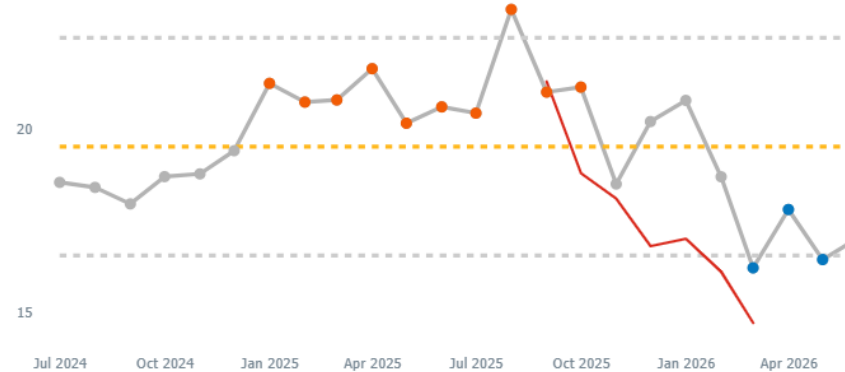
M | Jun 26

17.0%

Num: 2K
Denom: 14K

Timescale	Value	Target	Num	Denom
M Jul-25	20.4%		2,625	12.8K
M Aug-25	23.3%		2,820	12.1K
M Sep-25	21.0%	21.3%	2,600	12.4K
M Oct-25	21.2%	18.8%	2,788	13.2K
M Nov-25	18.5%	18.1%	2,446	13.2K
M Dec-25	20.2%	16.8%	2,839	14.0K
M Jan-26	20.8%	17.0%	2,793	13.4K
M Feb-26	18.7%	16.1%	2,344	12.5K
M Mar-26	16.2%	14.7%	2,448	15.1K
M Apr-26	17.8%		2,377	13.4K
M May-26	16.4%		2,319	14.1K
M Jun-26	17.0%		2,396	14.1K

XMR Run Chart
M_00113_12hr



Special cause variation
Special cause of improving nature or lower pressure due to Higher values.



No set target
No set target.



Commentary

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGRESS UPDATE
Demand outstrips capacity	-	Dep COO and Site Tri's	Q1 to Q4	Future modelling for 2026/27 is in progress with a required and maintained outflow model of discharges. Clinically led SDEC review of protocols for acute sites with SOP's for patient flow to reduce los and admissions has taken place, workshop 1 occurred in April 2026 at WHH supported by GIRFT.
Ambulance waiting times	Maintain handover times with IPS below 30 minutes Minimise all 30 to 45 minute handover times All handover waiting times >45 minutes have a zero target, in line with UEC plan June 25, and will be reported upon an individual whilst highlighted in the system.	CG Tri WHH/QEQM	Q1 to Q4	Handover processes to be followed with the utilisation of the above mentioned action cards to be followed when all patients are at a 30-minute wait with ED and site teams.
High number of Mental Health (MH) patients in ED with long waits	Framework for all MH patients around admission decision making with partners. MH escalation flowchart.	CG Tri WHH/QEQM	Q1 to Q4	New Framework from January 2026 is fully utilised at both sites with MH partners. KMMH have introduced and implemented a new escalation flowchart to support the elimination of corridor care programme in ED and reduce patient waiting times.

Patients

Urgent & Emergency Care

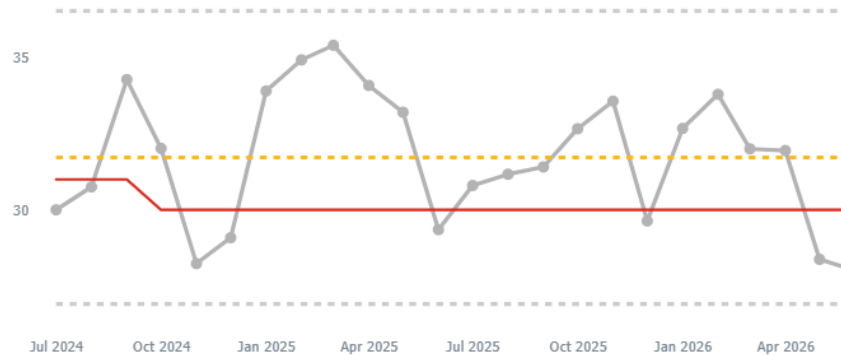
In-Hospital Spells with a Length of Stay over 14 Days

M | Jun 26
28.0%

Num: 8K
Denom: 30K

Timescale	Value	Target	Num	Denom
M Jul-25	30.8%	30.0%	9,533	31.0K
M Aug-25	31.2%	30.0%	9,655	31.0K
M Sep-25	31.4%	30.0%	9,475	30.2K
M Oct-25	32.7%	30.0%	10.2K	31.2K
M Nov-25	33.6%	30.0%	10.0K	29.9K
M Dec-25	29.6%	30.0%	9,054	30.6K
M Jan-26	32.7%	30.0%	10.1K	30.9K
M Feb-26	33.8%	30.0%	9,382	27.8K
M Mar-26	32.0%	30.0%	9,785	30.6K
M Apr-26	31.9%	30.0%	9,464	29.6K
M May-26	28.4%	30.0%	8,650	30.5K
M Jun-26	28.0%	30.0%	8,295	29.6K

XMR Run Chart
M_01141_Beds_Occupied_14plus



Common cause variation
Common cause - no significant change.



Inconsistent performance
Will not consistently pass or fail the target if nothing changes.



Commentary
For the month beginning 01.06.2026 the latest % Beds Occupied 14+ performance is 28.0% against a Trajectory target of 30.0% (lower is better).

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGRESS UPDATE
Alternatives to hospital and discharge with partners	Community Business cases 1 and 2 focus upon additional P1 discharges and admission avoidance for a cohort pilot of frail patients through a neighbourhood health scheme are planned to commence from April 2026. Board round SOP to be implemented at both sites. Review the role of therapies in relation to a discharge to assess model.	Dep COO, Imp lead, MD'S	Q1 to Q4	Monitor the impact of the KCHFT changes for reduction in the los for P1 pts and the number of admissions at the WHH of PNHG10 and 11. Implementation of the SOP's across the wards. Following the completion of the 7-day working consultation.
Patients not meeting the criteria to reside	Implement MDT meetings for all three sites daily for all NCTR patients with RTS and JBT. Daily three site wash up meeting. Escalation process to be in place for complex patients or spot purchasing.	Dep COO, Adon's and RTS with KCHFT	Q1 to Q4	Improvement of NCTR position is a theme of the eliminating corridor care plan. Daily monitoring of the nctr position to weekly trajectory and discussions. Themes of community capacity to be reviewed and considered, for example LD patients and the homeless pathway for further refinement.
Discharge Lounge utilisation	Golden patients to be identified and agreed daily for end of day bed meetings for early transfers to the discharge lounge.	Deputy COO & MDs	Q1 to Q4	Daily site rhythm of the day SOP's to be developed and introduced in qtr. 1.

Patients

Cancer Care

Cancer 28 Day Performance

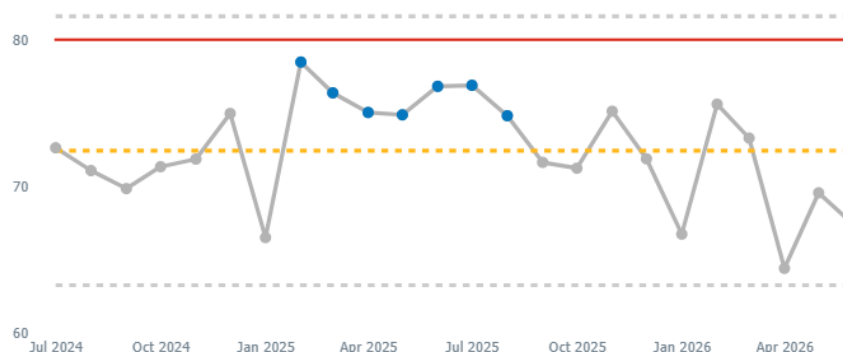
M | Jun 26

67.3%

Num: 3K
Denom: 4K

Timescale	Value	Target	Num	Denom
M Jul-25	76.9%	80.0%	3,565	4,637
M Aug-25	74.8%	80.0%	3,013	4,028
M Sep-25	71.6%	80.0%	3,148	4,396
M Oct-25	71.2%	80.0%	3,448	4,842
M Nov-25	75.1%	80.0%	3,165	4,214
M Dec-25	71.9%	80.0%	2,982	4,150
M Jan-26	66.7%	80.0%	2,666	3,997
M Feb-26	75.6%	80.0%	2,877	3,806
M Mar-26	73.3%	80.0%	2,988	4,078
M Apr-26	64.4%	80.0%	2,514	3,906
M May-26	69.5%	80.0%	2,521	3,626
M Jun-26	67.3%	80.0%	2,982	4,430

XMR Run Chart
M_00897



Common cause variation

Common cause - no significant change.



Inconsistent performance

Will not consistently pass or fail the target if nothing changes.



Commentary

For the month beginning 01.06.2026 the latest Cancer 28d Combined Performance performance is 67.3% against a static target of 80.0% (higher is better).

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGRESS UPDATE
Access to timely diagnostic		Radiology Endoscopy	Ongoing	•Additional capacity has been established at WHH site, providing access to 2 CT Biopsy slots per day. This increased capacity is expected to clear the current patient backlog by the first week of August. Appropriate Datix reporting and documentation of any patient impact are being maintained through established governance processes. Once the backlog has been eliminated, planned capacity will be sufficient to align service provision with ongoing demand. Prolonged request-to-report times continue to be observed across all diagnostic modalities for both 2WW and Urgent referrals. The average wait in June for request-to-report timeframes increased to 25 days with Upper and Lower GI subject to average of 31 days turnaround. Booking staff remains key area of concern with vacancies to ad delayed by the QIA process. MRI reporting for Head and Neck remains subject to significant delays due to lack of reporting radiologists and limited outsourcing options. Endoscopy timeframes remain elongated and regularly exceed 20 days from request to exam. Additional capacity is being put on where feasible but additional weekend lists are being impacted by the change in NHSP rates.
First OPA Capacity	Capacity to meet demand Nursing and estate support for additional clinics	Cancer compliance Admin Consultant	25/26	Teams have been challenged with reviewing all first outpatient appointment slots to ensure there is sufficient capacity to support 1st OPA within 10 days an area of particular focus over the summer holidays with anticipated high levels of clinical absence. Skin remains one of the most challenged tumour sites as referral numbers increase aligned with seasonal patterns. Breast one stop demand and capacity being reviewed to determine what capacity is required to reduce weight times from 14days+ to under 10 days.

Cancer 62d Combined Performance

FILTER: TOTAL | RP07218 | M_01390 | Updated: 14/07/2026 08:35

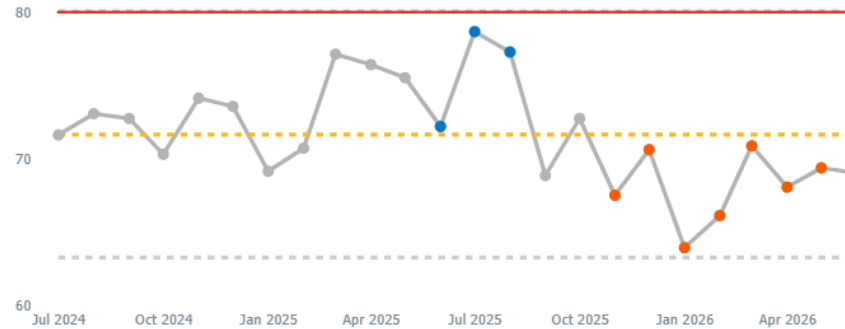
M | Jun 26

69.0%

Num: 312.5
Denom: 453

Timescale		Value	Target	Num	Denom
M Jul-25	🌤️	78.7%	80.0%	330	420
M Aug-25	🌤️	77.3%	80.0%	286	370
M Sep-25	🌤️	68.8%	80.0%	261	379
M Oct-25	🌤️	72.7%	80.0%	300	413
M Nov-25	🌤️	67.5%	80.0%	265	392
M Dec-25	🌤️	70.6%	80.0%	285	403
M Jan-26	🌤️	63.9%	80.0%	238	373
M Feb-26	🌤️	66.1%	80.0%	248	375
M Mar-26	🌤️	70.9%	80.0%	299	422
M Apr-26	🌤️	68.0%	80.0%	299	440
M May-26	🌤️	69.4%	80.0%	246	354
M Jun-26	🌤️	69.0%	80.0%	313	453

XMR Run Chart
M_01390



Special cause variation

Special cause of concerning nature or higher pressure due to Higher values.



Inconsistent performance

Will not consistently pass or fail the target if nothing changes.



Commentary

For the month beginning 01.06.2026 the latest Cancer 62d Combined Performance performance is 69.0% against a static target of 80.0% (higher is better).

Cancer Over 62d on PTL

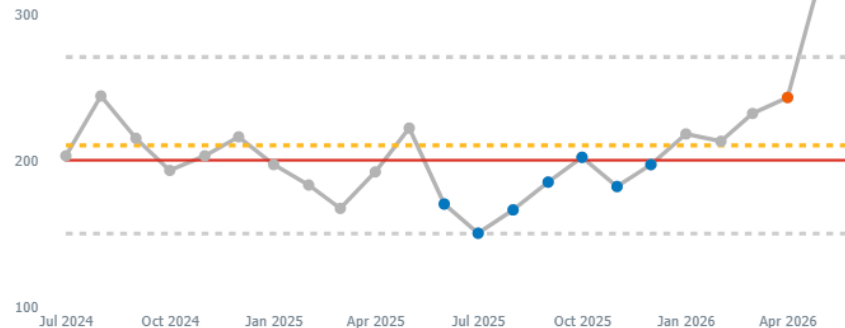
FILTER: TOTAL | RP07218 | M_00725 | Updated: 14/07/2026 08:34

M | Jun 26

324

Timescale		Value	Target	Num	Denom
M Jul-25	🌤️	150	200	150	
M Aug-25	🌤️	166	200	166	
M Sep-25	🌤️	185	200	185	
M Oct-25	🌤️	202	200	202	
M Nov-25	🌤️	182	200	182	
M Dec-25	🌤️	197	200	197	
M Jan-26	🌤️	218	200	218	
M Feb-26	🌤️	213	200	213	
M Mar-26	🌤️	232	200	232	
M Apr-26	🌤️	243	200	243	
M May-26	🌤️	328	200	328	
M Jun-26	🌤️	324	200	324	

XMR Run Chart
M_00725



Special cause variation

Special cause of concerning nature or higher pressure due to Higher values.



Inconsistent performance

Will not consistently pass or fail the target if nothing changes.



Commentary

For the month beginning 01.06.2026 the latest Cancer Over 62d on PTL performance is 324 against a static target of 200 (lower is better).

Cancer 62d Performance & >62d PTL Patient Actions

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGRESS UPDATE
Chemotherapy provision		Cancer Services/ Oncology/ Pharmacy	26/27	At present we are experiencing an increasing waits for new patient appointments and pre-chemo appointments due to high levels of nursing vacancies. Timeframes are currently extending to 2-3 weeks. Vacant staffing posts have started to be supported through the QIA process and recruitment in some areas is in progress. Daily reviews of staffing levels are being completed to maximise chair capacity whilst maintaining safe staffing levels. Recruitment to the substantive posts is the first priority, followed by recruitment to the increased posts to support the necessary expansion of the chemotherapy service to meet the predicted 7-10% growth in demand. The required aseptic order volumes required to treat the current demand, exceeds the current daily cap, which is constrained by staffing levels. This is resulting in the delay to treatment for some patients. Recruitment is underway for both substantive aseptic staff and additional roles supported through a recent business case to enable service expansion. It is anticipated that recruitment will be completed by October, after which the daily order cap can be reviewed and potentially increased.
Diagnostic request to report TAT	Reducing the timeframes of the diagnostic components of the cancer pathway	Radiology	Q2	Extended timeframes are being observed across all diagnostic modalities. At the time of writing the average request to report turnaround time (TAT) is 25 days. This position is impacting FDS, post MDM further investigations, subsequent pathway/follow up diagnostics and surveillance patients. Detailed escalation information is provided and discussed however, the position continues to deteriorate driven predominantly by booking staff vacancies and radiologist vacancies that would support vetting and reporting.
62 Breach Backlog	The increase in LGI pathway of those patients in a breached positions	Endoscopy/Radiology/ LGI teams		The cancer backlog has increase significantly with the Lower GI specialty being the largest contributing specialty to this growth This growth in backlog is driven by a combination of extended diagnostic timeframes for CT, Endoscopy, GA Endoscopy, Complex Polyp, and Virtual Colonography. The majority of patients on the Lower GI pathway, who are not discharged at first appointment, or following endoscopy, are now breaching the 62-day standard.
Summer – High levels of absence	Impact on capacity Limited take up of extra capacity	All services	Q2/Q3	Through operational access meetings, teams continue to actively manage workforce/clinical availability to ensure rotas are fully covered over the summer month during high periods of annual leave. However, while core rota coverage is being achieved, a number of service relay on Waiting List Initiatives (WLIs) and additional clinical sessions to deliver the capacity required to meet demand. The availability of this supplementary capacity is typically reduced during the summer holiday period, when annual leave is at its highest level. As a results, an impact is anticipated across a number of pathways. There has been a demonstrable reduction in clinical update of WLIs following changes to clinical rates. This reduction is available additional activity is likely to further constrain capacity.

Patients

Planned Care

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

RTT 1st OPA Performance

FILTER: TOTAL | RP07218 | M_01304_Incompletes_New_OP | Updated: 14/07/2026 13:26

M | Jun 26

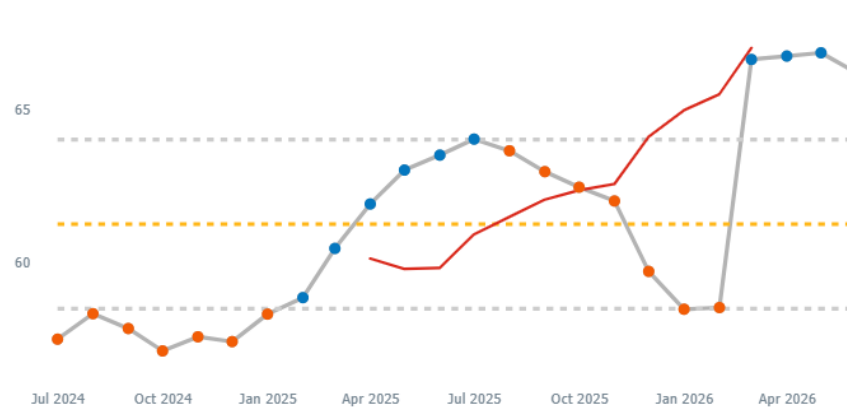
66.2%

Num: 33K
Denom: 50K

Timescale		Value	Target	Num	Denom
M Jul-25	🟢	64.0%	60.9%	31.2K	48.8K
M Aug-25	🟡	63.6%	61.5%	31.3K	49.2K
M Sep-25	🟡	63.0%	62.0%	30.2K	48.0K
M Oct-25	🟡	62.5%	62.4%	30.0K	48.0K
M Nov-25	🟡	62.0%	62.6%	29.1K	46.9K
M Dec-25	🟡	59.7%	64.1%	27.2K	45.6K
M Jan-26	🟡	58.4%	65.0%	26.5K	45.4K
M Feb-26	🟡	58.5%	65.5%	25.8K	44.1K
M Mar-26	🟢	66.6%	67.0%	32.4K	48.6K
M Apr-26	🟢	66.8%		33.4K	50.0K
M May-26	🟢	66.9%		34.1K	50.9K
M Jun-26	🟢	66.2%		33.3K	50.3K

XMR Run Chart

M_01304_Incompletes_New_OP



Special cause variation

Special cause of improving nature or lower pressure due to Higher values.



No set target

No set target.



Commentary

RTT 52w Performance

FILTER: TOTAL | RP07218 | M_01304_Incompletes_52_Perf | Updated: 14/07/2026 13:26

M | Jun 26

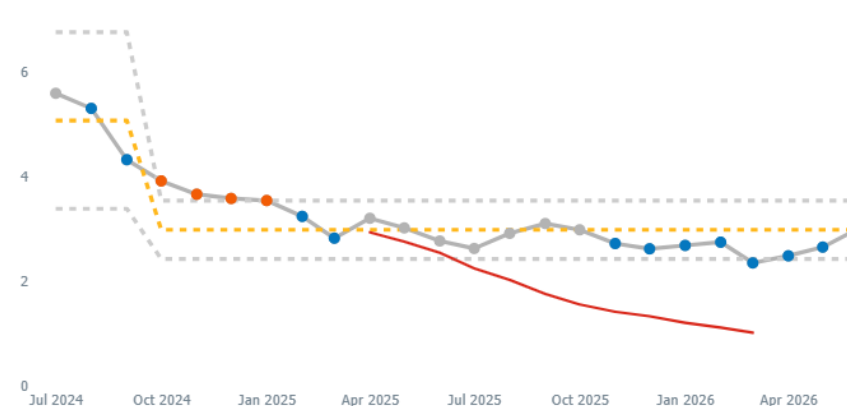
3.0%

Num: 2K
Denom: 82K

Timescale		Value	Target	Num	Denom
M Jul-25	🟡	2.6%	2.2%	2,087	80.0K
M Aug-25	🟡	2.9%	2.0%	2,320	80.1K
M Sep-25	🟡	3.1%	1.7%	2,435	78.9K
M Oct-25	🟡	3.0%	1.5%	2,327	78.4K
M Nov-25	🟢	2.7%	1.4%	2,078	76.9K
M Dec-25	🟢	2.6%	1.3%	1,977	76.0K
M Jan-26	🟢	2.7%	1.2%	2,006	75.2K
M Feb-26	🟢	2.7%	1.1%	2,016	73.9K
M Mar-26	🟢	2.3%	1.0%	1,848	79.2K
M Apr-26	🟢	2.5%		1,992	80.7K
M May-26	🟢	2.6%		2,161	82.0K
M Jun-26	🟡	3.0%		2,462	82.4K

XMR Run Chart

M_01304_Incompletes_52_Perf



Common cause variation

Common cause - no significant change.



No set target

No set target.



Commentary

Patients

Planned Care

Referral to Treatment Waiting Times; Incomplete Pathways Performance

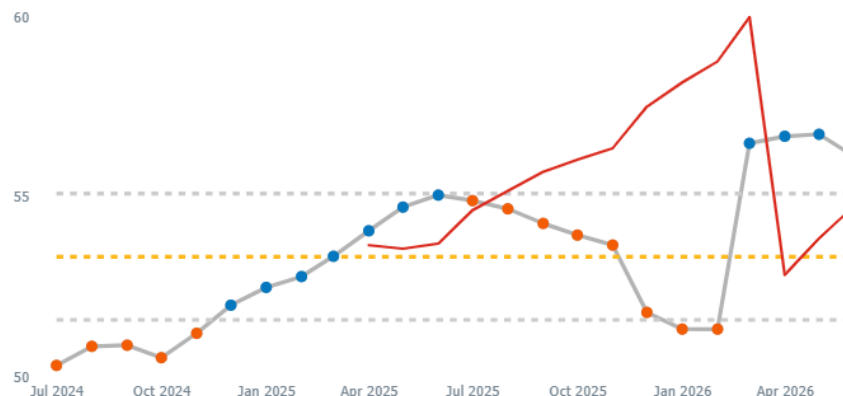
M | Jun 26

56.1%

Num: 46K
Denom: 82K

Timescale	Value	Target	Num	Denom
M Jul-25	54.9%	54.6%	43.9K	80.0K
M Aug-25	54.7%	55.2%	43.8K	80.1K
M Sep-25	54.3%	55.7%	42.8K	78.9K
M Oct-25	53.9%	56.0%	42.3K	78.4K
M Nov-25	53.6%	56.3%	41.2K	76.9K
M Dec-25	51.8%	57.5%	39.3K	76.0K
M Jan-26	51.3%	58.2%	38.6K	75.2K
M Feb-26	51.3%	58.8%	37.9K	73.9K
M Mar-26	56.5%	60.0%	44.7K	79.2K
M Apr-26	56.7%	52.8%	45.7K	80.7K
M May-26	56.7%	53.8%	46.5K	82.0K
M Jun-26	56.1%	54.7%	46.2K	82.4K

XMR Run Chart
M_01304_Incompletes



Special cause variation

Special cause of improving nature or lower pressure due to Higher values.



Inconsistent performance

Will not consistently pass or fail the target if nothing changes.



Commentary

For the month beginning 01.06.2026 the latest RTT Incomplete Performance performance is 56.1% against a Trajectory target of 54.7% (higher is better).

KEY ISSUE

ACTION TO RESOLVE

OWNER

TIMESCALE

PROGRESS UPDATE

Drive to eradicate 65 week waits and sustain as well as reduce the level of 52 week waits to <1% of PTL from a baseline of 3.6%.
Trust enters Tier 1 Support from February 2026 for Elective Care and Tier 2 for Diagnostics.

Initiate 2026/27 Operating Plan to deliver activity and Performance Targets

Activity Deficit at M3

- Initiate weekly activity and long wait reviews with each Care Group focusing on ensuring activity is in line with plan and that long waiting patient treatments are expedited.
- Devise further Cardiology long wait recovery plan
- Agree participation in the Kent and Medway Referral Management Programme incorporating Single Point of Access, Advise and Refer and standardised best practice pathways.
- Engage with Strategic Partner on programme to improve productivity and efficiency and reduce unwarranted variation across planned care
- Recovery Plan to recover to be submitted to Trust Board

COO

Director Planned Care Recovery
Director Planned Care Recovery

Director, Planned Care Recovery

Director Planned Care Recovery

June 30

July 31

June 24 - complete

June 30 - Complete

July 31

- First meeting held w/b 15/06/26

- Cardiology plan complete. Further diagnostic action plan relating to CTCA to be devised. Delayed pending pathway revision.
- Agreed at Trust Management Committee May 20. Programme team set up and workshop planned for 24/06/26 – complete.

- Initial meetings held and data collection concluded. Project Initiation Documents are being drafted for presentation in June.

- Awaiting Board Decision

Patients

Planned Care

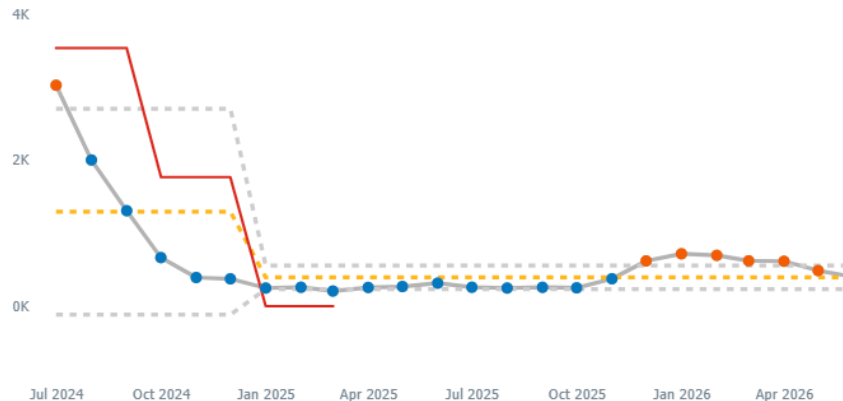
Endoscopy Backlog; Overdue Surveillance and Routine Waits

M | Jun 26

400

Timescale		Value	Target	Num	Denom
M Jul-25	🟢	258		258	
M Aug-25	🟢	247		247	
M Sep-25	🟢	257		257	
M Oct-25	🟢	250		250	
M Nov-25	🟢	374		374	
M Dec-25	🟡	618		618	
M Jan-26	🟡	715		715	
M Feb-26	🟡	694		694	
M Mar-26	🟡	619		619	
M Apr-26	🟡	613		613	
M May-26	🟡	486		486	
M Jun-26	🟡	400		400	

XMR Run Chart
M_01063_Endo_BL



Special cause variation

Special cause of concerning nature or higher pressure due to Higher values.



No set target

No set target.



Commentary

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGRESS UPDATE
Focus on site-wide utilisation of capacity				•Initial improvement seen in booking rates since.
Reduced Capacity due to booking utilisation and cessation of weekend (Sunday) lists	Daily huddles to be implemented to ensure maximum utilisation of capacity and weekly oversight by Care Group Tri.	Jade Pilcher	Ongoing	Daily huddles and weekly oversight now in place. Utilisation improved from 86.6% to 91%
	Vacancies & NHSp requests delayed through VCP. Escalation to MD to resolve.	• Sunny Chada	Complete	New WLI rates have seen no additional shifts picked up by the internal team.
	Sunday insourced lists reinstated to provide additional capacity until alternative pathways in place.	Sunny Chada	Ongoing	
Unable to implement alternative pathways at pace due to recruitment delays	Recruitment of nursing posts required to implement alternative pathways	Jo Williams	Ongoing	Delays in approval for external recruitment impacting on implementation timeline.

In line with the above plans we have seen the backlog plateau and are working towards full compliance and return of backlog to target (<200) by end of July 2026

Patients

Planned Care

Diagnostics; DM01 Compliance % Patients Waiting less then 6 Weeks

M | Jun 26

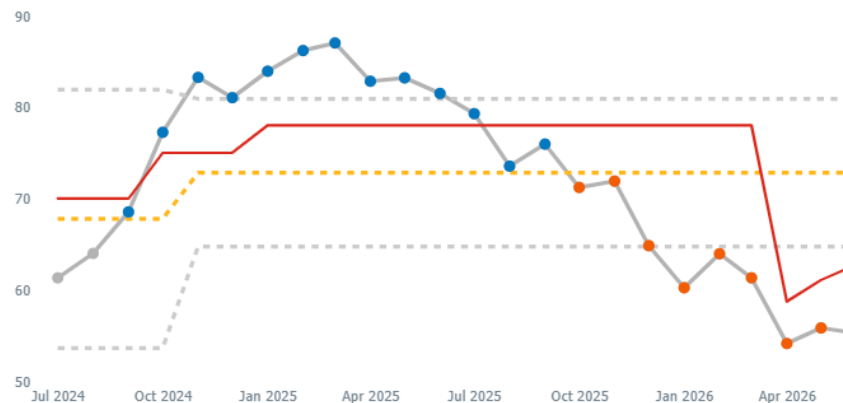
55.2%

Num: 21K
Denom: 37K

Timescale		Value	Target	Num	Denom
M Jul-25	🟢	79.3%	78.0%	16.7K	21.1K
M Aug-25	🟢	73.5%	78.0%	14.9K	20.3K
M Sep-25	🟢	76.0%	78.0%	16.8K	22.1K
M Oct-25	🟡	71.2%	78.0%	18.1K	25.5K
M Nov-25	🟡	71.9%	78.0%	19.0K	26.4K
M Dec-25	🔴	64.8%	78.0%	18.5K	28.6K
M Jan-26	🔴	60.2%	78.0%	18.5K	30.7K
M Feb-26	🔴	63.9%	78.0%	21.1K	33.0K
M Mar-26	🔴	61.3%	78.0%	21.8K	35.6K
M Apr-26	🔴	54.1%	58.7%	19.0K	35.1K
M May-26	🔴	55.8%	61.1%	20.0K	35.7K
M Jun-26	🔴	55.2%	62.8%	20.7K	37.4K

XMR Run Chart

M_00190_DM01_Compliance



Special cause variation

Special cause of concerning nature or higher pressure due to Higher values.



Consistently passing the target

Will consistently pass the target if nothing changes.



Commentary

For the month beginning 01.06.2026 the latest DM01 Compliance performance is 55.2% against a Trajectory target of 62.8% (higher is better).

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGRESS UPDATE
Cardiac MRI Backlog		•Cardiology GM	•March 2027	•New consultant is now in post. •Additional weekend lists being put on at OAH. •Discussions ongoing around booking processes and chronology, and capacity use. •MTW undertaking non-stress lists to support. •Continued issues with adenosine availability at the OAH = delay in stress scanning. •Discussion underway re bringing back in house. Awaiting funding confirmation (NHSE)

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGRESS UPDATE
MRI (exc. Cardiac) Booking Capacity Consultant Vetting; delays extending wait times & restricting patient flow Insufficient capacity for sedation & GA patients Current vacancy levels High Cancellation Rates @ Buckland & Deal Sites Reliability of aged equipment	•Training ongoing to increase the pool of staff with the knowledge and skills to book MRI •Review consultant job plans to ensure sufficient vetting time within job plans and explore options for radiographer led vetting. •Full demand capacity modelling to be undertaken to consider option for increased capacity •Establishment review requested to understand requirement. •Training for booking teams to manage messaging with patients to increase patient willingness to travel to satellite sites •Capital replacement programme due to commence Q3 for MRI •Development of MSK MRI referral criteria	Head of Operations Radiology	August 2026	2 new starters in MRI booking team has supported improved booking utilisation to almost 100% across all scanners. Further recruitment to booking team in progress Complex pathway review undertaken ie interpreters, GA to streamline and reduce delays Loss of activity at Chaucer for MSK MRI for 9 days due to equipment failure Volunteer support to target high risk DNA patients
CT (exc. Cardiac) Booking Capacity Consultant Vetting; delays extending wait times & restricting patient flow High Cancellation Rates @ Buckland & downtime CT Biopsy capacity	•Training ongoing to increase the pool of staff with the knowledge and skills to book CT • •Review consultant job plans to ensure sufficient vetting time within job plans and explore options for radiographer led vetting. • •The downtime of CT's have contributed to a number of cancellations. Two CTs were due for replacement this year due to age but this has been delayed and both CTs have had downtime due to faults. Replacement programme has now commenced • •CT Biopsy is an ongoing challenge due to consultant capacity. This is further impacted currently by the lack of recovery space at WHH following the SDEC moves. An urgent solution has been identified.	•Head of Operations Radiology	August 2026	Training Underway. Booking utilisation has declined in month due to high volumes of staff sickness •A dashboard has been created to monitor vetting performance which is monitored by the operational team and escalated to site leads as necessary. •Recovery space for CT Biopsy identified at WHH and increased capacity in place to manage backlog •CT replacement programme at QEOM completed now planning for CT at WHH to be replaced from end of July 2026. •Ongoing recruitment into booking team vacancies

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGRESS UPDATE
CT Cardiac Underlying capacity deficit		•Head of Operations Radiology	•August 2026	•Demand capacity exercise has been undertaken which clearly demonstrates in house capacity is insufficient to meet the current demand. The service receives an average of 250 referrals per month. In house capacity is 140. We currently send 60 patients per month to the Chaucer leaving a monthly shortfall 50 slots. In 23/24 we sent 120 patients per month to the Chaucer but funding was reduced for 25/26 resulting in the worsening position. •In order to maintain current performance and prevent a worsening DM01 position additional funding is required of £380k for26/27 to increase Chaucer capacity back to 120 slots per month. This will maintain current performance. To clear the backlog and achieve DM01 compliance a further £500k would be required. •Deep dive underway into long term capacity requirements - options being explored for utilising capacity at Buckland. SOP in development •Chaucer contacted regarding increasing capacity which has been secured for March 2026
Non-Obstetric Ultrasound Booking Capacity Consultant Rotas (delay to production) High Cancellation Rates Recruitment	•Training ongoing to increase the pool of staff with the knowledge and skills to book NOUS •Significant delays in the production of consultant rotas impacting on the ability of booking staff to book ahead •Training for booking teams to manage messaging with patients. •Current vacancies for RDAs not recruited to due to delays with approvals. A high number of NOUS lists require a chaperone. Backfill with NHSP as available. •Current vacancies for booking staff not recruited to due to internal vacancy approvals processes	•Head of Operations Radiology	•August 2026	•Training Underway. Booking utilisation and performance has significantly declined in month due to staff vacancies and high sickness absence. Plan in place to support staffing gaps and deliver improvement. •Significant reduction in hospital cancellations due to targetted focus on historical reasons • Patchwork is due to be implemented from end of August which should improve rota production timing •Ongoing recruitment into RDA and booking team vacancies •Business case approved for increased insourcing support - due to commence August/September 2026 •Review of BMUS rejection criteria to ensure alignment with vetting SOP

Quality and safety

Key Performance Indicator (KPI) Assurances

M



KPI's Statistically Improving

KPI's Indicating Concern



Consistently failing the target
Will consistently fail the target if nothing changes.



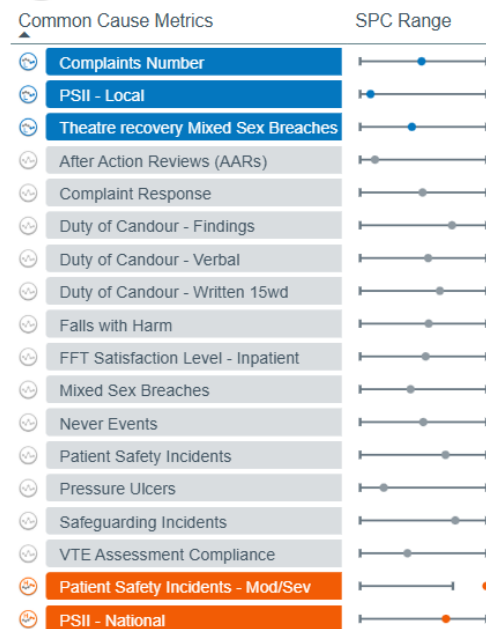
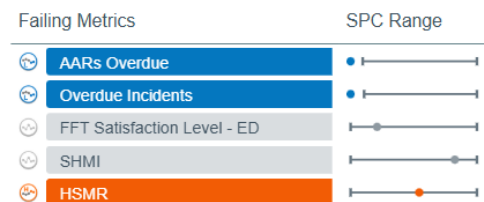
Inconsistent performance
Will not consistently pass or fail the target if nothing changes.



Consistently passing the target
Will consistently pass the target if nothing changes.



No set target
No set target.



Understanding the Data

The columns indicate the level of assurance that performance will deliver the expected standard (target). In order to achieve a "P" the target must be performing better than its respective confidence interval, as this indicates the performance standard will be maintained within natural variation.

Quality and safety

Scorecard View

Incident Reporting, Compliments/Complaints & Safeguarding

Key Performance Indicator (KPI)

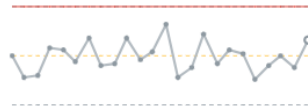
XMR Run Chart

Ranges

Patient Safety Incidents

FILTER: TOTAL
RP07218
M_00188_Patient_Incidents
Updated: 14/07/2026 06:47

M | Jun 26
2,174



UCL: 2,427
Mean: 2,037
LCL: 1,647
Targ: 2,427

Patient Safety Incidents - Mod/Sev

FILTER: TOTAL
RP07218
M_00188_Patient_Incidents_Severe
Updated: 14/07/2026 06:47

M | Jun 26
103



UCL: 82
Mean: 52
LCL: 22
Targ: 82

Overdue Incidents

FILTER: TOTAL
RP07218
M_01315_Overdue_incidents
Updated: 14/07/2026 07:03

M | Jun 26
459

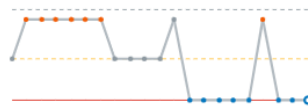


UCL: 1,188
Mean: 862
LCL: 537
Targ: 0

PSII - Local

FILTER: TOTAL
RP07218
M_01540_PSII_Internal
Updated: 14/07/2026 09:23

M | Jun 26
0

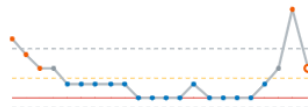


UCL: 2
Mean: 1
LCL: 0
Targ: 0

PSII - National

FILTER: TOTAL
RP07218
M_01539_PSII_National
Updated: 14/07/2026 09:21

M | Jun 26
2



UCL: 3
Mean: 1
LCL: -1
Targ: 0

After Action Reviews (AARs)

FILTER: TOTAL
RP07218
M_01541_After_Action_Reviews_(AARs)
Updated: 14/07/2026 09:19

M | Jun 26
1

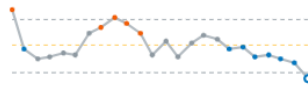


UCL: 14
Mean: 7
LCL: -1
Targ: 0

AARs Overdue

FILTER: TOTAL
RP07218
M_01542_Overdue_After_Action_Reviews_(AARs)_Snapshot
Updated: 14/07/2026 09:17

M | Jun 26
14



UCL: 41
Mean: 29
LCL: 17
Targ: 0

Key Performance Indicator (KPI)

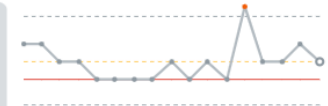
XMR Run Chart

Ranges

Never Events

FILTER: TOTAL
RP07218
M_00171_Never_Events
Updated: 14/07/2026 08:57

M | Jun 26
1

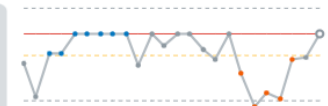


UCL: 3
Mean: 1
LCL: -1
Targ: 0

Duty of Candour - Findings

FILTER: TOTAL
RP07218
M_01043_DoC_Share_Findings
Updated: 14/07/2026 07:08

M | Jun 26
100%

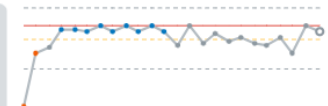


UCL: 107.2%
Mean: 94.0%
LCL: 80.9%
Targ: 100.0%

Duty of Candour - Written 15wd

FILTER: TOTAL
RP07218
M_01043_DoC_Written_15_WD
Updated: 14/07/2026 07:08

M | Jun 26
96.3%

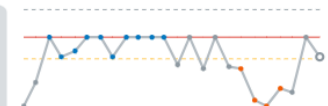


UCL: 110.0%
Mean: 91.4%
LCL: 72.8%
Targ: 100.0%

Duty of Candour - Verbal

FILTER: TOTAL
RP07218
M_01043_DoC_Verbal
Updated: 14/07/2026 07:08

M | Jun 26
96.2%

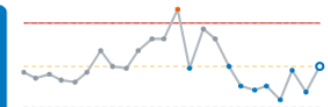


UCL: 105.5%
Mean: 95.4%
LCL: 85.3%
Targ: 100.0%

Complaints Number

FILTER: TOTAL
RP07218
M_01255_Number_of_Complaints
Updated: 14/07/2026 08:38

M | Jun 26
99



UCL: 147
Mean: 100
LCL: 54
Targ: 147

Complaint Response

FILTER: TOTAL
RP07218
M_01255_Comp_30_45_days
Updated: 14/07/2026 08:38

M | Jun 26
85.5%



UCL: 91.7%
Mean: 85.6%
LCL: 79.4%
Targ: 85.0%

FFT Satisfaction Level - ED

FILTER: TOTAL
RP07218
M_01110_FFT_Satisfaction_ED
Updated: 14/07/2026 11:58

M | Jun 26
81.0%



UCL: 86.9%
Mean: 83.2%
LCL: 79.4%
Targ: 90.0%

Quality and safety

Scorecard View

IPC, Patient Safety & Mortality

Key Performance Indicator (KPI)

XMR Run Chart

Ranges

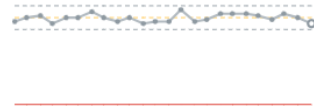
FFT Satisfaction Level - Outpatient

FILTER: TOTAL
RP07218
M_01110_FFT_Satisfaction_OP
Updated: 14/07/2026 11:58

M | Jun 26

95.3%

Num: 12K
Denom: 12K



UCL: 96.4%
Mean: 95.6%
LCL: 94.9%
Targ: 90.0%



FFT Satisfaction Level - Inpatient

FILTER: TOTAL
RP07218
M_01110_FFT_Satisfaction_IP
Updated: 14/07/2026 11:58

M | Jun 26

91.0%

Num: 699
Denom: 768



UCL: 93.7%
Mean: 90.9%
LCL: 88.1%
Targ: 90.0%



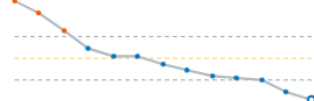
SJRs Outstanding

FILTER: TOTAL
RP07218
M_01559_SJRs_Outstanding
Updated: 01/07/2026 11:18

M | Jun 26

392

Num: 4K
Denom: 3K



UCL: 640
Mean: 554
LCL: 469
Targ:



Safeguarding Incidents

FILTER: TOTAL
RP07218
M_01137_Safeguarding_Incidents
Updated: 14/07/2026 07:04

M | Jun 26

38



UCL: 47
Mean: 28
LCL: 9
Targ: 47



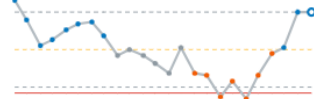
Safeguarding Children Training

FILTER: TOTAL
RP07218
M_00411_Safeguarding
Updated: 13/07/2026 17:58

M | Jun 26

92.0%

Num: 9K
Denom: 10K



UCL: 92.0%
Mean: 91.1%
LCL: 90.1%
Targ: 90.0%



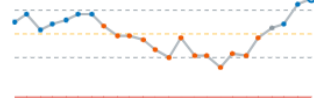
Safeguarding Adults Training

FILTER: TOTAL
RP07218
M_01176_Safeguarding_Training
Updated: 13/07/2026 18:45

M | Jun 26

93.9%

Num: 9K
Denom: 10K



UCL: 93.6%
Mean: 92.6%
LCL: 91.6%
Targ: 90.0%

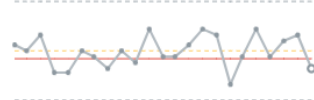


IPC: EColi Infections

FILTER: TOTAL
RP07218
M_01142_IPC_Infections_EColi
Updated: 17/07/2026 09:07

M | Jun 26

10



UCL: 22
Mean: 13
LCL: 4
Targ: 12



Key Performance Indicator (KPI)

XMR Run Chart

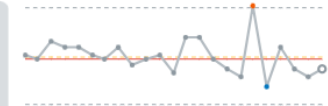
Ranges

IPC: CDiff Infections

FILTER: TOTAL
RP07218
M_01142_IPC_Infections_CDif
Updated: 17/07/2026 09:07

M | Jun 26

6



UCL: 20
Mean: 9
LCL: -2
Targ: 8



IPC: Klebsiella Infections

FILTER: TOTAL
RP07218
M_01142_IPC_Infections_Klebsiella
Updated: 17/07/2026 09:07

M | Jun 26

2



UCL: 14
Mean: 5
LCL: -4
Targ: 6



IPC: Pseudomonas Infections

FILTER: TOTAL
RP07218
M_01142_IPC_Infections_Pseudomonas
Updated: 17/07/2026 09:07

M | Jun 26

0



UCL: 11
Mean: 3
LCL: -5
Targ: 2



IPC: MRSA Infections

FILTER: TOTAL
RP07218
M_01142_IPC_Infections_MRSA
Updated: 17/07/2026 09:07

M | Jun 26

0



UCL: 1
Mean: 0
LCL: -1
Targ: 0



IPC: MSSA Infections

FILTER: TOTAL
RP07218
M_01142_IPC_Infections_MSSA
Updated: 17/07/2026 09:07

M | Jun 26

3



UCL: 15
Mean: 6
LCL: -3
Targ: 6



Falls with Harm

FILTER: TOTAL
RP07218
M_00320_Falls
Updated: 14/07/2026 08:07

M | Jun 26

6



UCL: 15
Mean: 5
LCL: -5
Targ: 15

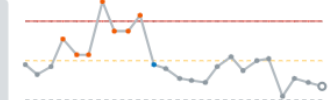


Pressure Ulcers

FILTER: TOTAL
RP07218
M_01177_Pressure_Ulcers
Updated: 14/07/2026 08:23

M | Jun 26

65



UCL: 107
Mean: 81
LCL: 55
Targ: 107



Quality and safety

Scorecard View

IPC, Patient Safety & Mortality

Key Performance Indicator (KPI)

XMR Run Chart

Ranges

Mixed Sex Breaches

FILTER: TOTAL

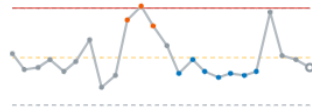
RP07218

M_00160_Mixed_Sex_Breach

Updated: 14/07/2026 08:05

M | Jun 26

58



UCL: 131
Mean: 70
LCL: 10
Targ: 131



Theatre recovery Mixed Sex Breaches

FILTER: TOTAL

RP07218

M_00160_Mixed_Sex_Breach_Theatres

Updated: 14/07/2026 08:05

M | Jun 26

0



UCL: 3
Mean: 0
LCL: -2
Targ: 3



HSMR

FILTER: TOTAL

RP07218

M_00133_HSMR_Index

Updated: 14/07/2026 09:55

M | Feb 26

102.5

Num: 2K
Denom: 1.6K



UCL: 104.9
Mean: 102.3
LCL: 99.6
Targ: 96.0



SHMI

FILTER: TOTAL

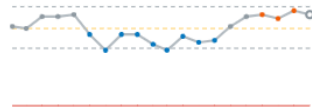
RP07218

M_00272_SHMI

Updated: 14/07/2026 08:03

M | Feb 26

1.142



UCL: 1.147
Mean: 1.131
LCL: 1.115
Targ: 1.070



VTE Assessment Compliance

FILTER: TOTAL

RP07218

M_00297_VTE_Assessment_Compliance

Updated: 14/07/2026 08:16

M | Jun 26

94.0%

Num: 12K
Denom: 13K



UCL: 95.7%
Mean: 94.3%
LCL: 92.9%
Targ: 95.0%



NICE Compliance

FILTER: TOTAL

RP07218

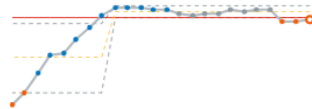
M_01456_NICE_COMPLIANCE

Updated: 14/07/2026 11:32

M | Jun 26

89.3%

Num: 394
Denom: 441



UCL: 98.7%
Mean: 94.5%
LCL: 90.2%
Targ: 90.0%



Key Performance Indicator (KPI)

XMR Run Chart

Ranges

Patient Safety Incident Investigations

Incidents are reviewed and investigated under the Trust's Patient Safety Incident Response Framework (PSIRF) Policy and Plan which are available to the public on the Trust website.

The Trust, at the end of June had fifty-eight (58) open learning responses, of which seventeen (17) were nationally reportable incidents under investigation:

- Four (4) Never Events - a wrong site block, retained wire, retained PICC line, retained vaginal pack.
- Four (4) Learning from deaths cases.
- Nine (9) Maternity and Neonatal Safety Investigations (MNSI)

There were four (4) externally led investigations in progress requiring input from the Trust.

After Action Reviews: 26 internally led AARs (one externally led additional AAR in data). Thirteen (13) AARs were closed in June, and one (1) new AAR was commenced. Fourteen (14) AARs were overdue for completion, of which 2 have since been approved in July to date.

The CNMO and Director of Quality Governance meet with the Care Group Directors of Nursing/Midwifery twice a week to review PSIRF investigation progress. This enables challenges to completion to be addressed and ensures further breaches to agreed timeframes are minimised. An escalation process has been drafted and tested in June prior to implementation. The Corporate Patient Safety and Care Group Quality Governance teams continue to provide direct support to the investigation leads.

Moderate/Severe/Death Harm Data

There continues to be a data quality issue resulting in an overstatement of moderate and above harms. This is because the data is now being extracted from the LFPSE harm fields rather than the Trust severity field. Data quality checks and revisions are ongoing to resolve the issue. A plan is in place to remove the severity field for LFPSE incidents by the end of July, which will resolve this issue. All data anomalies where the severity and LFPSE harm fields do not align are included in the weekly anomalies report which is sent to the governance teams to review and address.

The correct data for June 2026 is: 90 (Moderate harm = 78; Severe harm = 4; Death harm = 6)

This is above normal variation. The incident categories that reported above normal variation were: Thirty-five (35) Tissue Viability incidents of which 34 were admitted with tissue damage/pressure ulcers. Eleven (11) were complications of procedures/operations (nine of which were recognised complications with no identified issues with care) and six (6) Women's Health - obstetric complications. There were nine (9) Delay failure incidents of which one has since been downgraded.

Every patient safety incident is reviewed and the Datix is updated. Where moderate and above harm has occurred, Duty of Candour is undertaken and any learning is actioned and added to the Datix. The incident will be discussed at the Pre-Incident Review Panel (Pre-IRP) if it meets the criteria identified in the PSIRF Policy. This ensures an appropriate learning response is determined and the learning that is then generated from the response will be set into actions to close the gaps and improve future outcomes. The Executive-led Incident Review Panel (IRP) and Learning Response approval Panel (LRAP) have oversight of this process.

Overdue Incidents:

The number of overdue incidents increased from 415 to 459 at the end of June. Of these 108 are justifiable overdue incidents due to extended timeframe investigations e.g. safeguarding reviews awaiting KCC outcomes, AARs and PSIIIs.

A total of 2,393 incidents in total were closed in May; however, 420 incidents became overdue in the month.

The weekly overdue and anomalies report is shared with the Care Group Leadership teams contains information about the number of incidents about to become overdue to support prioritisation within the care groups. Care Group Governance teams also circulate weekly detailed information to relevant leads and escalation to Care Group Leadership. The standard operating procedure (SOP) for Incident Management is in place, which aims to ensure that, where necessary, bottlenecks for handlers are identified and managed, and there is oversight (and action) at the appropriate level within the Care Group structures to facilitate timely closure. Governance staff are meeting regularly with handlers with high numbers of overdue incidents to support closure.

Duty of Candour

In June, Duty of Candour compliance was:

- Verbal compliance was 96.2% (one maternity case being completed outside of KPI due to translation requirements)
- Written compliance was 96.3% (one maternity case being delayed due need for letter to be translated)
- Findings compliance was 100%

The Duty of Candour escalation process ensures patient safety team, Care Group Triumvirate and Executive oversight of potential breaches to Trust defined timeframes for completion of verbal, written and investigation findings. Care group quality governance teams support clinical staff in completion of duty of candour requirements, oversee timely completion and ensure a record is kept on the Trust incident management system. Quality governance staff attend a weekly working group supported by the patient safety team. This is focused on supporting discussions of complex cases, timely escalation and preventing unjustified breaches to the Trust defined timeframes.

Overdue AARs (and PSIRF learning responses)

- The Patient Safety Team have oversight of completion of all PSIRF learning response via the Trust Incident Management System and through line management of five care groups. The Head of Governance for Maternity has oversight of Women's Health learning responses.
- A weekly report is shared with Executives, and this has now been extended to the Directors of Nursing / Midwifery.
- A twice-weekly meeting with the CNMO and DOQG provides oversight of the trajectory to closure.
- Timeframes for completion have been allocated and the PSIRF plan application and agreement of timeframes reviews.
- The aim is to reduce to zero and prevent further breaches by the end of August 2026 based on the current trajectory we are on track to achieve this.

Never Events

There was one (1) declared never event in June:

- A retained foreign object post colonoscopy procedure: Discussed at IRP- The learning has already been identified therefore no further investigation methodology is required. The action plan will be reviewed via LRAP to confirm completion of all actions and learning. This NE had no identified themes with previous NE.

Mixed Sex Breaches

58 mixed sex accommodation breaches occurred during June 2026. Of these, WHH Critical Care accounted for 46 breaches, QEQM Intensive Care Unit 11 breaches, and KCH Intensive Care and High Dependency Unit 1 breach.

The review of WHH Critical Care has now confirmed that reported breaches are being identified in accordance with Trust policy and NHS England guidance, with patient flow pressures identified as the primary contributor to reported breaches. Subsequent assurance work has identified opportunities to strengthen the consistency of operational interpretation and application of MSA reporting across the Trust. Work is progressing to support a standardised approach to MSA reporting and validation, informed by review of complex clinical scenarios and engagement with clinical areas.

Safeguarding

Training The Trust continues to benchmark safeguarding training compliance against the national standard of 85%, with current compliance for Adult and Children's Safeguarding Levels 1–4 exceeding the required benchmark.

- **Training Capacity:** Sufficient capacity is in place to support staff completion of mandatory safeguarding training.
- **Monitoring and Governance:** Training compliance is monitored through monthly Care Group Performance Review Meetings (PRMs) and the Safeguarding Operational Group (SOG), with monthly exception reporting sustained performance over past two months .

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS): An organisational audit identified opportunities to improve the quality and consistency of MCA assessments, best-interest decision-making, and DoLS documentation. A targeted improvement programme is underway, supported by enhanced training, quality assurance processes, and oversight through the MCA Steering Group and Safeguarding Assurance Committee.

Safeguarding Supervision: Compliance with safeguarding supervision requirements remains strong within the Safeguarding Team, with internal supervision at 100%.

Digital Transformation: Progress delays continue to impact efficiency and are reflected within the safeguarding risk profile.

Safeguarding Administration Capacity and Data Quality: Ongoing administrative capacity challenges have resulted in delays to safeguarding record management, statutory reporting, and patient flagging processes. This has created a backlog of safeguarding activity and remains a corporate risk. Mitigating actions are in place to strengthen administrative resilience, improve reporting timeliness, and enhance data quality and assurance.

Infection Prevention and Control

The new thresholds for infection prevention and control have not yet been released but are also expected to include additional information not previously reported as mandatory, which will compare rates of testing for *Clostridioides-difficile* (C-diff) and rates of blood culture collection to enable comparison across providers to ensure all those that should be tested, are tested. Currently, we report the latter information on the external DCS (UKHSA system) so nil new external reporting required but will potentially commence reporting internally once thresholds are set and agreed.

In June, all reportable Health care associated infections (HCAI's) were below the 2025/26 threshold.

There were:

- 6 *Clostridioides difficile* cases,
- 10 cases of E.coli ,
- 2 cases of Klebsiella,
- 0 pseudomonas,
- 3 MSSA's and
- 0 MRSA's.

Focus for the next year continues to be *Clostridioides difficile* reduction and antimicrobial stewardship. There is a renewed focus on bladder and catheter care and the Trust is rolling out a campaign around hydration with the aim to reduce the number of E-coli blood stream infections.

The healthcare associated infection (HCAI) objectives for 2025/26:

- *Clostridioides difficile* 98 (145 in 2024/25)
- E. coli 141 (160 in 2024/25)
- Klebsiella 76 (77 in 2024/25)
- Pseudomonas 24 (24 in 2024/25)
- MSSA 83 (5% reduction on cases in 2024/25 at 87)
- MRSA zero tolerance (2 in 2024/25)

Quality and safety

Safe Care

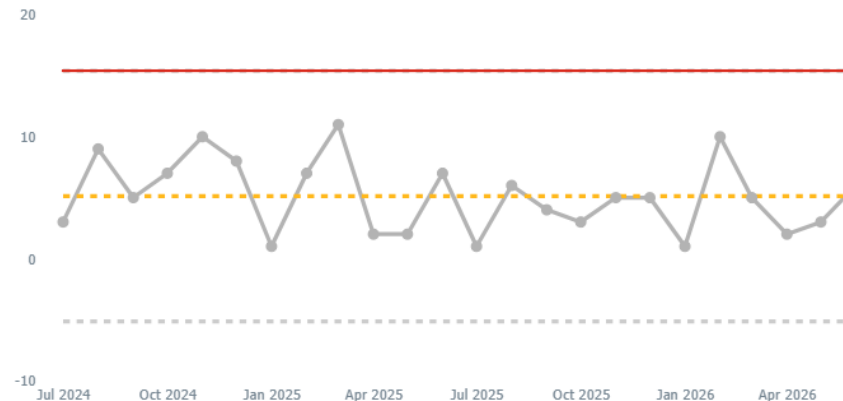
Patient Falls with Moderate or Above Harm Recorded

M | Jun 26

6

Timescale		Value	Target	Num	Denom
M Jul-25	😊	1	15	1	
M Aug-25	😊	6	15	6	
M Sep-25	😊	4	15	4	
M Oct-25	😊	3	15	3	
M Nov-25	😊	5	15	5	
M Dec-25	😊	5	15	5	
M Jan-26	😊	1	15	1	
M Feb-26	😊	10	15	10	
M Mar-26	😊	5	15	5	
M Apr-26	😊	2	15	2	
M May-26	😊	3	15	3	
M Jun-26	😊	6	15	6	

XMR Run Chart
M_00320_Falls



Common cause variation
Common cause - no significant change.



Inconsistent performance
Will not consistently pass or fail the target if nothing changes.



Commentary
For the month beginning 01.06.2026 the latest Falls with Harm performance is 6 against a (6 Sigma Threshold) target of 15 (lower is better).

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGRESS UPDATE
Following a consistent position of 2 incidents reported in both April and May, June saw an increase to 7 incidents. These comprised 5 moderate harm incidents, 1 severe harm incident, and 1 death. Ongoing focus is required to reduce harm severity, with continued emphasis on targeted interventions to support the 10% reduction trajectory for moderate harm and above.	Monitor incident trends to identify recurring themes and areas for improvement.	Falls lead	July 2026	Review of quarter 1 data, with identified themes and trends and impact of actions taken being presented to Fundamentals of Care Committee in July 2026.
	Implement any required action plans arising from investigations and audit compliance with agreed actions.	HCOOP Audit lead/Falls lead	September 2026	In addition, work is ongoing to strengthen preventative approaches, including proposed audit cycle 3 focusing on lying and standing blood pressure monitoring and broader falls prevention measures. Including developing guidelines on the management of postural hypotension.
	Review findings from all moderate, severe harm and death incidents through SWARM governance encouraging ward staff to review systems processes.	Patient safety team/lead and ward teams	September 2026	SWARM training on-going with expected completion date of September 2026. Compliance and action plan completion continue to be monitored through governance processes.

Falls with Harm (cont.)

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGRESS UPDATE
Increase in falls resulting in low and no harm in ward areas where the focus is to encourage patients to sit out of bed and get moving.	•Strengthen safe mobilisation practices to support prevention of deconditioning whilst reducing low and no harm falls. •Reaffirm MDT expectations for early mobilisation in line with individualised risk assessments and patient capability. •Embed consistent use of falls risk assessment (MASA) alongside functional assessment to guide safe mobilisation decisions. •Enhance staff confidence and competency in supported mobility (e.g. sit-to-stand, aided transfers) through targeted training and real-time ward support from Manual Handling and Therapy teams. •Align deconditioning prevention work with falls prevention standards to ensure mobilisation activity is both proactive and safe.	AHP Lead/Therapy Leads Trust Wide/ Falls Lead/ Manual Handling Lead	December 2026	•The Patient Care and Deconditioning Working Group has been established and is actively progressing. A MDT stakeholder event was held on the 30th June 2026, with the We Care team supporting the application of improvement methodology to ensure structured delivery and embedding of learning. •Enablement bays across care groups are showing positive impact, with We Care projects contributing to improved post-operative functional movement. Work is underway to triangulate these initiatives within a wider Patient Care and Deconditioning model to ensure consistency across care groups. •The Manual Handling team had planned to undertake real-time ward-based competency reviews to strengthen safe patient mobility, including assisted sit-to-stand. •This has not commenced, as the Manual Handling team have confirmed they are currently unable to deliver this programme due to capacity constraints. •In response, work is underway to implement an alternative delivery model using a 'train the trainer' approach, enabling wards to support competency development locally. This approach is being progressed to ensure continued focus on safe mobility practices and alignment with current service pressures. •Terms of Reference and objectives are in development in collaboration with AHP and Therapy leads.

Falls with Harm (cont.)

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGRESS UPDATE
MASA risk assessments are not always fully completed timely.	- Falls dashboard to be created to include MASA completion, including time of medical reviews, radiology reports and status of clinician completing review. - Simplify the risk assessment process through triangulation of FOC services within one document to enable fluid streamline documentation into the risk assessment.	Falls Lead	September 2026	IT agreed and for Sunrise amendments, latest update regarding care plans further delayed until September 2026.
		FOC lead nurses/IT sunrise	July 2026	- Meeting took place on the 2nd October 2025 between Sunrise team and FOC lead nurses. Sunrise advise a 6-month timeline due to other workstreams. Plan to discuss the relevant information being pulled into Drs notes. Delay due to sunrise and IT updates, work on hold until July 2026. - Completed, positive feedback and engagement. Further workshop scheduled to support continued rollout and refinement prior to wider Trust implementation. - FOC champion held in March 2026, successful attendance further meetings scheduled. A second session completed on 19 May 2026, with ongoing programme of sessions planned to sustain engagement and support implementation., work supports embedding of Fundamentals of Care principles, strengthening frontline ownership of risk assessment and harm prevention.
	Review white boards to create live boards for information and updated assessment information to be pulled through to the white board.	IT transformation team/Falls lead WDET	August 2026	Second stake holder meeting held on 24th February 2026 plan to co create white boards trust wide with live information. ADON IIT proposed to be discussed at matrons forum to have an understanding of requirements for whiteboard icons. Further meeting awaited Date TBC. From IT ADON and Head of information and data.
Identified gap in knowledge regarding undertaking Dynamic Risk Assessments and redeployment of staff as patient's acuity and dependency changes during shift	Implementation of the Dynamic risk assessment tool developed	Falls Lead/ADoN FoC/ADON WDET	September 2026	- Partial overlap of assessment tools and audits in place noted as a key issue. Plan to build on previous review. - Nursing audit work to be agreed/confirmed prior to implementation. - DRMT to be taken back to NMEC April to agree timeline of a proposed role out. Delayed for NMEC June 2026.
	DRMT to be accessed and completed digitally	Falls Lead/ADoN FoC/ADON WDET	September 2026	DRMT currently in paper format discussed with ADON IT standalone document. Awaiting feedback as for discussion with CN. IT report waiting times for work streams, document will present as a standalone document for IT with priority. Delays until after September.

Quality and safety

Safe Care

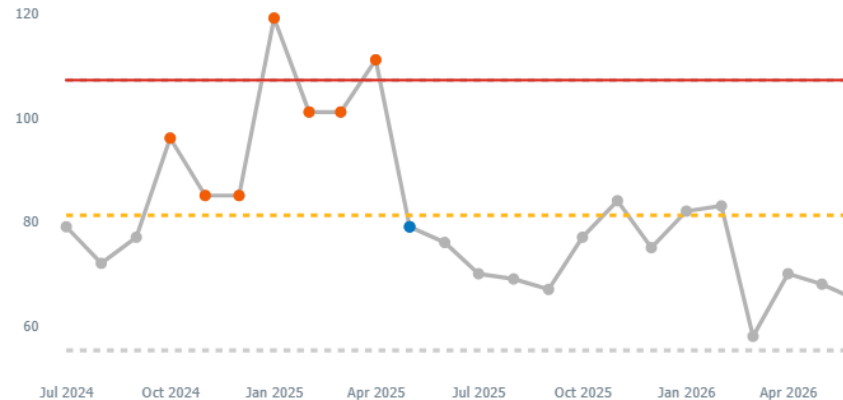
Pressure Ulcers; Hospital Associated

M | Jun 26

65

Timescale		Value	Target	Num	Denom
M Jul-25	😊	70	107	70	
M Aug-25	😊	69	107	69	
M Sep-25	😊	67	107	67	
M Oct-25	😊	77	107	77	
M Nov-25	😊	84	107	84	
M Dec-25	😊	75	107	75	
M Jan-26	😊	82	107	82	
M Feb-26	😊	83	107	83	
M Mar-26	😊	58	107	58	
M Apr-26	😊	70	107	70	
M May-26	😊	68	107	68	
M Jun-26	😊	65	107	65	

XMR Run Chart
M_01177_Pressure_Ulcers



Common cause variation

Common cause - no significant change.



Inconsistent performance

Will not consistently pass or fail the target if nothing changes.



Commentary

For the month beginning 01.06.2026 the latest Pressure Ulcers performance is 65 against a (6 Sigma Threshold) target of 107 (lower is better).

KEY ISSUE

ACTION TO RESOLVE

OWNER

TIMESCALE

PROGRESS UPDATE

10% trajectory for reduction in hospital acquired ulcers for 2026/27 for category 2 and above. Slight reduction in category 2 and above with 43 being reported in May compared to 50 in April. 32% reduction noted on H/A category 2 and above in quarter 1 compared to 25/26

To continue to work with areas of high reporting to review themes and identify learning.

Continue to monitor progress against the TWIP through the Tissue Viability Steering Group

To offer virtual pressure ulcer prevention management sessions, to be more accessible for staff to attend.

Fundamentals of Care Leads

TV Team/ Care group Matrons and Ward Managers

TV Team

March 2027

July 2026

August 2026

Data analysis showed hotspot areas, with focused specialist review and targeted interventions to support a reduction in pressure ulcer development.

Progress for Quarter 1 has been fed back to TVSG and will be presented to FoCC in July 2026. Feedback forms continue to be presented at TVSG for care groups to present updates on progress with the TWIP in their areas.

2 sessions booked for August to trial, to be recorded for on demand access

Pressure Ulcers (cont.)

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGRESS UPDATE
Pressure Ulcer risk assessments are incomplete or inaccurate leading to delayed pressure ulcer prevention strategies.	•A full documentation review is taking place with the Sunrise team to simplify & streamline the documentation process for all clinical staff.	Deputy Chief Nurse	September 2026	•The Deputy Chief Nurse is reviewing existing documentation to reduce duplication and ensure alignment with the new approach.
	•Review the Risk assessment process on Sunrise to simplify & reduce duplication. •Simplify the risk assessment process through triangulation of FOC services within one document to enable fluid streamline documentation into the risk assessment.	FOC Lead Nurse/Sunrise team	September 2026 December 2026	- PURPOSE T risk assessment to be amalgamated into SKINS bundle, to reduce duplication, inconsistencies with risk assessment, this will occur following the Sunrise upgrade which has been delayed until September 2026. TVN to meet Sunrise team after the date to discuss required adjustments. - There is an increased focus on a multi-disciplinary risk assessment with increased discussion at huddles and handovers. Second joint FoC team risk assessment workshop held at WHH in June. - Planning to hold a FoC champion stake holder event in December 2026 following low attendance at virtual sessions.
	•To improve the compliance with risk assessment & SKINS bundle completion within Maternity.	Maternity Unit Managers/ TV Team	September 2026	- Maternity to transfer documents to Sunrise. Meeting held to discuss the finalised content and training to be held prior to launch. Meeting between TVN and FOC champion to discuss changes. - To arrange study sessions to update on the changes & support on the completion of the documents. Plan to attend community midwife away day. TVN has emailed ward manager availability for training dates. Maternity has identified a QE FoC champion.
	•To review the current provision of Hybrid mattresses, trust wide.	Deputy Chief Nurse	September 2026	A multidisciplinary working group, led by the Deputy Chief Nurse, continues to review clinical need and current processes ahead of the procurement of new hybrid mattress systems. Specification has been agreed and put out to tender, working group meeting scheduled for 3rd August to review responses & to select companies to progress to a demo day. To be monitored through the MDG.
	•To review equipment to assist staff in repositioning complex patients, meaning fewer staff are required to reposition these patients appropriately. To procure a single tubular slide sheet.	Manual Handling Team	July 2026	Manual Handling lead working with procurement to secure an agreement regarding purchasing of tubular slide sheets via NHSSC.
	•To reduce the risk of pressure ulcer development by preventing patient deconditioning.	Associate Director of Therapy Services	August 2026	The Patient Care and Deconditioning Working Group has been set up. An MDT stakeholder event was held on 30th June 2026, with the We Care team supporting the application of improvement methodology. An action plan with recommendations to be disseminated to Associate Directors of Nursing/Heads of Midwifery and their teams

Pressure Ulcers (cont.)

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGRESS UPDATE
Ineffective heel offloading continues to be a recurrent theme in the development of hospital acquired pressure ulcers.	Trust wide heel offloading campaign as part of National Stop the Pressure Awareness week & Site based study days (Sept & Oct) to highlight appropriate offloading techniques. To continue to raise awareness of the appropriate techniques for offloading heels	Tissue Viability Team Tissue Viability Steering Group	September 2026 September 2026	- Results of the annual TV audit have been collated & action plan being developed. - TV team to repeat heel offloading audit at all acute sites. - Reviewing new guidance from EPUAP & NPIAP to align trust wide policy and best practice. - PAG asked to review current pillow supplier to provide a more effective product. TV team have reviewed and fed back the best product to PAG. - Aspen representative led a workshop at recent TV champion study day on 9th June with good feedback from attendees. Wards encouraged to approach Aspen representative for bespoke training.
Incidence of Medical device related pressure ulcers continues to be high with 175 incidents reported in 2025/26. 4 category 2 medical device related pressure ulcers reported in June, 6 reported in May, which is a reduction from 13 in April.	Continue to monitor key causative factors of medical device damage and to provide updates to Procurement assurance group of any issues	Tissue Viability Team Procurement Assurance Group	August 2026 July 2026	- TV team to work with industry to create QR codes on the management of medical devices. An initial meeting has been held with the Aspen representative representative who has led a workshop at upcoming TV champion study day. - Cambridge J2 and M2 highlighted the increase in reporting of damage due to O2 tubing behind the ear. Now using silicone pressure reducing tape in conjunction with TV team as a preventative measure. To monitor progress and to present at TVSG in July 2026. - TV link on Harvey ward at K&C has arranged collar care training, with Aspen representative, to improve the management of skin under Orthopaedic collars. Similar training has been conducted on Brabourne ward.
Missed opportunities for earlier skin inspection and escalation of pressure damage. May data demonstrates an increased reporting of category 1 pressure ulcers. 26 reported in May compared to 22 in April. 19 category 1 pressure ulcers reported in June.	Focus on reporting of category one damage. TV team looking at individual actions from recent hospital acquired incidents for shared learning across the trust. Dynamic risk assessment to be developed to support staff with managing shift and mitigation	Lead Tissue Viability Nurse Falls Lead/ADoN FoC/ADON WDET	July 2026 August 2026 July 2026	- Tissue Viability training material adapted to emphasise the recognition and reporting of category 1 damage. - ED practitioner at QEQM has developed a ED fundamentals of care programme to be rolled out trust wide which includes skin inspection and risk assessment in ED. ED matron continues to monitor the completion of risk assessments and body mapping. - Following discussions at TVSG, matrons to feedback to ward managers & wards the importance of early identification of category 1 pressure damage & escalation of this. - TV team to attend ward manager meetings to highlight importance of early skin inspection & escalation of pressure damage. - August 2026 Virtual sessions on the recognition and reporting of category 1 damage to include how to recognise on darkly pigmented skin. - Tool to be digitalised meeting held with ADoN IT plan for standalone document to be developed. In queue with IT.

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGRESS UPDATE
Patient Safety Incident Response (PSIR) Framework.	- Annual review of PSIRF policy is up to date and available on Policy Centre. The updated plan was presented to Operational Quality Governance Committee in June 2026 - Patient safety training programme in place: PSIRF, Swarm, AAR, Incident Investigation, Engagement/Duty of Candour, Human Factors. - The Patient Safety Partners policy has been approved and is available on Policy Centre. Two (2) PSPs are now in roles, and they are attending a variety of panels as part of their induction in July. A third PSP has been recruited and checking processes are ongoing commenced. A fourth PSP is attending for interview in July. This will complete the recruitment process. - Training compliance with level 1 of the patient safety syllabus was 94.4% Trust wide in June, which is above the 85% KPI. There are four non-compliant areas: Trust Board (73.8%), Operations management (70%), Radiology (66.7%), and DCB Care Group management (75%)	Head of Patient Safety and Improvement.	30/08/2026	- Weekly report to Executives includes details of all learning responses. - Training Needs Analysis in place. A review of training content is now on a rolling annual planner to ensure timely reviews and updates of all content. - Incident Investigation, Swarm, DoC and AAR training dates are available on to book on ESR - PSIRF Plan is available on the external Trust website along with the policy. - Duty of Candour (DoC) updated policy has been made available on Policy Centre in January. All template letters and resources have been updated. - PSIRF plan annual update completed and approved by Operational Quality Governance Committee review.
One (1) Never event reported in June.	WEB335558: The patient attended for a colonoscopy. Upon leaving the theatre and arriving in recover it was identified that an air seal remained in situ.	Head of Patient Safety and Improvement	30/08/2026	- Escalated to IRP - Implement formal counting and confirmation processes for air seal devices. - Embed air seal device checks within team briefs, sign-in/sign-out procedures, and patient documentation. - Introduce a mandatory physical check of air seal devices before the patient leaves theatre. - Implement the new SOP and undertake regular audits to monitor compliance. - Establish clear accountability for completion of sign-out documentation. - Conduct a SEIPS-style review of recent Never Events to identify contributory factors and improvement opportunities. - Strengthen compliance with NATSSIP standards and improve adherence to safety checklist processes, focusing on meaningful application rather than a tick-box approach.
Investigations commenced in June	- One (1) MNSI investigations initiated due to neonatal death - One (1) National PSII Learning from Death incident to explore SDEC discharge. - Three (3) AARs: a surgical site infection, a delayed AKI management and an inappropriate escalation deteriorating patient. - Five (5) SEIPs investigations: Delayed diagnosis Subdural haemorrhage, Delayed Cancer Diagnosis, Inappropriate discharge, Delayed Sepsis Treatment and a tumour lysis monitoring incident.	Head of Patient Safety and Improvement	06/11/2026	- Locally investigated cases have had lead investigators identified - Progress of investigations will be provided in weekly executive report - All nationally reportable investigations will have LRAP sign off

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGRESS UPDATE
Themes and Trends from patient safety events	The top 5 themes for incidents affecting patients in June are illustrated below. - The top subcategories for Tissue Viability were; Admitted with category 2 PU (196), Hospital acquired other ulcers (skin tears, bruises minor cuts) (50), and admitted with Category 3 PU (45). Work is being undertaken with community colleagues to address actions as required. - The top subcategories for Care/Treatment were; Delay in providing treatment (122), inappropriate treatment (49) and lack of nursing care (26). These are all within normal variation for these subcategories. - The top subcategories for Medication incidents were Drug error – administering (73), Drug error – prescribing (37), and Drug missing (18). These incident are themed and reviewed through the Medication Safety Advisory Group. - The sub-categories for patient falls were: Found on floor (54), Fall- other (28) Assisted fall / lowered to floor (not a fall) (16). Themes and trends are discussed in falls steering group with actions identified to address. - The top subcategories for Security incidents were; Patient did not wait (39), Patient behaviour-aggressive (29) and security other (13). Staff being exposed to aggression and violence is being managed as part of the Mental Health Steering Group workstream.			Trends and themes of reported patient safety events are reviewed monthly and reported in the Quality Governance report.
IPC processes across all sites to focus on the reduction of avoidable infections. Thresholds for 25/26 have challenging trajectories, with no more than 98 C. diff cases. (2026/7 thresholds not yet published)	- Focus on C-dif specimen taking - Focus on antimicrobial stewardship - Environmental capital projects to increase isolation and improve IPC in environment 'C-dif' ward rounds to specifically review antibiotic treatment	IPC Team	Ongoing and measured against monthly trajectories to achieve below 25/26-year end. (will update to 2026/27 when thresholds received)	- Post infection reviews continue to identify learning - Faecal samples made to identify Bristol stool chart - Focus on training within ED - Renewed focus on antimicrobial stewardship commenced - Antimicrobials stewardship 'rounds' identifying some changes in practice
Strengthening consistency in the operational interpretation of Mixed Sex Accommodation (MSA) reporting	Continue assurance work to review complex MSA scenarios and support consistent operational interpretation and application of Trust policy and NHS England guidance where required.	•WACA Lead Nurse	September 2026	Review of WHH Critical Care has confirmed that reported breaches are being identified in accordance with Trust policy and NHS England guidance, with patient flow pressures identified as the principal contributor to reported breaches. Assurance work has subsequently highlighted opportunities to strengthen consistency in the operational interpretation and application of MSA reporting in complex clinical scenarios. Further review and engagement with clinical areas will inform any additional guidance required.

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGRESS UPDATE
FFT ED: satisfaction levels remain below the Trust target of 90% satisfaction (85% for April 2026, a 3% increase on March). Not all patients currently have their communication needs met Patients' communication needs are not always met or shared by ED staff with the receiving ward / SDEC or when they are sent for a diagnostic test	•All ED, AMU, SDEC and UTC staff to undertake the AIS e-learning •All ED, AMU, SDEC and UTC staff to learn to use the BSL video on demand service. •ED must add the patient's communication needs to Sunrise when the patient books in. •Staff to be made aware of the importance of using interpreters, especially to gain consent, explain diagnosis and treatment. Patients' family / friends must not be used unless the issue the patient presents with is clinically urgent or life threatening. •Carers / family say they were sign-posted to the Carers Support Hospital Service [note: due to KCC contract changes this service may not continue from August 2026]	•Associate Directors of Nursing for UEAM at QEQM and WHH / Operational Managers •Associate Directors of Nursing for UEAM at QEQM and WHH / Operational Managers •ED Managers with support from Trust interpreting lead	•By September 2026 •By end of August 2026 •By September 2026 •July 2026	Benchmark data: •Data on use of BSL video on demand in UEAM: BSL video on demand used once at QEQM ED between April 2025 and end of March 2026. • April 2026: No BSL interpreting – neither video nor face to face •May 2026: No BSL interpreting – neither video nor face to face •June 2026: No BSL interpreting – neither video nor face to face Benchmark: •Number of patients whose communication needs are recorded on Sunrise (trust wide) • 10,392 as of 1st December 2025 •31st March 2026: 12,377 • 30th June 2026: 13,722. Achieved a 32% increase Benchmark data: •Current level of use of interpreting in ED and UTC – from April 2025 to end of December 2025: WHH 279, QEQM 247, K&CH 115, Buckland 71. TOTAL: 698 interpreting sessions (spoken languages) •Use in April 2026: WHH ED -17, WHH UTC – 11, QEQM ED – 9, QEQM UTC – 4, K&CH – 16, Buckland – 7 = TOTAL of 64 (all telephone) •Use in May 2026: WHH ED -14, WHH UTC – 14, QEQM ED – 25 , QEQM UTC – 15, K&CH UTC – 13, Buckland UTC – 9 = TOTAL of 90 (all telephone) •Use in June 2026: WHH ED - 19, WHH UTC – 16, QEQM ED – 33 , QEQM UTC – 9, K&CH UTC – 9, Buckland UTC – 5 = TOTAL of 96 (all telephone) Completed: New question added to Carers Survey: Did staff give you enough information about agencies in your local area which might be able to help and support you as a carer? In June 2026 100% of respondents said NO.

Quality and safety

Safe Care

Patient Experience; Friends & Family Test (FFT)

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGRESS UPDATE
Inpatient care: Patients are able to get meals that meet their dietary and cultural needs. Patients say they were involved in decisions about their care and treatment Patients / carers say the carer / family were involved in the discharge of their loved one Patients say that their communication needs were met whilst in hospital Patients say their spiritual needs were met whilst they are an inpatient	•Patient feedback via our in-house inpatient survey shows an improvement in patients saying their dietary and cultural needs are being met. From 77% (CQC inpatient survey 2024) to 85% (our in-house inpatient survey) by March 2027. •Improved score in next CQC adult inpatient survey •Improve the use of shared decision-making tools (e.g. BRAN) – evidence of use in five specialisms (clinical audit) •Develop a training package for doctors on shared decision making and pilot Implement the NHSE Carers and Hospital Discharge toolkit: •Establish a task and finish group •FFT additional question •Carers survey promoted by ward staff and through social media / posters •Ward Accreditation audits •CQC inpatient survey 2025 / inhouse inpatient survey •Chaplaincy service profile and data on patient contacts	•Directors of Nursing / Associate Directors of Nursing •Directors of Nursing / Associate Directors of Nursing •Care Group Medical Directors •Audit team •Medical Education team / Patient Voice and Involvement •Deputy COO / Associate Director of Patient Experience / Heads of Nursing / Ward staff •Lead for Patient Voice and Involvement •Matrons / Ward Managers / Communications team •QIWA team •Patient Voice and Involvement team •Chaplaincy team	•By end of March 2027 •September 2026 •December 2026 •End of August 2026 •February 2026 •April 2026 •February to April 2026 •September 2026 •Six-month report to Patient Exp Cttee	Inpatient Survey: 89% of patients who needed food outside of normal mealtimes were given something to eat: May 2026: 79% K&C, 100% QEQM, 83% WHH June 2026: 80% K&C, 29% QEQM, 67% WHH – a significant reduction at QEQM compared to May. Carer's Survey: June 2026: 66.7% of respondents in June 2026 said yes, the person they care for had their dietary needs met, 33.3% said no. This is worse compared to previous months. Data will be available later in 2026 Benchmark: CQC inpatient Survey 2024: Involved in decisions about care and treatment: overall 73% (no change compared to 2023); 85% K&C, 71% QEQM, 72% WHH. 2025 survey results due to be published soon. Not able to proceed due to lack of resources. Delayed: at risk. Initial discussion with Deputy COO and ADofPE taken place and DoNs asked for information on any checklists currently in use. DoNs report going to July Patient Experience Committee. Completed (added to Inpatient FFT survey additional questions) Q. Were your family or carers involved in discussions about leaving hospital? Yes – 53%, No – 23%, N/A 24% (May 2026) Yes – 45%, No – 41%, N/A 14% (June 2026) – score has got worse. Survey promoted during Carers Week 8-14 June 2026. Response numbers remain low. Benchmark data from Trust inpatient survey: 41% of patients with spiritual needs said these needs were met as an inpatient; 36% K&C, 33% QEQM, 63% WHH June 2026: 18% of patients with spiritual needs said these needs were met as an inpatient Trust wide: None asked but also none said they had spiritual needs for K&C, 21% QEQM, 0% WHH. Report to May 2026 Patient Experience Committee: In 2025-26 the chaplaincy service supported 7,000 patients, 890 relatives and 1,500 staff

Staff Type	Vacancy Rate Jun 26 (Target 10%)	Sickness Rate Jun 26 (Target 5%)	Safe Care Red Flags Jun 26
Registered Nursing & Midwifery	1.2%	5.51%	432
Registered Nursing Associate	N/A	N/A	
Health Care Support Worker	21.61%	N/A	
Staff Type	Care Hours Per Patient Day (CHPPD) Jun 26	Avg Fill Rate Day Jun 26	Avg Fill Rate Night Jun 26
Registered Nursing & Midwifery	6.1	88%	92%
Registered Nursing Associate	0.1	100%	100%
Health Care Support Worker	2.9	81%	101%

Safe Staffing:

The average fill rates for June 2026 continue to be at an acceptable level overall. Staff are redeployed across the sites daily to mitigate staffing based on dynamic risk assessment of patient acuity and dependency levels, with ward managers working clinically as needed. Operational meetings are held throughout the day to support safe staffing levels. St Augustine's QEQM remains closed with staff being redeployed to other areas to provide support and mitigate staffing shortfalls. Invicta continues to see fluctuating elective electivity. Cambridge K has seen a change in function to a short stay frailty ward, along with the relocation of the frailty assessment unit to this area. Roster templates for Fordwich, St Margaret's and Brabourne were amended for the roster period commencing the 15th June, with some impact on fill rates observed. Continued work to support redeployment of staff on SafeCare Live is required to ensure fill rates are reflective of all actions taken. A review across reported maternity fill rates, red flags and alignment with mitigations has been undertaken which has evidenced further work is required to evidence the transfer of staff on the systems used to ensure it is reflective of the actions taken.

Several areas did work on amber shifts, as defined within our organisation. There was one red shift declared in maternity at QEQM. Shift review meetings were completed to recognise real time escalation and to support ongoing learning.

People

Key Performance Indicator (KPI) Assurances

M



KPI's Statistically Improving

KPI's Indicating Concern



Consistently failing the target

Will consistently fail the target if nothing changes.



Inconsistent performance

Will not consistently pass or fail the target if nothing changes.



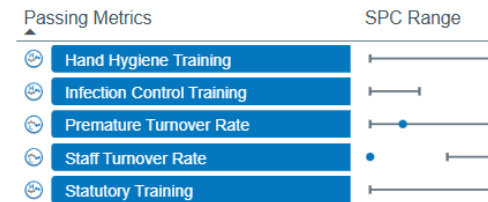
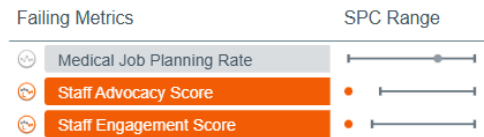
Consistently passing the target

Will consistently pass the target if nothing changes.



No set target

No set target.



Understanding the Data

The columns indicate the level of assurance that performance will deliver the expected standard (target) . In order to achieve a "P" the target must be performing better than its respective confidence interval, as this indicates the performance standard will be maintained within natural variation.

Key Performance Indicator (KPI)

XMR Run Chart

Ranges

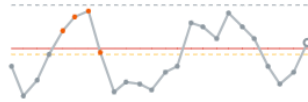
Sickness

FILTER: TOTAL
RP07218
M_00874_Sickness
Updated: 14/07/2026 12:25

M | Jun 26

5.1%

Num: 14.0K
Denom: 275.6K



UCL: 5.6%
Mean: 4.9%
LCL: 4.3%
Targ: 5.0%



Vacancy Rate

FILTER: TOTAL
RP07218
M_00872_Vacancy_Rate
Updated: 13/07/2026 18:42

M | Jun 26

9.2%

Num: 928.1
Denom: 10.1K



UCL: 10.1%
Mean: 9.0%
LCL: 8.0%
Targ: 10.0%



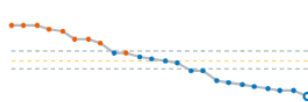
Staff Turnover Rate

FILTER: TOTAL
RP07218
M_00240_Staff_Turnover_Rate
Updated: 13/07/2026 18:53

M | Jun 26

6.0%

Num: 509.3
Denom: 8.5K



UCL: 7.9%
Mean: 7.5%
LCL: 7.1%
Targ: 10.0%



Premature Turnover Rate

FILTER: TOTAL
RP07218
M_00240_Premature_Turnover
Updated: 13/07/2026 18:53

M | Jun 26

12.9%

Num: 98.0
Denom: 761.1



UCL: 14.2%
Mean: 13.3%
LCL: 12.4%
Targ: 25.0%



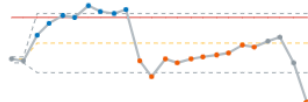
Appraisals Compliance

FILTER: TOTAL
RP07218
M_00127_Appraisals_Completed
Updated: 13/07/2026 18:28

M | Jun 26

69.3%

Num: 5K
Denom: 8K



UCL: 80.5%
Mean: 76.9%
LCL: 73.3%
Targ: 80.0%

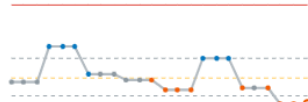


Staff Engagement Score

FILTER: TOTAL
RP07218
M_01146_Staff_Engagement
Updated: 14/07/2026 09:14

M | Jun 26

5.69



UCL: 6.20
Mean: 5.99
LCL: 5.79
Targ: 6.80



Key Performance Indicator (KPI)

XMR Run Chart

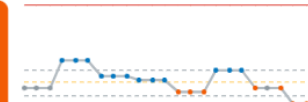
Ranges

Staff Advocacy Score

FILTER: TOTAL
RP07218
M_01146_Staff_Advocacy
Updated: 14/07/2026 09:14

M | Jun 26

5.08



UCL: 5.66
Mean: 5.44
LCL: 5.22
Targ: 6.70



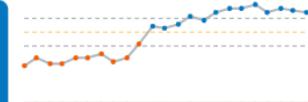
Statutory Training

FILTER: TOTAL
RP07218
M_00411_Statutory_Training_Compliance
Updated: 13/07/2026 17:58

M | Jun 26

93.6%

Num: 73K
Denom: 78K



UCL: 93.6%
Mean: 93.2%
LCL: 92.7%
Targ: 91.0%



Infection Control Training

FILTER: TOTAL
RP07218
M_00411_Infection_Control
Updated: 13/07/2026 17:58

M | Jun 26

96.8%

Num: 9K
Denom: 10K



UCL: 94.7%
Mean: 94.0%
LCL: 93.3%
Targ: 90.0%



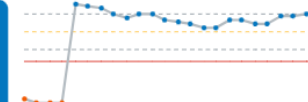
Hand Hygiene Training

FILTER: TOTAL
RP07218
M_01176_Hand_Hygiene
Updated: 13/07/2026 18:45

M | Jun 26

91.8%

Num: 7K
Denom: 7K



UCL: 91.9%
Mean: 89.3%
LCL: 86.8%
Targ: 85.0%



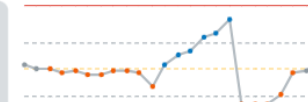
Medical Job Planning Rate

FILTER: TOTAL
RP07218
M_01311_Job_Planning
Updated: 13/07/2026 18:01

M | Jun 26

42.9%

Num: 331
Denom: 771



UCL: 57.3%
Mean: 32.8%
LCL: 8.3%
Targ: 90.0%



Sickness absence has risen to **5.07%** (from 4.69%), with 2,053 episodes affecting 1,921 colleagues. The increase is driven by stress, anxiety and depression, which has climbed from 217 episodes in April to 273 in June, adding an estimated cost pressure of £81.7k in the month of May alone. This coincides with the withdrawal of counselling services, and June data suggests further escalation and additional financial risk. A bid is being prepared for the Charitable Funds Committee to explore reinstating support. The long-term / short-term split (63%/37%) reinforces the psychological strain pattern, with the risk around sickness absence most pronounced in Women's, Children and Young People (6.78%). While gastrointestinal illness (381 episodes) and cough, cold and flu (300) remain the top causes by volume, these are acute and self-limiting. Overall, our current sickness pattern runs counter to usual seasonal trends, with psychological absence persistent and rising. This signals a cultural and wellbeing risk rather than a cyclical one.

Vacancy rate has reduced to **9.16%**, remaining below the threshold and continuing the stabilising trend seen over recent months. There are currently 928 vacancies, with the majority concentrated in Additional Professional, Scientific and Technical roles (564) and Admin & Clerical (233), and a smaller number in Nursing & Midwifery (82). Over half of all vacancies sit at Bands 3-4 (52%), while the Trust is over-established by 25 students and 24 clinical support roles. The roles provide some short-term mitigation but do not offset the underlying gaps in specialist and technical roles. Care group variation persists, with DCB (226), KCRVH (165) and WHH (150) carrying the highest vacancy volumes. The 40 WTE vacancies in SDEC at WHH remain a notable operational pressure point, given the services role in urgent care flow. Overall, the vacancy position is stable, but the concentration in APST and Bands 3-4 continues to signal a structural recruitment challenge, rather than a temporary fluctuation.

Turnover has reduced further to **6.01%**, the lowest rate in the Trust's history, with 509 leavers over the past 12 months. While this continues the long-term stabilising trend, the pattern now warrants closer interpretation. Extremely low turnover can signal latent retention risk as labour markets shift, particularly in roles with highly transferable skills. This is already evident. Leavers remain concentrated in Band 5 roles (132) - colleagues whose clinical skills enable easier movement across organisations, and in Nursing & Midwifery (186) and Admin & Clerical (122). Premature turnover has improved to 12.88% (down from 13.16%), with 98 colleagues leaving within their first year of service. This improvement is welcome, though early-career remains sensitive to onboarding quality, team climate and local leadership visibility. A notable emerging risk is the 37 leavers from Women's Services, which requires close attention in the context of the Amos report and the broader national focus on maternity culture and leadership. Overall, turnover remains historically low, but the underlying distribution (early career roles, Band 5 mobility, concentrated pressure in DCB and Women's Services) suggest the need for continued focus on leadership development, team engagement and local retention interventions to prevent a deteriorating effect as external conditions evolve.

Appraisal compliance has fallen to **69.3%**, the lowest rate in 12 months and reflective of sustained operational pressure. There are 2,326 outstanding and 1,113 due next month, with no care group at threshold. Activity remains concentrated in Nursing & Midwifery (919) and Admin & Clerical (620). Recovery will require targeted local focus, supported by audit activity and hotspots prioritised to re-establish momentum.

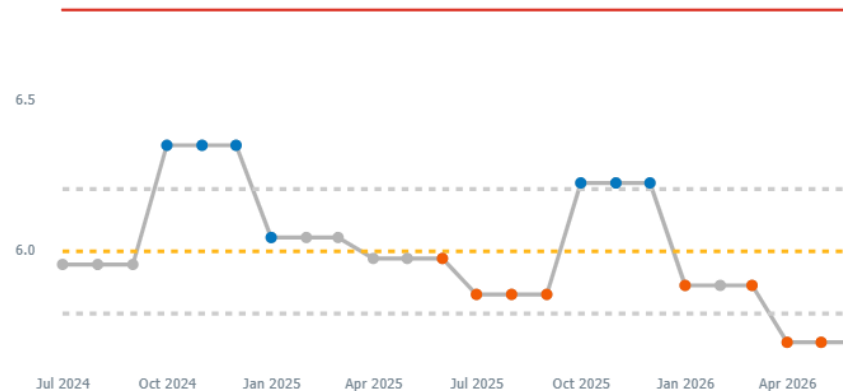
Statutory training compliance remains stable at **93.6%**, with 72,906 completions and 4,978 outstanding. While overall performance is holding, pressure persists against Information Governance and across Theatres and Maternity, which alone, collectively account for almost 600 outstanding completions (QEQM Theatres, 130; WHH Theatres (76); KCH Theatres, 67; maternity services at QEQM, 117; WHH, 109 and midwifery management, 93). These sustained hotspots indicate a systemic challenge, requiring targeted support through audit days and local solutions.

M | Jun 26

5.69

Timescale		Value	Target	Num	Denom
M Jul-25	🟡	5.85	6.80	6	
M Aug-25	🟡	5.85	6.80	6	
M Sep-25	🟡	5.85	6.80	6	
M Oct-25	🟢	6.22	6.80	6	
M Nov-25	🟢	6.22	6.80	6	
M Dec-25	🟢	6.22	6.80	6	
M Jan-26	🟡	5.88	6.80	6	
M Feb-26	🟡	5.88	6.80	6	
M Mar-26	🟡	5.88	6.80	6	
M Apr-26	🟡	5.69	6.80	6	
M May-26	🟡	5.69	6.80	6	
M Jun-26	🟡	5.69	6.80	6	

XMR Run Chart
M_01146_Staff_Engagement



Special cause variation

Special cause of concerning nature or higher pressure due to Higher values.



Consistently failing the target

Will consistently fail the target if nothing changes.



Commentary

For the month beginning 01.06.2026 the latest Staff Engagement Score performance is 5.69 against a static target of 6.80 (higher is better).

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGRESS UPDATE
Staff Engagement levels (5.69) are below the national average (6.71).		Head of Culture & Inclusion	End Sept 26	- Staff engagement remains below the national average, but the Trust continues to make progress against the priorities identified through the 2025 NHS Staff Survey 437 leaders have now completed the leadership programme, with 143 currently on-programme, and further cohorts added to accommodate 79 colleagues currently on the waitlist - The first leadership sprint (In-the-Moment Coaching) has launched, with 43 attendees. Cultural Competence and Compassionate & Inclusive Leadership will follow shortly
Actions/ interventions initiated to improve staff engagement	Activity taking place across People & Culture Strategy delivery plans and local Care Group people plans	Head of Culture & Inclusion	End Sept 26	- Actions to improve staff engagement continue to centre on the strongest known levers; compassionate leadership, team climate and behavioural expectations. - Progress across the leadership curriculum has accelerated, with 205 colleagues completing Leadership Foundations (and 29 on-programme), 182 completing Leading People (with 96 on-programme) and 50 completing Strategic Leadership (with 18 on-programme). This totals 580 learners, ahead of further cohorts planned to action the waitlist - Leadership sprints are now being developed, with the first launched and attended by 43 colleagues. Wider behavioural interventions continue to strengthen culture, including Active Bystander training, which has now reached 629 attendees, alongside ongoing work to develop a new sexual misconduct policy
2026 NHS Staff Survey	Driving response rates across the 2026 NSS is key to improving engagement and the credibility of results	Head of Culture & Inclusion	End Nov 26	Planning for the 2026 NHS Staff Survey is well underway, with activity including; an 11-week fieldwork plan, a refreshed re-brand of the Big Staff Survey Week centred on demonstrating that action has been taken since the 2025 results, and work to align the survey narrative with the Trust's values and behavioural refresh. Incentives have been agreed at TMC to maximise participation.

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGRESS UPDATE
Ensuring vacancy rate remains below the Trust threshold of 10%.	- Monthly monitoring of vacancies across Care Groups, ensuring that active recruitment is taking place. - Focus on hard to recruit areas and supporting new ways of working to reduce reliance on temporary staffing.	Heads of P&C P&CBPs	Ongoing	- HCSW vacancies improving following the B2 to B3 uplift. - Working with Finance, Temporary Staffing and the CMO office to target areas of long-term and high-cost medical agency, and alternative ways of working. - Vacancies in maternity are at 6.6% following the recruitment of student midwives and other positive recruitment.
Keeping Anxiety & Stress related absence to a minimum, and below 15% of all absences.	Support from Health & Wellbeing Team and Occ Health to focus on areas of high stress related sickness. Improved Return To Work interviews to support intervention.	Heads of P&C, P&CBPs, OH	Ongoing	Sickness absence has continued upwards in June. This appears to align with the removal of the face-to-face counselling service, which officially concluded at the end of May, and which was therefore unable to accept new clients throughout the month of May itself.
Maintaining Staff Turnover against a gold standard of 10%	Improving HCSW, Nurse & Premature retention which are the main contributors to overall turnover	Head of Culture & Inclusion	Ongoing	- Staff Turnover remains below 10% (6.0%) and has achieved the gold standard (10%) for over a year. It is currently at the lowest rate the Trust has seen in 2 years. - While the overall trend is encouraging, we remain mindful that the current economic climate may be artificially suppressing movement – and that this will rise in a planned manner due to the launch of MARS.
Update calculation used to denote premature turnover as acutely sensitive to improvements in total turnover	New method of calculation agreed bringing PT in-line with other methods of measure & reducing sensitivity to wider improvements	Head of Culture & Inclusion	Complete	Premature turnover (12.9%) remains stable, improving by 28 points from 13.16% in May. This improvement is welcome, though early-career remains sensitive to onboarding quality, team climate and local leadership visibility
Staff Engagement levels (5.88) are below the national average (6.78)	- Priorities identified through NSS have been acted on, with a wide variety of actions initiated. - Focus on improving engagement and response rate for 2025 staff survey.	Head of Culture & Inclusion	Dec 26	Staff survey results indicate that staff engagement and experience have continued to deteriorate, following a downward trend over the past five years. Our corporate activity is underway, focusing on leadership development and team engagement/ effectiveness.
Medical staff levels of statutory training compliance are consistently low at an average of 75%. Has been below 80% for 4 years.	- Identifying those staff who are not compliant, and working with GMs and Clinical Leads to address compliance. - Care Groups contacting individuals directly to support improvement of compliance, particularly with trainee doctors.	CMO	Dec 25	Compliance for medical staff has plateaued at/ around 88.9% - though it is within touching distance of the required threshold for the first time in years. All Care Groups are targeting improvement within medical staff compliance – with compliance lowest in the Corporate Care Group (79.5%).

Sustainability

Key Performance Indicator (KPI) Assurances

M



KPI's Statistically Improving

KPI's Indicating Concern



Consistently failing the target

Will consistently fail the target if nothing changes.



Inconsistent performance

Will not consistently pass or fail the target if nothing changes.



Consistently passing the target

Will consistently pass the target if nothing changes.



No set target

No set target.

Failing Metrics SPC Range

Deficit In Month Group (£)

Common Cause Metrics SPC Range

Efficiencies Green Schemes (£M)	
Premium Pay	
WTE worked (All Pay Spend)	
WTE worked (Premium Pay)	
Efficiencies YTD Variance (£M)	
Total Pay Spend In Month	
Variance to Plan (£)	

Passing Metrics SPC Range

Metrics SPC Range

Understanding the Data

The columns indicate the level of assurance that performance will deliver the expected standard (target) . In order to achieve a "P" the target must be performing better than its respective confidence interval, as this indicates the performance standard will be maintained within natural variation.

Key Performance Indicator (KPI)

XMR Run Chart

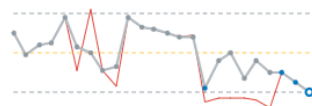
Ranges

Deficit In Month Group (£)

FILTER: TOTAL
RP07218
M_00136_IE_Deficit_GROUP
Updated: 14/07/2026 15:23

M | Jun 26

2.8M



UCL: 10M
Mean: 6M
LCL: 3M
Targ: 3M

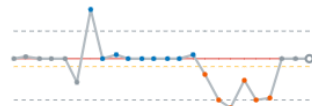


Variance to Plan (£)

FILTER: TOTAL
RP07218
M_00136_IE_Month_GROUP
Updated: 14/07/2026 15:23

M | Jun 26

8K



UCL: 2.24M
Mean: -0.65M
LCL: -3.54M
Targ: 0.00M

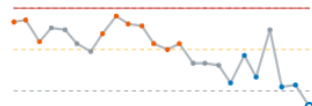


Premium Pay

FILTER: TOTAL
RP07218
M_00136_Premium_Pay
Updated: 14/07/2026 15:23

M | Jun 26

5.4M



UCL: 9.36M
Mean: 7.72M
LCL: 6.08M
Targ: 9.36M

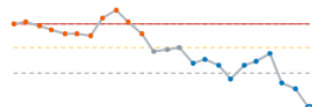


WTE worked (Premium Pay)

FILTER: TOTAL
RP07218
M_00136_WTE_PP
Updated: 14/07/2026 15:23

M | Jun 26

510



UCL: ,1029
Mean: ,882
LCL: ,734
Targ: ,1029



Total Pay Spend in Month

FILTER: TOTAL
RP07218
M_00136_Total_pay
Updated: 14/07/2026 15:23

M | Jun 26

56M



UCL: 62M
Mean: 55M
LCL: 48M
Targ: 62M

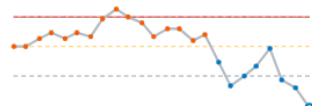


WTE worked (All Pay Spend)

FILTER: TOTAL
RP07218
M_00136_WTE_ALL
Updated: 14/07/2026 15:23

M | Jun 26

9,589



UCL: 10.3K
Mean: 10.0K
LCL: 9.8K
Targ: 10.3K



Key Performance Indicator (KPI)

XMR Run Chart

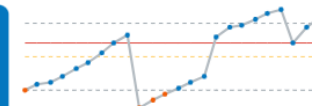
Ranges

Efficiencies Green Schemes (£M)

FILTER: TOTAL
RP07218
M_00143_CIP_GrSch
Updated: 14/07/2026 10:22

M | Jun 26

56



UCL: 52
Mean: 32
LCL: 12
Targ: 40

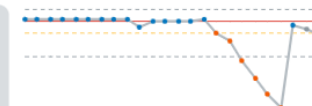


Efficiencies YTD Variance (£M)

FILTER: TOTAL
RP07218
M_00143_YTD
Updated: 14/07/2026 10:22

M | Jun 26

-3.3



UCL: 2.3
Mean: -2.9
LCL: -8.2
Targ: 0.0



The month 3 position for the Group was £0.1m surplus; £8k favourable to plan. This includes £2.9m of Deficit Support Funding (DSF), Excluding DSF, the position is £2.8m deficit.

YTD the position for the Group is £2.5m deficit; £23k favourable to plan. This includes £8.7m of DSF. Excluding DSF, the position is £11.3m deficit.

YTD the Trust is £3.1m deficit; £398k favourable to plan.

The Trust's income from patient care is £3.2m higher than plan YTD. This is predominantly driven by an increase in block income agreed with NHSE, £0.8m, alongside £0.9m of prior year income. Other areas of overperformance include variable NHSE activity (Chemo/Cardiac MRI), £0.4m, Overseas visitors income £0.2m and Targeted Lung Health screening £0.4m

Trust other operating income is £0.2m favourable to plan YTD. This largely relates to a rebate received following a dispute with a contractor.

Trust employee expenses are £3.3m adverse to plan YTD, due to unachieved CIP, this relates to substantive staffing, temporary staffing costs are in line with plan.

Other expenses are £0.2m favourable to plan YTD, with underspends in drugs, clinical negligence, premises costs, establishment and transport offset by overspends on clinical and non clinical supplies and services and management consultancy.

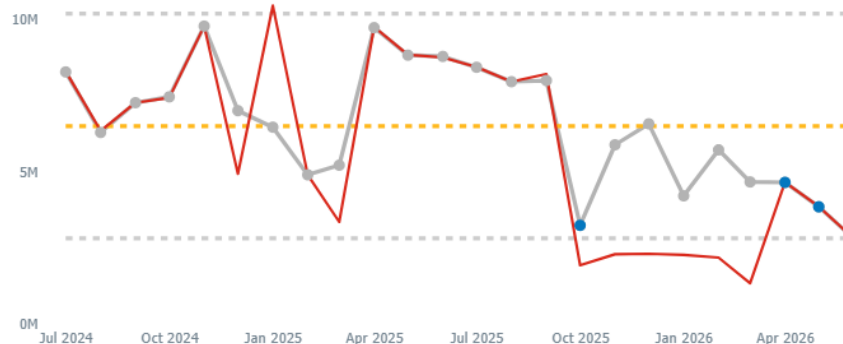
CIP achievement YTD is £13.0m, £3.3m below the plan of £16.3m. This has been mitigated by technical adjustments.

M | Jun 26

2.8M

Timescale		Value	Target	Num	Denom
M Jul-25	☹️	8.4M	8.4M	8.42M	
M Aug-25	☹️	7.9M	8.0M	7.95M	
M Sep-25	☹️	8.0M	8.2M	7.99M	
M Oct-25	🔄	3.2M	1.9M	3.23M	
M Nov-25	☹️	5.9M	2.3M	5.88M	
M Dec-25	☹️	6.6M	2.3M	6.56M	
M Jan-26	☹️	4.2M	2.3M	4.20M	
M Feb-26	☹️	5.7M	2.2M	5.71M	
M Mar-26	☹️	4.7M	1.3M	4.66M	
M Apr-26	🔄	4.6M	4.6M	4.64M	
M May-26	🔄	3.8M	3.8M	3.84M	
M Jun-26	🔄	2.8M	2.8M	2.79M	

XMR Run Chart
M_00136_IE_Deficit_GROUP



Special cause variation

Special cause of improving nature or lower pressure due to Higher values.



Consistently failing the target

Will consistently fail the target if nothing changes.



Commentary

For the month beginning 01.06.2026 the latest Deficit In Month Group (£) performance is 2.8M against a Trajectory target of 2.8M (lower is better).

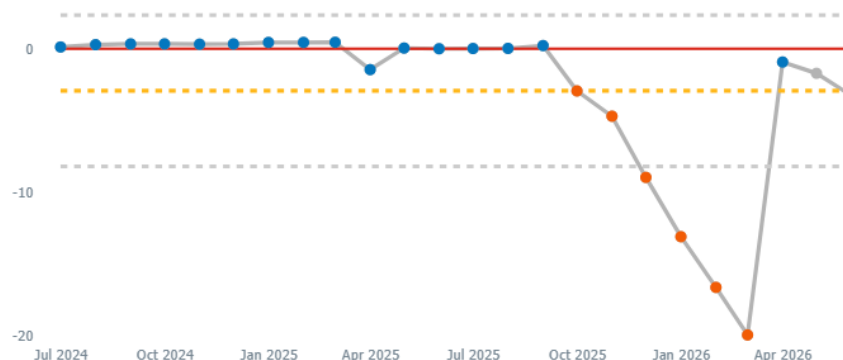
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGRESS UPDATE
Achievement of the financial plan for 26/27	- Development and delivery of CIP schemes to deliver the required £76m savings plan. - Target of £90m savings programme set for the organisation in order to ensure delivery of the required £76m.	- Theme leads - PMO	On-going	- As at Month 3, the Group's financial position (excluding DSF) year-to-date is in line with plan. - Weekly meetings led by the System Delivery Director are held with Care Groups and Executive leads, focusing on delivery of CIPs to reduce our run-rate expenditure. - An interim Turnaround Director and a Strategic Delivery Partner have been appointed to support the Trust in achieving the required CIP. - Further Grip and Control measure are being implemented across the Trust.

M | Jun 26

-3.3

Timescale		Value	Target	Num	Denom
M Jul-25	😊	0.0	0.0		
M Aug-25	😊	0.0	0.0		
M Sep-25	😊	0.2	0.0		
M Oct-25	😬	-2.9	0.0	-3	
M Nov-25	😬	-4.7	0.0	-5	
M Dec-25	😬	-9.0	0.0	-9	
M Jan-26	😬	-13.1	0.0	-13	
M Feb-26	😬	-16.7	0.0	-17	
M Mar-26	😬	-20.0	0.0	-20	
M Apr-26	😊	-0.9	0.0	-1	
M May-26	😬	-1.7	0.0	-2	
M Jun-26	😬	-3.3	0.0	-3	

XMR Run Chart
M_00143_YTD



Common cause variation

Common cause - no significant change.



Inconsistent performance

Will not consistently pass or fail the target if nothing changes.



Commentary

For the month beginning 01.06.2026 the latest Efficiencies YTD Variance (£M) performance is -3.3 against a static target of 0.0 (higher is better).

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGRESS UPDATE
Ensure identification of CIP opportunities sufficient to reach the required £75.9m target.	- Trust ambition to identify £90m opportunity to ensure delivery to target - Strategic Delivery Partner appointed and contracted to deliver in-year £40m CIP.	Care Group and Business Owner leads Financial Sustainability Director	On-going	- Weekly Finance meetings Chaired by System Delivery Director is supporting identification of CIP to targets across the Trust, as well as in-month delivery - External strategic delivery partner in place from May providing additional resourcing for targeted focus - Turnaround Director in post from April for 3 months providing additional support for key areas including forecasting of spend. - Senior CIP Managers and PMO are supporting key areas in development of CIP documentation requirements - As at month 3, the Trust has identified £82.8m of efficiencies against the annual target of £75.9m. YTD CIP delivery is £13.0m, which is £3.3m below the plan of £16.3m. This shortfall has been mitigated through technical adjustments, and work is ongoing to accelerate the delivery of CIP schemes currently phased to commence later in the year.
Ensuring robust CIP reporting of achievement	- Robust planning in place for delivery of schemes - Escalation in place to Executive Sponsors on deviances to plan	Financial Sustainability Director	On-going	- Weekly meetings take place with the ICB on the CIP report, with 'check and challenge' on the position (the report of which is shared at FRB as part of the ICB CIP position). - Internal governance includes weekly Care Group CIP meetings, fortnightly Executive Sponsor Progress forums, and the twice weekly Financial Recovery Board. - Use of Programme Management software to track milestones is being put in place which will increase visibility and support ownership of updates. - Alignment with ICB Finance Improvement Directors' recommendations for CIP reporting reviewed and is also being put in place which will include greater detail on forecast and risk range, as well as planning for 27/28.

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGRESS UPDATE
The Temporary Workforce team are finding it challenging to swap out high pay premium medical workers and/or negotiate alternative terms, such as becoming Direct Engagement (DE). Many of the high cost agency have been working with the Trust long term and embedded in the organisation.	- The Temporary Workforce/MTW team are meeting with each Care Group following the change to the agency managed service in December 2025. Working with the CMO, Managing Directors and Medical Directors to highlight the issues and gain support to reduce premium pay workers. - Need to increase DE workers, making the savings on VAT payments.	CPO	Ongoing	- Agency spend continues to reduce across medical staffing, with no agency usage recorded in AfC in June 2026. We have now had no agency usage within AfC for the last 12 weeks. - Joint sessions held with the MTW team and NHSP, CG MDs, Temp Workforce and PMO to review medical agency and bank usage, agree exit plans and recruitment plans. Meetings now scheduled to be held bi-weekly. The number of active agency locums decreased in June 2026, down to 35 (40 in May 2026). All agency locums to be reviewed with exit plans to be agreed. - Bi-Weekly meetings are now scheduled with all Care Groups. The MTW team and currently undertaking a review of current rates paid against the rate and commission caps and discuss plans to reduce these to improve our compliance. - Our DE throughput increased in June 2026 to 95%. Plans are now in place to remove/replace the long-term standard placement locums, with one long term locum switching to Direct Engagement. The number of locums engaged via Non-DE in June 2026 remained the same, we continue to have two standard placement locums. - Four long term agency locums completed their migration to the bank in June 2026. - Bank and Agency trackers tools shared with CG's; to be monitored weekly and monthly via PMO and CG finance meetings. - New EK Turnaround Director is implementing an improvement approach on variable pay with teams, which commenced on May 18th. This aligns with Simon Worthington advice to Trusts on measures to rapidly affect run rate
Agency management across the South East NHS Region means disparity across Kent and Medway Trusts for AfC rates.	- Sign up to the Kent and Medway Collaborative AFC Rate Card - Areas above cap to work with Temp Staffing & South East Temp Staffing Collaborative team to reduce inline with stepping down timescales.	CPO	Ongoing	- Agency Hours (all staff groups) continued to see a decrease in June 2026, down 13% when compared to May 2026. Overall medical agency hours also continue to reduce in line with exit plans (down 681 hours compared to May 2025). - A new AfC rate card (agency) was implemented on the 1st April 2025. All agency usage has now been removed (AfC). - The South East Temporary Staffing Programme has published their next step down rates for both agencies and bank. These have now been approved and were implemented in October 2025. - Working with the ICB, a number of new controls/processes have been implemented to support controlling overall demand and reduce our reliance on agencies. This will also support the Trust in achieving our objectives in relation to the workforce CIP schemes. We are now looking to implement similar controls for the bank. A new vacancy control feature is also due to be implemented for all medical bank requests. - Weekly meeting with the Care Groups and NHSP and MTW following the alignment of all AfC bank rates across Kent & Medway. This has now been agreed and was implemented on the 26th May which provided a saving of £300k in June 2026.

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGRESS UPDATE
Agency management across the South East NHS Region means disparity across Kent and Medway Trusts for Medical rates.	- Sign up to the Kent and Medway Collaborative Medical Rate Card - Areas above cap to work with the Temp Staffing team & South East Temp Staffing Collaborative team to reduce inline with stepping down timescales. - Regular meetings now held across the collaborative to current issues as we worked towards rate parity across the region.	CPO	•Ongoing	- Temp Staffing, PMO & South East Collaboration; monthly meetings scheduled, to progress and implement actions against CIPs. - To date, we have successfully reduced the hourly rates of 41 long-term agency locums. As a result of tighter controls, a number of agency locums are now considering migrating to the bank or joining the Trust substantively. Agreed exit plans discussed and in place for the majority of the remaining agency locums. Regular meetings are continuing, now being led by the MTW team following their implementation in December 2025. - A regional meeting was held with the South East Collaborative to review the current bank position with the intention of aligning our rate cards (medical). A new regional rate card has now been agreed and is due to be implemented from the 5th August 2026 across all acute Trusts in Kent & Medway. - Additional controls were introduced in March 26 in relation to escalated medical bank rates and a new cap implemented. This has seen escalated rates reduce significantly, this continues to be monitored on a weekly basis and will look to be removed once the new medical rate card is agreed.

Maternity

Key Performance Indicator (KPI) Assurances

M



KPI's Statistically Improving

KPI's Indicating Concern



Consistently failing the target
Will consistently fail the target if nothing changes.

Failing Metrics

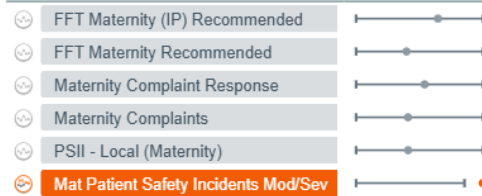
SPC Range



Inconsistent performance
Will not consistently pass or fail the target if nothing changes.

Common Cause Metrics

SPC Range



Consistently passing the target
Will consistently pass the target if nothing changes.

Passing Metrics

SPC Range



No set target

Metrics

SPC Range

Understanding the Data

The columns indicate the level of assurance that performance will deliver the expected standard (target) . In order to achieve a "P" the target must be performing better than its respective confidence interval, as this indicates the performance standard will be maintained within natural variation.

Maternity: Scorecard View

Maternity Metrics

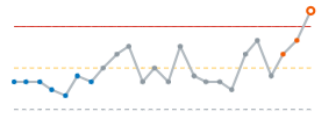
Key Performance Indicator (KPI)

XMR Run Chart

Ranges

Mat Patient Safety Incidents Mod/Sev
FILTER: TOTAL
RP07218
M_00168_Actual_Harm_Mat_Pat
Updated: 15/09/2026 15:05

M | May 26
12



UCL: 10
Mean: 4
LCL: -2
Targ: 10

PSII - Local (Maternity)
FILTER: TOTAL
RP07218
M_01540_PSII_Internal_Maternity
Updated: 12/09/2026 11:14

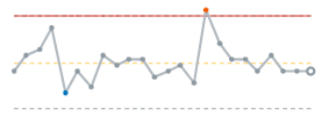
M | May 26
0



UCL: 2
Mean: 0
LCL: -1
Targ: 0

Maternity Complaints
FILTER: TOTAL
RP07218
M_01255_Maternity
Updated: 12/09/2026 08:34

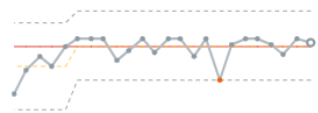
M | May 26
5



UCL: 15
Mean: 7
LCL: -2
Targ: 15

Maternity Complaint Response
FILTER: TOTAL
RP07218
M_01255_Comp_30_45_days_Mat
Updated: 12/09/2026 08:34

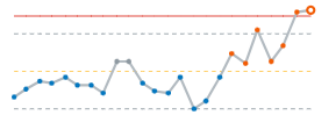
M | May 26
91.7%
Num: 11
Denom: 12



UCL: 147.5%
Mean: 86.6%
LCL: 25.7%
Targ: 85.0%

Extended Perinatal Mortality
FILTER: TOTAL
RP07218
M_01206_Perinatal_Death_Rate
Updated: 12/09/2026 10:48

M | May 26
5.53
Num: 32
Denom: 6K



UCL: 5.03
Mean: 4.20
LCL: 3.37
Targ: 5.44

FFT Maternity Response Rate
FILTER: TOTAL
RP07218
M_01110_FFT_MAT_response
Updated: 12/09/2026 05:04

M | May 26
34.3%
Num: 163
Denom: 475



UCL: 57.6%
Mean: 36.7%
LCL: 15.9%
Targ: 15.0%

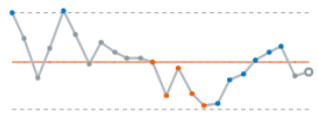
Key Performance Indicator (KPI)

XMR Run Chart

Ranges

FFT Maternity Recommended
FILTER: TOTAL
RP07218
M_01110_FFT_Extract_MAT_Rt
Updated: 12/09/2026 05:04

M | May 26
88.9%
Num: 352
Denom: 396



UCL: 95.7%
Mean: 90.0%
LCL: 84.4%
Targ: 90.0%

FFT Maternity (IP) Recommended
FILTER: TOTAL
RP07218
M_01110_Rt_Mat_IP
Updated: 12/09/2026 05:04

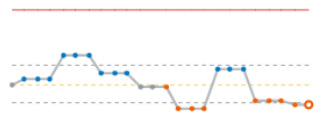
M | May 26
95.3%
Num: 204
Denom: 214



UCL: 101.2%
Mean: 92.9%
LCL: 84.6%
Targ: 90.0%

WH Engagement Score
FILTER: TOTAL
RP07218
M_01148_Mat_Engagement
Updated: 12/09/2026 09:38

M | May 26
5.84



UCL: 6.28
Mean: 6.07
LCL: 5.86
Targ: 6.90

Maternity: Executive Summary

Maternity Mortality Measures

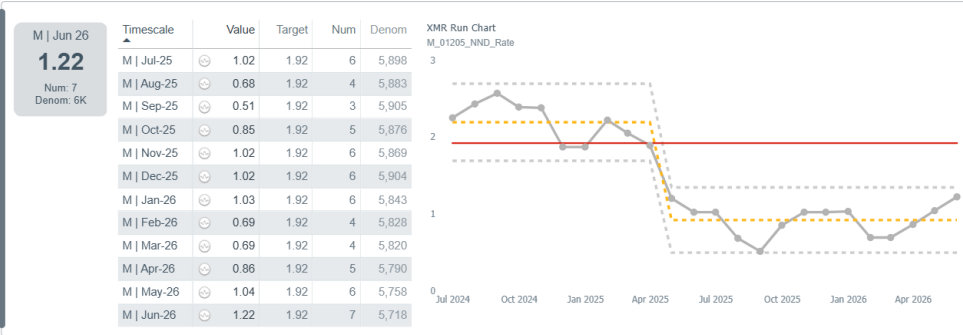
The extended perinatal rate is significantly above the normal range at 5.75 per 1,000 births, and above the threshold of 5.42 (set at the average of our comparable Trusts). This rate includes both stillbirths and neonatal deaths.

In June, the neonatal death 12 month rate remained below the MBRRACE threshold of 1.92 for the 14th consecutive month, at 1.22. The service reported one term neonatal death in month, and a total of 7 in the past 12 months.

The stillbirth rate is above the threshold of 3.50, at 4.53 in June. The service reported 1 preterm stillbirth in month and a total of 26 in the past 12 months. The term stillbirth rate is 2.47 per 1,000, and has also significantly increased with 13 term stillbirths in the past 12 months. A similar increase in the total stillbirth rate is observed at both WHH (4.06 per 1,000) and QEQM (4.49)

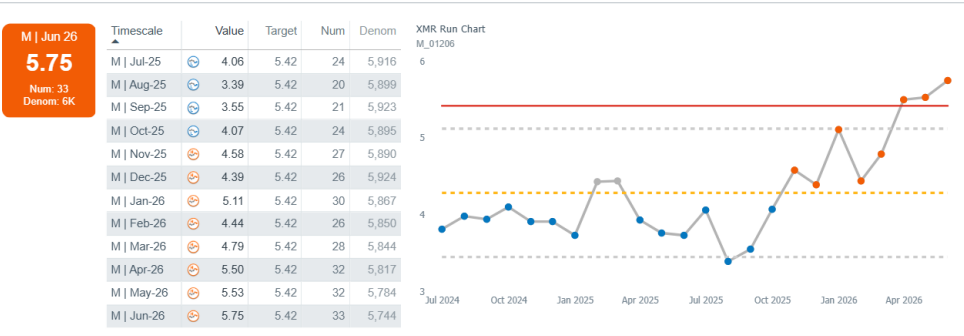
MBRRACE NND Rate 12m

FILTER: TOTAL | RP05230 | M_01205_NND_Rate | Updated: 14/07/2026 10:26



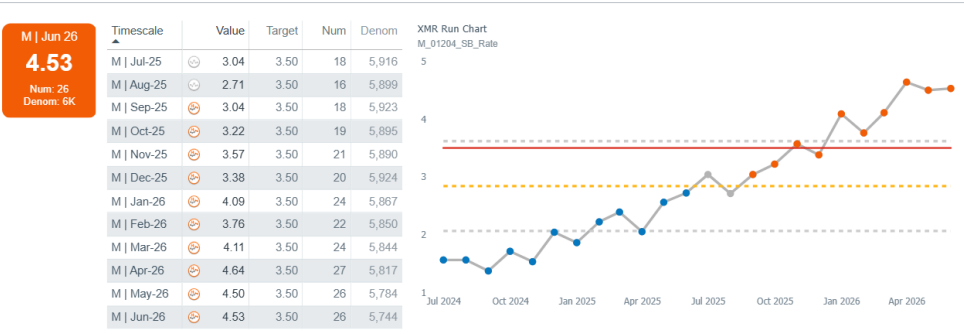
MBRRACE Ext Perinatal Rate 12m

FILTER: TOTAL | RP05230 | M_01206 | Updated: 14/07/2026 10:55



MBRRACE Stillbirth 12m Rate

FILTER: TOTAL | RP05230 | M_01204_SB_Rate | Updated: 14/07/2026 09:15



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

Maternity: Executive Summary

Maternity Investigations

Open MNSI investigations in progress June 2026	Progress
Intrapartum intrauterine death MI-050962	Investigation in progress, draft report received
Intrapartum uterine death MI-056707	Investigation in progress, awaiting draft report
Neonatal Therapeutic cooling –HIE MI-055169	Investigation in progress
Therapeutic cooling – Neonatal death MI-055934	Investigation in progress
Neonatal Therapeutic cooling –HIE MI-056606	Investigation in progress
Intrapartum uterine death MI-056908	Investigation in progress
Therapeutic cooling –HIE – Neonatal death MI - 057809	Investigation in progress
Intrapartum uterine death	Investigation in progress
MNSI new referrals June 2026	
Neonatal death MI – 061415	Referred to MNSI 16 th June 2026

Maternity: Executive Summary

Maternity Investigations

Current open local PSSI's	Progress
Term IUD WEB320567	Investigation in progress
Management of pre-term labour and maternal DVT WEB312352	Investigation approaching completion,
Surgical site infection (MRSA) WEB325532	Investigation in progress

5 moderate /severe patient safety incidents were reported in June, a significant increase compared to normal. The incidents were under the following categories:

- 1 delay in providing treatment
- 1 failure to administer adequate thromboprophylaxis
- 1 inappropriate treatment
- 1 neonatal collapse
- 1 UKOSS recognised complication of pregnancy

Maternity: Maternity Care

Patient Experience, Incident Reporting & Complaints

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGRESS UPDATE
Overdue Incidents	- Email and communication with individual overdue incident and action owners with ongoing monitoring of expected completion date - Daily targets set for completion of overdue incident reports - Daily communication of progress with incident management.	Head of Governance		The number of maternity overdue incidents at the end of June was 115 – an increase of 42 compared to last month: Timely incident management has been negatively impacted by redeployment clinical handlers away from administration duties into clinical practice to support the delivery of safe care. To reduce the number of overdue Datix incident reports a range of monitoring and escalation measures have been implemented. Weekly monitoring of performance in relation to incident management occurs on a weekly basis to identify outstanding reports and ensure timely follow up with the responsible handlers. Daily communication is maintained with responsible investigators to support, monitor progress, address any barriers to completion and reinforce reporting timescales. Where incidents remain overdue there is escalation to the triumvirate for oversight and action.
Complaints		Head of Governance		- Total of 10 maternity complaints received in June - Complaint response rate was 100% in June for Obstetrics against a threshold of 85%.
MOSS signal	MOSS Critical Safety check completed	Perinatal Leadership Team		One level 1 MOSS signal received in month in response to the sad case of a neonatal death at the WHH site.

26/56.2

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: Month 2 (M2) Finance Report
Meeting date: 28 July 2026
Board sponsor: Angela van der Lem, Chief Finance Officer (CFO)
Paper Author: Julie Wells, Deputy Chief Finance Officer – Performance (DCFO)

Appendices:

Month 2: Finance Report - Summarised

Executive summary:

Action required:	Information			
Purpose of the Report:	The report is to update the Board of Directors on the financial performance for May 2026 (Month 2).			
Summary of key issues:	The Month 2 Year-to-Date (YTD) position achieved by the <u>Group</u> (Pre-Deficit Support Funding (DSF)) was a deficit of £8.5m, £15k favourable to plan, as illustrated below.			
	£000	YTD Plan	YTD Actual	YTD Variance
	Patient care income	£164,979	£166,802	£1,823
	Other income	£10,794	£10,846	£52
	Employee Expenses	(£119,594)	(£122,338)	(£2,744)
	Other operating expenses	(£63,212)	(£62,277)	£935
	Non-operating expenses	(£1,456)	(£1,611)	(£155)
	Operating Surplus / (Deficit)	(£8,489)	(£8,578)	(£140)
	Technical Adjustments	(£7)	£97	£104
	TECHNICALLY ADJUSTED SURPLUS / (DEFICIT) EXCL DEFICIT SUPPORT	(£8,496)	(£8,481)	£15
	The <u>Trust's</u> Month 2 YTD position was a deficit of £9.0m, £115k favourable to plan, as illustrated below.			
	£000	YTD Plan	YTD Actual	YTD Variance
	Patient care income	161,900	163,401	1,501
	Other income	10,814	11,001	187
	Employee Expenses	(110,161)	(112,560)	(2,399)
	Other operating expenses	(70,239)	(69,373)	866
	Non-operating expenses	(1,462)	(1,605)	(143)
	Operating Surplus / (Deficit)	(£9,148)	(£9,136)	£12
	Technical Adjustments	(£7)	£96	£103
	TECHNICALLY ADJUSTED SURPLUS / (DEFICIT) EXCL DEFICIT SUPPORT	(£9,155)	(£9,040)	£115



26/56.2

	The Trust's income from patient care is £1.5m higher than plan YTD. This is predominantly driven by a £0.5m increase in block income agreed with NHS England (NHSE), alongside £0.7m of rechargeable high cost drugs and devices additional income (offset by additional costs). Trust other operating income is £0.2m favourable to plan YTD. This largely relates to a rebate received following a dispute with a contractor. Trust employee expenses are £2.4m adverse to plan YTD, due to unachieved Cost Improvement Programme (CIP). Substantive staffing is £2.2m adverse, and temporary staffing costs are £0.2m adverse (agency staff underspends offset bank staff overspends). Other operating expenses are £0.9m favourable to plan YTD, with reductions in drugs, clinical negligence premises costs, non-clinical supplies and transport offset by overspends on clinical supplies and management consultancy. Non-pay CIP is over-performing to plan YTD. CIP achievement YTD is £8.2m, £1.7m below the plan of £9.9m. This has been mitigated by technical adjustments and income overperformance. 2gether Support Solutions (2gether) reported a YTD surplus of £0.6m, which is £0.01m below plan. This variance is primarily attributable to Trust consumables, utilities, and capital pass-through costs being below the flat-phased budget profile, with expenditure expected to align later in the year. Spencer Private Hospitals (SPH) reported a £0.01m deficit, representing a £0.03m adverse variance against plan. Income is marginally higher than expected, and is offset by higher staff and other operating expenses.
Key recommendations:	The Board of Directors is asked to review and NOTE the financial performance of Month 2.

Implications:

Links to Strategic Theme:	Sustainability
Link to the Significant Risk Register (SRR):	SRR 3664: Failure to deliver the Trust financial plan for 2026/27.
Resource:	N - Key financial decisions and actions may be taken on the basis of this report.
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: Finance and Performance Committee 30 June 2026



Finance Performance Report 2026/27

May 2026

Chief Finance Officer
Angela van der Lem



Group Executive Summary

	Trust						Group						Annual Plan
	In Month			Year to Date			In Month			Year to Date			
(£'000)	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	
Income from Patient Care Activities	80,950	81,842	892	161,900	163,401	1,501	82,490	83,671	1,181	164,979	166,802	1,823	989,872
Other Operating Income	5,407	5,320	(87)	10,814	11,001	187	5,397	5,185	(212)	10,794	10,846	52	64,765
Employee Expenses	(54,765)	(56,267)	(1,501)	(110,161)	(112,560)	(2,399)	(59,482)	(61,207)	(1,725)	(119,594)	(122,338)	(2,744)	(704,547)
Other Operating Expenses	(35,053)	(34,246)	807	(70,239)	(69,373)	866	(31,521)	(30,729)	792	(63,212)	(62,277)	935	(383,219)
Non Operating Expenses	(713)	(804)	(91)	(1,462)	(1,605)	(143)	(728)	(804)	(76)	(1,456)	(1,611)	(155)	(8,752)
Profit / (Loss)	(4,174)	(4,154)	20	(9,148)	(9,136)	12	(3,844)	(3,884)	(40)	(8,489)	(8,578)	(89)	(41,881)
Less Technical Adjustments	(3)	42	45	(7)	96	103	(3)	43	46	(7)	97	104	6,885
Technically Adjusted Profit / (Loss)	(4,177)	(4,112)	65	(9,155)	(9,040)	115	(3,847)	(3,841)	6	(8,496)	(8,481)	15	(34,996)
Non Recurrent Deficit Support Revenue Allocation	2,916	2,916	0	5,833	5,833	0	2,916	2,916	0	5,833	5,833	0	34,996
Adjusted Profit / (Loss)	(1,261)	(1,196)	65	(3,322)	(3,207)	115	(931)	(925)	6	(2,663)	(2,648)	15	0

Key Messages:

The 2026/27 financial plan, as submitted to NHS England in March 2026, achieves a breakeven position, with £35m of non-recurrent Deficit Support Funding (DSF) included and delivery of a £75.9m Cost Improvement Programme (CIP).

Since the DSF allocation is non-recurrent, the finance report will focus on the financial performance prior to the DSF, with DSF shown below the line to maintain emphasis on the recurrent position.

Excluding the impact of DSF, the Group has reported a year-to-date deficit position of £8.5m which is £0.02m favourable to plan.

Group:

Income from Patient Care Activities - Group Clinical Income is £1.8m favourable to plan year to date. The variance is primarily driven by an increase in block income agreed with NHSE Specialist Commissioning, alongside higher rechargeable high cost drugs and devices income (offset by additional costs). The Specialist Commissioning final contract value is a £3.3m income benefit for the year.

Other Operating Income - Other operating income is in line with plan year to date, at a Group level.

Employee Expenses - Pay is £2.7m adverse to plan year to date. This position is predominantly attributable to under-delivery of CIP. Further detail is provided later in the report.

Other Operating Expenses - Non pay is £0.9m favourable to plan. Reductions in expenditure on drugs, clinical negligence premises costs, non clinical supplies and transport are partially offset by overspends on clinical supplies and management consultancy. Non pay CIP is over performing to plan year to date.

Group Cost Improvement Summary

£'000	Month 1			Month 2			YTD		
Cash Releasing Efficiency Savings	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Recurrent									
Pay - Recurrent	1,003	1,240	237	1,615	1,389	(226)	2,618	2,629	11
Non-pay - Recurrent	995	1,543	548	1,163	1,847	684	2,158	3,390	1,232
Income - Recurrent	53	60	7	53	43	(10)	106	103	(3)
Total recurrent efficiencies	2,051	2,843	792	2,831	3,279	448	4,882	6,122	1,240
Non recurrent									
Pay - Non-recurrent	1,750	118	(1,632)	1,750	248	(1,502)	3,500	365	(3,135)
Non-pay - Non-recurrent	778	691	(87)	778	1,011	233	1,556	1,702	146
Income - Non-recurrent	0	0	0	0	36	36	0	36	36
Total non-recurrent efficiencies	2,528	808	(1,720)	2,528	1,295	(1,233)	5,056	2,103	(2,953)
Total Efficiencies	4,579	3,651	(928)	5,359	4,574	(785)	9,938	8,225	(1,713)
Pay	2,753	1,357	(1,396)	3,365	1,637	(1,728)	6,118	2,994	(3,124)
Non pay	1,773	2,234	461	1,941	2,858	917	3,714	5,091	1,377
Income	53	60	7	53	79	26	106	139	33
Total Efficiencies	4,579	3,651	(928)	5,359	4,574	(785)	9,938	8,225	(1,713)

Key Messages:

The CIP plan for 2026/27 is £75.9m. The Trust has identified £77.0m of efficiencies against the CIP target, however this is dependent on delivery of plans not yet fully developed.

YTD CIP delivery is £8.2m against a CIP target of £9.9m; £1.7m adverse to plan year to date.

In-month CIP delivery was £1.6m on Pay schemes, £2.8m on Non-Pay schemes and £0.1m in Income.

YTD delivery is £3.0m Pay (£3.1m adverse to Pay CIP Target), £5.1m Non Pay (£1.4m favourable to Non Pay CIP Target) and £0.1m Income (in line with Income CIP Target).

In-year Recurrent delivery is 74% year to date.

Identified schemes by Care Group and 'Pillar' is outlined below. Central schemes will be devolved out to Care Groups as these trust wide schemes are further developed.

£'000	2Gether	CCASS	Central	Corporate	DCB	KCRVH	QEQM	SPH	Strategic Development	WCYP	WHH	Grand Total
1.Service Transformation in specific high opportunity specialties			4,695	250	424	1,343	150					6,862
2.Service optimisation		423			1,227	178	6,127			2,944	1,286	12,185
3.Clinical workforce optimisation		3,692		97	890	976	1,519			1,285	6,284	14,743
4.Productivity		648		530	2,225	1,153	530				1,915	7,000
5.Standardising, Centralising and Digitising	6,292	2,690	1,304	1,782	5,075	1,257	184		1,977	210	967	21,738
6.Enhanced Grip and Control		2,374	1,500	126	686	2,770	1,259		0	2,650	1,810	13,176
7.Capital enabled reductions in revenue expenditure					65	0			348		0	413
8.Commercial opportunities				331	402	0		186				919
Grand Total	6,292	9,826	7,499	3,117	10,995	7,676	9,769	186	2,325	7,090	12,262	77,037

Group Statement of Financial Position

(£'000)	Trust				Group				
	Mar-26	Apr-26	May-26	Movement In Month	Mar-26	Apr-26	May-26	YTD Plan	Variance to Plan
Non Current Assets	399,179	400,977	400,497	(480)	329,554	332,110	331,757	342,008	(10,251)
Inventories	5,106	4,678	5,139	461	12,635	12,333	12,794	14,000	(1,206)
Trade Receivables	39,971	39,652	41,192	1,540	44,020	41,343	43,691	52,709	(9,018)
Accrued Income and Other Receivables	(3,879)	(3,896)	(3,889)	7	(4,176)	(4,213)	(4,206)	(3,946)	(260)
Assets Held For Sale	0	0	0	0	0	0	0	0	0
Cash and Cash Equivalents	46,307	24,345	22,459	(1,886)	78,991	58,249	54,848	27,323	27,525
Current Assets	87,505	64,779	64,901	122	131,470	107,712	107,127	90,086	17,041
Payables and Accruals	98,664	75,229	76,378	1,149	116,798	91,821	92,008	97,001	(4,993)
Deferred Income and Other Liabilities	6,066	11,534	11,370	(164)	6,063	11,532	11,312	5,074	6,238
Provisions	4,825	4,787	4,932	145	4,825	4,787	4,932	4,368	564
Borrowing	4,722	4,757	4,748	(9)	3,341	3,532	3,572	2,465	1,107
Current Liabilities	114,277	96,307	97,428	1,121	131,027	111,672	111,824	108,908	2,916
Provisions	3,282	3,283	3,283	0	3,282	3,283	3,283	3,632	(349)
Borrowing	64,337	63,441	63,196	(245)	7,142	6,228	6,106	3,883	2,223
Non Current Liabilities	67,619	66,724	66,479	(245)	10,424	9,511	9,389	7,515	1,874
Net Assets	304,788	302,725	301,491	(1,234)	319,573	318,639	317,671	315,671	2,000
Public Dividend Capital	702,845	702,845	702,845	0	702,845	702,845	702,845	684,359	18,486
Retained Earnings	(452,977)	(455,038)	(456,279)	(1,241)	(441,009)	(441,936)	(442,904)	(432,948)	(9,956)
Revaluation Reserve	54,918	54,918	54,918	0	57,730	57,730	57,730	64,260	(6,530)
Taxpayers Equity	304,786	302,725	301,484	(1,241)	319,566	318,639	317,671	315,671	2,000

Key Messages:

The Group SoFP shows Net Relevant Assets of £317.7m.

Cash is at a higher level than plan, largely due to :
 1) Slippage in the Capital programme.
 2) Higher than planned balance of deferred income; which includes DSF received for quarter 1 in May.
 3) Higher than planned net liability of Working capital.

It is anticipated that these are timing issues and SoFP performance will re-align to plan throughout 2026/27.

Group :

Non Current Assets - The reported values reflect in year additions less depreciation and amortisation charges. Current Year performance is currently behind plan due to slippage in the 26/27 Capital programme.

Current Assets (Excl Cash) - these balances include Inventories and Receivables owed to the Trust. Current Year performance is £10.7m away from plan driven mainly by a lower than anticipated value of debtors.

Cash - The position is £27.5m ahead of plan, this is driven by the variances in both the Capital Programme and Working Capital performance.

Current Liabilities (excluding borrowings) - This includes Trade Creditors £5m lower than planned and a £6.2m divergence in deferred income compared to plan.

Borrowings - All Group entities now report on an IFRS16 basis (this accounting standard covers Leased Assets). The divergence to 26/27 plan is a consequence of a higher Right of Use Asset Balance than that included in the plan, due to additional Leases being added to the Group portfolio post completion of the plan submission.

Public Dividend Capital - No PDC has been drawn down in the current year; the variance to plan is due to Revenue Support PDC received in 2025/26 that was not included within the 2026/27 plan.

Group Capital Programme

(£'000)	Annual Plan	Forecast	Plan YTD	M02 YTD	Variance
PEIC (Critical Estates Priorities)	4,000	4,000	350	98	252
MDG (Medical Devices Replacement)	3,000	3,000	0	71	(71)
ERP (Equipment Replacement Programme)	3,000	3,000	246	71	175
IDG (IT Hardware and Systems Replacement)	4,910	4,910	200	123	77
Fire Compartmentation Strategy	4,340	4,340	200	297	(97)
Subsidiaries	600	600	0	0	0
Hyper Acute Stroke Unit (HASU)	5,955	5,955	40	22	18
Cardiac Catheter Lab and CADU	2,925	2,925	250	286	(36)
Pharmacy Automation Replacement at KCH	368	368	175	0	175
Robotic Assisted Surgery (WHH & QEQM)	0	0	0	64	(64)
Thanet CDC	3,846	3,846	0	35	(35)
Maternity (CQC) Urgent Works	768	768	15	24	(9)
GB Energy NHS Solar	397	397	264	8	256
Maternity Estates - QEQM Critical Investment - 2026/27 (Year 3)	7,850	7,850	190	11	179
Same Day Emergency Care (SDEC) Expansion Programme (QEQM & WHH)	17,578	17,578	4,403	4,383	20
2026/27 Constitutional Standards - Diagnostics	11,222	11,222	0	0	0
2026/27 Constitutional Standards - UEC	9,540	9,540	275	0	275
2026/27 Constitutional Standards - Community	875	875	0	0	0
Donated Assets	525	525	10	10	(0)
Right of Use Assets (RoUA) - IFRS16 Leases	162	162	0	155	(155)
Clinical and Estates Improvement Strategy	3,000	3,000	0	21	(21)
Other Smaller Schemes and VAT credits	300	300	55	36	19
Current Assets	85,161	85,161	6,673	5,717	956

Funding	Annual Plan	Forecast
Operational Capital	38,645	38,645
Donations	525	525
PDC	45,991	45,991
Total Funding	85,161	85,161

Funding Under/(Over) utilisation	0	0

Key Messages:

Whilst the current YTD spend is £1m below plan it is expected the capital plan will be delivered in full by the end of the financial year.

The Group's gross capital YTD spend to the end of Month 2 was £5.7m against a YTD Plan of £6.7m. Despite the £1m underspend the forecast remains at full delivery of the Annual Plan.

The 2026/27 Capital Plan submitted to NHSE in March 2026 was £85.2m, compliant with the available funding envelope. Three Constitutional Standards capital bids were included within the Trust's capital plan, these had been notionally endorsed by the K&M ICB. These comprised of:

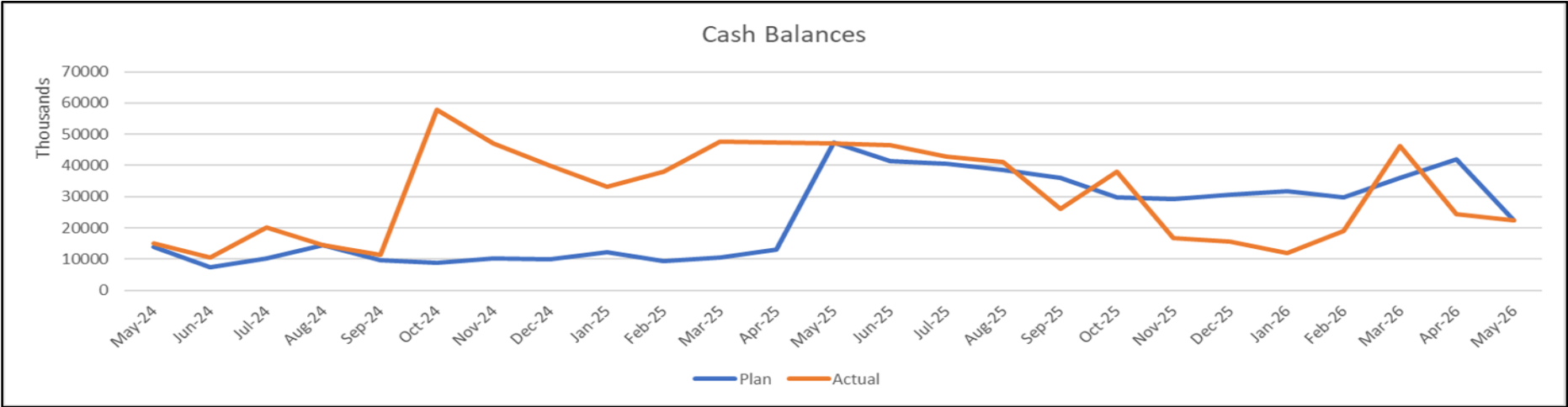
- £11.2m for bids under the Constitutional Standards Programme - Diagnostics;
- £12.5m for bids under the Constitutional Standards Programme - UEC;
- £0.9m for bids under the Constitutional Standards Programme - Community;

The outcome of the Constitutional Standards bids is expected to be confirmed imminently and an update will be provided in next month's report.

Although not included in the Capital Plan (as instructed by the National Team), further bids for £6.4m were made against the 2026/27 Estates Safety Fund (ESF). These have now been notionally approved by the National Team in late May 2026. Acceptance of this ESF capital funding was approved by the Trust Board in June 2026 and the associated MOU's are expected to be issued shortly. The ESF schemes are expected to be included in the 2026/27 Capital Programme as of M3.

Trust Cash Balances

- The closing unconsolidated cash balance at the end of May 2026 was £22.5m, £9.5m above plan.
- Significant YTD variances relate to the following items; Receipts for DSF £2.9m above plan (Full Q1 payment received in May compared to receipts forecast monthly), Kent & Medway ICB / NHS England receipts £4.0m above plan.
- Bank interest YTD stands at £0.3m. National Loan Fund interest rates are regularly reviewed but are not currently considered worthwhile, as the Trust does not have sufficient cash to invest a significant amount over a longer period. For example, based on rates as at 11 June, a £1m investment over 7 days would generate only £15 in additional return.



- The Trust's 2026/27 forecast closing Cash position is £19.6m.
- The Trust forecast includes Deficit Support Funding (DSF), £35.0m for the year and full delivery of cash releasing efficiencies.

Key Messages:
Trust cash has decreased from the 2026/27 opening position as prior year capital charges have been cleared. Cash is monitored closely, with forecasts reviewed and updated on a daily basis.

BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)

Committee: Finance and Performance Committee (FPC)
Meeting date: 9 June 2026
Chair: Richard Oirschot, Non-Executive Director (NED)
Quorate: Yes
Appendices: None

Declarations of interest made: The Committee considered an interest relating to the Chief Operating Officer's (COO's) nomination to the Spencer Private Hospitals (SPH) Board. Members discussed the distinction between acting as a Trust representative and holding a formal directorship, recognising the importance of clarifying responsibilities and legal duties associated with the role.

Assurances received at the Committee meeting:

Agenda item	Summary
Significant Risk Register (SRR)	The Committee received and NOTED the updated SRR which contained 39 risks, including 14 linked directly to finance and performance. One new risk relating to radiopharmaceutical failure had been escalated onto the register, whilst a quality and financial risk relating to middle grade rota gaps had been de-escalated following evidence of improved controls.
Cash paper update	The Committee RECEIVED assurance that the Trust's cash position remained strong. Deficit Support Funding (DSF) had also been received during Month 2. No further revenue support is currently anticipated in Quarter 1, with creditors continuing to be paid within 30 days. The Committee was advised that no new cash related risks had been identified, with the existing cash risk remaining low due to the strength of current balances, although potential risks to DSF arrangements will require ongoing monitoring.
Capital Investment Group (CIG) Assurance Report	The Committee received and NOTED CIG Assurance Report.
Group Tax Strategy	The Committee reviewed and APPROVED the updated Group Tax Strategy, noting there had been no significant changes beyond minor legislative updates. Members were assured that the strategy remained compliant with statutory requirements applicable to Trust subsidiaries.
We Care Integrated Performance Report (IPR): National Constitutional Standards for Emergency Access,	The Committee received and NOTED the IPR, reviewing current performance against national constitutional standards across urgent and emergency care (UEC), referral to treatment, cancer and diagnostics. The most significant operational risk relates to RTT performance. Mitigating actions are underway, including recruitment and additional diagnostic capacity.



Referral to Treatment (RTT), Cancer and Diagnostics	
Elimination of Corridor Care	The Committee received a comprehensive update on efforts to eliminate corridor care across the Trust, and NOTED continued progress in reducing corridor care and length of stay (LoS), supported by enhanced oversight of patients with no criteria to reside (NCTR).
Fire works update	The Committee RECEIVED a detailed update on fire safety compliance following recent inspections across Trust sites by Kent Fire and Rescue Service. The Committee received assurance that compliance improvement plans were being actively developed, additional fire safety expertise has been recruited, and further inspections are planned. Fire safety was recognised as a critical organisational risk requiring ongoing Executive oversight, with continued focus on compliance, governance and securing capital funding for the remaining fire safety programme.
Annual Accounts	The Committee NOTED that the external audit of the Annual Accounts was substantially complete, with no significant issues identified, and only disclosure related amendments proposed. The Committee also noted that the Value for Money assessment was expected to result in an adverse conclusion due to the Trust's ongoing financial challenges.
Chief Finance Officer (CFO) Policies	The revised Treasury Policy was reviewed and APPROVED , with members satisfied that it remains appropriate despite current limitations on investing funds.
Month 1 Finance Report	The Committee received the Month 1 Finance Report and NOTED its content. The Committee reviewed the Year to Date (YTD) financial position and discussed delivery of the Cost Improvement Programme (CIP) in detail, noting a stretch CIP target had been set internally to create additional resilience against delivery risks and offset the costs of delivery. The current pace of delivery was discussed, as well as further opportunities to improve productivity, strengthen control of staffing expenditure and pursue more fundamental service transformation. The Committee also recognised the growing tension between financial recovery and operational performance, particularly where performance improvement initiatives generated additional costs. The Committee emphasised the importance of developing medium term plans alongside immediate recovery actions and agreed that planning for future years should begin earlier to support delivery of major service changes and transformation programmes.

Workforce Planning (CIP)	The Committee RECEIVED the Workforce Planning update and noted the positive progress made in developing a comprehensive workforce savings programme. While a significant number of workforce reductions and efficiencies have been identified, the Committee noted that a substantial gap remains to achieve the overall workforce and financial targets. Further actions across workforce reductions, digital transformation and temporary staffing usage and rate efficiencies would be required before full delivery confidence could be achieved.
Turnaround Director Update	The Committee RECEIVED an update from the Turnaround Director regarding work undertaken during the first eight weeks of engagement. Members were advised that the review had identified four primary areas of focus: prospective planning, workforce affordability, productivity improvement and Care Group financial recovery. Discussion centred on increasing transparency regarding high cost staffing arrangements and ensuring greater compliance with existing workforce policies. The Committee also considered the impact of workforce management on operational performance, including appointment cancellations, rostering compliance and consultant availability.
Business cases: over £1.75m Requiring Investment £2.5m for Self-Funding. Capital Business Cases Over £1m	The Committee received and NOTED the Business Case Scrutiny Group (BCSG) Assurance Report. The following business cases and contract awards were reviewed. Thanet Community Diagnostic Centre (CDC) – MRI Build Contract Award Report – The report was presented primarily for noting, following previous out of committee APPROVAL. Emergency Department (ED) Consultant Establishment Business Case – The Committee considered the ED Consultant Establishment Business Case and noted that it was supported by robust analysis demonstrating the staffing levels required to deliver a safe and sustainable service. Members discussed the proposal in the context of wider efforts to improve control of high cost medical staffing and reduce reliance on temporary workforce arrangements. The operational pressures within the ED, were recognised, with members acknowledging that the current staffing model is not sustainable in the longer term. The Committee APPROVED the business case for presentation to the Board for final approval. Reconfiguration of Acute Stroke Services – Capital Costs - The Committee considered the Acute Stroke Services Reconfiguration Capital Business Case relating to the William Harvey Hospital (WHH), following receipt of updated contractor costs, which increased the capital requirement and exceeded the approved tolerance threshold. The increase had been subject to extensive scrutiny, challenge and a formal value for money assessment, with cost pressures largely attributed to market inflation, rising construction and engineering costs, workforce



	pressures and wider supply chain factors. The Committee noted that the scheme had already been reduced to the minimum clinically viable scope and that further reductions were limited. Given the urgency of the decision, the risk of further cost escalation if approval was delayed, and confirmation that the additional funding had been incorporated into the capital programme, members supported the proposal in principle. Members AGREED THAT APPROVAL SHOULD BE GRANTED SUBJECT TO the provision of additional detail on the cost increases to provide further assurance.
Virtual Ward Review and Mental Health Update	Item deferred to the next meeting on the 30 June 2026.
Northumbria/2gether Support Solutions (2gether) Value for Money Peer Review Lessons Update	Item deferred to the next meeting on the 30 June 2026.
Feedback to Board of Directors	There was no specific feedback to the Trust Board from this meeting.
Referrals to Other Board Committees	The Committee noted no referrals to other Board Committees.

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

Item	Purpose	Date
The FPC asks the BoD to receive and NOTE this assurance report.	Assurance	To Board on 28 July 2026



BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)

Committee: Finance and Performance Committee (FPC)

Meeting date: 30 June 2026

Chair: Richard Oirschot, Non-Executive Director (NED)

Quorate: Yes

Appendices: None

No Declarations of interest were made

Assurances received at the Committee meeting:

Agenda item	Summary
Month 2 Finance Report	The Committee received the Month 2 Finance Report and NOTED the Trust achieved its planned deficit position. However, significant concern remains regarding continued overspends in pay costs despite reductions in temporary staffing. The forecast year end risk was discussed. The Committee received LIMITED ASSURANCE due to the absence of sustainable reductions in the pay run rate and the requirement for further Executive led mitigation plans to ensure delivery of the financial plan. The Committee reviewed the Cost Improvement Programme (CIP) delivery and noted that £8.2m had been delivered against a planned £9.9m by Month 2. Whilst opportunities totalling c.£79.6m have been identified, only a proportion have progressed through full approval and implementation. Assurance was received that £76m of risk adjusted CIP will be fully developed by the end of July, and that enhanced programme management and external support are in place. The Committee received LIMITED ASSURANCE as delivery remains dependent on schemes that are still under development. The Committee recognised the need for a structured 'Plan B' to address the forecast financial gap and agreed that clear ownership and accountability are essential. The Committee received LIMITED ASSURANCE pending the presentation of a comprehensive mitigation programme with accountable leads and measurable outcomes.
Cash paper update	The Committee REVIEWED the cash position and was assured that cash remains stable, with creditors continuing to be paid within agreed timescales. Members noted, however, the ongoing risk that Deficit Support Funding (DSF) could be clawed back should the Trust fail to deliver its financial plan.



	The Committee received MODERATE ASSURANCE as current cash management remains stable, although future financial underperformance may place this position at risk.
Northumbria/2gether Support Solutions (2gether) Value for Money Peer Review Lessons Update	The Committee welcomed the findings of the peer review undertaken by 2gether and Northumbria, which identified a number of potential opportunities to support financial and operational improvement. Members received assurance that the review had not identified any significant missed opportunities and provided useful external challenge and benchmarking. The Committee received MODERATE ASSURANCE acknowledging that while a range of opportunities has been identified, the delivery and realisation of associated benefits remain at an early stage.
PA Consulting	The Committee RECEIVED an update from PA Consulting, noting the identification of opportunities, primarily within theatres and outpatients, with further benefits expected through service reviews. The Committee welcomed the focus on sustainable transformation and productivity. The Committee received MODERATE ASSURANCE with evidence of positive progress, while acknowledging that delivery and long term sustainability remain to be demonstrated.
Turnaround Director Update	The Committee RECEIVED a report from the Turnaround Director on workforce productivity, roster management and temporary staffing controls. Significant work is underway to improve prospective workforce planning, reduce dependency on high cost staffing arrangements and strengthen accountability within Care Groups. However, concerns remain regarding the pace of delivery and the achievement of workforce efficiencies. The Committee received LIMITED ASSURANCE until measurable improvements in pay expenditure and workforce productivity are evidenced.
Financial Sustainability Plan (FSP) Update	The Committee reviewed Version 4 of the FSP and noted that it incorporates current national planning assumptions, financial recovery requirements and the Trust's strategic priorities. Members acknowledged the significant challenge of delivering recurring savings over future years while managing estate, workforce and operational pressures, and highlighted key external risks including the ageing estate, capital constraints and the inefficiencies associated with the Trust's multi-site configuration. The Committee received MODERATE ASSURANCE, noting that while the plan provides a credible framework for financial recovery, delivery risks remain.
Productivity	The Committee APPROVED the establishment of a dedicated Productivity Improvement Board to strengthen oversight of the Trust's productivity agenda and provide assurance through operational and financial governance routes. Members recognised that achieving the Trust's productivity target of 3.7% will be critical to the delivery of both financial and operational plans.



Capital Plan	The Committee REVIEWED the capital programme and noted that capital expenditure remains behind plan, due to delays in national funding approvals. The Estate Safety Fund allocation has now been confirmed, increasing the Capital Plan to approximately £91.6m. The Committee discussed the need to balance essential infrastructure investment with transformation projects that generate productivity and financial benefits. The Committee received MODERATE ASSURANCE recognising that the programme remains deliverable, subject to timely funding decisions and effective prioritisation of resources.
Board Assurance Framework (BAF)	The Committee REVIEWED the draft BAF and welcomed the progress made in its development. Members agreed that the principal risks broadly reflect the Trust's strategic risk profile. The Committee received LIMITED ASSURANCE pending completion and validation of the revised framework.
Significant Risk Register (SRR)	The Committee received and NOTED the updated SRR. The Committee reviewed 14 significant risks and noted that three risks contain overdue actions which are being actively managed. The Committee received MODERATE ASSURANCE and was satisfied that the register provides appropriate oversight of key risks, but highlighted the need to strengthen action management and assurance reporting.
Cyber Security Risk	The Committee expressed concern regarding the level of assurance available in relation to cyber security. The Committee requested a dedicated deep dive review.
Virtual Ward Review and Mental Health Update	The Committee RECEIVED a verbal update on the Integrated Care Board (ICBs) intention to reduce virtual ward funding and transfer elements of the service into community settings. Whilst the strategic direction is understood, members recognised operational and financial risks associated with implementation, particularly in relation to specialist services such as Cardiology. The Committee received LIMITED ASSURANCE pending confirmation of commissioning intentions and delivery arrangements.
Fire works Update	The Committee RECEIVED an update on fire safety following the completion of a primary fire risk assessment of the Royal Victoria Hospital (RVH). Significant estate related risks remain, however, assurance was provided that risk assessments are being progressed and capital investment is being prioritised. The Committee received MODERATE ASSURANCE, with continued monitoring required given the scale of estate related risk.

Capital Investment Group (CIG) Assurance Report	The Committee received and NOTED CIG Assurance Report.
We Care Integrated Performance Report (IPR): National Constitutional Standards for Emergency Access, Referral to Treatment (RTT), Cancer and Diagnostics	The Committee received the IPR and NOTED that while some planned activity targets were being achieved, significant operational challenges remain across key performance indicators. RTT performance remained under pressure, with a material risk of financial penalties if activity targets are not achieved. Members emphasised the importance of understanding the balance between investing productivity gains into improved performance versus releasing cash savings. The Committee reviewed diagnostic performance and acknowledged that national funding requests have been submitted to support additional diagnostic capacity and equipment replacement.
Elimination of Corridor Care	The Committee DISCUSSED ongoing corridor care pressures, noting that sustained demand across Urgent and Emergency Care (UEC) continues to create operational risks and reliance on escalation spaces. While measures to improve patient flow, including Same Day Emergency Care (SDEC) and enhanced discharge processes, are in place, progress remains constrained by limited community capacity and delays in patient discharge. Members recognised that corridor care reflects wider system pressures rather than solely Trust operational issues and requested continued monitoring of mitigation actions, discharge performance and system wide flow improvements.
Business cases: over £1.75m Requiring Investment £2.5m for Self-Funding. Capital Business Cases Over £1m	The Committee noted that there were NO BUSINESS CASES PRESENTED FOR APPROVAL DURING THIS MEETING. The Committee discussed the need for future business cases to clearly demonstrate their contribution to financial recovery, productivity improvement and long term sustainability. Members emphasised that proposals should include measurable benefits, expected financial returns, implementation timescales, accountable leads and robust post-implementation monitoring, while clearly identifying whether benefits will be realised through cash-releasing savings, performance improvements or both.
Feedback to Board of Directors	There was no specific feedback to the Trust Board from this meeting.
Referrals to Other Board Committees	The Committee noted no referrals to other Board Committees.

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

Item	Purpose	Date
The FPC asks the BoD to receive and NOTE this assurance report.	Assurance	To Board on 28 July 2026



BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)

Committee: Charitable Funds Committee (CFC)

Meeting date: 2 June 2026

Chair: Richard Oirschot, Non-Executive Director (NED)

Paper Author: Executive Assistant

Quorate: Yes

Appendices: None

Declarations of interest made: None

Assurances received at the Committee meeting:

Agenda item	Summary
Fundraising Update	The Committee received ADEQUATE ASSURANCE from the Fundraising update noting that the Easter fundraising had exceeded expectations, with increased donations and repeat supporters contributing directly to wards. The Committee NOTED the following: • New, highly visible Charity signage had been installed across entrances to raise awareness of the Charity. • However, many external charities currently have a stronger presence than the Trust's own Charity on sites. • Investigations into whether these were paid for was underway.
Cancer Appeal Update	The Committee received and NOTED that the Cancer Appeal officially commenced on 1 May 2026 and was still in early stages. The team was currently awaiting the outcome of a capital funding bid to the NHS for Cathedral Day Unit. The outcome was critical, as it would shape the appeal's direction. If full funding was granted, the appeal may need to change or reduce, however, if partial or no funding was received, the appeal would continue and may be adapted. The Committee NOTED that the appeal was not limited to the Cathedral Day Unit, it also included other chemotherapy units and related improvements. Early donations were coming in, including a recent donation which showed encouraging momentum.
Charity Finances	The Committee received ADEQUATE ASSURANCE that the investment portfolio performance had been positive over the last two months. The Committee NOTED the following key points: • Virtual approval to move from a full audit to an independent examination.



	- The draft accounts would be ready by 1 September 2026 and reviewed through the governance route via Integrated Audit and Governance Committee (IAGC) and Board with final sign off by early December. - The accounts would be submitted to the Charity Commission by 31 January 2027.

Actions taken by the Committee within its Terms of Reference: None

Items to come back to the Committee outside its routine business cycle: None

Items referred to the BoD or another Committee for approval, decision or action: None

Item	Purpose	Date
CFC asks the BoD to discuss and receive ASSURANCE from the CFC Chair Assurance Report.	Assurance	28 July 2026



REPORT TO BOARD OF DIRECTORS (BoD)

Report title: Significant Risk Register (SRR) Report

Meeting date: 28 July 2026

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

Paper Author: Head of Quality Assurance, Compliance and Risk for Associate Director of Quality Governance (on behalf of Director of Quality Governance)

Appendices:

Executive summary:

Action required:	Assurance
Purpose of the Report:	This paper presents the current Significant Risk Report to ensure Board oversight of those risks rated as high and above (15>). All have an assigned Executive Director and are required to be updated monthly and reported through Trust Management Committee (TMC) and the appropriate Board Sub Committees to Board. This paper demonstrates movement in month, details those risks that have been de-escalated from the Significant Risk Register due to the mitigations in place and new risks.
Summary of key issues:	The majority of the risks contained in the significant risk report have had a 'review' within the last four weeks. As of 15 July 2026, when the Significant Risk Register was extracted there were 43 risks on the Significant Risk Register. There are three risks with associated overdue actions. These have been escalated with risk owners and delegates via the Risk Review Group and Accountable Executives informed. There have been four new risks approved since the last report and one escalated. There have been no risks de-escalated and one risk closed. Full details are within Section 4. Monthly meetings are in place with the executive leads for each significant risk (and their deputy/wider team as requested) to ensure regular monthly oversight and scrutiny. This month's report contains a forecast (where known) of when the risk is likely to be de-escalated due to mitigations. The remaining risks are under review and progress monitored with additional scrutiny of static risks via the Risk Review Group.



	The last Risk Review Group meeting was held on 26 June 2026. A deep dive was received from William Harvey Hospital (WHH) Care Group. There were no escalations from the meeting but Care Group and Corporate leads were asked to ensure that all risks are up to date – with significant risks reviewed at a minimum monthly as there has been a deteriorating in the position. Care Groups were also asked to ensure they are reviewing the monthly emerging risk report via their Care Group governance meetings.
Key recommendations:	The Board of Directors is asked to receive and NOTE the Significant Risk Report for assurance purposes and for visibility of key risks facing the organisation.

Implications:

Links to 'We Care' Strategic Objectives:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Board Assurance Framework (BAF):	This paper provides an update on the significant risks to the Trust which align with the risks on the BAF.
Link to the Corporate Risk Register (CRR):	This paper provides an update on the significant risks (to be known as the 'significant risk report') to the Trust which replaces the CRR.
Resource:	Yes. Additional resource will be required to mitigate some of the significant risks identified. The new Head of Quality Assurance, Compliance and Risk, an internal appointment, commenced in post on 1 June 2026 with a remit that covers CQC and regulatory compliance and risk – supported by the Compliance and Assurance Managers.
Legal and regulatory:	Yes. The Trust is required to comply with the requirements of a number of legal and regulatory bodies including but not limited to: • NHS England • Care Quality Commission • Health and Safety Executive
Subsidiary:	2gether Support Solutions (2gether) Spencer Private Hospitals (SPH)

Assurance route:

This was previously considered by:

A report was received by Trust Management Committee (TMC) on Wednesday 1 July 2026.

Reporting is also received monthly at the Finance and Performance Committee (FPC), and bi-monthly at Quality and Safety Committee (QSC) and People and Culture Committee (PCC).

It should be noted that as the Risk Register is a live document the supporting information was extracted on 15 July 2026.



SIGNIFICANT RISK REPORT

1. Purpose of the report

- 1.1 This report is provided to ensure the Board are aware of all risks rated high (15) and above on the Trust risk register.
- 1.2 This paper presents movement in month and details those risks that have been de-escalated from the Significant Risk Register due to the mitigations in place.
- 1.3 The last Risk Review Group (RRG) took place on 26 June 2026. A deep dive presentation was provided by William Harvey Hospital Care Group.

2. Background

- 2.1 A comprehensive review and refresh of the Corporate, Care Group and Specialty level risk registers was launched in November 23. This followed an initial review and recommendations made by an External Consultant on behalf of the Trust in October 23. Phase 1 of this work was concluded at the end of March 2024. Phase 2 will involve embedding the processes and governance improvements introduced and continuing to develop the risk culture in the organisation.
- 2.2 One of the outputs of the Trust Risk Review was the creation of a Significant Risk Report. The latest is summarised in Section 3 of this report.
- 2.3 The Risk Review Group was established in early February 24. The Group, which meets monthly and is chaired by the CNMO. Deep dives are presented by all Corporate and Clinical Care Groups twice a year.
- 2.4 The annual 'Risk Maturity Self-Assessment' was agreed at RRG on 17 March 2026. This will inform the refresh of the Risk Strategy (2023-2025) and risk management processes in 2026/27 to further develop and embed a positive risk culture.
- 2.5 A Board Development Workshop to agree the Risk Appetite took place on 02 July 2026. The plan will then be for the Risk Appetite to be formally agreed at closed/public Board on 28 July 26. The draft Risk Strategy (26-28), with the inclusion of the risk appetite statements, will then go to Trust Management Committee on 5 August and final Board sign off on 3 September 2026.

3. Current Significant Risk Register

- 3.1 There are currently 43 risks in total on the Significant Risk Report. This is an increase of four risks since the last Board report.
- 3.2 There has been four new risks approved since the last report and one risk escalated. There have been no risks de-escalated and one risk closed. This is a sign of a positive risk culture and one where risks are being reviewed and mitigated reflected by movement on the risk register.



3.3 There are overdue actions associated with three of the risks (marked in the bold on the supporting table). These have been escalated for immediate attention with the Risk Owners and Delegates and Accountable Executives informed.

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
678	Care Group - Diagnostics, Cancer and Buckland Accountable Executive: Chief Medical Officer (CMO) Forecast: Risk to be reviewed after External Review (October 2026) with consideration of whether the risk is accepted and should be closed.	Insufficient Pharmacy support for the safe (and secure) use of medicines on wards	High (15)		Low (4)	Request purchase of Sunrise medicines app for use by pharmacy staff with aim of improving processes on the system which have been impacted when switching to EPMA e.g. ordering and screening (Home function is required to improve MR process) Meeting has been held with sunrise to review two different models. The app to help pharmacy but also the option of using the home function. This will be developed into a SBC. The use of the app will increase clinical capacity to some extent. Person Responsible: Erden Batkhisig To be implemented by: 31 July 2026 Propose a new model of working to support review of most at risk patients. Proposal to include impact on other patients for Care Quality Commission (CQC) and Trust to review Person Responsible: Erden Batkhisig



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
						Due: 31 July 2026 (update – new model of working has been trialled. To remain open but links to action plan below) Generate & Complete an action plan linked to the recommendations generated from the weekend review by Alice Lo. Weekend action plan written and shared with wider team for awareness - working through actions; expected completion July 2026. Person Responsible: Emma Dodridge To be implemented by: 31 July 2026 Review Clinical Capacity following trial of cut off to identify whether dispensary rosters need altering and whether additional wards could be covered with a clinical service Person Responsible: Emma Dodridge To be implemented by: 31 August 2026 Use external review of pharmacy service to review risk 678 and add actions if relevant or close etc depending on outcome. (review scope



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
						in draft and timeline not confirmed yet) Person Responsible: Rebecca Morgan To be implemented by: 30 Oct 2026 Development of business case for Intensive Therapy Unit (ITU) speciality and Critical Care, Anaesthetics and Specialist Surgery Care Group (CCAS CG) to address gap between service & Guidelines for the Provision of Intensive Care Services (GPIC) GPIC standards Person Responsible: Rebecca Tarrant To be implemented by: 01 Dec 2026 Following action closures and external review-request Trust to record that they accept this risk in service and allow closure. Discussion with CMO and board to be arranged. Dependent on all other actions being closed. Person Responsible: Rebecca Morgan To be implemented by: 31 Mar 2027



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
679	Care Group – Diagnostics, Cancer and Buckland Accountable Executive: CMO Forecast: Risk score to be reviewed following completion of remedial works (for July Risk Review Group)	Failure to supply, from Pharmacy, scheduled chemotherapy treatments to patients	Extreme (20)		Moderate (10)	Appoint a Locum to strengthen QMS activity during staff shortages (action update - no candidates proposed yet via the Temp staffing team. All shifts uploaded onto patchwork and approvals gained). Person Responsible: Jenny Clements To be implemented by: 31 August 2026 Appoint a technical services lead (action update – Following most recent inspection the feedback is for the need for a GMP specialist - this is in essence the Tech services lead role. Director of Pharmacy (DoP) to resubmit to Vacancy Control Board (VCB) for the role to be filled by Pharmacist/Technician or AQP. Paper completed and needs to be approved by a decision making meeting given the advice/guidance on accountable pharmacists that the Trust is unable to recruit). Person Responsible: Will Willson To be implemented by: 31 August 2026



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
1350	Care Group – Diagnostics, Cancer and Buckland Accountable Executive: CMO	Failure to provide ward stock medicines in a timely fashion due to obsolescence of Pharmacy TWS Distribution robot	High (15)	↔	Low (6)	1. Final drawing and location of dispensary terminals to be confirmed with architect and 2gether project team. 2. Enabling works to be started on old IT room so temperature validation can commence. 3. Asbestos survey to be completed. 4. Pharmacy to secure date for robot install with BD Person Responsible: Emily Hunnisett To be implemented by: 31 July 2026
1679	Corporate People and Culture Accountable Executive: Chief People Officer (CPO) Forecast: Not expected to be de-escalated in short term. For review alongside Delivery Plan implementation. Links to	There is a risk of failure to address poor organisational culture	High (15)	↔	Low (4)	The People and Culture Strategy has been drafted and will be approved in conjunction with the Trust Strategy. The due date has been amended to reflect this. In the meantime, the Delivery Plan is progressing with regular update to Trust Management Committee. (Action update - Heads of People and Culture reviewed strategy 09/06/26 to identify priority areas and any changes needed to overarching strategy based on BAF).



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
	BAF FPC002.					Person Responsible: Norman Blissett Due: 31 July 2026
1814	Corporate – Strategic Development & Capital Planning Accountable Executive: Chief Strategy & Partnerships Officer (CSPO) Forecast: Not expected to be de-escalated in short term as external risk evolves but work underway to strengthen controls and response.	Loss of access to key operational / clinical systems from threats (cyber air con, break of external circuits, fire, floods etc) for a protracted period	High (15)		Moderate (10)	Following the review of the role of cyber responsibilities within the IT team a further action is to review and update Job Descriptions (JDs) to ensure they reflect post holders responsibilities. (Action update - Review of JDs underway , due date extended to allow time for completion & as consultation underway). Person Responsible: Rob Brown Due: 30 September 2026
1891	Corporate Operations Accountable Executive: Chief Operating Officer (COO) Forecast – not expected to de-escalate	Misalignment between Demand and Capacity across the Trust's urgent and emergency care pathway	Extreme (20)		Low (6)	Conduct a comprehensive review of current Emergency Department (ED) processes and identify areas for improvement - focussing initially on the opportunity to reduce the number of patients spending 12+ hour in ED. Refresh of Clinical Decision Unit (CDU) model as part of Same Day Emergency Care (SDEC) capital build



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
	in short term (linked to BAF FPC002)					process as an enabler. Colocation of Urgent Treatment Centre (UTC) to fully utilise Emergency Floor footprint. Review from September with Emergency Care Improvement Support Team (ECIST) support is underway at William Harvey Hospital (WHH) and areas of good practice with be transferred to Queen Elizabeth the Queen Mother Hospital (QEQM). to be included and referenced in Urgent and Emergency Care (UEC) Improvement Plan that now has structure and governance within the Programme Board to TMC. CDU estates changes in progress and nearly complete with a Standard Operating Procedure (SOP) for utilisation. Extensive bed modelling has taken place as part of the winter planning process for Board review in October. New SDEC capital builds at both sites are on schedule for July 2026 at QEQM and September 2026 WHH. New SDEC clinical modelling session in place with Getting it Right First Time (GIRFT)



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
						at WHH end of February 2026. Person Responsible: Alison Pirfo Due: 30 September 2026
2123	Corporate – Strategic Development & Capital Planning Accountable Executive: CSPO	Health and Safety Risk to staff and the potential unavailability of records at the point of need due to lack of storage space for Health Records.	High (15)	↔	Low (4)	Strategy to be developed and agreed regarding the creation of new paper records (Action update - CMO to meet with key stakeholders now service has transferred from Diagnostics, Cancer and Buckland (DCB) Care Group to Corporate Strategic Development (SD) and Capital Planning. Person Responsible: Helen Mackie Due: 31 July 2026
2163	Care Group - Diagnostics, Cancer and Buckland Accountable Executive: CMO EA inspector has issued a non-conformance for Radiopharmacy on 24/06/2026.	Failure in the provision of Radiopharmaceuticals due to deteriorating Radiopharmacy Facility	High (16)	↔	Low (8)	Address Radiopharmacy Capacity - Implementation of Band 4 post to improve capacity in the unit Person Responsible: Claire De-Lisle To be implemented by: 31 July 2026 Meet with Estates to discuss further actions required on Air Handling Unit (AHU) condition Person Responsible: Claire De-Lisle



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
						To be implemented by: 30 September 2026 Remedial works required in Radiopharmacy Lobby area - rust build-up, scratches on walls and bench in need of replacement Person Responsible: Claire De-Lisle To be implemented by: 30 September 2026 Biomedical Scientist (BMS) alarm to be installed in the event of the AHU failing Person Responsible: Claire De-Lisle To be implemented by: 30 September 2026 New bench required in the Radiopharmacy Assay area - current workbench is bowing under the weight of lead equipment Person Responsible: Claire De-Lisle To be implemented by: 30 September 2026 Rebalancing of clean rooms required in order to improve air change rates Person Responsible: Claire De-Lisle



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
						To be implemented by: 30 September 2026 Replacement of flexi-ductwork to reduce system pressure and improve airflow Person Responsible: Claire De-Lisle To be implemented by: 30 September 2026 Radiopharmacy to be transferred onto essential power supply Person Responsible: Claire De-Lisle To be implemented by: 30 Jan 2027 Refurbishment of clean room facility required due to degradation and rust build-up. Person Responsible: Claire De-Lisle To be implemented by: 30 Sep 2026 Develop business plan for new unit Person Responsible: Claire De-Lisle To be implemented by: 01 Nov 2026
2234	Care Group – Diagnostics, Cancer and Buckland	Significant delays to cancer and non-cancer reporting due to lack of	High (16)		Moderate (8)	Kent & Medway Pathology Network (KMPN) Digital Histopathology & AI project to improve performance &



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
	Accountable Executive: CMO Forecast: Not expected to close or be de-escalated in short term as relates to hard to recruit area. Mitigations in place and digital and AI solutions being implemented where appropriate Latest Review: 8 July 2026 Histopathology performance has significantly improved to 73% with backlog still <500 cases <45 days. x3BMS and x3AHCS appointed to, but not yet in post. No vacancies	sustainable staffing.				resilience. NB: this is an adjunct to maintaining service delivery and performance and NOT all histology cases can be reported using AI. Person Responsible: Stuart Turner Due: 31 Dec 2026 Update 26 Feb 26: Digital pathology is being rolled out however validation is still in progress therefore not yet UKAS accredited. Trust involved in discussions regarding a Kent & Medway Joint Venture. Trust to ensure areas of pressure are highlighted and worked up. Person Responsible: Helen Mackie. Due: April 2027(extended from 31 Jan 26) Update 26 Feb 2026: Moved to Phase 2 on 2 Feb 2026 - involves implementing the new single governance structure and single management team above Head BMS level to create the joint venture.
2599	Corporate – Medical	There is a risk of inadequate medical staffing	High (15)		Moderate (9)	Recruitment of 4x Medical Director posts 0.4 wte to commence,



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
	Accountable Executive: Chief Executive Officer (CEO) Forecast: Not expected to close or be de-escalated in short term as relates to hard to recruit areas.	levels and skills mix to meet patients' needs				view to complete by end of July Person responsible: Helen Mackie. Due: 31 July 2026. QEQM Business Case has been submitted for 2 additional acute physicians who will have either CCT or CESR. 3 month timeframe to recruit. (Action update - Due date extended - due to FRB on Wednesday 15 July 26) Person responsible: Sunny Chada. Due: 15 July 2026
2808	Care Group – QEQM Accountable Executive: CMNO	There is a risk of patient harm occurring due to delays in recognising and escalating deteriorating patients in ED due to capacity	High (15)	↔	Low (6)	Focus on ensuring full compliance with resus training (paediatric and adult) for all remaining staff that require it within department - in particular medical staff. Person Responsible: Hitendra Tanwar Due: 31 July 2026
3354	Queen Elizabeth Queen Mother Care Group Accountable Executive: CSPO Forecast: Review of Estates	Inability to deliver adequate care in clinical environment due to infrastructure deficiencies	High (16)	↔	Moderate (9)	Creation of a transparent system to see open estates requests and to be prioritised by triumvirate with 2gether. Reporting to be created and submitted through Health & Safety (H&S) committee into Board once produced. (Action update - Draft reports created and approved.



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
	risks has been completed by Director of Strategy which may impact on Care Group estates risks. Work remains in progress, presented to Risk Review Group. Relates to SRR risk 3384 and BAF					To commence reporting from August). Person Responsible: Sunny Chada Due: 14 August 2026 Pilot of handyman role approved by 2gether to focus on patient and staff environment improvements. Handyman now in place with weekly sign off of jobs. Review effectiveness in Q4 2025/26. Action update - Initial review completed and formal approval for permanent handyman to be made in July. Person Responsible: Sunny Chada Due: 31 July 2026 Site Security review completed and to be presented to corporate Security Group to secure 5 year improvement plan for funding deficiencies. Immediate doors for security breaches locked e.g. by Spencer Person Responsible: Sunny Chada



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
						Due: 31 July 2026 Issues with transfer of bariatric patients to and from Deal/Fordwich due to ramp. Currently utilising multiple porters but stronger bed mover options being reviewed. Person Responsible: Sunny Chada To be implemented by: 14 August 2026
3367	Corporate Medical Accountable Executive: CEO	Lack of timely review of diagnostic test results	Extreme (20)	↔	Low (6)	Audit to take place of below process: The radiology process should mirror the Pathology process already in place - the failsafe is sent to the Multi-disciplinary Meeting (MDM) co-ordinator. A copy of the results are sent to requesting clinician. Weekly spreadsheet generated based on SNOMED codes. Reviewed by MDM coordinators for review and addition of patients to MDM. (Action update - Action predates new action owners appointment to AMD role. To discuss with risk owner at next risk review meeting. Person Responsible: Nic Goodger Due: 7 August 2026



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
						Endoscopy Patient Tracking List (PTL) does not readily allow tracking, or feedback results, to the original referring clinician. A task and finish group concluded the management system needs to change to mirror imaging. This has been costed and the case will be brought by the Care Group. (Action update - A business case has been written, awaiting to see a module being used in another Trust to ensure this meets our needs and then we will progress with seeking approval for the purchase of this additional module. Timeframe extended to allow review of module being used in another Trust). Person Responsible: Jade Pilcher Due: 31 August 2026 Undertake a retrospective review of datix incidents and complaints which refer to delayed test results and potential harm reported in Q3 & Q4 2025-26 and report findings with any recommended actions to



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
						the Patient Safety Committee. Person Responsible: Helen Mackie To be implemented by: 31 August 2026 Internal audit commissioned to review if the Policy and processes are being followed for Radiology Person Responsible: Helen Mackie To be implemented by: 8 December 2026 Developing the Compass technology for the Inbox on Sunrise for consultants to review all results that are allocated to them. Delay in implementation due to delay of Sunrise upgrade Person Responsible: Michael Bedford To be implemented by: 31 Dec 2026
3384	Corporate – Strategic Development & Capital Planning Accountable Executive: CSPO Forecast: Not	The ability to deliver safe and effective services & implement improvements across Trust estate is compromised due to financial constraints for capital funding	High (16)		Moderate (12)	Business case to be approved by NHS England (NHSE) following approval at Trust Board. (Action update - Business Case has been reviewed by NHSE resulting in some supplementary questions which are being responded to. Due



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
	expected to be de-escalated in short term. Linked to BAF FPC003 and SRR 3700.	and assets replacement				date amended accordingly). Person Responsible: Nicky Bentley Due: 31 July 2026
3386	Care Group – Women, Children and Young People Accountable Executive: CNMO Forecast: A new Kent wide Maternity Information System is being procured (led by Dartford). Planned rollout winter 2026. Still an open Central Alerting System (CAS) alert. To understand if the mitigations in place will reduce risk ahead of mobilisation	Potential risk of inaccurate records due to Euroking back copying	High (16)		Low (6)	Work continues to implement MSR 2.1.1 into the Euroking Test environment to then be tested. If the testing is successful, then Trust to decide whether to move this into the live Euroking environment or stick with the current bespoke MSR. End date of Magentus support as part of NPSA project unclear. (action update - Upgrade to new MSR v wait for K2. E3 test environment implemented into test environment - testing ongoing. For further presentation to Maternity and Neonatal Assurance Board (MNAB) when testing complete for final decision Person Responsible: Sharon Gough Due: 30/07/2026 Procurement of new Maternity IT system to ensure adequate reporting integration with current systems and patient accessibility



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
	of new system.					Person Responsible: Cherrie Knight Due: 15/09/2026
3449	Corporate Medical Accountable Executive: CMO Forecast: Not expected to reduce imminently but to be informed by Plus 24 SOP audit and harm reviews. Links to SRR 1891 and BAF FPC002	There is a risk that patients who stay in ED for over 24 hours may not receive appropriate assessment and review	High (16)		Low (6)	These patients are included within the ED note audit which is ongoing. This will be reported monthly to ED governance meeting to identify learning & new actions (UEC governance meeting actions are reviewed by QEQM governance). Person Responsible: Carolyn Fleurat To be implemented by: 30 September 2026
3553	William Harvey Hospital Care Group Accountable Executive: CSPO Forecast: Risk will close following completion of capital works – which will be	Failure of Cardiac Catheter Suite equipment (Lab 1, 2 & 3) WHH	Extreme (20)		Low (5)	Capital to be identified across 26/27 and 27/28 capital programme with expected completion of end of 27/28 for complete replacement of all cath labs at WHH. Person Responsible: Nicky Bentley Due: 31 Mar 28



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
	completed in a phased approach					
3556	Corporate Nursing Accountable Executive: CNMO Priority action: Review risk with owners and WHH Care Group	Risk to patient safety, privacy and dignity and experience due to overcrowding and delivery of care in non-care spaces in the Emergency Departments	High (15)		Low (6)	Undertake a retrospective audit of M10 & M11 clinical harm reviews & report to the Quality Committee to inform actions for Q1 2026/2027. Person Responsible: Susan Brassington To be implemented by: 30 June 2026 Provide a progress report regarding the work with external partners and progress to alternative pathways and provision of services. To audit compliance. (Action update - new booklets created for all staff detailing services available in community. Now available to all ward and Urgent, Emergency and Acute Medicine (UEAM) staff. Completed in June 2026). Person Responsible: Sunny Chada To be implemented by: 31 August 2026 Provide a progress report on the work to date with South East Coast Ambulance



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
						Service (SECAmb) to reduce conveyances to ED. (Action update - GiRFT visit end of August and aligned to missed opportunities audit which they are leading on). Person Responsible: Sunny Chada To be implemented by: 31 August 2026 Report on work with patients & service user groups to improve knowledge/health education and use of alternative pathways to the Patient Experience Committee to identify further interventions required & progress to date Person Responsible: Susan Brassington To be implemented by: 30 June 2026 Ongoing work at Care Group Care Group Board level and UEC Improvement Board to support flow through alternative pathways of care. Action implementation date extended post SDEC build Person Responsible: Alison Pirfo



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
						To be implemented by: 31 Jul 2026
3557	William Harvey Hospital Care Group Accountable Executive: COO Forecast: Improved pathways but not expected to de-escalate imminently due to shortage of acute MH IP beds. Continued partnership work with external provider. 06/02/2026, DRO review New MH framework in place	Risk that mental health patients who present at our EDs will be in the Department for long periods (12 hours >)	High (16)	↔	Moderate (9)	Clinical Harm Review process has been introduced with a Datix completed for patients awaiting a mental health bed (and medically fit for discharge) who have waited in ED for over 12 hours. ADON (MH) tracking patients against daily site report. Work to embed this new process over Q2 with reporting on harm and learning via governance (to be specified) Person Responsible: Mark Anderson To be implemented by: 30 September 2026
3662	Kent & Canterbury Hospital Royal Victoria Hospital (KCHRVH) Care Group Accountable Executive: CNMO	There is a risk of poor patient experience and quality of care when receiving SACT treatment due to the volume of treatments, staff skill mix and pharmacy aseptic	High (16)	↔	Low (6)	SACT matron to meet with Workforce lead to complete establishment review for all units. Person responsible: Kelly Clements To be implemented by:: 31 July 2026 Recruitment of Nursing and Healthcare



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
		pressures leading to delays on the day				Assistant (HCA) staff to support Saturday opening as approved business case. Person responsible: Kelly Clements To be implemented by: 12 October 2026 Review of themes from patient safety incidents in last 6 months Person Responsible: Michelle Burrough Due: 31 May 2026 Review of policies that support the chemotherapy unit Person responsible: Carolyn Maynard To be implemented by: 31 July 2026 Training to be delivered by aseptics to enable nursing staff to use isolator boxes. Once complete this will impact on demand by enabling additional capacity. Person Responsible: Kelly Clements Due: 31 August 2026
3700	Corporate – Finance & Performance Management Accountable Executive: Chief	Failure to agree a Medium-term Financial Recovery Plan with System / Region and National Partners	Extreme (20)	↔	Moderate (12)	Development of the Financial Sustainability Plan (FSP) - Version 3 was produced and shared with the Board, version 4 is due to go to the Board in July 26.



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
	Finance Officer (CFO) Forecast: Risk may de-escalate pending agreement of the Plan					Person responsible: Lorna Gibson Due: 31 July 26 System Recovery Director has initiated a medium-term financial sustainability plan for the system, work to support this is ongoing across the Trust. Person responsible: Lorna Gibson Due: 31 August 2026 Work required with Integrated Care Board (ICB) around deconstruction of the block and the resulting risk. Person responsible: Angela Van der Lem Due: 31 August 2026
3702	Care Group – Critical Care, Anaesthetics and Specialist Surgery Accountable Executive: COO Forecast: Work-ongoing but not expected to be de-escalated in short term	Delayed discharge of patients from Critical Care when medically fit to be transferred to the ward	High (16)		Moderate (8)	Discussion with COO on Trust wide approach and strategy related to this. Controls in place and work led by CCASS leads but Trust wide approach needed. (Action update - Implementation date changed. We care project now underway, process mapping exercise commenced to understand site responsibilities). Person Responsible: Gemma Oliver



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
	as relates to system wide flow and emergency and elective demand. Linked to BAF FPC002 and SRR risk 1891.					To be implemented by: 31 July 2026
3719	KCHRVH Care Group Accountable Executive: CEO Forecast: Not within Trust control as Alliance wide procurement but risk to be updated once timeframes established.	There is a risk of patient harm from availability, delays and errors in SACT prescribing for adults due to system failures with the ARIA medonc system being out of date at Kent & Medway Cancer Collaborative (KMCC)	High (15)	↔	Low (5)	New E-prescribing system to be procured and implemented across the Cancer Alliance Person Responsible: Alexis Warman Due: 30 Sept 2026
3741	Care Group - Critical Care, Anaesthetics and Specialist Surgery	Synthes E-Pen Failures	High (16)	↔	Very low (1)	Replacement of Epen units with new trust standard device. Device failures discussed with Synthes. Potential causes investigated. Devices are lubricated as per Intestinal Failure Units (IFUs). Maintenance ruled out as devices have failed under 1 year old.



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
						Specification for replacement devices has been written and reviewed by J Relwani and D Tighe. Procurement to discuss with NHS Supply Chain (NHSSC). Due date extended due to procurement process Person Responsible: Howard Ford To be implemented by: 31 August 2026
3752	Corporate – Nursing Accountable Executive: CNMO Forecast: Risk remains but discussions and decision making via TMC and Quality & Safety Committee (Q&SC) as to away forward	There is a risk to patient and staff safety as additional beds have historically been put in permanently into four bedded bays to create six bedded bays on a number of wards across the Trust	High (15)		Low (4)	Paper to be discussed at TMC (March 26) regarding current risk vs risk of reducing bed capacity and impact on care in non-care spaces/flow. Following this a paper will be brought to the next Q&SC (May 26) Person Responsible: Kim Perry Update date extended to allow completion of review To be implemented by: 15 September 2026 Undertake Trust-wide, a bed space measurement review (to be supported by Directors of Nursing on each site) Person Responsible: Kim Perry To be implemented by: 15 September 2026



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
3764	Care Group - Women's Health Forecast: moves will take place w/c 24/07	Lack of infrastructure to enable training provision to meet national requirements	High (16)	↔	Low (4)	As part of the Cost Improvement Programme (CIP) plans - the ask is to review if training can be transferred to Trust on site facilities and cease lease contract on St Pauls House. (Action update - moves will take place w/c 24/07) Person Responsible: Cherrie Knight To be implemented by: 31 Jul 2026
3799	Care Group – William Harvey Accountable Executive: COO Forecast: To be kept under review until performance is at acceptable stage to de-escalate.	Insufficient capacity to deliver gastro OPA in a timely manner	High (15)	↔	Very Low (2)	Continuation of ID Medical gastro clinics being held at the weekend until December 25. (Action update - using ID Medical insourcing to support additional capacity but the backlog remains significantly long at 40 weeks for first OPA. This is due to the 2 vacancies we also have in consultant workforce so the additional insourcing capacity is essentially offsetting some of that lost capacity). Person Responsible: Susan Travis Due: 30 August 2026
3810	Corporate – Nursing Accountable Executive: CNMO	Lack of capital funding to adequately maintain the estate it is not always possible	High (16)	↔	Low (4)	Report through the Quality & Safety Committee to Board to ensure oversight of existing controls and



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
	Forecast: Risk likely to be static but with regular review of assurance Relates to SRR risk 3384 and BAF	to comply fully with HTM and HBN standards which enable prevention control measures including cleaning and ventilation				gaps in assurance- quarterly and annually Person Responsible: Sarah Hayes Due: 31/07/2026 Bid submitted for capital funding to increase side room availability & beds at QEQM - to monitor progress with bid implementation if successful. Person Responsible: Sunny Chada To be implemented by: 31 Oct 2026
3830	Care Group – Women, Children and Young People Accountable Executive: CNMO Forecast: Review current position with Director of Midwifery (DoM). This risk needs to be reviewed in relation to the whole woman's journey. This will in turn identify	Demand for maternity services will exceed the current environmental and community capacity required	High (16)		Low (4)	Rotation of midwifery staff into community settings following staffing uplift from substantive roles covering maternity leave Person Responsible: Jo Shayler Due: 1 October 2026 Review of community staffing roles in association with the review of the specialist midwives Person Responsible: Jo Shayler Due: 1 October 2026 To create a table detailing when staff are being uplifted and their locations so that rotation can be planned in



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
	the service need, staffing profile / establishment and capacity issues. This will require an MDT approach incorporating both maternity and neonatal service. This risk could then be closed or modified depending on the service review.					advance and staff are informed in good time Person Responsible: Sharon Hortal To be implemented by: 1 October 2026
3840	Care Group – Kent & Canterbury and Royal Victoria Accountable Executive: COO Current risk remains 15 until patients have been reviewed and validated until those that are not seen have	There is a risk that patients are coming to harm, dying and having cancer treatment delayed or not commenced due to a breakdown in the surveillance, monitoring and escalation through the urology cancer pathways.	High (15)	↔	Low (5)	Urology/Cancer services to set up a Task and Finish group to review the finding of this report and to continue to manage and complete the action plan points already agreed during meetings. Person Responsible: Matthew Crockett To be implemented by: 21 July 2026 Review current administration establishment, gap



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
	been managed.					analysis of staffing numbers against speciality needs. A business case needs to be agreed and completed based on results of analysis to increase establishment in correct administration roles. (action update - funding secured through the cancer alliance to employ a validator, this person would be responsible for validating through the patients on cancer surveillance & monitoring alongside a clinician to ensure there is a thorough oversight and any risks escalated immediately. This position has been advertised once and had zero applications, upon the request to re-advertise we have been asked to complete a Quality Impact Assessment (QIA) for the Vacancy control panel alongside a Equality and Health Inequalities Impact Assessment (EHIA). Both these have been completed and waiting to hear the outcome. Person Responsible: Alexander Chapman To be implemented by: 31 July 2026



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
3874	Corporate – Operations Accountable Executive: COO Forecast: Mitigation will involve significant investment. Pending BC review.	Risk of patient harm and poor patient experience due to non-Referral to Treatment (RTT) (Referral to Treatment) follow up backlog	High (15)		Low (6)	Business Case being produced for significant investment required for validation and mitigation of the risk. To be developed and a decision made by the end of Q1 2627 Person Responsible: Dan Gibbs Due: 30 June 2026
3866	Corporate – People and Culture Accountable Executive: CPO update – external vacancy freeze in place) Forecast – not expected to close but to be kept under review as linked to SRR 3838 above.	Risk of inability to deliver CIP due to not achieving planned workforce reductions	High (16)		Moderate (9)	Delivery of planned workforce headcount reductions 2627 Person Responsible: Norman Blissett Due: 31 Mar 2027
3890	Critical Care, Anaesthetics and Specialist Surgery	WHH ENT Operating Microscope at risk of failure due to age	High (16)		Low (4)	Replacement of existing microscope. Procurement exercise to select clinically approved replacement. (Action update - Bids received back from



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
	Accountable Executive: CSPO Forecast – risk to be de-escalated upon replacement of microscope or use of loan device (August 2026)					suppliers for replacement devices. To organise trial or demo days). Person Responsible: Howard Ford Due: 31 August 2026
3927	Critical Care, Anaesthetics and Specialist Surgery Accountable Executive: CMO	Gaps in Middle-Grade Workforce Leading to Resident Rota Instability	High (16)		Moderate (9)	Ensure recruited staff on boarding process goes without delay. Person Responsible: Anita Vincent To be implemented by: 30 Apr 2026 Review skill level of Anaesthetic staff matches shift requirements Person Responsible: Pradeep Basnyat To be implemented by: 30 Apr 2026 Review of job design and recruitment strategy Engagement with regional networks and training bodies to improve attraction Development of fellowship options Medium-term redesign of staffing model to improve resilience



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
						Strengthening of escalation and out-of-hours cover arrangements Person Responsible: Janine Thomas To be implemented by: 30 Sep 2026
3926	Critical Care, Anaesthetics and Specialist Surgery Accountable Executive: CMO	Lack of Registrar/ Airway trained doctors in WHH Critical Care	High (16)	↔	Low (6)	Start date for appointed doctors to be confirmed To be implemented by 30 September 2026 .
3935	Corporate - People and Culture Accountable Executive: CPO	There are delays in access to assessment and treatment for staff with Latent TB which results in a risk of exposure to others.	High (16)	↔	Low (4)	A business case to commission a TB Nurse for respiratory team to deal with the back log of treatment for latent TB and set up an ongoing Latent TB service. (Action update - Escalation from Head of OH who is experiencing lack of engagement from respiratory team. AD QG has escalated to care groups and informed CMO for information (and CPO as accountable exec) Person Responsible: Laura Duffell To be implemented by: 31 July 2026 Commission KCFT to provide Latent TB



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
						service for EKHUFT staff Person Responsible: Laura Duffell To be implemented by: 30 Sep 2026
3939	Corporate - Finance & Performance Management Accountable Executive: CFO	Failure to deliver the Trust Financial Plan for 26/27	High (16)		Moderate (12)	Development and delivery of CIP schemes to deliver the required £76m savings plan with the recurrent: non-recurrent ratio and stretch to £90m CIP to support funding for the cost of delivery. Person Responsible: Lorna Gibson To be implemented by: 31 August 2026 Delivery of workforce headcount reductions and reduction in bank, agency and Waiting List Initiative (WLI) spend. Person Responsible: Norman Blissett To be implemented by: 31 August 2026 Implementation of further grip and control measures to ensure delivery of the required CIP Person Responsible: Lisa Marsh To be implemented by: 31 July 2026



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
						Conduct full Zero based review Implement vacancy freeze for all but essential posts. (action update - Zero Based Review (ZBR) has been conducted. Outputs being translated into Whole Time Equivalent (WTE) reduction targets in line with affordable establishment review guidance. ZBR informing Q2 risk mitigation plans). Person Responsible: Norman Blissett To be implemented by: 31 July 2026 Utilise additional external resource via a Strategic Delivery Partner to support sustainable transformation. (Action update - Strategic Delivery Partner appointed May 2026.) Person Responsible: Lorna Gibson To be implemented by: 31 Aug 2026



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
3942	Care Group - Critical Care, Anaesthetics and Specialist Surgery Accountable Executive: CSPO	Failure of Cone Beam CT Machine in Maxillofacial Unit WHH	High (15)		Low (6)	Procurement progressing for new kit. Person Responsible: Howard Ford To be implemented by: 31 July 2026 Datix raised for cancelled clinics/patients Person Responsible: Donna Parker To be implemented by: 31 Aug 2026
3158	William Harvey Care Group Accountable Executive: COO	Cardiology - Delay in diagnostics for patients awaiting Computed Tomography Coronary Angiography (CTCA)	High (15) from moderate (12) following GIRFT meeting	Escalated	Very low (3)	No Actions
3957	DCB Care Group Accountable Executive: CMO	There is a risk of harm for patients on cancer pathways due to prolonged waiting times for CT-guided and Ultrasound-Guided biopsy.	High (16)	New	Low (6)	SOP to be signed off at WHH and DCB Governance Meetings Person Responsible: Naomi Webb To be implemented by: 31 Jul 2026 Assessment of nursing workforce capacity needed to support any revised model. Person Responsible: Heather Munro To be implemented by: 31 Jul 2026



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
						Any expansion of biopsy activity at QE to absorb WHH demand will require a clear workforce plan to ensure sufficient consultant cover across the week, aligned to the proposed activity shift. Person Responsible: Naomi Webb To be implemented by: 31 Jul 2026 Permanent recovery space to be identified post SDEC opening and commissioning of CT scanner at WHH Person Responsible: Naomi Webb To be implemented by: 30 Sep 2026 Harm reviews to be completed on any incidents reported Person Responsible: Stacey Tappenden To be implemented by: 30 Sep 2026



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
3962	Children and Young People Care Group Accountable Executive: TBC – proposed to be CMO	There is a risk that young people aged 16+ with long-term Paediatric conditions will experience unsafe or failed transition to adult services because adult specialties are not accepting or have lack of capacity to take over ongoing care	High (16)	New	Low (4)	Develop local transition protocols with identified adult specialties owners' Clinical leads (Paeds & Adult) Person Responsible: Peter Christian To be implemented by: 30 Apr 2027
3976	DCB Care Group – Pathology Accountable Executive: CMNO	The external surge body storage fridges located in the undercroft area does not meet Human Tissue Authority (HTA) expectations for secure premises and restricted access to authorised personnel	High (15)	New	High (15)	Introduce smart card access to rear doors (consider H&S and fire compliance). Person Responsible: Allan Norris To be implemented by: 31 Jul 2026 Urgent review of CCTV provision, doors, and access points. Repairs completed or underway. Person Responsible: Paul Moroney To be implemented by: 31 Jul 2026 Appoint external investigator / review with Maidstone and Tunbridge Wells NHS Trust (MTW) Person Responsible: Sarah Hayes



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
						To be implemented by: 30 Sep 2026
3981	Corporate - medical Accountable Executive: CMO	Patient harm from diminishing treatment options for bacterial, fungal infections due to increasing pathogen resistance to available treatments in current formulary.	High (15)	New	Moderate (12)	Include AMS compliance as part of monthly/quarterly care group performance reviews Person Responsible: Veronica Chorro-Mari To be implemented by: 30 Sep 2026 Need AMS champions that are consultants as role model for juniors, more AMS awareness: either going via MDs and implement a monthly/bimonthly AMS email update for all prescribers and pharmacists- too much info? Person Responsible: Veronica Chorro-Mari To be implemented by: 30 Sep 2026



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
						Use available audit data to provide focused feedback to departments with outlier prescribing behaviour, eg documentation/guidelines compliance. Person Responsible: Veronica Chorro-Mari To be implemented by: 30 Sep 2026 Update clinical notes to ensure mandatory AMS info is completed in: 1. Consultant 1st review notes and 2. Daily ward round review (tackle abx documentation, duration, guidelines, indication, CDI risk, plan for review, if weekend what to do if..) Person Responsible: Veronica Chorro-Mari To be implemented by: 30 Sep 2026 Report AMS audit results to clinical governance and care group boards to drive local ownership and support. Person Responsible: Veronica Chorro-Mari To be implemented by: 30 Sep 2026



Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
						AMS pharmacist/micro education during ward rounds with real case in situ discussions Person Responsible: Veronica Chorro-Mari To be implemented by: 30 Sep 2026 ASG meets monthly with split agenda, to encourage key specialties to attend/present to part A Person Responsible: Veronica Chorro-Mari To be implemented by: 30 Sep 2026 Need to develop a bespoke penicillin delabelling service that is adequately resourced rather than adhoc. Need to consider option to commission this operationally via virtual ward services / community with support from ICB; infrastructure mainly by allergy trained nurses and pharmacists if such options exists, with governance as led by Consultant in Allergy & Immunology, supported by Pharmacy & Microbiology. This needs to be set up in a sustainable manner that covers movement of EKHUFT patients



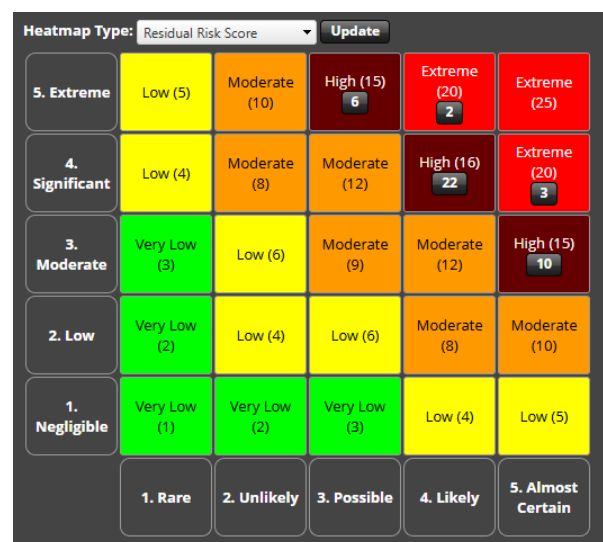
Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to April report	Target Risk Score	Actions summary
						between Acute services and Community. Person Responsible: Veronica Chorro-Mari To be implemented by: 31 Dec 2026 work with AI to develop validations for future tools that allow systems interface. Person Responsible: Veronica Chorro-Mari To be implemented by: 31 Dec 2026

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

Care Group	Residual Risk Score				Total
	15	16	20	25	
CCASS CG	1	5			6
DCB CG	3	3	1		7
K&C CG	2	1			3
QEQM CG	1	1			2
WHH CG	2		1		3
WCYP CG		4			4
Corporate Medical	1	2	1		4
Corporate Nursing	2	1			3
Corporate Operations	1	1	1		3
Corporate Strategic Development	2	1			3
Corporate Finance		1	1		2
Corporate Services					



	Residual Risk Score				
Care Group	15	16	20	25	Total
Corporate People and Culture	1	2			3
Total	16	22	5	0	43
CHANGE SINCE LAST REPORT	+2	+3	-1	0	+4



4. Changes since the last report

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

The below risks were escalated to the Significant Risk Report since the last report:

- Failure of Safe Transition for 16+ Child Health Patients (Risk ref. 3962). Children and Young People Care Group. Residual risk rating 16 (high). Added 29/06/2026.
- Breach of HTA licensing standards WHH mortuary (Risk ref. 3976). DCB Care Group - Pathology. This replaces previously escalated risk ref 3947. Residual risk rating 15 (high). Added 29/06/2026.
- Risk of harm for patients due to prolonged waiting times for CT-guided biopsy (Risk ref 3957). DCB Care Group – Radiology. Residual risk rating 16 (high). Added 30/06/2026.
- Patient harm from diminishing treatment options for bacterial, fungal infections due to increasing pathogen resistance to available treatments in current formulary (Risk ref. 3981). Corporate Medical – Medication Safety. Residual risk rating 16 (high). Added 30/06/2026.



- Cardiology – Delay in diagnostics for patients awaiting CTCA (risk ref. 3158) William Harvey Care Group. Rating increased to high (15) from moderate (12) following GIRFT meeting 22 June 2026.

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

The below risk has been de-escalated from the Significant Risk Register since the last Board report due to the mitigations in place:

- Overdue appointments for patient on the diabetes and endocrine outpatients PTL (risk ref: 3782) William Harvey Care Group. Previous residual risk rating extreme (20). Closed 16 June 2026. Endocrine and diabetes referenced in Trust wide non RTT significant risk (ref 3874).

5. Escalations from Risk Review Group

- 5.1** There were no escalations from the meeting but Care Group and Corporate leads were asked to ensure that all risks are up to date – with significant risks reviewed at a minimum monthly. Care Groups were also asked to ensure they are reviewing the monthly emerging risk report via their Care Group governance meetings.

6. Conclusion

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

End.



REPORT TO BOARD OF DIRECTORS (BoD)

Report title: Maternity and Neonatal Board Chair's Report

Meeting date: 28 July 2026

Board sponsor: Sarah Hayes, Chief Nursing and Midwifery Officer and Maternity/Neonatal Board Safety Champion

Paper Author: Stephanie Pease – Director of Midwifery and Gynaecology Services

Appendices:

None

Executive summary:

Action required:	Assurance
Purpose of the Report:	The document summarises the key discussions, updates, and decisions from the East Kent Hospitals MNAB meeting held on 9 June 2026.
Summary of key issues:	To provide an update on the Stillbirth Review report and the ESOG visit and the newly published National Maternity and Neonatal Investigation, including a summary of the '100-day Sprint'.
Key recommendations:	The Board of Directors is asked to discuss and NOTE Maternity and Neonatal Board Chair's Report.

Implications:

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

Assurance route:

Previously considered by: N/A

Key Areas of Assurance

The document summarises the key discussions, updates, and decisions from the East Kent Hospitals MNAB meeting held on 9 June 2026, an update on the Stillbirth Review report and the ESGO visit and the newly published National Maternity and Neonatal Investigation, including a summary of the '100-day Sprint'

1. Maternity and Neonatal Board Summary:

1.1 Neonatal and Maternity Improvement Plan Progress

- Positive progress reported across six neonatal workstreams, including strengthening leadership, cultural awareness, and high patient satisfaction.
- Activity levels are appropriate; 93% of Special Care Baby Unit (SCBU) admissions are clinically justified.
- Equipment upgrades and early maternal milk use improvements noted.
- Maternity Phase 1 nearly complete; Phase 2 planning underway with 16 July away day to align actions.
- Staff engagement and community involvement emphasised.

1.2 Performance and Quality Updates

- Neonatal data shows improvements in early maternal interventions; some measures like magnesium sulphate are below target but improving.
- Cord clamping performance aligns with national averages; temperature stability in infants is stable with slight improvements.
- Walk the Patch visits highlight communication issues, especially around translation services, with ongoing efforts to extend community engagement.
- Neonatal investigations and safety reviews show progress; overdue actions reduced, and investigations are ongoing.

1.3 Staffing and Safety

- Maternity staffing has been challenging with midwifery vacancies of 12.76 Whole Time Equivalent (WTE) and 8-12 WTE midwives on maternity leave per month.
- The recruitment trajectory is ongoing with new starters starting September / October to full establishment and to cover agreed maternity leave.
- Short- and long-term sickness levels challenges persist. The senior leadership team are working closely with Professional Midwifery Advocate (PMA) support services, Occupational Health and HR to support early returns or to find alternative employment solution.
- Perinatal Mortality Review Tool (PMRT) compliance is at 100% for Quarter 4, with progress toward Year 8 standards.

1.4 Communication and Safety Culture

- Efforts continue to improve patient communication include safety huddles, verbal safety-netting, and clearer investigation reporting.
- Feedback from staff and families emphasises compassionate care but highlights areas for clearer information delivery.
- Safety champions and staff feedback initiatives are ongoing, with focus on staff engagement and addressing concerns.
- First Maternity and Neonatal Staff Engagement Forum arranged weekly from 17 June.

- Maternity and Neonatal Safety Improvement Programme (MNIP) plan for away day 16 July.

2. Enhanced Oversight Group Visit

The Enhanced Support and Oversight Group (ESOG) team visited the East Maternity Services on the 4 and 5 of June.

The team visited both Queen Elizabeth the Queen Mother Hospital (QEQM) and the William Harvey Hospital (WHH) and spoke to a wide range of staff in small planned focus groups across all discipline and teams.

The ESOG have produced a report outlining their positive observations and areas of concern. An action plan has been completed to support the review and completion of this work.

There was one area of concern which was our Triage service. We have reviewed our current triage action plan and the task and finish workstream has been reviewed to incorporate any additional findings from this visit.

The ESOG report will be used to support the new MNIP Phase 2 programme.

3. Stillbirth Review Report

An increased incidence of stillbirths occurring around full-term was identified through the Trust's internal review systems. A request was made by the Trust, via the local Integrated Care Board, for an external team, consisting of a Consultant Midwife and a Consultant Obstetrician, to review these specific cases.

In January 2026, the Trust determined the terms of reference for the external review. The scope included all stillbirths at 34 weeks gestation or later, occurring at EKHUFT between the timeframe of 1 June 2025 and 20 December 2025. This timeframe was subsequently extended to the end of March 2026, in order to include 3 further stillbirths that had occurred after the review was commenced.

The report was presented to the MNAB and the QSC and will be presented to the Public Board in October 2026 to provide a summary of the actions and controls that were put in place prior to receipt of the Independent Stillbirth Review. A comprehensive review was subsequently completed to correlate the 11 cases compared with the original roundtable learning, actions taken and changes to practice.

The report focusses on the major modifiable factors and recommendations identified within the independent review. The maternity service is committed to giving equal consideration to the minor modifiable factors and wider learning arising from the report.

4. National Maternity and Neonatal Investigation - June 2026

The trust has now received the final report following the AMOS Review and this was published on 30 June 2026.

The trust have had an opportunity to meet with the review team to discuss the findings and the individual trust report.

4.1 Recommendations:

The reports recommendation includes the creation of a new statutory role of Maternity and Neonatal Commissioner, accountable to Parliament, who will be charged with having a relentless focus on improving maternity and neonatal care. Their primary role, in partnership with leaders in the maternity and neonatal system, will be to lead the redesign of the service, through a new 'Modern Service Framework'.

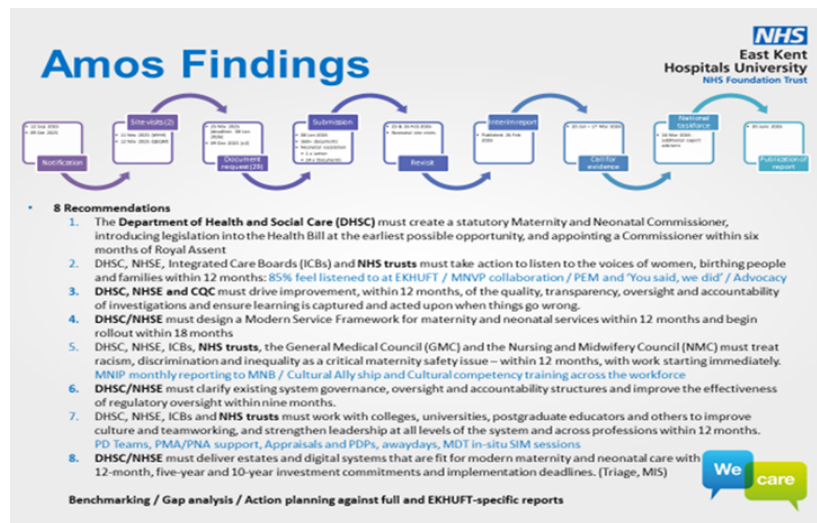
They must also ensure that the new Framework is designed in a way that ensures that the system consistently:

- Tackles critical safety issues, including those identified by this report which are to:
 - Listen to women, birthing people and families –
 - Eradicate racism and discrimination –
 - Develop a positive culture which prevents and tackles poor and unacceptable behaviour
- Apologises and acknowledges mistakes
- Improves leadership and culture
- Overhauls estates and IT
- Tackles workforce pressures
- Designs safe services
- Transforms processes if things go wrong to embed accountability.

The report has produced measurable recommendations given timeframes against expected outcomes.

A total of 895 distinct recommendations were identified, spanning the period 2014 to 2025. We extended the review period to 2014 to align with recommendations on the National Maternity and Neonatal Recommendations Register.¹²⁸ These recommendations demonstrate the scale of guidance issued to maternity and neo natal services over the past decade.

The table below demonstrates the timeline for completion and the publication of the National Maternity and Neonatal report (the Amos Report) and a resume of the eight recommendations:



4.2 The East Kent University Hospitals Report:

As part of the release, the findings have been reported in our own report as part of the 12 hospitals reviewed. This is a tough read for us all that have strived to make changes and improvements across both maternity and neonatal service es.

Our report describes the visits to East Kent Maternity and Neonatal services on the 11 and 12 November and the 25 and 26 February 2026.

Our report describes the snapshot view of the family's voices, staff conversation and interviews and the visiting team's observation of the estates/environment.

The report described the positive improvements across the services as well as areas of concern and need for change.

4.3 100 Days Maternity and Neonatal Sprint – Urgent Actions for NHS

Following the release of the National Maternity and Neonatal Report – the initial ask is for a 100-day sprint review through these key areas of improvements as below:

- Listening to women and their families by rolling out Martha rule
- Listening to women and their families via real time and transparently reported outcomes and experience and clinical audit data acted upon at Board level
- Dual Board level accountability between Medical Directors and Chief Nursing Officers for maternity and neonatal care
- Amos into action staff listening exercise
- Addressing health inequalities in maternity and neonatal outcomes–
- Ensuring 24/7 safety and responsiveness of maternity and neonatal services
- Trusts to review their homebirth services
- Responding to patient safety incidents, complaints and concerns with humanity, candour and through a trauma-informed approach
- Deliver safe and effective triage in maternity services
- Post death care

The Maternity and Neonatal team have set up a task and finish groups with action owners to progress these areas, set key principles for review/improvement and change. These groups will report back to MNAB and the Quality and Safety Committee (Q&SC).

4.4 The Next Steps:

1. Review the report, a gap analysis and review of recommendations from Nottingham independent review.
2. There will be a full benchmarking and GAP analysis of the recommendations from the AMOS report and the EKUFHT reports, which will be shared once complete.
3. A task and finish groups with action owners to progress the 100-day sprint actions areas.
4. We will work alongside our communications to respond to this report.

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: Infection Prevention and Control (IPC) Annual Report April 2025 – March 2026

Meeting date: 28 July 2026

Board sponsor: Sarah Hayes, Chief Nursing and Midwifery Officer (CNMO)/Director of Infection Prevention and Control (DIPC)

Paper Author: Lisa White, Deputy DIPC

Appendices:

Appendix 1: IPC Annual Report April 2025 – March 2026

Executive summary:

Action required:	Approval
Purpose of the Report:	The DIPC is required to produce an Annual Report on the state of healthcare associated infection (HCAI) in the organisation for which s/he is responsible and release it publicly according to the <i>Code of Practice on the prevention and control of infections and related guidance</i> (The Health and Social Care Act 2008).
Summary of key issues:	The Annual Report is produced for the Chief Executive and Trust Board of Directors and describes IPC activity during the year. - Reduction in healthcare associated <i>Meticillin-sensitive Staphylococcus aureus</i> (MSSA) and <i>Klebsiella</i> bacteraemias compared to 2024/25. - An increase of <i>Clostridioides difficile</i> (<i>C. diff</i>) infections and E-Coli bacteraemias – exceeding both thresholds, pseudomonas bacteraemias remained the same as 2024/25 – but also exceeded external threshold. - There were three MRSA bacteraemias reported for this period, with two deemed intractable. - Norovirus outbreaks affected a large number of patients at both William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother Hospital (QEQM). The outbreaks resulted in a number of beds and wards being closed, and contributed to critical incidents on both sites. - The Trust responded to a community outbreak of meningococcal infections, with 16 patients testing positive, over 500 more attending Emergency Departments (EDs) requiring testing and Intravenous (IV) treatment, and hundreds more requiring prophylactic antibiotics (provided jointly with community partners).



	• IPC audits of the environment, equipment and clinical procedures continued throughout the year, and there were notable improvements with scores based on previous yearly audit programmes. • Hand hygiene audit of compliance was 98.5% overall for the Trust. • The Trust compliance with IPC training was 95.7% • All IPC planned audits were completed in this year. • The Trust has an Antimicrobial stewardship strategy with reductions in prescribing of reserve antibiotics reducing. • Antimicrobial prescribing audits were completed during the year. • IPC team finalists in national Nursing Times IPC team of the year. • CLEAN TOGETHER campaign completed, collaborative focus on ongoing improvement in estates and facilities.
Key recommendations:	The Board of Directors is asked to APPROVE the IPC Annual Report April 2025 – March 2026.

Implications:

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

Assurance route:

Infection Prevention Control and Antimicrobial Stewardship Committee - April 2026
Quality and Safety Committee - May 2026



**INFECTION PREVENTION AND CONTROL
ANNUAL REPORT**

APRIL 2025 – MARCH 2026



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East Kent Hospitals University NHS Foundation Trust
INFECTION PREVENTION AND CONTROL ANNUAL REPORT

April 2025 – March 2026

1. Introduction

The Director of Infection Prevention and Control (DIPC) is required to produce an Annual Report on the state of healthcare associated infection (HCAI) in the organisation for which s/he is responsible and release it publicly according to the *Code of Practice on the prevention and control of infections and related guidance* (The Health and Social Care Act 2008). The Annual Report is aligned to the ten compliance criteria as outlined in the Code of Practice. This report covers the period from 1 April 2025 to 31 March 2026.

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

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

2. Executive Summary – The Year 2025/2026

The Chief Nursing and Midwifery Officer is the accountable board member for infection prevention and control (IPC), and undertakes the role of Director of Infection Prevention and Control (DIPC). The Trust also has a deputy DIPC who is responsible for managing the IPC team across all hospital sites. The DIPC continued to report to the Quality and Safety Committee, and periodically to the Trust Board on the status of infection prevention and control throughout this reporting year.

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

Overall, 2025/2026 was a challenging year, with a wide variety of IPC activities, in meeting key standards and regulatory requirements. Below is a summary of activity and achievements:

- Reduction in healthcare associated MSSA and Klebsiella bacteraemias compared to 2024/25
- An increase of *Clostridioides difficile* (*C. diff*) infections and E-Coli bacteraemias – exceeding both thresholds, and pseudomonas bacteraemias remained the same as 2024/25 – but also exceeded external threshold
- There were 3 MRSA bacteraemias reported for this period, with 2 deemed intractable.
- Norovirus outbreaks affected a large number of patients at both WHH and QEQM. The outbreaks resulted in a number of beds and wards being closed, and contributed to critical incidents on both sites
- The Trust responded to a community outbreak of meningococcal infections, with 16 patients testing positive, over 500 more attending ED's requiring testing and IV

treatment, and hundreds more requiring prophylactic antibiotics (provided jointly with community partners)

- IPC audits of the environment, equipment and clinical procedures continued throughout the year, and there were notable improvements with scores based on previous yearly audit programmes.
- Hand hygiene audit of compliance was 98.5% overall for the Trust.
- IPC education and training continued throughout the year, and the IPC link worker programme delivered a programme of training focusing on themes and learning from investigations.
- Continued focus on Infection prevention and control aspects in the ward accreditation
- Fit testing for the use of FFP3 respirators continued with over 950 staff being fit tested.
- Successful launch and implementation of the CLEAN2gether campaign – focussing on estates and facilities aspects of IPC, working collaboratively with 2gether Support Solutions.
- Review of processes for cleaning of equipment and environment
- IPC team were finalists in the 'Nursing Times' national awards for IPC – for the CLEAN campaign

Surgical site infection surveillance (SSIS) was carried out for repair of neck of femur fracture, hip and knee replacements. The SSI Steering Group met throughout the year, and the group holds responsibility for overseeing the progress of the actions to improve.

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

3. The Infection Prevention and Control Team (IPCT)

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

The IPC team provides specialist advice, support, education and training to all sites across the Trust. Each site has a dedicated team in place with occasional cross site cover to ensure delivery of service. In addition, the IPC nursing team work on a seven-day rota to provide on-site cover 365 days per year. The IPC team also provide the Trust wide fit testing service, and have a lead for Surgical site infection surveillance.

Working alongside the IPC team are medical microbiology and virology consultants. There is no specific named Infection control doctor in the Trust, all microbiologists support the team with different portfolios. There is also a Trust consultant pharmacist leading on antimicrobial stewardship 3 days a week, with 2 part time antimicrobial stewardship pharmacists supporting, and 1 consultant microbiologist has this as part of their portfolio.

4. Infection Prevention and Control Committee and Reporting Structure

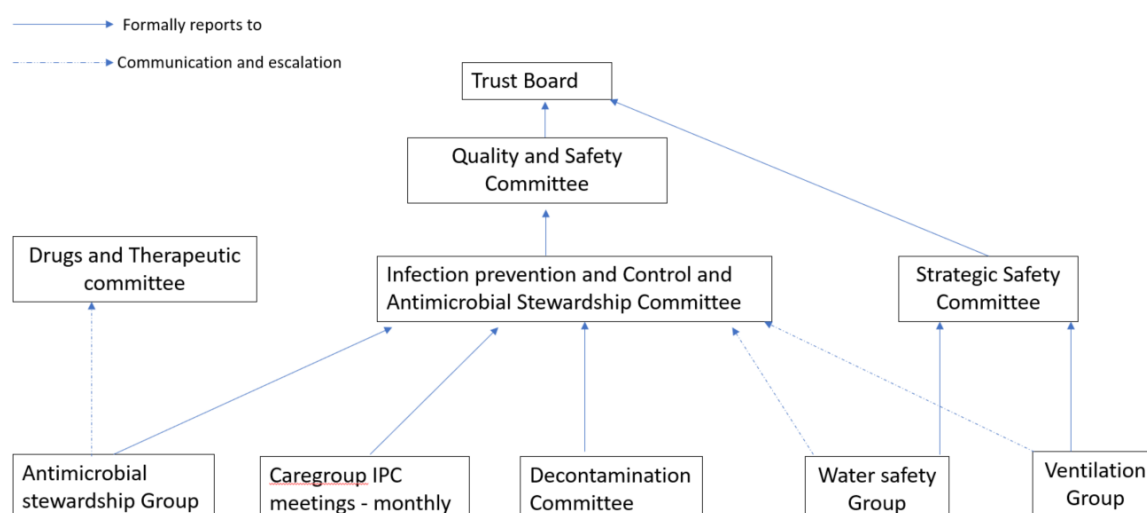
The structure includes Care Group Infection Prevention and Control meetings, chaired by the Caregroup Director, supported by the Infection prevention and control lead. These site groups are operationally focused and bring together clinical and non-clinical colleagues to discuss

challenges and successes and share the learning from investigations and review audit results and actions. Each of these groups along with groups for decontamination, water safety, ventilation safety and antimicrobial stewardship report to the Infection Prevention and Control and Antimicrobial Stewardship Committee (IPCAS).

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

IPC Reporting Structure

IPC and AMS governance and reporting 2025.



5. The Care Quality Commission (CQC)

There were no IPC specific or focussed CQC inspections in 2025/26. A CQC inspection took place within maternity, Emergency department at QEQM and WHH , and medicine at QEQM and which identified generally good IPC practice, but recognised the environmental challenges within the service, and the mitigations in place to address them.

6. Education and Training

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

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

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

Infection prevention and control training compliance March 2026 Trustwide 95.7%

Care Group	No. Compliant Staff	Staff Eligible	Outstanding Courses	Compliance (%)
WOMEN, CHILDREN AND YOUNG PEOPLE CARE GROUP	1,109	1,143	34	97.0%
WILLIAM HARVEY HOSPITAL CARE GROUP	1,573	1,619	46	97.2%
STRATEGY AND PARTNERSHIPS	243	262	19	92.7%
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL CARE GROUP	1,271	1,329	58	95.6%
KENT & CANTERBURY AND ROYAL VICTORIA HOSPITALS CARE GROUP	978	1,036	58	94.4%
DIAGNOSTICS, CANCER AND BUCKLAND HOSPITAL CARE GROUP	2,102	2,204	102	95.4%
CRITICAL CARE, ANAESTHETICS AND SPECIALIST SURGERY CARE GROUP	1,582	1,630	48	97.1%
CORPORATE	482	541	59	89.1%
Total	9,340	9,764	424	95.7%

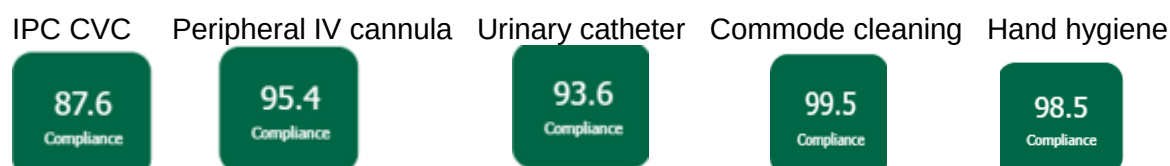
7. Link worker programme

The link worker programme continued throughout 2025/26 within the Trust, with each site hosting local study half /full days throughout the year with support and training focussing on hand hygiene, outbreak management, environmental aspects of infection prevention and control . The link worker programme was developed based on themes from learning following healthcare associated infection reviews. Currently there are over 200 link workers within the Trust, many of whom receive awards from the IPC site leads for 'link worker of the month' for a variety of projects / impacts influencing and improving patients safety.

8. Audit

The annual audits are undertaken by the IPC team, and where possible, jointly with support from estates, facilities and clinical colleagues. Actions are managed by the care groups and issues escalated through the infection prevention and control committee. All departments were audited throughout the year –both environmental and clinical practice audits completed, unfortunately the IT system procured for recording the audits was due to change in year, but that has been delayed, leading to reports being paper based Therefore it is not possible to provide electronic reports of comparisons year on year. Overall, there has been some improvement in environmental scores, however this does remain the biggest challenge in many of the older parts of the Trust

Local review and ongoing audit of invasive devices, hand hygiene compliance and commode cleaning continues, predominantly good adherence is reported , however a focus on compliance for central line care has been highlighted from these audits, and forms part of the Trustwide improvement plan (TWIP) for 2026/27.



9. Hospital Hygiene and the Healthcare Environment

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

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

PLACE scores 2025

2025	KCH	QEQM	WHH	National
Cleanliness	99.41%	99.47%	99.87%	98.55%
Food	91.20%	92.81%	95.31%	92.13%
Privacy & Dignity	88.32%	88.26%	91.42%	89.37%
Condition & Appearance	98.98%	99.50%	99.71%	97.00%
Dementia	88.52%	87.85%	94.85%	85.68%
Disability	88.70%	89.58%	96.30%	87.12%

The Director of Infection Prevention and Control (DIPC) and Deputy Director of Infection Prevention and Control (DDIPC) continue to work closely with Trust and 2gether teams to prioritise the limited capital investment available. This prioritisation considers a broad range of patient safety risks, including but not limited to IPC-related risks. These challenges continue to be reflected within the Trust's Corporate Risk Register.

Throughout 2025-2026, there has been a significant joint focus between the Trust and 2gether on improving cleaning standards. Stakeholder groups have been actively engaged in both strategic and operational planning to support and drive higher standards of cleanliness across all sites. This work has included a comprehensive review of existing cleaning standards and published cleaning arrangements, with a focus on strengthening accountability, governance, and staff understanding of required practices.

Key areas of progress and review have included:

- Delivery of IPC audit training programmes from 3rd parties to ensure joint training has been undertaken across 2gether domestic teams and Trust IPC teams.
- An external cleaning review has been undertaken, with high level detail to be published in May 2026 for trend analysis and to drive improving practices.

- A review of bed cleaning practices looking at local and organisational practices to drive change and accountability.
- The domestic services have also undertaken improved cleaning practices within all public bathroom areas which were identified as high complaint and high usage/footfall areas.
- There was a joint review of sink cleaning practices with an enhanced regime put in place and trained out across all areas of the domestic services.
- The BICS organisation conducted their annual audit of the sites to ensure compliance with the BICS regime, trend analysis of the audit led to a complete review of all cleaning cupboards and an upgrade across all sites of signage and documentation being refreshed.
- The 2gether team have also reviewed the disposable cleaning equipment used within high-risk and infectious areas, including the rollout of a new mopping system and are subsequently rolling out new equipment which will be used across both Trust and 2gether teams. The review has highlighted an opportunity to more closely manage the usage of disposable equipment across both parties and an update to working practices which should drive improvement and alignment.
- 2gether and the Trust IPC team worked 2gether to review the existing disposable curtain arrangements and implemented a new brand of curtain across all sites within the latter part of 2025. The review and roll out also gave an opportunity for all sites to participate in track maintenance which should improve the “glidability” of the curtains, but also the new curtains should deliver an improved experience to patients as they create reduced areas for entry within a bed space.
- Both the Trust and 2gether continue to review the detail and specification behind the New Cleaning Standards, with analysis undertaken over the detail of the elements and ongoing communication of the accountability for cleaning that sits within them. This continues to be an ongoing programme of work for 2gether and EKHUFT but with positive outcomes.
- 2gether also undertook a review of all of their vacuum cleaners, filtration systems, and ventilation cleaning Standard Operating Procedures (SOPs) alongside the updated Vent Cleaning Programme that was implemented alongside the IPC and Estates Teams.
- There continues to be a focus on Waste Segregation compliance with both 2gether and IPC leading the communication and escalation of issues raised at site level and up to the Trust Executive Team, ongoing awareness campaigns are a focus for 2026-2027.

Collectively, these actions demonstrate the Trust’s continued commitment to improving environmental cleanliness, strengthening IPC compliance, and enhancing both patient and staff experience across the organisation.

10. Incidents/Outbreaks of Healthcare Associated Infection

Outbreaks:

Throughout the year there have been a small number of COVID and Flu outbreaks, mainly contained within individual wards, however significant norovirus outbreaks impacted all sites between December and February, with unprecedented number of cases across the organisation, resulting in critical incidents being declared on both Acute Trust sites, owing to the impact on patient flow and bed closures (alongside high demand). A review of testing procedures will take place summer 2026, in order to ensure we have responsive testing facilities and capabilities for 2026/27 winter, as this was a key learning output from the

outbreaks. Ongoing challenges with lack of bedspace, siderooms and ventilation continue to impact the outbreaks, and are on the risk register.

Incidents.

Tb.

There have been 4 Tb positive results that required risk assessment, 2 required contact tracing, in both cases, those identified as at risk were either notified by letter and followed up by the community Tb team, or our occupational health team. One of the cases required a significant incident response and involved over 200 patients and 50 staff follow up. There were no onward transmission cases identified.

Hepatitis B incident.

In September 2025 it was identified that there had been a missed hepatitis B positive result on a renal dialysis patients, other patients were then informed and required follow up testing – nil onward transmission identified. Learning identified within renal service and implemented.

Meningococcal incident – community outbreak.

In March a Community meningococcal meningitis outbreak was identified, causing a critical incident – both internally and regionally, requiring significant UKHSA public health response, In total 15 patients tested positive from EKHUFT (total 21 in whole incident) , 2 died, 5 required ITU level care the remaining patients all cared for on wards, and have been discharged. Currently 2 remain inpatients, one at EKHUFT and one at GSTT. Over 500 other patients attended the Trust as possible cases, requiring testing and IV antibiotics, alongside many others requiring antibiotic prophylaxis. The incident will be independently reviewed to identify potential learning, and to share and feed into system partner reviews.

11. Surveillance and Epidemiology

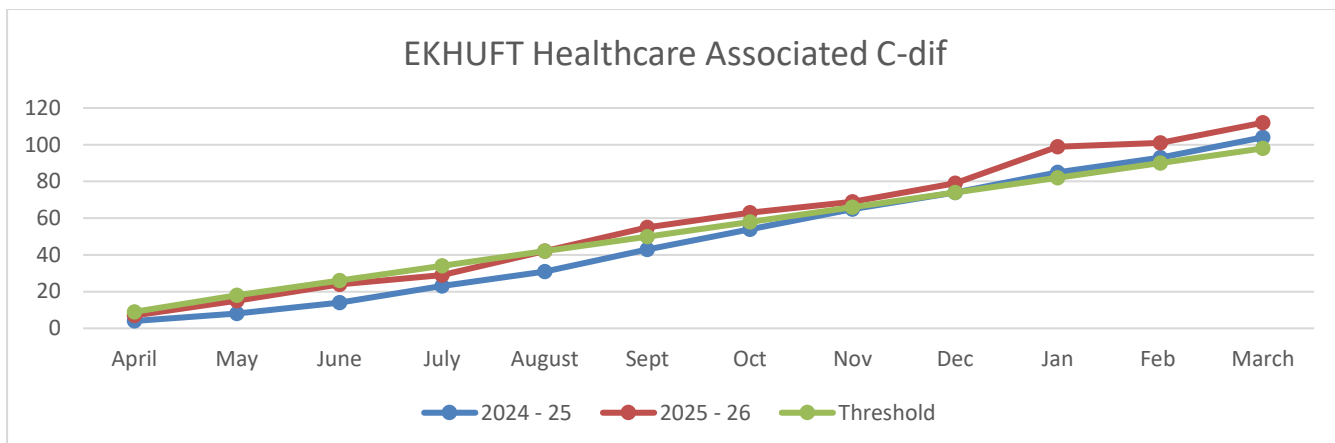
Reportable Infections

Thresholds for *Clostridioides difficile* and Gram-negative bloodstream infections (see below for details) were published for the year 2025/26, Trust performance against these thresholds and data for those infections where no threshold has been set are given below.

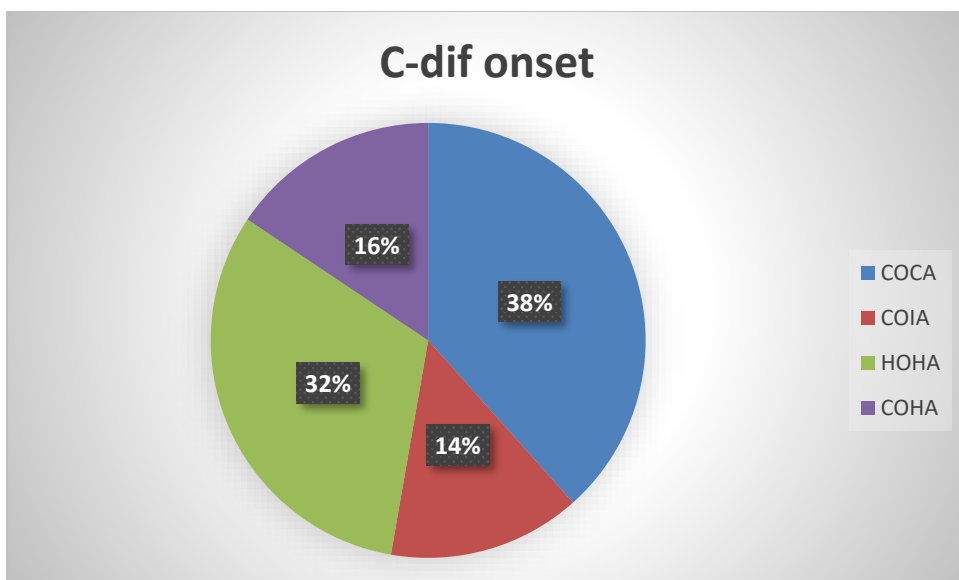
11.1 *Clostridioides difficile* (previously known as *Clostridium difficile*)

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

These cases are described as Hospital Onset Healthcare Associated (HOHA). In addition, any patient discharged from hospital in the 28 days prior to a positive test for *C. difficile* are also hospital attributable. These cases are described as Community Onset Healthcare Associated (COHA). These two categories are combined in figure 4 showing performance compared with 2024-2025 and a linear trajectory to the externally set threshold.



Following a continued focus on the reduction of C. diff the total attributable cases in 2025/26 was 112 – which, whilst this is an increase from 2024/25 and over threshold, it still reflects a reduction from 2023/24. In total 249 patients tested positive for C. diff in EKHUFT, highlighting that once again the community burden is very high..



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

	2023/24	2024/25	2025/26
Cross infection	10%	2.5%	2.5% (3 cases)
Antibiotic associated	63%	75%	79% (89 cases)
Of those antibiotic associated – percentage of non compliance	26%	19%	22% (25 cases)

Samples that were actually community cases, but delay in sending made attributable to Trust	9%	3%	8% (9 cases)
Relapse / re-infection	11%	2.5%	5% (6 cases)

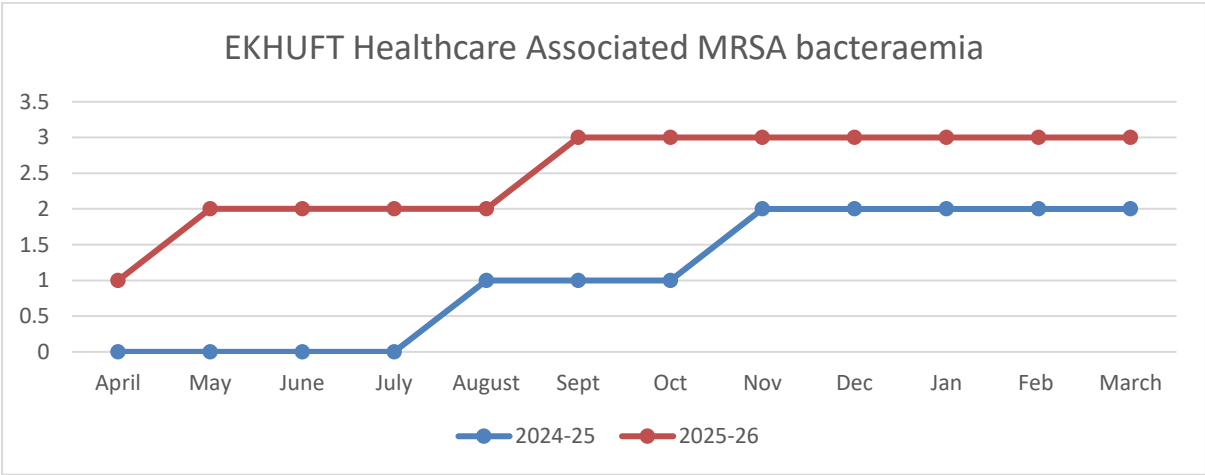
Actions for 2026/27 focus on c-dif reduction through antimicrobial stewardship , effective /timely sampling and rapid treatment.

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

11.2.1 MRSA

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

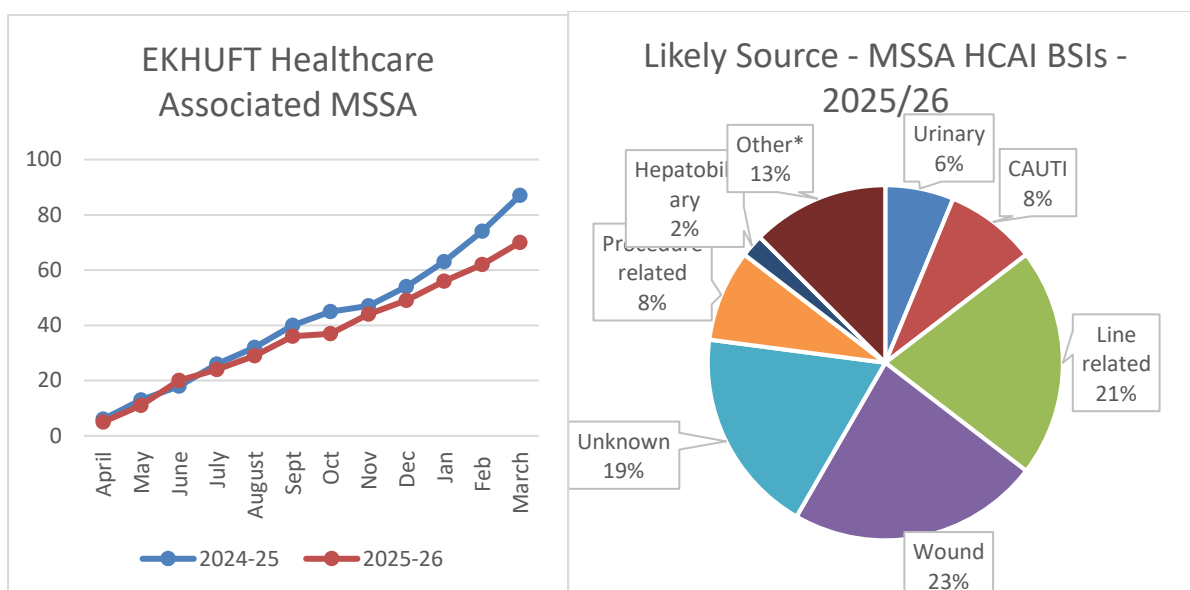
In 2025/2026 Compliance with MRSA screening for non elective patients varied throughout the year with poor compliance of just 75% reported in April 2025 , improving as months went by, with 100% compliance in June 25. After this date monthly MRSA auditing ceased, and became part of the infection prevention and control clinical audit, and good compliance was identified in areas audited. The Trust reported 3 MRSA bacteraemia cases in this timeframe, an increase of 1 from the previous year. All cases were reviewed for potential learning and 2 cases were deemed to have been intractable, and one identified some learning in relation to skin prep for colonised patients with skin conditions and learning disabilities.



11.2.2 MSSA

Meticillin sensitive *Staphylococcus aureus* (MSSA) bloodstream infections are common in both community and hospital settings. Healthcare associated infections are commonly related to vascular access catheters or surgical site infection. There is no externally set objective for MSSA bloodstream infections but an internal target was set to reduce by 10% from last year , and this was over achieved, with a 20% reduction seen this year

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



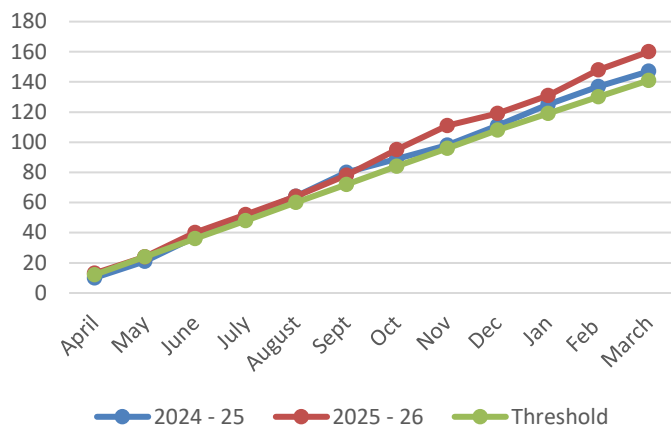
11.3 Gram Negative Bloodstream Infections

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

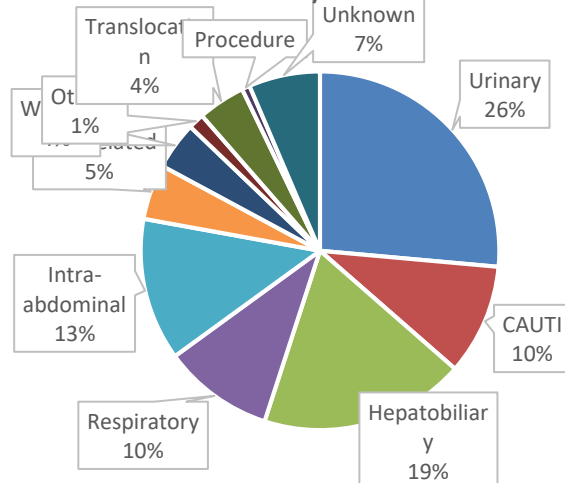
Results for reduction of gram negative bacteraemias varied this year, Klebsiella cases reduced, however, we were over trajectory for both E-coli and pseudomonas. Whilst there are actions continuing to focus on reduction of these cases, the targeted interventions for both E-coli and Klebsiella infections are similar, therefore hard to understand why the difference in cases, especially when the Klebsiella is reducing. Focus will continue on interventions to reduce urinary sources, and line sources, and the Trust Sepsis committee is now focussing on blood culture taking techniques and training, to decrease contaminants and ensure accurate reporting of blood stream infections.

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

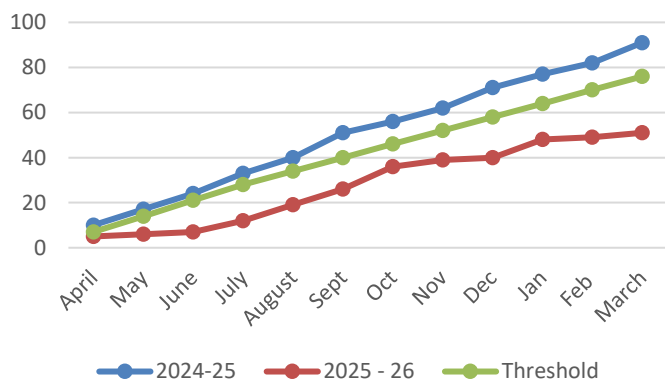
EKHUFT Healthcare Associated E coli



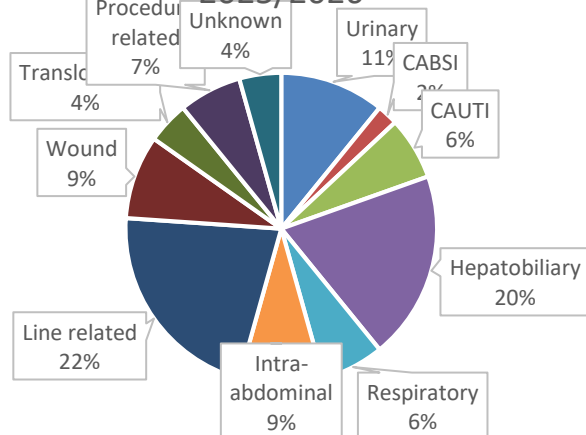
Likely Source - HCA E coli BSIs - 2025/26



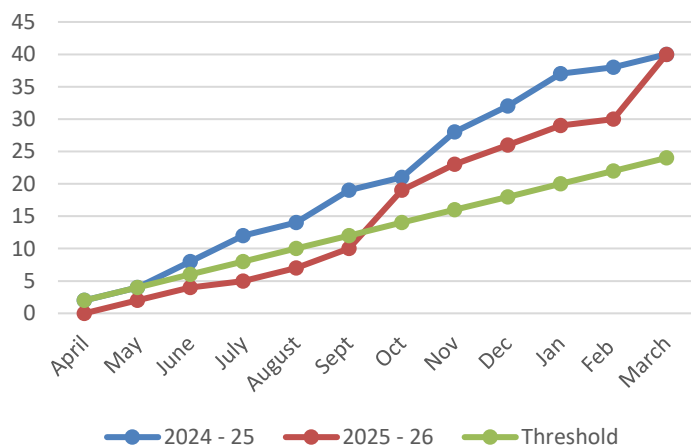
EKHUFT Healthcare Associated Klebsiella spp.



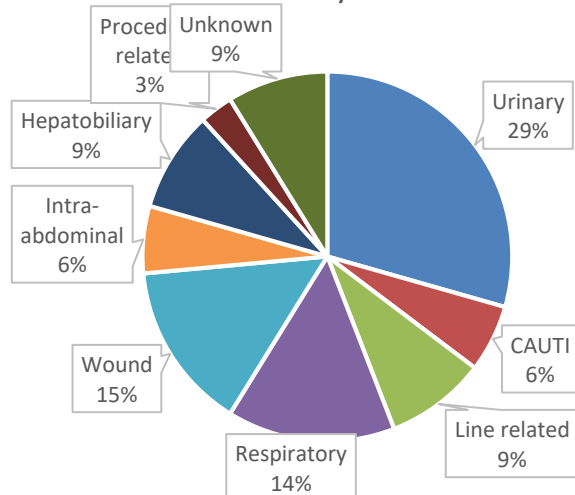
Likely source - HCA Klebsiella BSIs 2025/26



EKHUFT Healthcare Associated P.Aeruginosa



Likely Source - Pseudomonas BSIs 2025/26



11.4 Carbapenemase Producing Organisms (CPO)

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

12. Antimicrobial Stewardship

12.1 Current Antimicrobial Stewardship Team

Consultant Medical Microbiologist (Lead Consultant for AMS) – with ≤ 0.2 wte for AMS

Consultant Pharmacist (AMS) – 0.6WTE – in post

Advanced Pharmacist (AMS) based at WHH– 0.64 WTE – in post

Advanced Pharmacist (AMS) based at QEQM– 0.6 WTE- in post from September 2024

Other Consultant Medical Microbiologists and Clinical Fellows are available for advice/ward rounds if needed.

12.1.1 Expectations from clinical staff.

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

Nurses should have a way to refer to pharmacist for any antibiotic related queries and is something that will need to be explored in the future.

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

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

11.1.2 Main aims of the AMS Team for 2025-26

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

The pharmacy AMS team produced bimonthly reports summarising activities conducted during 2025 whilst ASG was reorganised with monthly meetings part A (main focus on usage/consumption) and part B (guidelines). ASG is keeping the monthly meetings with a split agenda.

11.1.3 Data

Unless stated otherwise, the graphs and tables presented in this report uses data collected from the RxInfo database. In order to compare data across different timeframes, the data is presented as Defined Daily Doses (DDD/1000 admissions).

It should be noted that since April 2020, admissions for the Emergency Department (ED) is not complete. The effect this has on the data presented, is not known.

FP10s have been included in the usage data. ED use a lot of FP10 prescriptions to facilitate discharge. To not include them would potentially skew the data and not give a true representation of the prescribing patterns within ED.

11.1.4 Standard Contract 2025/26 NATIONAL ACTION PLAN 2024-2029

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

The new National Action Plan (NAP) for 2024-29 has a theme related to AMS and 2 objectives to achieve by 2029:

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

Broad spectrum antibiotics usage has doubled in the past 10 years and Co-amoxiclav is the most used Watch and Reserve antibiotic in the trust, followed by clarithromycin, ciprofloxacin, levofloxacin and Tazocin® (piperacillin/tazobactam). Figure 1 represents the watch and reserve category usage in the Trust. Use of co-amoxiclav (Figure 2) has tripled across the trust between 2014 and 2024 and from 2023-24 we see a probable plateau in the trend, however there is still an excess of Co-amoxiclav usage (these are standardised data).

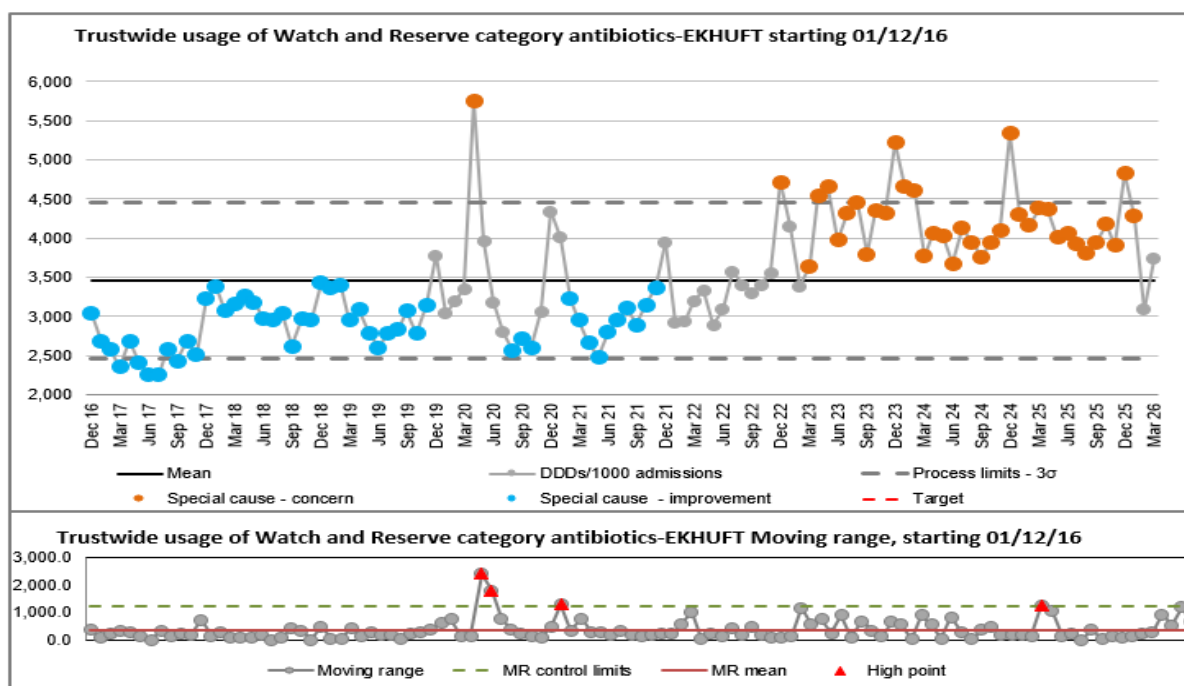


Figure 1: Watch and Reserve antibiotics usage (DDDs) – Trustwide, including EDs (Dec 16 – Mar 26)

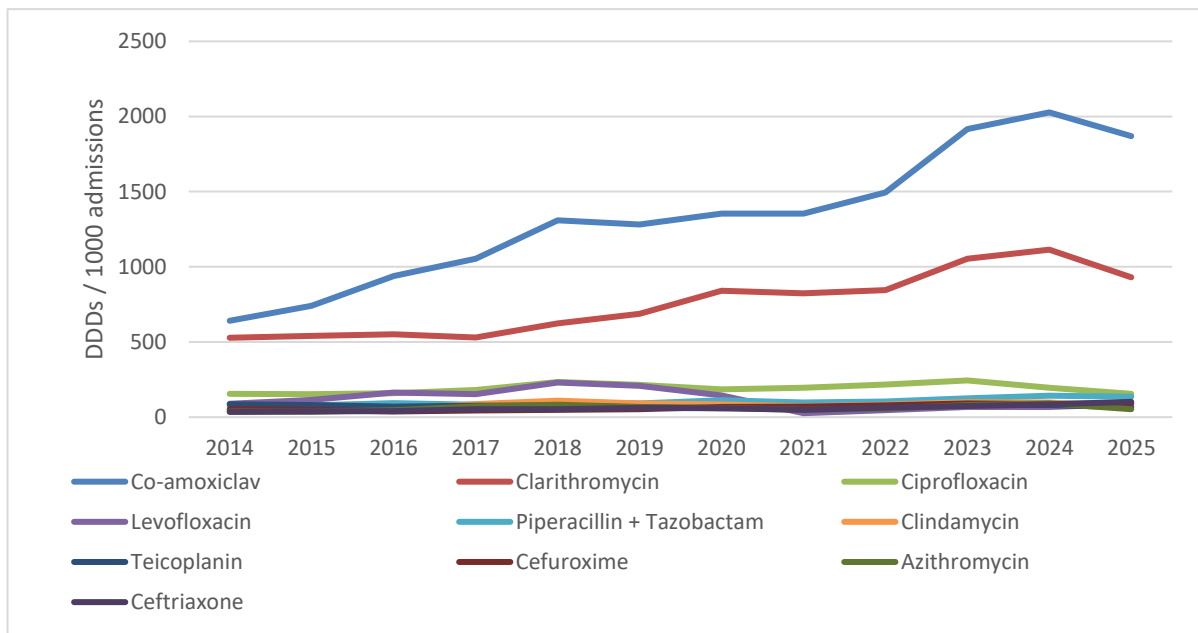


Figure 2: Consumption of Top 10 Watch and Reserve Antibiotics by drug in DDDs/1000 total admissions for 2014-2024 (including FP10s)

Figure 3 represents the Co-amoxiclav usage per specialty. Please note: WHH AMU and QEQM AMU B is included in Emergency Medicine data point. Remainder of QEQM AMU is included in Acute Medicine data.

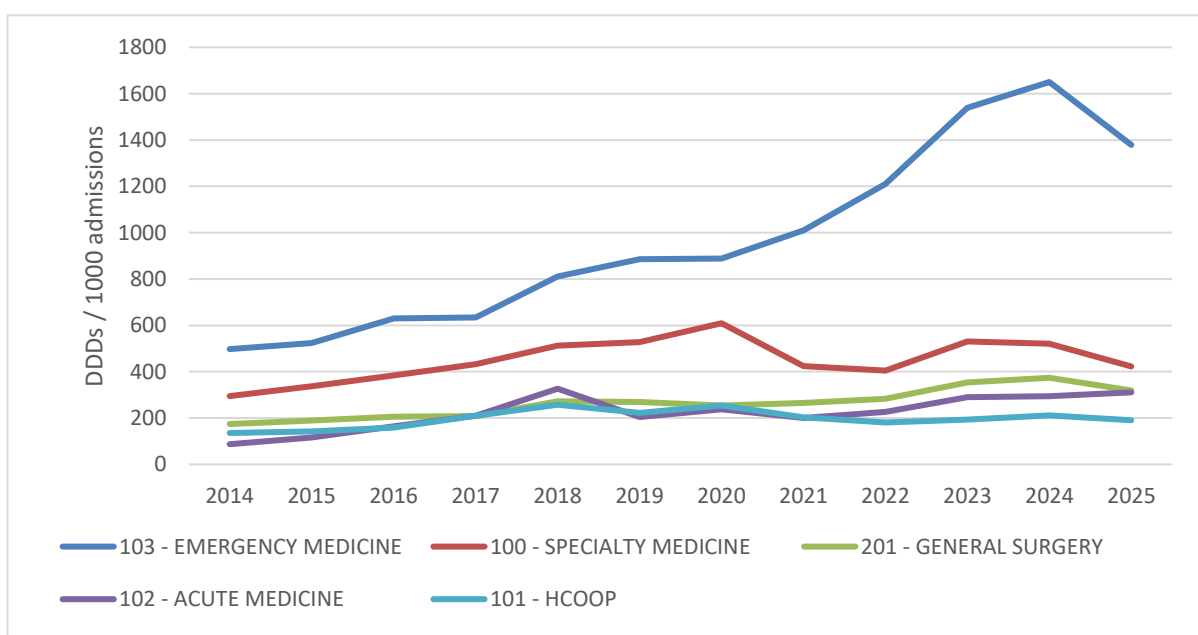


Figure 3: Consumption of Watch and Reserve Antibiotics by Top 5 local directorate in DDDs/1000 total admissions for 2014-2025 (including FP10s)

Emergency Medicine is the biggest user of Watch and Reserve antibiotics (figure 3). However it should be noted that the admissions data for ED from 2020 onwards is not complete, and that from July 2023 the SDEC data does not filter as admissions unless the patients are admitted to a ward, hence the denominator is not fully accurate and represents less number of patients than the ones seen.

Antibiotic usage has been steadily increasing in ED and across the trust since 2014, with co-amoxiclav and clarithromycin forming the largest portion.

ED and AMU AMS Key Performance Indicator audits were redefined for September and October 2024 to capture more information on which specialties are starting antibiotics in ED, for which indications and their compliance to guidelines.

September data has been presented at ED clinical governance meetings and discussions have been started on how to address poor compliance to guidelines in this area.

Figure 4 represents the Co-amoxiclav usage per in ED. Please note: WHH AMU and QEQM AMU B is included in Emergency Medicine data point. Remainder of QEQM AMU is included in Acute Medicine data. This information is intrinsic to the how the systems have been set up.

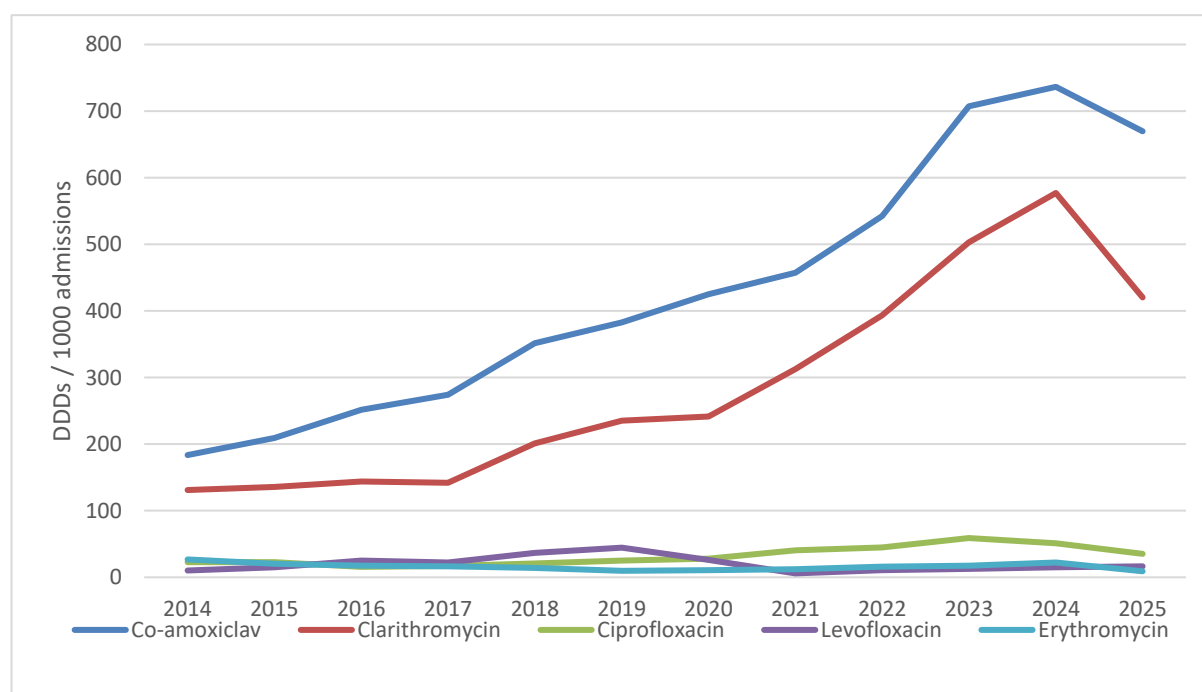


Figure 4: Consumption of Top 5 Watch and Reserve Antibiotics in ED (including FP10s) (excluding AMU units, but including UTCs)

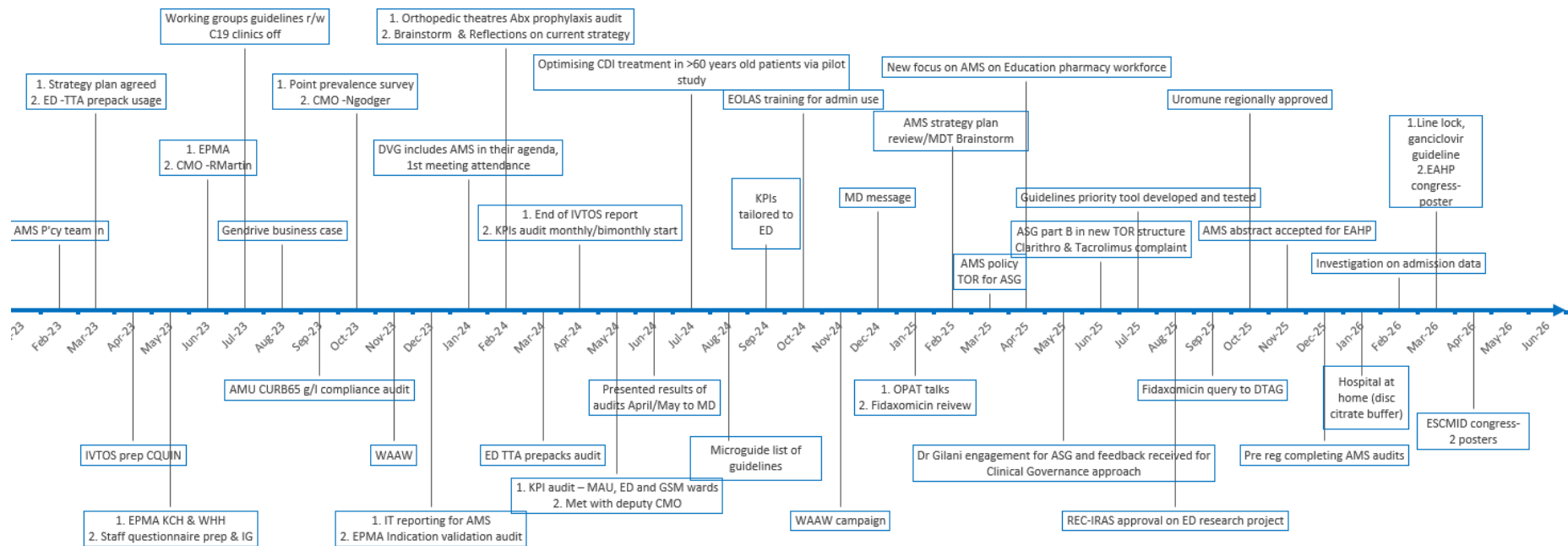
11.1.4 AMS Team audits/projects conducted and work coming in this near future

- KPI audits were defined with a link to risk of CDI and conducted regularly since 2024 in each different ward regularly. KPI results have been discussed at different specialties.

- Tazocin usage monitoring started in 2024 due to an increase of its demand. This usage and the KPI results confirm the Trust has opportunities in improving following guidelines.
- Junior doctors were asked to participate in a snapshot of the IVTOS quality improvement project as an element of embedding AMS to their practice during 2024-25, showing an improvement in IV usage from 28% to 19%. This activity was stopped and we have fallen back on IV use of 30%. Due to the regular rotation of doctors, the Trust has agreed to incorporate an IVTOS tool in EPMA that will inform doctors from indications in EPMA of when patients can be switched to oral.
- Recent audits have shown documentation is an improvement opportunity, especially in clinical notes, and AMS is working with IT to stream this.
- AMS team focussed in developing the junior workforce in pharmacy embedding AMS in their practice and escalate unoptimized use of antimicrobials to the AMS team during the first 6 months of the 2025-26 financial year, and this activity was relooked/ shaped.
- From October AMS team has actively participated in ward rounds in WHH. And from November at QEQM. At KCH there are no regular AMS ward rounds and conversations have started to see how this can be incorporated.

11.1.5. Highlights

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



Monthly highlights AMS- Pharmacy team involvement

12. Decontamination

12.1 Sterile Supplies (CSSD)

The Trust has a Decontamination Committee that is chaired by the Deputy DIPC as the designated decontamination lead for the Trust. Instrument reprocessing is outsourced to In House Sterile Services (IHSS) and the contract is managed through agreed key performance indicators. In 2025/26 the turnaround performance was above 98%, with quality performance above 98%, and any issues identified related to potential contamination of sets – which were identified and addressed at source. The conversion of many sets from wrapped covers to tins has significantly reduced the number of holes found, and therefore reduced cancelled surgery due to this.

12.2 Endoscope reprocessing

The EKHUFT authorising engineer for decontamination undertook the annual review of endoscopy units and overall general compliance was found, with some actions required relating to evidencing of ventilation and water reports. However two decontamination rooms (KCH urology and endoscopy) do not meet full best practice standards as they are built in one room, with mitigation in place to prevent potential clean / dirty cross over, and there continue to be challenges obtaining adequate pressure differential in QEQM scope room.

Via the decontamination committee, this year the main issues raised internally related to ongoing governance around Reverse Osmosis machinery, which have been failing in some areas, leading to cessation of scoping temporarily, or reducing scoping, but these are currently being addressed.

At WHH there were significant leaks from a water plant above scoping rooms, that lead to cessation of services within them, full estates works has now been completed, and work ongoing to ensure the issues are not repeated.

13. Surgical Site Surveillance

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

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

- Total hip replacements
- Knee replacements
- Hip hemiarthroplasties

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

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

The table below illustrates the confirmed orthopaedic SSIs rates attributed to each hospital site since April 2025 (Data for Quarter 4 (January–March 2026) are not available at the time of writing.):

SSI (Inpatient & Readmission Data)

National average in bracket ()

Quarter	EOC		QEQM			WHH		
	TKR	THR	NOF	TKR	THR	NOF	TKR	THR
Apr–Jun 25	0.7% (0.2%)	1.5% (0.3%)	1.4% (0.8%)		0% (0.3%)	0% (0.8%)	0% (0.2%)	0% (0.3%)
Jul–Sept 25	0% (0.2%)	1.6% (0.3%)	3.4% (0.8%)		8.3% (0.3%)	0% (0.8%)	0% (0.2%)	0% (0.3%)
Oct-Dec 25	0.7% (0.2%)	0% (0.3%)	0% (0.8%)	0% (0.2%)	0% (0.3%)	0% (0.8%)	0% (0.2%)	0% (0.3%)

Several key improvements were implemented during 2025–26, including:

- **Review of antimicrobial guidelines for prophylaxis:** A comprehensive review of current antimicrobial guidelines was undertaken to ensure they are up to date with the latest evidence.
- **Training activities and SSI awareness:** A number of training activities and awareness sessions were delivered to improve understanding and prevention of surgical site infections (SSI).
- **Preoperative nutritional support for high-risk patients:** High-risk patients undergoing repair of NOF receive additional nutritional support (therapeutic drinks) as part of their preoperative preparation.
- **Wound management training:** Ongoing refresher training in wound management has been provided to nursing staff.
- **Trial of alternative adhesive closure system for high-risk patients:** A trial of an alternative closure system for high-risk elective patients was conducted; data are currently being analysed.
- **Ventilation system review:** A thorough review of the ventilation system, including microbiological sampling (with negative results), was carried out in the Elective Orthopaedic Centre.

14. Conclusion

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

In the last year we have:

- Maintained a fully established IPC team, providing a 7 day service
- Reviewed the IPC training needs and education for all trust staff.
- Successfully continued and expanded the IPC Link Practitioner programme.
- Continued to contribute to the national standards highlighted in the National Infection Prevention and Control Manual (NIPCM).

- Commenced revision of the governance structure for the water safety and ventilation safety groups.
- Reviewed the surveillance of HCAI and continued a programme of improvement work.
- Continued to work collaboratively with system partners to implement Kent and Medway wide improvements.

We have achieved success in the following areas:

- The IPC team were finalists in Nursing Times Infection prevention and control team of the year
- The IPC team remained fully established.
- The Trust was below the external threshold for Klebsiella, and reduced compared to 2024/25.
- Continued with recording and reporting surgical site infection surveillance in Trauma and orthopaedics – with 0% infection in WHH (to end of Dec 2025) reducing infections in EOC and improvements in QEQM.
- Cleaning roles and responsibilities refined and defined
- Collaboration with architects and project teams for build of SDEC's, maternity and adhoc builds
- Fit testing for the use of FFP3 respirators is undertaken by a dedicated person within the IPC team, and over 900 staff members currently fit tested

The remaining challenges and areas of focus include:

- The Trust exceeded thresholds for all other reportable infections (Clostridioides difficile, Pseudomonas and Ecoli).
- Overall the state of our estate and physical infrastructure remains very challenging and does not support good IPC practice.
- Some SSI's continue above national average

Focus for coming year:

- Specific C-dif reduction focussing on sampling, early treatment, isolation and antimicrobial stewardship
- Implementing candidozyma auris testing
- Specific support to ED teams re: High consequence infectious diseases (HCID) and notification of infectious diseases
- Refocus on reduction of SSI's lead by clinical teams
- IT solutions for data collection and sharing, and audits

Nursing Times Finalists



CLEAN 2gether Campaign in 2025/26



2gether
support solutions

NHS
East Kent
Hospitals University
NHS Foundation Trust



2gether
support solutions

Help us to reduce health care associated infections, and improve patients' experience





C Clutter and cupboards

L Linen and laundry

E Environment and equipment

A All the waste in the right place

N Nobody should walk by

Search 'Clean' on staff zone

E

Environment and Equipment

Our environment, our responsibility

- Make sure you know the cleaning responsibilities for you and your team
- Wear appropriate and correct PPE
- Use the right product and equipment
- Follow a colour-coded system (**RED** for bathrooms, **BLUE** for general areas, **GREEN** for kitchens, **YELLOW** for isolation areas)
- Use correct dilution rates for cleaning chemicals and always follow the manufacturer's instructions
- Start with the cleanest area first and move to the dirty areas to prevent cross-contamination
- Wipe in an S shape pattern working from top to bottom
- If appropriate, add an 'I am clean' sticker
- Dispose of all waste correctly and remember your linen and laundry protocols.

A

All the waste in the right space

It's everyone's responsibility to segregate correctly to reduce the risk of harm and infection.

- Segregate your waste correctly, in accordance with our published guidance ensuring compliance to regulations
- Make sure bins are correctly labelled and in the right places
- Ensure that you have recycling in your area, or provide a sign directing to the nearest recycling point
- Invite waste manager, Mark Airey to review your waste and provide guidance and training. You can contact him on mark.airey@nhs.net
- Ensure all staff have been trained on waste management in the past 12 months
- Sharps bins not in use must have the temporary closure applied
- Ensure wash bowls and urine bottles are placed in pulp macerators.

N

Nobody should walk by

See it, sort it, report it

See it

- You see a litter, pick it up and bin it
- Stay vigilant for any environmental hazards

Sort it

- If you have to think twice if it's a hazard – it probably is!
- Encourage patients/family to reduce amount of things brought in
- Ensure availability of disinfectant wipes in the patients area to encourage cleaning
- Fix issues if you can, but only if it's 100% safe to do so.

Report it

- Report any issues, resolved or not. Simple as that
- Report any cleaning and estates issues immediately
- Report all environmental hazards to your manager.

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: Safeguarding Annual Report April 2025 – March 2026

Meeting date: 28 July 2006

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

Paper Author: Salli Alihodzic, Associate Director of Safeguarding

Appendices:

Appendix 1: Annual Safeguarding Report April 2025 – March 2026

Executive summary:

Action required:	Approval
Purpose of the Report:	The purpose of the annual report covering April 2025 – March 2026 is to inform the Board of the safeguarding structures, governance arrangements and activity undertaken to fulfil the responsibilities to safeguard both our patient's and EKHUFT's continued registration with the Care Quality Commission (CQC), it has to ensure the responsibilities under the Accountability and Assurance Framework (NHS England 2026) are fulfilled.
Summary of key issues:	Key Issues: • The report provides strong assurance that statutory safeguarding responsibilities are being discharged effectively. • Increasing safeguarding demand and complexity across adults, children and maternity services, driven by deprivation, homelessness, domestic abuse, exploitation, mental health needs, migration, ageing population and social admissions. • Workforce capacity and recruitment challenges within specialist safeguarding roles continue to affect delivery of the safeguarding sustainability plan and some workstreams. • Administrative capacity issues have led to delays in safeguarding data entry, reporting and record flagging, resulting in data quality risks and inclusion on the Corporate Risk Register (CRR). • Training compliance remains variable, particularly for Level 3 safeguarding training due to operational pressures affecting attendance. • Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) compliance audit identified significant gaps in documentation, capacity assessments, best-interest decision-making and use of available tools. • Transition safeguarding gap for vulnerable young people aged 18–26, particularly care-experienced adults and those with exploitation, mental health or complex social. • Challenges in maternity safeguarding supervision compliance, despite additional support mechanisms.



	- Increasing complexity of mental health presentations in children and young people, creating safeguarding challenges while awaiting specialist services. - Need for further improvement in safeguarding referral quality, including Making Safeguarding Personal (MSP), consent recording and documentation of actions taken. - Some audits and improvement workstreams were delayed due to sickness absence and service pressures. - Safe discharge remains an area requiring ongoing focus, particularly around self-discharge documentation, Think Family approaches and discharge planning. - Domestic abuse, self-neglect and homelessness remain significant safeguarding themes, requiring continued multi-agency response. - Three corporate risks remain open: - Safeguarding digital recording delays. - Delays in reporting and flagging due to safeguarding administration capacity. - Safeguarding training compliance.
Key recommendations:	The Board of Directors is asked to APPROVE the Safeguarding Annual Report April 2025 – March 2026 and Scrutinise Safeguarding Delivery. The principal issues requiring continued attention are: - Workforce sustainability and vacancies; - Administrative capacity and safeguarding record delays; - MCA and DoLS compliance; - Digital safeguarding systems; - Training and supervision compliance; - Transition safeguarding for vulnerable young adults; - Growing demand associated with homelessness, health inequalities and complex social vulnerabilities.

Implications:

Links to Strategic Theme:	- Quality and Safety - Patients - People - Partnerships - Sustainability
Link to the Trust Risk Register:	None
Resource:	Yes - Current resource in place to be maintained in order to fulfil this strategy.
Legal and regulatory:	Yes - Statutory safeguarding duties as defined in the Care Act and Children's Act legislation and statutory guidance.
Subsidiary:	No.



Assurance route:

Previously considered by: Safeguarding Assurance Committee and Quality and Safety Committee (Q&SC)





**East Kent
Hospitals University**
NHS Foundation Trust

Safeguarding Annual Report April 2025 – March 2026



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Annual Safeguarding Report

1. Purpose of the report

- 1.1 This report outlines the systems, processes, and governance arrangements in place across all Trust sites to safeguard adults, pregnant people, children, and young people receiving care at East Kent Hospitals University NHS Foundation Trust (EKHUFT). Safeguarding remains a core responsibility for all NHS organisations and staff, requiring a consistent, holistic, and person-centred approach to identifying and responding to risk, with the needs of those at risk of abuse or neglect central to all aspects of care delivery.
- 1.2 This Annual Report, covering the period April 2025 to March 2026, provides assurance to the Trust Board that EKHUFT continues to meet its statutory safeguarding responsibilities. These are defined within key legislation including the Children Act 1989 and 2004, Care Act 2014, Mental Capacity Act 2005 (as amended), Homelessness Reduction Act 2017, and Domestic Abuse Act 2021.
- 1.3 The report demonstrates compliance with national guidance and regulatory requirements, including *Working Together to Safeguard Children (2023)* and the Care Quality Commission (CQC) Regulation 13: Safeguarding Service Users from Abuse and Improper Treatment. It highlights areas of good practice, identifies risks and challenges, and outlines the actions in place to mitigate and manage these effectively.
- 1.4 Safeguarding is embedded as a fundamental duty across the organisation. All staff are expected to apply safeguarding principles consistently and proactively, ensuring that the protection and wellbeing of children, young people, and adults at risk underpin all clinical and operational practice.
- 1.5 The report provides assurance that EKHUFT continues to use data, learning, and feedback to drive continuous improvement in safeguarding practice, supporting early identification of risk and strengthening outcomes for patients.
- 1.6 It includes assurance on the effectiveness of the Safeguarding Assurance Committee in providing oversight, scrutiny, and governance of safeguarding activity across the Trust.
- 1.7 The report also provides an overview of safeguarding activity undertaken during 2025–2026, including key performance indicators, partnership working, and service developments.
- 1.8 To maintain compliance with Care Quality Commission (CQC) registration requirements, EKHUFT continues to meet its obligations under the NHS England Safeguarding Accountability and Assurance Framework and the safeguarding requirements set out within the NHS Standard Contract (Schedule 32).
- 1.9 Throughout 2025–2026, EKHUFT has demonstrated strong leadership, accountability, and assurance in safeguarding practice. This includes alignment with national policy, active engagement in local safeguarding partnerships, and responsiveness to system changes within the Kent and Medway Integrated Care System. The Trust remains committed to maintaining high standards of safeguarding practice to ensure the safety, dignity, and wellbeing of all individuals in its care.

2. Introduction

- 2.1 Safeguarding services within EKHUFT have continued to develop and strengthen throughout 2025–2026. The Trust remains aligned with the NHS Safeguarding Accountability and Assurance Framework, demonstrating compliance with statutory duties while responding to increasing demand and complexity. There has been a continued rise in safeguarding activity, reflecting both population need and improved recognition and reporting. Key areas requiring ongoing focus include transition safeguarding and ensuring workforce sustainability to meet demand.
- 2.2 Executive accountability for safeguarding sits with the Chief Nursing and Midwifery Officer (CNMO), a role that has remained substantively stable during the reporting period. The CNMO, in post since September 2023, is supported by a dedicated Safeguarding Team that provides strategic, clinical, and operational leadership across the organisation. The service has been led by a substantive Associate Director of Safeguarding since January 2024, providing consistent leadership and direction. Since 2024, safeguarding has also been included within the Deputy Chief Nursing and Midwifery Officer's leadership portfolio.
- 2.3 During 2025–2026, the Safeguarding Team has continued to operate within a challenging workforce environment, with vacancies across both leadership and operational roles. In response, targeted actions have been implemented to strengthen team resilience, including increased access to safeguarding supervision, more frequent one-to-one support, the development of a structured staff development programme, and a focus on team cohesion and wellbeing.
- 2.4 The Trust Safeguarding Strategy has been refreshed and extended during the year to reflect changes in team structure, population health needs, and the increasing complexity of safeguarding risks. It also incorporates new national policy and legislative developments, providing a strengthened framework to support consistent, proactive, and trauma-informed safeguarding practice across all services.
- 2.5 The Safeguarding Team supports individuals and families across the life course, adopting a 'think family' approach. Specialist practitioners within Adult, Children's, and Maternity Safeguarding ensure a coordinated and expert response to safeguarding concerns. The team is located within the Corporate Care Group, under Clinical Quality and Patient Safety, ensuring strong alignment with patient safety and quality governance structures.
- 2.6 Robust systems and processes are in place to ensure safeguarding activity is consistently recorded, monitored, and assured. These include the use of Electronic Patient Records (EPR) to document safeguarding concerns and actions, safeguarding alert systems to ensure visibility of risk, and incident reporting systems (e.g. DATIX) to support escalation and organisational learning. Multi-agency information sharing is facilitated through NHSmail, Child Protection Information Sharing (CP-IS), and local authority systems. These are complemented by standardised documentation, regular audit activity, safeguarding supervision, and governance reporting through dashboards and committees, providing transparency and organisational oversight.
- 2.7 Workforce capacity remains a key risk, with ongoing challenges in recruitment and retention of staff in specialist posts impacting delivery of the safeguarding sustainability plan. This continues to be mitigated through workforce development initiatives, and service redesign. The all-age safeguarding team model provides

flexibility and resilience, enabling cross-cover arrangements and maintaining service continuity during periods of vacancy, absence, or increased demand.

- 2.8** EKHUFT continues to promote a strong safeguarding culture, ensuring that safeguarding principles are embedded at every level of the organisation. This enables services to respond effectively to the needs of the local population, particularly those most vulnerable to abuse, neglect, or exploitation. The Safeguarding Team plays a critical role in supporting staff through advice, training and specialist clinical support, contributing to safe, high-quality and person-centred care.

PROTECT- The Trust has strengthened safeguarding systems ensuring patients are protected from harm. Increased safeguarding contacts and escalation of concerns demonstrate enhanced identification of risk. Safeguarding governance structures and statutory compliance requirements continue to be met.

EMPOWER- The Trust has embedded a culture of safeguarding ownership through workforce training, ward accreditation, workshops and supervision. Over 1300 staff trained in Prevent and high compliance across safeguarding training demonstrates improved workforce capability.

SAFEGUARD- Partnership working across Kent and Medway has strengthened system safeguarding responses. Increased participation in safeguarding reviews and development of data systems has improved organisational learning and system assurance.

3. Local Context

- 3.1** During this reporting period, EKHUFT operated within the Kent and Medway Integrated Care System under a single Integrated Care Board (ICB). The Trust is one of the largest acute hospital providers in England, comprising five hospital sites and a range of community and satellite services, serving a local population of approximately 700,000–759,000 people across East Kent. In addition to core acute services, the Trust provides a number of specialist services to a wider population, including renal services delivered across Medway and Maidstone, and a countywide cardiac service based at the William Harvey Hospital, Ashford.
- 3.2** The Trust continues to operate within a complex and changing health and social care landscape, characterised by increasing demand, system pressures, and ongoing

transformation across the Kent and Medway Integrated Care System, with a focus on prevention, community-based care, and reducing health inequalities.

- 3.3** During 2024–2025(Awaiting 25/26 Data), service activity across the Trust remained high and continues to inform safeguarding demand: This level of activity continues to drive safeguarding demand and informs workforce training requirements and service planning across the organisation.
- 3.4** Kent has a population of approximately 370,000 children and young people aged 0–19. Levels of child poverty remain a significant concern, with 15.3% of children under 16 living in absolute low-income households. Higher levels of deprivation persist within East Kent coastal districts, including Thanet, Dover, and Folkestone & Hythe, which are consistently identified among the most deprived areas in Kent. These factors are strongly associated with increased safeguarding vulnerability and demand.
- 3.5** Wider determinants of health, including poverty, housing instability, domestic abuse, and parental mental health, continue to impact on families accessing Trust services. These factors increase the complexity of safeguarding presentations and require coordinated, multi-agency responses.
- 3.6** East Kent has a higher proportion of older people compared to the national average, with a rapidly ageing population. This cohort is experiencing increasing levels of frailty, long-term conditions, and social vulnerability. Contributing factors include limited informal support networks, high thresholds for statutory services, and significant health inequalities, particularly in coastal and rural communities. These challenges increase safeguarding risk and require proactive, preventative approaches to support individuals to remain safe and independent.
- 3.7** The Trust continues to experience high levels of attendance from patients whose needs may be more appropriately met within primary care, community services, or social care provision. Work has been undertaken to review patients who do not meet the criteria to reside in hospital, highlighting system challenges in discharge pathways, access to community provision, and availability of care packages.
- 3.8** There remains an increasing requirement for safeguarding intervention linked to ‘social admissions’, often resulting from breakdowns in care packages, carer stress, or lack of appropriate community support. Additionally, social exclusion, isolation, and complexity of need within the population continue to contribute to safeguarding demand, requiring strengthened partnership working and system-wide responses.

3.9 Health Inclusion considerations

- 3.9.1** East Kent presents a complex safeguarding landscape shaped by deprivation, coastal inequality, and increasing population vulnerability. Key drivers include exploitation, mental health need, and a high-risk cohort of looked after children (LAC) and care experienced adults. A significant safeguarding gap exists during transition to adulthood (18–26), where vulnerable individuals may not meet adult safeguarding thresholds despite ongoing need.
- 3.9.2** East Kent has a predominantly White population (approx. 88.6%) with increasing diversity in coastal and urban areas. The population is ageing and includes growing numbers of people with disability, alongside vulnerable inclusion groups such as migrants, homeless populations and veterans.

- 3.9.3 East Kent supports a high number of LAC and care experienced adults, including out-of-area placements. This cohort experiences high levels of trauma, exploitation, and mental health need.
- 3.9.4 East Kent (Ashford, Canterbury, Dover, Folkestone & Hythe, Thanet) demonstrates marked inequality, with variation in health outcomes, deprivation and access to services. These factors drive safeguarding demand and complexity
- 3.9.5 Deprivation is concentrated in Thanet and Dover coastal communities experience a higher burden of ill health, including increased rates of preventable mortality, substance misuse and mental health needs, alongside poorer outcomes for children and young people. This concentration of disadvantage is associated with increased safeguarding demand, including higher prevalence of neglect, exploitation, domestic abuse, co-occurring conditions and complex family need., [\[instituteofequity.org\]](https://instituteofequity.org)
- 3.9.6 Homelessness continues to represent a significant and growing safeguarding concern across East Kent. Our homeless pathway team support this population on their identification at EKHUFT. Kent County data indicates that over 11,600 households were assessed as homeless or at risk in a single year, with over 2,000 households living in temporary accommodation at any one time (Kent analytics, 2026). Coastal districts such as Thanet and Folkestone and Hythe experience disproportionately high levels of need. These figures do not capture the hidden homelessness our patient experience, including sofa surfing and those living in insecure or unsafe housing. Individuals experiencing homelessness often present with complex and overlapping vulnerabilities, including mental ill health, substance misuse, trauma, domestic abuse and exploitation. For safeguarding services, homelessness is both a risk factor and an indicator of harm, associated with increased risks of self-neglect, abuse, exclusion from healthcare, and premature mortality. The intersection with deprivation, migration and rural access barriers in East Kent further amplifies these risks, requiring coordinated, multi-agency and trauma-informed.
- 3.9.7 Rough sleeping remains a significant and increasing issue across East Kent. The 2025 national snapshot demonstrated a 17% increase from the previous year. From the experience of individuals accessing care through the trust describing their living arrangement for discharge, this appears to be an under-estimation underestimation; the true scale of homelessness and hidden rough sleeping is significantly higher. Individuals experiencing rough sleeping often present to our two Emergency departments with complex safeguarding needs, including mental ill health, substance misuse, exposure to violence and exploitation, and barriers to accessing healthcare. This cohort is at heightened risk of premature mortality, self-neglect and safeguarding concerns, requiring coordinated multi-agency outreach and trauma-informed responses. (Annual Rough Sleeping Snapshot 2025 DLUHC). This is reflected in the themes from Safeguarding adults' reviews locally.
- 3.9.8 Due to its coastal geography and proximity to the Port of Dover and other industrial docking points, East Kent continues to be a primary entry location for people arriving in the UK via irregular routes. This contributes to a significant and complex transient population, including asylum seekers and unaccompanied asylum-seeking children (UASC). In 2025 approximately 39,000 individuals were recorded as arriving in the UK via small boat crossings across the English Channel. This continues to place sustained demand on local safeguarding, health, and social care services in East Kent, particularly in relation to trauma-informed care, communicable diseases, chronic health conditions, and injuries sustained during transit. Individuals arriving at

EKHUFT present with significant physical health needs including dehydration, hypothermia and untreated injuries, as well as psychological trauma linked to displacement, exploitation, and the journey itself. This necessitates a coordinated, multi-agency safeguarding response, particularly for vulnerable groups such as unaccompanied children (([GOV.UK, Immigration System Statistics, year ending March 2026](#))). The Border Security, Asylum and Immigration Act 2025 and evolving national policy continues to create acute pressures on frontline services.

- 3.9.9 Digital exclusion in East Kent is an additional and growing concern in relation to self-neglect. Limited broadband, digital dead zones and mobile connectivity in rural and coastal areas, combined with lower digital literacy and affordability barriers, restrict access to increasingly digital health and social care services. This disproportionately affects already vulnerable groups, including older people, low-income households and asylum-seeking populations, and may obscure safeguarding risks where individuals are unable to engage with services or seek help. [\[england.nhs.uk\]](#).

4. Governance and accountability arrangements

Roles and responsibilities

- 4.1.1 The safeguarding structure includes the required roles from both intercollegiate documents.
- 4.1.2 The Trust maintained a comprehensive safeguarding structure throughout 2025–2026 to ensure compliance with statutory requirements relating to safeguarding children, adults, maternity safeguarding, Prevent, Mental Capacity Act (MCA), and Deprivation of Liberty Safeguards (DoLS).

Trust Board

The Trust Board is ultimately accountable for ensuring that robust arrangements are in place to safeguard and promote the welfare of children, young people and adults at risk. The Board receives regular safeguarding assurance through the Safeguarding Assurance Committee and Quality Governance structures.

Executive Lead for Safeguarding

The Executive Lead provides executive oversight of safeguarding and ensures that safeguarding responsibilities are embedded within strategic and operational governance arrangements.

Responsibilities include:

- Providing Board assurance
- Supporting statutory compliance
- Ensuring safeguarding is integrated into quality and safety systems
- Responding to regulatory and commissioner requirements

Deputy Chief Nursing and Midwifery Officer

The Deputy Chief Nursing and Midwifery Officer provides line management to the Associate Director of Safeguarding and supports the delivery of the safeguarding portfolio, ensuring effective links with mental health, learning disabilities, patient experience, and quality and safety functions across the Trust.

Responsibilities include:

- Ensuring safeguarding is appropriately integrated within the Trust's quality and safety governance systems.
- Facilitating effective collaboration between safeguarding, mental health, learning disability, and patient experience services.
- Responding to safeguarding requirements from regulators, commissioners, and partner agencies.
- Supporting the implementation of safeguarding priorities, service developments, and improvement programmes.

Associate Director of Safeguarding

The Associate Director of Safeguarding has overall responsibility for professional leadership of safeguarding services and is responsible for:

- Delivery of the Trust Safeguarding Strategy
- Compliance with statutory safeguarding duties
- Strategic partnership engagement
- Safeguarding assurance reporting
- Oversight of safeguarding performance and quality improvement

Children's Safeguarding Roles

Named Nurse for Safeguarding Children

Responsible for:

- Professional leadership for children's safeguarding
- Providing expert safeguarding advice
- Policy development
- Staff training and supervision
- Child Safeguarding Practice Reviews (CSPRs)
- Liaison with local safeguarding partnerships

Named Doctors for Safeguarding Children

Responsible for:

- Medical leadership and expert safeguarding advice
- Supporting safeguarding decision-making
- Participation in reviews and audits
- Professional oversight of safeguarding practice

Named Midwife for Safeguarding

Responsible for:

- Leadership of maternity safeguarding
- Pre-birth safeguarding planning
- Domestic abuse and exploitation pathways
- Safeguarding unborn babies
- Partnership working with maternity and community services

Adult Safeguarding Roles

Named Nurse for Safeguarding Adults

Responsible for:

- Professional leadership for adult safeguarding
- Section 42 safeguarding enquiries
- Care Act implementation
- Self-neglect pathways
- Safeguarding Adult Reviews (SARs)
- Adult safeguarding policy and practice

Mental Capacity Act and Deprivation of Liberty Safeguards Leads

Responsible for:

- MCA and DoLS compliance
- Audit and quality improvement
- Training and professional support
- Governance reporting
- Preparation for Liberty Protection Safeguards implementation

Prevent Lead/ Named Nurse for looked After Children- Deputy Head of Safeguarding

The Trust Prevent Lead has responsibility for:

- Compliance with the Counter-Terrorism and Security Act 2015
- Delivery of Prevent training
- Monitoring referrals and Channel activity
- Supporting staff in recognising vulnerability to radicalisation
- Partnership working with Kent Prevent teams and police colleagues

Safeguarding Team

The wider safeguarding team provides:

- Trust-wide safeguarding advice
- Duty and response functions
- Supervision
- Education and training
- Safeguarding risk assessment
- Quality assurance
- Partnership representation

The team supports frontline staff in responding to:

- Child safeguarding concerns
- Adult safeguarding concerns
- Domestic abuse
- Exploitation
- Prevent referrals
- MCA and DoLS matters
- Missing children
- Looked After Children and care experienced adults

The Trust maintained all required statutory safeguarding roles throughout 2025–2026. These arrangements provide assurance that safeguarding governance, leadership, expertise, and accountability remain embedded across the organisation.

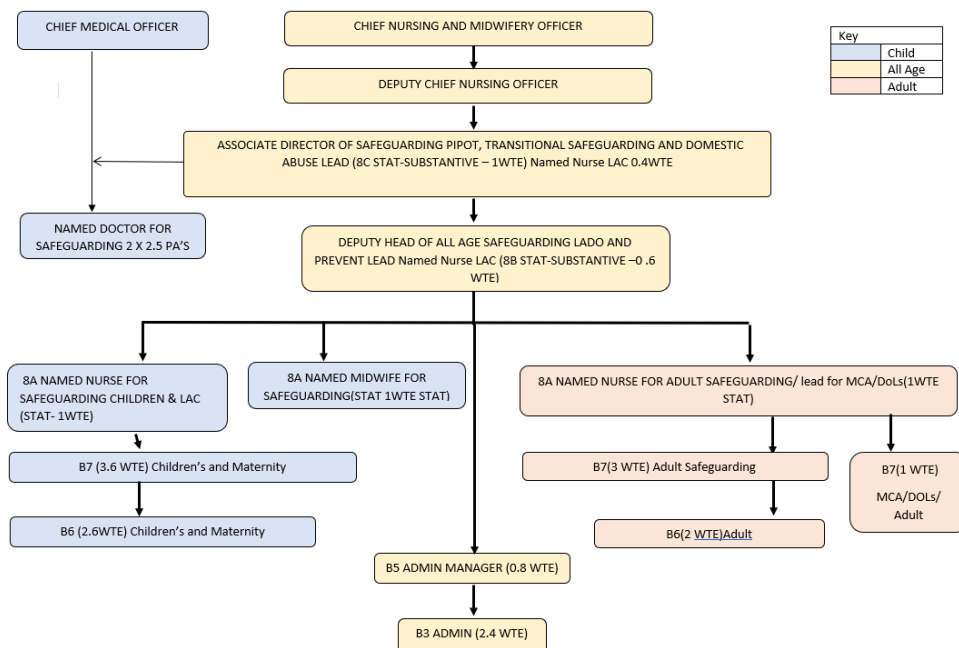


Figure 2: Safeguarding Team Structure

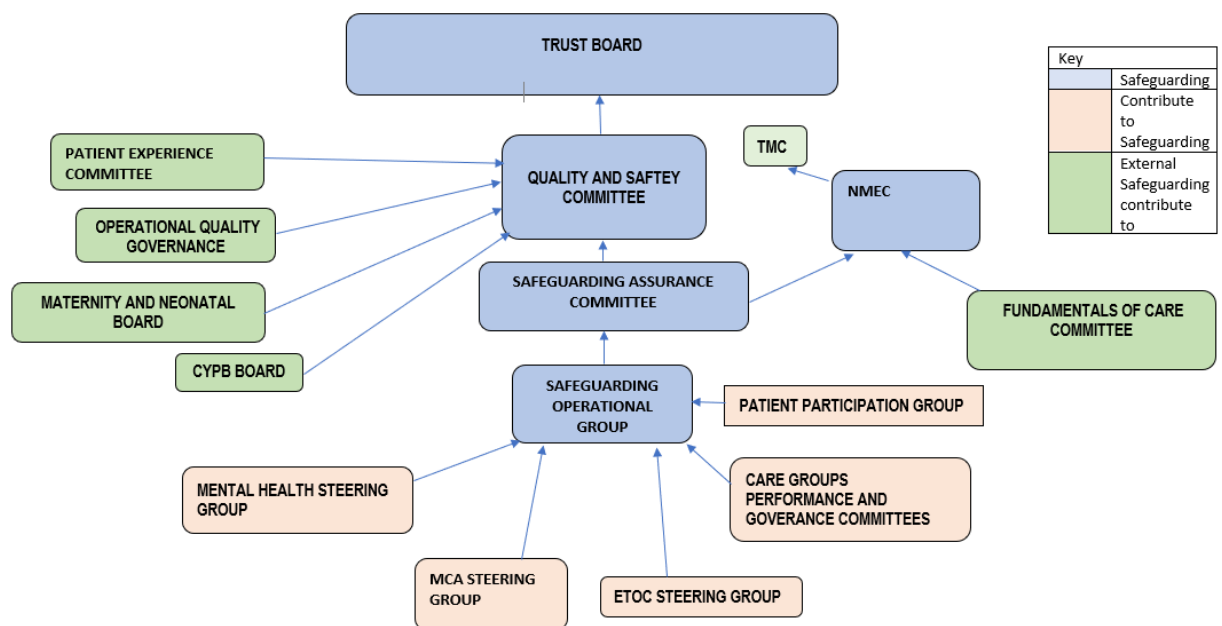
Statutory safeguarding responsibilities

4.2.1 East Kent Hospitals University NHS Foundation Trust has a legal and statutory duty to safeguard and promote the welfare of children, young people, unborn babies and adults at risk who access our services. Safeguarding is fundamental to the Trust's commitment to delivering safe, effective and compassionate care and is embedded within all aspects of clinical practice, governance, workforce development and partnership working.

The Trust discharges its safeguarding responsibilities in accordance with national legislation, statutory guidance, NHS England requirements, and local multi-agency safeguarding arrangements.

- Working Together to Safeguard Children
- Care Act 2014
- Mental Capacity Act 2005
- Deprivation of Liberty Safeguards
- Counter-Terrorism and Security Act 2015 (Prevent Duty)
- NHS England Safeguarding Accountability and Assurance Framework
- CQC Regulation 12 (Safe Care and Treatment)

5. Reporting Framework



5.1 Governance Structure

- 5.1.1 Operational safeguarding issues across all Care Groups are identified, reviewed, and mitigated through the Safeguarding Operational Group and associated Task and Finish Groups, with representation from all Care Groups to ensure a coordinated and consistent approach.
- 5.1.2 The Safeguarding Operational Group provides assurance and reports directly to the Safeguarding Assurance Committee.
- 5.1.3 The Safeguarding Assurance Committee reports onward to the Quality and Safety Committee.
- 5.1.4 The Quality and Safety Committee provides assurance to the Trust Board, which retains overall accountability for safeguarding.
- 5.1.5 Clear escalation pathways are in place to ensure safeguarding concerns are appropriately managed. Issues identified at operational level are escalated through the Safeguarding Assurance Committee to the Quality and Safety Committee and, where required, to the Trust Board. This structure ensures robust oversight of safeguarding from frontline services to Board level.
- 5.1.6 The Safeguarding Assurance Committee also escalates relevant concerns to other key governance forums, including the Patient Safety Committee and the Fundamentals of Care Committee, ensuring that safeguarding is fully integrated within wider patient safety and quality governance arrangements.
- 5.1.7 System-wide safeguarding issues affecting patients are escalated through the Safeguarding Assurance Committee, with oversight provided by the Quality and Safety Committee and Trust Board. Where appropriate, these issues are further escalated to external partners, including commissioners, local authorities, and NHS England, ensuring effective multi-agency oversight and response.

5.2 Safeguarding Operational Group

The Safeguarding Operational Group is chaired by the Associate Director of Safeguarding and provides a forum for reviewing operational safeguarding activity across the Trust. The group monitors delivery against a suite of safeguarding key performance indicators, with input from the Safeguarding Team, Associate Directors of Nursing, and Heads of Service. This supports oversight of performance, identification of emerging risks, and coordination of improvement actions.

5.3 Safeguarding Assurance Committee

The Safeguarding Assurance Committee met bi-monthly during the reporting period and is chaired by the Chief Nursing and Midwifery Officer as the Executive lead for safeguarding. The Committee provides strategic oversight, scrutinises safeguarding performance, and ensures effective governance and assurance across all safeguarding domains.

5.4 Safer Recruitment

The Trust has maintained robust arrangements for safer recruitment. Assurance is provided through monitoring staff compliance with safeguarding training and competency requirements, alongside clear escalation processes for non-compliance. An audit of Disclosure and Barring Service (DBS) checks confirmed that staff hold the appropriate level of clearance in line with Trust policy, national DBS guidance, and NHS Employment Check Standards, ensuring compliance with statutory requirements.

5.5 Participation in Wider Trust Governance

5.5.1 The Associate Director of Safeguarding attends, or is represented at, key governance forums including the Fundamentals of Care Committee, Maternity and Neonatal Board and the Nursing and Midwifery Executive Committee (NMEC). These forums enable the sharing of safeguarding themes, trends, and learning with Care Group leadership.

5.5.2 Named Nurse for Safeguarding children attends the Children and Young People's Board on behalf of the associate director of safeguarding, providing updates on safeguarding training compliance, risks, and performance. This ensures that safeguarding considerations are embedded within service development and improvement initiatives across children's services.

5.6 Care Group Governance Participation

5.6.1 The Safeguarding Team maintains active engagement within Care Group governance structures. The Deputy Head of All Age Safeguarding participates in the Children's Care Group clinical governance processes, while the Named Midwife contributes to Women's Health governance meetings.

5.6.2 Site-based safeguarding leads have expanded their engagement with Care Groups, including attendance at governance forums and collaboration with Patient Safety Business Partners, strengthening integration between safeguarding, quality, and patient safety agendas.

5.7 Patient Safety Incident Response Framework (PSIRF)

- 5.7.1 Safeguarding is embedded within the Trust's Patient Safety Incident Response Framework (PSIRF). Named Safeguarding Professionals attend weekly incident review meetings to provide specialist safeguarding advice and ensure risks are appropriately identified and managed.
- 5.7.2 The Associate Director of Safeguarding contributes to weekly decision-making regarding incident responses, ensuring that safeguarding considerations inform the level and type of investigation undertaken. The Safeguarding Team also works closely with patient safety colleagues, contributing to decision-making relating to falls, pressure ulcers, and nutrition, and maintains regular oversight of incidents reported through the Trust's incident reporting system (DATIX).

5.8 Service User Engagement

The Safeguarding Team works closely with the Patient Advice and Liaison Service (PALS) and the Patient Experience Team to ensure that safeguarding concerns arising from complaints or feedback are appropriately identified and addressed. Safeguarding representation is maintained at Serious Incident Panels, and relevant cases are regularly reviewed through internal safeguarding case management processes to ensure learning and oversight. A patient Participation partner is a key member of the Safeguarding Assurance committee and the Safeguarding Operational Group

5.9 Complaints

The Safeguarding Team provides specialist input into complaints where safeguarding considerations are identified. This includes contributing to written responses, supporting local resolution processes, and ensuring that safeguarding risks and learning are fully considered within complaint investigations.

6. Safeguarding Sustainability

- 6.1.1 During this period, the Trust has made progress against all areas of the safeguarding sustainability plan. There are identified areas for improvement across a number of workstreams.
- 6.1.2 The progress of the Safeguarding Sustainability plan is reviewed twice a year. This includes review of current safeguarding activity workstreams, progress against external oversight objectives, care group input and feedback from the Committee.
- 6.1.3 Throughout the year, safeguarding standards were self-assessed against the NHSE Safeguarding Accountability and Assurance Framework (SAAF). Progress and identified gaps are monitored through the Safeguarding Assurance Committee and supported by Integrated Care Board benchmarking activity.

7. Statutory Safeguarding reviews

- 7.1 During 2025–2026, EKHUFT contributed to a range of multi-agency learning reviews, demonstrating active engagement in system-wide learning. This included participation in Safeguarding Adult Reviews (SARs), Domestic Homicide Reviews (DHR), Domestic Abuse Related Death Reviews (DARDRs), Child Safeguarding Practice Reviews (CSPRs) and Rapid Reviews. This activity supports the identification of themes,

learning, and opportunities for service improvement both within the Trust and across the wider safeguarding system.

- 7.2 All recommendations arising from case reviews relevant to EKHUFT are formally tracked through internal governance processes. Progress against actions is monitored and reported to the Safeguarding Assurance Committee on a bi-monthly basis, with risks or delays escalated as appropriate to ensure effective implementation and organisational learning.

Safeguarding Adult Reviews (SARs)

- 7.3.1 During the reporting period, the Safeguarding Team contributed to **1** Safeguarding Adult Review (SAR), compared to 3 SARs in the previous year. In addition, the Trust completed 17 Rapid Reviews and provided 2 Summary of Agency Involvement reports.
- 7.3.2 All SAR-related activity is managed through structured case management processes, ensuring oversight of progress, quality, and timeliness. Where SARs are published by Kent and Medway Safeguarding Adults Board, they are systematically reviewed to identify key themes and learning relevant to EKHUFT. These are incorporated into internal workstreams, with progress monitored through the Safeguarding Assurance Committee.
- 7.3.3 The Trust has actively contributed to system-wide learning by presenting applied learning from SARs at the Adult Health Reference Group, demonstrating how learning is embedded into practice and supporting continuous improvement across the wider health system.

Domestic Abuse Related Death Reviews (DARDRs)

- 7.4.1 Under Section 9 of the Domestic Violence, Crime and Victims Act 2004, local areas are required to undertake multi-agency reviews following a domestic homicide. These reviews are overseen locally by Community Safety Partnerships, with contributions from all relevant agencies.
- 7.4.2 During 2025–2026, EKHUFT participated in 3 Domestic Abuse Related Death Reviews (DARDRs) and 1 associated rapid review, providing detailed information about Trust involvement and contributing to multi-agency learning.
- 7.4.3 Following legislative changes introduced through the Victims and Prisoners Act 2024, to consider Domestic Abuse Related Death Reviews (DARDRs). There are an increasing number of summaries of agency involvements requested by the community Safety partnership
- 7.4.4 Participation in DARDRs enables the Trust to identify missed opportunities, strengthen safeguarding responses, and improve partnership working, particularly in relation to identifying and responding to domestic abuse across healthcare settings.

Child safeguarding practice reviews

- 7.5 The children's specialist practitioners within the safeguarding team undertook eight rapid reviews during the reporting period, compared to two in 2024/25. There were no Child Safeguarding Practice Reviews this year, in contrast to one undertaken in 2024/25. This work involved the safeguarding team collating and analysing information relating to staff involved in each care episode, supporting attendance at

multi-agency practitioner events, and overseeing the development, implementation and monitoring of resulting action plans. All actions are systematically tracked through case management processes and monitored via the Safeguarding Assurance Group

Child Death reviews

- 7.6.1 The Local ICB lead the Child death process once reported. The Trust has new policy replacing the previous guideline that supports staff in the process to follow. All unexpected Child deaths trigger a joint agency response (JAR) to establish initial clinical interpretation of cause of death, any identified concerns and support for the family. The new child death A lead clinician is identified to attend with the safeguarding team if there are any identified safeguarding concerns. Following this the ICB co-ordinate review through the child death overview panel and are responsible for distributing learning across the health system. Learning from unexpected child deaths is incorporated into peer review.
- 7.6.2 During this reporting period 19 Child Deaths have been notified through Safeguarding
- 7.6.3 The Safeguarding team have provided information to Nine Joint Agency response meetings following an unexpected child death. This helps ensure forensic and safeguarding considerations effectively and plan a co-ordinated response

8. Other statutory Reporting

8.1 Female Genital Mutilation (FGM)

This is classified as a form of child abuse in the country and those participating in it can be prosecuted under the FGM Act (2003) The serious crime act (2015) requires all regulated health professionals in England and Wales to report any known cases of FGM where there is a risk to a child and directly identified cases in individuals to the police. Data about risk for 34 people was reported to the Department of Health as per statutory reporting requirements, Compared to 33 the previous year. There was no mandatory reporting required for individuals under 18.

- 8.1.1 FGM-IS system alerts the practitioner to FGM being within females in the family. The system can be checked if pregnant people under the age of 18 years present. If baby girls are born at EKHUFT to a mother with FGM then their details are added to FGM-IS, as a further safeguarding measure information about familial FGM is put in the baby's red book as per national guidance.
- 8.1.2 The FGM policy is in place which reflects national guidance.
- 8.1.3 During the final quarter of the year, reduced capacity within the Safeguarding Administration Team resulted in a backlog of data entry and reporting activity. Consequently, a number of safeguarding records relating to previous reporting periods were entered retrospectively and captured within a single month. This generated an apparent increase in reported activity, which reflects a reporting anomaly rather than a genuine rise in safeguarding referrals or workload. Although the backlog remains, measures are being implemented to strengthen administrative resilience, improve reporting capacity, and support the timeliness, accuracy, and reliability of safeguarding data going forward. This risk is reflected on the corporate risk register, has been escalated through the quality and Safety committee.

8.2 Child Protection Information System (CPIS)

- 8.2.1 The National CP-IS project was implemented at EKHUFT in early 2018. Staff in unscheduled settings such as ED, children's wards and maternity access the system using their smart card through an icon on the ZENworks desktop. This allows the staff member to see if the child is on a child protection plan or is 'looked after' and sends a message back to the Local Authority informing them of the attendance to EKHUFT. The UTCs now have a fully automated system so this area is no longer audited.
- 8.2.2 Audits of the use of the system have been undertaken on the children's wards.
- 8.2.3 The safeguarding team are no longer receiving a list of the children subject the CPP in mitigation the access to CPIS information and KMCR information would enable staff to contact the safeguarding team about patient in their care who require safeguarding.
- 8.2.4 Children with known with safeguarding history at EKHUFT are be flagged on Allscripts. All children with this flag continue to be alerted to the safeguarding team in real time. In addition, there are a small cohort of children who are additionally flagged at the request of our multi-agency partners or the safeguarding team. There are governance arrangements in place around the flagging.
- 8.2.5 The flagging for safeguarding concern alerts the safeguarding team of a child's admission to any EKHUFT site.

9. Policies

- 9.1.1 The Trust has continued to strengthen safeguarding systems, policies, and processes to ensure sustainability and compliance with statutory requirements
- 9.1.2 All safeguarding policies are current and aligned with national guidance
- 9.1.3 All trust policies which were renewed this year have been reviewed by the Safeguarding team as a member of the policy Approval group.

Safeguarding Policy Title	Date for review	Lead
Was Not Brought to Outpatient Appointments (Children)	27/07/2027	Safeguarding
Was Not Brought to Outpatient Appointments (Adults)	11/01/2028	Safeguarding
Safeguarding Children Policy	26/03/2027	Safeguarding
Child protection Medical Policy	27/03/2027	Safeguarding
All Age Safeguarding Supervision Policy	11/01/2028	Safeguarding
Covert Administration of Medicines Policy	01/11/28	Drugs and therapeutics committee

All Age Clinical Restraint, Restrictive and Safe Holding Practices Policy	27/05/2027	Mental Health
All age Mental health	27/03/2027	Mental Health
Domestic Abuse Policy (Patients and Staff)	01/01/2029	Safeguarding
Mental Capacity and Deprivation of Liberty Safeguards Policy	01/03/2028	Safeguarding
Missing Patient/Person Policy for Children, Young People and Adults (including Staff)	12/12/28	Mental Health
Managing Allegations against People in a position of Trust	30/04/26	Safeguarding
Safeguarding Adult Policy	30/04/2026	Safeguarding
Prevent Policy	30/04/2026	Safeguarding
Child Death review Policy	01/11/28	Safeguarding
Maternity Safeguarding Risk Assessment Guideline	<i>Published 2026</i>	<i>Maternity</i>
Perplexing Presentation and Fabricated/induced illness Guideline	24/05/2027	<i>Safeguarding</i>

Table 8: Safeguarding policies and Guidelines 2025-2026

10 PREVENT

As an NHS organisation the trust is required under the prevent duty (counter terrorism and security Act 2015) to provide training to ensure staff can recognise when a person is at risk of radicalisation and take steps to report it. The safeguarding team offer level 3 training, delivered face to face and level 2 online through ESR. The training materials were updated following input from the local Prevent team

- 10.1 No Prevent referrals were made in relation to an adults or children. Benchmarking information available from other acute NHS trusts indicates that referral numbers are typically very low and may vary considerably between organisations and reporting years. Therefore, the absence of referrals should not be interpreted in isolation as an indicator of either positive or negative performance. Assurance is instead derived from Prevent governance arrangements, workforce training compliance, staff awareness, and the organisation's ability to identify and appropriately escalate concerns when they arise.
- 10.2 Multi- agency, local Authority led Channel panels, supported by Kent Police aim to discuss the risks posed by an identified individual who is thought to have been

showing signs or involved in activity which would indicate they have been radicalised and could pose a risk to the local population. No referrals were made to the Channel panel for patients of any age.

- 10.3 The Safeguarding team received 35 PREVENT requests in relation to children compared with 28% the year before representing an increase 25%
- 10.4 For over 18s during this reporting period. Over the year, 57 requests were made to the team, this is an increase of 137% from the previous year.
- 10.5 PREVENT data returns were completed and sent quarterly as per our statutory reporting requirements.
- 10.6 1351 staff received Level 3 PREVENT training
- 10.7 91.6% of staff requiring Level 2 compliance achieved it.

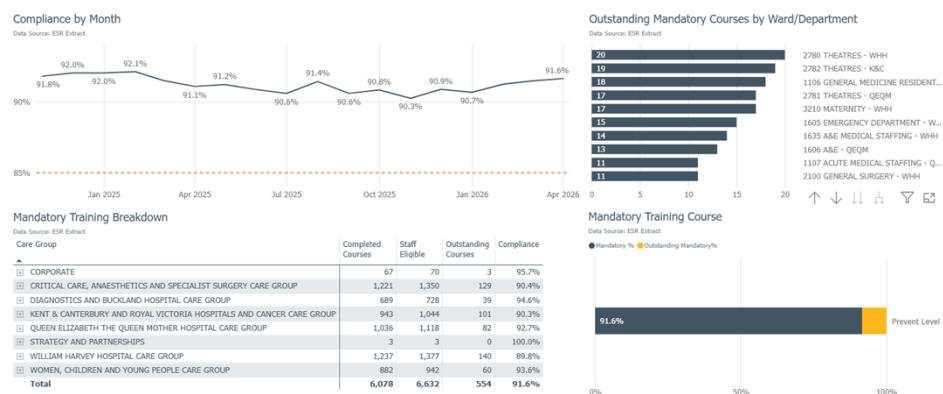


Figure 1: Number of staff trained in PREVENT at level 2

11. Other Regulated Activity

Child protection medicals

- 11.1 This year 61 Community Child protection medicals were performed until Community 'Paediatric services moved to KCHFT from October. Child protection Medicals continue to be completed within the Trust these numbers are reflected in the investigations for non-accidental injuries.

Site	2023-2024	2024-2025	2025-2026
Community Child Protection Medicals	119	115	60

12. Managing Allegations against Staff

- 12.1 The Trust has robust arrangements in place to oversee allegations, concerns, and incidents involving staff. Safeguarding services work in partnership with Human Resources, Professional Standards, Freedom to Speak Up, and operational leaders to ensure concerns are identified, risk assessed, and managed appropriately.
- 12.2 All allegations against staff are managed as per the Managing Allegations Against Staff Policy and are DATIX reported and investigated by the Police where appropriate. Oversight is maintained through established governance arrangements, including review of themes, trends, learning, and outcomes from allegations management

processes. This provides assurance that concerns are managed consistently, investigations are undertaken where required, immediate risks are mitigated, and appropriate actions are taken to safeguard patients and support staff throughout the process.

Managing Allegations Against Staff- Requiring referral to the Local Authority Designated Officer (LADO)

- 12.3 When an allegation is made against a member of the children's workforce, the needs of the child and other children with whom the professional comes into contact are considered paramount as advocated by the Children Act 1989. Employers, however, have an additional duty of care towards their staff and thus the complexities involved in responding to such allegations require balance and careful judgement to ensure risk and support are measured at both levels. During the year 11 cases involving staff were referred to the Kent Local Authority Designated Officer. There were no themes/departments overly identified, except most cases have been where staff 's own children have been subject to child protection investigations or plans.

Managing Allegations Against People in a Position of Trust (PiPoT)

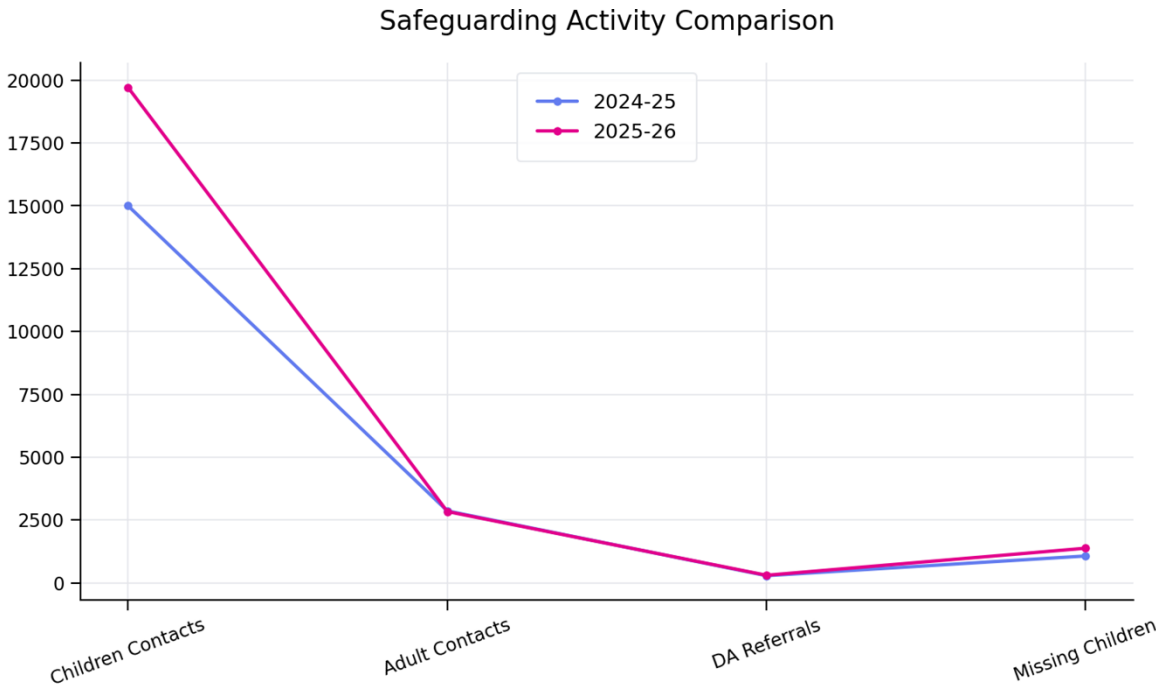
- 12.4.1 Where allegations meet the threshold for police involvement, patients are encouraged and supported to report their concerns to the police. As a healthcare organisation, we are not responsible for determining whether a criminal offence has been committed and do not have the authority to conduct criminal investigations; this is a matter for the police and other relevant law enforcement agencies.
- 12.4.2 Further support has been offered to senior managers who are supporting staff who have had an allegation made against them.
- 12.4.3 Managing allegations cases are discussed monthly with the Chief and Deputy Chief nursing and midwifery officer.
- 12.4.4 This year 32 referrals were made following allegations made against adults.

13. All age Safeguarding activity

Duty

- 13.1 The Safeguarding team continue to provide All age advice though a duty telephone and email service. Contact numbers remain high providing assurance that staff at EKHUFT have good awareness of what to do if they have concerns about a patient. The operation of a duty system, Monday to Friday 9-4, includes access to children, adult, midwifery, homeless, domestic abuse and mental capacity and DoLS expertise. This information is recorded with safeguarding systems to inform practitioners decisions on safe care and discharge pathways.
- 13.2 The duty system is also used by multi-agency partners and ensure they receive a prompt response when they need to request information sharing from the trust or share information with the trust in order to safeguard service users at EKHUFT.

Number of consultations



Multi-Agency information sharing

13.3 The Safeguarding Team plays a key role in facilitating and coordinating multi-agency information sharing to protect adults and children at risk of abuse or neglect. The team ensures that relevant information is shared lawfully, proportionately, and in a timely manner with partner agencies, including local authorities, the police, health providers, education services, and other statutory and voluntary organisations. This contributes to multi-agency risk assessments and safeguarding enquiries and promotes effective partnership working to support safeguarding outcomes.

Missing Persons

13.4 The Trust continue to be proactive working with our police partners to support the Missing Person agenda. The teams have undertaken reviews of people who went missing for the Police MCE Team to identify if any of these children have had engaged with the Trust at the point of the missing episodes. The adult team are also contacted daily for vulnerable missing adults (Table 2).

Activity	April 2022 – March 2023	April 2023 – March 2024	April 2024 – March 2025	April 2025 – March 2026
Missing and Child Exploitation reviewed children	1788	1074	1068	1376
Missing and Child Exploitation shared information	32	29	32	31
Missing Adults reviewed	549	660	463	509
Missing adults shared information	2	18	20	11

Table 1: Number of missing contacts from Kent Police

14. Supervision

- 14.1.1 It is essential that staff who are involved in safeguarding have access to supervision should they require it, the two Intercollegiate documents (RCN 2024, RCPCH 2025) set out the appropriate levels of supervision for specific roles.
- 14.1.2 The new Joint Trust supervision policy outlines the ways different levels of supervision could be accessed. Improving engagement with supervision has been an all-age priority this year. The Trust is responsible for ensuring that its workforce is competent to carry out their responsibilities for safeguarding and promoting the welfare of children, to do this, it is key an environment is developed where they feel supported and able to raise concerns. Supervision is available in different formats and all staff are also able to access 'individual supervision' through the duty system.
- 14.1.3 Supervisor training was delivered to maintain the number of available safeguarding supervisors.
- 14.2 The Safeguarding team have access to individual supervision during their monthly one to ones and through the leadership team if required throughout the day. There is weekly opportunity for group supervision during case management. The safeguarding leadership team have access to peer supervision through a provider network.
- 14.3 Group supervision is also available for the safeguarding team which is delivered by staff outside of the safeguarding team to ensure staff have a forum to express any safeguarding team challenges.
- 14.4 The Named Nurses and Named midwife are joining new quarterly peer supervision with their colleges from across the Kent and Medway health economy.
- 14.5 The Deputy and Associate Director of Safeguarding receive regular supervision.
- 14.6 Case-holding staff, are offered with 4 sessions, as per the policy, the expectation is that they will attend 3 of those sessions. The number of case holding staff has reduced due to the reconfiguration of community paediatric service, previous data is therefore no longer comparable.
- 14.7 Safeguarding supervision is beginning for the senior leadership team to support out of hours dynamic safeguarding risk assessment.
- 14.8 The safeguarding team internal supervision levels are 100% in compliance with the policy.
- 14.9 Maternity safeguarding supervision has continued to be a challenge compliance. Each community midwifery team are offered 8 sessions across the year, more virtual sessions were also provided open to all midwives.
- 14.10 Community Midwives have been offered sessions of supervision within their community teams throughout the year. Eight additional sessions were opened up to all community midwives offered during this year. There is also opportunity to discuss safeguarding cases at the daily sit rep with safeguarding community and inpatient services attend-149 individual supervision sessions maternity, sitrep.
- 14.11 Safeguarding Children Supervision has hybrid model across all specialities. In the Emergency Department figures this model of supervision has continued to be successful in supporting learning from practice.

- 14.12 All staff are offered supervision following and during completion of section 42 investigating officer report for safeguarding adults. 16 members of staff post section 42.
- 14.13 The Named professionals deliver peer supervision for the safeguarding team as part of case management weekly and ad hoc on individual cases as required.
- 14.14 Paediatricians also attend 'Peer Review' where case discussion, learning and support are offered. This is run by the Designated and Named Doctors quarterly and is well supported by the Paediatric Medical teams from both the Acute and Community sector teams attending. This is now including both EKHUFT and KCHFT employees. Members of the safeguarding team and health professionals from across child health attend these sessions. There was a 12% increase in attendance this year.
- 14.15 EKHUFT have a cohort of TRiM practitioners and managers, this is an initiative which is designed to provide psychological support to staff in the aftermath of potentially traumatic incidents. Trim practitioners are trained to help individuals who may be distressed and to facilitate onward referral for specialist support if this is deemed necessary. The Safeguarding team have 2 members of staff trained as a practitioner and they have been available to support teams across the Trust when incidents have occurred.

Activity	Q1	Q2	Q3	Q4	TOTAL	INCREASE
Safeguarding team					100%	
NICU SCBU	37	52	47	49	185	27%
Urgent and Emergency Care	68	92	99	115	374	26%
Peer Review	29	69	23	65	186	12%

15. Safeguarding Pregnant people and new born babies

- 15.1.1 Maternity Safeguarding includes the assessment of social risk and provides a unique opportunity for the earliest intervention to minimise risk to the new born baby when they arrive. It requires a holistic picture of the whole family or support network to consider safety, current risk or health issues which could affect the outcomes for the unborn baby and any other siblings. Professionals must try to enable the right support to be put in place to maximise parenting capacity whilst maintaining a safe environment.
- 15.1.2 The safeguarding of adults, children, unborn babies and neonates is a unique and critical component of maternity services. In response to ongoing national maternity reviews and improvement programmes, this has been a priority area for safeguarding development during the reporting period. Service changes have been designed to ensure that the voice of the unborn child is recognised, birthing people are protected from harm, and learning from *Reading the Signals*, local safeguarding reviews and national maternity improvement work is translated into practice.
- 15.1.3 The Safeguarding team contributed to the CQC inspection of Maternity services the inspection highlighted a comprehensive safeguarding approach.
- 15.1.4 The Named midwife provides leadership and expertise in the maternity safeguarding space. As part of the National maternity Network and co- chair of the south east named midwives network she is able to influence the local and national safeguarding agenda. Assurance is provided by the Named midwife on how we as a Trust

recognise pregnant people and their families at safeguarding risk who may require further support and babies who require protection within the first 28 days following birth.

- 15.1.5 In February, Maternity Services funded the recruitment of two Specialist Safeguarding Midwives (1.6 WTE) on a one-year fixed-term basis to support the embedding of safeguarding processes and practice. Their role includes providing ad hoc ward-based safeguarding supervision, improving compliance with maternity safeguarding audits, and strengthening safeguarding supervision arrangements. The impact and effectiveness of this initiative will be evaluated at the conclusion of the programme.
- 15.1.6 Joint work has been taking place with the Consultant Midwife and the Safeguarding team around supporting people who choose to Freebirth whilst trying to maintain measure to assess if safeguarding is required.
- 15.1.7 A preventative safeguarding approach has been taken when considering those patients with health inequalities struggling to access maternity care and the impact this can have on parenting capacity. As part of the Named midwives SE Network the Named Midwife for Safeguarding has contributed to work on a toolkit for supporting Asylum seeking pregnant people.

Positive feedback - "the team on the ward could not have been more helpful and supportive in a safe and sensitive way..." KCC Children's Social Care

- 15.1.8 The locally developed maternity support form acts as a way of considering concerns about the family pre-birth and once the birth has occurred against local safeguarding thresholds. In addition, it is used to share information with the wider health network including health visitor and GPs. The role is supported by the Safeguarding children's advisors and practitioners.
- 15.2 Local community health providers delivering Health Visiting services have revised their information-sharing arrangements and now accept referrals and information from 28 weeks' gestation onwards. This has presented challenges in ensuring the early transfer of relevant safeguarding information from the point of maternity booking. All of the acute trusts have been working with the ICB to try and resolve this issue.
- 15.3 The Complex maternity tool was evaluated during this year and it was nominated during safeguarding adults week for the innovation on safeguarding award
- 15.4 A new pack was created for recording inpatient safeguarding observations to enable greater recognition around parenting capacity and sharing information when new-borns are subject to family court proceedings at birth
- 15.5 Multi agency training was provided to support the management of cases where babies cannot go home with their birth family for safeguarding reasons.
- 15.6 The Safeguarding team received 3620 Maternity Support forms from Midwifery, these are reviewed at 34 weeks and safeguarding action plans determined for these families. The number of family's subject to pre-birth planning at the time of birth has continued to fall. The threshold for pre-birth plan is determined by the local authority.

Activity	April 2023 – March 2024	April 2024 – March 2025	April 2025 – March 2026
MSF	4304	3810	3620

Pre birth plans	201	174	161
Provided report	Data not available	84	67+1 review

- 15.7 Reports were provided for 67 initial pre- birth and one review child protection conference this is an important part of ensuring the voice of the child is heard from a health perspective.
- 15.8 An audit on the delivery of ICON messaging was completed and current practice is being evaluated in response to findings.
- 15.9 The Safeguarding team now attend a daily Sit rep to discuss maternity safeguarding risks. The safeguarding team also contributed to the national review of maternity services.
- 15.10 The Named midwife had contributed to Patient Safety Rapid reviews when safeguarding review was requested.
- 15.11 The Safeguarding team have also supported with information for GPLs attending Maternity Safeguarding Hubs hosted by the local authority.

16. Safeguarding Children

- 16.1.1 EKHUFT Safeguarding team received 19,709 general safeguarding children contacts during the reporting period, representing a 4% increase compared to the previous year. This included a 32% increase in contacts from Urgent Treatment Centres, equating to an additional 582 contacts. This increase is likely to reflect improved recognition of safeguarding concerns, greater staff confidence in seeking advice, and strengthened working relationships between safeguarding and clinical teams. It may also suggest that more children with safeguarding needs are presenting to UTC services. Ad hoc safeguarding supervision was undertaken for 1,042 admissions.
- 16.1.2 The Child Health Care group have been doing work throughout the year to capture the Voice of the child and use this to improve services. They have direct feedback from inpatients through Tops and Pants , a new little steps programme modelled on the 10 Steps programme to assess the ward environment and how this can be developed to make children and young people feel safe and well supported during their care.
- 16.1.3 The safeguarding team quality assured 304 Referrals for Support (RFS) to the Local Authority.
- 16.1.4 25 Cases were assessed and managed under the Non-accidental injury protocol with relevant multiagency liaison and investigations.
- 16.1.5 The Safeguarding assessment form on the electronic record was amended with contributions for the Emergency department teams on what improvements could be made to ensure children's safeguarding is identified and alerted to the team in a timely way.

Activity	Q1	Q2	Q3	Q4	TOTAL
Children managed under Non- accidental injury pathway	8	5	6	6	25

Referrals to Children's Social care	85	73	84	62	304(-10%)
Paediatric Liaison	69	74	47	44	234(-11%)
UTC contacts	146	160	150	126	582(32%)

16.1.6 A process is in place to monitor the quality assurance of the referrals into Social Services. A Quality Assurance checklist has been devised, scoring referrals out of a possible 10 and this has been incorporated into the Safeguarding Children Policy since 2018.

16.2 EKHUFT can provide assurance that all the written referrals undertaken by our staff all scored 7/10 or above, the majority scored 8/10 or above this demonstrates an improvement last year.

16.3 1757 Multi agency safeguarding reports were received by the team from children's social care, considered and added to child safeguarding records.

Activity	Q1	Q2	Q3	Q4	TOTAL
Strategy Discussion	71	94	77	76	318
Initial Child Protection Conference	0	1	5	5	11
Review child Protection Conference	0	1	0	0	1
Multiagency safeguarding reports received	275	933	629	709	2546
TOTAL	71	96	82	81	330

16.4 The team worked together to produce a resource for staff attending strategy meetings.

16.5 Training workshops were delivered on professional curiosity.

16.6 There have been changes to the way children's mental health is supported with the change over from NELFT to KMMH services and the number of specialist nurses supporting children with mental health challenges. Rising numbers of young people with complex needs and contextual risks presents a challenge for a service which is designed for physically unwell children. Keeping these children safe whilst awaiting appropriate care provision has presented a safeguarding challenge.

16.7 There has been a number of staff who have held the Named nurse for Safeguarding children role this has which impacted safeguarding leadership in other areas as the Named midwife and the deputy head of safeguarding stepped in to manage children's safeguarding workstreams.

17. Looked after children

17.1.1 The safeguarding team recognise the unique challenges faced by children who are currently in the care of the local authority. Whilst their needs will be individually assessed it is important that the EKHUFT workforce understand through training and case discussion the risks and health inequalities these young people face.

17.1.2 The Deputy head of Safeguarding and the Associate Director of Safeguarding now share the responsibility for looked after children.

- 17.1.3 In October when community paediatrics' moved so did the responsibility of the Trust for completing Looked after children's initial assessments.
- 17.1.4 Adoption forms recording health information are completed by the maternity team to capture Maternal and neonatal health history for children who are taken into the care of the local authority.
- 17.1.5 Following a child death work was completed with the children's workforce around parental responsibility and workshops about professional curiosity focusing on the some of the challenges care experienced children face.

18. Paediatric Liaison

- 18.1 As part of information sharing arrangements identified in the Children Act (2004), all ED attendances to EKHUFT are shared with our primary care partners, i.e. GPs, Health Visitors and School Nurses. These are primarily undertaken electronically with the support of our IT team. However, for those children who do not have an identifiable Kent postcode, this is managed manually by the Safeguarding team.

19. Was not Brought

- 19.1.1 Health exclusion is a significant factor for safeguarding particularly neglect. Early Intervention can be hugely significant outcomes for individual children ensuring that there has been re-engagement with the health provision they require to achieve their own individual potentials outcomes
- 19.1.2 This year, 1004 missed appointments were reviewed by the team compared with 1541.
- 19.1.3 There has been a reduction in the volume of cases where children not being brought to their health appointments (Figure 3) were reviewed by safeguarding due a reduction in children's health appointments conducted by EKHUFT since October.

Activity	Q1	Q2	Q3	Q4	TOTAL
Was not Brought	368	236	224	176	1004

Figure 2: Decrease in WNB April 2025 – March 2026

20. Safeguarding Adults

Safeguarding Adults workstreams

- 20.1.1 The Safeguarding Adult patient tracker list is used to monitor activity of the Safeguarding team, this is also available to wards
- 20.1.2 As part of the digital transformation a new section was created on DATIX to support the review of incidents from a safeguarding perspective
- 20.1.3 A new guide was created to support Making Safeguarding personal discussions

Safeguarding adult referrals

20.2 The care Act (2014) provides a definition of individuals with care and support needs who may be at risk of abuse, neglect or exploitation. The team also consider what further support might be required under the well-being principle of the care Act. The adult specialist in the team receive initial referrals identifying risk through the all-age duty system, these come in a range of formats.

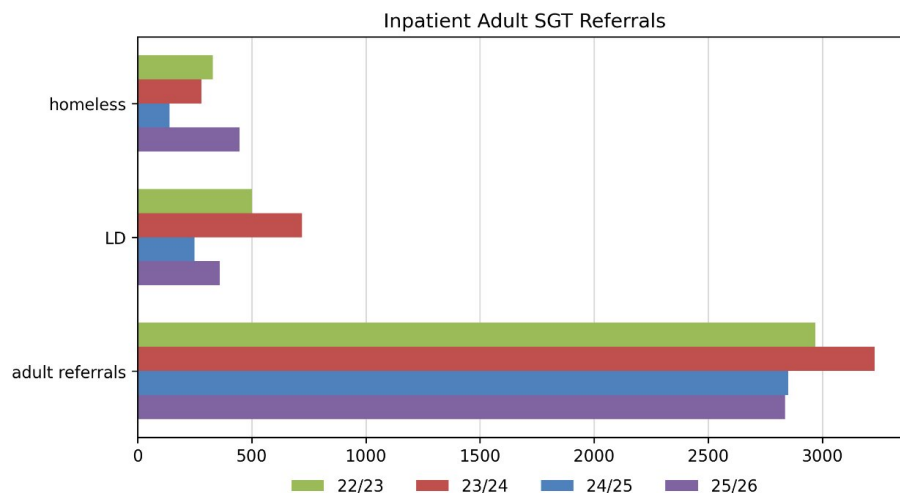


Figure 3: Number of Adult Referrals

Adult Social care Referrals

20.3 The EKHUFT workforce including the Safeguarding team raised Kent Adult Safeguarding concerns forms both against community services and against the Trust. They also responded to referral to the local authority raised by other agencies against the trust.

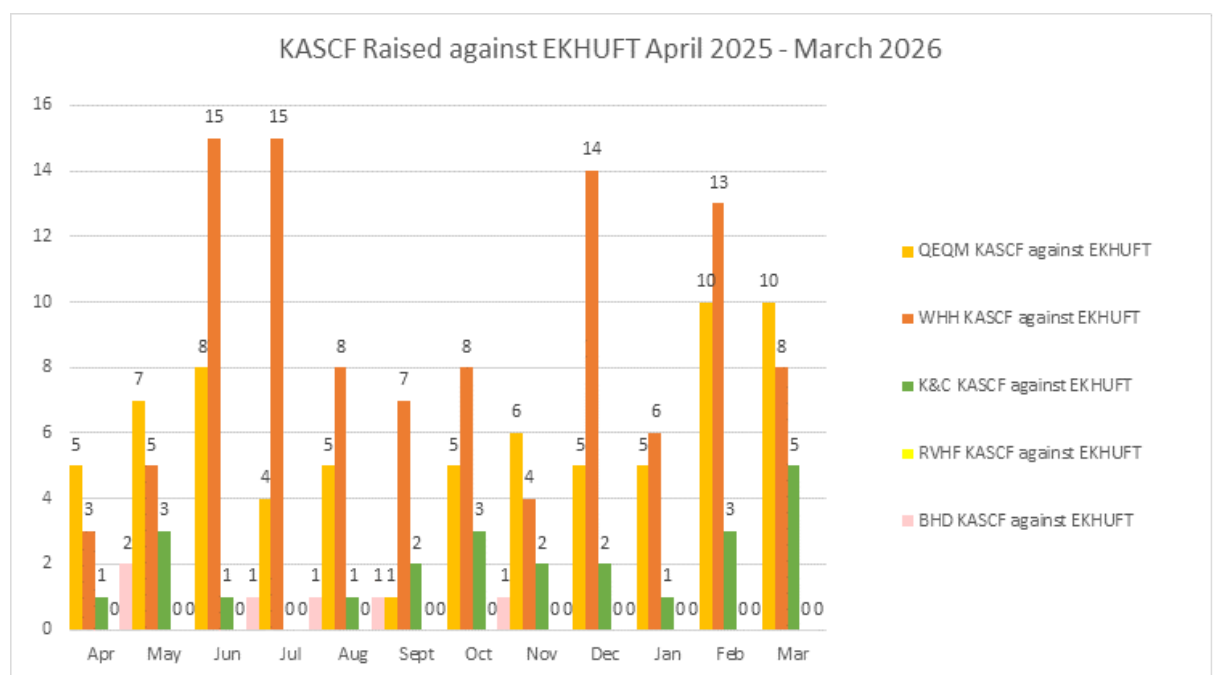


Figure 4: KASCFs raised against EKHUFT per site 2025-2026

20.4.1 Following receipt to the referral the local authority will decide if it meets threshold. All Section 42 Enquiries are notified to CQC by Social services. All cases raised as Care Act Section 42 Enquiries are logged on DATIX and those meeting the criteria for a

PSIRF investigation are reported to the ICB. All allegations against staff are managed as per the Managing Allegations Against Staff Policy and are DATIX reported and investigated by the Police where appropriate.

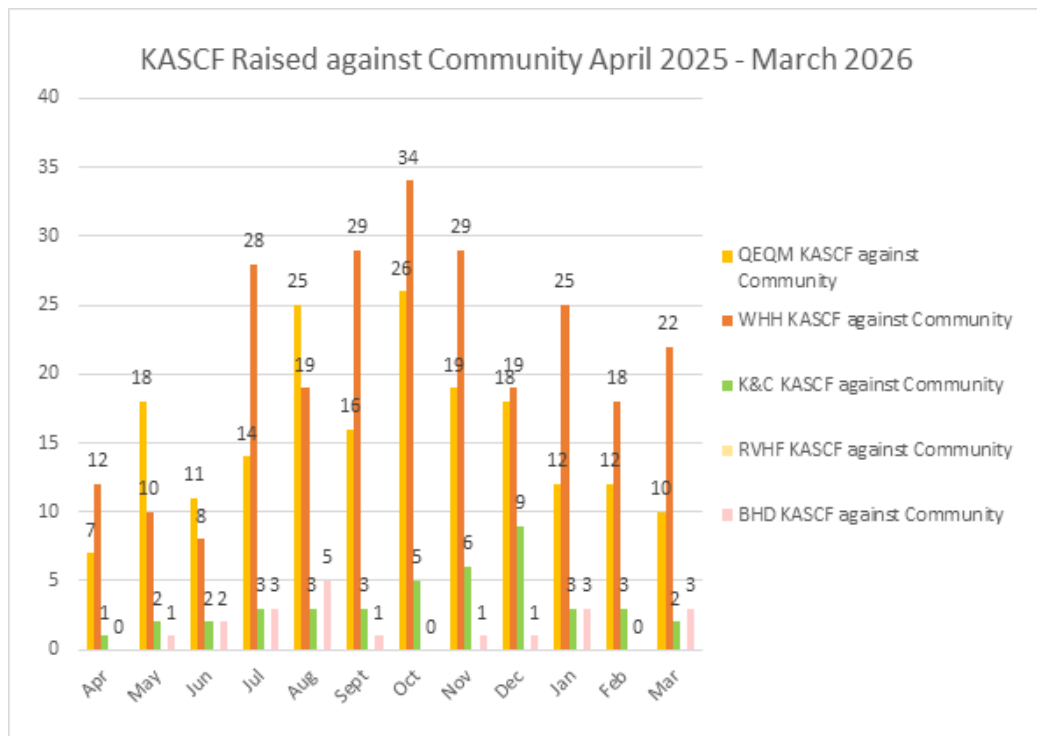


Figure 5: KASCFs raised by EKHUFT per site for community issues 2025-2026

Theme	Q1	Q2	Q3	Q4	TOTAL
Self Neglect	25	61	62	42	190
Neglect	18	29	22	38	107
Domestic Abuse	12	20	27	21	80
Physical	7	16	7	4	34
Financial	7	7	8	5	27
Emotional	2	6	9	3	20
Organisational	1	5	0	2	8
Sexual	1	1	4	1	7
Mate Crime	1	0	0	2	3
Trafficking	1	0	1	0	2
Not Applicable	1	1	3	3	8

Section 42 Enquiries

20.5 Since January 2024 delegate the completion of IO reports to the leads within the care groups. This is now supported by a standard operating procedure (SOP) for staff to follow and access to a training video and best practice guides/templates to aid high quality completion.

20.5.1 The operational group monitors themes emerging from individual care groups S42 Investigations highlighting actions and discussing lessons learnt. A report from this group is then sent to Safeguarding Assurance committee for oversight of themes and areas for learning and improvement. Exceptions are shared with the Quality and

Safety Committee and system wide issues shared with the Kent and Medway Safeguarding Adult Board.

- 20.5.2 The Safeguarding team meet monthly with Kent county council safeguarding teams to improve the responsiveness of the Trust and the Local Authority to section 42 Enquiries.

Outstanding section 42	Q1	Q2	Q3	Q4	End of year Outstanding
QEQM	6	2	0	3	0
WHH	5	2	1	2	2
KCH	2	1	0	0	0
Awaiting KCC decision	25	34	19	27	33

21. Mental Capacity

- 21.1 The Named Nurse for Safeguarding Adults also holds responsibility for MCA/ DoLS.

21.1.1 There is an operational Lead Nurse for MCA/DoLS to support EKHUFTs understanding through training and assurance in relation to application and Compliance with the Mental Capacity Act (MCA) including application for DoLS unfortunately due to sickness this person has been required to support the safeguarding adults function limiting progress with MCA and DoLS workstreams.

21.1.2 The first MCA /DoLS compliance audit was completed with significant areas for improvement in relation to utilization available tools and record keeping.

21.1.3 A bespoke training package has continued to be delivered virtually throughout the year this supports the application of a suite of support materials to aid assessing mental capacity, supporting best interest decision making and identifying any deprivation of liberty.

21.1.4 Training sessions and audit day presentations were delivered both face to face and virtually across a range of specialities to meet the specific needs of particular staffing groups including scenario-based application.

21.1.5 The Named Nurse for Safeguarding Adults/ MCA Lead provides safeguarding leadership within the Clinical Ethics Committee, contributing specialist expertise to guide and influence decision-making, while ensuring safeguarding principles and patient rights remain central to all deliberations.

21.1.6 The MCA Steering Group continues to oversee and coordinate this workstream, ensuring that assurance standards are maintained, best practice is promoted, learning from local and national systems is incorporated, and its application within the Trust is effectively monitored.

21.1.7 The Named nurse has supported the Kent and Medway Safeguarding adults board to update available resources in response to the themes of MCA utilization in Safeguarding adults' reviews.

21.1.8 An MCA /DoLS Policy is in place, and is currently being refreshed an audit to monitor adherence. MCA/DoLS training content is included in all levels of safeguarding training offer by the Trust. This is reflected in the training needs analysis.

21.1.9 A quality improvement project has been commenced including Dip Sampling compliance with DoLS in wards areas and weekly assessment of documentation for those patients where a DoLS application has been made.

22. Deprivation of Liberty Safeguards

22.1.1 The number of referrals for Deprivation of Liberty Safeguards (DoLS) remains proportionate to the size of the Trust. These figures are supplied by the DoLS office (KCC). The DoLS office share this information with the safeguarding team.

22.1.2 The number of referrals for Deprivation of Liberty Safeguards (DoLS) remains proportionate to the size and activity of the Trust.

22.1.3 The DoLS Office within Kent County Council (KCC) provides the EKHUFT Safeguarding Team with a weekly list to assess whether DoLS applications are still require assessment. The team share this any updated information around request in order for them to prioritise assessment and authorisation.

The outcome of DoLS applications by EKHUFT are notified to the CQC.

Site	2022-2023	2023-2024	2024-2025	2025-2026
K&C	202	222	202	210
WHH	563	589	607	548
QEQM	423	479	501	579
Total	1,188	1,290	1310	1337

Table 2: DoLS figures comparison 2022-2026

23. The impact of Mental Health and Learning disability workstreams on safeguarding

23.1.1 The Associate Director of Mental health, Learning Disability, Autism and Dementia reports safeguarding impacting workstreams in to the Safeguarding assurance committee, Nursing and Midwifery Executive and Fundamentals of Care Committee's.

23.1.2 The Mental health Lead reports operational considerations impacting safeguarding in the safeguarding operational group.

23.1.3 There has been a review of Learning Disability and Autism staffing provision. This has included recruitment and further development of services for service users who have neurodiversity. This supports the at times complex safeguarding required for these patients.

23.1.4 A new training programme has been delivered to support application of the restraint policy. This will enable the compassionate application of restrictive practice where they are required.

23.1.5 The safe use of restraint across the trust has been an area of challenge. The primary need to use restraint has been patients presenting a risk of harm to themselves, followed by risk to staff and other patients. Consistent recording of restraint is an area for development. The training offer around safe practice has been reconsidered. There is a new supporting positive behaviours group led by the deputy chief nurse.

23.1.6 A Number of policies which support effective Safeguarding have been updated by the Mental health team. These include the Enhanced Therapeutic observations policy which has new assessment criteria. A New Missing policy has been developed with multiagency partners.

23.1.7 A meeting has been established to aid collaborative working between the associate directors of safeguarding and mental health to discuss escalations, complex issues and cases.

24. Domestic abuse

24.1 The executive Lead for Domestic abuse is the CNMO.

24.2 The Trust has a Domestic abuse policy which has been updated this year.

24.2.1 The trust Safeguarding team are supported by Hospital domestic abuse advocates who work across EKHUFT sites in Margate, Canterbury and Ashford.

24.2.2 The Domestic Abuse Hospital Independent Violence Advocates (HIDVA) provide support to families and staff who are the subject of physical or psychological abuse via the provision of a dedicated Hospital Domestic Abuse Advocate.

24.2.3 The HIDVA team have delivered a conference this year to support staff understanding of domestic Abuse.

24.2.4 The Teams have provided training for staff in our emergency departments to improve confidence of staff asking questions about domestic abuse and what is best practice for supporting patients who disclose domestic abuse They have continued to provide support to staff and patients. The numbers of referral remain consistent, these are reported via the care flow system (Table 3). During this timeframe all HIDVAs were in post and covered all sites.

24.2.5 The Use of hospital independent domestic abuse advocates has continued to rise each year although there is room for this to grow further when considering the number of cases heard at MARAC.

Activity	Q1	Q2	Q3	Q4	TOTAL
WHH/KCH referrals to Rising sun team	40	28	48	49	175
QEQM referrals to Oasis	26	33	39	27	125
Activity	April 2022 – March 2023	April 2023 – March 2024	April 2024- March2025	April 2025- March2026	
HIDVA Referrals	193	214	283	300	

Table 3: HIDVA Referrals

24.2.6 The Services have attended the operational group to provide an update on available services and also to support practitioners asking difficult questions

24.3 The domestic abuse policy has been updated and training requirements have been refreshed, strategies for staff to use with patients and information for people managers supporting staff including the Trust's well-being services for staff have been added

25. MARAC

25.1.1 This year there have been significant changes to the way the MARAC collects information and triages cases with only the highest risk cases continuing to be heard. Unfortunately due to the new process despite there being less enquires there has been an equal amount of times spent due to the nature and duplication of requests. This information was shared and considered in the evaluation of the new system.

25.1.2 The following number of cases had data provided for the victim, perpetrator and any children for the family shared with the MARAC service around recent attendances to EKHUFT (Table 8), this helps support the safety planning for the victims. All victims and their children are flagged for one year from the start of their safety plan via the alert system on Allscripts, allowing practitioners to be aware of this information and to incorporate this into their assessment of the patient at their attendance.

25.1.3 The number of cases information is shared for has reduced by 45% this reflects a change to the MARAC process. Also following the initial set up EKHUFT was not notified of all cases of clients who may have accessed EKHUFT services. This meant south Kent cases information was not requested.

25.1.4 Retrospective flagging was completed following the MARAC sharing details of south Kent cases at risk 604 cases.

Sites	April 2022 – March 2023	April 2023 – March 2024	April 2024- March 2025	April 2024- March 2025
Ashford	173	181	154	52
Canterbury	166	200	183	73
Dover	179	163	181	150
Folkestone	91	150	168	52
Thanet	220	222	263	208
Total	578	916	948	535

Table 4: MARAC enquiries

Flagged	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Adult records	105	90	116	229	540
Childrens Records	138	122	152	307	782

26. Homelessness

26.1 EKHUFT have a statutory legal duty (Homelessness reduction Act 2017) to assist that individual; with their consent, to make a homelessness approach to the local authority. There is close liaison with all relevant Local Housing Authorities including the 'Rough Sleeper Teams' that sit within those local authorities. Encouraging Multi agency

working when an individual is admitted to hospital and requesting complex discharge planning meetings, has enabled staff to address the complex issues, that often-mean individuals have multiple attendances to the acute EKHUFT setting.

- 26.2 The Pathway Team includes a GP, Nurse, housing officer and charity sector worker. The team covers all sites across the Trust, offering advice support and guidance when an individual is identified as being homeless. Staff are supported and signposted if an individual is identified as having Adult Safeguarding/ Self neglect issues and assist with suggestions with regard to appropriate referrals interventions.
- 26.3 Many individuals who are homeless suffer health exclusion with limited interaction with Primary care services. Finding a GP practice, and registering proves challenges.
- 26.4 The Safeguarding team work closely on this project with the Homelessness Pathway team to providing support on the interface between homelessness and safeguarding, this had resulted in work being strengthened around discharge following the patient having no medical criteria to reside.
- 26.5 A significant proportion of individuals who are experiencing housing issues require advice or support to enable a safe discharge where possible.
- 26.6 Most patients experiencing homelessness have a history of significant trauma. Unstable housing itself can present additional safeguarding risks, including increased vulnerability to exploitation, neglect, poor physical and mental health outcomes, and barriers to accessing consistent care and support.
- 26.7 EKHUFT staff are encouraged to adopt a trauma-informed approach and to take into account the impact of Adverse Childhood Experiences (ACEs),. Awareness of these issues is embedded within Level 3 training and is regularly reinforced through interaction with the homeless pathway team.

Homeless Pilot pathway	37	31	37	36	46	49	42	48	43	42	31	36	447 (-1%)

Figure 6: Homeless Safeguarding Referrals

27. Reachable moments

- 27.1.1 Reachable moments project has supported young people attending hospital following suspected assaults this year ensuring they are offered support as part of a scheme launched by the Kent and Medway Violence Reduction Unit (VRU). As part of the 'Reachable Moments' project, youth workers were stationed at accident and emergency departments in Medway and Thanet to engage with those who may have been injured at the hands of others, including using weapons.

	Q1	Q2	Q3	Q4
23/24	21	33	43	52
24/25	75	71	70	89
25/26	84	66	89	36

Table 5: Reachable Moments per quarter

- 27.1.2 The safeguarding team interface with the community safety partnership to support disruption activity, with the aim to reduce the local exploitation risk.
- 27.1.3 The Reachable Moments Project will conclude at the end of this financial year. The project has extended beyond ED to the whole site and extending in age range from 12-25 years. The purpose of the project is to enable the victim to develop understanding about how they came to be hurt and what support they or their families may need to help them move away from criminal activity such as carrying knives or being involved in county lines or gang activity. Staff can be clearly identified by their bright orange polo shirts.
- 27.1.4 Quarter three data shows there were 89 referrals which is an increase of 35%. The referrals were mostly females 72/89, there were also 13/89 males and 3/89 non-binary people. 48/89 were under eighteen and 39/89 between 18-25 years.
- 27.1.5 Quarter four data shows there were 36 referrals. The referrals were mostly females 34/36. 22/36 were under eighteen and 14/36 between 18-25 years. The project will cease at the end of this financial year.

28. Risk Management

- 28.1.1 Care groups are responsible for reporting risk incidents the safeguarding team will report a risk when they become aware that a safeguarding risk has not been managed in an appropriate or timely way which has led to increased risk.
- 28.1.2 The Safeguarding team meet regularly with the Patient Safety team to consider any themes, delays and complex cases.
- 28.1.3 The Associate Director for Safeguarding attends the Incident Review Panel to Offer Safeguarding oversight on risk incidents across the trust.
- 28.1.4 The Named Nurse for Safeguarding Adults represents the Safeguarding Team at the Pre-Incident Review Panel and will involve other Named Nurses on a case-by-case basis, as appropriate. The Safeguarding Team's attendance at the Fundamentals of Care Panel and Rapid Review meetings is determined on a case-by-case basis, where they provide safeguarding risk analysis and contribute to informed, multidisciplinary decision-making.
- 28.1.5 The Senior Safeguarding specialists within the team review site-based incidents alerted to the Safeguarding team. Incidents are analysed to identify underlying contributory factors, safeguarding risks, and system-wide themes. This approach supports proportionate learning responses, including safety actions, thematic reviews, and quality improvement initiatives.
- 28.1.6 Themes from incidents are explored at the Safeguarding operational group. The group ensures that safeguarding insights are triangulated with wider patient safety intelligence, enabling cross-system learning and strengthening preventative practice. Emerging themes are used to inform policy development, staff training, and service improvement, and are escalated through governance structures as required to support organisational learning and patient safety improvement.
- 28.1.7 The Associate Director of Safeguarding reviews the safeguarding risks monthly.
- 28.1.8 At the end of this period of report there remained three open risks on the corporate register.

- Safeguarding Digital recording delays
- Delay in reporting and flagging records due to safeguarding administration capacity issue
- Safeguarding Training compliance

29. Partnership working

29.1.1 Multi-agency partnership working is fundamental to the effective safeguarding of adults, children, and families. The Integrated Care Board (ICB) fulfils its statutory safeguarding responsibilities by representing the health economy as one of the three safeguarding partners within both the Kent and Medway Safeguarding Adults Board (KMSAB) and the Kent and Medway Safeguarding Children Partnerships. This ensures a coordinated, system-wide approach to safeguarding, oversight, and accountability.

29.1.2 This year a major national transformation programme is in progress for children's social care, now being implemented across Kent through the Kent Safeguarding Children Multi-Agency Partnership and Kent County Council. The programme aims to fundamentally redesign how services support children and families, shifting from reactive, statutory intervention to earlier, preventative, and family-centred support. Locally, Kent is progressing this through a multi-agency, co-designed model involving children's services, health, police, education, and the voluntary sector. The Associate Director, Deputy Head of Safeguarding and the Named Nurses for Safeguarding Children have participated in the Health steering group for the Family's which is led by the ICB.

29.1.3 The Trust's Associate Director of Safeguarding and the Named Nurse for Safeguarding Adults maintain a strong and active presence across KMSAB subgroups, providing leadership, professional expertise, and assurance on behalf of the organisation. This includes participation in:

- Business Group
- Communications and Engagement Working Group
- Quality Assurance Working Group
- Policies, Practice and Procedures Working Group
- Safeguarding Adults Review (SAR) Group (with health representation supported by KMPT)

This engagement enables the Trust to influence strategic priorities, contribute to multi-agency learning, and ensure alignment with local safeguarding policies and expectations.

Work within the Task and finish groups of the board extends knowledge of the local safeguarding landscape and who we support our local population through co-ordinated work with services.

The Chief Nurse and on delegation the Deputy Chief nurse and the associate director of Safeguarding represent the trust at the executive safeguarding adults board.

29.1.4 The ICB represents all provider organisations within the Kent and Medway Safeguarding Children Partnership, ensuring coordinated health system engagement. The Trust Safeguarding Team actively contributes to partnership priorities through participation in task and finish groups as required. The Deputy Head of Safeguarding represents the Trust on the Policies and Procedures Group, supporting the development and implementation of multi-agency guidance. Children's

and Maternity Named Professionals further contribute to partnership activity through participation in multi-agency audit programmes and by promoting shared learning, strengthening safeguarding practice and continuous improvement across the system.

29.2 The team attend the SE Health provider network.

29.2.1 The Named Professionals participate in the Adults', Children's and All-Age Health Reference Groups, which provide a system-wide forum to bring together safeguarding leads across health organisations. These groups aim to promote consistency in safeguarding practice across health services in Kent, support the sharing of emerging risks and learning, and provide professional challenge and assurance across the health economy. Through active engagement, Named Professionals contribute specialist expertise, support the development, ensure that lessons from safeguarding reviews, audits, and incidents are embedded into practice. This participation strengthens the health voice within the Kent Safeguarding Partnerships and supports continuous improvement and the delivery of high-quality safeguarding care across the system.

29.3 The team attend the Maternity safeguarding networks.

29.3.1 The Associate Director of safeguarding and Named Midwife actively participate in the National Safeguarding Maternity Network, Named Midwife co-chairs the South East Regional Maternity Safeguarding Network, providing visible leadership and strategic influence across both regional and national forums. This role is of particular importance in the context of the local Ockenden reviews and, more recently, the National Maternity Review, which have highlighted significant failings in safeguarding, governance, and the identification and escalation of risk within maternity services. In response, there is an ongoing national focus on strengthening safety culture, multi-agency working, and early identification of vulnerability within maternity care. Through participation and leadership in these networks, the Named Midwife ensures that learning from national inquiries, emerging risks, and best practice are rapidly translated into local systems and practice. She is also able to offer unique insight from the East Kent Reading the signals response. This supports improved safeguarding oversight, enhances professional standards, and ensures that the Trust remains aligned with national expectations for maternity safety, quality, and safeguarding assurance.

29.4 The team attend the Safeguarding Adults National Network.

29.4.1 The Associate Director of Safeguarding actively participates in the National Safeguarding Adults Network, providing strategic oversight and contributing to the development of national safeguarding priorities. Over 2025–2026, this has included engagement in consultation and discussion on safeguarding transformation, particularly in relation to strengthening multi-agency assurance, improving system leadership, and responding to increasing complexity and demand within adult safeguarding services. In addition, this work aligns with priorities set by the Kent and Medway Safeguarding Adults Board (KMSAB) during 2025–2026, including a focus on prevention, early identification of risk, assurance of safeguarding practice, and embedding learning from Safeguarding Adults Reviews (SARs). Through participation at both national and local levels, the Associate Director ensures that emerging policy, learning, and best practice are translated into local governance and operational delivery, strengthening the Trust's contribution to system-wide safeguarding improvement and assurance.

30. Training

Level 2 Compliance

30.1.1 The annual figures show there has been an increase in meeting the agreed local compliance standard at level 2 (Figure 11, Figure 13). This is delivered through ESR.

Level Three training compliance

30.1.2 This has been inconsistent. As this is a face-to-face course, frontline staff must be available to attend the full-day session. This has been monitored weekly at care group level.

Level 4 Training compliance

30.1.3 There has been a bespoke level 4 Training session attended by the Safeguarding leadership team, Chief Nurse, Chief Medical Officer, Directors of Nursing and Midwifery or a representative of the Care group and the paediatric lead for child health.

30.2 The safeguarding team training figures show compliance of the whole team.

Training delivery

30.3 During the year 18 New starter level 3 courses were delivered with 482 attendees and an overall DNA rate of 15%.

30.3.1 During the year 23 courses Refresher level 3 courses were delivered with 659 attendees and an overall DNA rate of 11%.

30.3.2 A further seven level 3 courses were delivered as part of Doctors induction programme 201 participants attended and there was an overall DNA rate of 11%. This was a new and successful way to ensure Safeguarding training was delivered to new doctors in a timely way, it also gave availability for other Trust doctors to attend. This has supported the improved compliance across the medical and dental staffing groups.

Employees compliance at required level by staff group	Safeguarding Children			Safeguarding Adult		
	Head Count Required	Head Count Gained	Compliance %	Head Count Required	Head Count Gained	Compliance %
Add Prof Scientific and Technic	273	246	90	273	265	97
Additional Clinical Services	1729	1591	92	1729	1661	96
Administrative and Clerical	1941	1937	99	1941	1940	100
Allied Health Professionals	669	586	88	669	624	93
Estates and Ancillary	4	4	100	4	3	75
Healthcare Scientists	270	262	97	270	268	99
Medical and Dental	1367	1164	85	1367	1175	86
Nursing and Midwifery Registered	3462	3020	87	3462	3048	88
Students	25	21	84	25	23	92
Grand Total	9740	8831	91	9740	9007	92

Figure 7: Training Figures by staff group (March 26)

30.3.3 The training strategy and training needs analysis has been reviewed and updated against the current intercollegiate documents (RCPCH 2019 and RCN 2025) this is likely to be published in the first quarter of next year.

30.3.4 During the last quarter the have been weekly training reports shared with the care groups to ensure pockets of non-compliance in wards and departments are highlighted to care groups so action to improve and maintain compliance is undertaken.

2025-2026	Apri	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
L3	100	100	100	100	100	100	100	100	100	100	100	100
L4	100	100	100	100	100	100	100	100	100	100	100	100

Table 6: Safeguarding team Training Compliance levels 2025-2026

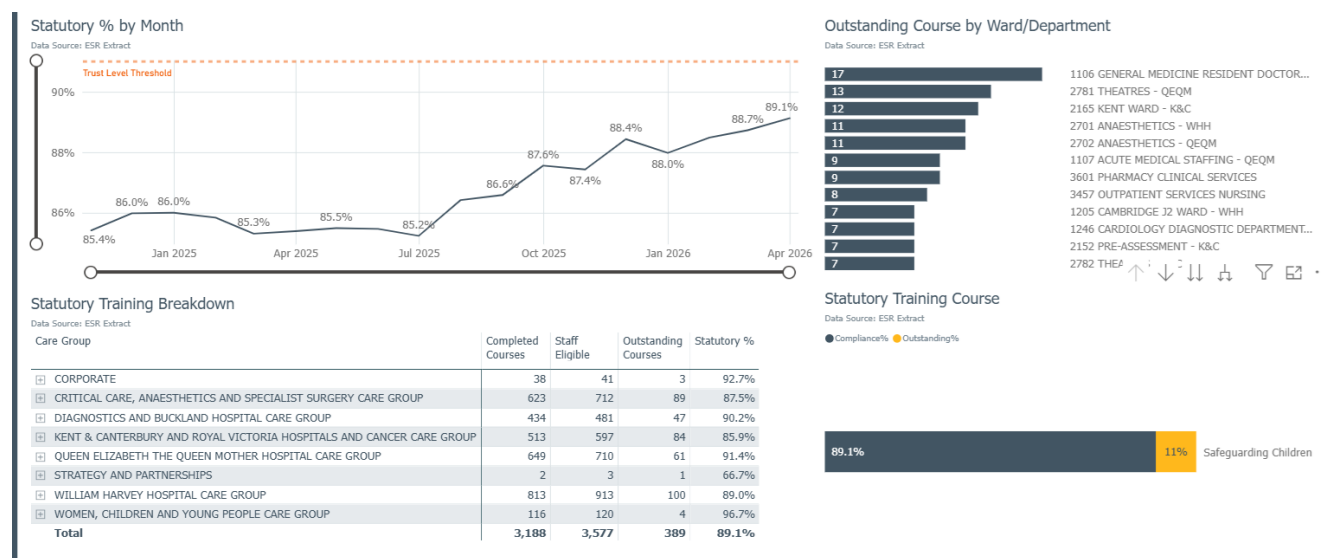


Figure 8: Safeguarding children's level 2 Training

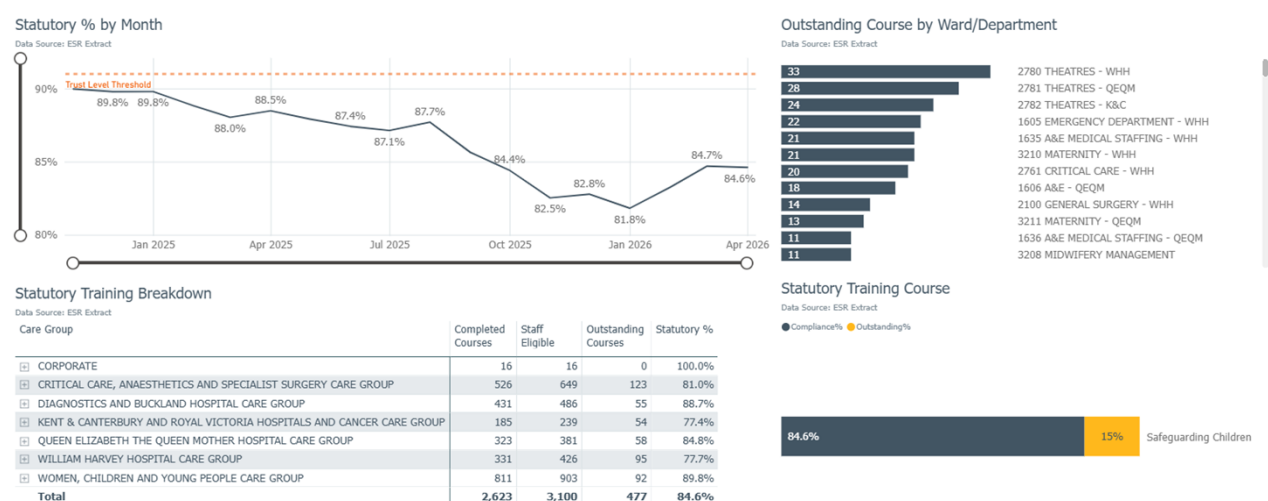


Figure 12: Safeguarding children's level 3 Training

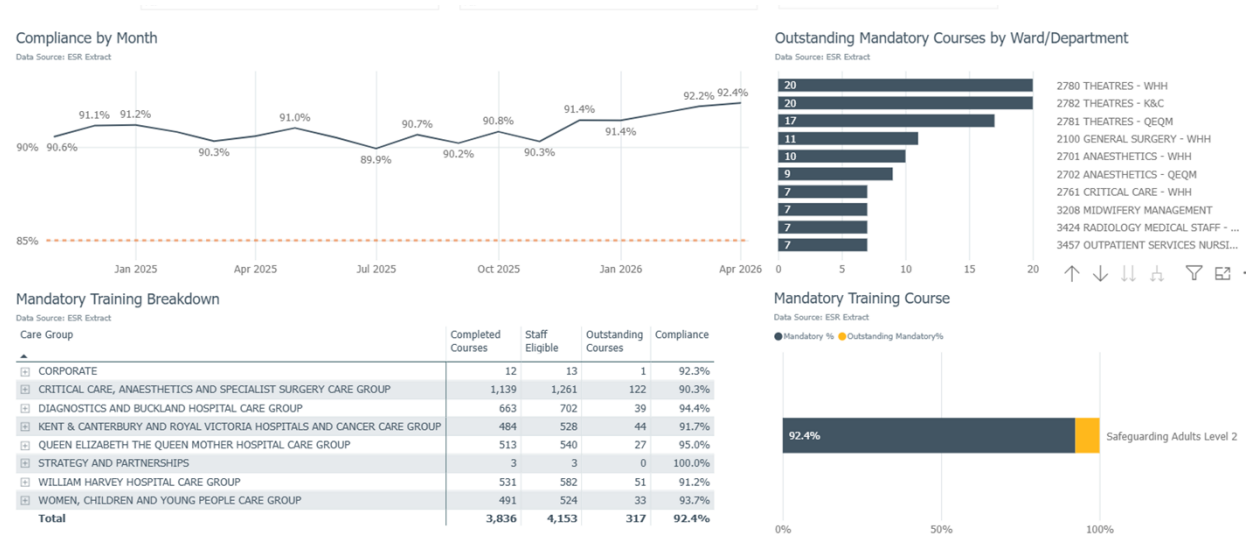


Figure 13: Safeguarding Adults level 2 Training

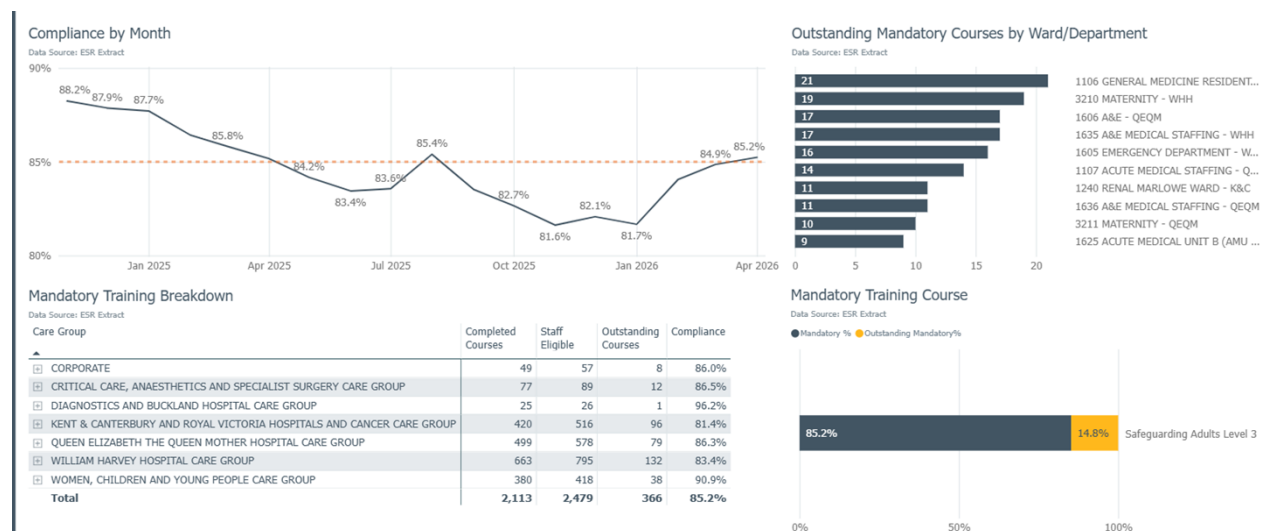


Figure 14: Safeguarding Adults level 3 Training

31. External Audit/Reporting

Adults

31.1.1 The Kent and Medway Safeguarding Adults Board (KMSAB) Self-Assessment Framework (SAF) was submitted. One amber-rated action was identified relating to the provision of coordinated support for patients with co-occurring conditions.

31.1.2 Assurance was provided that the Psychiatric Liaison Team has clear referral pathways into the co-occurring conditions panel and that documentation standards within the electronic patient record (EPR) are robust. On the basis of this evidence, the action was reviewed and closed at the first peer review.

31.1.3 At the time of writing, the Trust is awaiting feedback and outcomes from the next KMSAB SAF submission cycle. Any emerging actions will be incorporated into the safeguarding work programme.

Homelessness

31.1.4 EKHUFT contributed to a multi-agency audit focused on individuals at risk of, or experiencing, homelessness. The audit identified the following priority areas for improvement:

- Strengthening legal literacy in relation to the “Duty to Refer” and capacity assessments
- Improving the quality of professional curiosity regarding living arrangements
- Enhancing documentation and communication standards
- Embedding consistent multi-agency working practices

Actions: Targeted training, revised guidance, and strengthened partnership engagement are being progressed to address these gaps.

Carers Assessments

31.1.5 A Carers Assessment Audit, undertaken in response to Safeguarding Adult Review (SAR) *Lummy*, identified that fewer than 50% of staff understood eligibility criteria or knew how to make appropriate referrals.

Actions implemented:

- Delivery of targeted micro-teaching sessions by site-based practitioners
- Development and publication of enhanced carers' resources on the Trust intranet
- Trust-wide communication via Trust News

Next steps: Ongoing monitoring of staff knowledge and referral rates, with further training aligned to identified gaps.

Safe Discharge

31.1.6 Two Safe Discharge audits were completed during the year to assess whether learning from SARs has been embedded. These demonstrated measurable improvement.

Improvement actions completed:

- Introduction of revised discharge planning documentation
- Implementation of a multi-agency information-sharing platform hosted by EKHUFT
- Establishment of a Rapid Transfer Service-led workstream

Further areas for improvement:

- Embedding a “Think Family” approach
- Strengthening documentation relating to self-discharge
- Increasing effective use of discharge lounges
- Improving compliance with discharge checklists

31.1.7 An audit in response to Domestic Homicide Review (DHR) learning examined the recording of carer information. Findings indicated that carers were typically recorded by relationship only, with full details captured in just 2.5% of cases.

Actions:

- Reinforcement of documentation standards with clinical staff

- Targeted communications to improve recording of carer details
- Ongoing audit and monitoring to ensure improvement

32. Safeguarding Children

32.1.1 EKHUFT submitted its Section 11 self-assessment to the Kent and Medway Children's Safeguarding Partnership.

A Section 11 audit identified a small action plan (three actions) to ensure full compliance. Progress is overseen by the Safeguarding Assurance Committee, with one outstanding action relating to supervision levels.

Actions: A focused supervision improvement plan is in place, with progress monitored through governance structures.

32.1.2 Following a Children's Safeguarding Rapid Review relating to a dog bite incident, clinical guidance for ED and UTC settings was reviewed.

Findings:

- Strong recording of incident location
- Inconsistent safeguarding and clinical responses
- Gaps in police notification and safeguarding team involvement formatting same below

Actions:

- Delivery of targeted training on updated guidance
- Exploration of improved systems for recording and flagging dog bite incidents
- Strengthened escalation pathways to safeguarding teams and external agencies

33. Internal Audit

33.1 A comprehensive safeguarding audit programme has been delivered, providing assurance on compliance with policy, guidance, and the implementation of learning from SARs and Rapid Reviews. Audit outcomes also inform ICB metrics and statutory submissions (Section 11 and SAF). The programme has been supported by the Trust Audit Team.

33.2 Audit of Disclosure and Barring Service (DBS) checks confirmed alignment with Trust policy, national DBS guidance, and NHS Employment Check Standards.

All-Age Training

34.1 The impact of safeguarding training is being evaluated through structured assessment (e.g. quizzes) to measure knowledge acquisition.

Action: Data analysis is being used to target and strengthen areas of weaker understanding.

34.2 A quality assurance process for safeguarding trainers has commenced.

Action: Newly appointed staff will complete "train the trainer" programmes to ensure consistent delivery standards.

Children's Audits

- 35.1** Monthly audits of RAG rating completion and CP-IS utilisation on children's wards were introduced due to initial poor compliance.

Progress:

- Demonstrable improvement over time
- Consistent use of CP-IS at admission

Outstanding issues:

- Incomplete familial data within RAG ratings
- Lack of clarity regarding responsibility for safeguarding actions

Actions:

- Revision of the social ward round proforma to capture required information
- Ongoing review through governance forums
- Planned re-audit to confirm sustained improvement

- 35.2** NICU and SCBU discharge planning audit is behind schedule. Data collection has been completed and reporting is nearing completion.

- 35.3** Audit of the "Was Not Brought" policy demonstrates appropriate compliance.

Action: Findings have been shared through Child Health governance structures, with no significant concerns identified.

Maternity Audits

- 35.4** ICON compliance has reduced compared to the previous year.

Actions:

- Targeted awareness and resource distribution during ICON Week (September 2025)
- Repeat audit scheduled for April 2026

- 35.5** Acute maternity audit actions have been fully delivered.

Updates:

- New safeguarding maternity documentation introduced (August 2025)
- Transition from SBAR to revised documentation

Action: A Quality Improvement Project (QIP) will include quarterly audits from February 2026.

- 35.6.** Formal audit of the maternity RAG tool has been replaced by ongoing monitoring via the SNAP tool.

Actions:

- Quarterly data collection continues

- Annual QIP reporting
- Ongoing audit of maternity support forms and safeguarding plans

35.7 CP-IS and CITO audit identified gaps in documenting safeguarding checks within new maternity records.

Actions:

- Review and redesign of documentation fields underway
- Daily maternity SitRep updated to include safeguarding as a mitigation

35.8 The Complex Maternity Tool QIP demonstrated good awareness but inconsistent use.

Actions:

- Planned re-audit with increased sample size
- Integration into case supervision processes

Adult Audits

36.1 An MCA/DoLS audit identified poor compliance with completion of capacity assessments, best interest decisions, and DoLS documentation in the EPR.

Actions:

- Implementation of a formal action plan
- Weekly compliance monitoring
- Targeted MCA training delivered to clinical teams
- Oversight via MCA Steering Group and Safeguarding Assurance Committee

36.2 Audit of Kent Adult Safeguarding Concern Forms (KASCF) showed:

Strengths:

- Good identification of care and support needs
- Clear categorisation of abuse types

Areas for improvement:

- Making Safeguarding Personal (MSP), including recording desired outcomes
- Documenting actions taken prior to referral
- Clarity regarding consent

Actions:

- Trust-wide communication via Trust News
- Enhanced guidance provided via safeguarding duty advice line
- Focus on improving quality and consistency of referrals

37. Audit Delivery

37.1 Some safeguarding audits were delivered behind schedule due to staff sickness and sustained service pressures.

Mitigation:

- Revised audit scheduling and prioritisation
- Strengthened workforce resilience planning
- Continued oversight through governance structures to ensure completion and quality assurance

38. Strategy Delivery



Our Patients		PROTECT  EMPOWER  SAFEGUARD 
Voice of the child/Adult	Improving the outcomes of children, young people and adults by ensuring that their voice is heard through implementing person centred care and positive outcomes focused approaches through a range of information sharing platforms, patient engagement groups and resources that advocate for patients.	
	• Patient Participation attends Safeguarding Operational and Safeguarding Assurance Committee • Safeguarding team Attend Babies, Children and Young people board – Top and Pants feedback, Little steps work has commenced in paediatric ward areas to seek the feedback of children – Making safeguarding personal – prompt sheet, pull trust news articles – themes of complaints- maternity work advocating rapid reviews voice of child and family – supervision, report writing, HIVDAs, IMCAs, Complex maternity tool from lived experience of a family • Carer Involvement work KE experience of care strategy stakeholder group, carers and hospital discharge toolkit	
Listening	Listening to our patients when they tell us when things go wrong and how we can put this right to protect them.	
	• Participation in Complaints Responses and LRM • Consideration of way complaint are logged by the team and themes. SAI, Rapid review – PR/comms / recognition communication, DATIX reviews – change form	
Think Family	Ensuring that the 'Think Family' approach is embedded in the assessments of safeguarding risk for families and that the right referrals and assessments are undertaken to protect adults, pregnant people, young people, children and babies at risk.	
	• Duty system- Decision making – supervision, guidelines and policies. Professional curiosity. LADO PIPOT work • Policy provision Training – analysis of material • All tools on sunrise under review - Updated the ED tool, SIT REP – activities • MSF, safeguarding paperwork, RAG tool KMSAB audits(carers quality KASCF)	
Trauma informed Safeguarding	We will advocate and promote trauma informed approaches in dealing with complex safeguarding issues and how adverse childhood experiences may have an impact on patients' long-term outcomes and how they can be supported with this	
	• Agenda item at operational group • Workshop ED, FGM training / level 3 training, J11 – debrief supervision mental health / safeguarding sept restorative clinical supervision, Joint training with social care Court processes - Safeguarding ops	
Making Safeguarding Personal	Ensuring that all children, young people and adults are kept free from harm within our organisation by reducing abuse and neglect through developing a culture that upholds Making Safeguarding Personal, promoting the principals of the Care Act for adults and for children principles as outlined in the Children Act.	
	• Policy • New prompt sheet developed to share with staff/ Intranet guidance • Site based and duty support • QA- System to be established -	
Risk Assessments	Ensure that all children, young people and family safeguarding risk assessments are undertaken as outlined in statutory guidance relating to the Children Act. Safeguarding ward paperwork,	

Our Patients	
Care and support needs assessments	Ensure that patients are made aware of their right to have care and support needs assessments where this is indicated and that concerns are raised with the LA for this to be considered as part of the Care Act requirements in line with our safeguarding policies and procedures
• Intranet guidance • Duty system • Task and finish group on discharge considering discharge planning • RTS- pathway support – Discharge Hubs • Level 1 leaflet update , Tissue Viability work- meeting TOR and review of outcomes MSF Complex maternity tool	
Carers assessments	Ensure that patients are made aware of their right to have care and support needs assessments where this is indicated and that concerns are raised with the LA for this to be considered as part of the Care Act requirements in line with our safeguarding policies and procedures
• Carers resources shared with care groups • Parents policy • Carers policy • New position at QEOM carers support – to consider impact • Digital team looking at recording additional carers on EPR Discharge planning Pre birth planning joint ICPC parenting assessments , Coroners discharge follow up (NMEC minutes) Safeguarding adults week .	
advocacy	Ensure that our patients have the right to advocacy services and that the effectiveness of this is monitored as part of our safeguarding arrangements and the need to promote patient's rights to this service and support.
• Onsite advocacy services- Advocate nominated per main site 1 day a week – agreed joint quarterly overview figures • Intranet • Policy • Advocacy figures increasing on business report	
Population health inequalities	We will consider the needs of our local population , the impact of health inequalities and inclusion on there need for safeguarding support
• Homeless pathway provision LD dataset safeguarding NHSI improvement standards • HIDVAS- conference High sheriff visit HIDVA ED TRAINING • Reachable moments • Discharge work, IMCAs – mental health too, Data Consultant midwife health inequalities - Freebirth work / access to care ??bus	

Our People	
Effective governance	Ensuring that there is clear accountability and transparency with regards to delivering the safeguarding agenda, by developing a robust system where there is an effective governance assurance framework.
• SAAF Self assessment / exception reporting / assurance agenda setting and slide deck • Fuller – dignity in Death Pre birth work ICPC Stats/ SIT Rep Pressure ulcer weekly FOC, FOC panel , meeting , MCA , MH steering , IRP Pre irp , monthly (regular)ASC meetings	
Reporting	Empowering our staff to challenge, report and act if they see or suspect safeguarding issues and that knowledge and skills are based on effective training and competencies aligned to national and evidence-based guidance and standards.
• Reporting discussed at operational group • Duty activity – National reporting FGM reporting DOLS CQC notification ,	
Training	Having an effective workforce that demonstrates up to date training and competency in safeguarding in line with the Intercollegiate Documents (ICD) for adults and children and that this is evidenced from Board to frontline.
• Review TMA • Training levels trust assurance and operational group , Weekly training compliance monitoring Police KMSAB event with Dave • Train the trainer – supervisor training • Provision of workshops Strategy Discussion video ED SIM training April – DAM NAH training doctors Dr Shah peer review ?? Complex maternity tool, Babies who don't go home HDPE/ Social work RAB Day 2 (doctors doctors training paed and obs)	
MCA/DoLS	Deliver ,develop and monitor the impact of MCA/DoLS training at all relevant levels in line with best practice and the ICD.
• First Audit completed KMSABMCA toolkit , Online training bespoke service bases , audit days, nutritional conference , attended KM ICB steering group, NHS SE region MCA group • Action plan on agenda • Dip sample MCA / DoLS, New QIP DoLS weekly checks Complex maternity tool	
Domestic Abuse	Ensuring that there is robust leadership in domestic abuse within our organisation
• Policy refresh approved at PAG • 16 days of action , Presented at Safeguarding operational group March • Conference • Workshops HIDVAS day 2 training additional training ED and maternity- focus routine enquiry and safety planning – training slides in folder	
Safeguarding culture	Ensuring that all our staff understand the importance of safeguarding children, young people and adults from abuse and neglect and that they are aware of their responsibilities and have the skills and knowledge to achieve this.
• Safeguarding within policies Ward accreditation, Safeguarding Champions , PSIRF contributions , Fundamentals of care – groups • Considered as part of SBAR handover • Consideration at discharge Specialist midwives trial MARM Podcast with KCHFT al	

Our Sustainability

PROTECT  EMPOWER  SAFEGUARD 

Policy and procedures	We will have organisational policies and procedures that protect patients, and that these reflect the legal framework pertaining to safeguarding children, young people and adults and that these are aligned to our local safeguarding children and adult boards.
• New Policies on agenda • SOP access to records safeguarding risk assessment guideline comment on all maternity policy, antenatal care FGM policy – clinical management of FGM Guideline	
SAF/Section 11	We will ensure that there is continuous improvement for children, young people and adults captured in Section 11 and Self-Assessments Frameworks and that these are completed as part of our statutory duties and that actions are addressed timely as part of the assurance process
• New SAF submitted on the agenda • Section 11 on agenda	
Safeguarding impact assessments on workstreams	We will undertake Safeguarding Impact Assessments on all workstreams that impact on patients and all commissioned services and that safeguarding is visible from procurement, commissioning, contracting and monitoring of services to avoid poor outcomes and treatment, and that patients are not discriminated against access to services to reduce health inequalities
• Next steps to meet with commissioning and procurement to establish processes already embedded	
Partnership work	We will work in partnership with other agencies, commissioners and regulators and that there is transparency and productive ways to enable the organisation to manage safeguarding concerns through our robust and sustainable systems and processes which includes taking part in safeguarding children and adults boards workstreams and Subgroups activities
• policy group partnership work bruising – Escalation f, neglect, <u>Trix</u>, sexual abuse medical pathways complaint CPP conf, FGM, online safety . National maternity work and SE regional network co-chair – publish care for families and midwives – where there is separation at birth, toolkit supporting asylum seekers	
Information Sharing	We will share information with other health partners and multi-agency partners to ensure that we prevent and protect patients from harm, abuse and neglect.
• Process embedded in both safeguarding adult and children policy and trust information governance policy . Bi-Monthly meeting in place with IG lead and Access to records SOP on agenda • Flagging National alerts work, channel, missing A&C CPIS- Phase two work . audits, Attendances with Safeguarding form, Process- central MSF sharing GP HV MDT – figures Access to records -	
Safeguarding documentation	We will have systems and processes in place that staff can accurately document the data relating to Safeguarding
	Updated 30 June 2026.

Our Sustainability

PROTECT  EMPOWER  SAFEGUARD 

MCA Steering group

- We will develop sustainability plans where indicated to address any challenges relating to MCA/DoLS to ensure that we have robust systems and processes
- New action plan on the agenda
- Verbal update regarding dip samples
- WHH presentation at the William harvey focused improving MCA processes

Domestic Abuse HIDVAs DA conference New Policy

- We will have robust interagency working processes and systems that will enable us to demonstrate our commitment to tackling domestic abuse by attendance to partnership groups and work streams.
- We will have robust interagency working processes and systems that will enable us to demonstrate our commitment to tackling domestic abuse by attendance to partnership groups and work streams
- We will ensure that there is robust information sharing with HIDVAs to understand the numbers of domestic abuse referrals that have been made within our organisation to include that relating to staff
- We will and processes relating to domestic abuse are aligned to the statutory guidance and local system strategy and the NICE guidance PSO relating to Domestic Abuse and legislation ensure that our systems

Prevent New Training Package -

- We will provide Prevent returns to the Commissioners of all activities within the Trust in a timely manner
- We will provide Prevent training such that is in line with national guidance and NHSE requirements and consistent with key staff's roles.
- We will work with key partners and agree how we will meet our statutory duties relating to Channel Panel as outlined in national guidance. Updating policy, new prevent returns, work with Local lead Jess reviewed training package

Updated 30 June 2026.

Our Quality Safety	
Safeguarding incident response	We will respond to safeguarding incidents and concerns and that investigations are prioritised and reports submitted in a timely manner.
•Safeguarding team attend Pre IRP and IRP to consider safeguarding response , Rapid review when requested – pre irp •The Safeguarding Band 7 reviewing DATIX adults at site level children's through duty •New safeguarding section being trialled on DATIX	
Best interest decision making and restrictions	We will advocate and ensure that our patients are free from restrictive practices and that best interest assessments and plans are in line with the requirements under the MCA/DoLS/LPS.
•MCA Audit action planning •New QIP on DoLS •Clinical ethics work	
MARAC	We will ensure that there is evidence of attendance to Multi Agency Risk Assessment Conference (MARAC) and support with information gathering to address risks and actions as determined by key partners we work with
•Systems in place for contribution to MARAC process •New electronic process - •Flagging victims at risk	
MAPPA	We will have robust systems in place to support information gathering and sharing with relevant partners in relation to Multi Agency Public Protection Arrangement (MAPPA) and other data required, such as that from the Violent Reduction Unit as indicated by the Community Safety Partnership.
•Relevant contact in place through duty system •Talk to team around local process by lead at team meeting ?? Date	
Identification	We will have processes and systems for early identification of abuse and neglect and immediate action taken to minimise the risks associated with this to safeguard adults, young people and children at risk
•Workshops around professional curiosity Maternity Hubs Unborns GPLs Multiagency •Safeguarding intranet resources to be reviewed •Use of group supervision •Children ED form updated Childrens Policy – neglect tool NICU tool – supporting safe discharge MSF tool Duty system – supervision Mental links team – process	
Regulatory standards	We will monitor the quality of work and compliance required to meet the regulatory standards and requirements relating to safeguarding, such as NICE Guidance 179 for Children
Updated 30 June 2026.	

Our Quality Safety	
Dataset	We will have a dataset of information relating to safeguarding referrals and data that is monitored internally and externally, with quality metrics to enable the organisation to identify themes and trends, which need to be addressed in a timely manner..
•Metrics reviewed yearly •New regulatory and schedule 4 requirements considered •KPI what will improve safeguarding practice SAF/SAAF/S11/ Learning from reviews •Contribution to the KMSAB dashboard	
Commissioner Assurance	We will provide assurance to the Commissioners with regards to statutory duties and compliance in discharging safeguarding activities through quarterly dashboards and reports and attendance to relevant meetings as indicated
•Safeguarding operational group agenda setting •Safeguarding assurance group agenda setting •Monthly meetings	
DoLS compliance	We will ensure that all data pertaining to MCA/DoLS provided to the Local Authority is consistent with what is held within our organisation to ensure that there remains an accurate number and data pertaining to this.
•Systems in place for quality assurance •PTL dashboard	
PREVENT returns	We will provide data of all referrals pertaining to Prevent through quarterly returns to maintain our statutory duties relating to this..
•National Portal reporting now in place •Presented at SAC	
National portal reporting	We will report compliance with safeguarding accountability and assurance framework and Looked after children responsibilities
•Quarterly submissions made •IT/ report Dataset	
Complaints	We will strengthen and maintain the interface between safeguarding, complaints, serious incidents and fundamentals of care and recognise how the processes are aligned when parallel investigations are to be considered and undertaken and the learning from these jointly implemented
Updated 30 June 2026.	

Our Future / Partnerships

Learning lessons together

We will share learning of safeguarding and domestic homicide reviews undertaken locally, regionally and nationally with evidence of how recommendations have been implemented to reduce similar incidents occurring in the future. e will have a dataset of information relating to safeguarding referrals and data that is monitored internally and externally, with quality metrics to enable the organisation to identify themes and trends, which need to be addressed in a timely manner...

- SAR contributions
- DHDR CSPIR, Rapid reviews Audit shared SOG, SAC, news articles, Supervision, Attended practitioner events, Day in the life model, celebrated good practice safeguarding week good pieces of work, Awards and nominations, attend peer review with paediatricians, PSIRF Process
- Quality assurance section 42 – supervision around – actions – care group governance
- Training Maternity and neonatal board

LAC Outcomes

We will contribute to improving the health outcomes for Looked After Children through working with key partners and to ensure that transitional safeguarding from children into adulthood forms part of this as outlined in the relevant children and safeguarding adults.

- Safeguarding operational group agenda setting- **No longer undertake health assessments changed responsibility – learning AJ, trust new articles, workshop**
- Safeguarding assurance group agenda setting
- Monthly meetings

Rights and health inequalities

We will recognise every adult, young person and child's fundamental human right to live free from abuse and neglect and reduce incidents of poor outcomes.

- Dataset to inform commissioning and services
- PTL dashboard
- Support homeless pilot, presentation safeguarding operational group Neglect bits access to services
- Risk assessments EHIA policies – pre birth planning tool
- Advocacy for vulnerable groups

Changing practice

We will have systems and processes in place to demonstrate how we have embedded learning from incidents, serious incidents, safeguarding investigations and reviews in our organisation and have changed practice to improve future outcomes for our patients and prevent harm by reducing abuse and neglect.

- Spreadsheet of work completed
- Contribution to PSIRF process and trust learning
- Notes, specialist midwives, audit CPIS- actions

PROTECT

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Updated 30 June 2026.

39. Priorities for 2026/2027

- Improve the quality and documentation of Mental capacity assessments and Best Interest Meetings
- Constantly achieve training levels for all staff over 85%
- Embed quality assurance systems for adult safeguarding referrals
- Create SOPs for all safeguarding processes which improve efficiency and effectiveness
- Support staff to understand the learning from Safeguarding reviews and feedback from service users and use this to improve practice
- Continue work with care groups to improve early identification and recording of abuse or neglect
- Progress the implementation of the safeguarding strategy by developing preventative approaches that empower patients and carers to actively participate in decision-making, utilising family support networks and embedding a Making Safeguarding Personal approach
- Increase safeguarding resilience and organisational safeguarding capacity to discharge our safeguarding duties
- Collaborate with multi-agency and multi-disciplinary colleagues to ensure new DoLS thresholds, the new Families First meets the needs of individuals who require safeguarding whilst accessing care in an acute trust
- Explore use of care experienced patient experience partners to drive improvement in support for patients experiencing social challenges who require safeguarding
- Continue to work collaboratively with the End of Life Committee and Mortuary Team to ensure compliance with the recommendations of the Fuller Inquiry and the Safeguarding Accountability and Assurance Framework (SAAF), strengthening arrangements for safeguarding considerations after death and ensuring the dignity of the deceased is upheld.
- Implement an annual audit plan for which monitors and assesses safeguarding practices and outcomes

References:

- Department for Education (2023) *Working Together to Safeguard Children*. London: HM Government.
- EKHUFT (2026) *About East Kent Hospitals University NHS Foundation Trust*. Available at: www.ekhuft.nhs.uk
- Kent County Council (2025) *Indices of Deprivation 2025 and Local Analysis*. Maidstone: KCC.
- Kent County Council (2026) *Children in Poverty Statistical Bulletin*. Maidstone: KCC.
- Kent Public Health Observatory (2026) *Children and Young People Population Data*. Available at: www.kpho.org.uk
- National Crime Agency (2021) *National Strategic Assessment of Serious and Organised Crime*
- NHS England (2026) *Safeguarding Accountability and Assurance Framework*. London: NHS England.
- Royal College of Nursing (2024) *Adult Safeguarding: Roles and Competencies for Health Care Staff Inter-Collegiate Document*
- Royal College of Paediatrics and Child Health (RCPCH) (2025) *Safeguarding children and young people and children and young people in care: Competencies for healthcare staff (Intercollegiate document, 5th edn.)*. London: RCPCH. Available at: <https://child-health-safeguarding.rcpch.ac.uk/> (Accessed: 17 June 2026).

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: Complaints, Patient Advice and Liaison Service (PALS) and Compliments Annual Report 2025-2026

Meeting date: 28 July 2026

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

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

Appendices:

Appendix 1: Complaints, PALS and Compliments Annual Report 2025-2026

Executive summary:

Action required:	Approval
Purpose of the Report:	An annual review of complaints, compliments and PALS received by the Trust. To meet the requirements of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and the Parliamentary Health Service Ombudsman (PHSO) NHS Complaint Standards.
Summary of key issues:	A performance and thematic review of compliments, complaints and PALS. Details of the actions and learning from complaints and PALS, including any actions from complaints reviewed by the PHSO. A detail of the achievements in 2025-2026, alongside the plan for continuous improvement in 2026-2027.
Key recommendations:	The Board of Directors is asked to APPROVE the Complaints, PALS and Compliments Annual Report 2025-2026 to be published on the Trust website, for public review.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Trust Risk Register:	N



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

Assurance route:

Previously considered by: Quality and Safety Committee - May 2026



Complaints, PALS and Compliments Annual Report 2025-2026

1. Purpose of the report

- 1.1 This attached Annual Report provides an overview of the activity of complaints, PALS and compliments during 1 April 2025 to 31 March 2026 (2025-2026).

2. Background

- 2.1 This report is to meet the requirements of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and East Kent Hospitals University NHS Foundation Trust policies: Complaints Management Policy and PALS Policy
- 2.2 It is considered good practice and was recommended by the 2020 Healthwatch report Shifting the Mind-Set, for NHS trusts to publish their annual performance report on the organisation's website.
- 2.3 PHSO NHS Complaint Standards came into effect during 2024 and this report details some of continuous improvement to meet these standards.

3. Summary

- 3.1 This report is for approval to be added to the Trust's website.
- 3.2 The report meets the requirements of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and the Complaints Management Policy, which stipulates the following information forms the basis of the report:
- 3.2.1 Specify the number of complaints received;
 - 3.2.2 The number of complaints that were upheld, partially upheld or not upheld;
 - 3.2.3 The number of complaints referred to the PHSO;
 - 3.2.4 The subject matter of complaints;
 - 3.2.5 Any matters of general importance arising out of those complaints or the way in which they were handled;
 - 3.2.6 Lessons learnt from complaints, including any actions or service improvements made;
 - 3.2.7 The number of complaints acknowledged within three working days;
 - 3.2.8 The timescale complaints were acknowledged within.

4. Conclusion

- 4.1 This report is provided for approval and has been presented at the Patient Experience Committee on 28 May 2026, Quality and Safety Committee on 19 May 2026 and Trust Management Committee on 3 June 2026, before presentation at the Trust Board meeting.





**East Kent
Hospitals University**
NHS Foundation Trust

Complaints, Patient Advice Liaison Service (PALS) and Compliments

Annual Report - 2025-2026



1. Introduction

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

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

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

This Annual Report provides an overview of the activity of complaints, PALS and compliments during 01 April 2025 to 31 March 2026 (2025-2026).

2. Summary

- 2025-2026 there has been an 8.9%% increase in new complaints. 1297 new complaints received in 2025-2026, compared to 1191 in 2024-2025.
- On average, 98% of new complaints were acknowledged within three working days; the Key Performance Indicator (KPI) is 90%. The KPI has been consistently met for the year.
- The KPI for 85% of complaint responses completed within agreed timescales, has been achieved throughout the year.
- There has been a 22% increase in new PALS; 7284 received in 2025-2026, compared to 5963 received in 2024-2025.
- 33% of calls into the PALS team were answered live during 2025-2026.
- On average, 68% of PALS were responded to within timescales.
- In 2025-2026 there has been a 35% increase in compliments.

3. The process for giving feedback

The Trust's process for managing the complaints, compliments and PALS is aligned closely to the Parliamentary Health Service Ombudsman (PHSO) NHS Complaint Standards and their six principles for good complaint handling:

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

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

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

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

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

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

Wards and services record compliments as they are received, in order that information can be shared, this information is themed. Compliments received via the website or through the executive's office are recorded by the PALS team. Areas of high compliments are encouraged to share great working practices, or initiatives; this information is shared within monthly reports.

4. 2025-2026 Themes for Complaints, PALS and Compliments

The top 5 primary subject themes recorded across the Trust received in 2025-2026 are:

Complaints		PALS		Compliments	
Clinical Management	455	General Enquiries	1745	Nursing care	12,479
Communication	137	Appointments	924	Clinical Management	3926
Attitude	134	Communication	860	Communication	3578
Diagnosis	104	Delays	844	Attitude	3421
Delays	90	Patient Experience	758	Food	3082

In comparison, the top 5 primary subject themes received in 2024-2025 were:

Complaints		PALS		Compliments	
Clinical Management	265	General Enquiries	1747	Nursing care	9800
Communication	158	Delays	784	Attitude	2926
Delays	135	Communication	739	Communication	2599
Attitude	131	Appointments	565	Clinical Management	2422
Nursing Care	84	Patient Experience	542	Food	1767

There has been no change in the top theme for each feedback source.

For complaints, nursing care, featured at number 5 in 2024-2025, and has now been replaced by diagnosis. Clinical management and communication remain in the top two places. Delays have moved down the table to fifth place and attitude has moved to the third spot.

For PALS the top five remain the same as 2024-2025. However, appointments and delays have changed in the order. The number of contacts regarding appointments, communication, delays and patient experience have all increased. The number of contacts regarding general enquiries has only slightly decreased (by two contacts), compared to 2024-2025.

Compliments have had a change around of themes in the top five, with clinical management moving into second place.

5. Performance:

Below is a record of the numbers received between April 2025 and March 2026 and is colour coded where there is a KPI (red - target not met, amber – target partially met and green – fully met)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Number of contacts to PALS and complaint teams	1305	1193	1078	1231	1004	1157	1288	1202	1030	1401	1307	1311
New complaints received	118	130	129	160	98	139	129	100	79	73	78	64
% difference in nos. of new complaints from 2023-2024	8.3%	21.5%	2.2%	56.7%	0%	41.8%	40.2%	12.4%	21%	38.7%	21.2%	34%
	↑	↑	↓	↑	-	↑	↑	↑	↓	↓	↓	↓
Complaints acknowledged within 3 working days	96%	100%	100%	99%	100%	99%	96.9%	99%	97.5%	94.5%	97.4%	98.4%
Complaints responded to within agreed timescales	87.5% 77 of 88	85.3% 58 of 68	86.3% 63 of 73	85.4% 70 of 82	89.9% 71 of 79	85.3% 87 of 102	85.4% 76 of 89	85% 85 of 100	85.1% 97/114	85.9% 104/121	85.9% 85/99	85.7% 72/84
New PALS received	513	572	531	607	509	601	629	658	594	699	661	710
% difference in nos. of new PALS from 2023-2024	3.2%	22.5%	18.7%	16.9%	21.4%	31.7%	12.5%	39.4%	44.1%	23.0%	18.4%	27.6%
	↓	↑	↑	↑	↑	↑	↑	↑	↑	↑	↑	↑
No of telephone calls into PALS	625	659	487	527	600	550	551	520	432	610	568	651
% of live calls answered	41%	43%	25%	29%	37%	26%	11%	16%	37%	27%	37%	57%
Responded to within agreed timescales	68%	65%	49%	59%	69%	75%	63%	69%	77%	71%	79%	75%
Compliments received	2983	3387	3570	2945	3816	2657	3390	2327	3933	2156	2196	2914
Complaint to compliments ratio	1:25	1:26	1:28	1:18	1:39	1:19	1:26	1:23	1:37	1:30	1:28	1:46
MCCD* completed within 5 working days across the Trust	80%	82%	77%	81%	87%	92%	80%	85%	86%	84%	90%	92%

*Medical Certificate of Cause of Death

There are open PALS contacts received during 2025-2026 that still need closing. Compliments are retrospectively input by services. PALS and compliments data will therefore change as cases are closed/entered.

- Over the period from April 2025 to March 2026 there has been a total of 14,507 contacts with the team, which resulted in 8.2% (1,297) formal complaints and 41.1% (7,284) new PALS.
- There is a slight increase in PALS cases being responded to within 10 working days. There has been change in the method of reporting, to be consistent with complaint reporting.
- Compliments have increased by 35%.

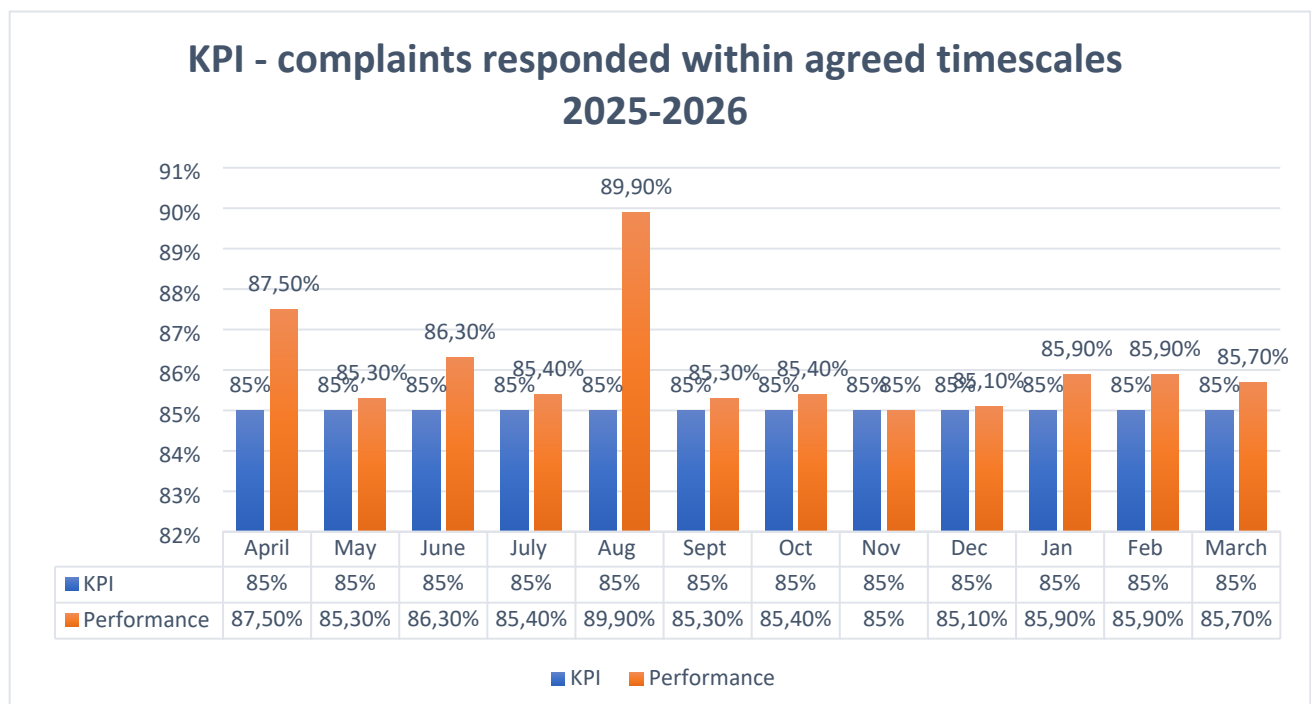
6. Complaints

There has been a consistent increase in complaints, which started during the pandemic. During 2024-2025 there were 1,191 and during 2025-2026 complaints totalled 1,297. This equates to an 8.9% increase.

The complexity of concerns and the number of issues being raised, has meant that more complaints are potentially identified during the initial triaging of phone calls, emails and letters received. The Complaints team are working to ensure that whenever possible, concerns are resolved as quickly as possible, therefore allowing the formal complaint to be deescalated. This is allowing the formal complaints process to be used, when the situation warrants it, this is in line with the Parliamentary and Health Services Ombudsman (PHSO) NHS Complaint Standards. In the last four months of the year, the complaint numbers were reduced, due to this work. This will be reflected in monthly reported from April 2026.

Complexity of concerns remains an issue with complaints. This does impact on the time required to investigate and provide a response. Most complaints cover several care group services and can also include other NHS organisations.

There has been continued focus on the complaints responses being finalised and sent to the client, within agreed timescales. The KPI is 85% of complaints responded to within agreed timescales. The trajectory has been consistently met, and the complaints team successfully continue to perform, meeting or exceeding the KPI.



2024-2025 saw the formation of a centralised team, with control of the complaint process. This work has enabled complaints to be more effectively managed, with one case handler acknowledging the complaint, reviewing the complaint with the client and working with the care group services to review

the concerns raised. The work started in 2024 had an impact on performance and meeting the KPI. Further work has ensured senior oversight of complaints and responsiveness, promoting a better complainant experience. Some of these actions are new or are continuing:

- Weekly/fortnightly reporting to the care group services and triumvirates, to identify breaching complaints and also age of complaints.
- An escalation process with the care group triumvirates supporting to promote quality and responsive resolutions.
- Fortnightly meetings with care group services to review complaints.
- Continued weekly bite sized team training sessions for the Complaints and PALS teams, on subjects related to complaints/PALS, or a presentation from a service within the organisation, to build better business intelligence/knowledge.
- Training provided to the care group service staff, this remains an ongoing piece of work.
- Clients are updated throughout the complaints process.
- A focus on quality control of written complaint responses.

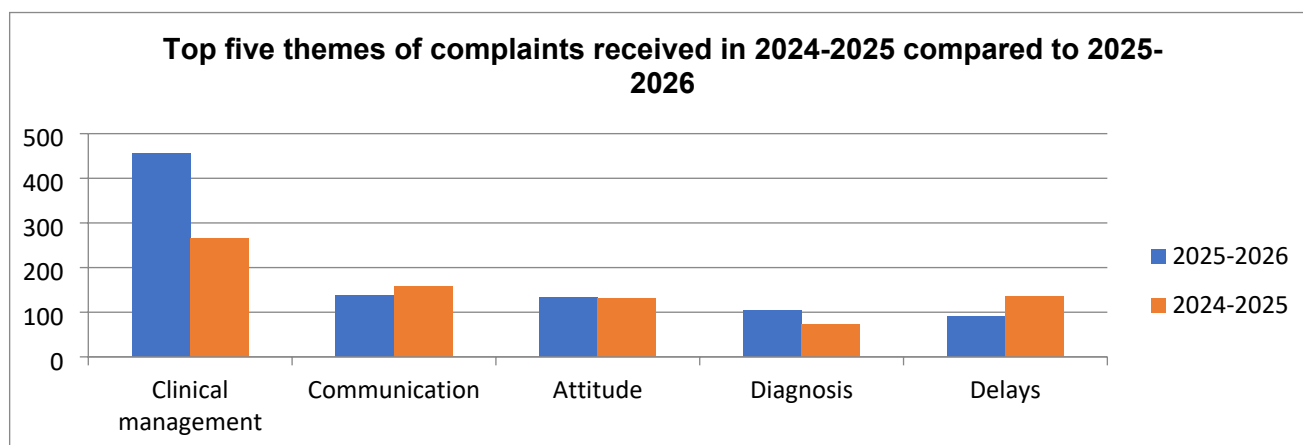
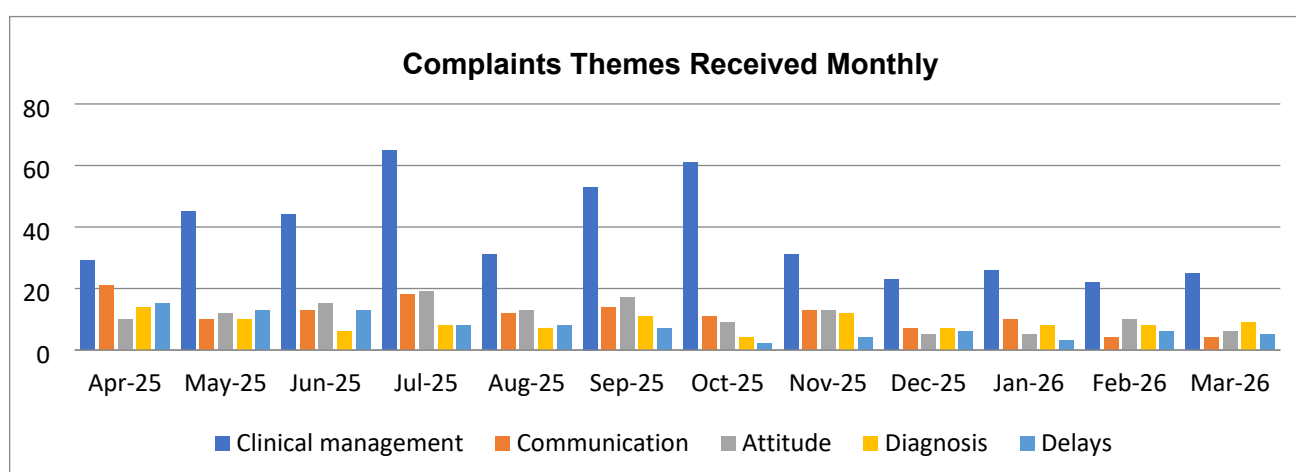
Themes:

The top five themes for complaints have been reasonably stable over 2025-2026. Diagnosis rose to number 4 from being number 6 in 2024-2025, and has replaced nursing care. The top five complaints themes are detailed below, broken down into the specific issues/sub-subjects. It should be noted that one complaint can have several concerns, which may relate to several themes and sub-subjects.

Clinical Management	455
Unhappy with treatment	397
Inappropriate ward Scans / X-rays not taken	16
Referral issues	13
Lack of / inappropriate pain management	10
Inappropriate ward	6
Incomplete examination carried out	5
End of Life / palliative care issues	4
Blood tests not carried out	4
Communication	137
Doctor communication issues	65
Nursing communication issues	21
Misleading or contradictory information given	18
Lack of information / explanation of how procedure went	8
Unable to contact department / ward	7
Other staff communication issues	6
Other communication issues	5
A&C staff communication issues	4
Unhappy with info on medical records	3
Attitude	134
Problems with doctor's attitude	67
Problems with nurse' attitude	46
Problems with other staff attitude	21
Diagnosis	104
Mis-diagnosis	35
Missed fracture / or other medical problem	32
Delay in receiving diagnosis	23
Delay for results	7
Delay for tests	5

Tests incomplete	1
Lost Blood Sample	1
Delays	90
Delays in receiving treatment	36
Delays in being seen in A&E	12
Delay with elective admission	10
Delay in allocation of outpatient appointment	8
Delay with emergency admission	7
Delay in referral	5
Delay in receiving x-ray results	5
Delay in going to theatre	4
Delay in being seen in outpatient department	3

Clinical management has remained the top theme for complaints during the year.



Complaint Outcomes and Actions from 2024-2025:

The following are some of the actions and learning identified from complaints:

Care group	Action
CCASS - Dermatology	Discussions are being held with patients and guardians, to ensure they are informed about phototherapy and what it entails. A visit to the clinical area is being offered to a child, before treatment commences. Phototherapy are formulating a child friendly information sheet on Ultraviolet treatment.
DCB - Cancer	A dedicated telephone for urgent calls, is now in use, carried at all times by the nurse in charge, to ensure that urgent calls are answered by a senior nurse who completes the UKONS triage assessment thoroughly.

	The Practice Development Nurses are currently updating their teaching materials to ensure all chemotherapy nursing staff receive comprehensive training on the UKONS Triage Tool.
KC&RVH - Urology	All patients discharged from the EAC and Clarke ward will be given a catheter passport on discharge. A catheter checklist has been devised which is to be followed by all practitioners on inserting a catheter. A Standard Operating Procedure will be designed and formulated for the urinary catheter change clinic.
KC&RVH – Trauma and Orthopaedics (T&O)	A review is being undertaken with the Royal National Orthopaedic Hospital to identify where the referral processing failure occurred, to take steps to prevent similar delays for future patients.
QEQM – Emergency Department (ED)	QEQM has become a national pilot site to trial a new way of being assessed as you present to ED, providing further training with ED staff around 'red flags' which a patient might mention or display concerning symptoms that would trigger a faster response from the doctors in ED.
QEQM - Respiratory	All wards have created a contact card which includes the ward nurse in charge's mobile number so relatives' calls can be answered swiftly going forward.
WCYPH – Gynaecology (Gynae)	Staff have been asked to review the Anti-D policy, which was also been discussed in a unit meeting.
WHH - Cardiology	The Cardiology team and the Emergency Medicine team are currently working on their processes to ensure cancelled echocardiograms will be communicated to the referring team.
WHH - ED	A strengthened leadership structure is now in place, including dedicated Ward Managers for each area. Acute Medical Unit has been made into smaller, more manageable units; allowing for closer oversight and more responsive support.
Trust wide	Two specific palliative care wards have been develop within the Trust for care for patients in the last days of their life.

Outcome of complaints closed in 2025-2026:

It is deemed good practice, by the PHSO, to record outcomes of complaints, under one of the categories in the table below. This within the NHS and Local Authority Complaint Regulations 2009 and was reinforced by the 2020 Healthwatch report 'Shifting the Mind-set'.

Period	Upheld	Partly Upheld	Not Upheld	Meeting Held	Withdrawn	On Hold
2024-2025	192	632	140	51	144	31
2025-2026	210	589	302	84	189	11

7. Parliamentary and Health Services Ombudsman (PHSO) Investigations

The complaints team closely monitor the number of cases that become formal investigations. There has been a decrease in the number of cases the PHSO has asked for initial information, this is to consider if they should undertake an investigation. There has also been a slight decrease in the number of cases being investigated, which coincides with a new Ombudsman being appointed. While a new Ombudsman is appointed, no cases are reported on and it can delay their review.

PHSO Cases Received	Enquiries	Formal Investigations
2024-2025	11	6
2025-2026	8	4

PHSO outcomes

The following are outcomes from cases that were reviewed and investigated by the PHSO. The outcome of their investigation is included for reference.

KCH&RV - T&O <u>Partially Upheld</u>	Complaint about the treatment the client received from EKHUFT from 16 April 2021 to 20 May 2021 and the Trust's complaint handling. Specifically: • The Trust misdiagnosed and failed to properly treat the client's hand injuries. • The Trust's poor complaint handling, as it did not properly investigate the above complaint or acknowledge what went wrong. The client also says because of the alleged clinical failings, the Trust missed the opportunity to properly treat their hand injury, fracture to hamate and dislocated fourth and fifth metacarpals. The client says this resulted in a permanent hand injury causing pain and lack of function in the ulnar side of their dominant hand. <u>Outcome and Actions:</u> The PHSO considered there was a failure to correctly diagnose the client's hand injuries. Their advisor has confirmed the evidence available to the consultant showed the patient likely had dislocations to their hand. The PHSO also considered there was a failing when the Trust did not appropriately treat the client's hand injuries. Overall the PHSO considered the Trust failed to recognise the client's injuries, which meant the patient did not receive the treatment needed. The Trust did instruct an independent medical expert, however, despite the report findings, the Trust failed to apologise for or acknowledge its failings. The Trust also did not say what it would do to avoid this happening again. Having considered all the above the PHSO partially upheld the complaint and recommended the Trust write to the patient, acknowledging and accepting the failings. Also to confirm what actions have been put in place to ensure appropriate hand treatment is not missed in the future.
QEQM - Endoscopy <u>Partially Upheld</u>	The PHSO reported concerns over the aspects of the patient's care and treatment from clinicians at WHH and QEQM, specifically: • The lack of treatment between the patient's diagnosis and a multidisciplinary meeting, on 4 January 2022, including during two emergency department attendances. • The decision to carry out an endoscopy, on 7 January 2022. • The communication with the patient and their family. The client questions whether the patient's sudden death could have been avoided. They believe the patient could have lived longer, with less pain and a better quality of life, if there had been no failing. The patient's sons felt they were denied an opportunity to spend more time with the patient towards the end of their life. It was also distressing that clinicians did not make them aware of what was happening. <u>Outcome and actions:</u> The PHSO found there was poor treatment by the Trust who were caring for the patient towards the end of their life. The Trust should have admitted the patient to hospital, on 29 December 2021 and should not have proceeded with the endoscopy. There was also evidence of poor communication from the clinicians to the patient. The PHSO also concluded that sadly, the patient's cancer was incurable. They recognised if the failings had not happened, it is likely the patient would have lived a short time longer and the quality of their life would have improved. The family were also denied more time with the patient at the end of their life. Also, the communication failings the PHSO noted meant the patient and their family were left without a clear understanding of what was happening. A plan was drawn up to show what learning and action had been taken from the PHSO findings, with recompense of £5,000 for the family with a letter of apology.

QEQM – HCOOP <u>Partially Upheld</u>	The PHSO reported the client complained about the care the patient received between 26 October 2020 and 19 February 2021. Specifically that the Trust: • Left the patient in their own urine. • Did not communicate with the client about the patient's condition. • Added incorrect information to the patient's EDN on 04 December 2020. • Did not act on the patient's low magnesium levels. • Did not discuss DNAR with the family before putting it in place. • Discharged the patient on 19 February 2021 when the doctors were unclear about their prognosis. The client was seeking service improvements and a financial remedy. <u>Outcome and actions:</u> The PHSO found failings regarding the personal care the Trust provided to the patient. The Trust missed an opportunity to explore whether the patient wanted to involve their family in their care and did not communicate significant changes in their condition to the family. The Trust missed the opportunity to avoid the patient's low magnesium levels by monitoring this. The PHSO reported they were sad to see the failings and impact this had on the family and could see this has been a very difficult and distressing process for them. A plan was drawn up to show what learning and action had been taken from the PHSO findings, with recompense of £550 for the family, with a letter of apology.
QEQM – HCOOP <u>Not Upheld</u>	The PHSO informed that the client has concerns over the care and treatment provided to the patient during their hospital admission, in February 2024. The client is concerned the clinicians decreased and then increased the patient's oxygen flow rated multiple times, which led to a decline in the patient's condition. The client believes this contributed to the patient's death, causing significant distress to the client and the rest of the family. The client is seeking an explanation, an apology and a financial remedy. <u>Outcome and Actions:</u> The PHSO decided not to uphold this complaint. They were truly sorry to hear about the client's concerns and recognise these events had a significant impact on them. The PHSO found the Trust appropriately managed the patient's oxygen levels during their admission in February 2024, in line with relevant clinical guidelines. PHSO could not see any wrong doing.
QEQM - Urgent and Emergency Care (UEC) <u>Not Upheld</u>	The client complained about aspects of the care and treatment the Trust provided to the patient during their admission, between 21 January to 8 February 2021. Specifically, the client says the Trust: • Did not take the appropriate steps in attempts to diagnose or treat the patient and caused a delay in the diagnosis of their recurrence of cancer • Made inappropriate discharge arrangements based on the patient's condition <u>Outcome and Actions:</u> The PHSO found all the patient's care and treatment provided was optimal.
WCYPH - Gynae <u>Partially Upheld</u>	The PHSO reported the client believes Trust prematurely discharged the patient from the obstetrics and gynaecology service, in January 2021, when they were diagnosed with an ovarian cyst. Also the Trust failed to monitor their cyst between January 2021 and January 2022. Had the patient been monitored, earlier identification of malignancy and then preventative treatment (hysterectomy) by the Trust for their ovarian cyst, could have meant their avoided developing Stage 3C bilateral high grade ovarian Serous Carcinoma, diagnosed in March 2022. The client could have then avoided requiring a full hysterectomy and removal of other areas the disease had spread to.

	The cancer diagnosis caused great mental stress. It also impacted on their cardiomyopathy and meant they had to reduce their medication for that condition whilst receiving treatment for cancer. The patient has developed peripheral neuropathy in their hands and feet as a result of having to change their cardiomyopathy medication, to treat cancer. The patient says this is likely to be permanent. The client is seeking the Trust to acknowledge it made mistakes, apologise and put service improvements in place. the patient is also seeking a financial remedy of over £12,500. <u>Outcome and actions:</u> The PHSO confirmed that had Trust followed RCOG guidance, it is likely the patient would have been scanned between April and June 2021 and this did not happen. The Trust also appears to have discharged the patient too soon. The PHSO have carefully considered the impact of the Trust failing to scan the patient, when it should have. As no imaging scans were completed for around 12 months after January 2021, it is not possible to determine the progression of the disease. It is not clear what a scan would have shown, or whether it would have shown cancer, if it was completed in line with guidance around June 2021. For these reasons, the PHSO could not find a clinical adviser who would be able to give them reliable advice on what the scan would have shown. Therefore, the PHSO could not say with certainty there was a delay in diagnosis by the Trust or link to the spread of the disease or any treatment required because of this. The PHSO could not say for certain a scan around June 2021 would have identified cancer. The PHSO recognised the patient will never know whether it would have been possible for an earlier diagnosis of cancer and whether this could have made a difference to the spread of cancer and the patient's prognosis. A plan was drawn up to show what learning and action had been taken from the PHSO's findings, with recompense of £1,200 for the patient, with a letter.
WCYPH - Paediatrics <u>Partially Upheld</u>	The PHSO reported the clients were concerned the Trust made an incorrect diagnosis of FII, based on inaccurate, un-evidenced and incomplete information. The Trust did not recognise there was a genuine explanation for the patient's symptoms or follow relevant guidance once that explanation became apparent. Specifically: • Paediatric consultants from the Trust did not attend the initial child protection conference (ICPC) in August 2017 or provide a report. • The Trust did not complete an independent review of the FII diagnosis agreed in August 2020. The parents say the diagnosis continues to harm their family, causing ongoing harm and trauma to the patient and hindering their recovery. They also state the lack of an independent review influenced decisions to start further child protection proceedings in March and November 2020, causing further stress and trauma. The parents were seeking a robust and independent review of the FII diagnosis. <u>Outcome and actions:</u> The PHSO decided, although there was sufficient clinical evidence to support the FII diagnosis, the Trust should have provided a better explanation of how it was reached. The PHSO also found failings in the Trust's input to the ICPC in August 2017. Given no doctor was going to be present, the PHSO do not think the analysis document was adequate and a more detailed report should have been provided. The ICPC therefore decided there was insufficient evidence to determine whether the patient was at risk. Consequently no child protection plan was put in place, although the patient remained a Child in Need. The Trust did not complete the independent review of the FII diagnosis that it committed to do in August 2020 or adequately explain why it was unable to do this. A letter of apology was sent to the parents for the above failings.

WHH - ED <u>Partially Upheld</u>	The client claims June 2020 the patient was discharged from the WHH ED without treatment for their breathing difficulties, abdominal pain and low haemoglobin levels. Staff delayed giving the patient blood transfusions, delayed draining their internal fluid build-up, did not treat their breathing difficulties during their admission and discharged them. The patient attended again with breathing difficulties and low oxygen levels and was again discharged. The client also believes there was an additional injustice, the alleged delays in the patient's treatment, meant they spent longer in hospital, which increased their exposure to Covid-19. The client also has concerns about the patient's hysterectomy, on 14 May 2020 and how this surgery contributed to the patient's need to go back into hospital and their death. <u>Outcome and Actions:</u> The PHSO found staff gave the patient care in line with guidelines, while a patient in the Trust in June 2020. However, the PHSO found the Trust did not act in line with guidelines when staff discharged the patient from the ED, on 18 June 2020. This meant staff missed an opportunity to give treatment. The PHSO could not conclude whether and how much of a difference this would have made and whether the patient's death was avoidable. They recognised this uncertainty will impact on the client's ability to find closure and cause them distress. The PHSO found the Trust did not take all the action it should to address this impact. For this reason, the PHSO decided to partly uphold the complaint and make recommendations. This includes the Trust making an apology to the client and providing a financial remedy of £1250.
WHH - ED <u>Partially Upheld</u>	The client had the following concerns about aspects of the patient's care and treatment: • The patient waited twelve hours in A&E to see a doctor, when they had chest pains – should they have been prioritised? • The Trust offered inadequate or delayed pain relief. • The client had to continually ask for fluids and medication. • The Trust should have acted on the patient's high blood pressure (BP) readings. • The client disagrees the difference in the BP readings in both arms. • The Trust should have done tests to identify the patient's cardiac issues sooner. • The patient had to wait 22 hours for a bed on a mixed-sex ward. • If the Trust had taken the right action, the patient would have received end of life care and been more comfortable. • The Trust gave the patient a number of different diagnoses. • The Trust gave incorrect treatment for one diagnosis and no treatment for other diagnoses. • Incorrect anticoagulant treatment hastened the patient's death and the family lost the opportunity to say goodbye. • The patient did not get the appropriate level of care and compassion, their needs were not addressed. • The Trust did not notice the patient's deterioration quickly enough. <u>Outcome and actions:</u> In some areas the PHSO found no failings, in others they felt the Trust had already done enough to put right the impact, no further action is being taken.
WHH - UEC <u>Upheld</u>	The client stated: • The Trust misread a CT scan, on 2 May 2022. • The Trust did not notify the client that a second quantitative faecal immune chemical test (qFIT) result was above the normal range. • Staff in ED did not listen to the client, assess them properly or arrange relevant tests and treatment.

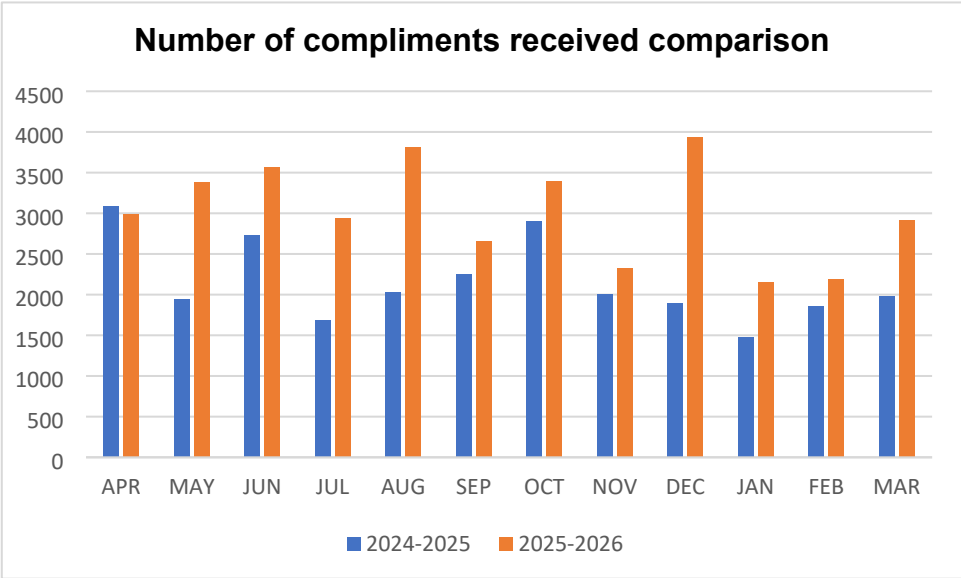
	The client seeks an apology, explanation, service improvements and recompense for expenses and suffering. <u>Outcome and Actions:</u> The Trust did not follow relevant guidelines when it arranged a CT scan on a suspected cancer pathway, to investigate the client's symptoms. The Trust did not identify the client's cancer on the CT scan carried out in May and therefore did not follow relevant guidelines to escalate this to the referring clinician. The Trust did not follow relevant guidelines when it discharged the client when they had symptoms which suggested a clinical obstruction. The PHSO recommended that the Trust complete an action plan to address the failings identified in investigating and diagnosing their cancer and discharging the client from the ED. The Trust were asked to write a letter of apology, create an action plan and make a payment of £1,200 to the client in recompense for their distress.

Currently there are 6 cases being formally investigated by the PHSO and 11 enquiries from the PHSO are under review.

8. Compliments

Compliments are entered, in the main, by wards and services, onto the Trust's compliments database. This information is generally added retrospectively; data for 2025-2026 may be subject to change.

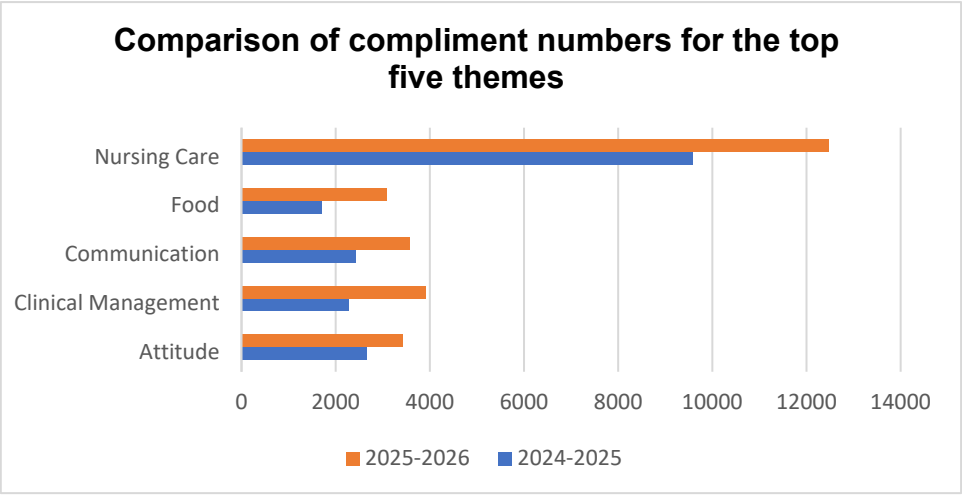
There has been a 35% increase in compliments received, 36,274 – this is the highest number for three years. In 2024-2025 there were 26,938 compliments and in 2023-2024 there were 30,668.



Themes and trends

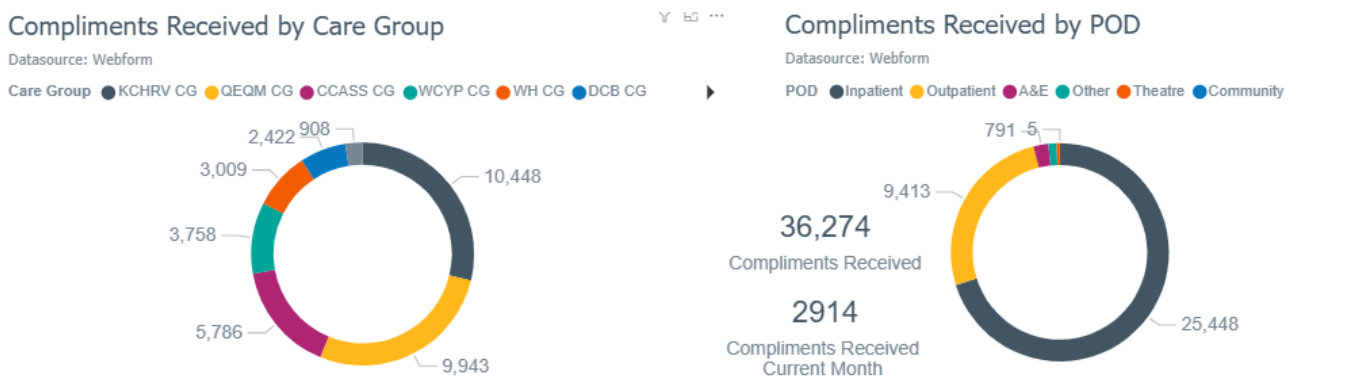
The top five themes identified from compliments for the past three years: 2023-2024, 2024-2025 and 2025-2026 are nursing care, clinical management, attitude, communication and food.

Communication also features in both complaints and PALS top five themes. Attitude and clinical management are also featured in complaints. Food is grouped into the patient experience category for PALS.



Below, compliments are broken down by care group and also by place of delivery (POD). KCH&RV CG have received the most compliments, 10,488. CCASS received the most compliments in 2024-2025, in 2025-2026 they have slipped to third place.

The majority of the compliments for place of delivery, came from inpatient admissions; this is consistent with 2024-2025.

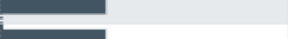
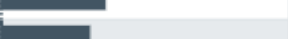
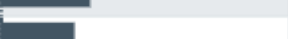
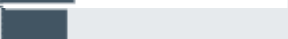
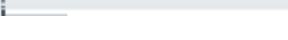


The following table shows the breakdown of the top 10 compliments received. The top 10 are slightly different to 2024-2025, end of life care has moved into the top 10, from position 12 in 2024-2025, displacing appointments. It is pleasing to see the majority of compliments received for the last five years relate to nursing care.

Compliment Group	Compliments Received
Nursing Care	12,479
Clinical Management	3,926
Communication	3,578
Attitude	3,421
Food	3,082
Cleanliness	1,877
Discharge	1,465
Service Provision	1,439
Privacy and Dignity	1,165
End of Life Care	948

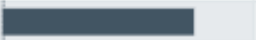
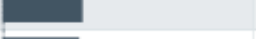
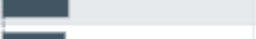
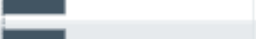
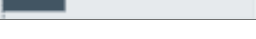
To see which areas have received the most compliments, we have identified the top ten wards/departments:

2025-2026

Ward	Compliments Received	
QEQM FORDWICH WARD		4,113
K&C OUTPATIENT		3,194
K&C INVICTA WARD		2,230
WHH CRITICAL CARE		2,169
QEQM CCU		1,992
QEQM ST. MARGARETS WARD		1,544
K&C INTENSIVE CARE AND HIGH DEPENDEN...		1,540
K&C KINGSTON WARD		1,338
X MED RENAL UNIT		1,078
K&C MARLOWE WARD		973

K&C Outpatients has been removed from the top spot and replaced by Fordwich Ward. There have been five changes and new appearances in the top five, compared to 2024-2025.

2024-2025

Ward	Compliments Received	
K&C OUTPATIENT		2,819
QEQM QUEX WARD		2,239
K&C INTENSIVE CARE AND HIGH DEPENDENCY UNIT		1,541
QEQM SEA BATHING WARD		1,440
K&C KINGSTON WARD		1,274
K&C EAST KENT NEURO REHAB		931
X MAID RENAL UNIT		889
QEQM DISCHARGE LOUNGE		763
QEQM FORDWICH WARD		731
WHH CRITICAL CARE		726

9. PALS

The top five themes for PALS, like complaints, have been stable during 2025-2026. The top five PALS themes are detailed below, with the themes broken down into the specific issues. It should be noted that PALS contacts may have several concerns, which may relate to a range of themes and then sub-subjects.

The complexity of PALS has, like complaints, generally increased. The team work to resolve as many issues as possible, to avoid the longer formal complaint process.

It should be noted that the PALS team have been support by colleagues who are unable to work in their substantive role. This additional resource has had a positive impact on PALS responsiveness.

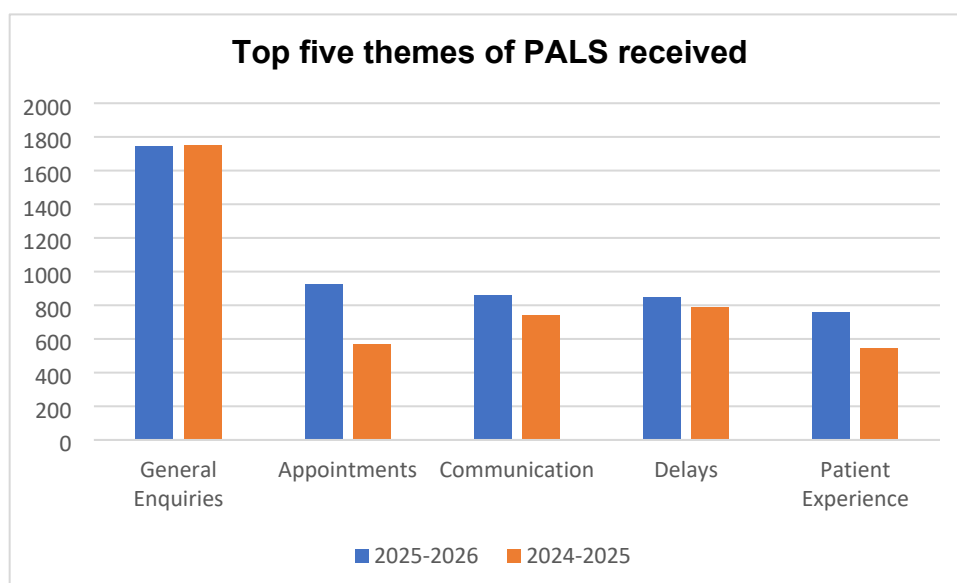
Themes and trends

The following table has the top five themes of PALS, broken down into the specific subject:

General enquiries	1745
Question / query asked	593
Chasing referral	288
Chasing elective admission	262
Chasing outpatient appointment	256
Chasing other results	162
Chasing radiology results	95
Equipment enquiry	46
Medical literature / information provided	18
Forms completed	11
Freedom of Information Request	8
Chasing emergency admission	4
Help for patient via volunteer / or staff	2
Appointments	924
Problems with department appointment	445
Problems with outpatient appointments	320
Problems with administration	84
Change of appointment date	73
Insufficient time to book transport	2
Communication	860
Unable to contact department / ward	279
Doctor communication issues	180
Other staff communication issues	91
Other communication issues	72
Misleading or contradictory information given	56
Admin and clerical staff communication issues	53
Nursing communication issues	41
Lack of information / explanation of how procedure went	33
Unhappy with info on medical records	31
Digital communication – appointment reminders	8
Digital communication – patient portal	7
Issues with interpreter service	5
Therapist communication issues	3
Hotel Services communication issues	1
Delays	844
Delays in receiving treatment	307
Delay in referral	142
Delay in allocation of outpatient appointment	137
Delay with elective admission	93
Delay in receiving x-ray results	53
Delay in sending / receiving medical records	42
Delay in being seen in outpatient department	30
Delays in being seen in A&E	24

Delay in receiving hearing aid / repair or surgical fittings	6
Delay with emergency admission	6
Delay in going to theatre	4
Patient Experience	758
Signposting	693
Raise complaint / comment	43
Complaint referred to complaint department	12
Comfort and support	8
Delay in responding due to delay with medical records	1
Explain complaint process	1

The top five themes in 2025-2026 are the same as those received in 2024-2025.



Outcomes and Actions from PALS 2025-2026:

The following are a sample of the actions and learning identified from the PALS contacts received in 2025-2026:

Care Group	Concern	Learning and Actions
CCASS – Dermatology	A patient was concerned regarding the use of a non-diluted alcohol wash prior to a vulva biopsy, causing severe pain and prolonged discomfort.	A Dermatology Registrar contacted the patient, apologised for their experience. Explained that chlorhexidine was initially used, followed by saline. The Registrar assured the patient that they will look into creating a local vulval biopsy protocol and only use saline going forward.
DCB – Outpatients Appointments	A patient contacted the Outpatients appointments line on three occasions and each time, the patient has been extremely high in the queue and there were a high number of people in the queue and the waits were unreasonable.	The Outpatients Manager contacted the patient and apologised for the long waiting time; they explained that the department was understaffed at the time, however, more staff had been recruited and they are exploring ways to reduce phone waiting times.

DCB – MRI	Patient had an MRI and was concerned about the delay in receiving the results.	The Radiology Business Administration Manager contacted the patient and apologised the MRI results weren't available for a clinical appointment. The Radiology Business Administration Manager is reviewing how patients can be informed about reporting times, when they attend for their scans and how scan results can be available for upcoming appointments.
DCB, Phlebotomy	A patient raised concerns with the state of the chairs in the department and also, that a member of staff would not help the patient get out of the chair; another patient helped and in doing so injured their skin.	The Phlebotomy Site Leads contacted the patient and apologised for the condition of the chairs. They advised the department was procuring new chairs and that reviewed the phlebotomists manual handling competencies had been reviewed and refresher manual handling training had been booked.
DCB, Paediatric Physiotherapy	A young patient's mother was unhappy they had attended the Children's Assessment Centre with their child and having checked in, waited for nearly an hour with other patients being seen before them. In the end, they needed to leave.	The Deputy Operations Manager for Therapies contacted the patient's mother and advised that the child was not checked in which was likely due to human error by reception. However, the physiotherapist should have checked in the reception area to see if they were waiting. This has been discussed with the physiotherapist who has agreed to check reception after 10 minutes from the appointment time to check they are not sat in the waiting room along with a telephone call to check if they are there.
KCH&RV – Neurology	A patient raised concerns around poor communication with the Motor Neurone Disease (MND) Clinic, along with voicemails not being returned.	The Clinical Lead for Neurosciences contacted the patient and apologised for the poor communication. This was due to a member of the team being on long term sick leave. A new direct line is being implemented, with a staff rota to cover. The website and letters are being updated to reflect this.
KCH&RV – Trauma & Orthopaedics	A patient raised concerns that the Fracture Clinic at QEOM had been moved and was now not easily accessible by patients due to the lack of space.	The Fracture Clinic Nurse Manager contacted the patient and apologised, the temporary move that was unavoidable. The Manager advised that the Clinic are trying to source a more permanent location with suitable space for patients.
KCH&RV – Trauma & Orthopaedics (T&O)	A patient raised concerns regarding the closure of the community Carpal Tunnel Service in Faversham and the impact on wait times for the service.	The T&O Service Manager apologised for the extended wait times. The patient was advised that the Trust were currently trying to source a location at QEOM to be able to provide a quicker service.
WCYPH – Obstetrics	A patient was upset that a room was not provided when their baby was to be removed into foster care by Social Services. they had to say goodbye on a busy ward with a curtain pulled across.	The Ward Manager contacted the patient and sincerely apologised for the lack of privacy and dignity. The Ward Manager is looking into how to facilitate care in these situations. They are sharing with staff to improve care and dignity.

WCYPH - Acute Paediatrics	A young patient's mother was unhappy with the waiting time for their child to be seen by the autism team for an assessment; the child having already waited 15 months.	The Acting Head of Community Child Health and CYP Therapies spoke with the child's mother and apologised for the long wait times for an assessment. It was agreed the child would be kept on the current wait list. The Acting Head also agreed to discuss with the paediatricians to see if the wait times across the localities can be equalised by offering a more flexible option in terms of location.
WHH – HCOOP	A family member raised concerns regarding the patient's care on the ward including being cared for in a corridor with no access to a call button, toilet or privacy, the patient being left soiled for 1.5 hours, the phones on the ward not being answered and nursing staff ignoring questions regarding care. The family member also had concerns around delay with discharge.	The Ward Sister spoke to the patient and apologised for the lapse in care. The Ward sister spoke with the family member and apologised for the care provided. They advised that the nurse in question was not a regular nurse on the ward and this would be discussed with them for learning. The following actions would also be taken: • Nurses and health care assistances should not be seen standing at the entrance of the bay talking, which may look like they were ignoring patients when they require assistance • High standard of care to be provided promptly to patients at all times • Ensure patients' needs are met and continue best practise and treatment • Ensure relatives and patients are updated • Ward meeting will be arranged to discuss the issue raised and take corrective measures Progress will be monitored

10. Risks for the Complaints and PALS services: 2026-2027

The identified risks to services, which should be highlighted are:

- PALS offices across sites are not visible to the public and all sites do not have meeting areas for people wanting to use the PALS service.
- PALS and Complaint numbers are high and complexity impacts on the responsiveness in being able to investigate and provide a quality response within agreed timescales.
- The PALS team are currently being supported by redeployed staff, which if removed, would impact on responsiveness.
- Resource in Bereavement Services, particularly during the winter months, continues to be a concern. The service is supported by PALS during periods of pressure.
- Resource in PALS is a concern. There are not sufficient staffing numbers, for the service to be resilient when there is sickness or annual leave within the team. The team are constantly struggling to be responsive and cover all the sites, and as a result the team are unable to work within the process timescales detailed in the PALS policy.
- The PALS team database is Datix Client, which is no longer supported by Datix.
- Lost property has also been recently included to the PALS portfolio.

11. Achievements for Complaints and PALS in 2025-26

- 2025-2026 has overall been a year of embedding and settling for the Complaints team, after the restructure and changes made in 2024-2025.
- The PALS team has seen a turnover of staff, due to career advancement. In light of the changes, inducting and training of new staff, the performance of the team should be commended.
- Complaint acknowledgements were consistently strong: on average 98% were acknowledged within three working days, exceeding the 90% KPI for all twelve months.
- Complaint responses within agreed timescales improved and the KPI of 85% was consistently met or exceeded during the year.
- There was a 22% increase in new PALS contacts (7,284 in 2025–2026 compared to 5,963 in 2024–2025) and on average, 68% of PALS were responded to within timescales, with 59% resolved and closed within ten working days.
- The PALS team answered calls live on average between 33% and 51% during the year.
- There was a 35% increase in compliments received in 2025–2026.
- Training on complaints and PALS was delivered to a range of staff groups, including new consultants and junior doctors.
- Closer working with the Patient Safety Team, ensuring the Patient Safety Incident Response Framework (PSIRF) is fully considered within complaints and PALS and enabling better triangulation, insight and improvement.
- Closer working with the Legal team to ensure information on complaints is shared for triangulation.
- Ongoing work to improve the quality of written responses, ensuring they meet the needs of service users.
- Regular engagement with care groups to monitor progress, remove barriers to timely responses, and support colleagues to meet timescales.
- Supporting colleagues who are redeployed to PALS – ensuring their well-being is monitored.

12. The future – plans for 2026-2027

We are keen to ensure the level of review and self-reflection continues for the Complaints and PALS services. For the coming year we have identified further actions and improvements, to ensure responsive and sustainable services. Some of the reviews and improvements include:

- To work with care groups to better capture outcomes and learning from complaints and PALS and to be part of the sustainable improvements.
- To produce a bi-monthly newsletter to share good practice for complaints and PALS, along with learning and actions being taken forward.
- Working jointly with our Quality Directorate services, to promote learning from complaints and PALS.
- To fully establish Complaint Hubs across the three sites and offer staff involved in complaints or complaint investigations the opportunity of seeking support.
- To continue the close working with the Patient Safety team to ensure the Patient Safety Incident Response Framework (PSIRF) is fully considered during the complaints and PALS process. To create opportunities for improved triangulation between the patient safety incidents and complaints, along with learning and improvements.
- To review the CPBS databases to ensure the robust systems of collating data, along with providing accurate and informative reports.
- To review returned complaints, capturing the reasons, themes/trends, to help focus on services/staff, who may need further support/development.

- To actively support sites to be able to have a PALS office in a visible and accessible location for our patients and their families.
- To continue working with the Patient Voice and Involvement team, ensuring full accessibility for the public to make a complaint, compliment or PALS.
- To ensure information about the complaints or PALS service is reviewed, including information provided on the Trust's web pages.
- To continuously work on the quality of written responses from PALS and the complaints team, to ensure they meet the needs of the recipient.
- To self-assess the PALS and complaint processes, to ensure it meets the needs of clients, PHSO NHS Complaint Standards and Care Quality Commission (CQC) Key Questions.
- To continuously identify any service efficiencies, across the three teams.
- To continue to regularly meet with each care group service to monitor complaint and PALS progress, to eliminate barriers for responding to PALS and complaints within timescales and support care group colleagues.
- To provide regular training to the complaints and PALS teams, to update their organisational knowledge, as well as providing support for specialist knowledge development.

The Complaints and PALS team at the away day March 2026.



Abbreviations:

Care groups:

Corporate (Corp)

Diagnostics, Cancer and Buckland Hospital (DCB CG)

Critical Care, Anaesthetics and Surgical Services (CCASS CG)

Kent and Canterbury Hospital and Royal Victoria Hospital (KCH&RV CG)

Queen Elizabeth the Queen Mother Hospital (QEQM CG)

Women's, Children and Young People's Health (WCYPH CG)

William Harvey Hospital (WHH CG)

Research & Innovation (R&I) Board Report 2026

Operational Delivery, Financial Contribution & Strategic Trajectory

A detailed operational assurance report mapping the expansion of our commercial portfolio, robust financial returns, and strategies for navigating current infrastructure constraints across EKHUFT.

Presented by Ms Jessica Evans
28 July 2026

Executive Summary

This report provides the Board with annual assurance regarding the delivery and strategic trajectory of the R&I portfolio across East Kent Hospitals University NHS Foundation Trust (EKHUFT).

We highlight **sustained recruitment performance** and significant **financial contributions**, particularly through our Commercial Capacity Building.

Crucially, this report flags pressing **operational risk**, including administrative workforce deficits and severe clinical space constraints, that require Board awareness to protect our future pipeline growth.



Income Generation & Savings

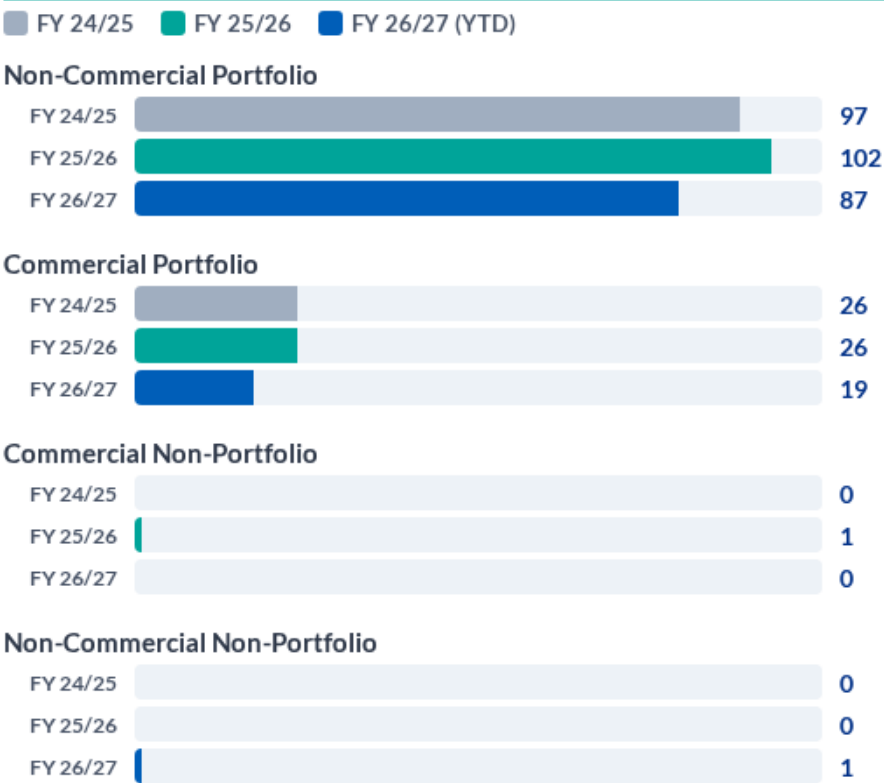
The R&I directorate continues to be a major financial asset to the Trust. The commercial capacity building consistently generates returns that greatly exceed total operational team costs, delivering **net positive funding**.

R&I Income Generated by Type	FY 24/25	FY 25/26	FY 26/27 (YTD)
RDN (Research Delivery Network)	£ 1,357,122	£ 1,398,795	£ 303,740
Grants	£ 296,271	£ 458,672	£ 0
Other (Commercial & Strategic)	£ 1,327,310	£ 1,665,602	£ 335,432
Total Income Generated	£ 2,980,703	£ 3,523,068	£ 639,172

Detailed Recruitment & Portfolio Overview

Year-on-Year Trend Analysis: Total patient recruitment increased from 1,568 (Financial Year (FY) 24/25) to a peak of 1,656 (FY 25/26). This was primarily driven by growth in non-commercial studies (expanding from 97 to 102). Concurrently, our high-value commercial portfolio maintained a stable capacity of 26 active studies across both full years, securing robust income generation. **FY 26/27 reflects Year to Date (YTD) performance.*

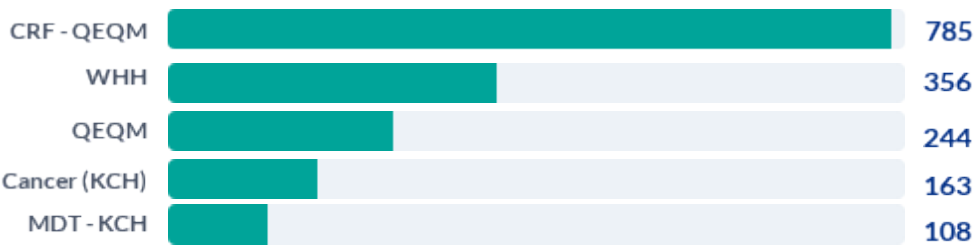
Open Studies by Category



Total Participants Recruited



Recruitment by Site (FY 25/26 Full Year)



Strategic Successes & Milestones



Oncology Expansion (EKCRC)

Secured the **first global and UK patients** for key commercial trials. Top 3 national recruiter for RADAR, Her-2, TRAC, Mag-16, and Majestec-7. Solid tumour research is generating robust income and prestigious academic publications.



Commercial Capacity Building

The Kent & Canterbury Hospital (K&C) Multispecialty team achieved consecutive YoY commercial income growth. Their financial contribution continuously exceeds total operational team cost, cementing R&I as a net positive funding source for the Trust.



Women's Health & Cardiology

The pre-cancer RICH Study at Queen Elizabeth the Queen Mother Hospital (QEQM) vastly exceeded its target (recruiting 30 vs 17 target). At William Harvey Hospital (WHH), the COMPLETE-2 Cardiology trial exceeded recruitment plans and retained **100% of participants**, aided by dedicated Clinical Research Practitioners.

High Impact Portfolio Examples

Landmark & Commercial Trials

The Horizon Study (K&C): A landmark commercial trial evaluating a novel mRNA vaccine for early Multiple Sclerosis, targeting the Epstein-Barr Virus to address a massive national treatment gap.

Commercial CTIMPs (EKCRC): Magnetissm-32, Majestic-7, Trilogy 4+7, Trofuse, Cadance, and Golseek-4 provide local patients access to novel therapies completely unavailable on standard NHS pathways.

EJS ACT-PD (WHH): The world's largest clinical trial for Parkinson's disease. WHH is the only site in Kent offering this landmark platform study.

Innovation & Practice-Changing Delivery

TRACC (EKCRC K&C): Conducted with the Royal Marsden, this trial utilises CTdna blood tests to safely de-escalate cancer treatments. With >70 local recruits, it is highly likely to be practice-changing.

Fraiya (QEQM): EKHUFT is one of only four national sites selected to bring AI-assisted 20-week anomaly scans to pregnant patients, targeting 2,000 recruits in a single year.

DIRECT (QEQM & WHH): Trust-wide randomised study comparing Low molecular weight heparin (LMWH) and aspirin for Venous Thromboembolism (VTE) prevention in fragility hip fractures. Targets significant recruitment via national database.

Operational Risks & Mitigations

-  **Admin Deficit:** The K&C Multispecialty team lost two critical posts (vacancy freeze). Nurses are absorbing duties.
Mitigation: May reduce intake of complex commercial studies where admin requirements are highest.

-  **Estate Constraints:** WHH research team loses office space in Aug 2026 due to Same Day Emergency Care (SDEC) with no alternative.
Mitigation: Prioritising online consent/tele-follow ups; applying for mobile research bus funding.

-  **Clinical Support:** Severe lack of clinic space and pharmacy capacity (APU/dispensary). Setup delays are failing sponsor expectations.
Mitigation: Prioritising easiest/lucrative trials, selectively withdrawing from others.

-  **Escalation - Maternity Funding:** Split-role research midwives at QEQM rely entirely on unconfirmed department funding. Without Executive commitment, current/future reproductive health studies will fail.

Strategic Growth & Pipeline Development

-  **Commercial Structure & Staffing Optimisation (K&C):** Scaling the commercial portfolio by targeting an optimal nurse-to-admin ratio of 2:1, expanding Band 5 practitioner roles, and creating dedicated administrative leadership to strictly manage sponsor expectations.
-  **Specialty & Regulatory Expansion:** Actively targeting historically lucrative clinical areas including renal, stroke, neurology, and vascular specialties. Engaging with regulatory workflows to offload Principal Investigator (PI) burdens and cultivate the next generation of Trust PIs.
-  **Maternity & Reproductive Health:** QEQM is primed to integrate maternity research alongside the development of the new unit, capitalising on a massive pipeline of studies. This potential strictly requires steadfast Trust backing for dedicated research midwives.
-  **Oncology Expansion:** The EKCRC opened the first commercial Clinical Trial of an Investigational Medicinal Product (CTIMP) solid tumour trials in a decade. We are retraining in Systemic Anti-Cancer Therapy (SACT) administration to transition delivery to QEQM, awaiting two dedicated chemo research nurses to rapidly expand lung, colorectal, and gynae trials.
-  **Acute & Emergency Care (WHH):** Expanding the acute research footprint across Emergency Department (ED), Trauma & Orthopaedics, and Theatres, while sustaining the highly active Cardiology portfolio.

Questions?

Thank you for your continued support of Research & Innovation at EKHUFT.

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: Care Quality Commission (CQC) Update Report

Meeting date: 28 July 2026

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

Paper Author: Clare Hollyer, Compliance and Assurance Manager for Director of Quality Governance

Appendices:

Appendix 1: Ward accreditation status 25 June 2026

Executive summary:

Action required:	Assurance
Purpose of the Report:	This report provides an update on CQC inspection activities, oversight, assurance and related improvement work. This report covers the period mid-March 2026 to June 2026 and covers: • CQC inspections; • CQC engagement meetings; • Summary of progress with the CQC self-assessment and check and challenge meeting programmes; • Ward and clinic accreditation update; • Update on performance against the CQC inspection reports from May and July 2023, published in December 2023; • Update on performance against 'historical' open CQC action plans (2018, 2020 and 2021); • Summary of CQC queries; • Recent CQC publications.
Summary of key issues:	The CQC have completed four unannounced inspections to date this year. Urgent and Emergency Care (UEC) at Queen Elizabeth the Queen Mother Hospital (QEQM) in January and May, General Medicine at QEQM in January and UEC at William Harvey Hospital (WHH) in February. The Trust is awaiting the draft reports from the CQC for the QEQM inspections. These are anticipated week commencing 20 July 2026. Following inspection of the QEQM UEC Core Service on 9 January 2026 the Trust received a Letter of Intent that required submission of an action plan on 12 January 2026. The Trust have committed to provide the CQC and the Board of Directors with weekly reporting on the progress of the priority action plan. Following the visit on 6 and 7 May 2026, a further 15 additional actions have been added to this weekly action plan taking the total number of actions on the plan to 66. We have recently received confirmation from the CQC that these weekly reports, which were not a requirement but we were submitting to provide ongoing assurance, can be stood down. Regular internal reporting will continue. The WHH UEC Core Service Inspection report from the February 2026 inspection, was published on the 10 July 2026. The overall status remains



	'requires improvement'. Ratings remained 'good' for 'caring and the ratings for 'effective' and 'well-led' were upgraded from 'requires improvement' to 'good' There are now only 3% of actions remaining open from the 2023 inspections. Multiple actions are associated with medical compliance with statutory and mandatory training (UEC and medical care) which is still not at Trust target. Leadership is being provided by the Chief Medical Officer (CMO) and performance is being monitored via the Oversight Meetings. The remaining Must Do actions are around pharmacy staffing. Updates are provided within the paper in relation to these remaining open actions. Self-assessments will now be completed using the refreshed self-assessments tool which has been aligned with the new CQC assessment framework. A bespoke UEC tool has also been produced.
Key recommendations:	The Board of Directors is asked to receive the attached report and RECEIVE the assurance provided in relation to query management, and the self-assessment and check and challenge meeting programme.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients
Link to the Trust Risk Register:	There is a risk of non-compliance with CQC regulations which would have an impact on registration and may lead to repeat enforcement action, improvement notices and a critical report (ref 3636). Residual Risk 12 (moderate).
Resource:	Y: Two outstanding CQC requirements relate to pharmacy (Must Do). The new Head of Quality Assurance, Compliance and Risk commenced in post on the 1 June 2026.
Legal and regulatory:	Y: Inability to provide assurance to our regulators impacting on the quality and safety of care provided to our patients and service users.
Subsidiary:	N

Assurance route:

Previously considered by:

Quality and Safety Committee (14 May 2026)

CQC Oversight and Assurance meeting (22 May 2026)

Regulatory Oversight Group (23 June 2026).

A bi-monthly Chairs report is received from Regulatory Oversight Group to TMC (including CQC escalations). This was last received at Trust Management Committee (TMC) on 1 July 2026.

Escalations are made as appropriate outside of the meeting.

Quality and Safety Committee (14 July 2026)



Care Quality Commission (CQC) Update Report

1. Purpose of the report

- 1.1** This report provides an update on CQC inspection activities, oversight, assurance and related improvement work. This report covers the period Mid-March to June 2026 and includes:
- CQC inspections;
 - CQC engagement meetings;
 - Summary of status of the CQC self-assessment and check and challenge meeting programmes;
 - Ward and clinic accreditation update;
 - Update on performance against the CQC inspection reports from May and July 2023, published in December 2023;
 - Update on performance against 'historical' open CQC action plans (2018, 2020 and 2021);
 - Summary of CQC queries;
 - Recent CQC publications.

2. Background

- 2.1** The CQC rated the Trust as 'requires improvement' following Core Service and a Trust wide Well Led inspection in May and July 2023. The Maternity Core Service was inspected in December 2024 with a 'Good' rating for both the QEQM and the WHH sites. The UEC Core Service was inspected in February 2026 and rated as 'requires improvement' at the WHH site but with improvements in the domains of effective and well led. Continuing to improve our CQC rating is a Trust Strategic Initiative and a key part of the Quality Strategy and Quality Priority objectives as outlined in the Quality Account 2025/26.

3. CQC inspections

- 3.1** On 6-7 January 2026, the CQC undertook an unannounced inspection of the UEC Core Service at the QEQM. This was part of the Winter Pressures inspection programme. Following the visit on 9 January 2026 the Trust received a Letter of Intent that required submission of an action plan on 12 January 2026.
- 3.2** The CQC made a further unannounced inspection visit to QEQM on the 6-7 May 2026 to inspect again the Emergency and UEC Core Service. We have been informed that this was not a repeat inspection but should be considered as separate, although we have sought advice and clarity regarding this. Verbal feedback provided by the Inspectors showed evidence of considerable improvement since the January inspection.
- 3.3** The Trust have committed to provide the CQC and the Board of Directors with weekly reporting on the progress of the priority action plan. Following the visit in May 2026 a further 15 additional actions have been added to this weekly action plan taking the total number of actions on the plan to 66. The report summarises the overall position and the



week to date. At the time of this report, the last submission was made on Friday 10 July 2026.

- 3.4** We have recently received confirmation from the CQC that these weekly reports, which were not a requirement but we were submitting to provide ongoing assurance, can be stood down. Regular internal reporting will continue.

Theme				
1.Safe care and treatment in temporary escalation areas				33
2.Flow of patients within the ED				2
3.Staffing (medical)	1			9
4.Staffing (Mental Health)				6
5. Areas for Improvement outlined in CQC letter of 11 May 26	6			10
Total number of actions	7			59

- 3.5** Of the 66 actions, 59 actions are complete with evidence approved and assured and seven actions remain in progress (as of week ending Friday 10 July 2026).
- 3.6** The Trust received a provider information request from the CQC following the QEQM Emergency Care May inspection for a further 96 pieces of evidence which was submitted by the requested date of 5 June 2026.
- 3.7** The Trust is awaiting the draft reports from the CQC for three QEQM inspections.
- 3.8** The Trust has received the report for the WHH UEC Inspection which took place in February 2026, the report was published on the 10 July 2026. The overall status remains 'requires improvement'. The ratings remained 'good' for 'caring and the ratings for 'effective' and 'well-led' were upgraded from 'requires improvement' to 'good' due to the improvements witnessed by the inspectors and evidence of improvement provided.
- 3.9** The rating for 'effective' was upgraded to 'good' as the the CQC were able to find evidence that patients had their needs assessed and were at the centre of their care. There was evidence that leaders instilled a culture of improvement and exploring best practice was part of their everyday work.
- 3.10** The rating for 'well-led' was upgraded to 'good' as evidence identified the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.



- 3.11** The overall rating remained 'requires improvement' due to the overcrowding and corridor care the CQC saw in the department. This included extended periods in environments that were not intended for patient care which did not offer privacy and dignity. Delays were also noted in triage and monitoring of patients including long waits for medical reviews. Patients and family were mostly positive about the staff treating them with warmth and kindness and providing effective care and treatment. However, patients in temporary escalation areas were unhappy with the level of privacy and length of time in these areas.

4. CQC Engagement meeting

- 4.1** A Trust Engagement Meeting took place on 19 May 2026 between the CQC, CNMO, Director of Quality Governance and Associate Director of Quality Governance.
- 4.2** An agenda was shared by the CQC ahead of the meeting and a slide pack containing updates on Never Events, Board changes, areas of media interest and interprofessional standards was shared by the CNMO during the meeting.
- 4.3** At that meeting the new Director of Midwifery and Gynaecology Nursing for the Trust was introduced and an update on maternity services was provided at the request of the CQC.
- 4.4** Both parties reflected positively on the developing relationship. CQC emphasised a collaborative, non-punitive approach and a desire to better understand frontline services and improvement work.
- 4.5** A further CQC engagement meeting took place on 14 July 2026. An agenda was shared by the CQC ahead of the meeting which focused on actions from Preventing Future Death responses from 2024 and 2025, hospital acquired pressure damage and Freedom to Speak Up to include any areas of concern, recent speak ups any themes, areas and any Trust wide work on improving culture. The CMO attended to provide an update on Anaesthetics.
- 4.6** The next CQC Engagement Meeting will take place in September 2026.

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

- 5.1** The self-assessment Check and Challenge meetings, chaired by the CNMO, and attended by the CMO, Chief Operating Officer (COO), Director of Quality Governance, Associate Director of Quality Governance and members of each Care Group's leadership team, commenced in May 2024.
- 5.2** The Compliance and Assurance Team have refreshed the check and challenge schedule for the next year and this has been shared with all Care Groups.
- 5.3** The percentage of quality statements rated as fully met are shown in the below table, this table shows the ratings care groups scored prior to using the new self-assessment tool (see 5.6 Kent & Canterbury and Victoria Hospital (KCVH) check and challenge).



Date of meeting last meeting	No of assessments completed	Percentage of Quality Statements rated as fully met					
			Safe	Effective	Caring	Responsive	Well Led
19.08.25	2	Children & Young People (CYP)	44%	50%	100%	79%	88%
09.07.24	2	Women's Health	81%	75%	90%	71%	75%
24.09.25	17	CCASS	68%	89%	88%	87%	95%
03.02.25	2	End of Life Care (EOLC)	25%	42%	40%	7%	56%
04.03.25	4	QEQM	38%	63%	65%	54%	57%
16.12.25	2	WHH	69%	58%	70%	64%	74%
14.04.25	17	Diagnostics, Cancer and Buckland (DCB)	57%	76%	80%	70%	80%

- 5.4** The CQC have recently published a new draft assessment framework for Hospitals (secondary and specialist care) following internal and external engagement and consultation work and following the recommendations of the independent reviews by Dr Penny Dash, Professor Sir Mike Richards and the Care Provider Alliance.
- 5.5** The main changes within the new draft self-assessment are a return to the rating characteristics (additional information on what care within each Domain looks like against each CQC rating from inadequate to outstanding) and the removal of scoring from the CQC assessment methodology, with rating judgements instead being made directly at key question level.
- 5.6** The KCVH completed a check and challenge meeting on the 17 June 2026 using this scoring method but using the self-assessment tool prior to the CQC assessment update. Cancer specialties were also included in this review having moved from DCB Care Group to KCVH Care Group as an interim arrangement.

	Safe	Effective	Caring	Responsive	Well led
Renal	RI	RI	Good	Good	RI
Stroke	RI	Good	Good	Good	RI
T&O	Inadequate	RI	Good	RI	RI



Neurology	No self-assessments returned to review				
Vascular	RI	RI	Good	RI	RI
Urology	RI	RI	RI	RI	RI
CCHHP	RI	RI	Good	RI	RI

- 5.7** A specialist assessment for UEC has been produced – incorporating feedback and learning from the January 2026 inspections. Separate to the routine Self-Assessment schedule (which has just been signed off for 2026/27) both EDs will be asked to complete the tool and an action plan and ensure processes are in place for oversight of progress. This will be part of continued work to embed the improvements made through the QEQM priority action plan (reported weekly post inspection) pending its closure later this month.
- 5.8** The Compliance and Assurance Team will support communication and engagement around the new self-assessment tools. These will be used for all self-assessments from July 2026 onwards.

6. Ward and clinic accreditation update

- 6.1** Appendix 1 shows the current Ward Accreditation rating status as of 25 June 2026. Wards currently on white status remain on four weekly reassessment schedules until Bronze status is achieved.
- 6.2** Please see a summary as reported through the April Ward and Clinic Accreditation Steering Group (June 2026).
- 6.3** Round 2 accreditation activity has been completed across all sites, with Round 3 substantially progressed and Round 4 commencing in selected areas.
- 6.4** Trust wide reassessment activity completed to date includes:
- Round 2: 186 reassessments
 - Round 3: 63 reassessments
- 6.5** The reduction in reassessment activity between rounds may indicate improving compliance and embedding of standards, although further analysis will be undertaken within the annual report.
- 6.6** Year-on-year site performance demonstrates improvement across all hospital sites



Site	Year 1 Jun 24 – May 25	Year 2 June 25 – Jun 26	Improvement
QEQM	71%	75%	+4 %
WHH	68%	70%	+2 %
K&C	66%	72%	+6 %
Trust wide	68%	72%	+4%

6.7 High-performing mandatory criteria continue to include:

- Statutory and mandatory training compliance (98%)
- Safe storage of controlled drugs (94%)
- Medication administration procedures (92%)

6.8 Areas for continued improvement include:

- Timely recording of National Early Warning Score (NEWS) (27%)
- Falls risk assessment completion (33%)
- Weekly Purpose T review (48%)

6.9 Significant progress has been made in digital enablement. The Tendable dashboard configuration has progressed to final stages and now supports area, site, Trust wide, theme and action reporting. Some advanced analytical functionality remains unavailable and manual analysis may still be required for certain enquiries. Following procurement, the Trust has awarded the contract to Genome, with Trust wide transition and implementation underway. The planned go-live date is 27 July 2026.

6.10 Genome has confirmed that historical data migration from Tendable is not currently possible. This presents a risk to longitudinal reporting, trend analysis and historical accreditation records. Further discussions are ongoing to establish arrangements for access to legacy data.

6.11 Collaborative work with Business Intelligence Unit (BIU) continues to progress, supporting the development of more automated, centralised and sustainable reporting arrangements for accreditation and wider audit activity.

7. Update on performance against the 2023 CQC inspection report

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



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

7.2 Monthly reports showing progress and status of each action plan have been provided to the CQC Oversight and Assurance Group and on to the Regulatory Oversight Group (ROG) and Quality and Safety Committee (Q&SC) since the plans' commencement in January 2024. A fortnightly meeting is held with the CNMO and Director of Quality Governance. Two actions on the 2023 CQC inspection action plan have been closed following review.

- **WHH GM action plan:** GM medical staff have shown three months compliance for mandatory training of over 85%.
- **DCB action plan:** The Trust should ensure they have enough Allied Health Professionals (AHP) available to provide care to all patients on medical wards, including those in escalation areas where medically fit patients reside. An AHP Workforce Review has been undertaken by the Deputy Chief AHP, an update paper was presented to Trust Management Committee (TMC) on 5 November 2025 which focused on delivery of a 7 day a week service. Ongoing work against the agreed plan is to be managed as part of Business As Usual (BAU) rather than via the CQC plan.

7.3 This report includes the current status of the Must and Should Do requirements, and how many associated actions remain open. It shows the status on 15 July 2026 as reported at CQC Oversight and Assurance group 22 May 2026 and the ROG 23 June 2026.

7.4 Statutory and mandatory training for doctors had an extended target date of 30 September 2024, as agreed by the CMO. This target was not met and the CMO was informed. Actions are in place to recover this this. June 2026 data is presented below.

7.5 There has been a slight increase in performance but further work is required to recover the position with a focus on UEC and Medicine. For UEC and Medicine data please see point 8.3 below.



Statutory training for medical staff:

Statutory % by Month

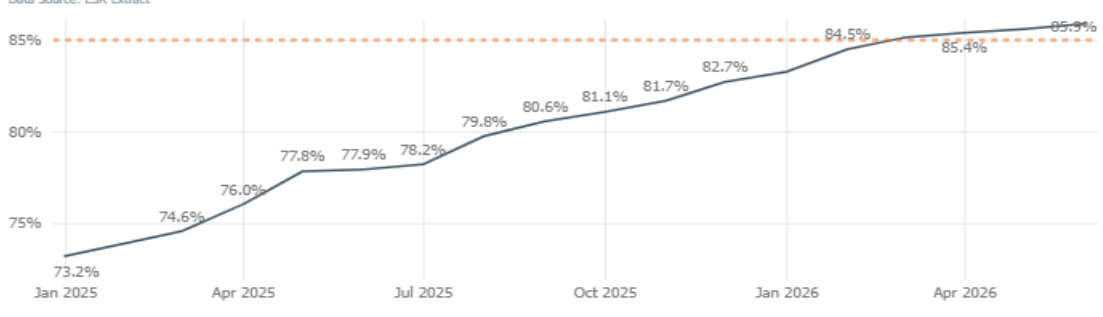
Data Source: ESR Extract



Mandatory training for medical staff:

Compliance by Month

Data Source: ESR Extract



- 7.6** There are five Must Do (out of 28) and one Should Do (out of 25) requirements that remain open (some requirements feature on multiple action plans or on two sites). There is a total of six out of 206 (3%) actions open across all action plans, as shown in the table below.

OPEN REQUIREMENTS AND ACTIONS

Action plan	Open Must Do Requirements	Open Should Do Requirements	Total number of actions on plan	Number of open actions (05/05/2026)
Well-led	0 of 4 (0%)	0 of 8 (0%)	56	0
2gether	0 of 4 (0%)	N/A	7	0
QEQM Urgent, Emergency & Acute Medicine (UEAM)	1 of 6 (17%)	0 of 3 (0%)	26	1
QEQM GM	1 of 7 (7%)	0 of 5 (0%)	26	1
WHH GM	1 of 8 (13%)	0 of 4 (0%)	33	1



WHH UEAM	1 of 4 (25%)	0 of 2 (0%)	13	1
Women, Children & Young People (WCYP)	0 of 11 (0%)	0 of 9 (0%)	28	0
DCB	1 of 11 (9%)	1 of 1 (100%)	12	2
Corporate	0 of 4 (0%)	0 of 1 (0%)	5	0
TOTAL			206	6 (3%)

7.7 Of these six open actions:

- Four relate to medical training compliance. A six-month extension to 30 September 2024 was agreed for medics to achieve the compliance rates seen across nursing, midwifery, allied health professionals and clerical and managerial groupings. This was not met. Additional actions have been put into place to improve compliance. Data as reported above.
- Two actions relate to staffing (Pharmacy):
- Pharmacy: Director of Pharmacy is looking at how Electronic Prescribing and Medicines Administration (EPMA) can be used to plan staffing, input and optimise current pharmacists. The first phase of this work is a project to increase consistency and reporting of medicines reconciliation (MR). This was completed in January 2026. A recent national benchmarking report will enable a re-set of expectations around the MR rate – and following this a proposed redistribution of resources (Phase 2) which has been completed. This project will improve prioritisation of pharmacy support but it will not enable the closure of this Must Do (which also relates to risk 678). Meeting scheduled with CMO and Director of Quality Governance on 3 July 2026 to agree approach to this open action and tolerance of the risk. It was agreed that this action would remain open but pending an external workforce review for Pharmacy which is due to be undertaken shortly.

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

- 8.1** There are four open inspection action plans relating to CQC inspections that took place between 2018 and January 2023. These action plans are also subject to regular review and update by the specialities, supported by the Compliance & Assurance Team (C&AT).
- 8.2** Two actions have been closed following approval by CNMO. (one Should do and one Must do)

WHH GM 2021	SD02.MED.K&C & WHH.2021 The Trust should ensure that all staff complete their mandatory training. (Also, on May 2023 action plan)	Closure approved by CNMO also closed on 2023 action plan
WHH UEC 2020	MD16.UEC. WHH the Trust must ensure critical fluids and medicines	Discussions ongoing with CMO and Director of Pharmacy. Further pharmacy support for ED



	are administered and recorded in a timely manner.	WHH recruited. Missed Dose Dashboard used to monitor compliance and reported through Medicines Safety Group. Closure approved by CNMO for BAU oversight and monitoring via the new dashboard.

8.3 The following requirements remain open:

Care Group (CG) and Speciality	Requirement	Status
WHH UEC 2020	MD01.UEC.WHH The Trust must ensure staff complete their mandatory training and each module meets their compliance targets, including; Mental Capacity Act training, life support training, and dementia training. (Also, on May 2023 action plan) MD28.UEC.QEQM&WHH.2023	Data 15/07/2026 Medical compliance WHH UEAM: June 2026 Statutory compliance –83.9% (target 91%) 4 of 8 courses below Trust target Mandatory compliance –81.5% (target 85%) 8 of 12 courses below Trust target
WHH UEC 2020	SD05.UEC.WHH The Trust should ensure all staff have access to the training needed for their role including advanced life support.	Data 15/07/2026 Medical: June 2026 RESUS Adult 87.3% (target 85%) RESUS Paed 71.2% (target 85%)
K&C GM 2021	SD02.MED.K&C & WHH.2021 The trust should ensure that all staff complete their mandatory training. (Also, on May 2023 action plan)	Data 15/07/2026 Medical K&C June 2026 Statutory compliance – 86.1% (target 91%) 7 of 8 courses below Trust target Mandatory compliance –81.7% (target 85%) 7 of 14 courses below Trust target.
QEQM UEC 2020	MD01.UEC.WHH The Trust must ensure staff complete their mandatory training and each module meets their compliance targets, including; Mental Capacity Act training, life support training, and dementia training. Also, on 2023 action plan MD28.UEC.QEQM&WHH.2023	Data 15/07/2026 Medical QEQM UEAM June 26 Statutory compliance – 91.9% (target 91%) 3 of 8 courses below Trust target Mandatory compliance – 87.6% (target 85%) 4 of 12 courses below Trust target
WHH & QEQM UEC 2020	SD03.UEC.QEQM & WHH the Trust should ensure medicines reconciliation is undertaken in a timely manner	Discussions ongoing with CMO and Director of Pharmacy to ascertain outcome measures to provide assurance that this can be closed. This remains an issue due to long waiters as full reconciliation happens on admission. Mitigating



Care Group (CG) and Speciality	Requirement	Status
		actions proposed to ensure review of high priority patients.
EOLC 2018	MD37 Ensure that consent to care and treatment is always sought in line with legislation and guidance in relation to records of mental capacity assessments relating to decisions regarding 'Do not attempt cardiopulmonary resuscitation' (DNACPR).	Deputy CMO is co-chairing a task and finish group with the Trust Mental Capacity Act (MCA) Lead to address the issues identified. Awaiting confirmation that actions are in place to be managed by task and finish group. Evidence to be submitted to CNMO for a view (week commencing 6 July 2026).

9. CQC Queries Update

- 9.1** There were 29 queries received from the CQC during March and April 2026. During that period, 24 were fully responded to.
- 9.2** There were 19 queries received from the CQC during May and June 2026. During that period, 14 were fully responded to.
- 9.3** 18 of these queries had deadlines set by the CQC, eight of which were met within or ahead of target. Two queries did not meet the target date set by the CQC. One query required an extension which was met. One query with a due date was closed down by the CQC due to being unable to identify a patient in order for us to proceed but has since been re-opened but does no longer have a due date for us.
- 9.4** At the end of June 2026, one response remains open for 2024, seven responses remain open from 2025 and 22 remain open from 2026.

10. CQC publications

- 10.1** The CQC have shared the following publications. These updates have been shared at the CQC Oversight and Assurance Group and ROG.
- Strengthening our commitment to listening and acting on people's lived experiences Published 04.03.26
 - Our March update Published 24.03.26
 - Give your views on draft sector-specific assessment Published 25.03.26
 - Chris Dziki to leave CQC Published 20.04.26
 - What makes care outstanding? Published 14.04.26
 - Maternity survey 2025 Published 05.01.26
 - CQC publishes research on good practice for dementia care Published 10.03.26



11. Conclusion

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

End.



Site	Ward and Department	Previous Rating	Current Rating	Mandatory Criterion Improvement	Percentage Improvement	Inspection Status
KCH	Brabourne	Bronze (81%)	Bronze (63%)	N	N	In timeframe
KCH	Clarke	Bronze (64%)	Bronze (78%)	Y	Y	In timeframe
KCH	Critical Care Unit	Bronze (83%)	Silver (89%)	Y	Y	In timeframe
KCH	EKNR (Harvey)	Bronze (64%)	Bronze (69%)	Y	Y	In timeframe
KCH	Harbledown	Bronze (68%)	Bronze (72%)	N	Y	In timeframe
KCH	Invicta	Bronze (83%)	Silver (93%)	Y	Y	In timeframe
KCH	Kent	Bronze (67%)	Bronze (67%)	Y	N	In timeframe
KCH	Kingston	Bronze (88%)	Bronze (82%)	N	N	In timeframe
KCH	Marlowe	Bronze (60%)	White (69%)	Y	Y	4 weekly Reassessment Schedule
KCH	Mount McMaster	Bronze (79%)	White (74%)	N	N	4 weekly Reassessment Schedule
KCH	St Lawrence	Bronze (67%)	Silver (81%)	Y	Y	In timeframe
QEQM	AMU A	Bronze (67%)	White (76%)	Y	Y	4 weekly Reassessment Schedule
QEQM	AMU B	Bronze (66%)	White (81%)	Y	Y	4 weekly Reassessment Schedule
QEQM	Birchington	Bronze (61%)	White (74%)	Y	Y	4 weekly Reassessment Schedule
QEQM	Bishopstone	Bronze (71%)	White (73%)	N	Y	4 weekly Reassessment Schedule
QEQM	CCU	Bronze (82%)	Silver (83%)	Y	Y	In timeframe
QEQM	Critical Care	Bronze (73%)	Bronze (84%)	Y	Y	In timeframe
QEQM	CSF	Bronze (68%)	White (67%)	Y	N	4 weekly Reassessment Schedule
QEQM	CSM	Bronze (62%)	White (67%)	Y	Y	4 weekly Reassessment Schedule
QEQM	Deal	Silver (82%)	White (75%)	N	N	4 weekly Reassessment Schedule
QEQM	Emergency Department	Bronze (68%)	Bronze (72%)	N	Y	In timeframe
QEQM	Fordwich	Bronze (83%)	Silver (84%)	Y	Y	In timeframe
QEQM	Kingsgate	Bronze (85%)	Silver (88%)	Y	Y	In timeframe
QEQM	Paeds ED	Bronze (91%)	Bronze (85%)	N	N	In timeframe
QEQM	Rainbow	Bronze (68%)	Bronze (73%)	N	Y	In timeframe
QEQM	Sandwich Bay	Bronze (85%)	Bronze (81%)	Y	N	In timeframe
QEQM	SCBU	Bronze (92%)	Bronze (89%)	N	N	In timeframe
QEQM	Seabathing	Bronze (62%)	Bronze (78%)	Y	Y	In timeframe
QEQM	St. Augustines	Bronze (63%)	White (71%)	Y	Y	4 weekly Reassessment Schedule
QEQM	St. Margarets	Bronze (74%)	Silver (85%)	Y	Y	In timeframe
WHH	AMU A	Bronze (70%)	Bronze (61%)	Y	N	In timeframe

WHH	AMU B	Bronze (69%)	Bronze (60%)	Y	N	In timeframe
WHH	Bartholomew	Bronze (68%)	White (83%)	N	Y	4 weekly Reassessment Schedule
WHH	Cambridge J1	Bronze (67%)	White (68%)	N	Y	4 weekly Reassessment Schedule
WHH	Cambridge J2	Bronze (64%)	White (63%)	Y	N	4 weekly Reassessment Schedule
WHH	Cambridge K	Bronze (68%)	Bronze (66%)	N	N	In timeframe
WHH	Cambridge L	Bronze(83%)	Bronze (62%)	N	N	In timeframe
WHH	Cambridge M1	Bronze (70%)	White (70%)	N	N	4 weekly Reassessment Schedule
WHH	Cambridge M2	Bronze (87%)	Bronze (68%)	N	N	In timeframe
WHH	CCU	Bronze (78%)	White (71%)	Y	N	4 weekly Reassessment Schedule
WHH	Critical Care	Bronze(83%)	White (75%)	N	N	4 weekly Reassessment Schedule
WHH	Emergency Department	Bronze (69%)	White (63%)	N	N	4 weekly Reassessment Schedule
WHH	Folkestone	Bronze (76%)	White (72%)	N	N	4 weekly Reassessment Schedule
WHH	Kennington	Bronze (64%)	Bronze (67%)	N	Y	In timeframe
WHH	Kings A2	Bronze (69%)	White (70%)	N	Y	4 weekly Reassessment Schedule
WHH	Kings B	Bronze (82%)	White (67%)	N	N	4 weekly Reassessment Schedule
WHH	Kings C1	Bronze (73%)	White (64%)	Y	N	4 weekly Reassessment Schedule
WHH	Kings C2	Bronze (80%)	White (65%)	N	N	4 weekly Reassessment Schedule
WHH	Kings D1 Male	Bronze (73%)	White (70%)	Y	N	4 weekly Reassessment Schedule
WHH	Kings D2 Female	Bronze (66%)	White (69%)	Y	Y	4 weekly Reassessment Schedule
WHH	NICU	Silver (80%)	White (81%)	N	Y	4 weekly Reassessment Schedule
WHH	Oxford	Bronze (64%)	Bronze (60%)	N	N	In timeframe
WHH	Padua	Bronze (80%)	Bronze (76%)	N	N	In timeframe
WHH	Paediatric ED	Silver (90%)	White (64%)	N	N	4 weekly Reassessment Schedule
WHH	Richard Stevens	Bronze (67%)	Bronze (69%)	Y	Y	In timeframe
WHH	Rotary	Bronze (74%)	White (68%)	N	N	4 weekly Reassessment Schedule

Overall Improvement is determined by an improvement in both Mandatory criterion and Percentage.

BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)

Committee: Quality and Safety Committee (Q&SC)

Meeting date: 19 May 2026

Chair: Dr Andrew Catto, Non-Executive Director (NED)

Paper Author: Executive Assistant

Quorate: Yes

Appendices:

None

Declarations of interest made:

Dan Gibbs, Chief Operating Officer (COO), confirmed he was also the Director in Common for Spencer Private Hospitals (SPH).

Assurances received at the Committee meeting - focus on learning and improvement:

Agenda item	Summary
CARE GROUP DEEP DIVE- CRITICAL CARE ANAESTHETICS AND SPECIALIST SURGERY (CCASS)	The Committee received the report and NOTED the following key updates: - The Committee received assurance regarding governance arrangements, risk management processes and quality monitoring across the Care Group. Members noted positive achievements, including theatre accreditation through the Association for Perioperative Practice and a strong incident reporting culture. - The key risks identified included delayed step down from critical care, equipment failures, workforce challenges and bed capacity pressures. - The occurrence of six surgical never events (October 2025 – May 2026) was discussed, and assurance was provided that Patient Safety Incident Response Framework (PSIRF) reviews had been completed and presented to the Incident Review Panel (IRP), with immediate actions and learning embedded. No key themes had been identified.
CORRIDOR CARE UPDATE	The Committee received the report and NOTED the following key updates: - The team were working very hard on the Corridor Care Reduction Plan. Care in the corridors was no longer taking place, but work continued to stop all care in non-care spaces. - The Trust was working hard with mental health trust colleagues to reduce the time mental health patients spent in the departments. We continued to manage our patient experience well; however, many complaints related to patients experiencing long waits in our Emergency Departments (EDs). - The ED at Queen Elizabeth the Queen Mother Hospital (QEQM) was re-inspected by the Care Quality Commission (CQC) on 6-7 May. The outcome of the inspection was broadly positive, and we were awaiting their report. Some elements had been removed from the enforcement notice following the previous inspection in January, and discussions were ongoing.



END OF LIFE (EOL) TRAINING DEEP DIVE	- The Committee received the report and NOTED the following key updates: - An update was provided on EOL care following a patient story previously presented to the Board. The Committee heard about improvements already implemented and discussed the ongoing challenge of ensuring staff attendance at EOL training. - The Committee considered alternative methods of delivering education, including ward based and bite sized learning approaches, while recognising the challenges of releasing staff for training and monitoring compliance. - The Committee supported the principle of additional training investment but noted that funding arrangements would need to be worked through existing education governance processes.
QUALITY GOVERNANCE REPORT (PATIENT EXPERIENCE, INQUESTS, CLAIMS, INCIDENTS AND CENTRAL ALERTING SYSTEM (CAS))	- The Committee received the report and NOTED the following key updates: - The Committee noted ongoing oversight of serious incidents (SIs), never events, complaints, patient safety investigations and governance compliance. - The number of complaints remained high; however, the incidents backlog continued to decrease. It was clear that there was sustained Executive focus. - There were recent never events relating to a retained Peripherally Inserted Central Catheter (PICC) line and a retained swab. The Committee was assured that investigations were underway, learning was being embedded, and regulatory bodies remained informed.
DETERIORATING PATIENT PLAN UPDATE	- The Committee received and NOTED the following key updates: - Significant improvements in patient safety were noted, including progress against national standards for recognising and responding to deterioration. - The Committee was advised that implementation of the digital deteriorating patient tracker remained delayed due to external supplier issues with the IT system. - The Committee also considered findings from ED audits, which identified opportunities to improve observation documentation and ensure consistent implementation of standard operating procedures across both William Harvey Hospital (WHH) and QEQM.
LEARNING DISABILITY CARE AND ACTION UPDATE	- The Committee NOTED the following key updates: - Members noted improvements to leadership arrangements and workforce structures but recognised that challenges remained regarding workforce capacity, training compliance and Mental Capacity Act assurance.



SAFEGUARDING COMMITTEE CHAIR'S REPORT	The Committee NOTED the following key updates: - Assurance regarding the Safeguarding Strategy was only partial. - Following the Fuller Review, mortuary oversight had been incorporated into the Safeguarding Committee, and a mortuary working group had recently been established to address the additional work required. This would be updated at the July 2026 meeting. - Further work was also required in relation to Mental Capacity Act compliance.
MONTHLY SIGNIFICANT RISK REGISTER UPDATE	The Committee NOTED the following key updates: - The Significant Risk Register was reviewed, and the Committee noted 39 active strategic risks, including 22 quality risks, eight of which had outstanding actions. - Attention was drawn to the two new risks relating to pharmacy safety and maternity infrastructure.
CARE QUALITY COMMISSION (CQC) UPDATE REPORT	The Committee received and NOTED the report. - Since January 2026, the Trust has had three unannounced inspections. Most identified actions have now been completed. - The CQC enforcement notice was under review. It was also confirmed that the new ED self-assessment framework was being implemented. - Weekly update reports were provided to the CQC, and the Committee noted ongoing engagement with regulators and welcomed progress in addressing outstanding areas of concern.
INFECTION PREVENTION AND CONTROL (IPC) ANNUAL REPORT	- The Committee received and NOTED the report. - The Committee received assurance regarding IPC performance. Members noted improvements compared with previous years, although some performance thresholds continued to be exceeded. - Discussion focused on antimicrobial stewardship, outbreak management, surgical site infection reduction, and the impact of estate limitations, particularly the availability of side rooms and isolation facilities. The Committee noted that improvement plans remained in place. - The Norovirus outbreaks at both QEQM and WHH resulted in critical incidents being declared. - There was a reduction in healthcare-associated Meticillin-sensitive <i>Staphylococcus aureus</i> (MSSA) and <i>Klebsiella</i> bacteraemias compared with 2024/25; however, <i>Clostridioides difficile</i> (C. diff) infections and <i>E. coli</i> bacteraemias increased, exceeding both thresholds. - The Trust responded to a community outbreak of meningococcal infections, with 16 patients testing positive, over 500 more attending EDs requiring testing and Intravenous (IV) treatment, and hundreds more requiring prophylactic antibiotics (provided jointly with community partners).
QUARTER 4 (Q4) AND END OF YEAR UPDATE ON QUALITY PRIORITIES	The Committee received the report and NOTED the following key updates: - The report provided a Q4 update on the Trust's quality priorities and on 2024/25 Quality Account objectives. - The Quality Account 2025/26 was published in June. The draft was sent to the Integrated Care Board (ICB) for comment and presented at the May Council of Governors meeting.



	It was noted that our targets for deteriorating patients, pressure ulcers, and falls had been exceeded, reflecting significant work. Future work was required regarding patient access priorities.
NON-REFERRAL TO TREATMENT (RTT) FOLLOWING UP TO COMMITTEE	The Committee received the report and NOTED the following key updates: - The Committee received an update on non-RTT waits and backlog management. Members noted the significant work underway to address high risk specialty backlogs, particularly in ophthalmology, and discussed the associated workforce and financial implications. - It noted that one of the root causes of the deterioration in RTT was a shortage of booking clerks to book patients for their procedures, following the Trust's recruitment freeze.
TRUST RADIATION COMMITTEE (TRAC) UPDATE	The Committee received and NOTED the report. Workforce shortages within medical physics services remained a concern, and Members requested continued oversight and benchmarking against comparable organisations.
MORTALITY STEERING & SURVEILLANCE GROUP (MSSG) CHAIR'S REPORT	The Committee received the MSSG report and NOTED it. Previous actions in relation to the Summary Hospital-level Mortality Indicator (SHMI) (thoroughly reviewed at the March 2026 meeting) were ongoing.
MATERNITY & NEONATAL BOARD (M&NB)	The Committee received the report and NOTED the following updates: - The Committee discussed the recent increases in intrauterine and neonatal deaths, which had resulted in the Trust receiving a Maternity Outcomes Signal System (MOSS) Alert. Assurance was given that detailed reviews were underway and that no evidence currently linked outcomes to staffing levels. - There had been a change in family representation, and a new Governor had recently joined M&NB. - Work continued on the restorative work programme, and issues regarding piped gases were being addressed.
AMOS REVIEW UPDATE	The Committee NOTED the following key updates: - The Trust was due to receive the Amos review in the near future. We were included in the review because we have been involved in a national inquiry. - We have received two visits from the review team, as neonatal concerns had been raised. - The review would identify national themes and individual Trusts would not be named. - We were expecting feedback regarding the relationships within Neonatal Intensive Care Unit (NICU), and Organisational Development work was taking place with our team.
COMPLAINTS ANNUAL REPORT	- The Committee received the report and NOTED the following key updates: - The Committee reviewed the Annual Complaints Report and noted increases in complaints (by 8.9%), Patient Advice and Liaison Service (PALS) activity (by 22%) and compliments (by 35%) during the



	reporting period. The issues highlighted to the Team were also more complex. 98% of our complaints were reviewed within three working days, exceeding our Key Performance Indicator (KPI) of 90%. PALS was more challenging, with 68% of responses provided within the agreed timeframe. - Communication, clinical care and delays remained the most common complaint themes. - There was strong evidence of learning from our complaint investigations. - The action for the coming year was to maintain performance and response times, improve accessibility and visibility of our services, and further increase and embed learning. We also need to review our data management system.
CLINICAL ETHICS COMMITTEE (CEC) ANNUAL REPORT	The Committee received the report and NOTED the following key updates: - The Committee noted the rising number of referrals and the successful development of a more responsive “bedside ethics” model, which provides direct support to clinical teams managing complex ethical issues. - The Committee approved amendments to the CEC Terms of Reference to reflect this evolving function and welcomed evidence that the service had helped prevent potential patient harm.
Q&SC EFFECTIVENESS REVIEW – FREQUENCY OF MEETING DISCUSSION	The Committee agreed to introduce bi-monthly Quality Huddles in-between formal meetings to strengthen oversight of quality and safety issues. These would be attended by the Chief Nursing and Midwifery Officer (CNMO), Chief Medical Officer (CMO) and Q&SC Chair.
INTEGRATED PERFORMANCE REVIEW (IPR)	The Committee received and NOTED the IPR.
PATIENT EXPERIENCE COMMITTEE ASSURANCE REPORT	The Committee received and NOTED the Patient Experience Committee report.
ORGAN DONATION POLICY	The Organ Donation Policy was approved, subject to confirmation of the interim Executive lead.

Referrals from other Board Committees: None

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

Item	Purpose	Date
The Committee asks the BoD to discuss and NOTE this Q&SC Chair Assurance Report.	Assurance	28 July 2026



REPORT TO BOARD OF DIRECTORS (BoD)

Report Title: Guardian of Safe Working Hours (GoSWH) Quarterly Report
Quarter 1 (Q1): 01 January 2026 - 31 March 2026 (3 Months) and
Annual Report 2025

Meeting Date: 28 July 2026

Board Sponsor: Dr Helen Mackie, Acting Chief Medical Officer (CMO)

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

Appendices:

Appendix 1: GoSW Annual Report 2025

Executive summary:

Action required:	Information
Purpose of the Report:	The purpose of this report is to give assurance to senior management (and to doctors themselves) that doctors and dentists in training (known as resident doctors from Sep-24) are safely rostered and that their working hours are compliant with the NHS Doctors and Dentists in training Terms and Conditions (England) 2016 (T&C's).
Summary of key issues:	• Work to establish numbers of resident doctors and locally employed doctors within the Trust and vacancy rates is ongoing. • The Framework Agreement for Exception Reporting reforms was implemented from 4 February 2026, with local Standard Operating Procedures being developed to support delivery. • Work continues to improve resident doctors' working lives through implementation of the NHS England 10 Point Plan. • Exception reporting activity remains high within Acute/ Emergency Medicine, General Internal Medicine and General Surgery, reflecting sustained clinical workload and patient acuity. • Vascular Surgery and Urology - Ongoing concerns remain regarding workload intensity and the training environment within Vascular Surgery and Urology services at Kent & Canterbury Hospital (K&C). • The prospective cover review is in progress.
Key recommendations:	The Board of Directors is asked to discuss the GoSWH report and NOTE: • Continue to strengthen exception reporting culture across all grades of resident doctors. • Continue collaborative working to improve resident doctor wellbeing, rostering and access to rest breaks.

	• Support implementation of the national exception reporting reform framework and associated governance processes. • Progress the prospective cover review. • Maintain oversight of workload and supervision concerns within Vascular Surgery and Urology.

Implications:

Links to Strategic Theme:	All
Link to the Board Assurance Framework (BAF):	Yes
Link to the Corporate Risk Register (CRR):	No
Resource:	N/A
Legal and regulatory:	N/A
Subsidiary:	N/A

Assurance route:

Previously considered by: PCC – 21 July 2026

GUARDIAN OF SAFE WORKING HOURS (GOSWH) QUARTERLY REPORT
Q1: 01 January 2026 - 31 March 2026 (3-months)

1. Introduction

As per the Terms and Conditions of Service for NHS Doctors and Dentists in training Terms and Conditions (England) 2016 (T&C's), the Guardian of Safe Working Hours (GoSWH) acts as a champion of safe working hours for doctors and dentists in training (known as resident doctors from Sep-24) and ensures that action is taken to address any areas of concern, providing support and assurance to enable a safe and positive working and learning environment for our doctors. The GoSWH is responsible for providing assurance (or otherwise) to the Trust Board, senior management and the Director of Medical Education that doctors are safely rostered and are working hours that are safe and in compliance with the T&C'S.

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

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

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

Resident Doctors

Head count of resident doctors to include F1, F2 and Registrars within all specialties, GP Practice and Psychiatry as at dates shown:

	16-Apr-25	6-Aug-25	31-Dec-25	31-Mar-26
Resident FY1	71	87	83	
Resident FY2	67	78	71	
Resident ST1 to ST8	257	283	291	
Res Lead Emp Model	85	85	85	
Total	480	533	530	

Trust Doctors

Head count of Trust Grade Doctors to include equivalent F1, F2 and Registrars within all specialties as at dates shown:

	16-Apr-25	6-Aug-25	31-Dec-25	31-Mar-26
Trust Doctor FY1	6	N/A	6	
Trust Doctor FY2	15	N/A	16	
Trust Grade Registrar	167	N/A	167	
Total	188	N/A	189	

Total Doctors employed - Resident and Trust Grade

Total Doctors employed - Resident and Trust Grade within all specialties, GP Practice and Psychiatry as at dates shown:

	16-Apr-25	6-Aug-25	31-Dec-25	31-Mar-26
Total	668	N/A	719	

Number of doctors / dentists in training (total) employed within reporting period.	
Amount of time available in job plan for guardian to do their role:	2 PA's for GoSWH (8 hours per week) - Two GoSWH - one PA each. - Second GoSWH appointed Dec-25.
Admin support provided to the guardian (if any):	0.50 Whole Time Equivalent (WTE)

3. Exception Reporting Analysis (Period: 01-Jan-26 to 31-Mar-26)

Type of Exception Report raised	Total Q1	Total Q2	Total Q3	Total Q4
Total number of exception reports submitted	135			
Number relating to immediate safety concern	4			
Number relating to hours and rest	135			
Number relating to missed breaks	27			
Number relating to educational opportunities	2			
Number relating to difference in work pattern	2			

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

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

Exception reporting data and trainee feedback suggest that resident doctors continue to experience difficulty accessing uninterrupted rest breaks during periods of sustained clinical demand and high patient acuity. In these circumstances, it is essential that doctors are able to take appropriate rest breaks to support both their wellbeing and safe patient care. The GoSWH continues to encourage exception reporting relating to missed breaks and promotes collaborative approaches within teams to facilitate sequential breaks wherever operationally possible.

Exception Reports by Department/Specialties	Total Q1	Total Q2	Total Q3	Total Q4
Anaesthetics	2			
Acute / Emergency Medicine	56			
General Internal Medicine	31			
Neurology / Stroke	2			
Obstetrics & Gynaecology	3			
Paediatrics (incl. Neo-natal)	1			
Renal	13			
Surgery (General & Upper)	24			
Vascular Surgery and Urology	3			
Others (i.e. GP, Hospice)	0			

Note: During this reporting period there has been a continued high level of exception reporting from the medical specialties, particularly Acute/Emergency Medicine and General Internal Medicine. It remains challenging to determine whether reports relate specifically to specialty workload or on-call activity; however, the volume of reports reflects the sustained acuity and demand across acute services.

Exception reporting within the surgical specialties also remains elevated, with the majority originating from Foundation doctors working within General Surgery at QEQM. Although reports from Vascular Surgery and Urology at K&C have reduced compared to previous quarters, concerns remain regarding workload intensity, patient acuity and the overall working environment experienced by Foundation doctors within these services.

Exception Reports by Grade	Total Q1	Total Q2	Total Q3	Total Q4
FY1	87			
FY2	28			
IMT1+	6			
CT1-2 / ST1-2	5			
CT3 / ST3-5	1			
ST6-8	0			
GPST1+	8			

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

Exception Reports by Site	Total Q1	Total Q2	Total Q3	Total Q4
QEQM	74			
William Harvey Hospital (WHH)	42			
K&C	19			
Other (i.e. GP, Hospice)	0			

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

Exception Reports by Response Time	Addressed (within 0-2 days)	Addressed (within 3-7 days)	Addressed (longer than 7 days)	Still open
All specialities	64	59	12	

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

Exception reports exceeding the seven-day timeframe are generally reviewed by the GoSWH to undertake an investigation and may request further discussion between the trainee and supervisor where appropriate. Some reports remain open temporarily due to outstanding queries, annual leave or operational delays.

Actions on Exception Reports	Total Q1	Total Q2	Total Q3	Total Q4
Not agreed	3			
Time off in lieu (TOIL)	44			
Additional Pay	79			
No effect on time or pay / No effect	9			
Awaiting Response	0			

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

Where TOIL is selected, resident doctors are required to work with rota co-ordinators to ensure leave is taken within the contractual fulfilment period. Once TOIL has been taken, the resident doctor is responsible for updating the exception report to confirm completion.

During this reporting period, additional payment remained the preferred option selected by resident doctors. The GoSWH continues to encourage the use of TOIL where clinically and operationally feasible in order to support staff wellbeing, appropriate recovery and safe working practices.

4. Vacancies

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

5. GoSWH Fine Monies

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

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

6. Positives / Good Practice

Exception Reporting Reform for Resident Doctors

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

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

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

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

The SOP introduces a simplified, confidential exception reporting process. The new approach removes educational and clinical supervisors from the initial review stage and provides resident doctors with greater autonomy in determining appropriate outcomes.

Key procedural changes include:

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

- **Additional penalties:** New fines will apply where doctors are not provided with timely access to exception reporting systems or where inappropriate information sharing impedes the reporting process.

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

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

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

In addition, the GoSWH hosted a virtual briefing session for resident doctors to support understanding of the exception reporting reforms and their practical implications on 26th January. Promotional materials have been displayed across Medical Education Centres to raise awareness of the changes that have been implemented.

10 Point Plan to Improve Resident Doctors Working Lives

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

<https://www.england.nhs.uk/publication/getting-the-basics-right-for-resident-doctors-10-point-plan/>

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

Progress against the NHS England 10 Point Plan will continue to be monitored through the Medical Education governance structure, the RDF and Trust Board reporting mechanisms.

7. Areas for highlight

Prospective Cover

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

It has been identified that the generic rota model did not originally account for additional leave entitlements - 15 days for Foundation Year 2 (FY2) doctors and 30 days for doctors at higher grades. As a result, a retrospective review of generic rotas from February 2020

onwards is required to determine whether affected doctors are entitled to additional remuneration.

This work has commenced; however, progress has been slower than anticipated and remains time-intensive due to limited staffing resources.

The Medical Workforce Team is currently liaising with the software provider to explore whether a more efficient method of completing this task is available. The software provider is presently investigating potential solutions.

Rotas worked between February 2020 and December 2024 were reassessed incorporating the correct leave entitlements, enabling the calculation of any potential underpayments.

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

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

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

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

Exception Reporting for Locally Employed Doctors (LED's)

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

Following previous discussions at RDF's a three-month pilot commenced at the beginning of Mar-25 for LEDs at QEPMH across all specialties, enabling them to submit exception reports via a spreadsheet. Communications regarding the process was distributed to HR Business Partners, Consultants, and Rota Co-ordinators, who were instructed to relay the information to the relevant doctors. The process was for the rota co-ordinators to forward any data collected to the Medical Workforce Manager for analysis. The aim of this pilot was to identify potential issues and evaluate the next steps. The findings confirm the Trust received 3 exception reports across the pilot duration, all coming from the same specialty. The information received correlated very well with the information that we knew from resident doctors.

Following recent discussion at the RDF in Dec-25 the JLNC Chair has agreed to consider raising exception reporting for LED's in East Kent at the next JLNC meeting.

Vascular Surgery and Urology Work Environment

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

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

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

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

Q1 has seen few exception reports from the resident doctors in Vascular Surgery and Urology. But the issues around work intensity and supervision remain. The NHS England (NHSE) Kent Surrey Sussex (KSS) Education Quality team undertook a Risk-based review in Vascular Surgery on 6 November 2025. One of the mandatory requirements from the visit relate to exception reporting and the GoSWH.

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

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

In order to meet this mandatory requirement, the GoSWH attended the Vascular Surgery and Urology Foundation Induction in Dec-25 to encourage the resident doctors to use exception reporting for working beyond their scheduled hours, missed breaks and loss of education and training. This will continue to be monitored.

Resident Doctor Forum (RDF)

The RDF meeting in March 2026 continues to experience challenges in securing resident doctor attendance. Some meetings were aligned with the Doctors Voice Group (DVG) meetings to encourage greater resident doctor participation within the RDF; however, the most recent DVG meeting was unfortunately rescheduled at short notice.

The RDF continues to explore opportunities and initiatives to improve attendance and engagement at these forums.

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: Progress on Implementation of the NHS England (NHSE) Resident Doctor 10 Point Plan

Meeting date: 28 July 2026

Board sponsor: Dr Helen Mackie, Acting Chief Medical Officer (CMO)

Paper Author: Dr Helen Mackie, Acting CMO

Appendices:

None

Executive summary:

Action required:	Assurance
Purpose of the Report:	To provide an update to Board on the delivery of the 10 Point Plan (10PP).
Summary of key issues:	The Trust continues to make steady, demonstrable progress in delivering the NHSE Resident Doctor 10PP. The Trust has taken forward actions across all ten domains, with several areas already embedded, others on track, and some requiring system level support or national guidance before completion.
Key recommendations:	The Board of Directors is asked to discuss and NOTE this progress report on the Implementation of the NHSE Resident Doctor 10PP and the following: • Note substantial progress and strengthened governance across the 10PP. • Endorse ongoing actions to improve rota timeliness, rest facilities, and annual leave equity. • Support continued alignment with national payroll, rotations, and training frameworks as guidance becomes available. • Receive a further consolidated update once Phase 2 requirements are issued nationally.

Implications:

Links to Strategic Theme:	• Quality and Safety • People • Partnerships
Link to the Trust Risk Register:	None
Resource:	N



Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: None



PROGRESS ON IMPLEMENTATION OF THE NHS ENGLAND RESIDENT DOCTOR 10 POINT PLAN

1. Improving the Working Environment & Wellbeing of Resident Doctors

The Trust has participated fully in NHSE's update sessions and established a fortnightly Steering Group to oversee delivery. It has promoted the Safe Learning Environment Charter and ensured visibility through induction.

The links with the Health & Wellbeing team have been strengthened, with wellbeing discussions embedded through the Doctors' Voices Group. Work has begun to improve mess visibility, rest spaces, locker access, and 24/7 food provision, including hot-food vending where catering is limited. Gaps remain at the Canterbury site and are being taken forward with the Chief Strategy and Partnerships Officer (CSPO). The Trust has also commenced work to ensure consistent access to Self-Directed Training (SDT) time, addressing variation across specialties.

National survey results discussed regionally highlight improvements in hot food, parking, and rest facilities, which align with the Trust's current trajectory.

2. Timely Work Schedules & Rotas

Compliance monitoring is in place via the Guardian of Safe Working (GoSW) and the South East GoSW network. The Trust has appointed a second GoSW to strengthen oversight. The Trust has also improved timeliness of rota production, with approximately 65% of rotas now submitted by the eight week publication point, demonstrating steady improvement. A formalised escalation framework is being developed to achieve full compliance, and a new monitoring processes are being introduced for personalised six-week rotas, enhancing accountability.

Work is also underway to extend exemption reporting to Locally employed doctors. A recent trial at Queen Elizabeth the Queen Mother Hospital (QEQM) was disappointing with limited engagement. The introduction of a new e-rostering platform "Patchwork" across the Trust provides the opportunity for data to be managed within a single system.

The GoSW has identified a improvement in the rate of incident reporting since the changes to improve confidentiality. This demonstrates and increased confidence of resident doctors to report and therefore for the organisation to be sighted on areas of concern

3. Fair & Equitable Annual Leave

The Trust's annual leave policy is under review, with resident-doctor-specific provisions now incorporated. One key issue is the inability to request leave before joining rota systems. Mitigation is underway through the rollout of "Patchwork", which will enable pre-start leave requests.

4. Appointment of Senior & Peer Representatives

The senior Board-level lead is the Acting Chief Executive Officer (CEO)/Chief Medical Officer (CMO), Dr Des Holden. Peer representative recruitment is in progress, with interviews scheduled following Trust-wide advertisement. The engagement mechanisms have also been strengthened,



including a proposal to merge the Doctors' Voices Group with the Resident Doctor Forum for streamlined governance. A paper has been submitted to the Trust Management Committee (TMC).

5. Eliminating Payroll Errors

The Trust has established Board-level governance, with the Chief People Officer (CPO) leading oversight. Trust representatives attended the national Payroll Improvement Webinars, and preparatory work is underway for national data submissions. Final national guidance is awaited before full implementation. National conversations emphasise that payroll errors should be treated similarly to incident reporting, a principle the Trust supports.

6. Avoiding Repetition of Statutory & Mandatory Training

The Trust implemented a redesigned Electronic Staff Record (ESR) onboarding process in 2024 using pre-hire Inter Authority Transfers (IATs) to transfer training records. A new training capture form mitigates inconsistent data transfers from previous employers. Further alignment is expected through the national Lead Employer workstream.

7. Embedding Exception Reporting Culture

Significant progress has been made, including GoSW participation in the regional network. The Trust has strengthened processes ahead of the new national framework through timely onboarding to the Doctors Rostering System (DRS), QR-based mobile access, monitoring and follow-up of unaddressed reports, improved confidentiality through the removal of grades, and transitioning towards centralised closure of exception reports by February 2026. The 28 day submission window and education specific reporting routes have also been reinforced.

8. Timely Reimbursement of Course Fees

Mandatory courses are now reimbursed at the point of expense. Wider reimbursement processes were reviewed at local faculty groups, with strengthened communication to ensure resident doctors understand their entitlement.

9. Minimising the Impact of Rotations

Minimising the Impact of Rotations depends on national rotations and lead-employer workstreams, with trusts awaiting further guidance. The Trust is prepared to respond once the national framework is finalised. Early regional discussion emphasised the need to reduce disruption and embed Phase 2 cultural work, including Non-Executive Director (NED) oversight of Resident Doctor Peer Lead roles.

10. Conclusion

The Trust is making meaningful, sustained progress across most elements of the 10PP.

Good progress has been made on engagement, mandatory training and induction.



Areas which actions are well developed and on track, include, hot food provision at all three sites (re-tender underway for catering), strengthening Quality Assurance (QA) processes around payroll errors (regular audit and monitoring).

Opportunity to carry over leave remains limited and requires further exploration. Car parking for doctors coming on to shift during midday periods also remains an issue. Further work is underway to scope the number of rosters affected and consider solutions.

Progress is lacking in two areas which require national interventions such as the NHSE rotations workstream, which aims to reduce the impact of rotations and the practical impact of moving employers. The Trust remains an active participant in the SE regional group.



REPORT TO BOARD OF DIRECTORS (BoD)

Report title: Nursing Band 5 Job Evaluation Role Review

Date: 28 July 2026

Board sponsor: Norman Blissett, Chief People Officer (CPO)/Sarah Hayes, Chief Nursing and Midwifery Officer (CNMO)

Paper Author: Associate Director Workforce Development and Education, Nursing, Midwifery & Allied Health Professionals (AHP)

Appendices:

Appendix 1: Completed national delivery planning template for EKHUFT

Executive summary:

Action required:	Approval
Purpose of the Report:	The report details the process for the implementation of the Band 5 nursing job evaluation.
Summary of key issues:	National Requirement and Timescales The Trust is required to undertake an employer-led review of all Band 5 nursing roles in line with national NHS Job Evaluation guidance and in partnership with recognised staff-side representatives. A regional delivery plan must be submitted by 31 July 2026, with all reviews and implementation of outcomes completed by October 2028. Funding National funding has been made available to support delivery of the Band 5 Nursing Role Review Programme, including job evaluation capacity, training, programme management, partnership working and staff engagement Governance, Leadership and Partnership Working Implementation of the Band 5 Nursing Job Evaluation Programme requires robust governance arrangements, including Board-level oversight and active partnership working with key stakeholders such as Staff Committee, Care Group Nursing Leadership Teams and Band 5 Registered Nurses. Success will be dependent on effective communication, transparency, and meaningful stakeholder engagement. Delivery, Monitoring and Risk Management A dedicated project lead, supported by senior nursing and workforce leaders, will oversee delivery of the programme. A staff engagement methodology and detailed action plan have been developed to support implementation, monitor progress and provide regular assurance reporting to sub-committees and the Board.



Key recommendations:	The Board of Directors is asked to: 1. NOTE the collaborative and partnership-based approach to implementation, ensuring ongoing engagement with People & Culture, the Staff Committee, recognised Trade Unions, Care Group Nursing Leadership Teams and Band 5 Registered Nurses throughout the programme. 2. APPROVE the submission of the completed national delivery planning template (Appendix 1) to Region.

Implications:

Links to 'We Care' Strategic Objectives:	Our people
Link to the Board Assurance Framework (BAF):	BAFPCC001 A failure to recruit and retain staff could lead to: the quality and quantity of healthcare being impaired; pressure on existing staff and decreased resilience, health & wellbeing and staff morale; over-reliance on agency staffing at high cost.
Link to the Corporate Risk Register (CRR):	N/A
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: Nursing & Midwifery Executive Committee (NMEC) 14 July 2026
People & Culture Committee (P&CC) 21 July 2026



Nursing Band 5 Job Evaluation Role Review

1. Purpose of the report

- 1.1** This report details the process for the implementation of the Band 5 nursing job evaluation.

2. Background

- 2.1** In February 2026, the Secretary of State committed to an employer-led review of all Band 5 nursing roles as part of the Government's commitment to deliver a fairer deal for nurses.
- 2.2** This builds on the NHS Staff Council publication of the national nursing and midwifery profiles in June 2025, and subsequent Staff Council guidance on implementation.
- 2.3** It is expected the review will be undertaken in accordance with the NHS Job Evaluation Scheme, the NHS Job Evaluation Handbook and relevant national nursing and midwifery job evaluation guidance. Reviews should be undertaken in partnership with staff-side representatives, consistent with the principles of the NHS Job Evaluation Scheme.
- 2.4** Organisations are expected to complete reviews and implement any outcomes by October 2028 and have been asked to submit regional delivery plans by 31 July 2026. This will support regional and national assurance, identification of delivery risks and targeting of support where required.
- 2.5** Funding has been made available to support implementation of the Band 5 nursing role review programme. The 2026/27 NHS Payment Scheme Cost Uplift Factor (CUF) will be updated to recognise the costs associated with this programme. Further updates to the CUF are planned for 2027/28 and 2028/29 to reflect the ongoing nature of the work.
- 2.6** Funding may be used to support delivery of the band 5 nursing programme, including job evaluation capacity, training, programme management, partnership working and staff engagement.

3. Implementation and monitoring

- 3.1** The national delivery planning template (Appendix 1) required evidence of an identified board level senior reporting officer, partnership working arrangements (including how recognised trade unions have been involved in developing the plan) as well as identifying any capacity or capability gaps.
- 3.2** The key to the successful implantation, is effective communication, transparent processes and importantly partnership working with people & culture, staff committee, trade unions, care group nursing leadership teams and our Band 5 registered nurses.



- 3.3** The Associate Director Workforce Development and Education, Nursing, Midwifery & Allied Health Professionals will act as project lead for this workstream with support from the Deputy Director of People & Culture and Deputy Chief Nurse, Workforce, Strategy and Professional Standards.
- 3.4** Whilst it is recognised that every organisation is different there is a recommended approach to staff engagement for job description reviews. As this approach offers a constructive approach which promotes active engagement it will be used as the template for the implementation of the Band 5 nursing job evaluation within the Trust.
- 3.5** Although the reviews and implementation of any outcomes need to be completed by October 2028, it is envisaged that enacting the proposed delivery plan will allow for this workstream to be delivered earlier than this.

4. Recommendations

- 4.1** Note the collaborative and partnership-based approach to implementation, ensuring ongoing engagement with People & Culture, the Staff Committee, recognised Trade Unions, Care Group Nursing Leadership Teams and Band 5 Registered Nurses throughout the programme.
- 4.2** Note the recommended staff engagement methodology outlined in Appendix 1 as the Trust's approach to job description reviews, recognising its emphasis on transparency and active staff participation.
- 4.3** Approve the submission of the completed national delivery planning template (Appendix 1) to Region.

5. Conclusion

- 6.1** The Band 5 Nursing Job Evaluation Programme provides an important opportunity to ensure nursing roles are appropriately evaluated in line with national policy, NHS Job Evaluation principles and the Government's commitment to a fairer deal for nurses. The Trust is required to submit its delivery plan by 31 July 2026 and complete all reviews and implementation activities by October 2028.

A robust implementation framework has been established, underpinned by strong governance, clear leadership, partnership working with staff-side representatives and a transparent staff engagement approach. The proposed action plan will enable effective monitoring and reporting through the Trust's governance structures, providing ongoing assurance to the Board.



Nursing Band 5 Job Evaluation Role Review Submission



East Kent Hospitals University NHS Foundation Trust

Trust details:

Please provide the nominated main point of contact for your trust, for regular NHSE communication:

Trust name	East Kent Hospitals University NHS Foundation Trust
Trust contact name, role	Associate Director Workforce Development Education Training for Nursing, Midwifery & Allied
Trust contact email	isetchfield@nhs.net

Purpose:

The template supports provider delivery planning and regional as well as national assurance in relation to the commitment to review all AfC Band 5 registered nursing roles.

The template should be completed in partnership and discussed through appropriate local partnership arrangements.

It is intended to provide an overview and **does not replace local implementation plans or programme documentation**.

Submission:

The deadline for submission is **31st July 2026**. Please submit your completed template to england.nursingworkforce@nhs.net and your regional team who will be in touch with you in due course.

Key definitions:

JES - NHS Job Evaluation Scheme

Headcount - The number of individual AfC Band 5 nursing staff employed directly by the organisation in the specified category at the point of submission.

WTE - The whole-time equivalent (WTE) of AfC Band 5 nursing staff employed directly by the organisation in the specified category at the point of submission.

Establishment - Total budgetted whole-time equivalent (WTE), including vacancies.

Adult Acute / Inpatient - Adult nursing services delivered primarily within inpatient hospital settings, including medical, surgical and specialty wards (excluding any specialties referenced below, e.g. critical care).

Adult Community - Adult nursing services delivered primarily in community settings, including district nursing, community nursing teams and community-based services.

Children's Acute / Inpatient - Children's nursing services delivered primarily within inpatient hospital settings (excluding any specialties referenced below, e.g. critical care).

Children's Community - Children's nursing services delivered primarily in community settings, including community children's nursing teams.

Neonatal - Neonatal nursing services, including neonatal intensive care units (NICU), local neonatal units (LNU) and special care baby units (SCBU).

Mental Health - Mental health nursing services delivered across inpatient, community and specialist mental health settings.

Learning Disability - Learning disability nursing services delivered across inpatient, community and specialist learning disability settings.

Emergency Department / Urgent Care - Nursing services delivered within emergency departments, urgent treatment centres, same-day emergency care and equivalent urgent care settings.

Critical Care - Adult or children's critical care, intensive care and high dependency services.

Theatres / Perioperative - Operating theatres, anaesthetics, recovery and perioperative services.

Outpatients / Ambulatory Care - Outpatient, ambulatory care, day-case and assessment services.

Specialist Services - Specialist nursing services not captured elsewhere, including oncology, haematology, renal, cardiac, respiratory, gastroenterology/endoscopy, neurosciences, burns and plastics, tissue viability, specialist community services, virtual wards and other specialist clinical nursing services.

Corporate Nursing - Corporate nursing roles focused on organisation-wide nursing functions, including governance, quality, patient safety, safeguarding, infection prevention and control, professional standards and professional leadership.

Education, Research and Practice Development - Nursing roles primarily focused on education, research, workforce development, clinical education, practice development and quality improvement activities.

Other - Band 5 nursing roles not reasonably captured within any of the categories above. The use of "Other" should be minimised wherever possible. Organisations should provide a brief description of the role or service.

Please complete the following sections:

1 Ownership, Oversight and Partnership

1.1	Executive Senior Responsible Officer (SRO) <i>Please provide name and contact for the SRO responsible for the nursing band 5 programme in the trust; if more than one SRO, please list all</i>	Norman Blissett, Chief People Officer Sarah Hayes - CNMO
1.2	Has this template for regional and national assurance been developed and reviewed through local partnership arrangements, including with staff-side chair?	Yes
i	If no, please provide details:	
1.3	Does the organisation have its own local implementation plan in place to support completion of the programme?	Yes
1.4	Which Board, committee or programme governance forum oversees delivery? <i>Examples may include Workforce Committee, People Committee, Nursing Committee, Quality Committee, Programme Board or equivalent governance forum</i>	Staff Committee, Nursing Midwifery Executive Committee, People & Culture Committee
1.5	How is or will partnership working be maintained throughout delivery of this programme? <i>Examples may include partnership forums, JNC/PF arrangements, staff-side representation on programme boards, JE panels and regular partnership review meetings</i>	Regular partnership meetings with senior nursing leadership teams, ward managers, staff side and unions. Focus groups with ward managers and band 5 registered nurses. People culture team – JE panels. Regular communication with all stakeholders
1.6	How will progress be regularly reported through governance and partnership arrangements?	Regular progress reports to required committees and communications to ward managers/band 5 registered nurses

2 Workforce Baseline and Current Position

Please refer to definitions on the cover sheet when completing this section

2.1	What is the Band 5 nursing staff establishment as at 30 June 2026?	WTE	1628.32
2.2	How many Band 5 nursing staff are employed directly by the organisation as at 30 June 2026?	WTE	1682.08
2.3		Headcount	1790
2.4	Of the Band 5 nursing staff in post, how many fall into each of the principal nursing specialties and care settings listed below?		
<u>Notes for completion:</u>			
- Please enter WTE and headcount as a numeric value			
- Categories should be mutually exclusive to avoid double counting; where a role could reasonably fit more than one category, organisations should record it against the category that best reflects the individual's principal area of work (please see cover sheet for description of categories)			
- Organisations should use the most appropriate category available and reserve "Other" only for services not reasonably captured elsewhere.			
Area of Nursing (see cover sheet for definitions)		WTE	Headcount
Adult Acute / Inpatient		287.67	295
Adult Community		0	0
Children's Acute / Inpatient		57.12	63
Children's Community		0	0
Neonatal		38.57	44

	Mental Health	0	0
	Learning Disability	0	0
	Emergency Department / Urgent Care	293.84	301
	Critical Care	134.57	147
	Theatres / Perioperative	166.49	179
	Outpatients / Ambulatory Care	19.37	25
	Specialist Services	637.01	684
	Corporate Nursing	6.31	7
	Education, Research and Practice Development	0	0
	Other	41.13	45
	<i>Please specify other:</i>	Midwives and student midwives	
	Total		
Not commenced			
2.6			
i	How many unique band 5 nursing job descriptions (JDs) have been identified within the organisation?	Unique JDs - total identified	Please enter as a numeric value
ii	Of which how many job descriptions have been revised and put through job evaluation?	Unique JDs - evaluation complete	Please enter as a numeric value
iii	As a result, how many nurses does this impact?	WTE	Please enter as a numeric value
		Headcount	Please enter as a numeric value
iv	Can you confirm you have engaged with nurses individually on the outcome of the review?	Please select from the dropdown	
2.7	Outcomes from recent job evaluations:		
i			Please enter as a numeric value
			Please enter as a numeric value
			Please enter as a numeric value
3 JD Readiness and Staff Engagement			
3.1	How do you currently, or plan to, develop band 5 JDs in accordance with the NHS Staff Council guidance on nursing and midwifery profiles?	Please tick all that apply	☒ Individual JDs ☒ Ward-based JDs ☒ Team-based JDs
3.2	How will nursing staff and trade union representatives be fully involved throughout the review process? Examples may include staff briefings, FAQs, trade union engagement, intranet communications, drop-in sessions and dedicated communication channels.	Staff briefings Site based drop in sessions Development of FAQ's Union engagement via staff side committee Regular communication i.e. dedicated intranet page, trust news, email and letters	
3.3	How will the organisation assure itself that:		
i	Updated job descriptions have been reviewed with the affected nurses/postholder(s)?	Staff briefings Action log Progress reports to relevant committees	

ii	Postholder(s) have confirmed whether the documentation accurately reflects their role?	Staff briefings Feedback form Declaration form
iii	Any areas of disagreement have been identified and addressed before matching or evaluation takes place?	Action plan Progress reports
3.4	How will staff be kept informed of progress and outcomes throughout delivery?	Staff briefings – site based/speciality meetings, attendance at CNMO matron/ward managers forums, care group managers meetings Communications – email, trust intranet etc

4 JE Governance, Process and Capacity

4.1	Based on your recent JE Audit findings, please explain what actions are being taken forward to ensure you can meet the Band 5 programme requirements.	Staff briefings Site based drop in sessions Development of FAQ's

5 Methodology, Sequencing and Trajectory

5.1	What methodology will be used to undertake the review?		Combination of Matching and Job Evaluation Delivery will be phased by sites and care groups.
5.2	How will delivery be phased, including any required capacity building, job description review activity and matching/evaluation activity?		1.Initial stakeholder events with Directors of Nursing, Associate Directors, matrons and ward managers to socialise workstream (Jul/Aug 26) 2.Written communication to all post holders which will include proposed draft JD outline, invitation to be part of focus groups and details of how to feedback (Jul/Aug 26)
5.3	Planned completion date of all band 5 nursing job evaluations <i>This should not be later than October 2028</i>	DD/MM/YYYY	01/06/2028
5.4	Planned quarterly milestones to support delivery by completion date: <i>Quarterly trajectory - number of unique JD evaluations planned to be completed in quarter</i> <u>Notes for completion:</u> - Please enter number of JDs estimated to be established per quarter as a numeric value - Where total number of JDs is yet to be determined e.g. to be established within JE process, please provide an estimate based on current - Where phasing is variable, for example due to initial establishment of process or consideration of role type, preceptorships, please provide this context in 'Additional Comments' section		
	Time period	Unique JDs evaluated - in quarter	Additional Comments
	July - September 2026 (2026/27 - Q2)	0	Initial establishment of process
	October - December 2026 (2026/27 - Q3)	50	Ongoing process to be established within JE process
	January - March 2027 (2026/27 - Q4)	300	Estimation
	April - June 2027 (2027/28 - Q1)	300	Estimation
	July - September 2027 (2027/28 - Q2)	300	Estimation
	October - December 2027 (2027/28 - Q3)	300	Estimation
	January - March 2028 (2027/28 - Q4)	300	Estimation
	April - June 2028 (2028/29 - Q1)	240	Estimation
	July - September 2028 (2028/29 - Q2)		
	October 2028 (Deadline for completion)		
	Total number of unique JDs evaluated:	1790	

6 Completed Reviews and Retrospective Assurance

To be completed by those selecting 'completed' or 'commenced only'

6.1	Was the review undertaken in accordance with the NHS Job Evaluation Scheme?	Please select from the dropdown

6.2	Was the review undertaken in partnership?	Please select from the dropdown
6.3	Are there any outstanding review requests, appeals or disputes?	Please select from the dropdown
	If yes, how many? Please report as headcount of Band 5 nurses affected	

7 Risks and Escalation

7.1	What are the key risks to delivery and how are they being managed? <i>Red: Significant risks identified which are likely to impact delivery and require additional intervention or support</i> <i>Amber: Risks identified which may impact delivery but are being actively managed</i> <i>Green: On track to deliver</i>	
	Risk	RAG rating Mitigation
	Insufficient job evaluation capacity and capability	Amber Undertake a capacity assessment Provide training for panel members
	Insufficient partnership working with trade unions	Amber Establish formal partnership governance arrangements and involve recognised trade unions
	Failure to identify all Band 5 nursing posts	Amber Establish an accurate baseline of all Band 5 nursing posts and maintain a central tracking
	Programme delivery delays	Green Realistic delivery plan with clear milestones Accountable leads
	Equality, diversity and inclusivity	Green Monitor workforce and demographic data throughout the programme QIA and EHIA
	Financial impact of re-banding	Green Work closely with Chief Finance Officers Model potential costs
	High volume of appeals, grievances or disputes	Amber Transparent processes Maintain robust documentation
7.2	Please describe the arrangements the organisation has/ will put in place to identify, monitor and mitigate equality, inclusion and engagement risks throughout delivery. <i>This should include how the organisation will review workforce and demographic data to assure itself that review processes, outcomes, appeals/disputes and timescales are being applied fairly, consistently and without discrimination across protected characteristics, actions as a result of recent audit findings, and other relevant workforce groups.</i>	QIA and EHIA Action plan Progress reports to appropriate committees
7.3	Are there any issues requiring regional escalation?	No
i	If yes, please provide details:	

8 Support Requirements

8.1	Does the organisation require additional support to support delivery of the review programme?	No
8.2	Please identify any additional support required, including measures to build capacity, to ensure the organisation can deliver this work effectively in partnership and in accordance with the NHS JES:	
	Area of support	Please tick: Additional comments
	Job Evaluation Capacity	☐
	Job Evaluation Training	☐
	Matching/Evaluation Support	☐
	Programme Management	☐
	Staff Engagement	☐
	Partnership Working	☐
	Appeals/ Reviews	☐
	Interpretation of Guidance	☐
	Other	☐

8.3	Are there any areas where further national guidance or clarification would assist implementation?	No
i	If yes, please provide details:	

9

Sign-off and Assurance

9.1	Has this assurance submission been reviewed and endorsed by the Chief Nurse, Chief People Officer and JNC/PF chair?	Please select from the dropdown
i	If no, please provide details:	

PEOPLE AND CULTURE COMMITTEE (P&CC) ASSURANCE REPORT

Committee: People and Culture Committee (PCC)

Meeting date: 21 July 2026

Chair: Ffion Griffith, Non-Executive Director (NED)

Paper Author: Executive Assistant

Quorate: Yes

Appendices:

None

Declarations of interest made:

None

Assurances received at the Committee meeting:

Agenda item	Summary
Staff Viewpoint – Doctors' Voice Group	The Committee heard from Dr Kevin Regi, Medical Education Fellow and Doctors' Voice Group Lead, and NOTED strong Resident Doctor engagement, direct access to the Executive team and positive feedback from Resident Doctors around the Doctors' Voice Group activities. Areas of concern are ensuring continuity following imminent departure of the current Group Lead and ensuring that locally employed doctors have equal support in their development compared to doctors in training. The Committee received ADEQUATE ASSURANCE of the Doctors' Voice Group activities and their positive impact on Resident Doctors' professional life.
People and Culture Board Assurance Framework (BAF) Risks Mitigations	The Committee RECEIVED the early draft of the P&CC BAF for Quarter 1 2026/2, and NOTED that the document would continue to be refined as the Committee, the Board, and Executive Leads provide further input. The Committee AGREED that the identified People risks remained relevant and NOTED that a structured BAF template had been developed and the planned alignment of mitigating actions with the Improvement Recovery Plan (IRP). The Committee received LIMITED ASSURANCE in relation to the P&CC BAF noting that some risk scores (i.e. workforce and psychological safety risks) might be understated and controls were not fully evidenced.



People and Culture BAF 004 Deep Dive (Workforce plan).	The Committee NOTED: • Significant work underway including Zero-Based Reviews (ZBR), workforce reduction programme, transformation planning and governance arrangements. • There was no clear workforce design strategy currently and no clarity as to what the high number of recommendations would achieve and timescales for this. The Committee discussed the importance of digital transformation as an enabler for workforce transformation and AGREED to escalate this to the Finance and Performance Committee (FPC). The Committee received LIMITED ASSURANCE from the BAF 004 risk deep dive.
Care Group Deep Dive – William Harvey Care Group	The Managing Director and Head of People and Culture of the William Harvey Care Group attended the meeting to update the Committee on successes and challenges around People aspects in the Care Group. The Committee was made aware of positive cultural shift, reduced vacancies, low turnover and strong appraisal performance. In addition, there were no active Employment Tribunal cases in the Care Group. The Committee heard that work pressures, burnout, moral injury, and violence and aggression towards staff, particularly in the Emergency Department, were the biggest challenges in the Care Group. The Care Group Managing Director noted that the Freedom to Speak Up Guardian (FTSUG) data was not readily available noting it would be beneficial to have regular meetings with the FTSUG. The Committee agreed to raise this matter with the FTSUG. The Committee commended the areas of good practice, and encouraged the Head of People & Culture to share good practice with colleagues in other Care Groups. The Committee received LIMITED ASSURANCE in relation to the workforce matters in the William Harvey Care Group.
Chief People Officer's (CPO's) Report	The Committee received and NOTED the CPO's report outlining workforce performance, emerging risks, and the actions being taken by the People and Culture team to mitigate those risks and sustain improvement. In particular, the Committee noted that the system-wide People Programme Board chaired by the EKHUFT CPO had been established. Workforce redesign and culture reset were noted as the key priorities.



	The CPO highlighted significant rise in sickness absence and appraisal compliance deterioration. The Committee was made aware that the recent bank rates reduction was affecting staff morale and may be contributing to the increased sickness levels. The Committee heard that operational pressures and the move from appraisal window to appraisal cycle might have impacted appraisal compliance. The Committee Chair requested that the reasons for appraisal deterioration were identified and the action plan to improve the compliance brought back to the next Committee meeting.
Delivery Plan - Band 5 nursing job description review	The Committee APPROVED the staff engagement approach to Band 5 Nursing Job Description Reviews outlined in the report, and RECOMMENDED the submission of the national delivery planning template to Trust Board for approval.
Progress against Cost Improvement Programme (CIP) Plan	The Committee received NO ASSURANCE on the delivery of workforce CIP targets noting there was LIMITED ASSURANCE on the controls in place to support delivery of CIPs. The Committee acknowledged a potential quality and operational impact if CIPs were pursued without workforce redesign. The Committee AGREED to formally escalate to FPC the concerns raised by the Committee with regards to workforce CIPs targets and to Quality & Safety Committee (Q&SC) the potential impact on quality standards of workforce reductions without process redesign.
Significant Risk Register (SRR) – Status and Actions	The Committee received and APPROVED the updated SRR relevant to its remit. The Committee challenged the small number of People risks on the SRR noting it may be an underrepresentation of current organisational challenges.
Guardian of Safe Working Bi-Annual Report	The Committee received the Guardian of Safe Working Bi-Annual Report. The key positive elements noted were increased exception reporting, improved supervision, prospective cover reimbursement and confidence in the Guardians of Safe Working. The Committee received LIMITED ASSURANCE noting significant concerns remain regarding Foundation doctors' experience in Vascular and Urology Departments at Kent and Canterbury Hospital; and perception of unsupported working and workload pressures.
Critical Care, Anaesthetics and	The Committee received a verbal update and NOTED that following three external reviews, the reports had been discussed with the teams and action



Specialist Surgery (CCASS) Care Group External Reviews– Progress with Action Plans	planning had commenced including leadership model review and service redesign work. However, significant concerns remain, particularly in Anaesthetics. The Committee received LIMITED ASSURANCE that there is strong oversight through formal action tracking, primarily due to the absence of the anticipated written report, and requested that a written report is presented at to all P&CC meetings until actions are complete.
Freedom to Speak Up (FTSU) Annual Review	The Committee received LIMITED ASSURANCE and noted that although valuable intelligence was available, absence of comprehensive triangulated FTSU data across Care Groups constrained insight. Staff confidence in raising concerns and confidence that they will be acted upon remains variable. The Committee AGREED that stronger reporting mechanisms, Care Group level intelligence, timeliness of management responses and leadership accountability for concerns raised were required, and SUPPORTED Board ownership of these actions.

Other items of business: None

Actions taken by the Committee within its Terms of Reference:

Noted above

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

None

Items escalated to the BoD or another Committee:

- Digital transformation governance and oversight arrangements escalated to FPC.
- High risk of the Pay CIPs reductions not being delivered escalated to FPC.
- Impact of workforce reductions without workforce redesign on quality standards escalated to Q&SC.



BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)

Committee: Integrated Audit and Governance Committee (IAGC)

Meeting date: 23 June 2026

Interim Chair: Richard Oirschot, Non-Executive Director (NED)

Paper Author: Board Support Secretary

Quorate: Yes

Appendices:

None

Declarations of interest made:

No additional declarations of interest were made

The Purpose of the Committee Terms of Reference (ToR) extracts:

The IAGC is the high-level committee with overarching responsibility for risk. The role of the IAGC is to scrutinise and review the Trust's systems of governance, risk management, and internal control. It reports to the Board of Directors (herein shown as the Board) on its work in support of the Annual Report, Quality Report, Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness of risk management arrangements, and the robustness of the self-assessment against Care Quality Commission (CQC) regulations.

Assurances received at the Committee meeting:

External Audit

Assurance received on the effectiveness of the external audit process and the work of external auditors.

External Audit - Audit Findings 2025/26 Report and Auditor's Annual Report 2025/26	- The Committee received Assurance and noted the External Audit – Audit Findings (ISA260 Report) 2025/26 and the Auditor's Annual Report 2025/26. - The Committee noted confirmation from the External Auditors of a high quality audit process, no material adjustments to the financial position, only minor presentational changes, and a small number of low risk recommendations. Intention to issue an unmodified audit opinion. - The Committee noted the ongoing risks in relation to financial sustainability, governance, operational performance, and efficiency and effectiveness (including cultural factors), acknowledging these were consistent with previous years and required continued close monitoring and focus.



Financial Reporting

Assurances received on the integrity of the financial statements of the Trust and formal announcements relating to the Trust's financial performance.

Audited Group Accounts 2025/26 Management Representation Letter	- The Committee received Assurance from the 2025/26 Annual Accounts, reviewed the final audited position, noting no changes to the reported financial figures from the draft accounts previously presented to the Board, and the reported deficit remained consistent with expectations. - The Committee acknowledged minor narrative and disclosure amendments arising from the audit. This related to a specific issue regarding a £1.98m CT scanner acquired through a vesting certificate. The Trust management maintained ownership and control transferred to the Trust before year end, therefore, the asset had been appropriately recognised in the 2025/26 accounts. External Auditors held a different view and considered ownership had not transferred due to the supplier continuing to insure the asset whilst it remained at the supplier's premises. Committee members noted the item was below materiality thresholds and that both parties had agreed to maintain their respective positions without adjustment to the accounts. The Committee accepted this approach and agreed to note the matter, and recognised referenced in the Management Representation Letter. - The Committee reviewed and confirmed the document 'Informing the audit risk assessment for East Kent Hospitals University NHS Foundation Trust 2025/26'. - The Committee reviewed the Management Representation Letter. - The Committee Approved the audited Annual Accounts 2025/26 and Management Representation letter, and recommended these for approval by the Board of Directors at its Closed meeting on 24 June 2026.

Internal Audit

Assurances received on the effectiveness of the Trust's internal audit function and counter-fraud arrangements:

Internal Audit – Annual Report 2025/26 Head of Internal Audit Opinion 2025/26	- The Committee received Assurance, noting the Internal Audit – Annual Report 2025/26, and the Head of Internal Audit Opinion (HIAO) 2025/26. - The Committee discussed and noted the HIAO positive (second level) assurance opinion, indicating improvement compared to the previous year, particularly within the control environment, maturity and risk management processes. Whilst this recognised progress, it was noted challenges remained in areas such as financial planning and efficiency, emphasising the need to continue strengthening action around implementation and policy management. - The Committee noted the HIAO and its alignment with the Trust's Annual Governance Statement (AGS) (included in the 2025/26 Annual Report).



Governance

Assurances received on the effectiveness of the Trust's system of integrated governance, risk management, and internal control (clinical and non-clinical) across the whole of the organisation's activities that support the achievement of the Trust's objectives.

Quality Account 2025/26 – Final Draft	- The Committee received Assurance from the 2025/26 Quality Account, noting early drafts reviewed by the Trust Management Committee (TMC), Quality and Safety Committee (Q&SC), as well as IAGC and Board. Noting external statements (from Healthwatch, Council of Governors (CoG) and Integrated Care Board (ICB)) recognising improvements whilst identifying ongoing priorities. - The Committee noted arrangements for the final version once approved to be published on the Trust's website by the required publication date of 30 June 2026. - The Committee noted performance against priorities to be monitored through the established governance routes (Q&SC). - The Committee Approved the Quality Account 2025/26 and recommended this to the Board of Directors for approval at its Closed meeting on 24 June 2026.
Annual Report 2025/26 (including Annual Governance Statement (AGS))	The Committee received Assurance from the 2025/26 Annual Report including the AGS, noting minor outstanding amendments that were non-material corrections and updates) to be incorporated prior to consideration by the Board of Directors the following day. Subject to these final updates, the Committee Approved the Annual Report 2025/26 and recommended this to the Board of Directors for approval at its Closed meeting on 24 June 2026.

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

Item	Purpose	Date
The Committee asks the BoD: - To NOTE the Committee concluded it had sufficient assurance to Approve all of the annual statutory documents and recommended these to the Board of Directors for approval at its Closed meeting on 24 June 2026. - To NOTE thanks to all staff for their hard work and support in producing the annual statutory documents. - To discuss and NOTE this assurance report from IAGC, and that all of the annual statutory documents were approved at the Board of Directors Closed meeting on 24 June 2026.	Assurance	To Board on 28 July 2026.

