

Board of Directors meeting in Public

16 September 2026, 9.30am to 12.30pm

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

Agenda and Papers

Trust Board Meeting (in Public)

Wednesday 16 September 2026, 9.30am to 12.30pm, Meeting rooms 6 and 7, KCHFT offices, 110 – 120 Upper Pemberton, Eureka Park, Ashford, TN25 4AZ

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

DL	Description	FOR	Format	Lead	Time
1.	Welcome and apologies	FN	Verbal	Trust Chair	9.30
2.	Declarations of Interest	FN	Verbal	Trust Chair/All	
Board reflection items					
3.	Patient Story	FD	Verbal	Chief Medical Officer	9.35
Standing items					
4.	Minutes from the meeting of 15 July 2026	FA	Paper	Trust Chair	9.50
5.	Action log and matters arising	FA	Paper	Trust Chair	
6.	Chair’s report	FN	Paper	Trust Chair	
7.	Chief Executive’s report (incl. update on MCH-KCHFT integration)	FN	Paper	Chief Executive	
Strategy, culture and system reports					
8.	Board Assurance Framework	FA	Paper	Interim Trust Secretary	10.05
9.	National NHS Staff Standards – what it means for the KCHFT Board	FD	Paper	Chief People Officer	10.15
10.	Nobody Left Behind report (WRES and WDES reports)	FA	Paper	Chief People Officer	10.35
11.	Winter Operational Surge Plan 2026/27	FA	Paper	Chief Operating Officer	11.00
10-minute scheduled break					
Assurance and performance					
12.	Finance, Business and Investment Committee Chair’s assurance report – meeting held on 22 July 2026	FN	Paper	Finance, Business and Investment Committee Chair	11.20
13.	People Committee Chair’s assurance report – meeting held on 26 August 2026 Approval of Freedom to Speak Up Policy	FN	Paper	People Committee Chair	
14.	Quality Committee Chair’s assurance report – meeting held on 3 September 2026.	FN	Paper	Quality Committee Chair	

	Learning from Deaths report (published externally)				
15.	Integrated performance report	FD	Paper	Chief Finance Officer and Executive Directors	11.40
Governance & Compliance					
16.	Standing Financial Instructions and Scheme of Delegation	FA	Paper	Chief Finance Officer	11.55
17.	Medical appraisal and validation report	FA	Paper	Chief Medical Officer	12.00
18.	Infection Prevention and Control Board Assurance Framework	FN	Paper	Chief Nursing Officer	12.10
19.	Use of the Trust Seal – six monthly report	FN	Paper	Interim Trust Secretary	12.15
Closing items					
20.	Any other items of business previously notified to the Board	FD	Verbal	Trust Chair	12.20
21.	Evaluation of the meeting and delivery of the Trust’s values	FD	Verbal	Trust Chair	
22.	Questions relating to the agenda items from Governors and public	FD	Verbal	Trust Chair	
Date and venue of next meeting					
18 November 2026 – Meeting rooms 6 and 7, KCHFT offices, 110 – 120 Upper Pemberton, Eureka Park, Ashford, Kent TN25 4AZ					

Members:		
Colin Lynch	CL	Trust Chair
Dr Andy Brooks	AB	Associate Non-Executive Director (non-voting)
Dr MaryAnn Ferreux	MF	Non-Executive Director
Kim Lowe	KL	Non-Executive Director (Deputy Trust Chair)
Olu Odeniyi	OO	Non-Executive Director
Dr Razia Shariff	RS	Non-Executive Director (Senior Independent Director)
Faham Sinan-Katamba	FSK	Associate Non-Executive Director (non-voting)
Karen Taylor	KT	Non-Executive Director
Mairead McCormick	MM	Chief Executive
Caroline Bates	CB	Chief Nursing Officer
Pauline Butterworth	PB	Chief Operating Officer and Deputy Chief Executive
Ali Carruth	AC	Executive Director for Prevention, Inequalities and Children's Services (non-voting)
Rachel Dalton	RD	Chief Allied Health Professional Officer (CAHPO) (non-voting)
Gordon Flack	GF	Chief Finance Officer
Dr Sarah Phillips	SP	Chief Medical Officer
Victoria Robinson-Collins	VRC	Chief People Officer
Stephen Waring	SW	Non-Executive Director
In attendance:		
Gina Baines	GB	Assistant Trust Secretary (minute-taker)
Julia Rogers	JR	Director of Communications and Engagement

Tony Saroy

TS

Trust Secretary for Kent & Medway Mental Health NHS
Trust (KMMH) and Interim Trust Secretary for Kent
Community Health NHS Foundation Trust (KCHFT)

Apologies:

Trust Board Meeting in Public

UNCONFIRMED Minutes of the Kent Community Health NHS Foundation Trust Board Meeting in Public, held on Wednesday 15 July 2026 in meeting rooms 6 and 7, Trinity House, Eureka Park, Ashford, Kent TN25 4AZ

Present

Colin Lynch, Trust Chair (Chair)
Caroline Bates, Chief Nursing Officer
Pauline Butterworth, Deputy Chief Executive and Chief Operating Officer
Ali Carruth, Executive Director of Health Inequalities and Prevention (non-voting)
Rachel Dalton, Chief Allied Health Professional Officer (non-voting)
Dr MaryAnn Ferreux, Non-Executive Director
Gordon Flack, Chief Finance Officer
Kim Lowe, Non-Executive Director
Mairead McCormick, Chief Executive Officer
Olu Odeniyi, Non-Executive Director
Dr Afifa Qazi, Interim Chief Medical Officer
Victoria Robinson-Collins, Chief People Officer
Dr Razia Shariff, Non-Executive Director
Faham Sinan-Katamba, Associate Non-Executive Director (non-voting)
Karen Taylor, Non-Executive Director
Stephen Waring, Non-Executive Director

In attendance

Gina Baines, Assistant Trust Secretary and Committee Secretary (minute taker)
Magdalena Bourne-Fanti, Clinical Lead for Immunisations (agenda item 3)
Shelly Carter, The Guardian Service (agenda item 20)
Julia Rogers, Director of Communications and Engagement
Tony Saroy, Trust Secretary for Kent and Medway Mental Health NHS Trust and Interim Trust Secretary for Kent Community Health NHS Foundation Trust
Danielle Truelove, Lead Specialist Practitioner District Nurse
Claire Venes, Head of Service, East Kent Long Term Services

Apologies

Dr Andy Brooks - Associate Non-Executive Director (non-voting)

15/07/138 Welcome and apologies for absence

Colin Lynch welcomed everyone present to the Public Board meeting of Kent Community Health NHS Foundation Trust (the Trust), including

governors and members of the public attending virtually. Apologies were noted. The meeting was quorate.

15/07/139 Declarations of interest

Kim Lowe updated the Board that her current role as Council Member of the University of Kent would cease on 31 July 2026. From 1 August 2026, she had been appointed as an Independent Governor for London and South East University Group (LASE). This would be a voluntary, unpaid role. The register of interests would be updated accordingly.

No other conflicts of interest were declared other than those formerly recorded.

15/07/140 Patient story

The Board welcomed James Thompson, accompanied by Magdalena Bourne-Fanti, Claire Venes and Danielle Truelove, to share his experience of the Trust's response to the meningitis B outbreak which had occurred in Canterbury in March 2026. James described the outbreak as frightening and stressful for students and explained that receiving the vaccination and antibiotics had helped him to feel more secure. He reflected on the importance of students supporting one another and keeping each other informed during the outbreak.

Magdalena Bourne-Fanti, Claire Venes and Danielle Truelove described the Trust's response, including the close working with the University of Kent, the establishment of vaccination and antibiotic hubs, and the emotional impact on students and staff. The Board noted that the response had been proactive, well-organised and delivered at pace.

Board members discussed the importance of clear communication, peer support, pastoral support and the impact of social media messaging during public health incidents. The Board thanked James for sharing his story and thanked the immunisation and community nursing teams for leading such a positive and effective response.

The Board **NOTED** the patient story.

15/07/141 Minutes of the Public Board meeting held on 15 April 2026

The minutes were reviewed for accuracy. It was noted that the patient story name should be amended on pages two and three to read Mark Burt rather than Mark Burr.

The Board **APPROVED** the minutes of its meeting held on 15 April 2026 as an accurate record, subject to the amendment.

15/07/142 Action log and matters arising

The Chair suggested that the actions proposed for closure should be closed. The Board agreed.

The action log was **APPROVED**.

Matters arising

Victoria Robinson-Collins updated the Board on the new national NHS staff standards and the national leadership framework being developed following the Lord Mann review. The Board emphasised the importance of the standards, noted that the Trust would need to review the standards, and the Board and People Committee to receive a paper setting out the responsibilities of both the Board and senior leaders.

Action: At the September 2026 Board meeting (in Public), Victoria Robinson-Collins to present a paper on the new national NHS staff standards, setting out the responsibilities of both the Board and senior leaders in delivering the standards.

15/07/143 Chair's report

Colin Lynch presented his report to the Board for noting.

He thanked colleagues for the warm welcome he had received since joining the Trust and acknowledged the support provided by John Goulston during the handover period.

The Chair highlighted elements of the three key themes outlined in his report. These are themes that are important to the successful delivery of the Trust's strategy and as such will help shape the Board's work and future development programme. Namely: effective and consistent colleague and team engagement and empowerment and the link to sustainable service quality improvement; the Trust's system leadership role for public benefit, including the pivotal importance of Integrated Neighbourhood Care; and Board effectiveness and resilience, including being 'fit for the future' as well as for the Trust's current agenda.

Members reflected on the importance of culture, communication and engagement in supporting colleagues through a period of significant organisational change, including neighbourhood health and the prospective integration with Medway Community Healthcare (MCH).

The Board noted that a Board meeting on internal well-led assurance was being arranged as part of the Board development programme, and

that a Board development programme through to March 2027 would be presented to a future meeting.

Action: By September 2026, Tony Saroy to discuss with the Chair and Chief Executive and prepare a paper for the next Board meeting (in Public) setting out the Board development programme to March 2027; and a reflection on the themes of the programme for 2027/28

The Board also discussed opportunities to strengthen the assurance arrangements relating to non-executive director service visits and the engagement of Governors in such visits.

Action: By September 2026, Tony Saroy to ensure a refreshed process for non-executive director service visits is in place, including use of a common feedback form, arrangements for analysis of that feedback and better integration with the Trust's assurance architecture.

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

15/07/144 Chief executive's report (including 2026/27 We Care Strategy Breakthrough Objectives)

Mairead McCormick presented the report to the Board for noting.

The Board welcomed the successful transfer of the All Age Continuing Care and Medicines Optimisation services and noted the learning being applied from these service transfers to the forthcoming integration activities with MCH. Members noted the importance of supporting new colleagues through practical concerns relating to job security, leadership arrangements and operational onboarding.

The Board noted progress with the development of neighbourhood health hubs and teams, and reflected that the recent meningitis response discussed in the Patient Story item demonstrated the benefits of neighbourhood-based working in practice.

The Board acknowledged the results of the 2025 Guardian Service Freedom to Speak Up index which placed the Trust third out of all 206 NHS trusts nationally. This achievement recognised the commitment by the Trust to create an open, inclusive environment where colleagues felt safe, supported and confident to raise concerns. It was noted however that with the agenda facing the organisation, there was likely to be movement in this and other rankings in the short-term.

The Board also welcomed confirmation that the Trust had been included for assessment within wave two of the Advanced Foundation Trust programme.

Members discussed the opportunities and risks associated with the ongoing introduction of automation and digital technologies, including Copilot and ambient voice technology. The Board recognised the importance of effective communication with colleagues, appropriate governance, environmental considerations and supporting both staff and partners particularly voluntary and community sector partners during this period of fast-paced change.

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

15/07/145 Board assurance framework

Tony Saroy presented the Board Assurance Framework (BAF) to the Board for approval. This was the second iteration of the redesigned framework to be received by the Board.

Tony Saroy highlighted that risk ID 6956, relating to capability, leadership and workforce resilience, would be disaggregated into two separate risks, with one risk having an enhanced focus on the culture of the organisation. He would be discussing this with Victoria Robinson-Collins and intended to update the Board on the outcome of the discussion when the Board next reviewed the framework.

Members discussed the need for the BAF to continue to evolve in light of MCH integration and the development of neighbourhood health. Committee chairs were asked to consider the impact of these developments when reviewing BAF risks through their committees.

The Board **APPROVED** the Board Assurance Framework.

15/07/146 All Age Continuing Care and Medicines Optimisation Services Transfer

Pauline Butterworth presented the report to the Board for discussion.

The Board noted that the transfer had gone well and that good feedback had been received from colleagues. However, the Trust had inherited significant delays in delivering completion of the 28-day decision support tool and access to packages of care. The Board also noted that the service development and improvement plan had not progressed as expected and that the deadline in the contract for completion by the end of July was unlikely. An extension had been requested.

Regarding the barriers which were affecting the delivery of the cost improvement programme, Pauline Butterworth explained that the Trust was in the middle of a procurement process, led by the integrated care board (ICB), which had stalled and led to a variance in the original timeframes.

The Board noted that the All Age Continuing Care service had historically been difficult to recruit to, but that there was an opportunity to build capacity and develop a positive offer for staff to join the service and for the population it served.

The Board **RECEIVED** the All Age Continuing Care and Medicines Optimisation Service Transfer report and **NOTED** its assurance.

15/07/147 System Governance and Joint Committee Alignment

Mairead McCormick presented the report to the Board for approval.

The Board discussed the proposed approach to system governance and joint committee alignment, including mechanisms for challenge where provider boards disagreed, the role of Chairs in supporting assurance, and the development of a system financial framework.

Members discussed how the effectiveness of the joint committee would be assessed, including through quality metrics, outcomes, return on investment and monitoring arrangements. The Board recognised that some areas would require innovation, aligned incentives and appropriate risk sharing between organisations.

Members also discussed the importance of patient and community voice within system decision-making and noted that this would be a key element of neighbourhood health hubs and future health and care alliances.

The Board **APPROVED** the approach set out in the report, noting the concerns raised and the further points still to be developed.

15/07/148 Quality Committee chair's assurance reports for the meetings held on 7 May and 2 July 2026

- **including the Learning from Deaths report (published externally)**

MaryAnn Ferreux presented the report to the Board for noting. The reports were taken as read, with discussion focused on the key areas of assurance and challenge considered by the Committee.

The Board noted that the Committee had received assurance on progress on key quality risks including safer staffing, community hospitals, infection prevention and control, and the surveillance of an MRSA bacteraemia incident. The Committee had also discussed deferred and missed visits, the potential impact of these on the neighbourhood health model, and the move from analogue to digital clinical care delivery, including cyber threats and staff competencies. It had also received the Learning from Deaths quarterly report and annual reports. These included the Director of Infection Prevention and Control (IPC) report including the Trust's annual

IPC declaration, the Safeguarding Annual Report, the Research Annual Report.

Members discussed the learning from the MRSA bacteraemia incident and was assured that a full post-infection review had been shared with the Quality Committee.

Members also discussed the National Audit of Care at the End of Life results which highlighted that further improvement was required in the community hospitals around capturing on the inpatient's clinical record any unmet spiritual, religious and cultural needs. It was explained that the end of life care team and the community hospitals senior leadership team were working on raising staff awareness around the importance of discussing and capturing this information and improvements were already being observed. The Board noted that an action plan would be presented to the Quality Committee in September, where assurance would also be sought for the improved capture in the patient record of ethnicity data.

The Board **NOTED** the Quality Committee chair's assurance report and the Learning from Deaths report.

15/07/149 People Committee chair's assurance report for the meetings held on 29 April and 24 June 2026

Kim Lowe presented the report to the Board for noting. The reports were taken as read, with discussion focused on the principal assurance issues arising from the Committee's work.

The Committee had reflected on recent learning from the Care Quality Commission findings at Kent and Medway Mental Health NHS Trust and had considered how assurance reporting could place greater emphasis on outcomes and impact rather than completion of actions alone. Future reporting to the Board would reflect this change of emphasis.

The Committee highlighted the scale of organisational change facing colleagues and the associated impact on staff experience. Particular areas of focus included staff anxiety, organisational culture, lengthy employee relations processes, and the importance of understanding variation at local team level rather than relying solely on organisational averages. The Board noted the increasing triangulation of intelligence from staff surveys, Freedom to Speak Up, organisational development feedback and staff voice arrangements, and welcomed the Committee's focus on strengthening assurance through these mechanisms.

Members discussed the introduction of automation and digital technologies into services and recognized there were a number of factors at play that impacted on staff experience. Some teams were relying on delivering future digital efficiencies within their cost improvement plans. There was also enthusiasm amongst many clinical teams to embrace innovation and to act as test beds for new solutions. Alongside this there

was an ongoing internal debate about the proportionate size of a clinical record which when resolved would have a significant impact on reducing the time spent on record-keeping and lead to unlocking many of the benefits the technologies offered for both patients and staff. The Committee would continue monitor the changes and alert the Board to any areas that needed further assurance.

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

15/07/150 Finance, Business and Investment Committee chair's assurance report for the meeting held on 27 May 2026

Olu Odeniyi presented the report to the Board for noting. The report was taken as read, with discussion focused on areas where the Committee believed additional Board awareness and assurance were required.

The Committee highlighted cyber security as an area requiring continued oversight. Whilst assurance had been received that the Trust remained compliant with the Data Security and Protection Toolkit requirements, members recognised that cyber threats continued to evolve and that ongoing vigilance was required.

The Committee had also reviewed estate-related risks, including backlog maintenance and the longer-term sustainability of parts of the Trust's estate. Discussion recognised the need to balance investment priorities with future estate strategy, whilst maintaining a focus on staff and patient experience, particularly in the context of climate change and increasingly extreme weather events.

The Board welcomed the Committee's continued focus on these strategic risks and agreed that both cyber security and estate resilience would require ongoing scrutiny.

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

15/07/151 Audit and Risk Committee chair's assurance report for the meetings held on 8 and 17 June 2026

Karen Taylor presented the reports to the Board for noting. The reports were taken as read, with discussion focused on the key assurance matters considered by the Committee.

The Committee had undertaken detailed scrutiny of the Board Assurance Framework, Corporate Risk Register and annual governance arrangements. Internal and external audit annual reports had also been reviewed, providing assurance regarding the effectiveness of the Trust's governance, risk management and control arrangements.

The Board noted that the Trust had completed and submitted its Annual Report and Accounts earlier than many other organisations across the system and acknowledged the contribution of both the Finance Team and Trust's Corporate Governance Team.

Members also reflected on the importance of continuing to strengthen Board understanding of the Board Assurance Framework and how it should be used to support strategic oversight and risk management. Further Board development on the board assurance framework would be considered as part of the Board's development programme.

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

15/07/152 Charitable Funds Committee chair's assurance report for the meeting held on 1 July 2026.

Razia Shariff presented the report to the Board for noting. The report was taken as read, with discussion focused on the principal issues considered by the Committee.

The Committee had welcomed colleagues from Medway Community Healthcare and received assurance regarding arrangements for the transfer of charitable funds into the KCHFT Charity. The Board noted that these funds would remain ringfenced and that local oversight would be maintained through dedicated fund managers.

The Committee continued to monitor the balance between restricted and unrestricted funding and discussed opportunities to maximise the impact of charitable funds across the organisation and within neighbourhood health developments. The Committee also noted the ending of NHS Charities Together wellbeing funding and the need to continue developing fundraising opportunities and wider collaborative arrangements with system partners.

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

15/07/153 Terms of Reference of the sub-Board Committees

Tony Saroy presented the report to the Board for approval.

The Board **APPROVED** the Terms of Reference of the sub-Board Committees.

15/07/154 Proposed amendments to the constitution

Tony Saroy presented the report to the Board for approval.

The Board noted the proposed introduction of the single transferable vote system to support fairer and more representative election outcomes. The Board also noted the proposal to strengthen representation in the Medway area in light of the integration with MCH.

Members discussed the equity, diversity and inclusion considerations and the evidence base for the single transferable vote approach. The Board noted that advice had been received from Civica and that engagement work would continue to ensure that the Medway voice was heard.

The Board **APPROVED** the proposed amendments to the constitution for onward consideration by the Council of Governors.

15/07/155 Safer Staffing Report

Caroline Bates presented the report to the Board for discussion.

The report had previously been considered in detail by the Quality Committee at its meeting on 2 July 2026.

The Board noted the key themes from the report, including missed and deferred visits, associated risks of patient harm, areas of improvement and continuing fragility. The Board also noted the importance of National Quality Board compliance and the need to shape future safer staffing models around physical and mental health capability, population health and health inequalities.

Members discussed future workforce requirements, including skill mix, competencies, staff working to the top of their licence and the need for a refreshed workforce plan aligned to neighbourhood health. Members also discussed phlebotomy, end of life care, insulin demand, staff wellbeing, sickness absence and burnout.

The Board recognised that continuing with existing models would not address current pressures and that neighbourhood health created opportunities to work differently, including with voluntary sector partners. The Board endorsed the Trust's proposed bid to the national programme for 13 apprenticeships in East Kent, based on population health and safer staffing evidence.

The Board **RECEIVED** the Safer Staffing report and **NOTED** its assurance; and **ENDORSED** the recommendations in the report.

15/07/156 Integrated performance report

Gordon Flack presented the report to the Board for discussion.

The Board noted that, based on the Quarter Four NHS Oversight Framework segmentation results, the Trust was ranked first among non-acute trusts, first in the South East region and eighth nationally. Continued

improvement was noted in allied health professional access times, community paediatric waits and Friends and Family Test performance.

Members discussed performance relating to Looked After Children Initial Health Assessments, neurodiversity pathways, health visiting indicators, child BCG vaccinations and Education, Health and Care Plan advice. The Board noted the actions underway to improve pathways, strengthen reporting and address capacity challenges.

Ali Carruth clarified that the health visiting antenatal checks indicator was incorrectly showing as a consistently failing target because the reporting was based on an old target. She stressed that all families were receiving a health visitor visit and that the reporting would change in time as the new target was introduced into the report.

Members also discussed no criteria to reside delays and the ongoing work with Kent County Council and internally with the All Age Continuing Care service to improve pathways and support community hospitals. Members also discussed differences in Did Not Attend rates and the need for targeted community engagement, particularly for patients living in areas of higher deprivation.

Pauline Butterworth thanked Mark Johnson, Deputy Chief Medical Officer, who would be retiring in August, for his significant contribution in overseeing the reduction in waiting times across many of the services.

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

15/07/157 Freedom to Speak Up Annual Report

Shelly Carter joined the meeting to present the report to the Board for discussion.

The report had previously been considered in detail by the People Committee at its meeting on 24 June 2026.

The Board noted that the main themes continued to relate to management issues, relationships and systems and processes. The Board also noted the continuing preference of some colleagues to raise concerns anonymously and the need to increase the visibility of the Freedom to Speak Up (FTSU) service.

Members discussed the importance of closing the loop with colleagues who raised concerns. Response times were strong, but follow-up and resolution could take longer. Members also discussed how data could be analysed differently while maintaining confidentiality and anonymity. Karen Taylor, as the non-executive director FTSU champion, reported that she met regularly with Shelly Carter and Pauline Butterworth, and asked about FTSU during service visits. Anecdotal feedback suggested to her

that more colleagues were aware of the service, while smaller teams might feel less need to escalate issues when they were being dealt with locally.

The Board noted that Pauline Butterworth owned the recommendations from The Guardian Service and she would continue to work with Shelly Carter to ensure traction against the actions.

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

**15/07/158 Deep dive – triangulated workforce, culture and safety review
(Learning from Freedom to Speak Up and Safer Staffing data)**

The Chair introduced the deep dive item, reminding Board members that the intention was to discuss the findings of cross-directorate analysis of important themes relating to elements of service safety and Trust culture, with a view to seeing what the Board could learn, seek assurance on workstreams and agree how we can maximise our efforts. Caroline Bates, Pauline Butterworth and Victoria Robinson-Collins presented the report to the Board for discussion.

The review highlighted a number of themes relating to workforce resilience, culture, staff wellbeing and patient safety. The Board noted that while many teams continued to perform strongly in challenging circumstances, there was evidence that some of this performance was reliant upon personal resilience and colleagues going 'above and beyond'. Potential concerns therefore arise regarding the sustainability of this performance and colleague well-being. Opportunities to improve process as well as supportive behaviour were discussed and highlighted

Members discussed the importance of identifying concerns earlier, strengthening professional judgement conversations, improving triangulation of intelligence and ensuring that Staff Voice continued to inform organisational decision-making.

Members reflected on the challenges associated with service change, workforce pressures and geographically dispersed teams. The Board also noted that neighbourhood health, mental health and social care integration would change team dynamics and microcultures, and that this would need to be considered in future assurance reporting.

The Board commended the report and requested a further update in six months to understand the impact of the actions that would be taken as outlined in the report. The Board supported the approach being used in the paper as a model for future deep-dive reviews.

Action: At the January 2027 Board meeting (in Public), Pauline

Butterworth and Caroline Bates to present a paper updating the Board on what has happened in the Trust consequent upon the findings in the report.

The Board **RECEIVED** the Deep Dive – Triangulated workforce, culture and safety review (Learning from Freedom to Speak Up and Safer Staffing data) and **NOTED** its assurance.

15/07/159 10 Point Plan to Improve Resident Doctors' Working Lives – Update and Next Steps

Dr Afifa Qazi presented the report to the Board for discussion.

The report had previously been considered in detail by the People Committee at its meeting on 24 June 2026.

The Board noted that compliance had improved from 59% to 86%. Two areas remained amber and continued to be progressed. Two areas remained red but were outside the control of the Trust, as resident doctors were not employed by the Trust but came into its services through training arrangements.

The Board **RECEIVED** the 10 point plan to improve resident doctors' working lives – update and next steps report and **NOTED** its assurance.

15/07/160 Any other items of business previously notified to the chair

There was no other business.

15/07/161 Evaluation of the meeting and delivery of the Trust's values

The Chair invited comments from Board members regarding the meeting, including whether the papers and the discussions sufficiently reflected each of the Trust's values. Board members reflected that there had been constructive engagement, including an enhanced degree of interactive discussions both by and between executive and non-executive directors.

15/07/162 Questions relating to the agenda items from Governors and public

Lindsey Tilley, staff governor, commented on the role of professional judgement advocates and the opportunity to use them to support triangulation and gather different perspectives. She also reflected on automation and noted that learning from previous service transfers should be considered as part of the MCH integration, particularly where integration activity had slowed automation work.

Jan Allen asked whether the Trust had considered employing someone to provide pastoral care. Victoria Robinson-Collins explained that the Trust had taken a broader approach through its Health and Wellbeing Lead role but agreed to discuss the question with clinical colleagues.

Action: By September 2026, Victoria Robinson-Collins to discuss with clinical colleagues whether there is an opportunity for a pastoral care offer within the Trust.

15/07/163

Date and time of next meeting

16 September 2026; Meeting rooms 6 and 7, Kent Community Health NHS Foundation Trust offices, Trinity House, 110 – 120 Upper Pemberton, Eureka Park, Ashford, Kent TN25 4AZ and on MS Teams

The meeting finished at 12noon.

Action Log of Trust Board meetings (in Public)

Monitoring Open, Pending and Closed Actions

Actions due on 16 September 2026

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Due Date	Comments (incl. impact achieved)	Status
15/07/26	15/07/142	Action log and matters arising	Present a paper on the new national NHS staff standards to the next Board meeting (in Public), setting out the responsibilities of both the Board and senior leaders in delivering the standards.	Victoria Robinson-Collins	16/09/26	This was presented at the August People Committee meeting where assurance was received that the Staff Standards were being assessed and that the staff were being engaged in the review and development of solution. The paper now comes to the September Public Board meeting.	Propose Close
15/07/26	15/07/143	Chair's report	Discuss with the Chair and Chief Executive and prepare a paper for the next Board meeting (in Public) setting out the Board development programme to March 2027;	Tony Saroy	16/09/26	Following agreement with the Chair, a briefing note was circulated to Board members on the development programme to March	Propose Close

Key

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

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Due Date	Comments (incl. impact achieved)	Status
			and a reflection on the themes of the programme for 2027/28			2027; and a reflection on the themes of the programme for 2027/28. The briefing note was also circulated to the Council of Governors	
15/07/26	15/07/143	Chair's report	To be in place a refreshed process for the non-executive director visits including use of a common feedback form, arrangements for analysis of that feedback and better integration with the Trust's assurance architecture.	Tony Saroy	16/09/26	A refreshed process for non-executive director visits has been implemented; with an overview of the changes included within the Chair's report.	Propose Close
15/07/26	15/07/162	Questions from governors and public	Discuss with clinical colleagues whether there is an opportunity for a pastoral care offer within the Trust	Victoria Robinson-Collins	16/09/26	Pastoral support is in place for colleagues going through employee relation cases or change. Trauma Risk Management (TRiM) is being progressed using a charity bid for	In progress

Key

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

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Due Date	Comments (incl. impact achieved)	Status
						trauma informed support for colleagues. Chief Nursing Officers are reviewing potential for a shared chaplaincy offer across the system.	

Actions pending (not due)

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Due/ Revised Date	Comments	Status
15/07/26	15/07/158	Deep dive – triangulated workforce, culture and safety review – Learning from Freedom to Speak Up and Safer Staffing data	Present a paper to 20 January 2027 Board meeting (in Public) updating the Board on what has happened in the Trust consequent upon the findings in the report.	Pauline Butterworth Caroline Bates	20/01/27		

Key

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

Closed at last meeting or completed between meetings

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Closed Date	Comments	Status
21/01/2026	21/01/08	We CARE strategy – breakthrough objectives progress report	Schedule a report on KCHFT's Five Year organizational plan for the April Public Board meeting and the Council of Governors meeting	Mairead McCormick	15/04/2026	The CEO report addresses material matters that will affect the Trust such as Advanced Foundation Trust status, MCH KCHFT integration and neighbourhood health. Partnership working with system partners will be discussed in the Board's part two meeting.	Closed
21/01/2026	21/01/16	Freedom to Speak Up (FTSU) report	For the Communications Team to work with The Guardian Service on messaging/communication mechanisms to raise the profile of the Guardian Service with colleagues.	Julia Rogers	15/07/2026	A number of actions have been put in place by the Comms Team in collaboration with the Guardian Service. These include a relaunch of the service with	Closed

Key

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

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Closed Date	Comments	Status
						associated action plan; a quarterly FTSU update now a standing item on the Staff Council agenda, with forward reporting to the People Committee; Shelly Carter, our FTSU Guardian is also a standing member of the Staff Council and is invited to all meetings.	
15/04/2026	15/04/87	Board assurance framework	Schedule an annual review of the Board's risk appetite on the Board's development forward plan	Tony Saroy	15/07/2026	An annual review of the Trust's risk appetite session has been scheduled for each year, in December.	Closed
15/04/26	15/04/88	Risk management framework	Draft a high level, one page summary of the risk management framework and governance structure to be shared with the Council of Governors at	Tony Saroy	15/07/2026	Action complete	Closed

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

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Closed Date	Comments	Status
			its Council meeting on 22 July 2026; and shared more widely with staff to encourage their engagement with the risk agenda.				
15/04/26	15/04/88	Risk management framework	Correct the errors identified in the framework	Tony Saroy	15/07/2026	The errors were duly corrected, and the Risk Management Framework subsequently published on Flo.	Closed

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

Title of Meeting	Board of Directors (Public)
Meeting Date	16 September 2026
Title	Chair's Report
Author	Colin Lynch, Trust Chair
Presenter	Colin Lynch, Trust Chair
Purpose	For noting

1. Introduction

Since the previous Kent Community Health NHS Foundation Trust ("The Trust") Board meeting, the Board and I agreed a revised cadence to Board meetings. We have increased the number of meetings held in public from four to six. This will better enable the Trust to keep members of the public updated on developments and our plans during this period of significant change both locally, and nationally across the NHS. Today's meeting reflects the first of the new cadence, and the revised dates can be found on the [Trust's website](#).

My report focuses on both matters of key significance to the Trust and my activity over the past two months. This is aligned to the three themes that I set out in my first report and that I believe are key to the successful delivery of our We Care Strategy.

2. Key themes, activity and reflections

Trust colleagues, team and public engagement and service improvement

The Council of Governors (COG) development and information session on 22 July was informative and engaging. In addition to an update on integrated neighbourhood health developments and how locally this is improving outcomes, the Governors discussed further ideas around patient, population and colleague inclusion and engagement. This was followed up by our Chief Executive and me in an informal meeting on 12 August with Staff Governors. We listened to feedback and ideas regarding colleague engagement, including in the context of the prospective integration with Medway Community Healthcare (MCH). Some related themes, including the need for effective and timely two-way communication in a time of change, are reflected in the collated feedback from Non-Executive Director (NED) visits ([see section 4 below](#)).

On 4 August, I visited our Single Point of Access (SPOA) services, based in the Southeast Coast Ambulance Service (SECAMB) building in Ashford. Involving true hand in glove multi-disciplinary team working with acute trust, GP and SECAMB colleagues, this SPOA service has embedded significant reductions in acute hospital admissions and more appropriate, more timely treatment for local 999 callers.

The Trust's We Care Webinar on 10 August focused on the new Unitary Authority areas, neighbourhood health models, what will happen from day one of the integration with MCH

and what this means for colleagues across the Trust. The Board and our management colleagues must continue to listen, and support colleagues during this period of transition

On 20 August, at the invitation of Public Governor, Pirthipal Kang (known as Kang), I visited Sri Guru Nanak Darbar Gurdwara, Gravesend. In addition to learning about our Sikh community's faith, customs, local history and the potential for disseminating public health and care information, we visited the on-site health and wellbeing centre. The centre manager was engaging and explained their partnership working with the local acute Trust and Voluntary, Community and Social Enterprise (VCSE) providers. There are opportunities for further partnerships and community engagement. My thanks to Kang for his time, hospitality and company.

On 27 August, I visited the Appleby Dental Services in East London. It was positive to experience first-hand the obviously good team dynamics, learn about the digital service developments and significantly reduced number of missed patient appointments, as well as hear suggestions for how we can be more productive and reduce colleague frustrations if we can be more permissive and encouraging of local decision-making and accountability.

System leadership for sustainable patient, public and partner benefit

Since the last Public Board meeting, I have visited the Chairs of East Kent Hospitals University NHS Foundation Trust, Medway NHS Foundation Trust and Maidstone and Tunbridge Wells NHS Trust. We discussed our respective opportunities and challenges, how we can best be effective system partners, any key feedback for our respective executive colleagues and the system transformation work to date. All Kent and Medway system NHS Chairs also meet informally on a monthly basis.

On 14 August, I attended the Kent and Medway Provider Alliance meeting of NHS Chief Executives and Chairs, GP and system transformation colleagues. The meeting focussed on constructive challenge and seeking assurance on the improvement and transformation work of the Acute, Neighbourhood and emerging Primary Care Collaboratives; progress with the system financial recovery plans and the work of the executive led system Professional Groups. Subsequently, I've also had update and system progress meetings with NHS England (NHSE) system lead and Southeast Region Chair and the Chief Executive of the Kent and Medway Integrated Care Board (ICB).

On 18 August, I visited the Chief Executive of Alzheimer's and Dementia Support Services (ADSS), together with the Chief Executive of KMMH. Part of the discussion was about ADSS interface with physical community health services, around End-of-Life care in particular. The meeting was a good reminder that our system VCSE partners are essential to the removal of barriers to effective care and sustained improvement, including via single and multi-neighbourhood integrated care arrangements, of health and care outcomes.

On 1 September, I represented the Trust and Kent and Medway Mental Health NHS Trust (KMMH) on the stakeholder panel for the recruitment of the Kent and Medway ICB

permanent Chair. We met three very credible and engaged candidates. At the time of writing this report, that recruitment process is ongoing.

In addition to NHS provider, NHSE and ICB colleagues, I look forward to developing and maintaining relationships with Local Government, Primary Care Collaborative and VCSE colleagues, building on the current networks and relationships in our Trust and KMMH.

Board effectiveness, resilience and being fit for the future

At the July COG meeting, the Governors provided feedback from members of their constituencies and approved the proposed amendments to the Trust Constitution. Those amendments will support a more equitable and inclusive approach to future Staff Governor elections. The COG also approved the proposed process for the Annual General Meeting / Annual Members Meeting on 15 September 2026.

On 25 August, the Board held a reflective and productive development session. The focus of the session was to discuss and agree the learning from our internal Well-Led interviews. Helpful themes emerged such as being better able to articulate and evidence the positive changes that have occurred following constructive Board challenge. We also discussed and reaffirmed our commitment to press ahead with the application to NHSE for Advanced Foundation Trust (AFT) status. The Board emphasised the need to engage with system partners, so as best to understand how becoming an AFT, if we are successful, will help deliver sustained improvements in patient outcomes and population health, as well as other system benefits. Finally, the Board also discussed the integration with MCH.

As I alluded to in my previous Chair's report, work has now been completed in conjunction with our Chief Executive and Governance team on a forward looking, more themed plan to our Board development work. Each of the topics have been designed with clear outcomes and purpose in place, as well as consideration of the benefits which could be achieved from wider participation. Several of the areas of focus for 2026/27 include:

- Leading for impact
- Integration, learning and next-year priorities
- Conditions for sustained success
- Board assurance in a population health system
- Building on relationships with KMMH

3. New NED visit process

Following work with our Governance team and Chief Executive on how we can integrate reporting and analysis of feedback from NED visits, I am pleased to report that a revised process has been agreed. The revised approach is a more coordinated approach to visits and the collation of feedback, with a programme of visits developed in conjunction with the Quality Management Team, aligned to our We Care Strategy and, going forward, Cost Improvement Programmes. The intention is to triangulate the valuable feedback, including impact upon colleagues across the Trust, with other data available, so as to improve our

management and Board assurance. The process is supported by a new service visit form to standardise the data captured and enable thematic analysis. The feedback is mapped against a range of categories and themes to identify recurring messages, areas of good practice and emerging risks or opportunities for improvement.

Each finding will first be shared with the relevant executive and service leads to inform existing work programmes, priorities, risk controls and improvement plans. A named owner, action, timescale and evidence of outcome will be recorded for concerns and escalations. The primary Board committee will then receive focused assurance through its own area of responsibility, with a linked committee involved only where the issue genuinely crosses remits. This approach is intended to avoid duplicate reporting, make accountability clear and show colleagues what has changed as a result of their feedback.

What this means for colleagues. To help show colleagues how their feedback is being used, the Board is invited to consider whether regular “We said, you did” updates could be shared on the staff intranet. These could summarise the main themes raised, the action agreed, who is responsible, progress made and any issues that may take longer to resolve. Updates would protect confidentiality and help demonstrate how colleague feedback has informed decisions, improvement work and the sharing of good practice.

4. Thematic review of Trust Chair and NED visits

Purpose	Triangulated assurance arising from NED service visits
Overview	Ten completed visits provided 135 findings across good practice, improvement opportunities, concerns and escalations. The paper draws together visit summaries, thematic analysis, good practice, emerging risks and issues for Board attention.
Governance implications	The evidence identifies recurring themes requiring named management ownership, action and triangulation with formal information. Findings are routed to the most appropriate Board committee for oversight, with linked committee involvement only where necessary. Visit intelligence supplements, rather than replaces, established management and governance processes.
Assurance rating	Limited. There is strong positive frontline evidence, but recurring workforce and change concerns, wider control gaps and incomplete triangulation prevent a higher rating.
Board action requested	Note the report and the limited assurance rating Discuss evidence that recurring concerns have accountable actions, measurable outcomes and closed feedback loops.

Executive Summary

- **Evidence base:** Ten visits across Dental, Adult Clinical and Prevention, Inequalities and Children’s services, generating 135 mapped findings.
- **Positive assurance:** Strongest evidence relates to team culture, clinical effectiveness, improved access, partnership working, staff voice and practical innovation.

- **Recurring concerns:** Workforce capacity appears across seven visits and change communication across six visits. Digital constraints, equipment, wellbeing and governance also require targeted assurance.
- **Strategic judgement:** Frontline strengths are clear, but recurring workforce pressures, change communication concerns, control gaps, two Immediate Escalations and incomplete triangulation support an overall Limited Assurance rating.

Assurance Statement and Mapping Method

The overall assurance is based on structured mapping of evidence from each completed NED visit. Each observation is recorded as Good Practice, an Improvement Opportunity, a Concern or an Escalation. One visit can therefore generate several findings. Each finding is assigned a theme, the most appropriate primary governance route, an escalation status and an evidence scope of Local, Directorate-wide or Trust-wide. Repetition across visits increases the weight given to a theme. A single or uncorroborated observation is treated as a signal requiring triangulation rather than proof of a wider issue. This prevents local feedback from being overstated.

The current evidence provides strong positive assurance about the Trusts culture, care, access and innovation. However, only a limited assurance rating can be allocated due to recurring workforce capacity and change communication concerns.

Headline Assurance Position

Clinical effectiveness and patient experience provide strong positive evidence, with good local practice reported across six visits, improved access and positive patient feedback. Workforce findings across seven visits identify pressure relating to capacity, skill mix, administration support, retention, maternity cover and the effect on service delivery.

Feedback on change communication highlighted repeated concern that colleagues and local managers felt that they do not always receive timely information or see how their feedback has influenced decisions. Digital systems show both benefit and constraint. Automation has released colleague time in some services, particularly the 12 digital bots used by Adult Community Dietetics to support routine administration, triage and discharge. However, the same service reported that “clunky” clinical record forms and equipment limitations can create avoidable administration and prevent digital tools from reducing workload as intended.

Pathway and flow feedback was mixed, with good multidisciplinary working and smoother transfers balanced by hidden waits, continuity concerns and gaps between services.

Estates, transport and equipment pressures were evidenced by several specific examples. Faversham Dental Service reported that fewer vehicles reduced effective use of colleague time across Kent and Medway, while reduced office space affected colleagues' ability to work and their wellbeing. Lymphoedema reported patient delays in receiving compression

garments and stressed the importance of clinical input to procurement and contract decisions. Dartford Health Visiting reported crossing costs, congestion and only eleven parking permits shared across the team, alongside concern that rapid housing growth in North Kent will place further pressure on access and service capacity. Adult Community Dietetics also reported equipment limitations that prevent digital tools from reducing administration as intended. These findings may affect travel time, appointment capacity, timely treatment, productivity and colleague wellbeing.

Governance, delegated authority and administrative burden. Assurance remains limited because four visits highlighted areas where governance arrangements may benefit from further review, with related feedback from two visits about avoidable administrative burden. Colleagues described several approval layers, escalation routes that were not always clear, repeated reporting for the same issue and a cautious approach that may delay timely local action. Examples included Appleby Dental Service, where managers felt that several approvals could limit their ability to act or innovate. Home First, where duplicate reporting was described as adding to the governance burden and Podiatry, where colleagues were not always clear which escalation route to use. This feedback does not suggest that controls should be weakened. Rather, it indicates an opportunity to consider whether controls are proportionate, delegated authority is sufficiently clear and escalation routes enable accountable local managers to act promptly. A focused review could explore delegated authority, decision times, escalation routes and duplicate reporting. This could identify practical improvements, named ownership and measures to assess whether delays and administrative burden have reduced. This would support the Trust's aim to remove work that does not add value and reduce time spent on administration.

Visit Activity Overview

The visit register covers ten completed visits between June and August 2026. These visits generated 135 findings, which are summarised within this report. It does not reproduce the full underlying visit feedback or follow-up records because the granular detail may include information about individual colleagues, local circumstances or matters requiring confidential handling. The detailed assurance mapping and supporting evidence can be provided to Board members where required through an appropriate confidential route.

Thematic Assurance Analysis

Communication and engagement. Six change communication concerns across six visits indicate a recurring Trust-wide signal. Colleagues and local managers reported that they did not always receive timely information or understand how their feedback affects decisions. Operational triangulation and visible feedback loops are required.

Colleague voice. Five findings across five visits show strong local openness in places, but reduced confidence that feedback influences wider decisions. This is particularly evident in Adult Community Dietetics, where colleagues provided evidence about the

specialist administration service but did not feel it had been fully understood or acted on during the administration review. The concern is therefore not only whether colleagues were consulted, but whether their operational evidence influenced the proposal and whether the Trust can demonstrate what changed as a result. Further assurance should show that colleagues know how to raise concerns, that specialist knowledge is considered before decisions are made and that feedback loops are visibly closed.

Workforce. Fifteen findings across seven visits make workforce capacity the strongest recurring risk. Capacity, skill mix, maternity and bank cover, administration support, retention and workforce planning for population growth require coordinated oversight and evidence of impact on patient care. The Adult Community Dietetics administration review illustrates the risk of treating administrative capacity as separate from clinical delivery. West Kent Community Nursing adds evidence concerning deferred visits and the effect of staffing shortages on safe, timely and relational care.

Quality. Positive clinical effectiveness evidence appears across six visits, including improved access and responsive care. This is balanced by hidden waits, deferred visits and continuity concerns. Two separate issues also required Immediate Escalation. The first relates to a gap in the commissioned pathway for children under eight with avoidant or restrictive eating needs. As the ICB owns the commissioning response, the Trust should formally raise the gap and monitor any related risk within its own services. The second relates to a reported medicines-policy issue affecting access to anaphylaxis treatment. This requires prompt review within the Trust, with appropriate interim controls. Both issues require clear ownership, agreed action and an assurance trail through to resolution.

Estates. Office, parking, shared premises and infrastructure constraints appear across three visits and may worsen with population growth. Further assurance is required on responsibilities, impact assessment, investment planning and the effect on access, productivity and colleague wellbeing.

Digital. Eleven findings across seven visits show both material benefits and stalled delivery. Automation and digital working have released colleague time and reduced paper in some services. Unsuitable systems, poor connectivity, equipment constraints, a rigid bank-booking process and delayed development continue to add burden elsewhere. Benefits realisation and user impact require validation.

Flow and discharge. Multidisciplinary working, smooth transfers and reported reductions in acute admissions provide positive evidence. Fragmented pathways, hidden waits and inconsistent information transfer weaken assurance and require triangulation with pathway and performance information.

Organisational culture. Supportive local teams, trusted leadership and psychological safety are repeated strengths. These sit alongside concerns about risk aversion, delayed decisions, change communication, speaking-up confidence and whether colleagues feel heard beyond their immediate teams. The assurance question is whether the Trust can

retain necessary controls while giving capable managers clearer permission to act, test improvements and resolve local problems without avoidable delay.

Good Practice Spotlight

- Supportive team cultures, safeguarding and home-visit safety, patient-led care and strong multidisciplinary working should be shared through established learning and improvement routes. Examples include trusted local leadership in Faversham Dental Service, strong safeguarding practice in Dartford Health Visiting and responsive joint working in Adult Community Dietetics and the Ashford Single Point of Access.
- The specialist administration model in Adult Community Dietetics should be considered by other suitable services because it supports triage, patient navigation, cross-cover and efficient use of clinical time. Podiatry's partnership working with acute, integrated care and mental health colleagues also provides a model that may strengthen pathways elsewhere.
- Dartford Health Visiting's use of a culturally representative workforce and colleagues lived experience to build trust with local communities has wider organisational value. Any spread should be planned with a named owner, clear objectives and consideration of how the approach can be adapted to different communities.
- Digital bots, Sunday dental clinics, reported reductions in acute admissions, waiting-list recovery and self-management approaches show potential benefits. Before wider adoption, the Trust should confirm the baseline, outcomes, cost, colleague impact and sustainability so that promising local practice is supported by reliable evidence.

Supporting the spread of learning. The Board is invited to consider whether a more systematic approach could help positive practice be shared beyond individual services. Good practice could be recorded as Share, Adopt, Scale or Evaluate, with a named owner, route and intended outcome. Committees could then receive assurance on whether learning has been tested elsewhere, what benefit was achieved and where wider adoption was not appropriate. This could help service visits provide a practical route for sharing innovation and good practice across the Trust.

Emerging Risks and Issues for Board Attention

- **Commissioned pathway gap:** The ICB owns the response for children under eight with avoidant or restrictive eating needs. The Trust should raise the gap and monitor any patient risk within its services.
- **Medicines policy and patient safety:** Confirm immediate controls and policy action for the reported restriction affecting access to anaphylaxis treatment for colleagues administering insulin.
- **Workforce resilience:** Recurring pressures across seven visits include capacity, skill mix, maternity and bank cover, retention, administrative support and business-continuity concerns.

- **Change communication and colleague voice:** Colleagues do not always receive timely information or see how their evidence affects decisions. The Adult Community Dietetics administration review remains the clearest example.
- **Antenatal referral controls:** An unresolved referral-timing dispute in Dartford may create safeguarding and allocation risk.
- **Digital and administrative burden:** Stalled automation, clunky clinical records and duplicate reporting may reduce productivity and transfer avoidable work to frontline colleagues.
- **Equipment, estates and North Kent infrastructure:** Transport, parking, office-space and equipment constraints may affect access and productivity, while population growth may outpace workforce and infrastructure plans.
- **Governance and risk controls:** Unclear escalation routes, duplicate reporting and unresolved business-continuity concerns require clear ownership and evidence of closure.
- **Delegated authority and timely local action:** Repeated evidence suggests approval layers, unclear routes and over-reporting can prevent capable managers from acting quickly. The Board should seek assurance that decisions are taken at the lowest safe level, with clear boundaries, proportionate controls and evidence that delays have reduced.

Recommendations

- **Note** the Limited Assurance rating, alongside the balance of positive frontline evidence and recurring organisational concerns.
- **Consider** whether a consolidated update on escalated findings would provide helpful assurance, including accountable owners, actions, timescales, measurable outcomes, management responses and how feedback has been closed with colleagues.
- **Consider** whether regular “We said, you did” updates on the staff intranet could help demonstrate the feedback received, action taken, accountable owner, progress and outcome, while protecting confidentiality.
- **Consider** whether a more systematic approach to sharing, adopting, scaling and evaluating proven good practice would be helpful, including named ownership and evidence of benefit.
- **Consider** whether a focused project could explore how greater local autonomy and accountable decision-making might reduce approval layers, duplicate reporting and administrative burden. The project could test clearer decision boundaries, proportionate controls and practical support for teams, while continuing to protect patient safety and statutory accountability. Measures could include whether decisions are made more quickly, colleagues have more time for care and successful local improvements are easier to share.
- **Consider** the remaining assurance gaps and themes that may benefit from further triangulation.

Conclusion

- **Overall assurance:** The available evidence supports a Limited Assurance rating.
- **Main strengths:** The visits highlighted patient focus, supportive team cultures, improved access, partnership working, safeguarding expertise and practical innovation.
- **Areas for further assurance:** These include workforce capacity, change communication, pathway gaps, deferred visits, the medicines-policy issue, digital and administrative constraints, equipment and infrastructure pressures.
- **Organisational learning:** The Board is invited to consider how strong local practice could be shared more consistently and how recurring concerns could be supported by named ownership, clear action and visible feedback to colleagues.
- **Future focus:** The Board may wish to consider continued monitoring of recurring themes, validation of reported benefits, assurance from the Integrated Care Board on the commissioned pathway gap and monitoring of any related risk within Trust services. Future visits could also include more observation, shadowing and triangulation with service-user insight where appropriate.

Chief Executive Officer Report – September 2026

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

1. Introduction

This report provides a high-level summary of key developments since our last Board meeting in July. It includes updates and alignment to system working and is structured by our *We Care Strategy* four ambitions, focusing on progress made against our six corporate projects and five refreshed 2026/27 breakthrough objectives.

2. National, regional and system alignment

2.1 Kent and Medway Provider Alliance

Since my last report, further progress has been made in establishing the Kent and Medway Provider Alliance. Recruitment is now underway for a chief executive to lead the Alliance, alongside two Managing Director roles to lead the Acute and Neighbourhood Collaboratives. This marks an important step in moving the Alliance from its development phase into a more formal delivery model, with dedicated leadership to drive system priorities and enhance collective accountability across partner organisations.

The creation of dedicated leadership roles for the collaboratives reflects the increasing importance of neighbourhood health within the wider Kent and Medway transformation programme. It also provides greater capacity and focus to drive delivery at scale while enabling provider chief executives to maintain their focus on leading their organisations and contributing to system-wide priorities through the Alliance.

2.2 Responding to the ICB's commissioning intentions

Over recent months, NHS Kent and Medway has been engaging extensively with partners on its future commissioning intentions, setting out how health and care services may be commissioned and delivered in future. The proposals are structured around the four layers of care model - acute, single neighbourhood, multi-neighbourhood and primary care. The overall ambition is to improve population health, reduce inequalities, strengthen prevention and increase the delivery of joined-up care closer to home.

KCHFT submitted a detailed organisational response to the draft commissioning intentions. The ICB welcomed our feedback and recognised the strong alignment between the ambitions of the transformation programme and our *We Care* strategy. They particularly noted our focus on prevention, neighbourhood health, integrated multidisciplinary working and delivering more care closer to home.

The ICB also acknowledged the importance of the issues we raised regarding the pace of transformation, the need for sufficient investment and capacity in community services, reducing variation across Kent and Medway, and ensuring resources are aligned to clinical priorities and population need.

In addition, they welcomed our support for the proposed alliance and joint committee arrangements, recognising the importance of continued partnership working across the system to improve outcomes for local people. I would like to thank colleagues across the organisation who contributed to the development of our response, ensuring that the views and expertise of community services were strongly represented.

2.3 Review of all-age mental health, learning disability, autism and ADHD

Alongside this work, the ICB has announced an independent review of all-age mental health, learning disability, autism and ADHD services across Kent and Medway. The review will examine how services are commissioned and delivered across the four layers of care, assess whether current arrangements are achieving the outcomes people need and consider how services can best meet future demand. KCHFT has been involved in shaping the scope of the review and we will continue to work closely with partners, people with lived experience and local communities as this work progresses.

3. Trust updates

3.1 Changes to Executive Team

We welcome Dr Sarah Phillips back to KCHFT, who has returned to the trust as our Chief Medical Officer, following her secondment to a neighbourhood health role, with Dr Afifa Qazi returning to her sole role with Kent and Medway Mental Health Trust. I would like to thank Dr Qazi for her efforts in the past year and thank Sarah, for all her hard work on the neighbourhood health pilot in Folkestone and Hythe, which has already shown promising results for our communities on the south Kent coast.

3.2 Recent serious incidents related to water shortages in Kent

I want to thank our Emergency Preparedness and Response Team, and many others in our operational teams, for the swift actions taken in response to several serious incidences this summer of low or no water supply to some of our patients and sites. As a result of their coordinated response and close liaison with the water companies we were able to keep our patients safe and well, including in our community hospitals.

3.3 Care Quality Commission inspections at West View Integrated Care Centre and Victoria Hospital, Deal

The Care Quality Commission (CQC) undertook a comprehensive assessment of West View Rehabilitation Unit on 30 June and 1 July 2026, reviewing 34 quality statements across the Safe, Effective, Caring, Responsive and Well-Led domains. CQC also conducted this inspection under their new hybrid approach and piloted the draft sector-specific framework, which we consented to.

The full report is expected within 85 days, in-line with usual reporting timescales. However, initial verbal feedback from the inspection team is positive, highlighting the perfect ward is developing a positive enablement culture for patients. The inspection team observed that patients are treated with kindness, dignity and respect, and engage positively with therapy activities. Both patients and staff raised concerns around staffing levels, which are perceived to be too low, including nursing and therapy staff. Staff rotas and skills mixing will be explored further to determine effective staffing levels on the ward.

Learning from the CQC inspection has already been shared across all community hospital inpatient units, to support consistency, standardisation of processes, and the delivery of safe, effective and person-centred care. The CQC announced an inspection of the inpatient ward at Victoria Hospital, Deal, on Tuesday 2 September. We expect a third inpatient site to be confirmed for inspection shortly.

3.4 Preparing for winter and flu

We have submitted our winter plan to the Integrated Care Board, setting out how we will maintain safe, timely and effective services during the period of greatest seasonal pressure. The plan focuses on ensuring resilience across urgent community response, hospital discharge and admission avoidance services, supporting system flow, protecting capacity in our community services, and working closely with acute, primary care and social care partners to meet increased demand over the winter months.

We are also starting our staff flu vaccination campaign to help protect colleagues and patients this winter. From 1 October, colleagues will be able to receive their vaccination from a team peer vaccinator, at a community clinic or through a local pharmacy using the NHS App. We are encouraging registered healthcare professionals with the appropriate training and manager support to volunteer as flu peer vaccinators.

3.5 Advanced Foundation Trust status

KCHFT is being considered for inclusion in wave two of advanced foundation trust status. This reflects the sustained progress we have made in strengthening our operational performance and organisational maturity, as well as our ability to deliver consistently for patients and partners. This development represents an important milestone in our ambition to operate with greater autonomy while continuing to demonstrate strong accountability and system leadership.

3.6 Listening to and involving communities

We have developed a communications and engagement strategy to support our community services transformation plan. It draws on insight from NHS Kent and Medway's What Matters Most programme, engagement on commissioning intentions, service-specific activity, patient experience, complaints and feedback, colleague engagement and improvement work, and Healthwatch and voluntary, community and social enterprise organisations. The strategy also complements NHS Kent and Medway's 18-month plan for involving people and communities.

4. Progress against our We care strategy

4.1 Putting communities first

4.1.1 Integration with Medway Community Healthcare: Stronger together

The planned integration of KCHFT and Medway Community Healthcare remains on track for Thursday, 1 October 2026, following approval of the business case by NHS England and

continued engagement with colleagues throughout the consultation period. Planning has focused on maintaining continuity of services for patients, establishing future leadership arrangements and supporting colleagues through the transition. Alongside several online webinars, we have planned two days of in-person welcome events for colleagues joining the trust.

I would like to commend colleagues across both organisations for the substantial work taking place behind the scenes to support a safe and successful integration. We all recognise the importance of maintaining high-quality services and positive experiences for patients throughout this period of change.

4.1.2 Embedding Neighbourhood Health

We are preparing to consult colleagues on proposals to align services more closely with neighbourhood footprints. As part of this shift, we will also recruiting four practising GPs as Medical Directors across multi-neighbourhoods, strengthening local clinical leadership and helping to ensure decisions are made as close as possible to the populations we serve.

This work is focused on providing more care closer to home, strengthening multidisciplinary working and improving population health outcomes through closer collaboration between health, care and community services.

Last week, the Government announced that the local government reorganisation (LGR) in Kent and Medway – alongside other councils across the country – is to be paused pending a review. We will maintain a close watch on developments and consider any emerging implications for KCHFT, as our plans for neighbourhood health develop.

National pioneer site in Folkestone and Hythe

The Folkestone, Hythe and Romney Marsh Neighbourhood Health Pioneer, has continued to move from planning into delivery during July and August 2026, testing how health, care and voluntary sector partners can work as a single neighbourhood team around local communities. Key developments include, the expansion of a multidisciplinary Neighbourhood Health Team providing hospital-level care at home for frail and housebound patients, the use of proactive population health approaches to identify and support people at risk of deteriorating health before they reach crisis point, and work in Romney Marsh to improve access to outpatient services, earlier diagnosis and coordinated care closer to home.

Early indications show the programme is having an impact on reducing hospital admissions for patients in the 10/11+ patient need groups (PNGs), of around nine per cent since the beginning of April. The pioneer site is now generating practical learning for the wider Kent and Medway system on integrated working, prevention, community-based care and reducing avoidable hospital admissions, helping to shape the future neighbourhood health model across the county.

I also welcome the collaborative approach being taken by East Kent GP Confederation and system partners as we continue to develop neighbourhood health services across east Kent. Recent discussions highlighted strong enthusiasm for working together across primary care, community services, hospices, urgent care and hospital services to design more integrated models of care. This partnership approach is essential if we are to deliver the ambitions of

neighbourhood health, improve experience for patients and help more people receive the right care, in the right place, at the right time.

4.1.3 WorkWell

Preparations are progressing for the launch of WorkWell across Kent and Medway in November 2026. This is a new KCHFT-led service, which will provide support for people whose health is affecting their ability to stay in work, return after sickness absence or move towards employment. The programme reflects the system's commitment to prevention and tackling health inequalities by offering early support before health and employment difficulties become more serious. We are working closely with local health, employment and community partners to develop referral routes and make sure the service meets the needs of local people, communities and employers.

4.2 Sustainable care

4.2.1 Financial position and productivity

Financial and productivity performance remains strong. The trust is reporting a year-to-date surplus of £57k at the end of July while delivering activity at 108.2 per cent of plan. External agency expenditure for July remains exceptionally low at 0.1 per cent of pay costs and year-to-date external agency expenditure is £4k under-plan, however staff bank spend year-to-date is currently £625k above the year-to-date plan.

Our Cost Improvement Programme (CIP) delivery is £49,000 ahead of target with total savings for the full-year forecast to be £20.255m, in line with the plan, demonstrating continued focus on financial sustainability alongside high levels of service delivery.

4.2.2 Automation

In August, our Agentic Process Automation (APA) bank approval agent was shortlisted for an HSJ Award in the Using AI to enhance care quality and efficiency category. Developed in six weeks by colleagues from our people and digital teams, the automation supports fair and consistent decisions on bank duty requests. It is expected to deliver around £2 million in annual savings and has contributed to a 25 per cent reduction in bank duties worked each month. The shortlist is further national recognition for our growing use of automation and AI to improve efficiency and reduce administrative burden, building on previous award success and interest from NHS England.

4.3 Better patient experience

4.3.1 Strengthening partnership working

During August, Executive Teams from KCHFT and East Kent Hospitals University NHS Foundation Trust met to review shared priorities around patient flow, intermediate care and reducing avoidable hospital stays. Discussions focused on how community, acute and wider system partners can work together to support more people to receive care closer to home while improving outcomes and experiences for patients. The meeting reinforced a shared commitment to developing sustainable solutions that improve access to care and support the wider neighbourhood health agenda.

The discussion also considered opportunities to strengthen joint planning and the use of data to support decision-making across organisational boundaries. Both organisations agreed the importance of a consistent understanding of demand, capacity and patient pathways as work continues to develop intermediate care services and support the Kent and Medway ambition to shift care from hospital settings into community-based models wherever appropriate.

4.3.2 Transforming intermediate care

We are committed to supporting our acute partners to eradicate corridor care, recognising our shared responsibility for the care of Kent and Medway residents. Home First continued to perform strongly, reducing waiting times for Pathway 1 patients. During the first half of quarter two, the service supported more than 600 patients and delivered 16,768 appointments. The average length of stay was just over 14 days.

West Kent Home First has progressed to a seven-day model and east Kent is strengthening capacity through successful recruitment of five band 4 assessors and two band 5 senior assessors, alongside ongoing recruitment and onboarding of 34 band 3 support workers. The programme is supporting more people to remain independent, with the percentage of patients who are self-managing on discharge showing encouraging progress across both localities and is contributing to a reduction in the number of patients waiting for Pathway 1 and Pathway 2 support.

The perfect ward seven-day therapy programme at West View also remains on track, with therapy team lead and assistant roles fully recruited, discharge co-ordinators appointed and the seven-day therapy model expected to be fully rostered by September. Early implementation of improved discharge processes, trusted assessor arrangements and enhanced therapy capacity is helping to improve patient flow, reduce delays and strengthen transfer of care arrangements across the system.

4.3.3 Engaging on our new frailty strategy and next steps for frailty services

We are working with colleagues to develop a new strategy for supporting people with frailty in the community, with the overall aim of reducing demand on acute hospitals and allowing people in our community to live and die well, through earlier identification of frailty, proactive care planning and care aligned to their wishes. We carried out seven staff engagement sessions, attended by 227 colleagues and we will continue to test our approach with colleagues, patients, carers and stakeholders.

Alongside this, we have been working with adult rehabilitation services to design and facilitate engagement focus groups for members of the public, along with their friends and carers, to build understanding of our home treatment services and gather feedback on our approach to shifting care away from hospital to community.

We are planning a conference in October for stakeholders, GPs, acute sector partners, care home managers and other partners, to showcase the investment already made in services specifically designed to support frail elderly people to stay at home, for example our home treatment services, Home First and the clinical navigations hubs in east and west Kent.

5. A great place to work

5.1 Building our future culture

NHS England's six staff standards set clear expectations for a positive and consistent colleague experience, including supportive line management, health and wellbeing, preventing violence, championing sexual safety, tackling racism and promoting flexible working. We will assess our position against the standards, identify any gaps and develop an action plan, building on our strong NHS Staff Survey results.

The Building Supportive Teams campaign continues to strengthen how KCHFT supports colleague wellbeing during change. Our recent wellbeing survey received responses from **412 colleagues**, providing a robust and timely snapshot of staff experience. Results show that **68.8 per cent** of respondents said their immediate manager takes a positive interest in their health and wellbeing and **67.9 per cent** felt able to discuss health concerns with their manager, demonstrating a strong foundation of support and openness across teams.

There are also early signs of improvement in presenteeism. However, workforce pressures remain evident, with **51.4 per cent** reporting feelings of burnout and only **42.8 per cent** feeling prepared for the year ahead. We will continue our focus on energy and recovery, supporting teams to have open conversations about working preferences, breaks and practical recovery habits that can help sustain wellbeing and reduce the risk of burnout.

5.2 NHS People Portal

As an early adopter organisation, we're playing an important role in testing, influencing and preparing for the new NHS workforce solution 'NHS People Portal', which will eventually replace ESR. This gives us an opportunity to shape the solution before its wider NHS rollout, using colleagues' experience to help make sure it works well in practice. We are now planning, improving data quality, reviewing workforce processes and preparing for implementation with Kent and Medway partners and the national programme team. KCHFT is expected to go live between February and March 2028.

5.3 Our flo fit challenge

Our 2026 flo fit Big 50 challenge ended in July, which saw approximately 450 colleagues walking, running, cycling and swimming 68,230 miles in 50 days. Flo fit is available all year round, to help boost colleague wellbeing, build connections and create a sense of team spirit.

5.4 Long service awards 2026

More than 780 digital long service certificates were sent out in August to colleagues celebrating a career milestone in 2025-26. The awards recognise colleagues who reach their five, 10, 15, 20, 25, 30, 35, 40, 45 or 50-year continuous NHS service milestone while working at KCHFT. A special celebration event will take place this September for colleagues who have reached 15-plus years of service.

5.5 Executive Team visits

In the first part of Q2, myself and other members of the Executive Team visited these services:

- IMSK physiotherapy
- East Kent respiratory
- Frailty
- HIV pharmacy
- Quality management
- Frequent user service
- Gravesend health visiting
- Orthopaedics
- East Sussex school health
- Looked-after children

Themes from these visits suggest our colleagues demonstrate a commitment to patient-centred care, with many teams receiving positive feedback from patients and families about the quality, compassion and professionalism of the care they provide. Executives observed highly engaged, resilient and supportive teams, with strong local leadership and a positive culture of collaboration.

Many services show a culture of innovation and continuous improvement, using quality improvement methodologies to reduce waiting times, redesign pathways and improve efficiency. There was a strong sense of pride in delivering excellent patient outcomes and confidence in the expertise and experience of the workforce.

However, colleagues are still sharing concerns about workforce pressures, including vacancies, recruitment challenges, sickness absence and retention issues. Uncertainty about the wider organisational strategy, neighbourhood health developments and future service structures was a recurring theme, alongside frustrations relating to estates, transport, parking, equipment availability and administrative burdens that reduce clinical time.

Across all services, there is a clear appetite for change and improvement, with teams identifying opportunities to strengthen communication around strategic priorities, invest in workforce development, succession planning and leadership capability, and continue to develop innovative ways of working that improve care for local people, themes which align well with our plans for transforming community services.

As always, the details in this report are only a snapshot of the work taking place across the trust to look after patients, carers and communities.

A huge thank you to all my colleagues.

Mairead McCormick
Chief Executive

Front Sheet – Board Assurance Framework

This paper aims to ensure that the Trust Board is well-informed about the current risk environment, fostering a proactive approach to risk management and organisational resilience.

Meeting:	Board Meeting - Part 1 (Public)
Date of meeting:	16 September 2026
Agenda item no:	Item 8
Report title:	Board Assurance Framework
Executive sponsor(s):	Tony Saroy, Interim Trust Secretary
Report author(s):	Daryl Judges, Deputy Trust Secretary
Action this paper is for:	Approval
Public/non-public	Public

Executive summary

Overview of paper:

This paper provides an update to the Board on the Board Assurance Framework (BAF).

Risk Appetite Statement:

The revised BAF, which was approved by the Board on 15 April 2026, has been refreshed to align with the Trust's breakthrough objectives, and informed by the December 2025 Board Development Risk Appetite Session. The revised approach confirms the Trust's risk appetite, updates risk formulation, and defines a focused set of strategic risks covering delivery, quality, sustainability, governance, workforce, digital resilience, and system collaboration.

As part of the BAF reporting cycle the Key Risk Indicators (KRIs) have been updated to reflect the latest information reported through the Trust's governance structure, and meetings have been held with each of the Executive Risk Owners, to update the controls, assurances, and provide a 'check and challenge' of the KRIs.

The Board is requested to review the totality of the risk profile, taking assurance from the sub-committee review process, with a specific focus on whether the controls are sufficient, and whether the actions outlined to close the control gaps are appropriate, or whether any additional actions are required.

The content of the "Fail to ensure we implement secure, cost effective, and innovative digital solutions that are fit for the future (incl. automation and AI, while protecting against cyber threats)" risk has been omitted, for security reasons; however, the full details are available to Board members within the Diligent Library.

The Board is requested to consider whether any of the risks should be moved to a 'watch metric' position, noting that all risks with a consequence score of 5 should continue to be actively monitored due to the disproportionate impact of the risk if it materialised.

Items of concern

The Risk Management Policy is currently going through the Trust's governance structure for sign-off is required to ensure the embedding of the Trust's risk management approach across the organisation. The programme of work is expected to be completed by the end of September 2026, with a reasonable confidence level that this will be achieved.

Significant improvements in previous areas of concern:

The Risk Management e-learning package has been scheduled for discussion at the Training Quality Assurance Group (TQAG) on 15 September 2026, following completion of the necessary governance documentation. Once considered at TQAG the training package will be notified to the Education Group and subsequently 'go live' on the Trust's e-learning system.

The 'go live' is anticipated to coincide with the integration with Medway Community Healthcare (MCH), to ensure those staff joining the Trust are informed of the Trust's approach to risk management and risk formulation.

Items of excellence:

The BAF has supported active engagement at the Board sub-committee meetings, with Committee's conducting in-depth reviews into specific risk entries and encouraging the controls and assurances which have been provided, to seek assurance that the control environment remains robust.

Following discussions at the Executive Team Meeting, the following enhancements have been made:

- Addition of each of the domains to start of the risk in the "Summary Overview" to aid accessibility and expedite identification of the risk concerned within discussions.
- Alternating colour schemes for each of the risk pages, to support transition between risks.
- Review, and amendment, of the "KCHFT'S Risk Story" section, to reflect the findings of the CQC Well-led Board Development session.

There continues to be monthly meetings with each of the executive risk owners to ensure that the information provided represents a 'live' position.

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

- People Committee 26 August 2026
- Quality Committee 3 September 2026
- Executive Team Meeting 8 September 2026

Recommendation(s)

The Board is asked to **Approve** the report

Link to CQC domain

☐ Safe ☐ Effective ☐ Caring ☐ Responsive ☒ Well-led

Assurance level

Reasonable

Rationale for Assurance level

The amendments to the strategic risks have been informed through triangulation of information submitted to the Board and Board Sub-Committees. The amendments were subsequently reviewed and refined with Executive Risk Owners.

Implications

Links to BAF risks / CRR	☒ BAF	☐ CRR
Equity, diversity and inclusion	No	
Legal and regulatory	Yes. Reflects expectations set out within the Well led domain of the CQC single assessment framework, including governance, risk management, and oversight	

Executive sponsors sign off
Tony Saroy, Interim Trust Secretary
Date: 08 September 2026

Board Assurance Framework

Tony Saroy
Interim Trust Secretary



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KCHFT'S Risk Story

The Trust is translating the 10 year plan into a local working model and changing how care is delivered while still keeping patients safe every day as we transition. This is challenging because the NHS is under pressure from major restructuring, extremely stretched finances, and workforce challenges including industrial action. One of the biggest risks is not having enough staff capacity and capability to provide safe and reliable care.

At the same time, financial pressures across the whole health system limit how quickly services can improve or invest in new ways of working. The Trust also relies on strong partnerships with other organisations, but shared pressures can slow progress and make decisions harder. Digital systems can make care better and more efficient, but old technology and the risk of cyber-attacks create new challenges.

During periods of major change, there is a real risk that quality of care or patient experience could be impacted if it is not carefully monitored. Strong leadership and clear governance are therefore essential to keep the organisation focused on what matters most. The Trust closely tracks these risks (as detailed within this BAF report) and puts plans in place to reduce them over time.

Maintaining a positive culture throughout change is equally important. The Trust must continue to promote inclusion, psychological safety and speaking up, ensuring that staff, patient and partner feedback is translated into visible action and improvement. The organisation must also ensure that performance intelligence, audit findings, patient experience information and learning from incidents are consistently used to inform decisions and drive measurable benefits

Overall, the main challenge is one of balancing transformation and innovation with the continued delivery of safe, high-quality services, whilst demonstrating through evidence that strong governance, effective leadership and collaborative working are achieving better outcomes for the populations it serves.

Executive Summary (1) - Purpose

- The Board Assurance Framework (BAF) enables the Board to identify and understand the principal risks to achieving its strategic objectives; receive assurance that suitable controls are in place to manage these risks and where improvements are required, action plans are in place and are being delivered to reduce the control gaps; provide an assessment of the risk to achieving the objectives based on the strength of controls and assurances in place (risk rating)
- The BAF details the controls in place to mitigate each risk, any gap in control, assurance of the controls' effectiveness, the actions planned and being executed together with the date by when the actions are due to be completed. Each action on the BAF is allocated a status update to illustrate whether it is on-track, off-track, delayed due to external factors, suspended, overdue or completed. This enables actions that have either breached their initial target completion date or are considered unachievable to be identified more readily, and enables action owners to be held to account.
- The BAF includes positive and negative key risk indicators, which are triangulated via the various Committee and Board reports, and performance within the Integrated Performance Report, to illustrate whether the risk to the Trust has increased or decreased within the reporting period.
- The BAF details any emerging risks which have been identified, to enable monitoring and escalation in the event the risk becomes material to the Trust.

Executive Summary (2) – Reformulated Risks

- The Trust's principal risks have been reformulated from the “if”, “then”, “resulting in”, approach to a causes and effect approach, which enables the identification of multiple contributory factors and outcomes to the overall risk, with an individual cause potentially leading to more than one effect. The revised approach also enables improved targeting of controls and actions to reduce any control gaps.
- As this the first iteration, all risks have been escalated. In future iterations the Executive Summary will be populated with the changes within the reporting period, which will include changes in ratings, those risks that have been moved to a ‘watch’ status; and any areas of concern or excellence which require the Board's attention
- The Board are asked to review the controls, assurances and risk ratings, and confirm that these accord with the Board's understanding of the wider operating environment.
- The Board is also requested to review the emerging risks which have been identified, and determine whether there is:
 - a) Any omissions
 - b) Whether any emerging risks should be escalated into formal entries on either the Corporate Risk Register or the BAF

Risk Appetite Parameters

Transformational: Higher levels of risk are acceptable where the potential benefits are substantial, mitigations are appropriate, consistently applied and alignment with long-term strategic objectives is clear.

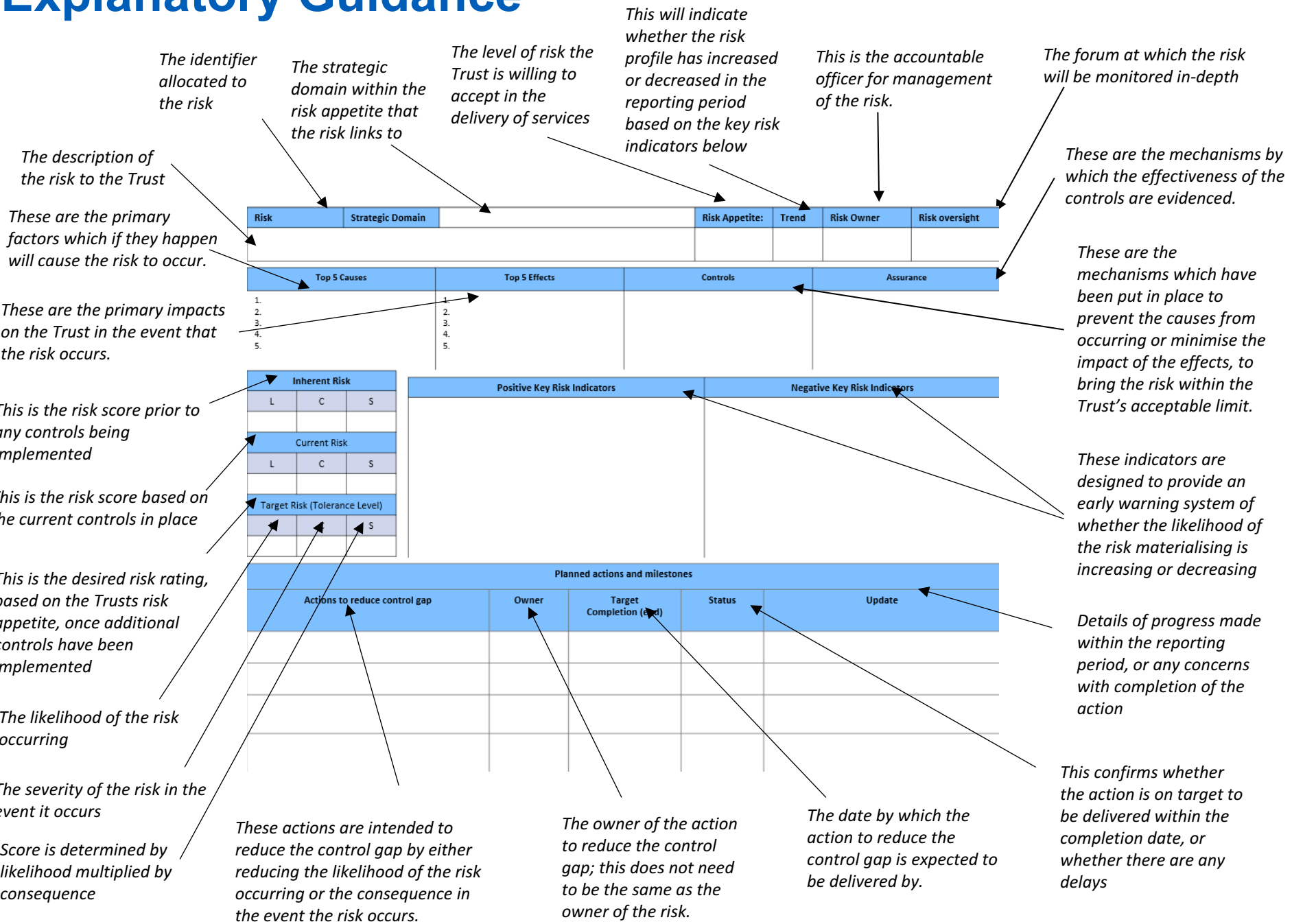
Progressive: Higher levels of risk are acceptable where benefits are clear, mitigations are appropriate, and alignment with strategic objectives is maintained.

Moderate: We are willing to accept moderate risk where there is compelling evidence of benefit and appropriate mitigation measures in place supported by strong governance.

Limited: We take a cautious approach, accepting only low levels of risk. Any risk must be well understood, tightly controlled, and supported by strong assurance..

Averse: We adopt an extremely cautious stance, Any exposure is tolerated only when unavoidable and subject to rigorous controls.

Explanatory Guidance



Summary overview

Risk ID	Risk	Primary assurance forum	Current risk rating	Risk Appetite (Max rating)	Target risk rating	Trend
6962	Quality and Safety: Fail to ensure consistent delivery of high quality, safe care and positive patient experience during times of organisational transition, financial constraint, and workforce challenge	Quality Committee	15	Moderate (9)	10	
6961	Governance: Fail to ensure we maintain appropriate governance and clarity of purpose during a period of significant change, avoiding disruption to our core mission to deliver safe, evidence-based care and improve population health outcomes	Audit and Risk Committee	12	Moderate (9)	6	
6960	Financial Sustainability and Strategic Investment: Fail to ensure we manage our finances effectively to deliver transformation, improve quality, and invest in neighbourhood health, while responding to system wide financial instability and increasing efficiency demands	FBI Committee	12	Moderate → Progressive (12)	8	
6958	Collaboration and System Influence: Fail to ensure we maintain strong partnerships and influence within the ICS and wider health and social care network, limiting our ability to lead on community transformation	Trust Board	12	Transformational (16)	9	
6955	Agility and System Adaptation: Fail to ensure we can adapt to significant external changes while continuing to deliver safe, high-quality care and progress towards population health objectives	Trust Board	9	Progressive (12)	4	
6956	Capability, Leadership and Workforce Resilience: Fail to ensure we have the leadership continuity, workforce capacity and right skills mix to deliver our vision for neighbourhood health, transformation, and innovation while maintaining staff wellbeing and engagement	People Committee	12	Moderate → Progressive (12)	12	
6957	Capacity and Operational Delivery: Fail to ensure we can adapt to significant external changes while continuing to deliver safe, high-quality care and progress towards population health objectives	People Committee	12	Progressive → Transformational (16)	12	
6959	Digital Technology and Cyber Resilience: Fail to ensure we implement secure, cost effective, and innovative digital solutions that are fit for the future. (incl. automation and AI, while protecting against cyber threats)	FBI Committee	10	Progressive (Averse on Cyber) (12)	10	

In-depth overview of risks



Risk : ID 6962		Strategic Domain:		Quality and Safety		Risk Appetite:	Trend	Risk Owner	Risk oversight
Fail to ensure consistent delivery of high quality, safe care and positive patient experience during times of organisational transition, financial constraint, and workforce challenge						Moderate		Chief Nurse	Quality Committee
Top 5 Causes			Top 5 Effects		Controls			Assurance	
1. Competing demands and priorities on acute and community services plus potential digital disruption 2. Workforce challenges 3. Pathway reconfiguration increasing handover risk 4. Productivity drive outpacing safe change capacity 5. Underperformance/constraints in partner providers shifting demand			1. Patient harm/never events and reducing patient outcomes 2. Patient access & flow deterioration 3. CQC rating risk, potential reduction in segmentation score, and morale impact 4. Complaints/claims impacting on patient experience & external scrutiny 5. Inequalities widen if vulnerable groups impacted		Continuous improvement process Regular training of staff on clinical best practice Quality Impact Assessments in line with developing workforce safeguards Early warning system through the assurance programme which identifies issues Active recruitment pipeline to address clinical role shortages Multidisciplinary working to ensure service continuity in times of organisational change			• Six-monthly safer staffing review • Review of staff training compliance • Oversight by Quality Committee and People Committee of learning and development • Clinical governance oversight of patient themes and trends, with develop on robust action plans • SBAR established for clinical and nursing competencies • Patient experience survey	
Inherent Risk			Positive Key Risk Indicators				Negative Key Risk Indicators		
L	C	S	- Sustained achievement of key quality, safety and performance indicators during periods of organisational change and service transition - Improvement in access, waiting time and operational performance measures - Positive assurance regarding safer staffing arrangements, workforce deployment and oversight - Reduction in workforce vacancy and turnover rates, supporting continuity of care and organisational stability during periods of change. - Positive internal audit, quality and governance assurance indicating that risk management, clinical governance and control arrangements remain effective during transition - Maintenance of patient safety standards, with incidents and emerging risks managed effectively				- Escalation in staffing pressures requiring increased reliance on temporary staffing, enhanced observations, service restrictions or other mitigating controls - Financial pressures, cost improvement requirements or resource constraints creating challenges in maintaining quality, safety and patient experience standards - Increased patient flow pressures, discharge delays or system capacity issues adversely impacting service performance and patient experience - Growth in the number of quality, safety or workforce risks requiring escalation to corporate risk registers, committees or the Board.		
5	5	25							
Current Risk									
L	C	S							
3	5	15							
Target Risk (Tolerance Level)									
L	C	S							
2	5	10							
Planned actions and milestones									
Actions to reduce control gap			Owner	Target Completion (end)	Status	Update			
Roll out of early warning system as a trial in the Adults Directorate			Samuel Owiredo	September 2026	On track	Oversight by Quality Committee			
Procurement of external core services review and response to findings			Caroline Bates	August 2026	Complete	The programme of work was suspended due to active CQC inspections which will provide the findings that would be captured as part of the core services review			
Further in-depth review of the data quality gaps regarding ‘Delayed and Missed Visits’ to determine any impact on patient harm and outcomes			Harriet Barker	October 2026	On track	Community Nursing Deferred Visits Improvement Steering group stood up, meeting monthly with relevant stakeholders to improve data capture and quality and to align RAG rating across KCHFT/MCH ahead of 1 st October			
Embedding of continued learning from clinical audit and continuous improvement work to improve quality and standards of care.			Michelle Gatehouse	November 2026	On track	Clinical audit policy reviewed setting out clearer responsibility for divisions to have overview of clinical audit assurance and follow up actions. Divisional reports now embedded into CEG agenda which gives divisional opportunity to triangulate performance and outcomes with Audit and Quality Improvement			

Risk : ID 6961		Strategic Domain:		Governance		Risk Appetite:	Trend	Risk Owner	Risk oversight						
Fail to ensure we maintain appropriate governance and clarity of purpose during a period of significant change, avoiding disruption to our core mission to deliver safe, evidence-based care and improve population health outcomes						Moderate		Deputy Chief Executive	Audit and Risk Committee						
Top 5 Causes			Top 5 Effects		Controls			Assurance							
1. Board distraction by multiple programmes & external demands 2. Assurance dilution—blending strategic assurance with delivery reporting 3. CQC inspection focus diverting capacity 4. Short-termism driven by system FRP and national asks 5. Evolving structures (IHO/INTs) creating decision ambiguity			1. Loss of strategic grip and unclear ownership of risks/outcomes 2. Inconsistent decisions vs risk appetite 3. Paper-heavy assurance that masks exposure 4. Delayed benefits from transformation/INT pilots 5. Staff confusion, reduced engagement and alignment		• Ongoing review of CQC compliance as Business as usual with Ad hoc Active CQC preparation supported by External reviews • Robust but flexible workplan for meeting Board demands as well as Board Development / Seminar workplan with monthly reviews by CEO and Chair • Monthly CIP meeting and weekly CIP meeting with each division • Five-year year to prevent short-termism • Participation in neighbourhood programme Board and mobilising the neighbourhood business case			Regular review of local and national priorities Monthly EPR to ensure Exec and Divisions focused on key risks and deliverables Regular updates to Exec and Board around financial position and the left shift Independent well-led review Oversight of governance arrangements by Audit and Risk Committee							
Inherent Risk			Positive Key Risk Indicators			Negative Key Risk Indicators									
L	C	S	• Strong organisational performance maintained during significant change, with the Trust continuing to perform strongly against national and local measures despite service transitions and integration activity • Delivery of major transformation and integration milestones to agreed timescales, with defined mobilisation workstreams • Positive internal and external assurance opinions provide objective evidence that governance, risk management and control arrangements remain effective • Committee and Board assurance structures continue to operate effectively, with regular escalation of assurance, risk and performance information • Organisational prioritisation remains effective, with Executive oversight confirming capacity is focused on agreed strategic programmes			• Increasing number of concurrent strategic, operational and system-wide change programmes creating organisational pressure • System-wide financial pressures, savings requirements and uncertainty regarding transformation funding • Increased number of strategic or programme risks requiring management • Leadership instability, turnover or reduced organisational capacity across the wider health and care system affecting continuity of decision-making, partnership working and programme delivery. • Evidence that programme complexity, competing priorities or external system change are leading to delayed benefits realisation, reduced strategic focus and competing organisational priorities.									
5	4	20													
Current Risk															
L	C	S													
4	3	12													
Target Risk (Tolerance Level)															
L	C	S													
2	3	6													
Planned actions and milestones															
Actions to reduce control gap									Owner	Target Completion (end)	Status	Update			
Engagement of external compliance experts to identify areas of improvement			Caroline Bates	October 2026	Complete	The programme of work was suspended due to active CQC inspections which will provide the findings that would be captured as part of the core services review									
Maintain shared operational leadership in the approach to the transaction to identify and manage areas of risk to performance			Clare Thomas	October 2026	On track	The Trust is participating in system wide groups to ensure that safe services are maintained in partnership. However, some of the Urgent Care Boards have been paused, with the work being largely co-ordinated through the eliminating Corridor care work and the provider alliance.									

Risk : ID 6960		Strategic Domain:		Financial Sustainability and Strategic Investment		Risk Appetite:	Trend	Risk Owner	Risk oversight
Fail to ensure we manage our finances effectively to deliver transformation, improve quality, and invest in neighbourhood health, while responding to system wide financial instability and increasing efficiency demands.						Moderate → Progressive		Chief Finance Officer	FBI Committee
Top 5 Causes			Top 5 Effects			Controls		Assurance	
1. System deficit limiting investment in new models 2. Funding constraints for estates transformation 3. CIP under-delivery 4. Failure to achieve local incentive payments 5. MCH deteriorating financial position, increased CIP target, and non-currency of CIP			1. Resource shortfalls to deliver strategy 2. Inability to complete estates ambitions 3. Delayed neighbourhood model investment and slower left shift 4. Assurance challenges and risk escalation to Board committees 5. Reduced innovation capacity (digital/workforce/prevention) due to capital and revenue constraints			CIP PMO and weekly monitoring reporting with executive and system oversight Transformational plan development oversight by executive leads Operational scrutiny of KPIs and EPRs to give executive oversight Due diligence on MCH transaction Active engagement with ICB and MCH to ameliorate the position System-wide medium-term plan under development		CIP plan assessed by external review Panel reviewed acceptance of MARS applications Draft transformation plan shared and in feedback loop with ICB KPI assessment under way MCH Due Diligent report Initial month 5 position break-even Completion of provider assurance model	
Inherent Risk			Positive Key Risk Indicators				Negative Key Risk Indicators		
L	C	S	- Delivery of the Trust financial plan whilst maintaining a breakeven position despite significant system-wide financial pressures - Strengthening Cost Improvement Programme (CIP) pipeline, demonstrating increased organisational capability to identify and deliver sustainable efficiencies - Successful delivery of transformation funding and gain-share arrangements supporting service redesign and long-term sustainability - Financial plans supported by robust governance, scrutiny and oversight - Positive external assurance regarding financial management, annual accounts and control arrangements - Increased productivity or efficiency benefits realised through integration, collaboration and service transformation programmes				- Increasing reliance on non-recurrent measures to maintain financial balance, reducing long-term financial sustainability - Significant system deficits and financial instability creating uncertainty regarding future funding, commissioning intentions and investment decisions - Cost Improvement Programme schemes remaining at an early stage of development, increasing delivery risk and reducing confidence in forecast savings - Increasing divergence between organisational financial plans and wider system financial expectations, creating additional financial or operational risk - Delays to transformation funding and system financial recovery programmes impacting delivery of planned improvements		
4	4	16							
Current Risk									
L	C	S							
3	4	12							
Target Risk (Tolerance Level)									
L	C	S							
2	4	8							
Planned actions and milestones									
Actions to reduce control gap			Owner	Target Completion (end)	Status	Update			
Forecasting process for all KPIs that attract local incentive payments			Nick Plummer / Gordon Flack	July 2026	Overdue	Confirmation of approach received from Kent and Medway ICB, awaiting formalisation of KPIs			
Programme Governance of system-wide collaboration to ensure financial recovery of the K&M ICS			Mairead McCormick	30 June 2026	Completed	Joint Committee ToR and system governance on the approved at the July 2026 Public Board meeting. Alliance work programmes agreed as part of governance			
Active discussion at CEO Forum to rebalance the financing of activity delivered by MCH			Gordon Flack / Mairead McCormick	1 September 2026	Overdue	Meeting scheduled for 4 September 2026, mitigation plan developed in the event finances not rebalanced, verbal progress can be reported at Board.			

Risk : ID 6958			Strategic Domain:		Collaboration and System Influence			Risk Appetite:		Trend	Risk Owner		Risk oversight																													
Fail to ensure we maintain strong partnerships and influence within the ICS and wider health and social care network, limiting our ability to lead on community transformation								Transformational			Deputy Chief Executive		Trust Board																													
Top 5 Causes				Top 5 Effects				Controls				Assurance																														
1. Leadership turnover across health/social care 2. Divergent incentives 3. Insufficient mind-set shift for neighbourhood care 4. Ambiguous governance/accountabilities in neighbourhood/INT models 5. Over-emphasis on organisational change vs place outcomes				1. Inability to implement new care models and missed targets 2. Continuation of models that don't meet population needs 3. Resources not used to maximum 4. Left shift stalls; inequalities persist 5. Reduced influence in ICS decisions				• Attendance of the system-wide planning meetings • Active participation in the neighbourhood programme board • Weekly East Kent COO Meetings to identify issues and act promptly • Place-based mobilisation of business cases • Chief Executive SRO for Neighbourhood health pillar				• Learning from NNHIP shared via K&M NH Programme board and National NH programme supporting wider implementation/roll out • Metrics include admission rates for 10/11+ population cohort in Folkestone district, patient reported experience measure and staff engagement measure																														
<table><tr><th colspan="3">Inherent Risk</th></tr><tr><td>L</td><td>C</td><td>S</td></tr><tr><td>5</td><td>5</td><td>25</td></tr><tr><th colspan="3">Current Risk</th></tr><tr><td>L</td><td>C</td><td>S</td></tr><tr><td>3</td><td>4</td><td>12</td></tr><tr><th colspan="3">Target Risk (Tolerance Level)</th></tr><tr><td>L</td><td>C</td><td>S</td></tr><tr><td>3</td><td>3</td><td>9</td></tr></table>				Inherent Risk			L	C	S	5	5	25	Current Risk			L	C	S	3	4	12	Target Risk (Tolerance Level)			L	C	S	3	3	9	Positive Key Risk Indicators				Negative Key Risk Indicators							
				Inherent Risk																																						
				L	C	S																																				
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				3	4	12																																				
Target Risk (Tolerance Level)																																										
L	C	S																																								
3	3	9																																								
				- Active participation and leadership within system-wide governance forums, neighbourhood health programmes - Successful progression of the Medway Community Healthcare integration programme, with positive engagement from partners, staff and regulators - Approval and continued development of neighbourhood health, intermediate care and provider alliance initiatives through partnership working across Kent and Medway - Evidence that the Trust continues to support system priorities and future service models - Progress in reducing discharge delays, improving patient flow and developing integrated models of care through joint working - Recognition of the Trust as a high-performing community provider and credible system leader				- Leadership turnover, or changes in key relationships across Kent and Medway reducing continuity within partnership arrangements - Significant system financial pressures, recovery plans or commissioning changes resulting in reduced focus on long-term transformation and community investment - Delays in implementation of neighbourhood health, intermediate care or integration programmes due to lack of partner alignment, competing priorities or governance complexity - Increasing divergence between organisational, place-based and system priorities - Escalation of system pressures relating to patient flow, discharge delays, social care capacity or urgent care demand, reducing capacity for transformational activity - Reduced partner engagement, attendance or participation in collaborative programmes																																		
Planned actions and milestones																																										
Actions to reduce control gap				Owner		Target Completion (end)		Status		Update																																
Active participation in K&M programme board				CEO/Chief Medical Officer Neighbour Health		March 2027		On track		Active participation in K+M NH board, CNO and CMO for NHs are members of the board, regularly attend and have fortnightly touch points with K+M ICB NH team																																
Sharing of NNHIP work with K&M Programme Board				CMO for NH		March 2027		On track		Sharing of NNHIP learning and outputs with K+M programme board, presentation went to the April K+M Programme board, next steps is linking NNHIP learning with newly formed of the NH Collaborative board which will over see delivery																																
At scale implementation of left shift via NHs programme				CEO		3-5 year programme		On track		CEO system lead for NH implementation																																

Risk : ID 6955	Strategic Domain:	Agility and System Adaptation	Risk Appetite:	Trend	Risk Owner	Risk oversight
Fail to ensure we can adapt to significant external changes while continuing to deliver safe, high-quality care and progress towards population health objectives			Progressive		Deputy Chief Executive	Trust Board
Top 5 Causes		Top 5 Effects	Controls		Assurance	
1. System restrictions/special measures or deficit conditions driving short-term priorities over transformation 2. Policy/political shifts and changing strategic direction 3. Changing organisational landscape & timelines creating frequent re-prioritisations 4. System partners’ support varying for new models of care 5. Structural changes affecting community care configuration		1. Delayed implementation of neighbourhood/left-shift models 2. Resource shortfalls to deliver strategy 3. Stop–start programmes and diminished staff confidence 4. Reduced ICS influence on allocations and pathway decisions 5. Widening inequalities	• Active participation in the neighbourhood programme board lead by the ICB • Involvement in national pilot for neighbourhood teams • Established inequalities workstream led by public health division • Development of the five-year strategy and associated timelines • Yearly corporate project timelines to support resource prioritisation • Active engagement with system partners for key programmes of work		• Inequalities actively monitored as part of monthly performance report • Monthly EPR where the Executive Team work with divisions to identify any difficulties to delivering the strategy and corporate projects	
Inherent Risk			Positive Key Risk Indicators		Negative Key Risk Indicators	
L	C	S	- Operational performance improvement during system pressure (ranked 1st of 61 non-acute trusts) - Improvement in access, waiting times and operational flow metrics - Successful delivery of neighbourhood health, intermediate care and transformation programme milestones, evidencing organisational agility and adaptation to new models of care - Positive assurance that major change programmes remain on track with established governance risk management and readiness arrangements. - Achievement of financial control targets whilst maintaining quality, safety and performance standards - Continued leadership and influence within neighbourhood health and system transformation programmes, supporting delivery of population health objectives and long-term strategic priorities		- Escalating system financial deficits, recovery requirements or changes to commissioning intentions reducing organisational capacity to focus on strategic transformation and population health objectives. - Increasing workforce pressures, leadership capacity constraints or competing priorities arising from multiple concurrent transformation programmes - Increasing pressures within social care, patient flow and discharge pathways adversely affecting the ability to deliver system-wide transformational objectives - Emerging corporate risks linked to external policy changes, ICS restructuring, financial recovery programmes or regulatory changes requiring reprioritisation of resources - Variance from planned transformation funding assumptions	
5	4	20				
Current Risk						
L	C	S				
3	3	9				
Target Risk (Tolerance Level)						
L	C	S				
2	2	4				
Planned actions and milestones						
Actions to reduce control gap		Owner	Target Completion (end)	Status	Update	
Embedding of the system improvement group to discuss system-wide risks / initiatives		Mairead McCormick	October 2026	On track		
Participation in system-wide groups (e.g. urgent care board)		Clare Thomas	October 2026	On track		

Risks that are within Risk Appetite



Risks that are within Risk Appetite

- The following Strategic Risks sit within the Board's stated Risk Appetite and are presented here on a 'watch metric' basis.

Risk: ID 6956	Strategic Domain	Capability, Leadership and Workforce Resilience	Risk Appetite:	Trend	Risk Owner	Risk oversight
Fail to ensure we have the leadership continuity, workforce capacity and right skills mix to deliver our vision for neighbourhood health, transformation, and innovation while maintaining staff wellbeing and engagement.			Moderate to progressive		Chief People Officer	People Committee

Top 5 Causes	Top 5 Effects	Controls	Assurance
- Staff burnout/ morale pressures - Leadership turnover during major change - Recruitment/retention challenges - Skill gaps for neighbourhood models, integration and digital/ AI capability - Change fatigue due to multiple concurrent programmes	- Lower staff engagement - Quality variation and pressure on CQC outcomes - Higher agency spend and reduced financial flexibility - Slower adoption of neighbourhood - Resilience dips in winter / incident scenarios	- Business continuity plans to ensure continued service delivery - Succession planning for senior roles - Daily sitrep of staffing position against establishment - Agentic process automation for the deployment of temporary staff - Implementation of wellbeing and burnout offer to support staff - Organisational change policies and procedures and refreshed sickness policy	- Annual Staff Survey and Pulse Surveys - Audit of recruitment against vacancies - Monthly review of breakthrough objective and workforce KPIs at Integrated People Meeting and Quarterly at People Committee - Monitoring of impact of change on staffing groups involved - Staff voice mechanisms and nobody left behind metrics - Staff partnership forum - Internal Audit reviews of people process

Inherent Risk		
L	C	S
5	4	20
Current Risk		
L	C	S
3	4	12
Target Risk (Tolerance Level)		
L	C	S
3	4	12

Positive Key Risk Indicators	Negative Key Risk Indicators
- Continued improvement in workforce vacancy rates and turnover, demonstrating increased workforce stability and organisational resilience - Sustained delivery of safer staffing standards across services, providing assurance that workforce capacity remains sufficient to meet patient need during periods of change - Positive staff engagement with major organisational programmes, evidenced by constructive feedback and support for future organisational arrangements - Successful recruitment and retention of individuals with specialist skills required to support neighbourhood health, integration, digital transformation and service redesign - Leadership capacity maintained throughout organisational transition, with designated executive and senior leadership arrangements	- Rising staff turnover within leadership, clinical or hard-to-recruit workforce groups resulting in loss of organisational knowledge and capability - Evidence of leadership succession gaps and delays in filling key posts - Increasing sickness absence, wellbeing concerns or signs of workforce fatigue associated with service pressures, organisational change or transformation activity - Increasing reliance on temporary staffing, agency solutions or short-term workforce mitigations to maintain service delivery - Areas of resistance to change limiting organisational adaptability - Workforce capacity constraints resulting in delays to transformation, innovation or neighbourhood health initiatives despite agreed strategic priorities

Planned actions and milestones

Please note the planned actions and milestones have been captured on the next page

Risk: ID 6956	Strategic Domain	Capability, Leadership and Workforce Resilience	Risk Appetite:	Trend	Risk Owner	Risk oversight
Fail to ensure we have the leadership continuity, workforce capacity and right skills mix to deliver our vision for neighbourhood health, transformation, and innovation while maintaining staff wellbeing and engagement.			Moderate to progressive		Chief People Officer	People Committee

Planned actions and milestones					
Actions to reduce control gap	Owner	Target Completion (end)	Status	Update	
Crucial conversation training rollout to all managers during Q1-4 of 2026/27 to enable positive communication and culture driving wellbeing and engagement during widespread change	Margaret Daly	March 2027	On track	This is all on track with all booked cohorts to date completed as planned. Excellent feedback received so far from colleagues. Some cohorts are being re-phased to support capacity due to the forthcoming integration with MCH.	
Implementation of collaborative working forums to support the merger with MCH, including people & culture board, sub-groups, joining the SPF leads, aligning EMF and staff council	Victoria Robinson-Collins	October 2026	On track	All steering groups and sub-groups are in place, and comprehensive engagement plan developed in partnership to support TUPE consultation process	
Engagement with the system to ensure sufficient capacity for neighbourhood models by enabling movement of workforce capacity between providers and ensuring clinical and workforce models are aligned	Victoria Robinson-Collins	July 2026	Complete	This work is led between the CNO, CAHPO, COO and CPO professional networks at system – there are active formal routes for discussions, actions and accountability via the professional groups, the People Programme Board and through to the Alliance.	
Supporting the implementation of intermediate care with onboarding, development programmes and recruitment enabling capacity and skill mix	Victoria Robinson-Collins	July 2026	Complete	Rapid recruitment for Home First expansion being managed through the team, with supportive measures in place to ensure sponsorship applications are prioritised to expedite onboarding and service delivery.	
Engagement events for MCH and KCHFT colleagues ahead of Integration to enable engagement and communication	Victoria Robinson-Collins Julia Rogers	October 2026	On track	Face to face and virtual engagement events running throughout the summer for MCH and webinars for KCHFT colleagues complete. FAQs regularly updated following events. Staff Council engaged and all formal engagement, consultation and negotiation as appropriate being progressed via Staff Partnership Forum.	

Risk: ID 6957	Strategic Domain:	Capacity and Operational Delivery	Risk Appetite:	Trend	Risk Owner	Risk oversight
Fail to ensure we have the workforce capacity to deliver multiple major strategic priorities without compromising clinical effectiveness, patient safety, and patient and staff experience			Progressive to Transformational		Chief People Officer	People Committee

Top 5 Causes	Top 5 Effects	Controls	Assurance
1. Scale and convergence of change 2. Competing priorities in stretched system 3. Commissioned capacity constraints and high demand 4. Partner maturity variation and back-office consolidation 5. Programme resourcing gaps	1. Waiting time breaches and patient outcomes impact 2. Complaints and staff morale impact 3. Delivery slippage of transformation milestones 4. Operational incidents / near misses during transition 5. Reputational impact with partners if delivery fails	- Business continuity plans to ensure continued service delivery - Daily sitrep of staffing position and operational capacity - Agentic process automation for the deployment of temporary staff - Implementation of wellbeing and burnout offers to support staff - Organisational change policies and procedures and refreshed sickness policy - Investment business cases for neighbourhood care and intermediate care	- Annual Staff Survey and Pulse Surveys - Audit of recruitment against vacancies - Monthly review of waiting times, patient related KPI’s and workforce KPIs in committees and Integrated Performance Report at Board - Staff voice mechanisms and nobody left behind metrics triangulated with Datix incidents - Staff partnership forum - Internal Audit reviews of people process

Inherent Risk		
L	C	S
5	4	20
Current Risk		
L	C	S
3	4	12
Target Risk (Tolerance Level)		
L	C	S
3	4	12

Positive Key Risk Indicators	Negative Key Risk Indicators
- Executive assurance that organisational capacity and prioritisation arrangements are regularly reviewed to ensure resources remain focused on agreed strategic programmes and operational priorities - Percentage of major programmes reporting sufficient workforce capacity to achieve planned delivery. - Number of strategic programmes delivered without workforce-related escalation - Percentage of services maintaining agreed safer staffing levels whilst supporting transformation activity - Percentage of strategic programme workstreams reporting Green workforce capacity status	- Critical vacancies in key roles (e.g. social worker capacity gaps impacting discharge pathways) - Evidence that service pressures, programme workload or competing organisational demands are affecting patient experience, staff experience or delivery timescales. - Reduced ability to release staff for transformation, improvement, innovation or programme activity due to operational workload pressures - Increasing reliance on a limited number of key individuals, programme leads or specialist teams to deliver multiple organisational priorities, creating concentration risk - Increasing number of major strategic programmes competing for the same workforce resources, reducing organisational capacity to deliver all priorities effectively

Planned actions and milestones

Please note the planned actions and milestones have been captured on the next page

Risk: ID 6957	Strategic Domain:	Capacity and Operational Delivery	Risk Appetite:	Trend	Risk Owner	Risk oversight
Fail to ensure we have the workforce capacity to deliver multiple major strategic priorities without compromising clinical effectiveness, patient safety, and patient and staff experience			Progressive to Transformational		Chief People Officer	People Committee

Planned actions and milestones				
Actions to reduce control gap	Owner	Target Completion (end)	Status	Update
Enable swift deployment of therapy resources from acute into community settings via system deployment mechanisms	Victoria Robinson-Collins	September 2026	On track	This is being completed between the CNO, CAHPO, COO and CPO professional networks at system.
Engagement with the system to ensure sufficient capacity and capability for neighbourhood models	Victoria Robinson-Collins	July 2026	Complete	This work is led between the CNO, CAHPO, COO and CPO professional networks at system – there are active formal routes for discussions, actions and accountability via the professional groups, the People Programme Board and through to the Alliance.
Supporting the implementation of intermediate care with onboarding, development programmes and recruitment	Victoria Robinson-Collins	July 2026	Complete	Rapid recruitment for Home First expansion being managed through the team, with supportive measures in place to ensure sponsorship applications are prioritised to expedite onboarding and service delivery.
Recruitment to key clinical roles identified including RN apprenticeships as part of the community nursing safer staffing review and the need to deliver neighbourhood models of care	Caroline Bates Victoria Robinson-Collins	October 2026	On track	CNO and CPO have updated system colleagues ahead of using redeployment house as first step to support recruitment. Colleagues identifying suitable areas for apprenticeship placements ahead of recruitment campaign.

Risk : ID 6959	Strategic Domain:	Digital Technology and Cyber Resilience			Risk Appetite:	Trend	Risk Owner	Risk oversight
Fail to ensure we implement secure, cost effective, and innovative digital solutions that are fit for the future. (incl. automation and AI, while protecting against cyber threats)					Progressive (Averse on Cyber)		Chief Finance Officer	FBI Committee
Top 5 Causes		Top 5 Effects		Controls		Assurance		
Omitted for security reasons		Omitted for security reasons		Omitted for security reasons		Omitted for security reasons		
Inherent Risk			Positive Key Risk Indicators			Negative Key Risk Indicators		
L	C	S	Omitted for security reasons			Omitted for security reasons		
3	5	15						
Current Risk								
L	C	S						
2	5	10						
Target Risk (Tolerance Level)								
L	C	S						
2	5	10						
Planned actions and milestones								
Actions to reduce control gap		Owner	Target Completion (end)	Status	Update			
Omitted for security reasons								

Emerging Risks



Emerging Risks

- Severe workforce shortages – especially within the district nursing cohort.
- Financial pressure and efficiency requirements – tight 2025/26 allocations, 2%+ efficiency expectation, and reduced flexibility on agency/bank spend.
- Contracting and procurement uncertainty – new Payment Systems Regulator rules increasing challenge and appeal risk for community contracts.
- Digital and cyber risk elevation – Data Security and Protection Toolkit alignment to National Cyber Security Centre Cyber Assessment Framework and Cyber Essentials Plus supplier requirements.
- Estates deterioration and capital constraints – NHS maintenance backlog nearing £16bn.
- Variation and fragility in virtual ward and urgent community response delivery – inconsistent capacity, data quality and digital exclusion risks.
- Care Quality Commission regulatory shift – new Single Assessment Framework increasing evidence and assurance requirements.
- Integrated Care System organisational flux and financial cuts – reorganisation and cost-reduction pressures limiting community investment.
- Rising unmet and complex demand – ageing population and increased referrals in community and mental health.
- Equity and access risks – digital-first pathways potentially widening inequalities.
- Increase in costs associated with digital technology – triggered by geopolitical instability and increased demands from Artificial Intelligence
- Climate change – adverse impacts to the delivery of services and sites due to the impacts of climate change, such as rising sea level, and adverse weather.
- Medication non-availability – circa. 20% of supply disruption notifications in 2024 classified as having a medium to high patient safety risk

Front Sheet – National NHS Staff Standards – what it means for the Kent Community Health NHS Foundation Trust Board

NHS England published the national NHS Staff Standards in July 2026. The paper describes the six standards and proposes a local self-assessment, stakeholder engagement and action-planning process, with oversight through the Integrated People Meeting and People Committee.

Meeting:	Board Meeting - Part 1 (Public)
Date of meeting:	16 September 2026
Agenda item no:	Item 9
Report title:	National NHS Staff Standards – what it means for Kent Community Health NHS Foundation Trust Board
Executive sponsor(s):	Victoria Robinson-Collins, Chief People Officer
Report author(s):	Victoria Robinson-Collins, Chief People Officer
Action this paper is for:	Discussion
Public/non-public	Public

Executive summary

NHS England published the national NHS Staff Standards in July 2026. All NHS trusts are expected to implement them to support a consistent staff experience. The paper describes the six standards and proposes a local self-assessment, stakeholder engagement and action-planning process, with oversight through the Integrated People Meeting and People Committee.

Key points

- National standards cover line management; health and wellbeing; violence prevention and reduction; championing sexual safety; tackling racism; and promoting flexible working.
- A task and finish group will complete the initial self-assessment and engage the Staff Partnership Forum, Staff Networks, Health and Wellbeing Champions and Staff Council.
- Findings will identify current practice, gaps, risks and required actions, and will inform work on behaviours linked to the We CARE values during integration with Medway Community Healthcare.
- Progress and risk will be reported to the Integrated People Meeting, with the People Committee providing oversight and assurance to the Board.

NHS Staff Standards (Appendix One) is available to Board members within the Diligent library.

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

- Executive Team Meeting, 4 August 2026 – agreed plans to review and engage staff on identifying gaps and developing solutions.

- People Committee, 26 August 2026 – Provided assurance that the Staff Standards were being assessed and that staff were being engaged in the review and development of solutions.

Recommendation(s)

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

Link to CQC domain

☐ Safe
 ☐ Effective
 ☐ Caring
 ☐ Responsive
 ☒ Well-led

Assurance level

Reasonable

Rationale for assurance level

A reasonable assurance level is recommended, as the report demonstrates that appropriate controls and oversight arrangements are in place, while recognising that some areas require further action and continued monitoring.

Implications

Links to BAF risks / Corporate Risk Register

☒ BAF

☐ CRR

Equity, diversity and inclusion

Yes (provide a brief sentence describing the issue)
All of the standards link to areas which fall within our Nobody Left Behind (NLB) action plan and this review will strengthen those areas we identify as needing further work. It should also highlight areas of good practice as part of the review

Legal and regulatory

Yes (provide a brief sentence describing the issue)
Progress against the Staff Standards will be assessed through existing accountability and assurance mechanisms, including the NHS Oversight Framework (NOF) and Provider Capability Assessment.

Executive sponsors sign off

Name and designation: Victoria Robinson-Collins, Chief People Officer

Date: 08 September 2026

Situation

NHS England (NHSE) published the national NHS Staff Standards in July 2026. All NHS trusts are expected to implement them to provide a consistent staff experience across the NHS. Progress will be assessed through existing accountability and assurance mechanisms, including the NHS Oversight Framework (NOF) and Provider Capability Assessment.

This paper outlines the six NHS Staff Standards and the proposed approach to self-assessment. The findings will inform an action plan, with oversight provided by the People Committee.

Background

Nationally, significant emphasis has been placed on improving staff experience through the NHS People Promise, although the impact of these initiatives has varied across the NHS. Kent Community Health NHS Foundation Trust (KCHFT) has undertaken substantial work to embed the People Promise across the organisation. This commitment is reflected in the 2025 NHS Staff Survey, in which KCHFT scored above the sector average across all survey elements.

The 10-Year Health Plan for England committed to developing a new set of staff standards that defines the minimum expectations for modern employment. The standards are intended to improve staff experience, reduce turnover, strengthen retention, improve service delivery and ensure that organisations give staff experience appropriate priority.

Assessment

The six standards

- Line management
- Health and wellbeing
- Violence reduction and prevention
- Championing sexual safety
- Tackling racism
- Promoting flexible working

Each standard, set out in Appendix One, is supported by a defined set of actions for employers to implement. Progress will be monitored through the NHS Staff Survey and incorporated into the NOF alongside existing workforce measures, including sickness absence, staff engagement, education and training indicators, and the National Education and Training Survey (NETS) satisfaction score.

The standards are set nationally but must be put into practice locally. They establish clear expectations for employers, who remain accountable for meeting them. Successful delivery

also depends on partnership with staff, who help shape workplace culture, provide feedback on their experience and drive improvement.

A self-assessment tool has been provided to help identify current practice and policy, gaps, risks and the actions required to meet the standards fully. Beginning this work as colleagues from Medway Community Healthcare (MCH) join the organisation provides an opportunity for the combined organisation to shape its future culture through colleague voice and shared priorities.

A task and finish group, comprising leads from each area, will complete the initial self-assessment. The group will engage key stakeholders—including the Staff Partnership Forum, Staff Networks, Health and Wellbeing Champions, and Staff Council—to gather informed views and shape local improvements.

The group will report to the Integrated People Meeting (IPM), which will receive regular updates on progress and risk with oversight to the People Committee which will provide assurance to the Board.

Implementation timetable

August: Each lead completes the self-assessment.

September: Engagement takes place with colleagues.

October: Findings are presented to IPM, with a verbal update provided to the People Committee.

December: Findings, actions and priorities are agreed and presented to the People Committee.

The self-assessment findings will inform the joint review of the behaviours linked to the We CARE values as part of the forthcoming integration with MCH. The scope of this work will be considered at the joint KCHFT Staff Council and MCH Elected Members' Forum meeting in September, and the outcome will inform the report presented to IPM.

Recommendations

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

- **note** the proposed review of the NHS Staff Standards against KCHFT's existing staff offer; and
- **note** that the People Committee will provide regular oversight and assurance.

Victoria Robinson-Collins
Chief People Office
3 September 2026

Front sheet – Workforce Race Equality Standard and Workforce Disability Equality Standard reports 2026

The annual Workforce Race and Disability Equality Standard reports for the financial year 2025/26

Meeting:	Board Meeting - Part 1 (Public)
Date of meeting:	16 September 2026
Agenda item no:	Item 10
Report title:	Workforce Race Equality Standard Workforce Disability Equality Standard
Executive sponsor(s):	Victoria Robinson-Collins, Chief People Officer
Report author(s):	Hasan Reza, Head of Workforce Equity, Diversity, Inclusion, Health and Wellbeing
Action this paper is for:	Approval
Public/non-public	Non-Public

Executive summary

Overview:

The Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports provide assurance regarding the Trust's performance against nationally mandated NHS England workforce equality standards.

Following the data presented to the Executive Team, People Committee and Board in April / May 2026 these two reports contain the in-depth analysis of each metric for both reporting standards. Areas of excellence and concern were highlighted in the associated documentation submitted in April and May respectfully.

In their August presentation to the Executive Team and People Committee, the Equity, Diversity and Inclusion Health and Wellbeing (EDIH&Wb) team requested feedback on changes to both reports for the 2027 reporting period. They noted that since the last review and update in 2022 the Trust had continued to progress at pace with its Nobody Left Behind (NLB) programmes of work and the engagement both at an Executive level and a organisational level with the subject had increased significantly. As such, the length of the report was beginning to be seen as a barrier to its success and much of the in-depth analysis contained therein was of most interest and benefit to the team themselves and the People Directorate. This internal intelligence could still be captured and presented through other forums while continuing to streamline the annual WRES and WDES reports to ensure the most accessibility and the best utilisation of capacity as committee level. Examples were presented to both forums which were well received and a mandate was given for the team to use the 2026 Gender Pay Gap (GPG) and Workforce Sexual Orientation Equality Standards (WSOES) which will be prepared in Winter 2026 to practically demonstrates a new approach to EDI and Wellbeing reporting.

The benefits expected from this change in approach are to:

- Reduce the volume of content that has to be reviewed at an Executive Team, People Committee and Board level

- Utilise that additional capacity at each of those forums and within the EDIH&Wb team to increase the volume of content being produced related to our specific NLB and associated programmes of work (especially in light of the test Well Led meeting that was convened in early summer 2026 where there was limited knowledge of our EDIH&Wb programmes of work)
- Increase engagement through a more accessible reporting format
- Ensure the necessary analysis and narrative is still available through internal communications for the Chief People Officer and People Directorate / interested parties

In depth analysis of the areas for concern, improvement and excellence was provided in the April and May 2026 frontsheets that accompanied the raw data ahead of the 31 May 2026 submission deadline.

Items of concern: N/A

Significant improvements in previous areas of concern: N/A

Items of excellence: N/A

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

The reports have been developed in accordance with NHS England WRES and WDES reporting requirements. The underlying data that forms the basis of these reports has been reviewed and approved by the Executive Team, People Committee and Board over April and May 2026. Consultation sessions have been held with the Cultural Equality, Disability and Carers, and Neurodiversity networks in July 2026. Following executive team meeting (ETM) approval the reports were sent to People Committee in August 2026 and approved, and will be approved by the Board in September 2026 and published on the Trust public website by 31 October 2026 to ensure our continued compliance with the national mandate.

Recommendation(s)

The Board is asked to **Approve** the report

Link to CQC domain

☐ Safe ☐ Effective ☒ Caring ☒ Responsive ☒ Well-led

Assurance level

Reasonable

Rationale for assurance level

The reasonable assurance rating reflects that the reports comply with NHS England WRES and WDES requirements, are underpinned by data previously reviewed and approved through established Trust governance processes, and have been informed by consultation with relevant staff networks.

Implications

Links to BAF risks / CRR	☐ BAF	☐ CRR
Equity, diversity and inclusion	Yes (provide a brief sentence describing the issue) Evidences our approach to ensuring we are addressing disparities and striving to ensure equity amongst people of the same and different protected characteristics.	
Legal and regulatory	Yes (provide a brief sentence describing the issue)	

	Equality Act 2010 Public Sector Equality Duty (Section 149 Equality Act 2010) NHS England WRES and WDES
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Executive sponsors sign off
Victoria Robinson-Collins, Chief People Officer
Date: 03 September 2026

Workforce Race Equality Standard Report 2026





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Introduction

Kent Community Health NHS Foundation Trust (KCHFT)⁽¹⁾ is one of the largest NHS Community Providers in England, employing and providing health services to a population of 3.6 million across Kent, East Sussex, and London. As of 31 March 2026, the KCHFT workforce population was 5,321.

KCHFT takes the issues of fairness, rights, and equity very seriously. We recognise the value of our colleagues and their diversity, act to ensure that our workforce is representative of the communities we serve and understand that colleagues work better when they can be themselves.

We appreciate the quality, understanding and experience that colleagues bring to our organisation and are committed to taking a transparent and proactive approach to addressing inequity. The need to be an inclusive employer is paramount to this and is a central tenet of both our organisational strategy (We Care⁽²⁾) and our [Nobody Left Behind \(NLB\)](#) approach to equity, diversity, inclusion, health, and wellbeing. This is particularly visible through our NLB action plan⁽³⁾.

We recognise the interconnection between equity, diversity and inclusion, and health and wellbeing. Taking an intersectional approach, we acknowledge the significant impact that racism and discrimination can have on an individual's ability to thrive at work and experience a sense of belonging.

Due to a number of secondment arrangements, some colleagues working in KCHFT are not included in the datasets as these colleagues are included in their host organisations workforce reports including their Equity, Diversity and Inclusion (EDI) reporting. KCHFT has embraced the shared systems approach being encouraged across the Kent and Medway Integrated Care Board (ICB), which brings greater diversity of thought, representation, and perspective.

⁽¹⁾ [About Kent Community Health NHS Foundation Trust](#)

⁽²⁾ [Our we care strategy 2023 to 2028 | Kent Community Health NHS Foundation Trust](#)

⁽³⁾ <https://www.kentcht.nhs.uk/about-us/equity-diversity/>



What is the Workforce Race Equality Standard?

The Workforce Race Equality Standard (WRES) was introduced in April 2015 as a mandated data collection. The WRES is a collection of nine metrics that aim to compare the workplace experiences of colleagues of different ethnicities. NHS Trusts and NHS Foundation Trusts are required to report and publish data, on an annual basis, for each of these metrics.

The WRES was devised to ensure colleagues from Black and Minority Ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. Evidence shows that a motivated, included and valued workforce helps to deliver high-quality patient care, increased patient satisfaction and better patient safety; it also leads to more innovative and efficient organisations.

Ethnicity categories

Colleagues at KCHFT can record ethnicity on their [Electronic Staff Record \(ESR\)](#) and declare this through their response to the NHS Staff Survey. For reporting purposes, ethnicity declaration from both data collection sources is categorised into the following groups to ensure the anonymity of minority groups and individuals within the Trust is protected. These categories are applied consistently across both ESR and Staff Survey datasets to support comparable analysis and protect confidentiality.

- **White**
- **Black and Minority Ethnic (BME) backgrounds**
- **Unknown (ESR only)**

A full breakdown of the ethnicity categories colleagues can record in both ESR and the Staff Survey is provided in [Appendix 2](#).



WRES metrics

The WRES consists of nine metrics to analyse data relating to substantive members of the KCHFT workforce, allowing for the identification and reduction of any inequalities between colleagues of different ethnicities.

Metrics one to four focus on workforce data as at 31 March 2026.

1. Workforce representation

- 1a) Percentage of colleagues in the overall workforce, by ethnicity
- 1b) Percentage of clinical and non-clinical colleagues in [Agenda for Change \(AfC\)](#) pay bands, [Very Senior Management \(VSM\)](#) and [Medical and Dental subgroups](#), compared with the percentage of colleagues in the overall workforce, by ethnicity.

2. Appointment from shortlisting

[Relative likelihood](#) of White applicants being appointed from shortlisting compared to BME applicants, across all posts.

3. Formal disciplinary process

Relative likelihood of BME colleagues entering the [formal disciplinary process](#) compared to White colleagues, as measured by entry into a formal disciplinary investigation.

4. Training

Relative likelihood of White colleagues accessing [non-mandatory training](#) and [continuing professional development \(CPD\)](#) compared to BME colleagues.

Metrics five to eight focus on data from responses to the 2025 National NHS Staff Survey.

5. Harassment, bullying or abuse – public

Percentage of colleagues experiencing harassment, bullying or abuse from patients, service users or the public in the last twelve months, by ethnicity.

6. Harassment, bullying or abuse – colleagues

Percentage of colleagues experiencing harassment, bullying or abuse from colleagues in the last twelve months, by ethnicity.

7. Career progression

Percentage of colleagues believing that the trust provides equal opportunities for career progression or promotion, by ethnicity.



8. Discrimination at work

Percentage of colleagues experiencing discrimination at work from a manager / team leader or other colleagues in the last twelve months, by ethnicity.

Metric nine focuses on ethnicity representation on the KCHFT Board as at 31 March 2026.

9. Board representation

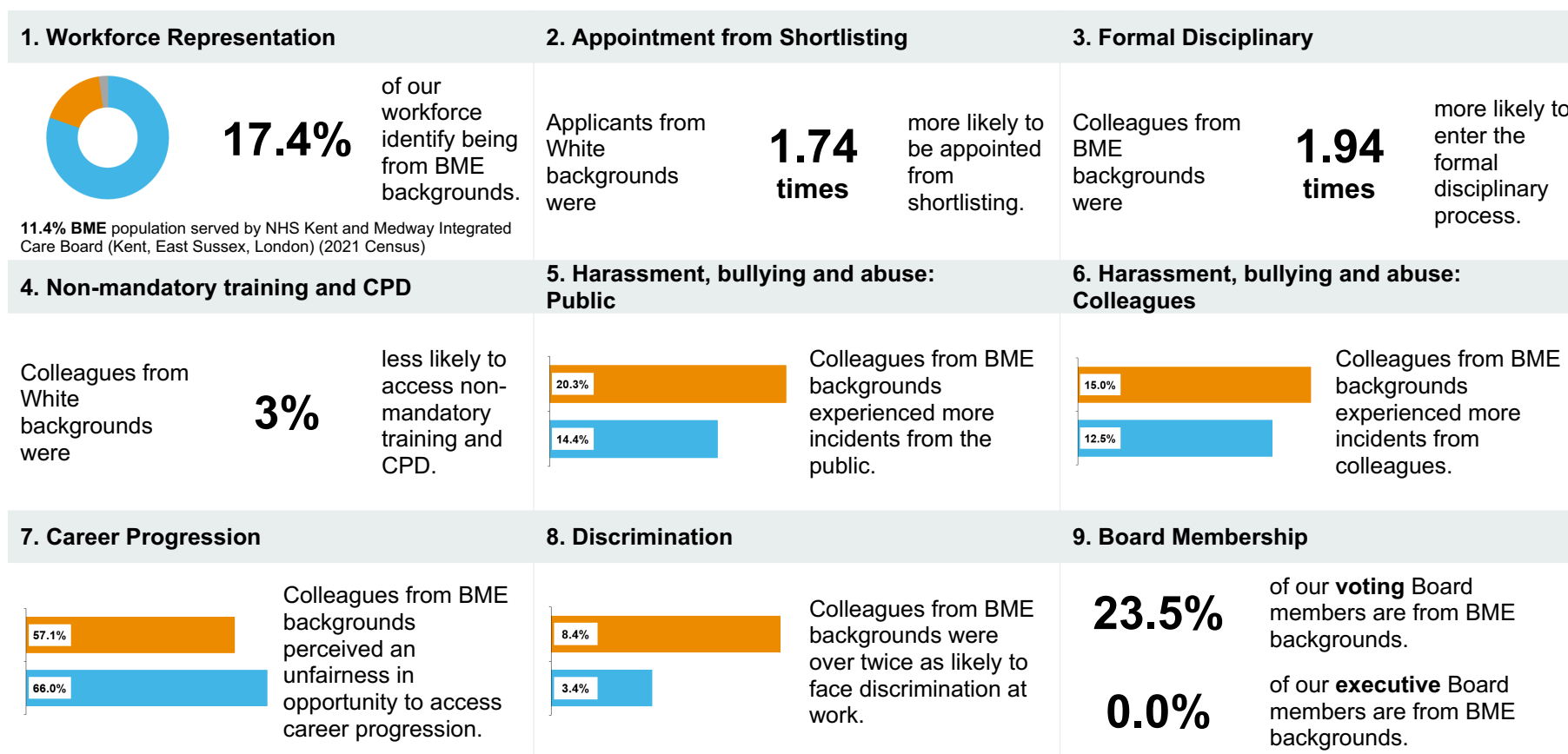
Percentage difference between the ethnicity of KCHFT [Board members](#) and the overall workforce, and by voting and executive membership.



WRES 2025-26 Summary Dashboard

Metrics 1 – 4 and 9 are taken from workforce data as of 31 March 2026.
Metrics 5 – 8 are taken from responses to the 2025 National NHS Staff Survey.

White Black and Minority Ethnic (BME) Unknown



This dashboard can be provided in an alternative format, if required.



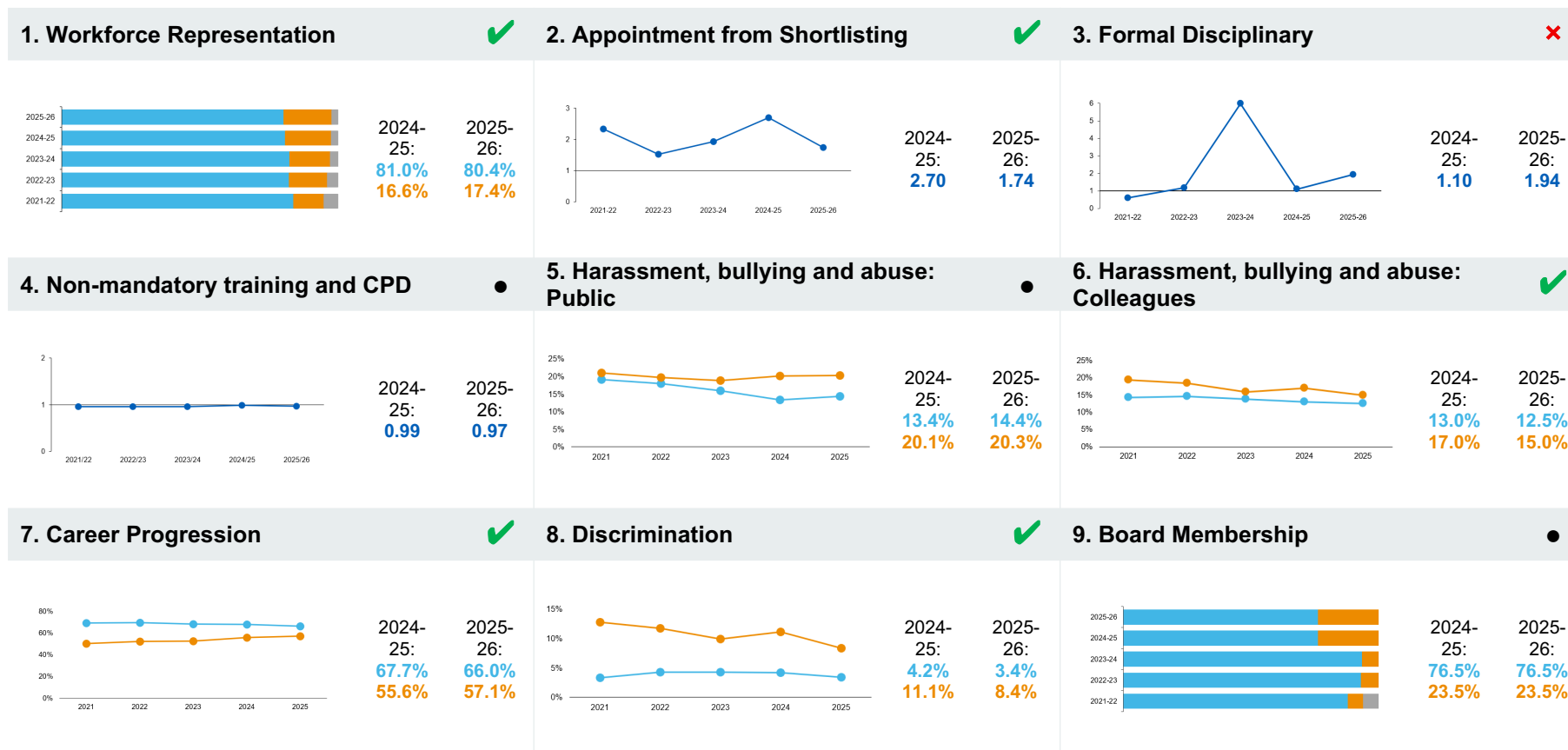
WRES Year-on-Year Trends Dashboard (2021-2026)

Metrics 1 - 4 and 9 are taken from workforce data as of 31 March 2026.
Metrics 5 – 8 are taken from responses to the 2025 National NHS Staff Survey.

Comparison to last year for BME:

White Black and Minority Ethnic (BME) Unknown

Better ✓ No change ● Worse x



This dashboard can be provided in an alternative format, if required.

WRES Community Trusts Average Comparison

- The following data reflects results from the 2026 WDES submissions for the NHS Community Trusts peer group, which includes all community trusts in England.
- It includes both peer-group [benchmark](#) and [median](#) values, allowing comparison against typical performance levels within the peer group for each WRES metric.
- Percentages shown in the table represent the responses of BME colleagues, except for Metric 2, Metric 3 and Metric 4, which present the relative likelihood figures.
- The green highlight indicates who is performing more favourably compared with the other.

WRES Metric	KCHFT	Peer group average
Metric 1 Overall workforce representation	17.4%	15.3%
Metric 2 Appointment from shortlisting	1.74	2.04
Metric 3 Formal disciplinary process	1.94	1.35
Metric 4 Non-mandatory training and CPD	0.97	0.98
Metric 5 Harassment, bullying and abuse: Public	20.3%	22.2%
Metric 6 Harassment, bullying and abuse: Colleagues	15.0%	17.7%
Metric 7 Career progression	57.1%	52.9%
Metric 8 Discrimination at work	8.5%	10.5%
Metric 9 Board Representation	23.5%	13.3%

- KCHFT is performing more favourably than the peer group average for the majority of the WRES metrics.
- KCHFT is performing less favourably than the peer group average for **Metric 3 (Formal disciplinary process)**.



- KCHFT is in line with the peer group average for **Metric 4 (Non-mandatory training and CPD)**.

Metric 1: Workforce representation

1a) Overall workforce

Figure 1 shows the percentage of colleagues at KCHFT by ethnicity, as recorded on ESR.

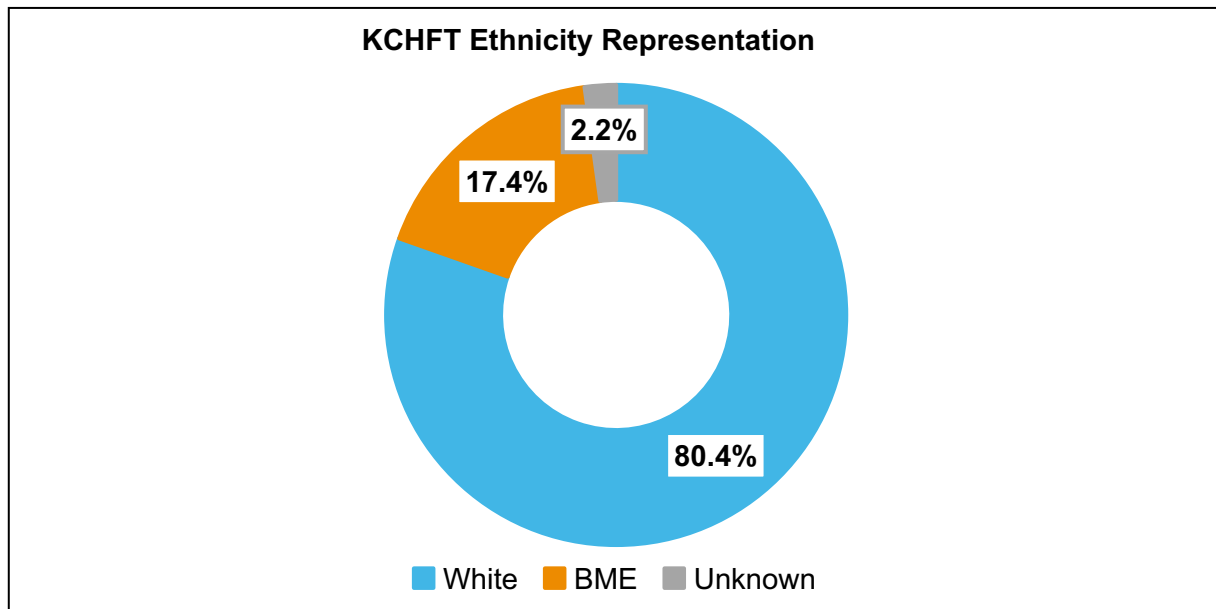


Figure 1

- 80.4% of KCHFT colleagues are White, with 17.4% BME and 2.2% unknown or not declared on ESR.

Figure 2 shows the trend in ethnicity declaration rates at KCHFT since 2021-22.

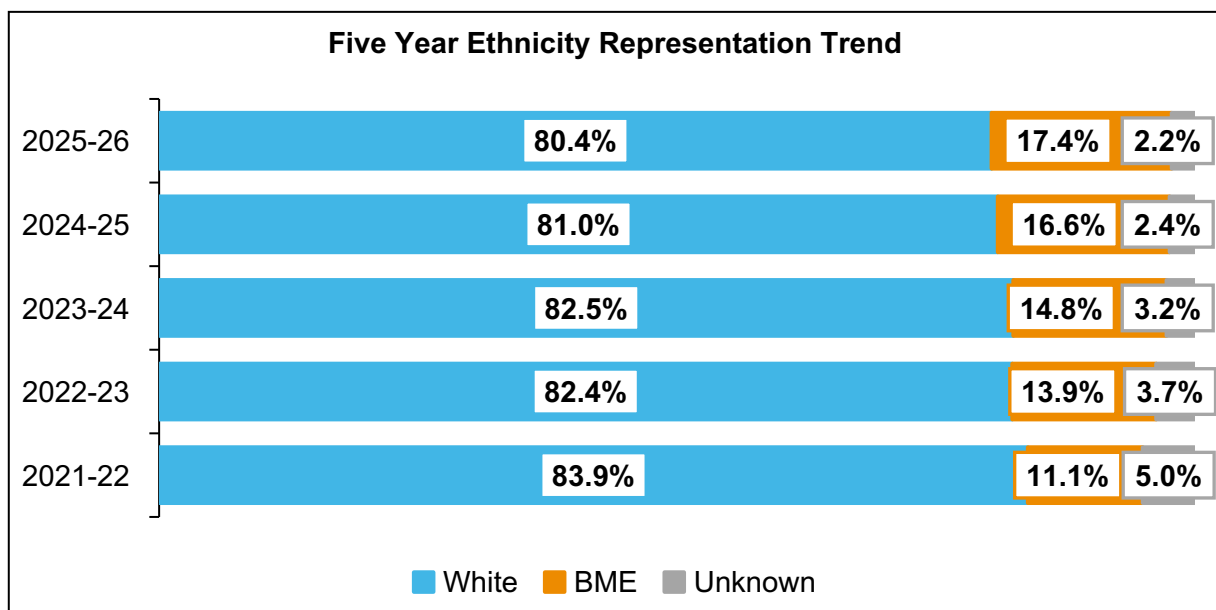


Figure 2



- The workforce remains predominantly White, whilst the steady increase in BME representation over the five-year period indicates sustained progress and improvement, with the rise from 11.1% to 17.4% representing a significant and meaningful shift.
- Our NLB approach supports positive messages regarding declaration by creating an environment where colleagues feel safe, valued, and confident to share their personal information. Through its focus on inclusive culture, visible allyship, and equitable systems, NLB encourages open conversations about identity and belonging.
- The Culture Equality Network (CEN) has also been integral to contributing towards this, including embedding NLB principles such as psychological safety, representation, and active inclusion.
- The Black and Minority Ethnic (BAME) Network was renamed to the Cultural Equality Network, to reflect a broader commitment to inclusivity and representation across the organisation. The name change aimed to ensure that the network is a space where everyone feels seen, valued and able to contribute, regardless of their background or lived experience.
- The network co-chairs have expressed their commitment to creating an inclusive and supportive space where everyone has a voice, and its strength comes from the diversity of its members.
- Feedback has been positive and the following was received from a colleague:

“As someone from a Mixed other background, I didn’t feel comfortable joining when the name was the BAME Network as I didn’t feel that my identity was represented by this name. Since the name change to the CEN, I finally feel like I can join as it feels genuinely inclusive and reflective of the diverse experiences across our workforce and that I can contribute and support as a true member.”

1b) Clinical and non-clinical colleagues by AfC pay bands, VSM and Medical and Dental subgroups

Figure 3 shows the percentage distribution of non-clinical KCHFT colleagues by ethnicity and pay band, as recorded on ESR.

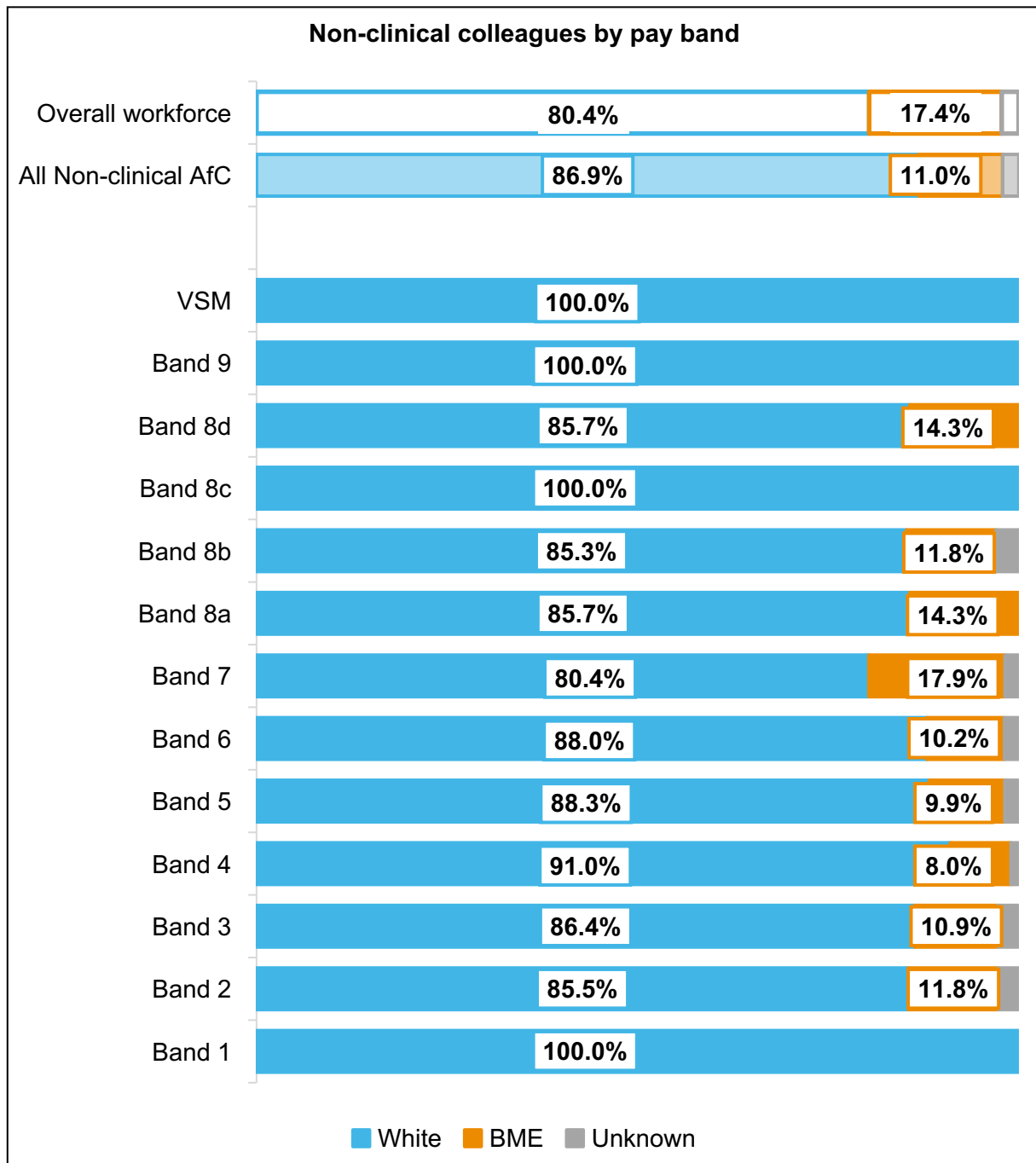


Figure 3



- The overall AfC non-clinical BME representation is 11.0%, below the overall workforce figure. This reflects consistently lower BME representation across almost all non-clinical AfC pay bands, with the majority remaining below the workforce figure.
- Band 7 has the highest proportion of non-clinical BME colleagues at 17.9%, broadly aligning with the overall workforce representation.
- Bands 1, 8c, 9 and VSM within the AfC non-clinical workforce are comprised of only White colleagues, resulting in no BME representation at these levels.
- Following the 2024-25 report there has been an increase in diversity in Bands 8b and 8d in keeping with the organisational efforts to diversify our senior leadership roles.
- Further analysis will follow in the section on [Metric 2](#) however one of the key focuses of our Inclusion Ambassador programme has been to support senior leader recruitment with the programme supporting 19 recruitments at Band 8a and above.

Figure 4 shows the percentage distribution of clinical KCHFT colleagues by ethnicity and pay band, as recorded on ESR.

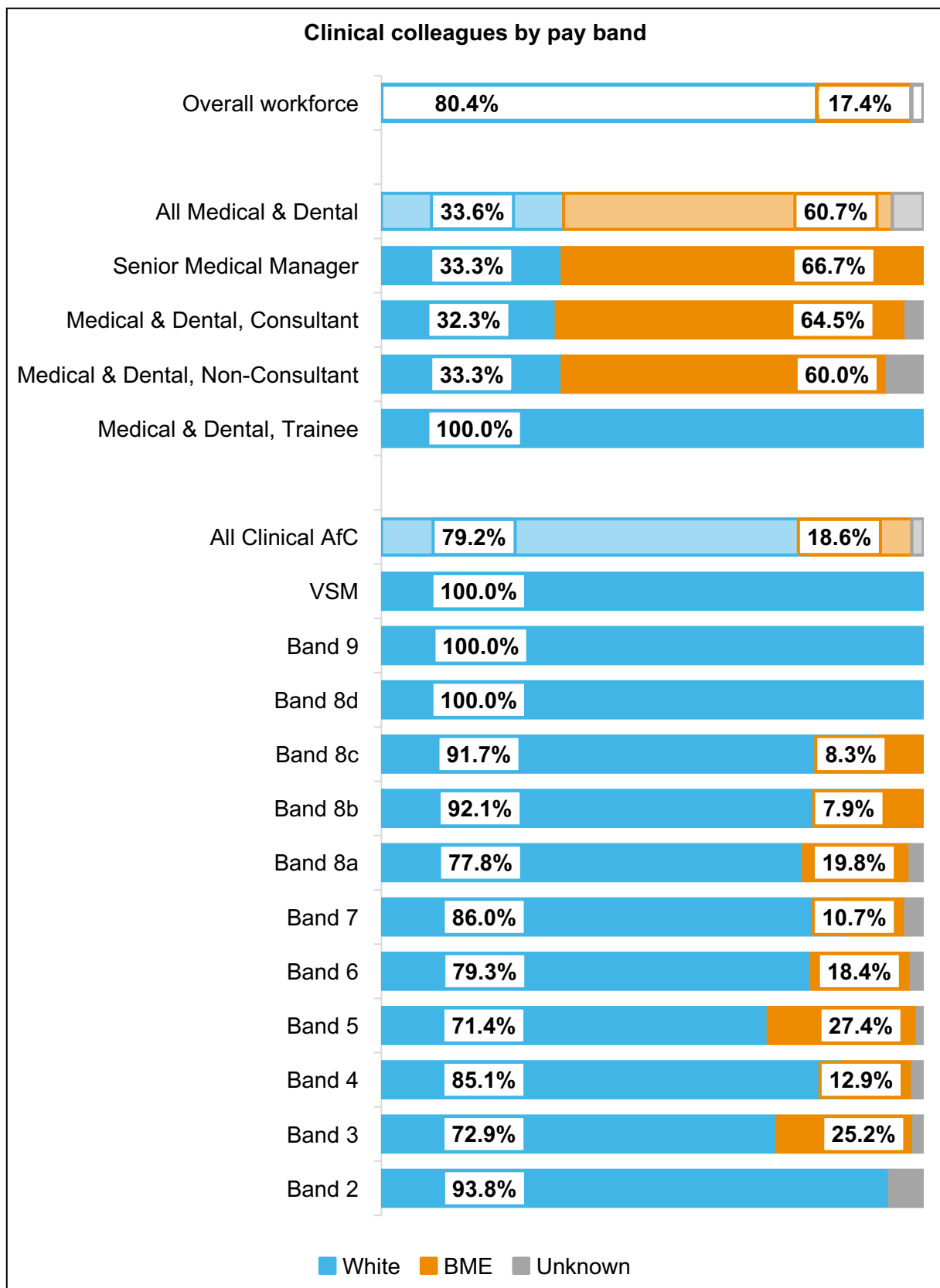


Figure 4



- Overall AfC clinical BME representation is at 18.6%, which is above overall workforce representation.
- Band 5 has the highest proportion of BME colleagues within AfC clinical roles at 27.4%, well above the overall clinical and workforce representation.
- Bands 3, 6 and 8a clinical BME representation are also all above the overall workforce figure, at 25.2%, 18.4% and 19.8% respectively.
- Bands 8d, 9 and VSM within the AfC clinical workforce comprise only White colleagues.
- Of Medical and Dental colleagues, 60.7% are from BME backgrounds. This majority BME profile is consistently reflected across Non-Consultants, Consultants, and Senior Medical Managers.
- Medical and Dental Trainees are currently comprised entirely of White colleagues, this is due in part to the very small sample sizes within this subgroup.

Metric 2: Appointment from shortlisting

Table 1 shows the breakdown of applicants shortlisted and appointed by KCHFT between 1 April 2025 and 31 March 2026, by ethnicity.

Ethnicity	Total Shortlisted	Total Appointed	% Appointed from Shortlisting
White	1560	534	34.2%
BME	1618	318	19.7%
Unknown	65	27	41.5%
Relative Likelihood Ratio (White over BME): 1.74			

Table 1

- White shortlisted candidates were 1.74 times more likely to be appointed than their BME counterparts.
- Whilst further intervention is needed, it is encouraging to note that BME applicants accounted for 19.7% of appointments from shortlisted candidates, compared with a workforce representation of 17.4%, demonstrating continued progress.

Figure 5 shows the trend of relative likelihood of appointment since 2021-22.

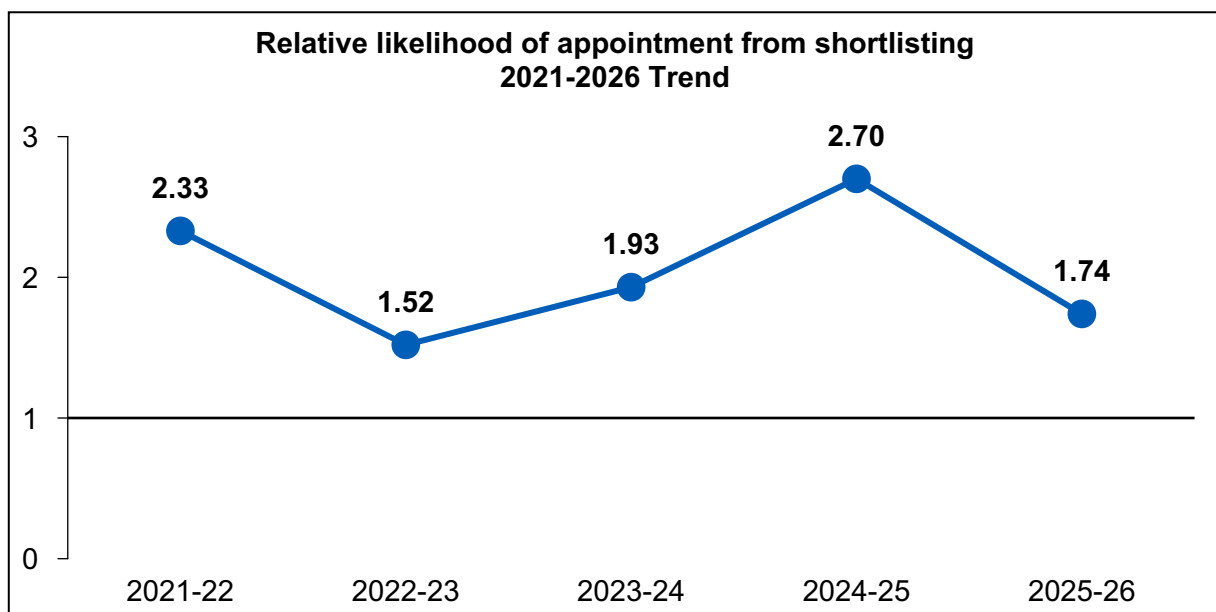


Figure 5

- Over the period, the relative likelihood has consistently remained above 1, demonstrating inconsistent progress and disproportionately less favourable outcomes for BME applicants at appointment stage.
- To address the inequity seen in previous years, a bespoke inclusive recruitment programme titled the 'Inclusion Ambassador Programme' was developed and piloted between August 2024 and August 2025.
- Inclusion Ambassadors (IAs) were trained in inclusive recruitment representing the breadth and depth of diversity as per the Equality Act 2010 definitions of protected characteristics.
- Crucial to the programme, IAs were given equal status on recruitment panels and involved in both shortlisting and interviewing processes. They are provided support from the Workforce Equity, Diversity, Inclusion, Health and Wellbeing (WEDIH&Wb) Team, Recruitment Team and have an escalation route to the Chief People Officer.
- Teams in a particular directorate were identified to take part in the pilot and were those with the highest likelihood of appointment ratios alongside the lowest existing representation. We have seen a measurable impact in improving inclusive recruitment within the areas the IAs were deployed.

Table 2 shows the change in relative likelihood of appointment from before and after implementation of the programme in the pilot areas.

	September 2023	August 2024 IA programme implemented	September 2025	Change
Relative likelihood of White applicants being appointed from shortlisting compared to BME applicants	10.32		3.73	-6.59

Table 2

- The 6.59 point improvement shows significant evidence of the success of the programme.
- A paper was presented to the Trust Executive leadership team in December 2025 proposing a long-term programme of IAs. With their agreement this has been developed by the WEDIH&Wb Team who have made necessary changes following lessons learnt from the pilot.



- During the pilot there were requests for IAs from recruiting managers outside of the pilot teams. The programme has since been opened to the whole Trust and additional IA cohorts are being recruited and trained.
- Feedback has been positive and the following was received from a current IA:

“Being part of the interview process has made me feel that my voice is genuinely being heard and that my experiences and opinions can help shape positive change. It has also been a great opportunity to meet so many different people, learn from their perspectives, and build meaningful connections. I am proud to be involved in changes that are moving in the right direction and helping to create a more inclusive and supportive environment for everyone.”

- Further feedback was received from a recruiting manager outside of the pilot areas who requested an IA:

“A particular IA...integrated into the panel brilliantly, giving input related to the We care values but also scoring on the candidates’ overall performance, not just their EDI results...I think having an independent person reduced bias, therefore creating a fairer and more robust recruitment process for the candidates.”

- In 2025 the Trust overhauled a recruitment e-learning package, making it mandatory for all colleagues with management responsibilities. Feedback and completion rates have been the strongest seen for a new e-learning programme. The training also supports the adoption of more inclusive recruitment practices.
- Feedback for this training can be seen in **Table 5** and **Figure 7**, with high completion and evaluation response rates and a positive Net Promoter Score. Learners consistently highlighted the focus on values-based recruitment, fairness and consistency, with content on bias and microaggressions frequently described as impactful and eye-opening.
- This feedback provides a helpful evidence base to inform consideration at the next planned review or refresh of the content.
- The Trust is cognisant of the realities in the work still needed, however is reassured that the disparity is decreasing and that the interventions of the WEDIH&Wb team have proven successful.

Completion rate	Compliance	Evaluation completion rate	Recommendation rate
890 colleagues have completed the module since its launch in November 2025	94.4% managers have completed the training (those with direct line management in TAPs)	31.5% of colleagues who completed the training also completed an evaluation form (organisational average is 18%)	63.8% of colleagues would recommend the module

Table 3

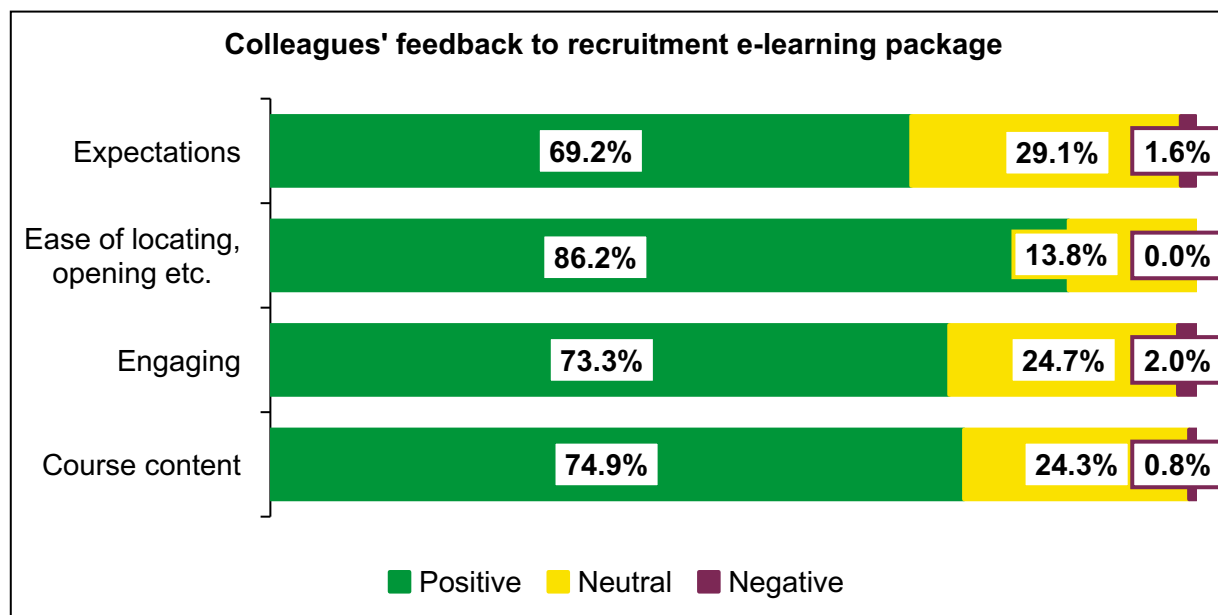


Figure 6

Metric 3: Formal disciplinary process

Table 6 shows the breakdown of colleagues entering the formal disciplinary process between 1 April 2025 and 31 March 2026, by ethnicity.

Ethnicity	Total colleagues	Total entering formal disciplinary	% entering formal disciplinary
White	4277	31	0.7%
BME	925	13	1.4%
Unknown	119	0	0.0%
Relative Likelihood Ratio (BME over White): 1.94			

Table 4

- BME colleagues were more than twice as likely to enter a formal disciplinary process than White colleagues.

Figure 7 shows the trend of relative likelihood of entering the formal disciplinary process since 2021-22.

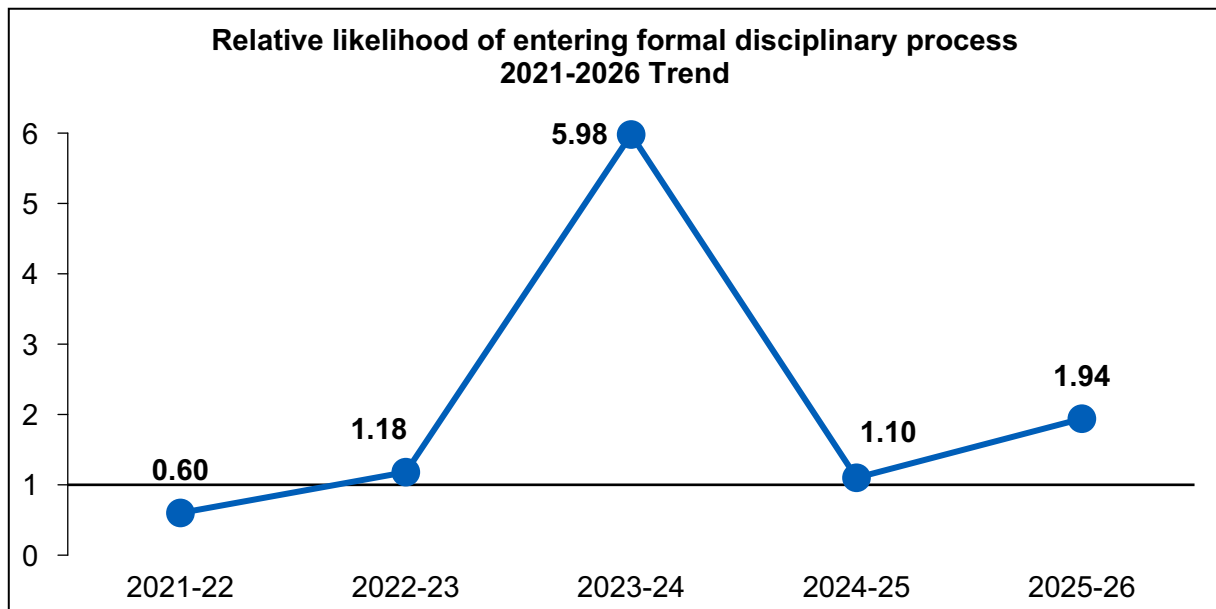


Figure 7



- Over the period, the relative likelihood has mainly remained above 1, indicating inequity in entering the formal disciplinary process.
- We report this figure to the Board on a monthly basis; in response to the worsening trend, the Board requested further analysis.
- Several cases were identified where no action by the Trust could have altered the outcome due to the circumstances that had led to the disciplinary process.
- These cases involved colleagues who either no longer held the necessary right to work in the UK or did not hold the necessary qualifications to perform the role they had been employed in. In these circumstances the Trust had followed a process that would not be regarded as a disciplinary process within the meaning of the technical definition in the WRES guidance.
- Following this analysis, data from April 2026 does not include these cases.

Metric 4: Non mandatory training and CPD

Table 5 shows the breakdown of applicants accessing non-mandatory training and CPD between 1 April 2025 and 31 March 2026, by ethnicity.

Ethnicity	Total colleagues	Total accessing non-mandatory training / CPD	% accessing non-mandatory training / CPD
White	4277	471	11.0%
BME	925	105	11.4%
Unknown	119	8	6.7%
Relative Likelihood Ratio (White over BME): 0.97			

Table 5

- The figure of 0.97 shows that White colleagues were 3% less likely to access non-mandatory training or CPD than colleagues from BME backgrounds.

Figure 8 shows the trend of relative likelihood of accessing non-mandatory training since 2021-22.

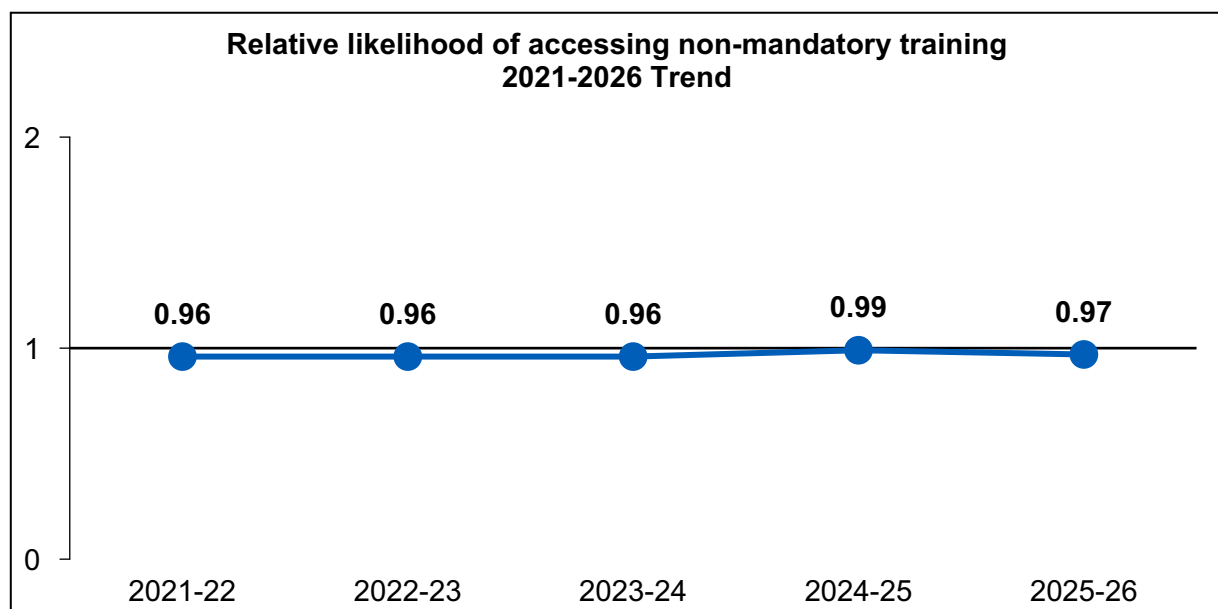


Figure 8

- The minimal variation and stability indicates there is no significant disparity and that opportunities for non-mandatory training are being accessed at similar rates.

Metric 5: Harassment, bullying or abuse – public

Figure 9 shows the percentages of KCHFT colleagues whose response to the following Staff Survey question indicated they had experienced it at least once, by ethnicity. A total of 3,487 colleagues responded to this question in 2025 (65.5% of the overall workforce).

In the last 12 months, how many times have you personally experienced harassment, bullying or abuse at work from – Patients / service users, their relatives or other members of the public.

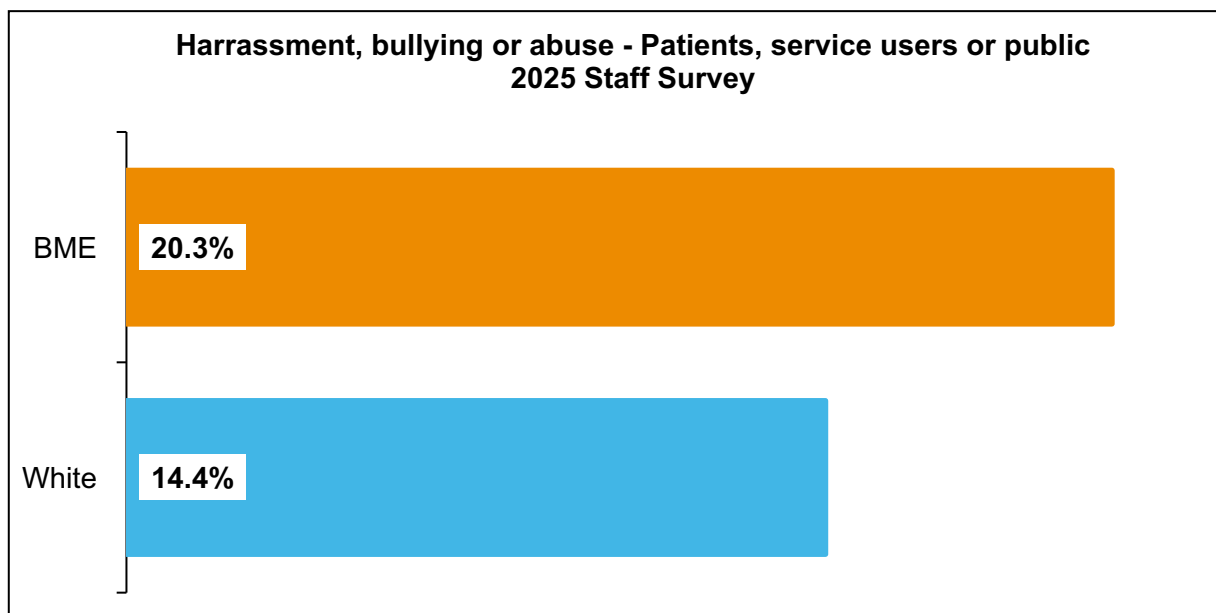


Figure 9

- 20.3% of BME colleagues experienced harassment, bullying, or abuse from the public, compared to 14.4% of White colleagues.
- Although the percentage for White colleagues is lower, 14.4% still represents a significant proportion of the workforce and demonstrates that public-facing aggression is not isolated to one group.
- The data highlights that unacceptable behaviour from patients, and the public is a widespread and systemic issue, affecting colleagues across all groups in the workforce and creating a challenging environment for everyone.
- The staff groups where BME staff experienced the highest levels of harassment, bullying or abuse from patients, relatives or the public were Additional Clinical Services at 27.6%, followed by Additional Professional Scientific and Technical and Medical and Dental at 25.9% and 25.8% respectively.

Figure 10 shows the trends of colleagues experiencing harassment, bullying or abuse from patients at least once since the 2021 Staff Survey, by ethnicity.

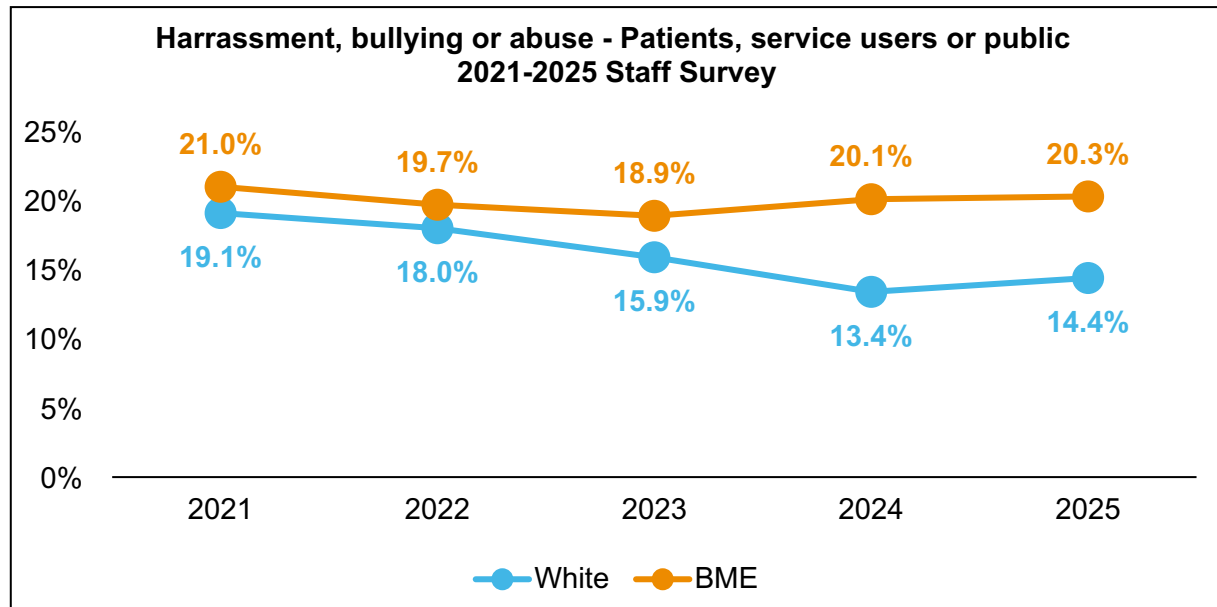


Figure 10

- BME colleagues consistently report higher levels of harassment, bullying or abuse from patients than White colleagues.
- There has been a steady decreasing trend for White colleagues, while BME colleagues have shown an increasing trend since 2023, which has stabilised since 2024.
- The disparity between BME and White colleagues is therefore widening, with the largest disparity shown in 2024.
- As a community trust our workforce is in the unique position of having to deliver many clinical services in people's homes and private spaces, which can also bring significant vulnerabilities.
- Lone Worker Guidance ensures our colleagues who are lone working are compliant with legislation under the Health and Safety at Work Act and required to undertake Conflict Resolution Training. In addition, those colleagues who visit patients at their home address or work remotely in clinics and other locations and fit the Lone Worker Profile must complete Level 4 Lone Worker Training.

- In response to the scale of change within KCHFT and across the wider system, a new “Building Supportive Teams” toolkit has been introduced. Shaped by colleague feedback, it places preserving energy, open and honest conversations and time to rest and recover at the centre of team wellbeing.
- KCHFT has shown its continued support of its entire workforce. Our Chief Executive Officer and the Board have discussed the behaviours observed on multiple occasions and reminded the workforce and members of the public of our expected standards. Examples of these can be found on our public website.
- In October 2025 the Trust launched a new “Managing unacceptable behaviour” policy to improve how the organisation manages patient behaviour. The policy included actionable methods to operationalise our zero-tolerance policy, with clearer expectations communicated to the public and an aim to help colleagues to feel better equipped and supported in patient-facing situations.
- The aim of this policy is to support colleagues in managing incidents of violence, aggression, unacceptable behaviour and abuse from patients, relatives, carers, friends and members of the public. It recognises the significant impact such incidents can have on colleagues’ health and wellbeing and seeks to contribute to a positive culture of wellbeing across the Trust.
- This includes a Behaviour Sanction Panel with an escalation system, whereby sanctions including a yellow or red card can be issued to service users, carers and / or attendants if their behaviour is deemed to be unacceptable.
- Provisions have been made to ensure capacity is not a factor in the decision making of the panel and cases involving minors are not subjected to the same processes, although attendants and / or parents of minors who are abusive to our colleagues will be referred to the review panels as necessary.
- From October 2025 to January 2026, the panel reviewed 105 incidents with 20 progressed for a sanction hearing. Of these, 6 yellow cards have been issued, a further 5 are underway and 2 red cards were considered but downgraded due to the medical needs of the patient. Three apologies have been received including the following:

“He [the patient] just called to apologise profusely for his behaviour and how he spoke to me over the phone... he said he will never behave like that again to anyone of us...”

Figure 11 shows the distribution of key themes of each incident addressed since the implementation of the policy.

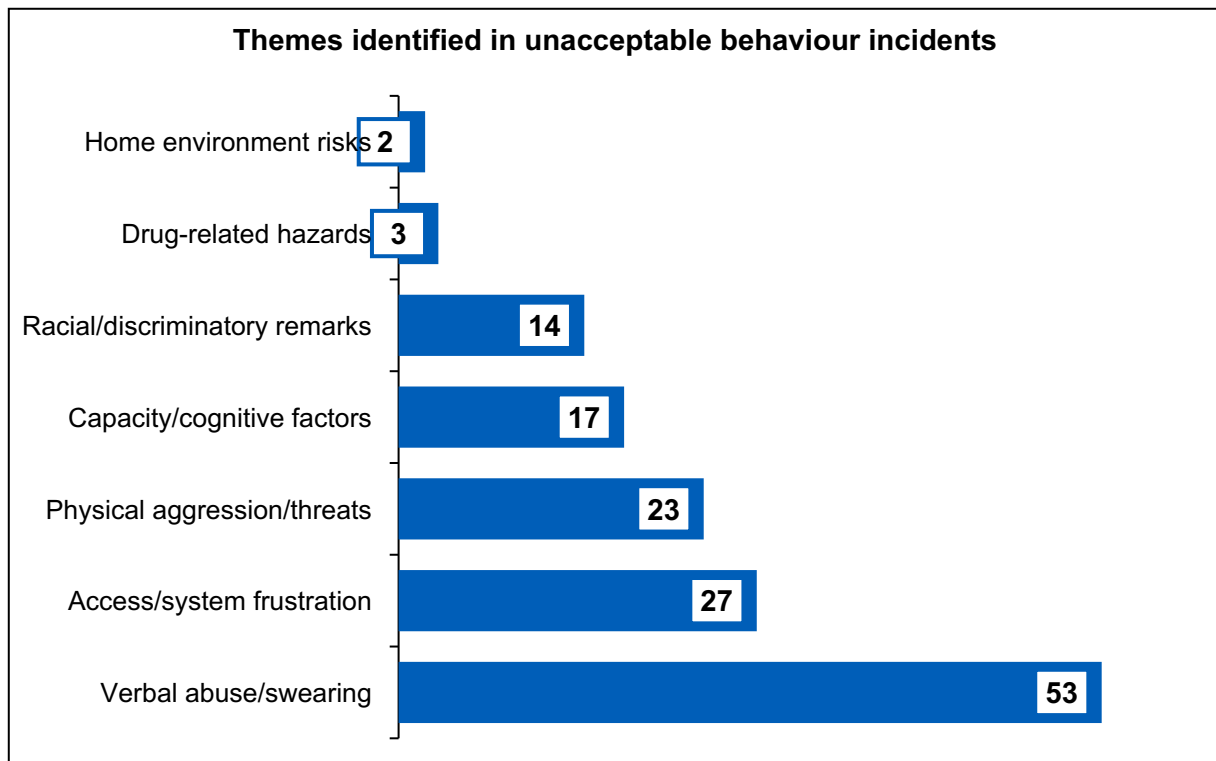


Figure 11

- Any increase in reporting is a positive indication that colleagues feel more confident in raising concerns and seeking support to address these behaviours, helping to ensure that unacceptable conduct is not tolerated.

Metric 6: Harassment, bullying or abuse – colleagues

Figure 12 shows the combined percentages of KCHFT colleagues whose responses to the following two Staff Survey questions indicated they had experienced it at least once, by ethnicity. A total of 3,468 colleagues responded to the first question (65.2% of the overall workforce), whilst 3,457 answered the second (65.0% of the overall workforce) in 2025.

In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from – Managers.

In the last 12 months, how many times have you personally experienced harassment, bullying or abuse at work from – Other colleagues.

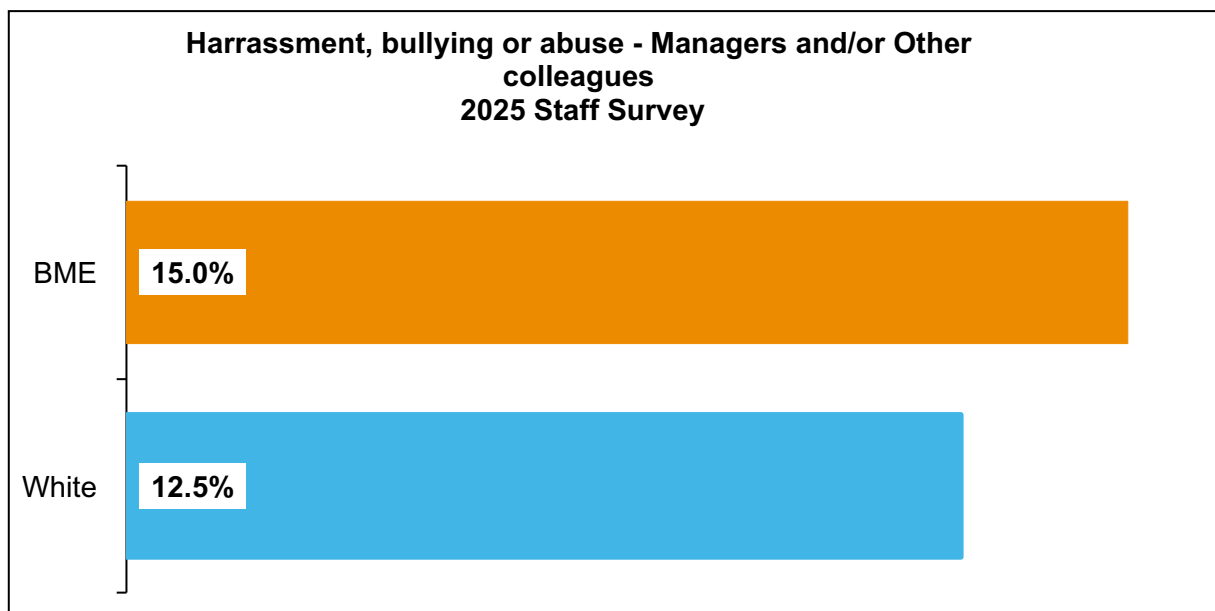


Figure 12

- 15.0% of BME colleagues experienced harassment, bullying, or abuse from the public, compared to 12.5% of White colleagues.
- Although the rates for both groups are lower than that from patients or the public for both groups, BME colleagues continue to be disproportionately affected across both sources of discriminatory behaviour.
- The staff groups where BME staff experienced the highest levels of harassment, bullying or abuse from other colleagues were Additional Professional Scientific and Technical at 30.8%, followed by Medical and Dental at 22.6%.

Figure 13 shows the trends of colleagues experiencing harassment, bullying or abuse from colleagues at least once since the 2021 Staff Survey, by ethnicity.

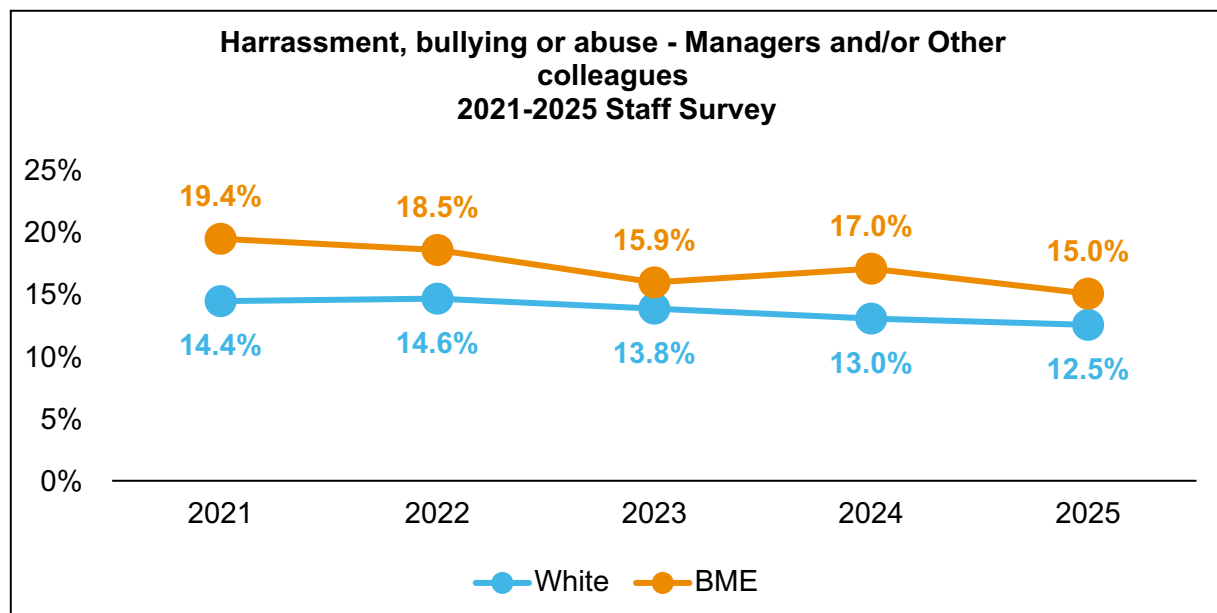


Figure 13

- BME colleagues consistently report higher levels of harassment, bullying or abuse from other colleagues than White colleagues.
- Both BME and White colleagues show a downward trend in incidents, with 15.0% of BME colleagues experiencing this being the lowest since 2021.
- The frequency of incidents is consistently lower than those involving patients, relatives or members of the public for both groups. Colleague behaviour is governed by professional standards, organisational policies, codes of conduct and HR processes, whereas members of the public are not subject to these same organisational requirements.
- The disparity also narrows over time, decreasing from 5.0% in 2021 to 2.5% in 2025.
- To support positive team culture, the Trust has introduced “Building Better Conversations” training for leaders, focusing on developing confidence and skills to hold open, supportive and constructive conversations, particularly during periods of change.
- Monitoring of new mandatory EDI training is ongoing, with an organisational target of 90% compliance by March 2027. As of June 2026, the compliance rate was 73.4%.

Metric 7: Career progression

Figure 14 shows the percentages of responses from KCHFT colleagues to the following Staff Survey question, by ethnicity. A total of 3,473 colleagues responded to this question in 2025 (65.3% of the overall workforce).

Does your organisation act fairly with regard to career progression / promotion, regardless of e.g. age, disability, ethnic background, gender reassignment, religion, sex or sexual orientation?

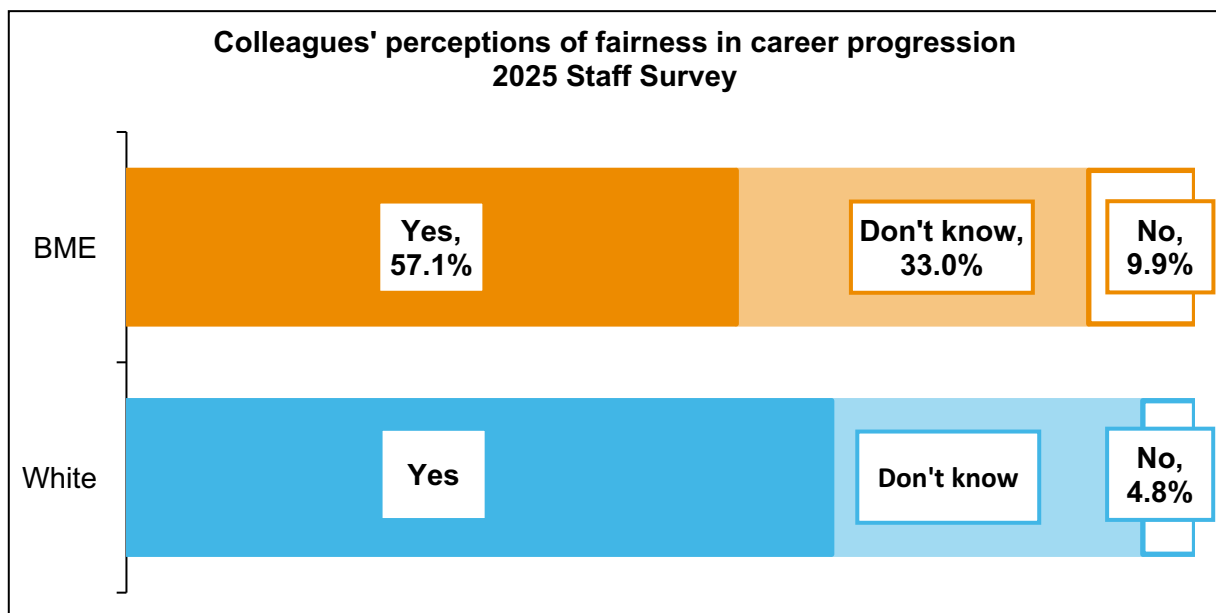


Figure 14

- White colleagues were more likely to perceive career progression as fair, with two thirds (66.0%) agreeing compared to just over half (57.1%) of BME colleagues.
- BME colleagues are also twice as likely to say progression is not fair, with 9.9% disagreeing compared to 4.8% of White colleagues.
- Both groups also show high rates of uncertainty, suggesting that regardless of ethnicity, a proportion of colleagues are unsure that there is fairness in career progression.

Figure 15 shows the trend of 'Yes' responses to whether KCHFT act fairly regarding career progression since the 2021 Staff Survey, by ethnicity.

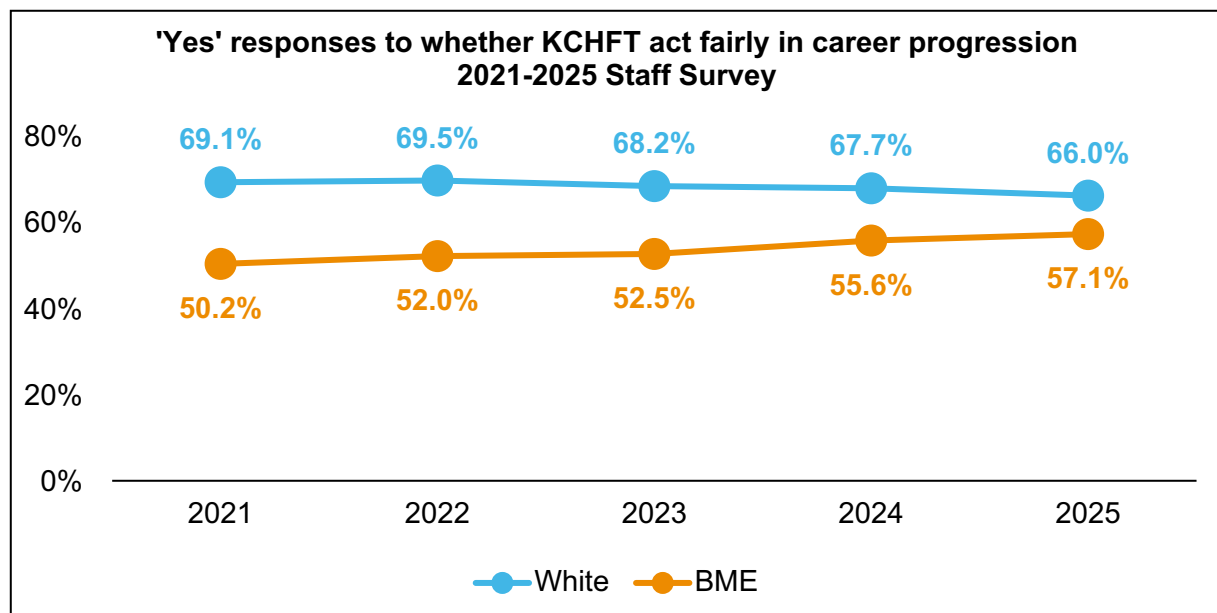


Figure 15

- White colleagues consistently report a higher rate of perceived fairness for career progression than BME colleagues.
- Responses from White colleagues remain steady across the period, indicating a broadly consistent experience, however the trend shows a gradual decline since 2023.
- In contrast, responses from BME colleagues show a steady and sustained improvement across the whole period, indicating increased perceptions of fairness in career progression for this ethnic group.
- The narrowing gap between White and BME colleagues suggests progress towards greater equity regarding perceptions of fairness in career progression.

Metric 8: Discrimination at work

Figure 16 shows the percentages of responses from KCHFT colleagues to the following Staff Survey question, by ethnicity. A total of 3,465 colleagues responded to this question in 2025 (65.1% of the overall workforce).

In the last 12 months have you personally experienced discrimination at work from any of the following – Manager / team leader or other colleagues.

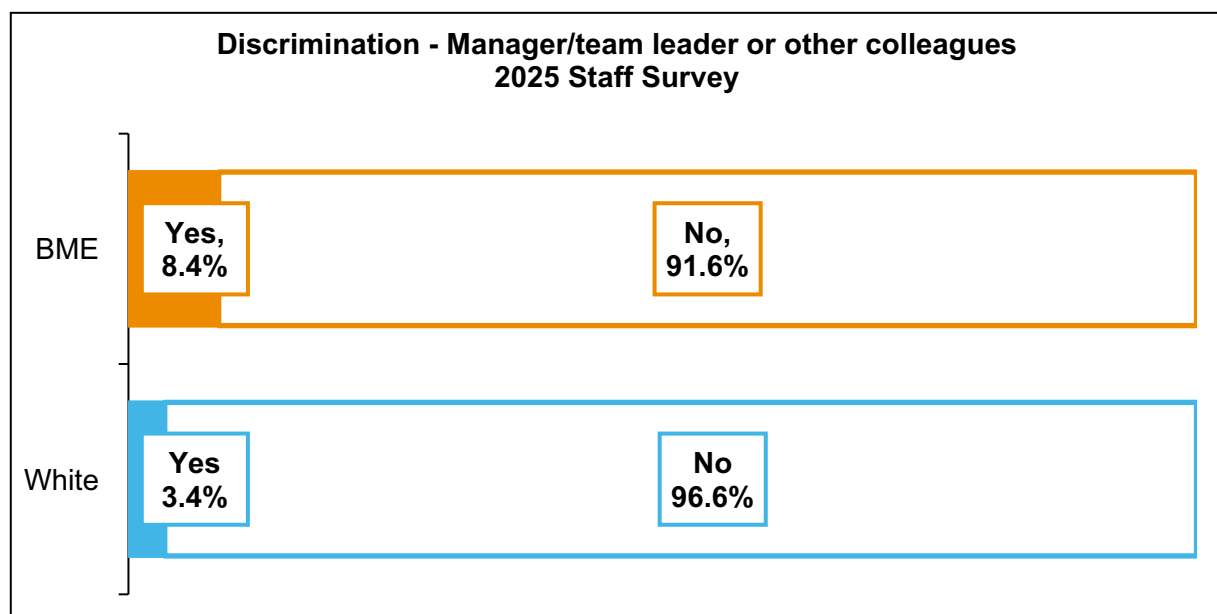


Figure 16

- BME colleagues were more likely to experience discrimination from managers or colleagues, with 8.4% reporting this compared to 3.4% of White colleagues.
- Both groups show a strong disagreement to the question with over 90% not experiencing discrimination from a manager or colleague, a positive finding suggesting inclusive practices are effective in fostering a safe and supportive environment for most colleagues.
- The staff groups where BME staff experienced the highest levels of discrimination at work were Additional Professional Scientific and Technical at 11.5%, followed by Nursing and Midwifery Registered at 11.3%.

Figure 17 shows the trend of Yes' responses to colleagues experiencing discrimination at work since the 2021 Staff Survey, by ethnicity.

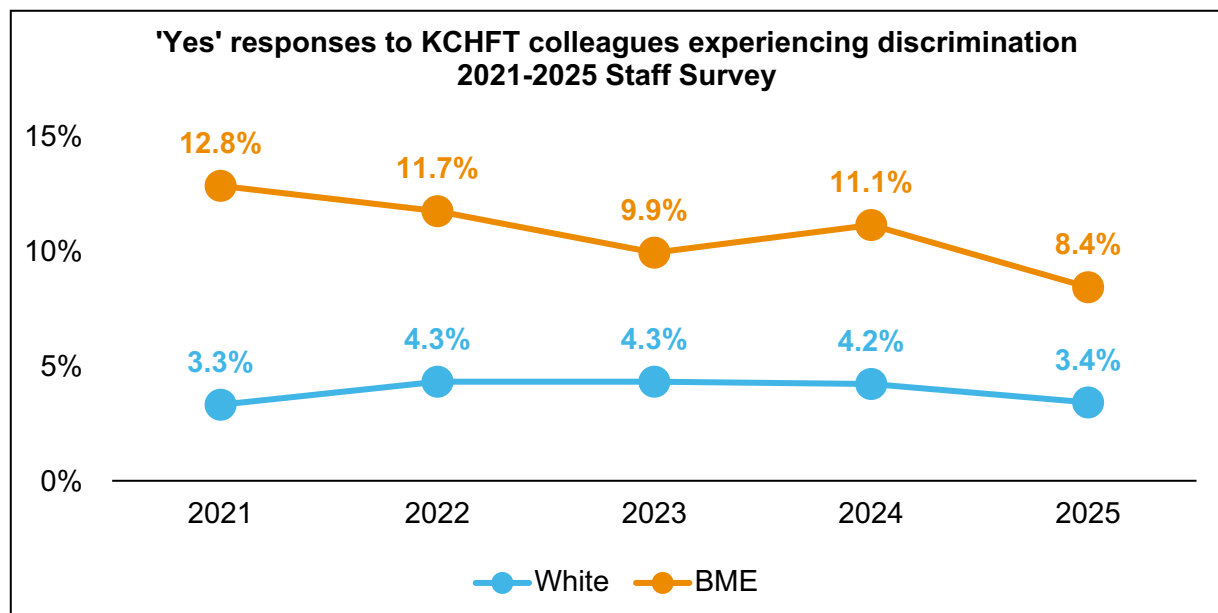


Figure 17

- The proportion of White colleagues reporting discrimination is consistently much lower than that of BME colleagues every year.
- Since 2021, the percentage of White colleagues experiencing discrimination remains stable, fluctuating only slightly between 3.3% and 4.3%. This suggests that for White colleagues, experiences of discrimination have not significantly changed over time.
- Conversely, the rate for BME colleagues shows a general downward trend, despite a small increase in 2024, and the overall decline suggests that discrimination experienced by BME colleagues is reducing.
- The drop from 11.1% in 2024 to 8.4% in 2025 is positive and is the lowest rate across the period.
- The gap between the two groups is narrowing over time, indicating progress towards greater equity in the workplace regarding discrimination. However, the disparity still indicates an unequal experience between groups.
- The Trust is exploring opportunity to participate in the NHS England South East “Microaggressions and Allyship” Train the Trainer programme, supporting the delivery of locally tailored workshops aimed at addressing non-inclusive behaviours.

Metric 9: Board representation

Table 6 shows the representation and percentage difference between the ethnicity of KCHFT Board members and the overall workforce, by voting and executive membership.

	White	BME	Unknown
Overall workforce	80.4%	17.4%	2.2%
All Board members	76.5%	23.5%	0.0%
Difference Board - Overall	-3.9%	+6.1%	-2.2%
Voting Board members	76.9%	23.1%	0.0%
Non-voting Board members	75.0%	25.0%	0.0%
Difference Voting - Overall	-3.5%	+5.7%	-2.2%
Executive Board members	100.0%	0.0%	0.0%
Non-executive Board members	55.6%	44.4%	0.0%
Difference Executive - Overall	+19.6%	-17.4%	-2.2%

Table 6

- There is a higher level of BME representation on the Board at 23.5% with the overall workforce at 17.4%, showing a difference of 6.1%.
- There is no Unknown ethnicity recorded at Board level, compared to 2.2% within the overall workforce, showing the entire Board have declared their ethnicity.
- The majority of voting Board members are White at 76.9%, however this is an underrepresentation compared to the overall workforce with a difference of 3.5%.
- BME colleagues are over-represented within voting Board membership at 23.1%, relative to their proportion within the workforce at 17.4%. showing a difference of 5.7%.
- 100% of Executive Board members are White, showing a significant under-representation of BME colleagues compared to the workforce profile.

Figure 18 shows the trend of ethnicity representation of all KCHFT Board members since 2021-22.

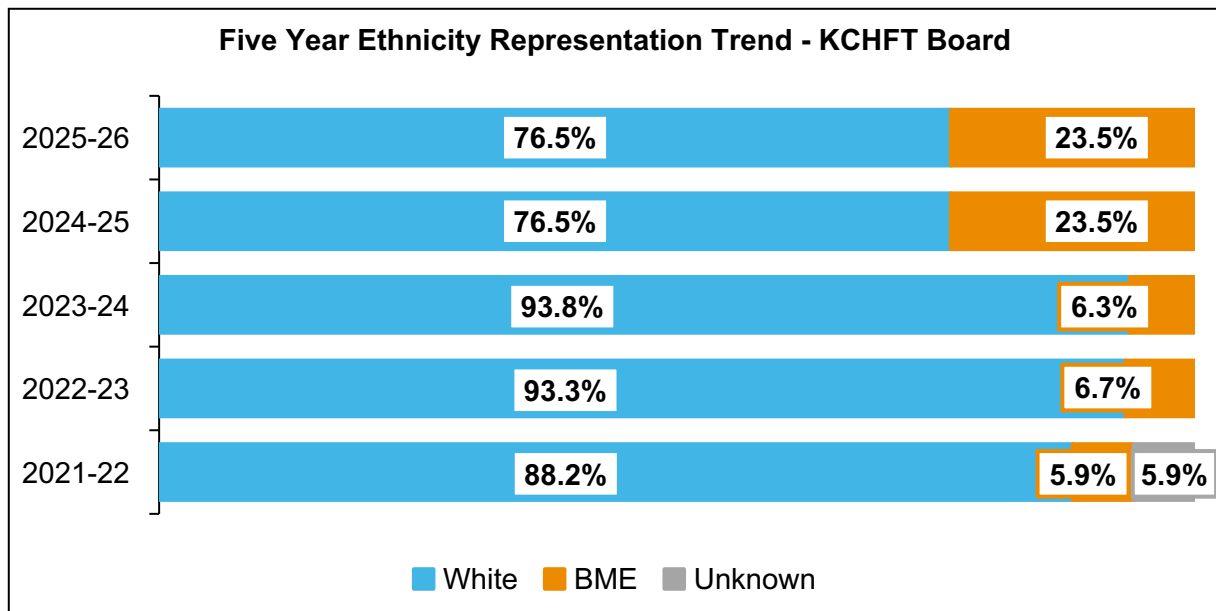


Figure 18

- 2023-24 showed an increase in BME representation on the KCHFT Board, with the rise from 6.3% to 23.5% representing a significant and meaningful shift.



Recommendations

Building on this year's WRES findings, KCHFT will continue to prioritise the continued implementation and expansion of targeted actions to address identified inequalities across employee relations and staff experience, while sustaining progress in areas where improvements have been achieved, including recruitment outcomes.

Actions will be delivered through the NLB approach, with ongoing oversight and co-production with key stakeholders including BME colleagues, Culture Equality Network (CEN) and wider staff networks to ensure progress remains responsive, transparent and sustainable.

Conclusion

The 2025–26 WRES report demonstrates that KCHFT continues to make meaningful progress. This is reflected in improving workforce diversity, increasing ethnicity declaration rates and sustained equitable access to training and development opportunities.

We value the quality, insight and experience that colleagues bring to our organisation and remain committed to taking a transparent and proactive approach to addressing inequity. Being an inclusive employer is central to both our organisational strategy (We Care) and our NLB approach to equity, diversity, inclusion, health and wellbeing.

The Workforce EDIH&Wb Team would like to thank all colleagues, champions, ambassadors, staff networks and Board members for their ongoing commitment and passion in ensuring that inclusion and equity remain central to how we support both colleagues, patients and service users.

Appendices

Appendix 1: Definitions

Nobody Left Behind (NLB)	Nobody Left Behind (NLB) is Kent Community Health NHS Foundation Trust's approach to Equity, Diversity, Inclusion, Health and Wellbeing (EDIH&Wb). It is designed to ensure that all colleagues feel valued, have their voices heard and are supported to thrive. The approach focuses on taking a transparent and proactive stance to embedding equity across recruitment, development and wellbeing. Formal delivery concluded in 2024, the ambitions of NLB continue to underpin our broader ways of working. The programme now informs our ongoing action plan and services as a guiding principle in the how we approach inclusion, wellbeing, and equity across KCHFT.
Electronic Staff Record (ESR)	The NHS Electronic Staff Record (ESR) ⁽⁴⁾ is a workforce system used by all NHS Trusts and Health Boards in England and Wales and manages the payroll for over 1.9 million NHS employees. ESR offers a hub which gives NHS employees control over their personal data as well as access to payslips, total reward statements and e-learning.
Agenda for Change (AfC)	The Pay system and framework for determining pay and conditions for the majority (pay Bands 1–9) of NHS employees in the UK.
Very Senior Management (VSM)	Chief executives. Executive directors, with the exception of those who are eligible to be on the consultant contract by virtue of their qualification and the requirements of the post (these colleagues will be classed as Senior Medical Managers and recorded amongst the Medical and Dental colleagues). Other senior managers with board level responsibility who report directly to the chief executive.

⁽⁴⁾ [Electronic Staff Record \(ESR\) Workforce Services | NHSBSA](#)

Medical and Dental subgroups	Medical and Dental subgroups: Trainee grade, Career grade, and Other medical and dental grades Colleagues paid using the Medical and Dental pay scales. Subgroups are identified by using the grade codes as recorded in the Electronic Staff Record.
Relative likelihood	Compares the likelihood of the criteria of one group over another, using the following formula (for Metric 2 example): $\% \text{ Appointed from shortlisting} = \frac{\text{Total appointed}}{\text{Total shortlisted}} \times 100$ (for each group) $\text{Relative likelihood of Group 1 compared to Group 2} = \frac{\text{Group 1 \%}}{\text{Group 2 \%}}$ Relative likelihood values: = 1.0 White and BME candidates are equally likely to be appointed from shortlisting > 1.0 White candidates are more likely to be appointed than BME candidates < 1.0 White candidates are less likely to be appointed than BME candidates.
Formal disciplinary process	Refers to colleagues who have entered into a formal disciplinary as prescribed by the local disciplinary process. Any occasional cases where disciplinary action is not preceded by an investigation are also included, as well as colleagues who have been subject to an investigation, but for whom no further action was taken. Cases where mediation has taken place rather than any kind of formal investigation or disciplinary action have not been counted.
Non-mandatory training	Refers to any learning, education, training or staff development activity undertaken by an employee, the completion of which is neither a statutory requirement (e.g., fire safety training) or mandated by the organisation (e.g., clinical records system training).
Continuing professional development (CPD)	The intentional, ongoing process of tracking and documenting the skills, knowledge, and experience gained throughout a professional career. CPD ensures qualifications remain current, generally combining work-based learning, formal courses, and self-directed study.

Board members	Board membership includes all members of the Board irrespective of whether they are executive or non-executive members and whether they are voting or non-voting members of the Board who may have been co-opted. An executive Board member is an employee of the organisation who sits on an organisation's Board of directors and advises current Organisational management on specific operations, e.g. Finance Director. A non-executive board member is a member of the Board of directors of the organisation who is not part of the executive management team. In NHS provider trusts, non-executive board members are typically appointed and employed by NHS England.
Benchmark	A benchmark is a reference point (often the average or mean of the peer group). It describes the typical performance level across the peer group.
Median	The median is the middle value when all groups results are ordered. It describes the midpoint of the peer group and is useful when the data is skewed by very high or very low values.

Appendix 2: Ethnicity categories

Ethnicity Category	ESR options	Staff Survey options
White	- White - British - White - Irish - White - Any other White background - White Northern Irish - White Unspecified - White English - White Scottish - White Welsh - White Cornish - White Cypriot - White Greek - White Greek Cypriot - White Turkish - White Turkish Cypriot - White Italian - White Irish Traveller - White Traveller - White Gypsy / Romany - White Polish - White ex-USSR - White Kosovan - White Albanian - White Bosnian - White Croatian - White Serbian - White Other Ex-Yugoslav - White Mixed - White Other European	- English / Welsh / Scottish / Northern Irish / British - Irish - Gypsy or Irish Traveller - Any other White background
BME	- Mixed - White & Black Caribbean - Mixed - White & Black African - Mixed - White & Asian - Mixed - Any other mixed background - Mixed - Black & Asian - Mixed - Black & Chinese - Mixed - Black & White - Mixed - Chinese & White - Mixed - Asian & Chinese - Mixed – Other / Unspecified - Asian or Asian British - Indian - Asian or Asian British - Pakistani - Asian or Asian British - Bangladeshi	- White and Black Caribbean - White and Black African - White and Asian - Any other Mixed / Multiple ethnic background - Indian - Pakistani - Bangladeshi - Chinese - Filipino - Any other Asian background - African - Caribbean - Any other Black / African / Caribbean background

	- Asian or Asian British - Any other Asian background - Asian Mixed - Asian Punjabi - Asian Kashmiri - Asian East African - Asian Sri Lankan - Asian Tamil - Asian Sinhalese - Asian British - Asian Caribbean - Asian Unspecified - Black or Black British - Caribbean - Black or Black British - African - Black or Black British - Any other Black background - Black Somali - Black Mixed - Black Nigerian - Black British - Black Unspecified - Chinese - Any Other Ethnic Group - Vietnamese - Japanese - Filipino - Malaysian - Other Specified	- Arab - Any other ethnic background
Unknown	Z Not stated	<i>No option available – colleagues can choose not to answer instead</i>



Kent Community Health
NHS Foundation Trust

**Workforce Equity, Diversity and Inclusion and
Health and Wellbeing Team**



www.kentcht.nhs.uk

Workforce Disability Equality Standard Report 2026





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Introduction

Kent Community Health NHS Foundation Trust (KCHFT)⁽¹⁾ is one of the largest NHS Community Providers in England, employing and providing health services to a population of 3.6 million across Kent, East Sussex, and London. As of 31 March 2026, the KCHFT workforce population was 5,321.

KCHFT takes the issues of fairness, rights, and equity very seriously. We recognise the value of our colleagues and their diversity, act to ensure that our workforce is representative of the communities we serve and understand that colleagues work better when they can be themselves.

We appreciate the quality, understanding and experience that colleagues bring to our organisation and are committed to taking a transparent and proactive approach to addressing inequity. The need to be an inclusive employer is paramount to this and is a central tenet of both our organisational strategy (We Care⁽²⁾) and our [Nobody Left Behind \(NLB\)](#) approach to equity, diversity, inclusion, health, and wellbeing. This is particularly visible through our NLB action plan⁽³⁾.

We recognise the interconnection between equity, diversity and inclusion, and health and wellbeing. Taking an intersectional approach, we acknowledge the significant impact that racism and discrimination can have on an individual's ability to thrive at work and experience a sense of belonging.

Due to a number of secondment arrangements, some colleagues working in KCHFT are not included in the datasets as these colleagues are included in their host organisations workforce reports including their Equity, Diversity and Inclusion (EDI) reporting. KCHFT has embraced the shared systems approach being encouraged across the Kent and Medway Integrated Care Board (ICB), which brings greater diversity of thought, representation, and perspective.

⁽¹⁾ [About Kent Community Health NHS Foundation Trust](#)

⁽²⁾ [Our we care strategy 2023 to 2028 | Kent Community Health NHS Foundation Trust](#)

⁽³⁾ <https://www.kentcht.nhs.uk/about-us/equity-diversity/>



What is the Workforce Disability Equality Standard?

The Workforce Disability Equality Standard (WDES) was introduced in April 2019 as a mandated data collection. The WDES is a collection of ten metrics that aim to compare the workplace experiences of disabled and non-disabled colleagues. NHS Trusts and NHS Foundation Trusts are required to report and publish data, on an annual basis, for each of these metrics.

The WDES was devised to make sure colleagues with a disability or long-term condition have equal access to career opportunities and receive fair treatment in the workplace. Evidence shows that a motivated, included and valued workforce helps to deliver high-quality patient care, increased patient satisfaction and better patient safety; it also leads to more innovative and efficient organisations.

Disability categories

Colleagues at KCHFT can record a disability on their [Electronic Staff Record \(ESR\)](#) and declare this through their response to the NHS Staff Survey. For reporting purposes, disability declaration from both data collection sources is categorised into the following groups to ensure the anonymity of minority groups and individuals within the Trust is protected. These categories are applied consistently across both ESR and Staff Survey datasets to support comparable analysis and protect confidentiality.

- **Non-disabled**
- **Disabled**
- **Unknown (ESR only)**

A full breakdown of the disability categories colleagues can record is provided in [Appendix 2](#).

It should be noted that the definitions of disability used within ESR, the NHS Staff Survey and NHS Jobs all differ with each other and with the legal definition of disability as set out in the Equality Act 2010⁽⁴⁾. Work is ongoing to align definitions of disability with the latter, as well as set up cross-system, agreed disability question(s).

⁽⁴⁾ [Equality Act 2010](#)



WDES metrics

The WDES consists of ten metrics to analyse data relating to substantive members of the KCHFT workforce, allowing for the identification and reduction of any inequalities between disabled and non-disabled colleagues.

Metrics one to three focus on workforce data as at 31 March 2026.

1. Workforce representation

- 1a) Percentage of colleagues in the overall workforce, by disability status
- 1b) Percentage of clinical and non-clinical colleagues in [Agenda for Change \(AfC\)](#) pay bands, [Very Senior Management \(VSM\)](#) and [Medical and Dental subgroups](#), compared with the percentage of colleagues in the overall workforce, by disability status.

2. Appointment from shortlisting

[Relative likelihood](#) of non-disabled applicants being appointed from shortlisting compared to disabled applicants, across all posts.

3. Formal capability process

Relative likelihood of disabled colleagues entering the [formal capability process](#) compared to non-disabled colleagues, as measured by entry into the formal capability procedure.

disc

Metrics four to nine (a) focus on data from responses to the 2025 National NHS Staff Survey.

4. Harassment, bullying or abuse

- 4a) Percentage of colleagues experiencing harassment, bullying or abuse from patients, service users or the public in the last twelve months, by disability status
- 4b) Percentage of colleagues experiencing harassment, bullying or abuse from managers in the last twelve months, by disability status
- 4c) Percentage of colleagues experiencing harassment, bullying or abuse from other colleagues in the last twelve months, by disability status
- 4d) Percentage of colleagues saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it, by disability status.

5. Career progression

Percentage of colleagues believing that the organisation provides equal opportunities for career progression or promotion, by disability status.



6. Presenteeism

Percentage of colleagues saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties, by disability status.

7. Feeling valued

Percentage of colleagues saying that they are satisfied with the extent to which their organisation values their work, by disability status.

8. Workplace adjustments

Percentage of disabled KCHFT colleagues saying that that their employer has made [reasonable adjustment\(s\)](#) to enable them to carry out their work.

9. Staff engagement

9a) The [Staff Engagement score](#) for colleagues, by disability status.

Metric nine (b) focuses on the voices of disabled colleagues.

9b) Have you taken action to facilitate the voices of colleagues staff in your organisation to be heard?

Metric ten focuses on disability representation on the KCHFT Board as at financial year end 31 March 2026.

10. Board representation

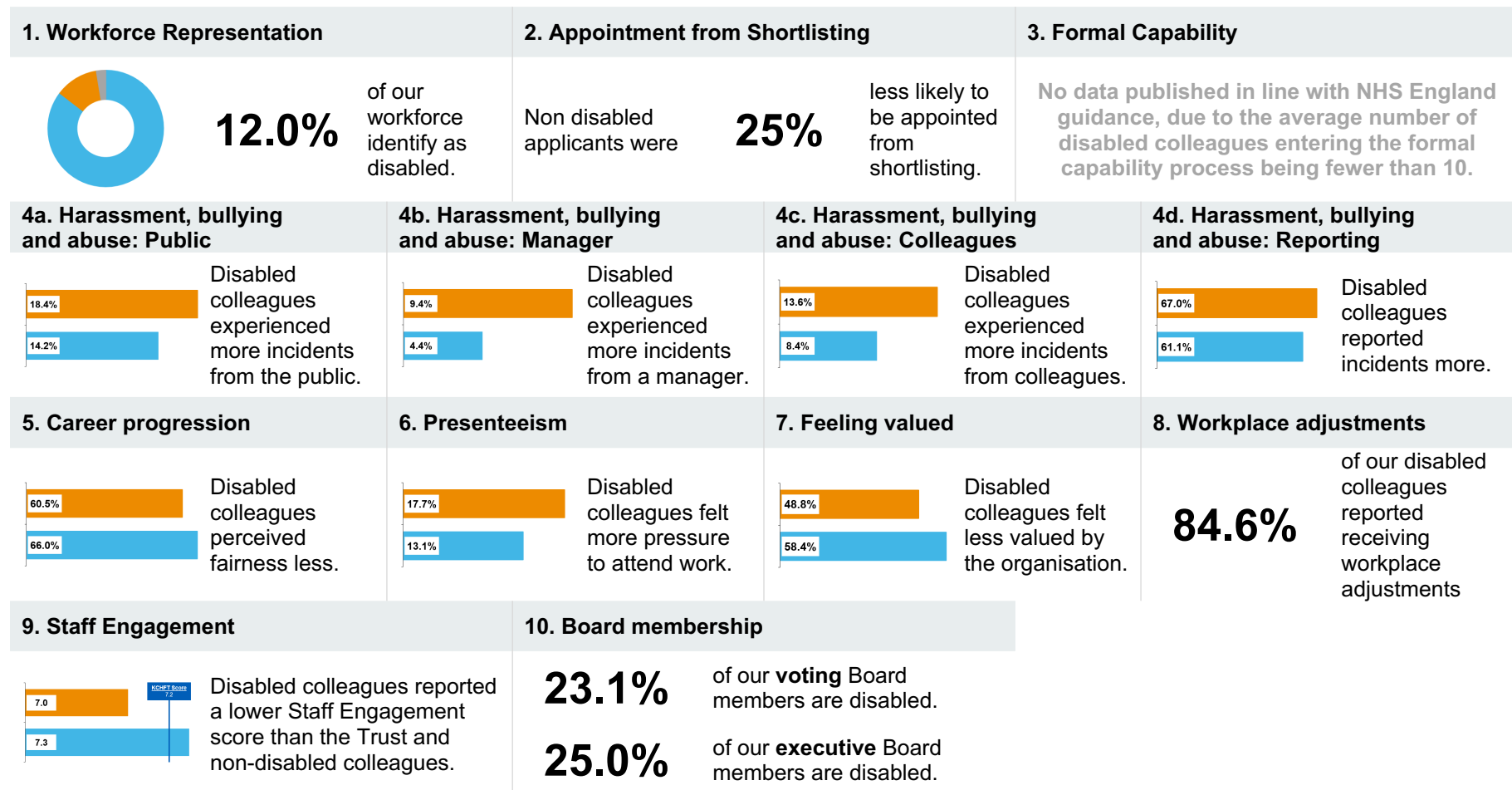
Percentage difference between the disability status of KCHFT [Board members](#) and the overall workforce, and by voting and executive membership.



WDES 2025-26 Summary Dashboard

Metrics 1 - 3 and 10 are taken from workforce data as of 31 March 2026.
Metrics 4 - 9 are taken from responses to the 2025 National NHS Staff Survey.

Non-disabled Disabled Unknown



This dashboard can be provided in an alternative format, if required.



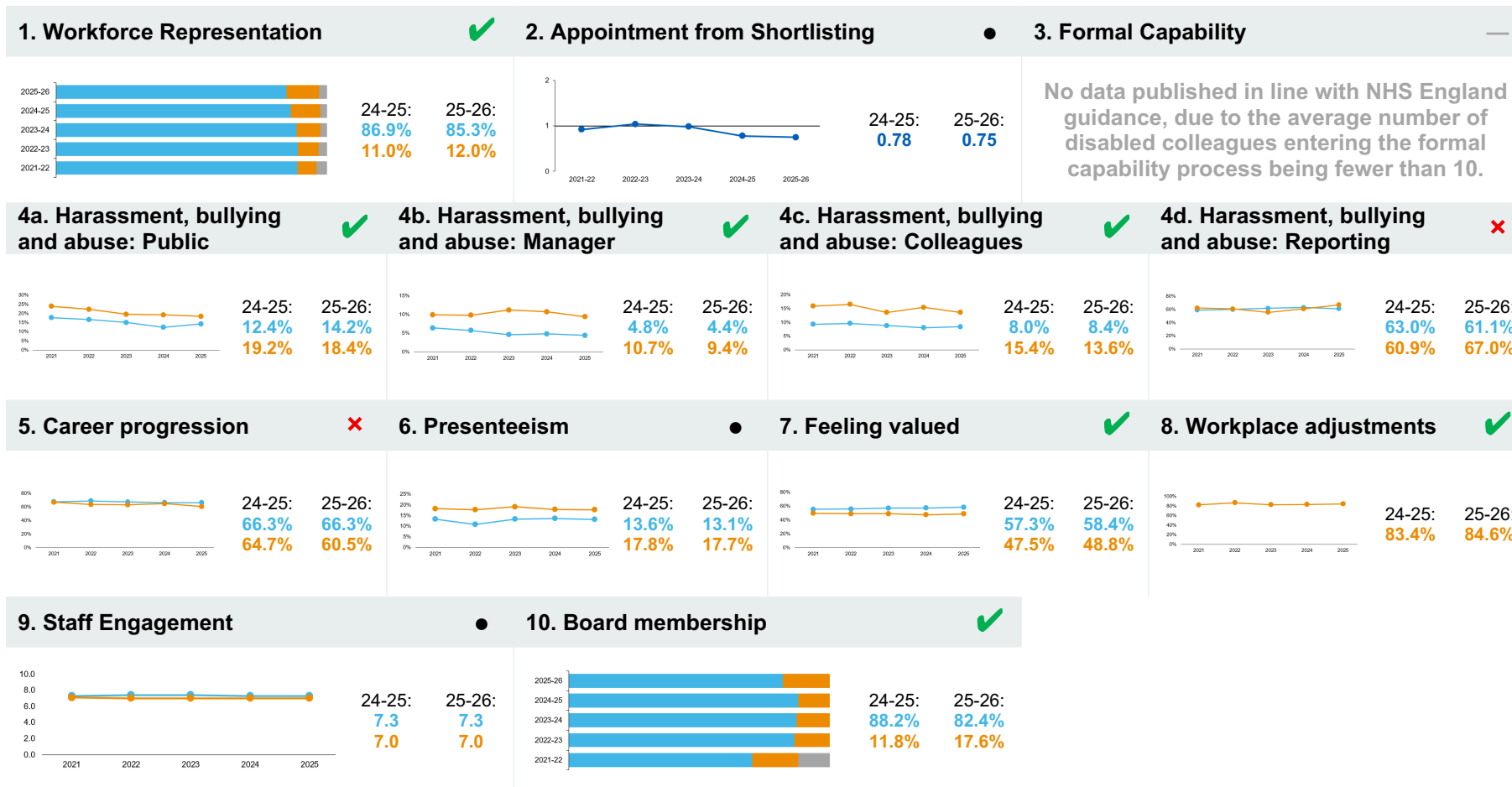
WDES Year-on-Year Trends Dashboard (2021-2026)

Metrics 1 - 3 and 10 are taken from workforce data as of 31 March 2026.
Metrics 4 - 9 are taken from responses to the 2025 National NHS Staff Survey.

Comparison to last year for disabled:

Non-disabled Disabled Unknown

Better ✓ No change ● Worse x



This dashboard can be provided in an alternative format, if required.

WDES Community Trusts Average Comparison

- The following data reflects results from the 2026 WDES submissions for the NHS Community Trusts peer group, which includes all community trusts in England.
- It includes both peer-group [benchmark](#) and [median](#) values, allowing comparison against typical performance levels within the peer group for each WDES metric.
- Percentages shown in the table represent the responses of disabled colleagues, except for Metric 2 and Metric 3, which present the relative likelihood figures.
- The green highlight indicates who is performing more favourably compared with the other.

WDES Metric	KCHFT	Peer group average
Metric 1 Overall workforce representation	12.0%	9.5%
Metric 2 Appointment from shortlisting	0.75 ⁽⁵⁾	1.01
Metric 3 Formal capability process	Not published	
Metric 4a Harassment, bullying and abuse: Public	18.4%	23.6%
Metric 4b Harassment, bullying and abuse: Manager	9.4%	9.4%
Metric 4c Harassment, bullying and abuse: Colleagues	13.6%	15.9%
Metric 4d Harassment, bullying and abuse: Reporting rate	67.0%	61.9%
Metric 5 Career progression	60.5%	54.9%
Metric 6 Presenteeism	17.7%	22.3%
Metric 7 Feeling valued	48.8%	41.1%
Metric 8 Workplace adjustments	84.6%	80.5%

⁽⁵⁾ As the population of people with disabilities at KCHFT (12.0%) is under the government national average (25%), the KCHFT figure is more favourable as it takes us nearer to true representation.



Metric 9a Staff engagement score	7.0	6.7
Metric 10 Board representation	17.6%	9.1%

- KCHFT is performing more favourably than the peer group average for the majority of the WDES metrics.
- KCHFT is in line with the peer group average for **Metric 4b (Harassment, bullying and abuse from patients, service users or the public)**.
- There is no comparison available for **Metric 3 (Formal capability process)** due to figures not being published in line with guidance from the NHS England.

Metric 1: Workforce representation

1a) Overall workforce

Figure 1 shows the percentage of colleagues at KCHFT by disability, as recorded on ESR.

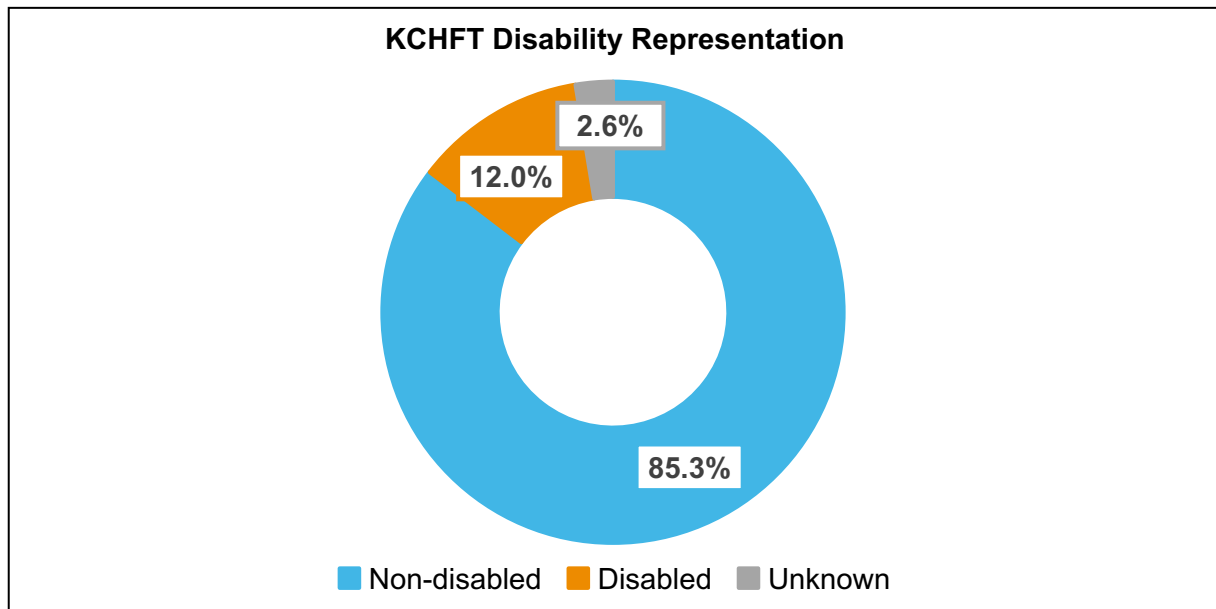


Figure 1

- 85.3% of KCHFT colleagues are non-disabled, with 12.0% disabled and 2.6% unknown or not declared on ESR.

Figure 2 shows the trend in disability declaration rates at KCHFT since 2021-22.

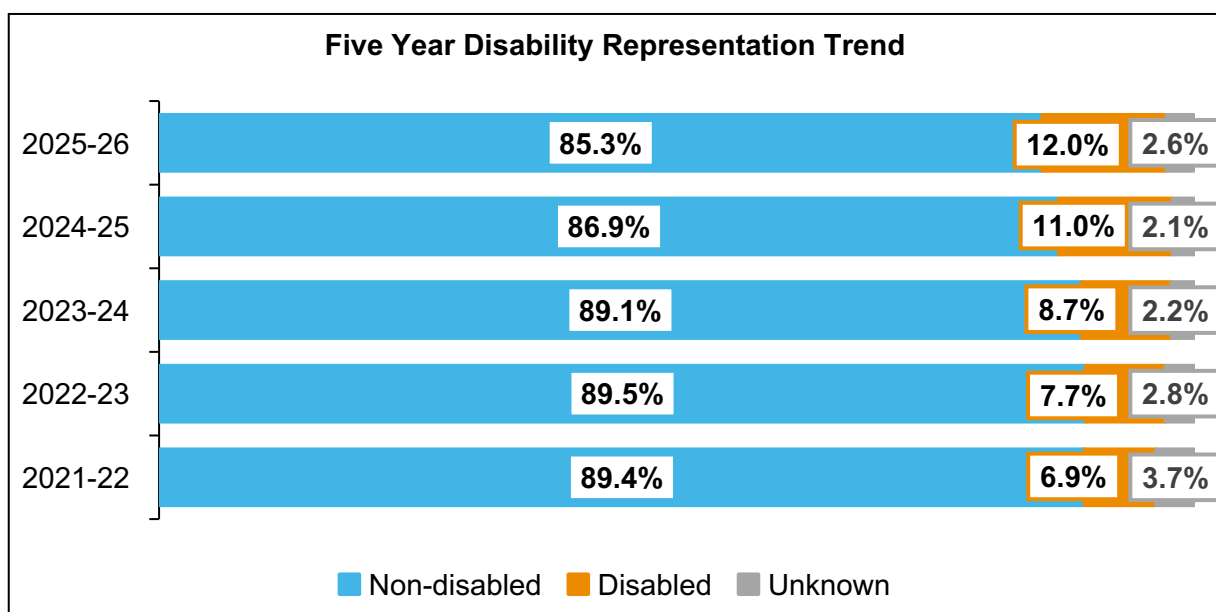


Figure 2



- The workforce remains predominantly non-disabled, however the consistent increase in disabled representation over the five-year period indicates sustained progress and improvement, with the rise from 6.9% to 12.0% representing a significant and meaningful shift.
- Our NLB approach supports positive messages regarding declaration by creating an environment where colleagues feel safe, valued, and confident to share their personal information. Through its focus on inclusive culture, visible allyship, and equitable systems, NLB encourages open conversations about identity and belonging.
- The Disability and Carer Staff Network and Neurodiversity Staff Network have been integral to contributing towards this, including embedding NLB principles such as psychological safety, representation, and active inclusion.
- As part of Neurodiversity Celebration Week this year, the Neurodiversity Staff Network hosted the first Neurodiversity Conference. This brought colleagues and allies together to build understanding, awareness and spark meaningful conversations about neurodiversity in the workplace.
- The Disability and Carer Staff Network have created a platform where members can add information about resources that they have found supportive. The information is available to all colleagues within KCHFT and promotes allyship through the learning of different lived experiences.

1b) Clinical and non-clinical colleagues by AfC pay bands, VSM and Medical and Dental subgroups

Figure 3 shows the percentage distribution of non-clinical KCHFT colleagues by disability status and clustered pay band, as recorded on ESR.

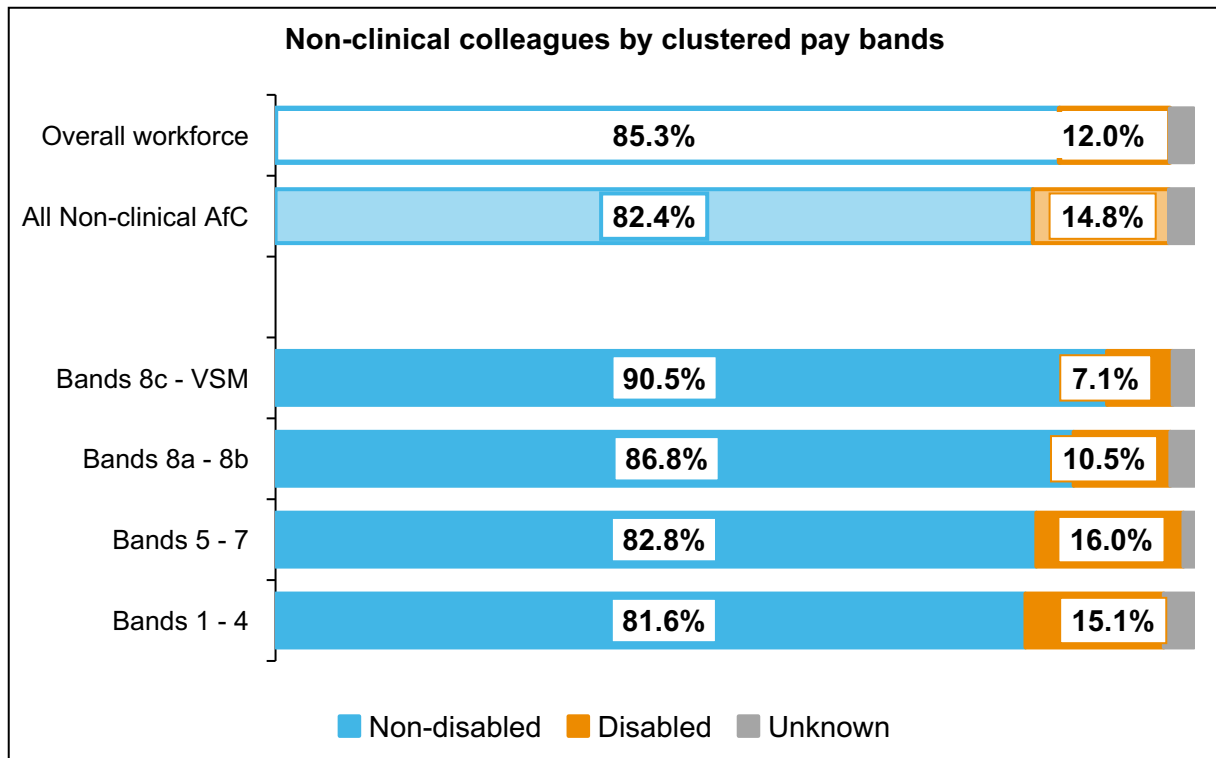


Figure 3

- The overall AfC non-clinical disabled representation is 14.8%, which is above the overall workforce figure. This reflects the workforce distribution where Bands 1–7 account for most staff and show higher disability rates, while Bands 8a+ represent a smaller cohort with lower rates, resulting in a higher overall percentage.
- Bands 1-4 of the non-clinical workforce have the highest proportion of disabled colleagues at 15.1%.
- Bands 8c-VSM have the lowest proportion of non-clinical disabled colleagues, with Bands 8a-8b also reporting lower representation than the overall workforce.
- Following the 2024-25 report there has been an increase in disabled representation in Bands 8a-8b in keeping with the organisational efforts to diversify our senior leadership roles.

- Further analysis will follow in the section on [Metric 2](#) however one of the key focuses of our Inclusion Ambassador programme has been to support senior leader recruitment with the programme supporting 19 recruitments at Band 8a and above.

Figure 4 shows the percentage distribution of clinical KCHFT colleagues by disability status and clustered pay band, as recorded on ESR.

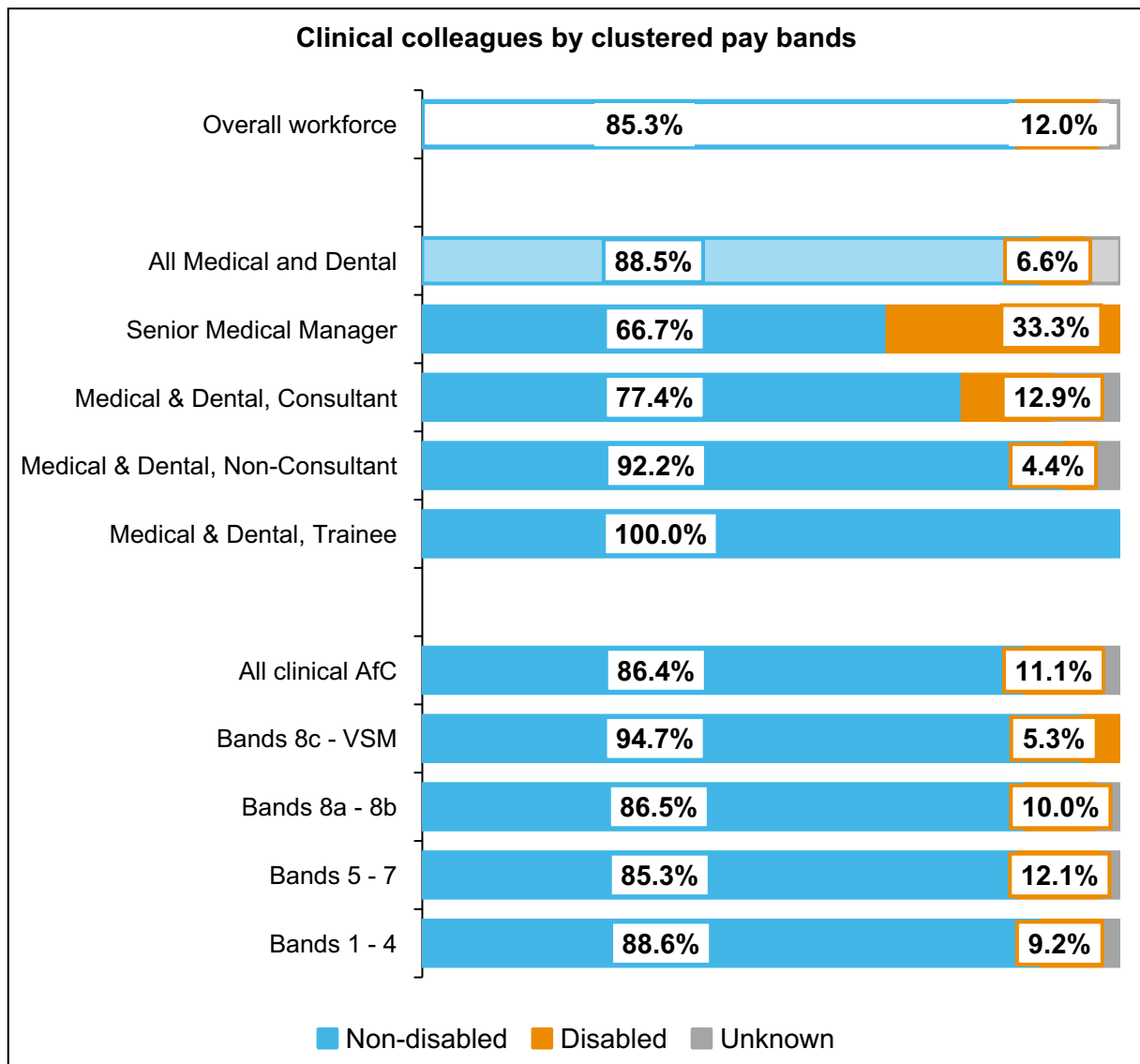


Figure 4

- Overall, AfC clinical disabled representation is 11.1%, which is below the overall workforce figure.
- Bands 5-7 have the highest proportion of disabled colleagues within AfC clinical roles at 12.1%, which is broadly comparable with overall workforce representation.



- In contrast, Bands 8c-VSM have the lowest proportion of disabled colleagues within AfC clinical roles.
- Of Medical and Dental colleagues, 10.9% are disabled, which is slightly below the overall workforce figure.
- Disabled representation is particularly low among non-Consultant grades at 4.4%, whilst Consultants show disabled representation broadly comparable with the overall workforce.
- Medical and Dental Trainees and Senior Medical Managers are comprised primarily of non-disabled colleagues, this is due in part to the very small sample sizes within these subgroups.

Metric 2: Appointment from shortlisting

Table 1 shows the breakdown of applicants shortlisted and appointed by KCHFT between 1 April 2025 and 31 March 2026, by disability status.

Disability status	Total Shortlisted	Total Appointed	% Appointed from Shortlisting
Non-disabled	2856	742	26.0%
Disabled	297	103	34.7%
Unknown	69	16	23.2%
Relative Likelihood Ratio (Non-disabled over Disabled): 0.75			

Table 1

- The relative likelihood score of 0.75 shows that a disabled applicant is more likely to be appointed from shortlisting compared to a non-disabled applicant.
- It is positive to note that with a workforce representation of 12.0%, the 34.7% appointment against shortlisting for disabled applicants is significant progress.

Figure 5 shows the trend of relative likelihood of appointment since 2021-22.

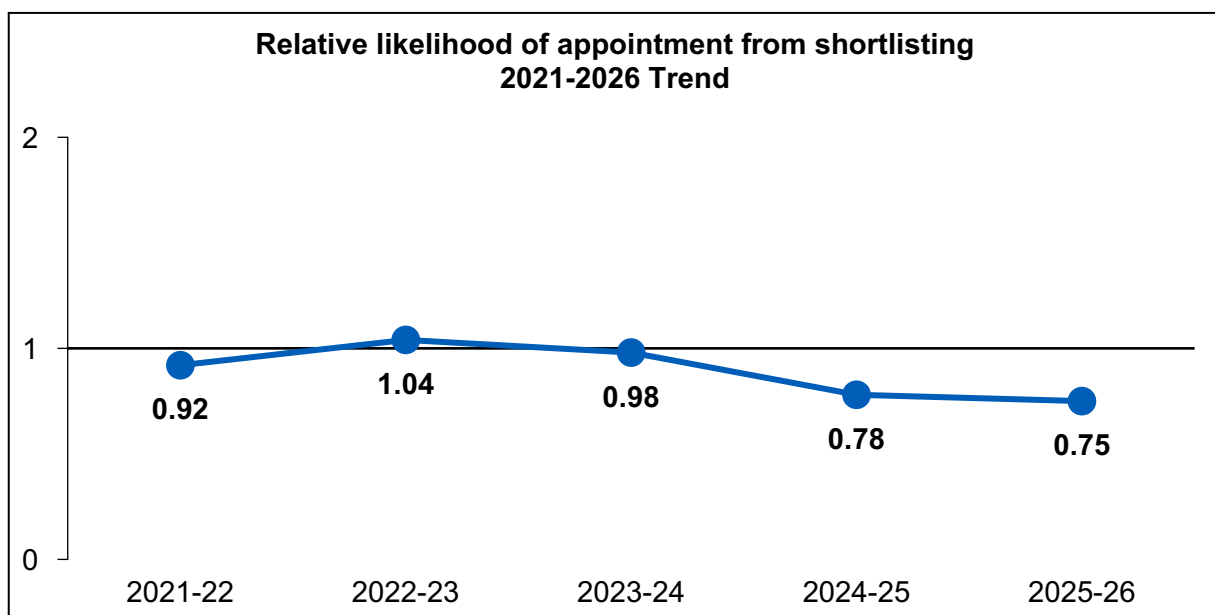


Figure 5

- Over the period, the relative likelihood has mostly remained below 1, demonstrating consistent favourable outcomes for disabled applicants at appointment stage.
- The significant shift in 2024-25 aligns with the implementation of a bespoke inclusive recruitment programme titled the 'Inclusion Ambassador Programme', which was developed and piloted between August 2024 and August 2025.
- Inclusion Ambassadors (IAs) were trained in inclusive recruitment representing the breadth and depth of diversity as per the Equality Act 2010 definitions of protected characteristics.
- Crucial to the programme, IAs were given equal status on recruitment panels and involved in both shortlisting and interviewing processes. They are provided support from the Workforce Equity, Diversity, Inclusion, Health and Wellbeing (WEDIH&Wb) Team, Recruitment Team and have an escalation route to the Chief People Officer.
- Teams in a particular directorate were identified to take part in the pilot and were those with the highest likelihood of appointment ratios alongside the lowest existing representation. We have seen a measurable impact in improving inclusive recruitment within the areas the IAs were deployed.

Table 2 shows the change in relative likelihood of appointment from before and after implementation of the programme in the pilot areas.

	September 2023	August 2024 IA programme implemented	September 2025	Change
Relative likelihood of non-disabled applicants being appointed from shortlisting compared to disabled applicants	2.25		0.39	-1.86

Table 2

- The 1.86 point improvement shows significant evidence of the success of the programme.
- A paper was presented to the Trust Executive leadership team in December 2025 proposing a long-term programme of IAs. With their agreement this has been developed by the WEDIH&Wb Team who have made necessary changes following lessons learnt from the pilot.



- During the pilot there were requests for IAs from recruiting managers outside of the pilot teams. The programme has since been opened to the whole Trust and additional IA cohorts are being recruited and trained.
- Feedback has been positive and the following was received from a current IA:

“Being part of the interview process has made me feel that my voice is genuinely being heard and that my experiences and opinions can help shape positive change. It has also been a great opportunity to meet so many different people, learn from their perspectives, and build meaningful connections. I am proud to be involved in changes that are moving in the right direction and helping to create a more inclusive and supportive environment for everyone.”

- Further feedback was received from a recruiting manager outside of the pilot areas who requested an IA:

“A particular IA...integrated into the panel brilliantly, giving input related to the We care values but also scoring on the candidates’ overall performance, not just their EDI results...I think having an independent person reduced bias, therefore creating a fairer and more robust recruitment process for the candidates.”

- KCHFT remains a Disability Confident Leader, the highest attainable status in the Department for Work and Pensions’ (DWP) Disability Confident Scheme⁽⁶⁾. This includes an offer of guaranteed interviews per the conditions of the scheme.
- In 2025 the Trust overhauled a recruitment e-learning package, making it mandatory for all colleagues with management responsibilities. Feedback and completion rates have been the strongest seen for a new e-learning programme. The training also supports the adoption of more inclusive recruitment practices.
- Training includes a dedicated section on adjustments that can be made to the recruitment and interview process, including changing the interview location, ensuring physical accessibility of the interview space and providing interview questions in advance on request.
- Feedback for this training can be seen in **Table 5** and **Figure 7**, with high completion and evaluation response rates and a positive Net Promoter Score. Learners consistently highlighted the focus on values-based recruitment, fairness and consistency, with content on bias and microaggressions frequently described as impactful and eye-opening.

⁽⁶⁾ [Disability Confident employer scheme - GOV.UK](https://www.gov.uk/disability-confident-employer-scheme)

- This feedback provides a helpful evidence base to inform consideration at the next planned review or refresh of the content.
- The Trust is cognisant of the realities in the work still needed, however is reassured that the disparity is decreasing and that the interventions of the WEDIH&Wb team have proven successful.

Completion rate	Compliance	Evaluation completion rate	Recommendation rate
890 colleagues have completed the module since its launch in November 2025	94.4% managers have completed the training (those with direct line management in TAPs)	31.5% of colleagues who completed the training also completed an evaluation form (organisational average is 18%)	63.8% of colleagues would recommend the module

Table 3

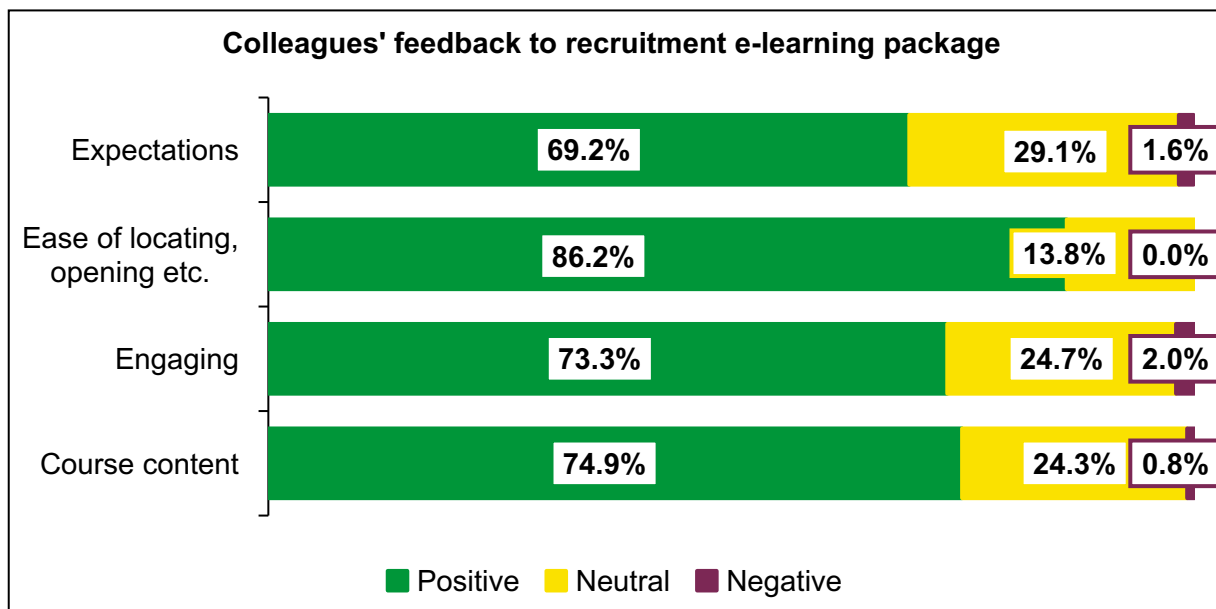


Figure 6



Metric 3: Formal capability process

The metric for colleagues entering the formal capability process is based on a two-year rolling average. This is derived by taking the total number of colleagues who entered the formal capability process between 1 April 2024 and 31 March 2026 and dividing this figure by two to produce an average annual figure. The data includes only cases related to performance and excludes those associated with ill-health.

- The average number of disabled colleagues entering the formal capability process over this two-year period was fewer than 10, and as such, the figure calculated for this metric has not been published in line with guidance from the NHS England.
- The Trust has had fewer than 10 colleagues with disabilities and / or long-term health conditions entering formal capability processes for the last four years and as such a trend cannot be ascertained.
- Maintaining such low numbers for a fourth year is an achievement. Our workforce embodies our values of empathy and care, making meaningful attempts to support colleagues across the organisation to succeed in their roles.

Metric 4: Harassment, bullying or abuse

4a) From patients, service users or the public

Figure 7 shows the percentages of KCHFT colleagues whose response to the following Staff Survey question indicated they had experienced it at least once, by disability status. A total of 3,487 colleagues responded to this question in 2025 (65.5% of the overall workforce).

In the last 12 months, how many times have you personally experienced harassment, bullying or abuse at work from – Patients / service users, their relatives or other members of the public.

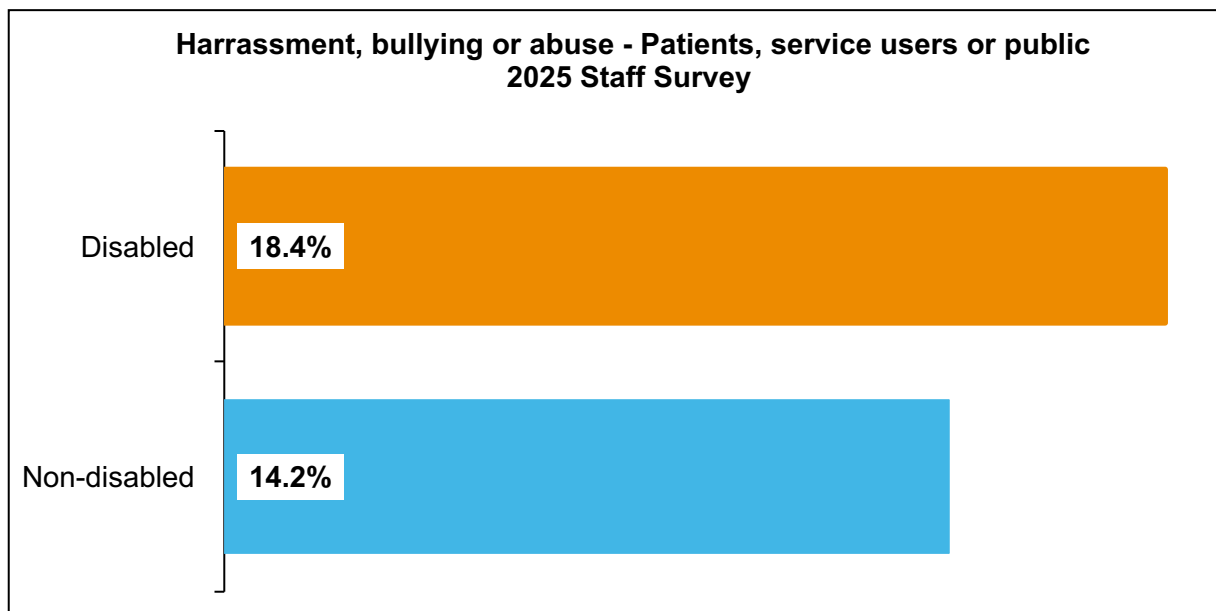


Figure 7

- 18.4% of disabled colleagues experienced harassment, bullying, or abuse from the public, compared to 14.2% of non-disabled colleagues.
- Although the percentage for non-disabled colleagues is lower, 14.2% still represents a significant proportion of the workforce and demonstrates that public-facing aggression is not isolated to one group.
- The data highlights that unacceptable behaviour from patients, and the public is a widespread and systemic issue, affecting colleagues across all groups in the workforce and creating a challenging environment for everyone.

Figure 8 shows the trends of colleagues experiencing harassment, bullying or abuse from patients at least once since the 2021 Staff Survey, by disability status.

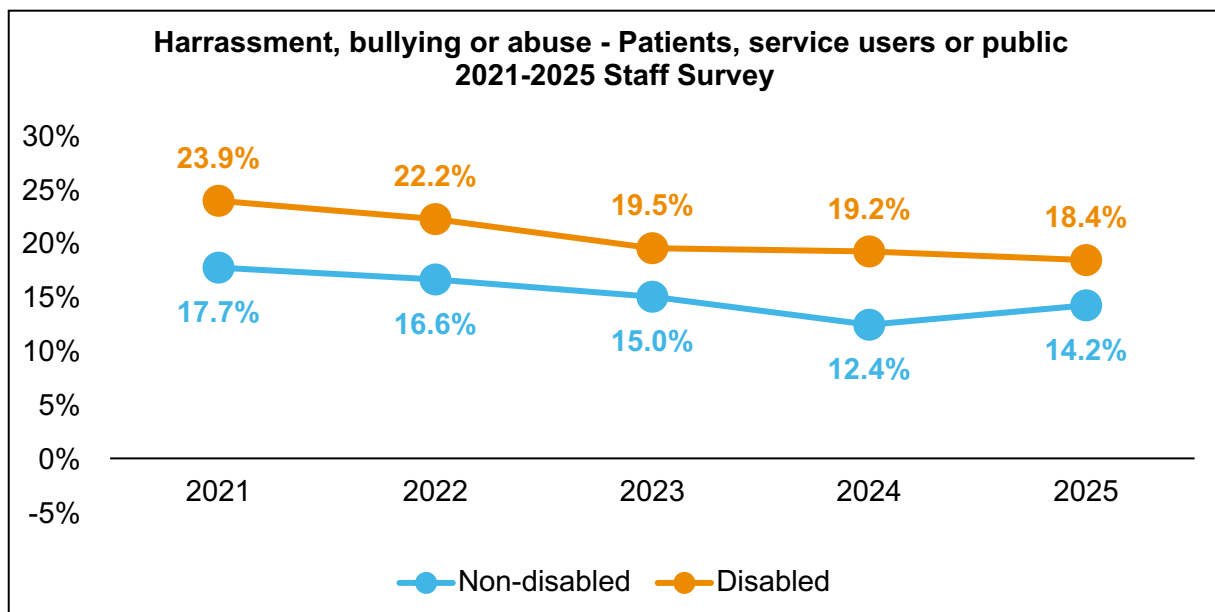


Figure 8

- Disabled colleagues consistently report higher levels of harassment, bullying or abuse from patients than non-disabled colleagues.
- There has been a steady decreasing trend for both non-disabled and disabled colleagues, however the former reported an increase in 2025.
- The disparity between disabled and non-disabled colleagues is narrowing, with 2025 showing the smallest gap to date.
- As a community trust our workforce is in the unique position of having to deliver many clinical services in people's homes and private spaces, which can also bring significant vulnerabilities.
- Lone Worker Guidance ensures our colleagues who are lone working are compliant with legislation under the Health and Safety at Work Act and required to undertake Conflict Resolution Training. In addition, those colleagues who visit patients at their home address or work remotely in clinics and other locations and fit the Lone Worker Profile must complete Level 4 Lone Worker Training.
- In response to the scale of change within KCHFT and across the wider system, a new "Building Supportive Teams" toolkit has been introduced. Shaped by colleague feedback, it places preserving energy, open and honest conversations and time to rest and recover at the centre of team wellbeing.



- KCHFT has shown its continued support of its entire workforce. Our Chief Executive Officer and the Board have discussed the behaviours observed on multiple occasions and reminded the workforce and members of the public of our expected standards. Examples of these can be found on our public website.
- In October 2025 the Trust launched a new “Managing unacceptable behaviour” policy to improve how the organisation manages patient behaviour. The policy included actionable methods to operationalise our zero-tolerance policy, with clearer expectations communicated to the public and an aim to help colleagues to feel better equipped and supported in patient-facing situations.
- The aim of this policy is to support colleagues in managing incidents of violence, aggression, unacceptable behaviour and abuse from patients, relatives, carers, friends and members of the public. It recognises the significant impact such incidents can have on colleagues’ health and wellbeing and seeks to contribute to a positive culture of wellbeing across the Trust.
- This includes a Behaviour Sanction Panel with an escalation system, whereby sanctions including a yellow or red card can be issued to service users, carers and / or attendants if their behaviour is deemed to be unacceptable.
- Provisions have been made to ensure capacity is not a factor in the decision making of the panel and cases involving minors are not subjected to the same processes, although attendants and / or parents of minors who are abusive to our colleagues will be referred to the review panels as necessary.
- From October 2025 to January 2026, the panel reviewed 105 incidents with 20 progressed for a sanction hearing. Of these, 6 yellow cards have been issued, a further 5 are underway and 2 red cards were considered but downgraded due to the medical needs of the patient. Three apologies have been received including the following:

“He [the patient] just called to apologise profusely for his behaviour and how he spoke to me over the phone... he said he will never behave like that again to anyone of us...”

Figure 11 shows the distribution of key themes of each incident addressed since the implementation of the policy.

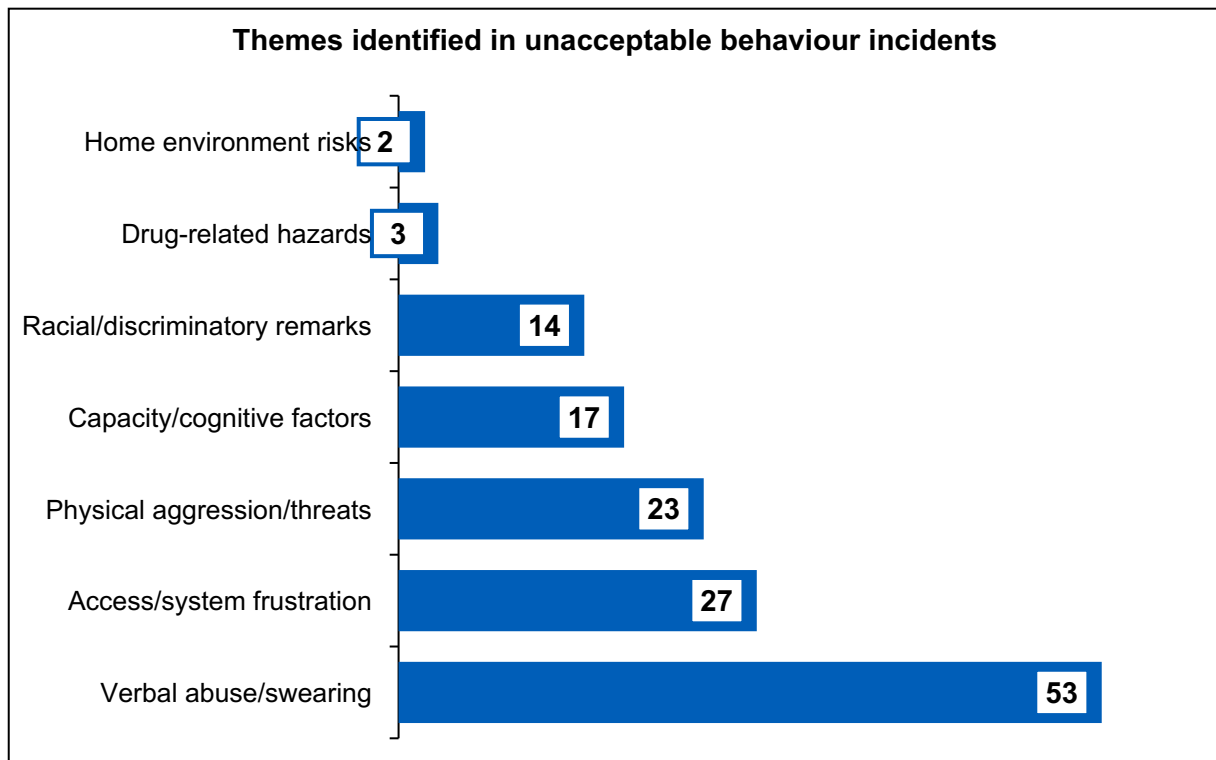


Figure 11

- Any increase in reporting is a positive indication that colleagues feel more confident in raising concerns and seeking support to address these behaviours, helping to ensure that unacceptable conduct is not tolerated.

4b) From a manager

Figure 10 shows the percentages of KCHFT colleagues whose response to the following Staff Survey question indicated they had experienced it at least once, by disability status. A total of 3,468 colleagues responded to this question in 2025 (65.2% of the overall workforce).

In the last 12 months, how many times have you personally experienced harassment, bullying or abuse at work from – Managers?

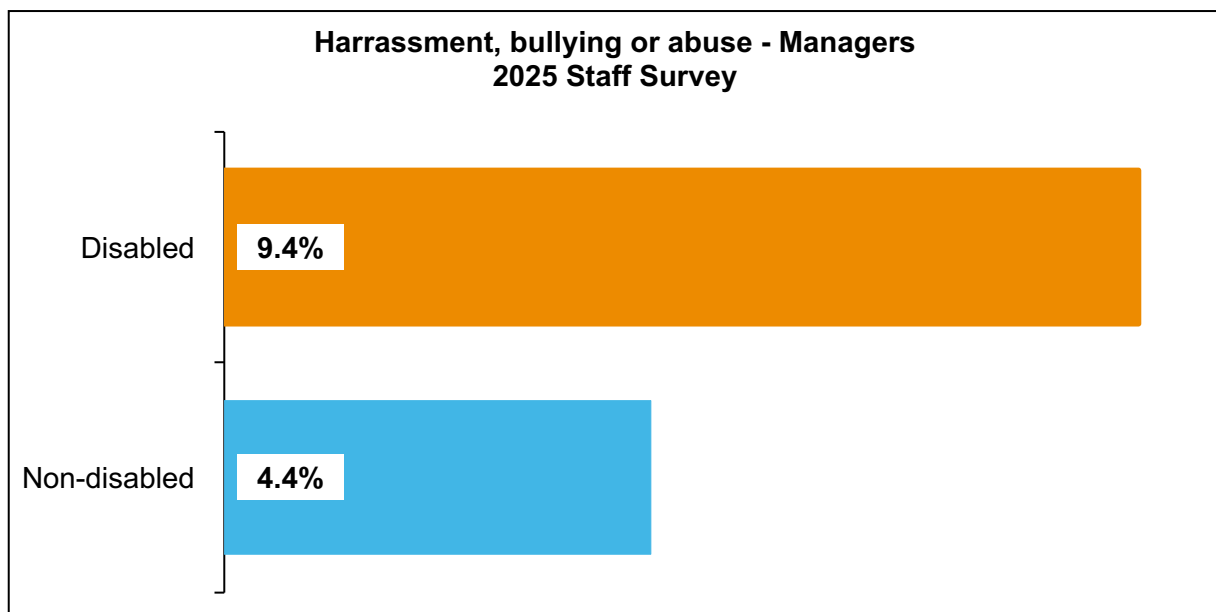


Figure 10

- Disabled colleagues were more than twice as likely to experience harassment, bullying, or abuse from a manager at 9.4% than non-disabled colleagues at 4.4%.
- Although the rates for both disabled and non-disabled groups are lower compared to experiences received from patients or public, disabled colleagues continue to be disproportionately affected across both sources of discriminatory behaviour.

Figure 11 shows the trend of colleagues experiencing harassment, bullying or abuse from a manager at least once since the 2021 Staff Survey, by disability status.

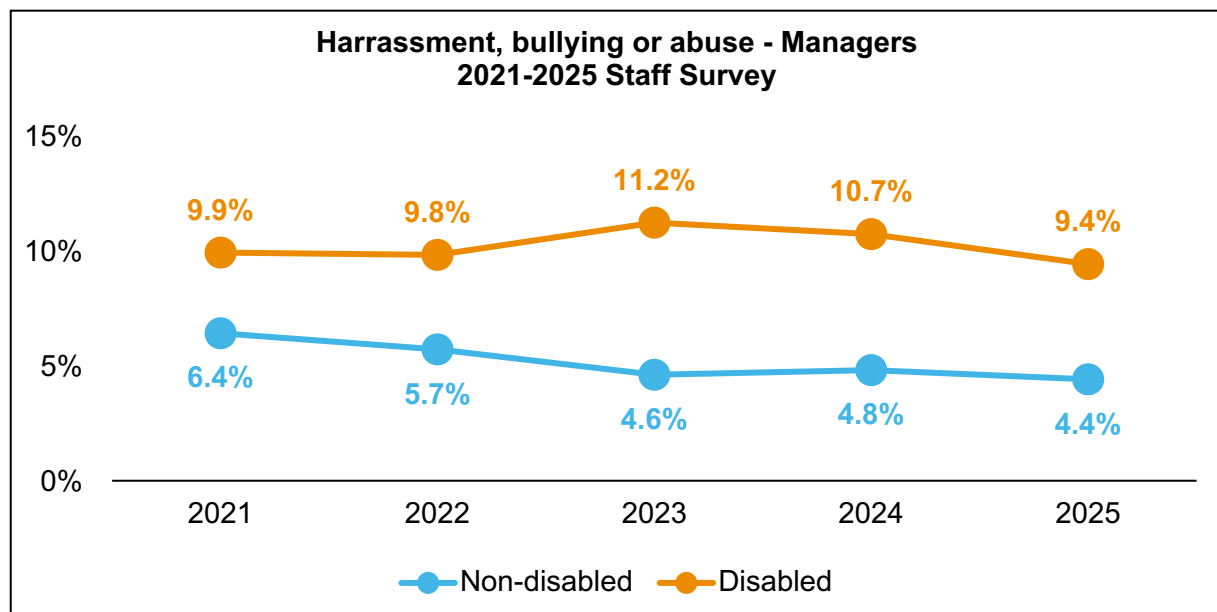


Figure 11

- Disabled colleagues consistently report higher levels of harassment, bullying or abuse from a manager than non-disabled colleagues.
- Non-disabled colleagues show a steady downward trend in incidents, whereas the trend for disabled colleagues increased in 2023 before falling again.
- 2025 shows the lowest incident rate for both groups since 2021.
- To support positive team culture, the Trust has introduced “Building Better Conversations” training for leaders, focusing on developing confidence and skills to hold open, supportive and constructive conversations, particularly during periods of change.
- Monitoring of new mandatory EDI training is ongoing, with an organisational target of 90% compliance by March 2027. As of June 2026, the compliance rate was 73.4%.

4c) From other colleagues

Figure 12 shows the percentages of KCHFT colleagues whose response to the following Staff Survey question indicated they had experienced it at least once, by disability status. A total of 3,457 colleagues responded to this question in 2025 (65.0% of the overall workforce).

In the last 12 months, how many times have you personally experienced harassment, bullying or abuse at work from – Other colleagues.

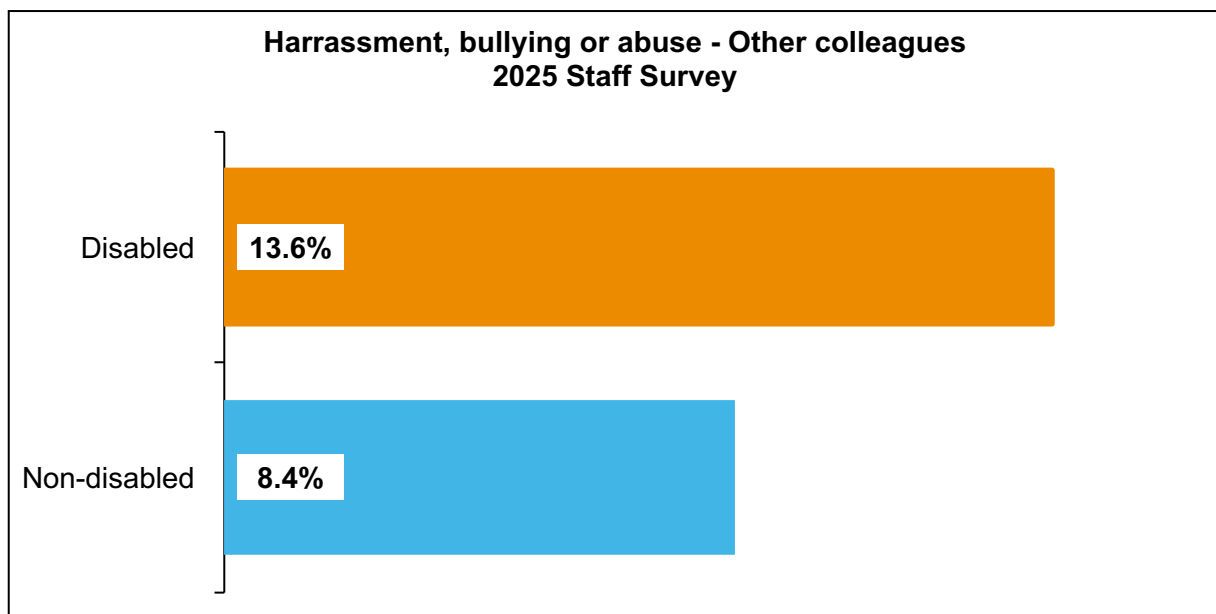


Figure 12

- 13.6% of disabled colleagues experienced harassment, bullying, or abuse from other colleagues, compared to 8.4% of non-disabled colleagues.
- Although the rates for both disabled and non-disabled groups are lower compared to experiences received from patients or public, disabled colleagues continue to be disproportionately affected.

Figure 13 shows the trend of colleagues experiencing harassment, bullying or abuse from other colleagues at least once since the 2021 Staff Survey, by disability status.

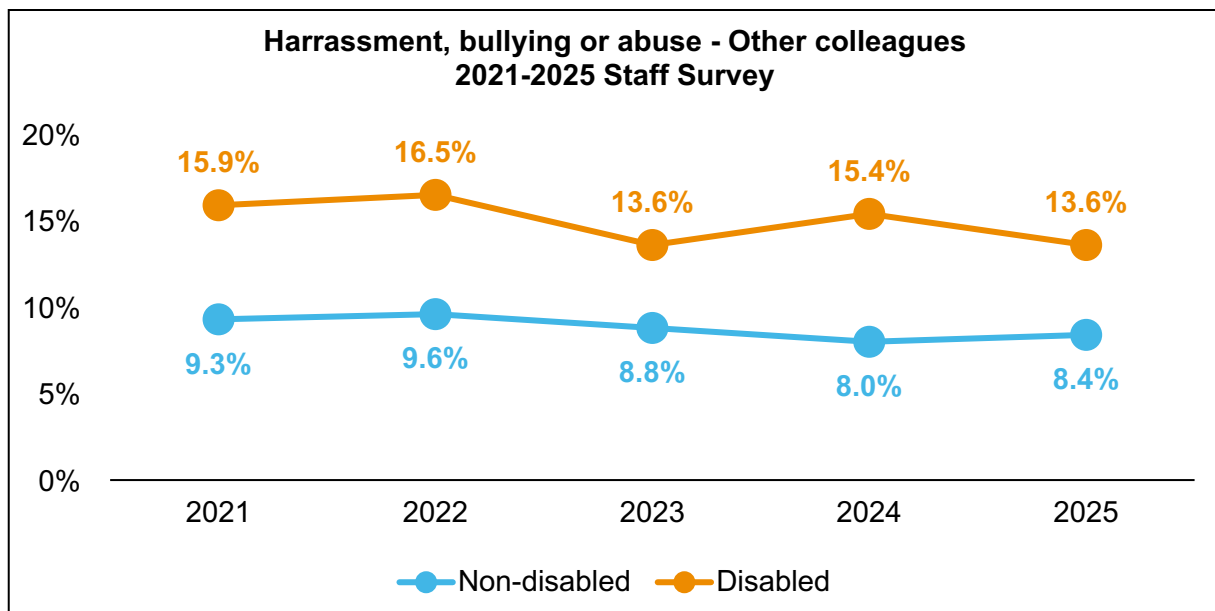


Figure 13

- Disabled colleagues consistently report higher levels of harassment, bullying or abuse from other colleagues than non-disabled colleagues.
- Non-disabled colleagues show a consistent downward trend in incidents, with only a minor rise in 2025, however disabled colleagues show a more variable pattern since 2022.
- The frequency of incidents is consistently lower than those involving patients, relatives or the public for both groups, largely because colleague behaviour is regulated by professional standards, policies, codes of conduct and HR processes, however the public are not bound by these expectations.
- The disparity between disabled and non-disabled colleagues was at its lowest in 2023, with the current trend suggesting that the disparity is moving back toward that earlier low point.

4d) Reporting of incidents

Figure 14 shows the percentages of responses from KCHFT colleagues to the following Staff Survey question, by disability. There were two response options of 'Don't know' and 'Not applicable' which are not included in this analysis. Of the average 3,471 colleagues who experienced harassment, bullying or abuse at work from any source in 2025, a total of 820 colleagues responded to this question (23.6%).

The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?

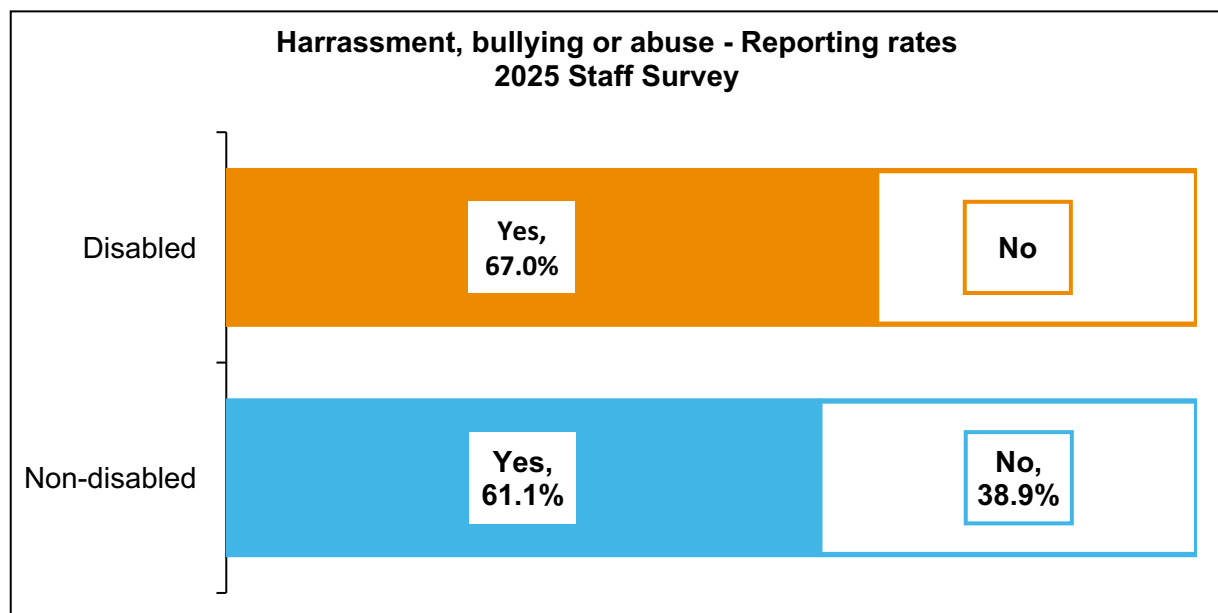


Figure 14

- The proportion of KCHFT colleagues who reported harassment, bullying or abuse in the last 12 months was highest among disabled colleagues, with 67.0% indicating either they or a colleague reported the incident, compared with 61.1% of non-disabled colleagues.

Figure 15 shows the trend of 'Yes' responses to colleagues reporting incidents of harassment, bullying or abuse since the 2021 Staff Survey, by disability status.

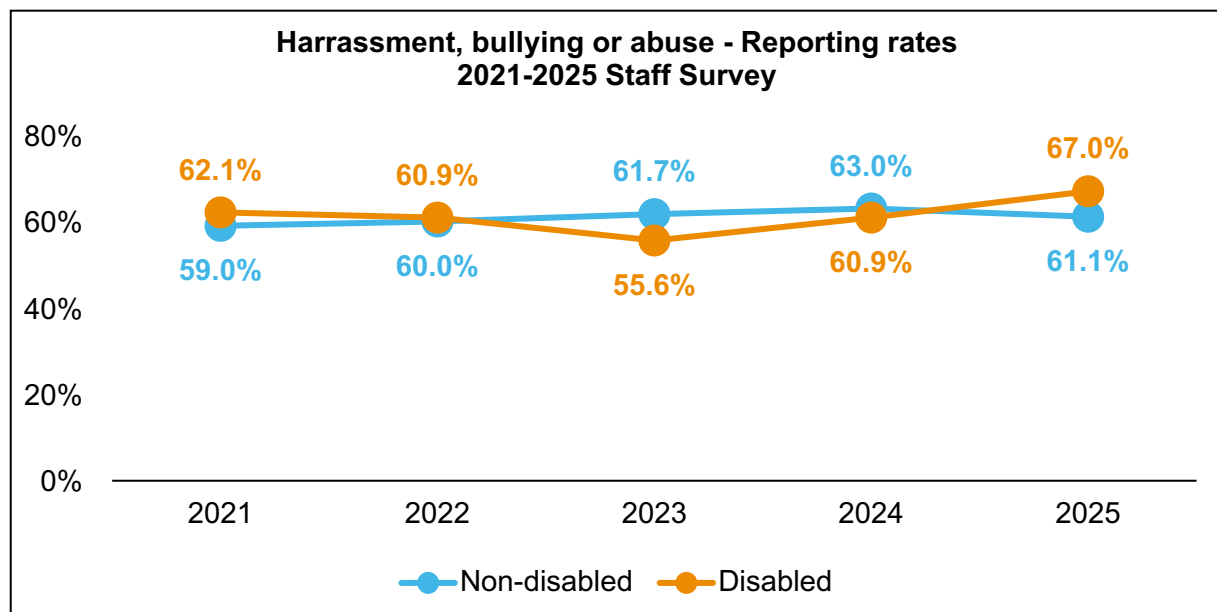


Figure 15

- Non-disabled colleagues showed an increasing trend until 2025 where there was a drop, whereas disabled colleagues saw a decreasing trend up to 2023 before rising again, with 2025 showing the highest rate across the period.
- The disparity between the two groups is approaching the largest gap as shown in 2023.
- The significant increase for disabled colleagues from 60.9% to 67.0% in 2025 aligns with the implementation of the “Managing unacceptable behaviour” policy in October 2025 as described in [Metric 4a](#).
- Colleagues at KCHFT are provided with confidential channels to report concerns, including Staff Side, Freedom to Speak Up (FTSU), Health and Wellbeing Champions and Staff Networks. Collectively, these measures aim to foster a culture of respect, accountability, and psychological safety.

Metric 5: Career progression

Figure 16 shows the percentages of responses from KCHFT colleagues to the following Staff Survey question, by disability status. A total of 3,473 colleagues responded to this question in 2025 (65.3% of the overall workforce).

Does your organisation act fairly with regard to career progression / promotion, regardless of e.g. age, disability, ethnic background, gender reassignment, religion, sex or sexual orientation

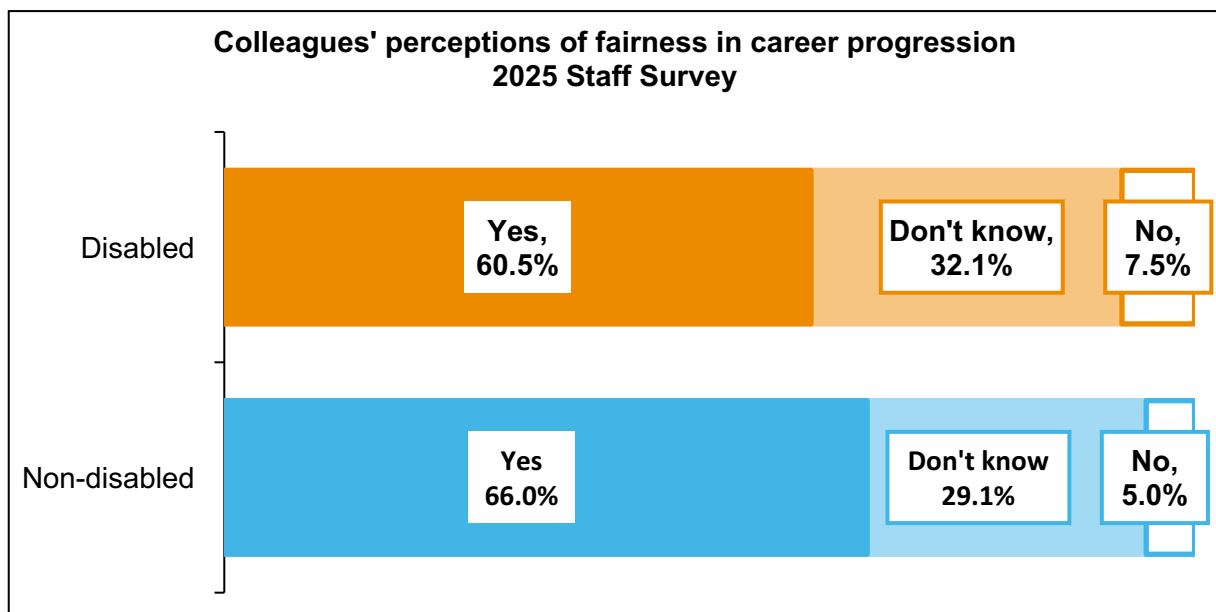


Figure 16

- Non-disabled colleagues were more likely to perceive career progression as fair, with 66.0% agreeing compared to 60.5% of disabled colleagues.
- Disabled colleagues are also more likely to say progression is not fair, with 7.5% disagreeing compared to 5.0% of non-disabled colleagues.
- Both groups show a similar rate of uncertainty, suggesting that regardless of disability status, a proportion of colleagues are unsure that there is fairness in career progression.

Figure 17 shows the trend of 'Yes' responses to whether KCHFT act fairly regarding career progression since 2021, by disability status.

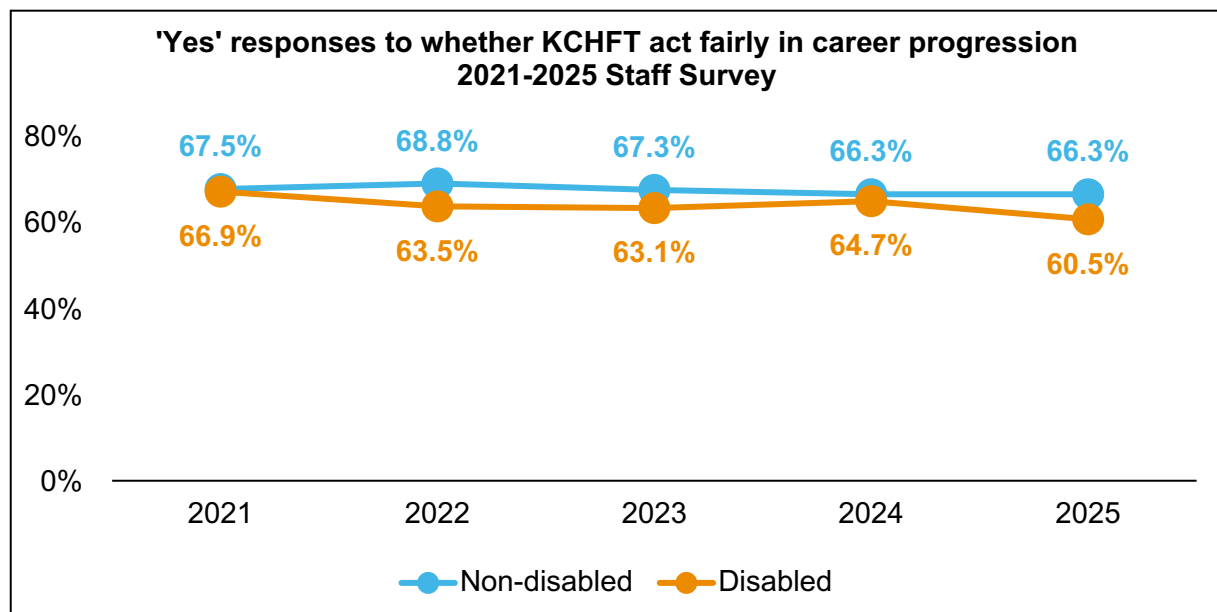


Figure 17

- Disabled colleagues consistently report a lower rate of perceived fairness for career progression than non-disabled colleagues.
- Responses from non-disabled colleagues remain steady across the period, indicating a broadly consistent experience, however the trend shows a gradual decline since 2022.
- Responses from disabled colleagues began to show an improvement in 2024, however a notable and significant drop was observed in 2025.

Metric 6: Presenteeism

Figure 18 shows the percentage of responses from KCHFT colleagues to the following Staff Survey question, by disability status. A total of 1,711 colleagues responded to this question in 2025 (32.1% of the overall workforce).

Have you felt pressure from your manager to come to work?

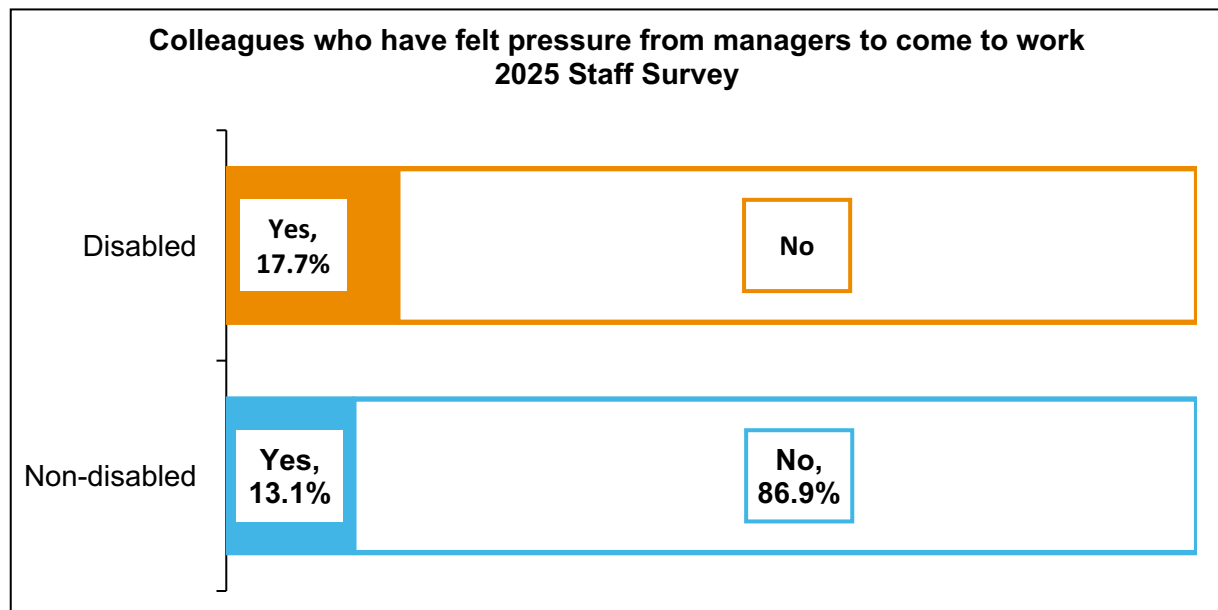


Figure 18

- 17.7% of disabled colleagues voiced that they felt pressure to come to work over the past 12 months, compared to 13.1% of non-disabled colleagues.

Figure 19 shows the trend of 'Yes' responses to colleagues feeling pressure to come to work since the 2021 Staff Survey, by disability status.

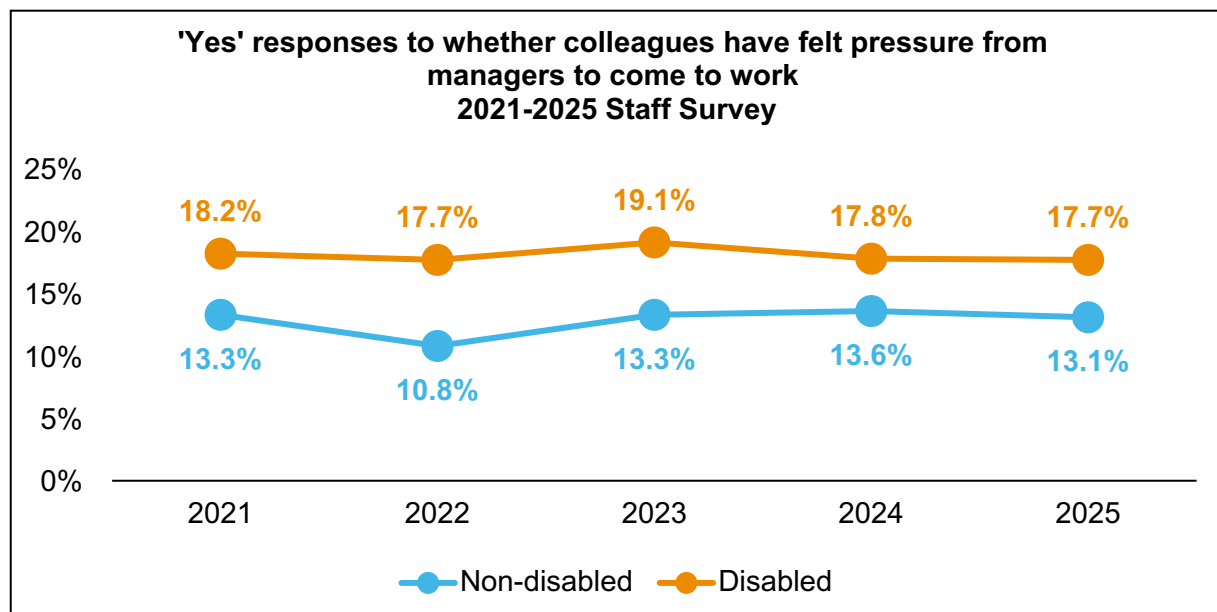


Figure 19

- Disabled colleagues consistently perceive or experience more pressure to attend work than non-disabled colleagues.
- The trends for both groups have been broadly consistent, and both groups reported the lowest rate in 2025 since 2021.
- The largest disparity was seen in 2022, however the narrowing gap suggests progress in creating a more equitable and supportive environment for disabled colleagues.
- The NLB approach continues to reduce presenteeism by improving mental health support, manager training and access to adjustments and flexible working.
- This includes access to resources on the staff intranet, a [Work and Wellbeing passport](#) and [Wellbeing Navigator](#) to make it easier for colleagues to request workplace adjustments and have open discussions with their line managers.
- Disability leave was primarily introduced to support colleagues with a disability or long-term health condition in managing their health needs. The Trust offers up to 10 days paid leave, pro rata, for those with disabilities, declared or undeclared, to attend appointments, treatments, therapies or other matters related to their disability.

- Prior to disability leave being introduced a volume of colleagues were using sickness absence, annual leave and other forms of leave to attend appointments, receive therapies and manage their health conditions. As a result this left no protected time or space to rest and recover throughout the year. This had a significant impact on the Trusts sickness absence incidences and in the presenteeism reports collected through the annual Staff Survey.
- Disability leave ensures people are not using sickness absence as a means to manage their long-term health condition, where possible, or use annual leave.

Figure 20 shows the proportion of the workforce utilising disability leave each financial year since 2023. Utilisation is presented both as total episodes, where one person may have many episodes in a given period, as well as utilisation per person, where every colleague is counted once regardless of a single or multiple episodes of disability leave.

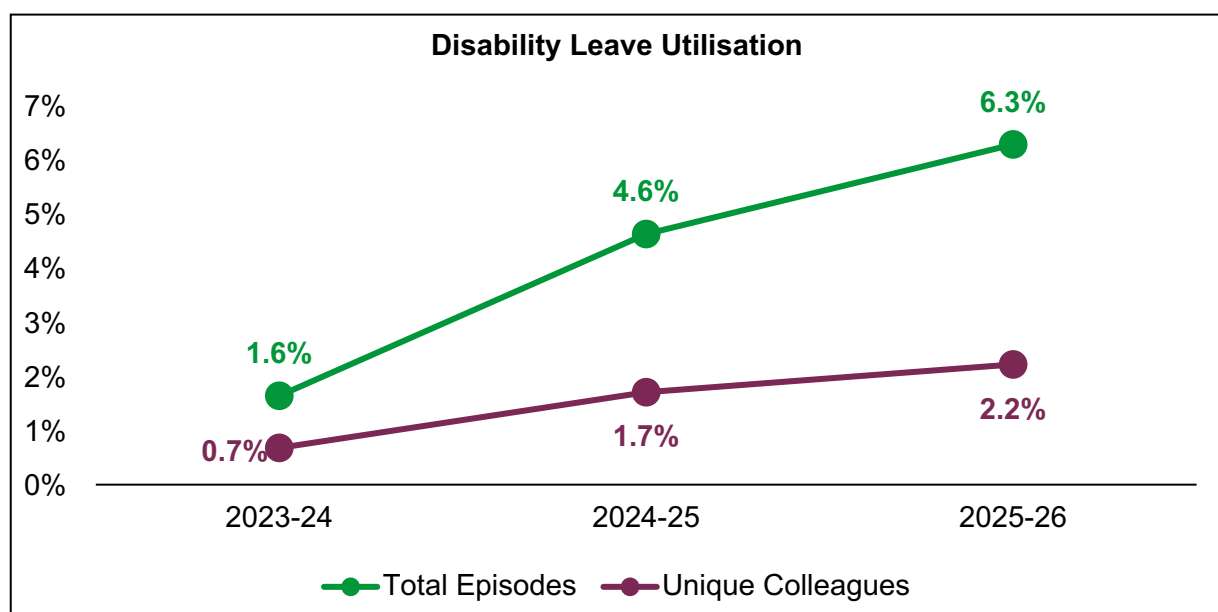


Figure 20

- As shown, disability leave utilisation continues to increase at KCHFT, both for the total episodes and the unique number of colleagues.
- The total episodes show the significant compound positive effect disability leave is having on our other, less appropriate forms of leave utilisation, whilst the utilisation per person shows a continued increase in unique colleagues becoming aware of and using the leave.

Metric 7: Feeling valued

Figure 21 shows the percentages of responses from KCHFT colleagues to the following Staff Survey question, by disability status. A total of 3,494 colleagues responded to this question in 2025 (65.7% of the overall workforce).

The extent to which my organisation values my work.

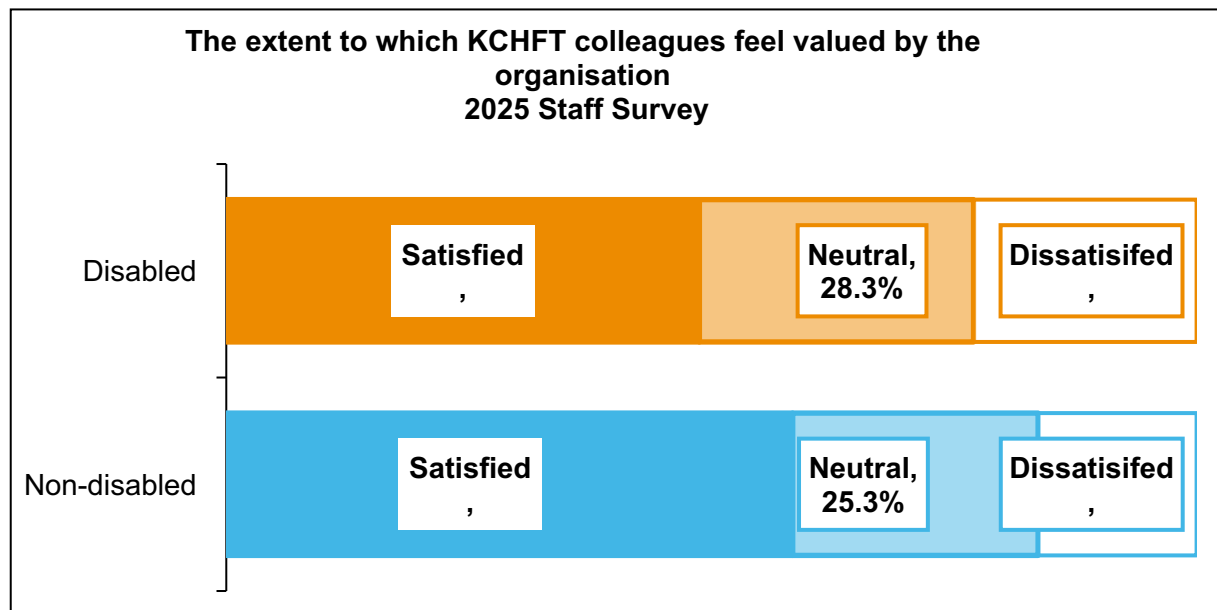


Figure 21

- Non-disabled colleagues had the highest satisfaction rate in feeling valued by KCHFT at 58.4%, whilst under half of disabled colleagues had the same view at 48.8%.
- Both groups show a similar rate of uncertainty, whilst disabled colleagues show a higher rate of dissatisfaction than non-disabled colleagues.

Figure 22 shows the trend of 'Satisfied' responses to colleagues feeling valued by the organisation since the 2021 Staff Survey, by disability status.

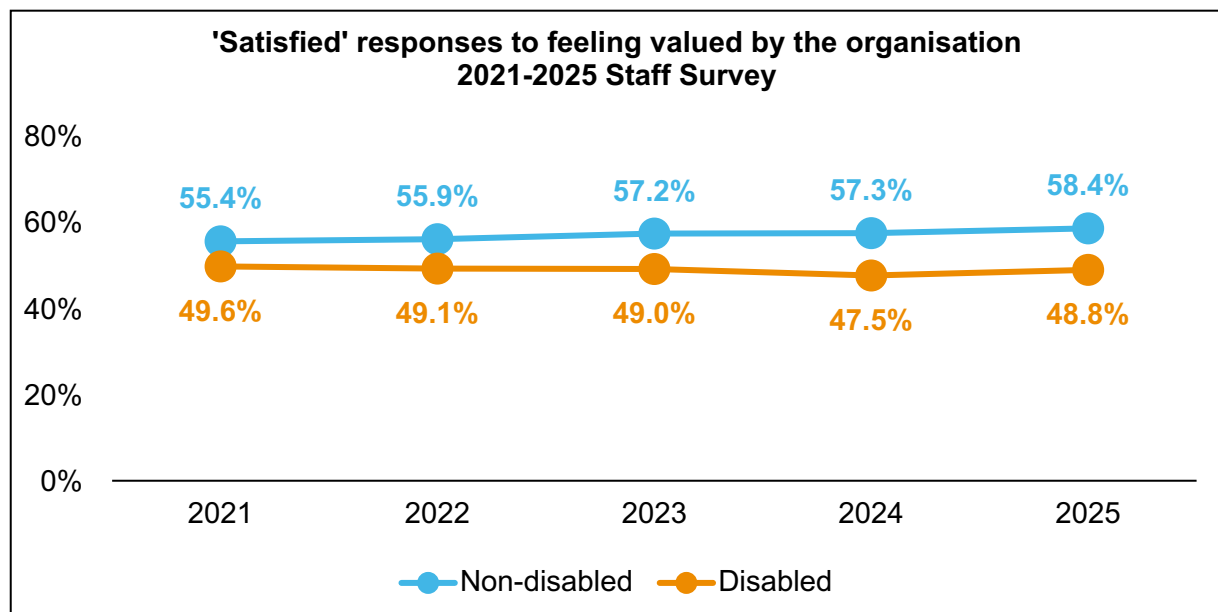


Figure 22

- Non-disabled colleagues consistently report feeling more valued by the organisation than disabled colleagues.
- There has been a steady improvement for non-disabled colleagues, whereas disabled colleagues have indicated a declining trend, with a small improvement in 2025.



Metric 8: Workplace adjustments

In keeping with our efforts to broaden understanding and ensure our language results in inclusive behaviour, KCHFT moved from the terminology of reasonable adjustments to workplace adjustments, reflecting the reality that many factors within a person's working life can be adjusted to ensure they have equitable access.

Our aim was to ensure colleagues understood that workplace adjustments may be required to support physical, mental health, neurodiverse or sensory needs, and can include changes to working patterns, working locations, assistive technology, and specialist equipment such as chairs and desks.

Everyone is unique and has their own needs. For some this means they need active adjustments throughout their career. For others it may mean they value the opportunity to have regular conversations with their line manager about their health and accessibility needs but will not necessarily require any changes be made to their work, working environment or ancillary working arrangements.

Workplace adjustments are tested against the Equality Act 2010 consideration of reasonableness. This means in reality we will not see a response of 100% for this metric as not every adjustment request can be reasonably implemented by a service. We do however take any requests for support or advice seriously and aspire to implement as many adjustment requests as is responsibly possible.

Figure 23 shows the percentages of responses from **disabled** KCHFT colleagues **only** to the following Staff Survey question. A total of 664 disabled colleagues responded to this question in 2025 (63.3% of all colleagues who declared a disability via the Staff Survey). 84.6% of disabled colleagues reported that they had received workplace adjustments to enable them to carry out their work in 2025.

Has your employer made reasonable adjustment(s) to enable you to carry out your work?

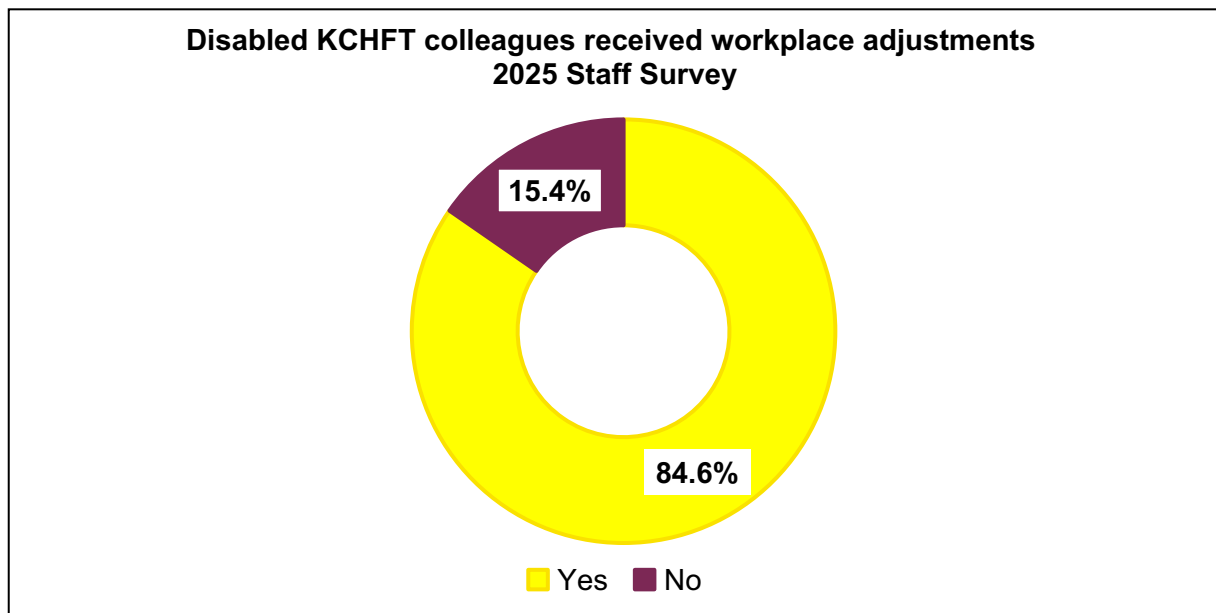


Figure 23

Figure 24 shows the trend of 'Yes' responses to disabled colleagues reporting they have had a workplace adjustment in place since 2021.

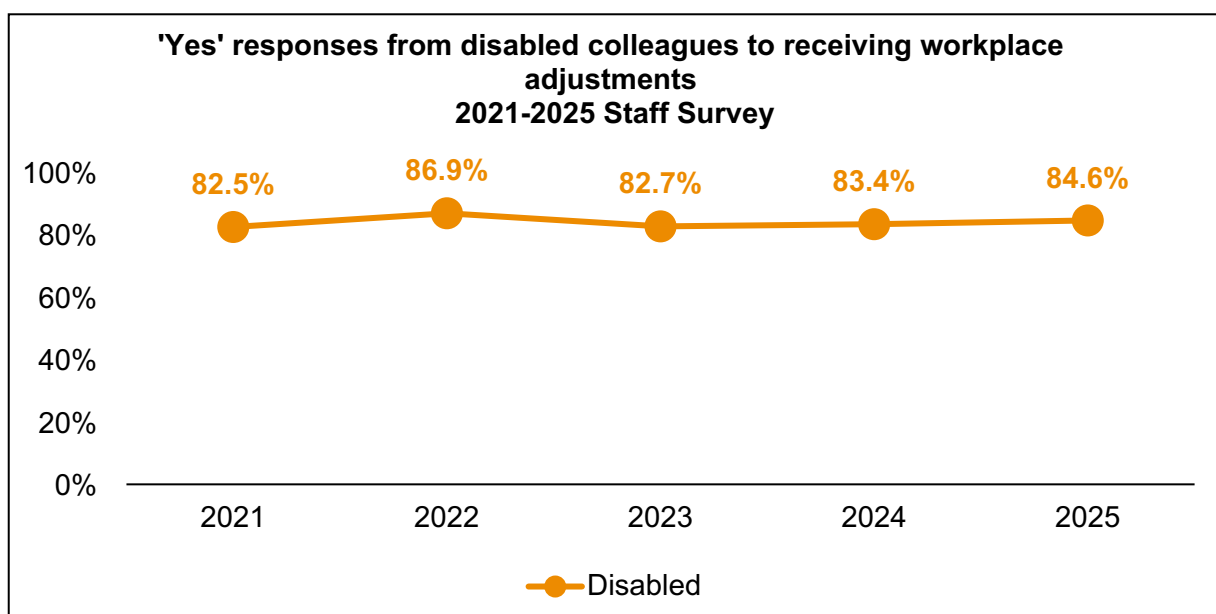


Figure 24



- There has been a consistently high level of disabled colleagues reporting that they have received workplace adjustments, with this improving each year since 2023.
- The highest rate was seen in 2022 followed by a significant drop in 2023. Although levels began improving again after 2023, they have not yet returned to the peak reported in 2022.
- The high proportion of disabled colleagues reporting that they receive workplace adjustments may reflect the positive impact of several initiatives introduced by the Trust. These include the Work and Wellbeing Passport, which supports colleagues and managers to have meaningful conversations and agree practical and personalised adjustment plans.
- In addition, the appointment of a Workforce Wellbeing and Accessibility Advisor and Health and Wellbeing Lead has strengthened pathways for accessing adjustments, improved organisational support and inclusion, and enabled the development of clear guidance on Access to Work.
- Having identified an unintended barrier to the consideration of adjustments in the financial pressure associated with the implementation, a centralised adjustments budget has been established. This should enable managers to consider adjustment requests in isolation of financial expectations and streamline the process.
- The Trust has also introduced a wide range of health and wellbeing resources available to all staff, covering social wellbeing, financial health, physical and mental health, and support for living and working with a long-term health condition and specific Disability and Neurodiversity awareness training.
- The Trust's staff networks provide valuable peer support and lived-experience insight, helping colleagues access advice on workplace adjustments and connect with others who may have similar experiences.

Metric 9: Staff engagement

9a) Staff Engagement scores

Figure 25 shows the Staff Engagement scores for KCHFT colleagues from the 2025 Staff Survey, by disability status. The overall Staff Engagement score for the whole Trust was **7.2**.

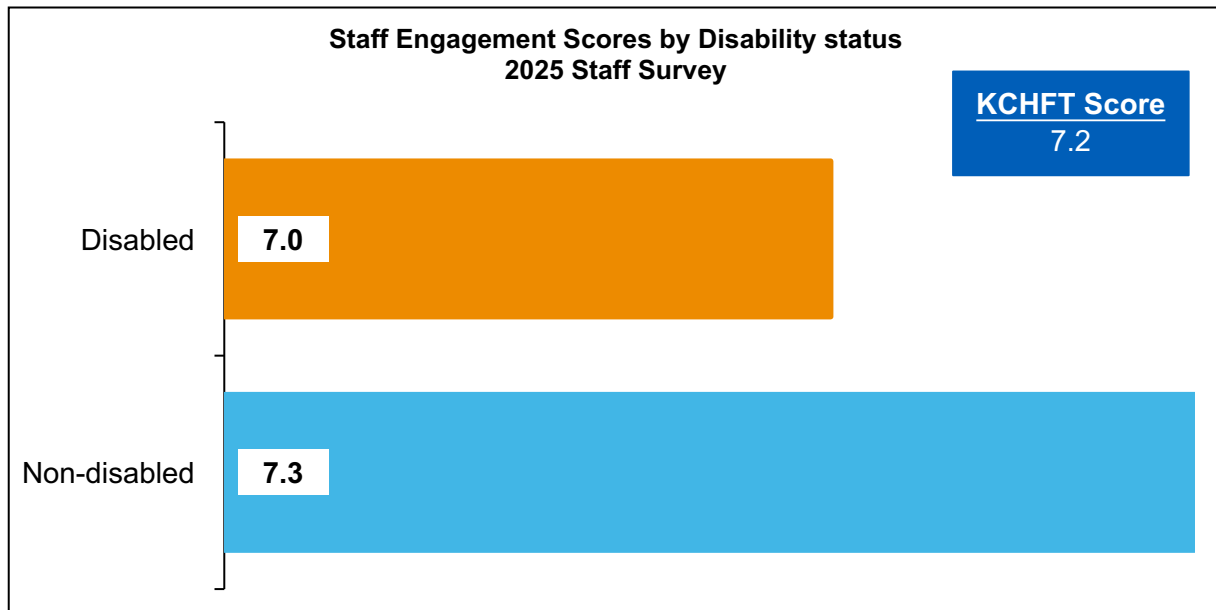


Figure 25

- Non-disabled colleagues had the highest score at 7.3, compared to 7.0 for disabled colleagues, with the former being above the overall organisation score.

Figure 26 shows the trend of Staff Engagement scores since 2021, by disability status.

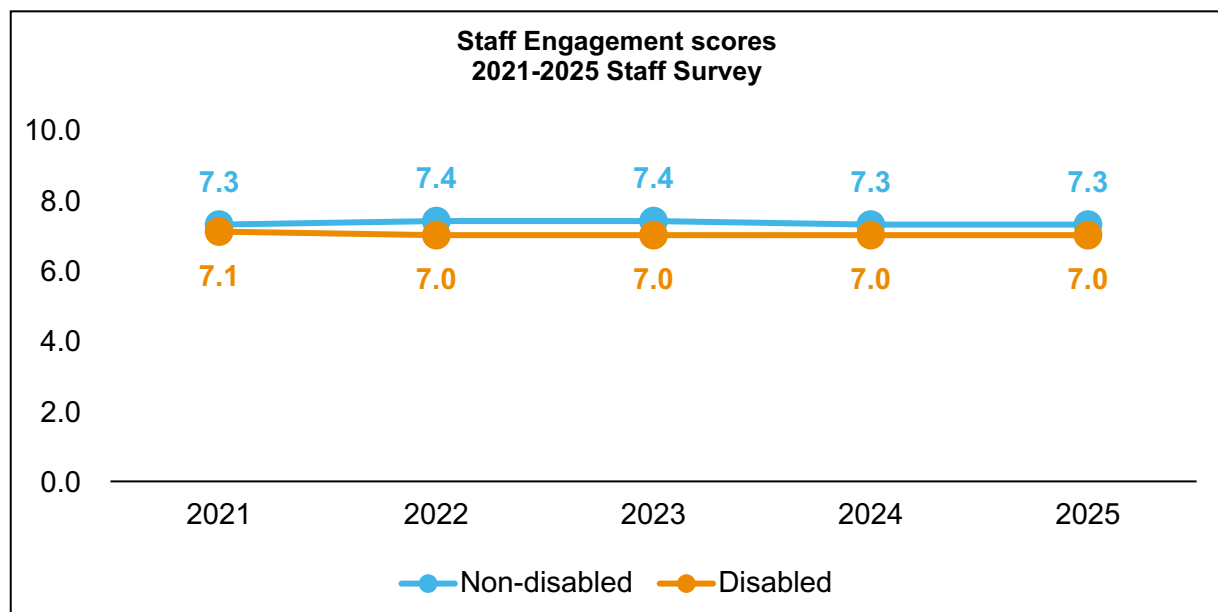


Figure 26

- Disabled colleagues consistently show a lower engagement score than non-disabled colleagues.
- The minimal changes and therefore persistent disparity in scores for both groups of colleagues suggests that there have been no significant shifts in the perceptions of either group about how valued, supported, or connected they feel.



9b) Actions taken to facilitate the voices of disabled colleagues in KCHFT to be heard

- KCHFT has long ensured that the voices of colleagues with long-term health conditions, disabilities and other health-related conditions are not only heard but are instrumental in influencing organisational action.
- Our Executive Team and Senior Leaders have spoken openly and passionately about their own lived experiences to help create a culture where colleagues feel safer seeking support.
- KCHFT has an active and influential Disability and Carers Network which meets regularly, is sponsored by an Executive Director, and presents to the Board and its sub-committees.
- Our NLB approach to health, wellbeing, equity, inclusion and diversity ensures that all voices are heard, including those of colleagues living with disabilities and long-term health conditions, as well as carers and loved ones.
- The strongest evidence of this cultural shift is reflected in declaration rates since the launch of NLB. These have improved from below 3% to 12% in the current reporting cycle and is not the result of widespread declaration campaigns, but of a sustained and meaningful change in organisational culture.
- Our Disability and Carers Network chair reflected on our NLB EDI action plan:

“This is a fantastic piece of work and it was so great being able to see how feedback from our network members and others from around the Trust has been incorporated into the actions. I think the actions are very supportive and it certainly makes me feel valued in the Trust from having read it.”

Metric 10: Board representation

Table 5 shows the representation and percentage difference between the disability status of KCHFT Board members and the overall workforce, by voting and executive membership.

	Non-disabled	Disabled	Unknown
Overall workforce	85.3%	12.0%	2.6%
Board members	82.4%	17.6%	0.0%
Difference Board – Overall	-3.0%	+5.6%	-2.6%
Voting members	76.9%	23.1%	0.0%
Non-voting members	100.0%	0.0%	0.0%
Difference Voting – Overall	-8.4%	+11.1%	-2.6%
Executive members	75.0%	25.0%	0.0%
Non-executive members	88.9%	11.1%	0.0%
Difference Executive – Overall	-10.3%	+13.0%	-2.6%

Table 5

- There is a higher level of disabled representation on the Board at 17.6% with the overall workforce at 12.0%, showing a difference of 5.6%.
- There is no Unknown disability status recorded at Board level, compared to 2.6% within the overall workforce, showing that the entire Board have declared their disability.
- The majority of voting Board members are non-disabled at 76.9%, however this is an underrepresentation compared to the overall workforce with a difference of 8.4%.
- Disabled colleagues are over-represented within voting Board membership at 23.1%, relative to their proportion within the workforce at 12.0%, showing a difference of 11.1%.

- The majority of executive Board members are non-disabled at 75.0%, however this is an underrepresentation compared to the overall workforce with a difference of 10.3%.
- Disabled colleagues are also over-represented within executive Board membership at 25.0%, relative to their proportion within the workforce at 12.0% showing a difference of 13.0%.

Figure 27 shows the trend of disabled representation of all KCHFT Board members since 2021.

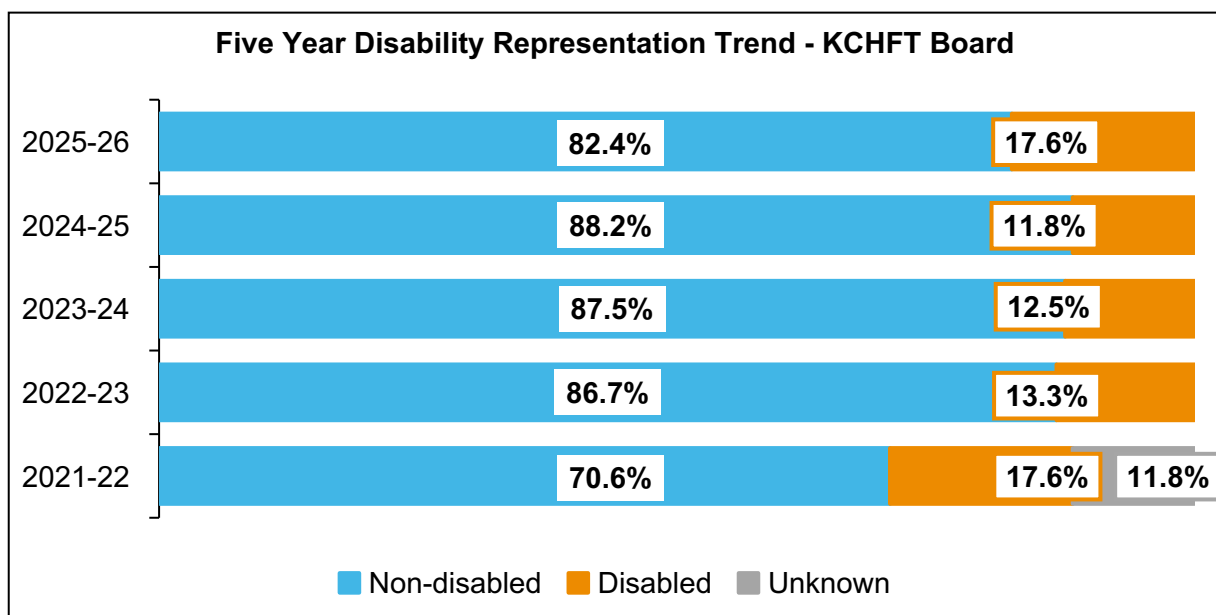


Figure 27

- 2023-24 showed a decrease in disabled representation on the KCHFT Board, with this trend continuing until 2024-25.
- 2025-26 has seen a notable rise from 11.8% to 17.6%, representing a significant and meaningful shift.



Recommendations

Building on this year's WDES findings, KCHFT will continue to prioritise the continued implementation and expansion of targeted actions to address identified inequalities across employee relations and staff experience, while sustaining progress in areas where improvements have been achieved, including recruitment outcomes.

Actions will be delivered through the NLB approach, with ongoing oversight and co-production with key stakeholders including disabled colleagues, Disability and Carers Network, Neurodiversity Network and wider staff networks to ensure progress remains responsive, transparent and sustainable.

Conclusion

The 2025-26 WDES report demonstrates that KCHFT continues to make meaningful progress. This is reflected in improving workforce diversity, increasing disability declaration rates and improvements in incidents of harassment, bullying and abuse.

We value the quality, insight and experience that colleagues bring to our organisation and remain committed to taking a transparent and proactive approach to addressing inequity. Being an inclusive employer is central to both our organisational strategy (We Care) and our NLB approach to equity, diversity, inclusion, health and wellbeing.

The Workforce EDIH&Wb Team would like to thank all colleagues, champions, ambassadors, staff networks and Board members for their ongoing commitment and passion in ensuring that inclusion and equity remain central to how we support both colleagues, patients and service users.



Appendices

Appendix 1: Definitions

Nobody Left Behind	Nobody Left Behind (NLB) is Kent Community Health NHS Foundation Trust's approach to Equity, Diversity, Inclusion, Health and Wellbeing (EDIH&Wb). It is designed to ensure that all colleagues feel valued, have their voices heard and are supported to thrive. The approach focuses on taking a transparent and proactive stance to embedding equity across recruitment, development and wellbeing. Formal delivery concluded in 2024, the ambitions of NLB continue to underpin our broader ways of working. The programme now informs our ongoing action plan and services as a guiding principle in the how we approach inclusion, wellbeing, and equity across KCHFT.
Electronic Staff Record (ESR)	The NHS Electronic Staff Record (ESR)⁽⁷⁾ is a workforce system used by all NHS Trusts and Health Boards in England and Wales and manages the payroll for over 1.9 million NHS employees. ESR offers a hub which gives NHS employees control over their personal data as well as access to payslips, total reward statements, and e-learning.
Agenda for Change (AfC)	The Pay system and framework for determining pay and conditions for the majority (pay Bands 1–9) of NHS employees in the UK.
Very Senior Management (VSM)	Chief executives. Executive directors, with the exception of those who are eligible to be on the consultant contract by virtue of their qualification and the requirements of the post (these colleagues will be classed as Senior Medical Managers and recorded amongst the Medical and Dental colleagues). Other senior managers with board level responsibility who report directly to the chief executive.
Medical and Dental subgroups	Medical and Dental subgroups: Trainee grade, Career grade, and Other medical and dental grades Colleagues paid using the Medical and Dental pay scales. Subgroups are identified by using the grade codes as recorded in the Electronic Staff Record.

⁽⁷⁾ [Electronic Staff Record \(ESR\) Workforce Services | NHSBSA](#)

Relative likelihood	Compares the likelihood of the criteria of one group over another, using the following formula (for Metric 2 example): $\% \text{ Appointed from shortlisting} = \frac{\text{Total appointed}}{\text{Total shortlisted}} \times 100$ (for each group) $\text{Relative likelihood of Group 1 compared to Group 2} = \frac{\text{Group 1 \%}}{\text{Group 2 \%}}$ Relative likelihood values: = 1.0 Disabled and Non-disabled candidates are equally likely to be appointed from shortlisting > 1.0 Non-disabled candidates are more likely to be appointed than BAME candidates < 1.0 Non-disabled candidates are less likely to be appointed than BAME candidates.
Formal capability process	Refers to colleagues who have entered the formal capability procedure on the grounds of performance, as set out in the organisation's performance management or equivalent policy.
Reasonable adjustment(s)	A reasonable adjustment is a change to the workplace, working arrangements, or the way things are done that removes or reduces a disadvantage experienced by a disabled person, enabling them to perform their role effectively and participate equally. Under the Equality Act 2010 ⁽⁸⁾ , employers have a legal duty to make reasonable adjustments where a disabled employee is placed at a substantial disadvantage compared with non-disabled colleagues.
Staff Engagement Score	The Staff Engagement score is a composite score measured from nine questions within the Staff Survey, relating to motivation, involvement, and advocacy. The Staff Engagement score falls between 0 and 10, where the higher the score, the more engaged the workforce.

⁽⁸⁾ [Equality Act 2010](#)

Board members	Board membership includes all members of the Board irrespective of whether they are executive or non-executive members and whether they are voting or non-voting members of the Board who may have been co-opted. An executive Board member is an employee of the organisation who sits on an organisation's Board of directors and advises current Organisational management on specific operations, e.g. Finance Director. A non-executive board member is a member of the Board of directors of the organisation who is not part of the executive management team. In NHS provider trusts, non-executive board members are typically appointed and employed by NHS England.
Benchmark	A benchmark is a reference point (often the average or mean of the peer group). It describes the typical performance level across the peer group.
Median	The median is the middle value when all groups results are ordered. It describes the midpoint of the peer group and is useful when the data is skewed by very high or very low values.
Work and Wellbeing Passport	The KCHFT Work and Wellbeing Passport is a tool to support open conversations between colleagues and their line manager. It's a practical tool to help identify what keeps colleagues well, potential challenges and any support you they need. Colleagues are able to access the passport online, complete and share this with their line manager as well as review this periodically. This digital tool can travel with a colleague should they move to a different team or role internally enabling their new line manager to understand their needs and provide them the best support they can.
Wellbeing Navigator	An online tool designed to help colleagues and managers identify appropriate health and wellbeing support quickly and easily.

Appendix 2: Disability categories

Equality Act 2010 (legal definition of disability):

A person (P) has a disability if –

- (a) P has a physical or mental impairment, and
- (b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.

	ESR	NHS Staff Survey	NHS Jobs
		Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?	Do you consider yourself to have a disability?
Non-disabled	No	No	No
Disabled	- Learning disability / difficulty - Long-standing illness - Mental Health Condition - Other - Physical Impairment - Sensory Impairment - Yes – Unspecified	Yes	- Yes Please state the type of impairment which applies to you. People may experience more than one type of impairment, in which case you may indicate more than one. If none of the categories apply, please mark 'other'. - Physical impairment - Learning Disability / Difficulty - Sensory impairment - Long-standing illness - Mental health condition - Other
Unknown	- Not Declared - Prefer Not to answer		I do not wish to disclose this information.



Kent Community Health
NHS Foundation Trust

**Workforce Equity, Diversity and Inclusion and
Health and Wellbeing Team**



www.kentcht.nhs.uk

Front Sheet – Winter Operational Surge Plan 2026/27

This paper describes the background context as Kent Community Health NHS Foundation Trust moves into the Winter period.

Meeting:	Board Meeting - Part 1 (Public)
Date of meeting:	16 September 2026
Agenda item no:	Item 11
Report title:	Winter Operational Surge Plan 2026/27
Executive sponsor(s):	Pauline Butterworth, Deputy CEO and Chief Operating Officer
Report author(s):	Clare Thomas, Deputy Chief Operating Officer
Action this paper is for:	Approval
Public/non-public	Public

Executive summary

Overview

The surge plan 2026/27 describes the background context as the Trust moves into the winter period in terms of current performance and challenge areas in adult discharge pathways. The plan outlines the approach taken to understand demand and capacity analysis with potential acute bed gaps and the interventions in place to mitigate the winter bed gap.

The plan also outlines the actions and preparation in place for: planned, specialist and public health services; workforce; supply chain; adverse weather and staff vaccinations.

The surge plan is an active document and is subject to updates.

This plan will be supported by a detailed Christmas and New Year plan which will detail service level and support service arrangements for the two-week festive period. This will be completed and presented to the integrated management meeting (IMM) and the executive team meeting (ETM) in early December 2026.

Also attached to the plan is:

- Equality Impact Assessment
- Human Rights Assessment
- Draft Board Assurance Template for NHS Trusts: Board Assurance Statement (BAS)

The plan, the equality impact assessment and the human rights assessment are available to Board members within the Diligent library.

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

Sent to IMM stakeholders in June 2026

Reviewed by community service directors (CSDs) on 3 September 2026

Reviewed by the Executive on 4 September 2026

Recommendation(s)

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

Link to CQC domain

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well-led
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Assurance level

Reasonable

Rationale for assurance level

Plans in place for all areas but final modelled bed gaps still being agreed with acute partners.

Implications

Links to BAF risks / CRR

☐ BAF

☒ CRR

Equity, diversity and inclusion

Yes (provide a brief sentence describing the issue)
The Equality Impact Assessment concludes that the Winter Plan is expected to have no negative impact on staff or patients across protected characteristics, with services continuing to be delivered based on clinical need. Positive impacts are identified for older people, individuals living with long-term conditions, and carers, as the plan focuses on supporting people to remain at home and reducing unnecessary hospital admissions.
The Human Rights Assessment finds no adverse impact on the FREDA principles (Freedom, Respect, Equality, Dignity and Autonomy). Existing policies and processes will remain in place to ensure staff rights, patient choice, dignity, and equitable access to care are maintained throughout the winter period.

Legal and regulatory

Yes (provide a brief sentence describing the issue)
The BAS confirms that the Trust has completed and board-assured its 2026/27 Winter Plan, demonstrating robust arrangements across prevention, discharge planning, workforce resilience, infection prevention and control, and operational leadership. The Trust received an overall self-assessment rating of **5 - Full Assurance**, with evidence of strong system-wide collaboration, tested escalation processes, comprehensive winter preparedness measures, and executive oversight led by the Deputy Chief Executive and Chief Operating Officer.

Executive sponsors sign off

Pauline Butterworth, Deputy CEO and Chief Operating Officer

Date: 07 September 2026

Winter Planning 26/27

Board Assurance Statement (BAS)



1. Purpose
The purpose of the Board Assurance Statement is to ensure the Trust Boards has oversight that all key considerations have been met. It should be signed off by both the Trust / Provider's Accountable Officer and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement
Please include the Trust / Provider name at the top of the tab.
This section gives Trust the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 26/27 Winter Plan checklist
This section provides a checklist of what Boards should ensure is covered in their 2026/27 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2026**.



Winter Planning 26/27

Section A: Board Assurance Statement (BAS)

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

Provider/Trust Name (drop down):

OTHER - Please write below

If Other, write Provider/Trust Name:

Kent Community Trust NHS Foundation Trust

Contact details (email, phone number):

kentchft.icc@nhs.net

Date:

07/09/2026

Assurance statement			Please complete these sections		
			Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Governance and executive leadership					
1	1.1	The Board has assured the Trust Winter Plan for 2026/27.	Yes	Presented to Board on 16.09.26	
	1.2	The Board is assured that a robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	Attached	
	1.3	The Board is assured that the Trust's plan was developed with appropriate input from and engagement with all system partners, including primary care and social care.	Yes	Plans agreed with all stakeholders	
	1.4	The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	Attended on 24.08.26	
	1.5	The Board has identified a named Executive Winter Sponsor with accountability for winter preparedness (including vaccinations), escalation and operational delivery.	Yes	Chief Operating Officer and Deputy Chief Executive	
	1.6	The Board is assured that clear governance arrangements, escalation processes and operational leadership arrangements are in place throughout the winter period.	Yes		

Winter Planning 26/27			This section provides a checklist on what Boards should assure themselves is covered by 26/27 Winter plans. Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.		
Section B: 26/27 Winter Plan checklist			Please complete these sections		
Section B: 26/27 Winter Plan checklist			Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Prevention					
1	1.1	The Board is assured there are plans in place to deliver a frontline healthcare worker (FHCW) flu vaccination programme that achieves the trust level uptake ambitions and demonstrates: •the offer is accessible to all frontline staff between 1 October – 31 March with the majority of vaccinations completed by 30 November; •that both walk-in and bookable appointments are available; •that all FHCW vaccination activity will be recorded on Record a Vaccination Service (RAVS); and •the FHCW flag has been applied to the ESR records of all clinical and non-clinical staff who are in direct contact with patients to ensure accurate reporting on FDP.	Yes		
	1.2	The Board is assured that frontline staff vaccination, respiratory virus prevention, and staff health measures are supported by targeted operational plans.	Yes		
	1.3	The Board is assured that plans are in place to offer vaccinations (flu and COVID-19) to long stay inpatients (21 days and above) and inpatients who are being discharged into a care home.	Yes		
	1.4	The Board is assured that population health intelligence and risk stratification information are used in partnership with system colleagues to identify and support vulnerable patients and high-risk cohorts ahead of and during periods of winter pressure.	Yes		
Occupancy and discharge					
2	2.1	The Board is assured that a review of discharges across each pathway required to manage bed demand and occupancy has taken place ahead of winter with system partners. These have been developed jointly with local authority, Community Health Service Providers and system partners, including holiday-period arrangements.	Yes	Demand and capacity modelling completed and discharge capacity schemes identified. 7-day discharge support in place in both partner acute Trusts and community hospitals	
	2.2	The Board is assured that model discharge pathway requirements are in place to optimise discharge seven days a week across acute, community and social care services. This should include: •coordinated escalation, surge and extreme surge response arrangements, including bed escalation capacity, which have been tested and capable of safe activation to maintain patient flow, create additional capacity and support operational resilience during periods of increased demand. •executive-led governance arrangements to provide oversight of occupancy, the number of discharges required and delivered each day to support safe bed availability and flow, along with the number of patients who are NCTR by pathways 1 to 3 with monitoring of patients with long discharge delays. •targeted operational actions to reduce long discharge delays. •Discharge to Assess pathways that operate effectively with home first as the default and assessment taking place outside hospital wherever possible. These should be supported by integrated escalation arrangements with community and social care partners to maintain patient flow.	Yes		
	2.3	The Board is assured that pre-Christmas and holiday-period occupancy reduction plans will be implemented.	Yes	The Winter Plan will be supported by a two-week period operational plan	
	2.4	The Board is assured that Same Day Emergency Care (SDEC) and ambulatory emergency care pathways have been optimised to support admission avoidance.	No	N/A	
	2.5	The Board is assured that frailty pathways have been reviewed and are operating effectively to support avoidance of unnecessary admission.	Yes		
Capacity					
3	3.1	The Board is assured that workforce resilience assumptions are evidenced and include safe staffing levels, appropriate skill mix, redeployment models and staff wellbeing support, with clear mitigations in place for sustained periods of increased demand.	Yes		
	3.2	The Board is assured that rotas have been reviewed to ensure consistent senior clinical decision-making capacity at times of peak pressure, including weekends, supported by clear escalation and supervision arrangements.	Yes		
	3.3	The Board is assured that elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes	Note Cancer Care not applicable	
	3.4	The Board has reviewed its 4-hour and 12-hour, and RTT trajectories, and is assured that the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off for 2026/27.	Yes		
	3.5	The Board is assured that there are effective operational actions in place to ensure urgent community capacity is prioritised for the sickest patients.	Yes		
Flow					
4	4.1	The Board is assured that emergency department crowding mitigations have been reviewed and implemented to actively eliminate corridor care as a patient safety priority. This should include implementation of relevant GIRFT recommendations, and with defined safety thresholds, clear escalation triggers, and routine Board level oversight of associated risks, including dignity, privacy and clinical harm.	No	N/A	
	4.2	The Board is assured that ambulance handover plans are deliverable and supported by appropriate operational arrangements and escalation processes.	Yes		
	4.3	The Board is assured that escalation arrangements with system partners support timely transfer of care and patient flow.	Yes		
	4.4	The Board is assured that plans are in place to implement the Model ED and Model Discharge requirements ahead of winter.	Yes		
Infection Prevention and Control (IPC)					
5	5.1	The Board is assured that plans, infrastructure, estates arrangements, IPC governance and operational capability are in place to enable the safe rapid reconfiguration of physical space, creation of additional clinical capacity and implementation of patient cohorting arrangements during periods of increased demand or infectious disease transmission, supported by appropriate environmental risk assessments and compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections.	Yes		
	5.2	The Board is assured that IPC colleagues, including the Director of Infection Prevention and Control or nominated IPC Lead, have been engaged in the development of the winter plan, and are confident in the planned mitigations and actions.	Yes	IPC lead reviewed and updated the Emerging pandemic plan which sits as an appendix to the Winter Plan	
	5.3	The Board is assured that fit testing arrangements are in place for relevant staff, are appropriately recorded and monitored, and can be rapidly expanded during periods of increased respiratory disease and gastrointestinal viral transmission. Appropriate PPE supply, stock management and escalation arrangements are in place to support periods of increased demand.	Yes	Compliance at 79.4%	
	5.4	The Board is assured, as encompassed by criterion 5 of the Health and Social Care Act 2008: code of practice on the prevention and control of infections, that a patient cohorting plan, including risk-based escalation, is in place that is understood by all staff and is ready to be activated by site management teams.	Yes	IPC team holds and maintains community hospitals inpatient sitreps which allows for direct assessment and support of clinical colleagues and bed management for best patient placement advice	
Leadership and operational grip					
6	6.1	The Board is assured that on-call arrangements are in place and have been tested, and those on-call have access to medical and nursing leaders for urgent advice, and effective operational oversight to ensure urgent community capacity is prioritised for the sickest patients, where needed.	Yes	Robust tactical and strategic rota in place	
	6.2	The Board is assured that plans are in place to monitor and report real-time pressures utilising the OPEL framework, with clear triggers for escalation and timely operational response.	Yes	National Community OPEL status supported by additional KCHFT Local triggers and twice-weekly IMM meetings	
	6.3	The Board is assured that mutual aid arrangements have been reviewed and are capable of activation, if required.	Yes		
	6.4	The Board is assured that business continuity plans have been reviewed and tested where appropriate.	Yes	Business Continuity Plan review completed as at end August 2026	
	6.5	The Board is assured that severe weather and infrastructure disruption contingencies have been reviewed.	Yes	EPK oversee robust cascade of information and co-ordinate required operational responses including leasing of 4x4 vehicles, spare room inventory for staff, monitoring of weather events via the Met Office, Environment Agency and the Department of Health – Pharmacy team to	
	6.6	The Board is assured that industrial action contingencies have been reviewed where relevant.	Yes		
	6.7	The Board is assured that plans are in place to support staff welfare through periods of high demand.	Yes		
Specific actions for Mental Health Trusts					
7	7.1	The Board is assured that a plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via NHS 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	No	Not Applicable	
	7.2	The Board is assured that any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	No	Not Applicable	
	7.3	The Board is assured that liaison psychiatry pathways and Section 136 arrangements remain resilient during periods of peak demand.	No	Not Applicable	

Executive Approval	
The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the Trust / Provider's Accountable Officer and Chair.	

Trust / Provider Name:	Kent Community Health NHS Foundation Trust
Provider CEO name:	Mairead McCormick
Date reviewed:	
Provider Chair name:	
Date reviewed:	

Please update following completion of the BAS template

Please provide name and contact details of designated Senior Responsible Officer (Executive Level)
Pauline Butterworth - Deputy Chief Executive & Chief Operating Officer Kent Community Health NHS Foundation Trust

Please provide confirmation that the SRO has reviewed and approved the responses within this document, confirming they are correct and complete.
The SRO has confirmed the plan is correct and complete, and has noted that it remains a live operational document that will continue to be refined throughout winter mobilisation as demand forecasts and system requirements evolve

Please confirm date reviewed
04/09/2026

BAS Self-Assessment Dashboard

Trust		
Overall Assessment Rating: 5 - Full assurance		
Section B		Rating
	Prevention	5 - Full assurance
	Flow, occupancy and discharge	4 - Substantial assurance
	Capacity and community	5 - Full assurance
	UEC Flow	3 - Moderate assurance
	Infection Prevention and Control (IPC)	5 - Full assurance
	Leadership and operational grip	5 - Full assurance
	Specific actions for Mental Health Trusts	1 - No or limited assurance

Front Sheet – Committee chairs' assurance reports

The reports which follow provide a summary to the Board of the discussions that took place at its sub-committees since the last Public Board meeting in July 2026.

Meeting:	Board Meeting - Part 1 (Public)
Date of meeting:	16 September 2026
Agenda item no:	Items 12, 13 and 14
Report title:	Committee chairs' assurance reports
Executive sponsor(s):	Colin Lynch, Chair
Report author(s):	Gina Baines, Assistant Trust Secretary / Committee Secretary Judith Richings, Governor Support Administrator
Action this paper is for:	Noting
Public/non-public	Public

Executive summary

Overview:

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

- Finance, Business and Investment Committee meeting held on 22 July 2026
- People Committee meeting held on 26 August 2026
- Approval of the Freedom to Speak Up Policy

The Freedom to Speak Up Policy is available to Board members within the Diligent library

- Quality Committee meeting held on 3 September 2026
- Learning from Deaths Report (published externally)

The meetings were called and convened in accordance with the committees' terms of reference and were quorate.

The Board is asked to receive and note the committee chairs' reports for assurance.

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

Not applicable

Recommendation(s)

The Board is asked to **Note** the reports.

Link to CQC domain

☐ Safe
 ☐ Effective
 ☐ Caring
 ☐ Responsive
 ☒ Well-led

Assurance level	Significant
Rationale for assurance level	The committees are operating effectively and have scrutinised key matters relating to quality, finance, workforce, risk and governance on the Board's behalf. Issues identified as requiring Board awareness are within the reports. Overall, there is effective oversight and assurance arrangements in place.

Implications		
Links to BAF risks / CRR	☐ BAF	☐ CRR
Equity, diversity and inclusion	No	
Legal and regulatory	No	

Executive sponsors sign off
Colin Lynch, Chair
Date: 09 September 2026

FINANCE, BUSINESS AND INVESTMENT COMMITTEE CHAIR'S ASSURANCE REPORT

This report is based on the Finance, Business and Investment Committee meeting held on 22 July 2026.

Agenda items

- Board Assurance Framework (BAF) and Corporate Risk Register (CRR)
- Digital plan updates
- Chief Finance Officer Focus report:
- Kent and Medway system finance report
- Medway Community Healthcare (MCH) transaction
- Transformation Plan
- Finance Report (Month 3)
- Productivity report including Cost Improvement Programme update
- Standing Financial Instructions and Scheme of Delegation – for approval
- Treasury Management Policy – for approval

Agenda item	Key points to note	Assure/alert/advise the Board
Board assurance framework and corporate risk register	The Committee reviewed the Board Assurance Framework and Corporate Risk Register and welcomed the ongoing developments in risk reporting. Members discussed the effectiveness of controls and sought assurance regarding cyber security risks and associated business continuity arrangements, and the management of risks arising from the Medway Community Healthcare (MCH) transaction. The Committee requested that future updates give further consideration to demonstrating control effectiveness and ensuring risks associated with the MCH transaction and digital shared service developments are appropriately reflected within Board-level risk reporting.	Assure
Digital Plan updates	The Committee received a comprehensive “deep dive” update report on progress against the Trust's Digital 2024–2028, Kent and Medway system priorities, digital, data and information governance shared services, and wider regional and national digital programmes. Among the	Assure

Agenda item	Key points to note	Assure/alert/advise the Board
	key topics reviewed were AI, automation, cyber security, clinical safety, MCH onboarding, and a range of other strategic priorities. Opportunities and risks associated with proposed shared digital service arrangements and broader digital transformation activities were considered. Assurance was received that the Trust's Digital & Data Programme remains on track, delivering significant measurable productivity and efficiency benefits, particularly through Rio optimisation, alongside continued improvements in digital maturity. Whilst noting a number of ongoing delivery dependencies, appropriate governance, controls and mitigations were evidenced to support delivery of the Trust's strategic objectives.	
Chief Finance Officer Focus report: Medway Community Healthcare transaction Transformation plan	The Committee considered the financial implications of the MCH transaction and the funding arrangements of the Trust's transformation plan for community services. Members sought assurance regarding the identification and mitigation of financial risks associated with the MCH transaction. The Committee emphasised the importance of maintaining close oversight of emerging financial risks as the transaction progresses.	Alert
Finance Report Month Three	The Committee reviewed the Month 3 Finance Report and received assurance regarding the Trust's current financial position and the actions being taken to manage emerging financial pressures and support delivery of the financial plan. The Committee noted that there had been a slow start to the allocation of capital expenditure but was given assurance that this was not unusual and would increase through the year to meet its target at year end.	Assure
Productivity report including Cost Improvement Programme update	The Committee received assurance that a clinical productivity programme has now been established, that workstreams and benchmarking activity are underway, and that productivity measures are being developed. However, clarification is still required of the emerging system-level models, and a defined approach to measuring productivity and efficiency within neighbourhood teams. The Committee recognised that the work remains under development and will become clearer as system plans and workstream outputs mature. The Committee will continue to monitor progress.	Assure
Standing Financial Instructions and Schemes of Delegation	The Committee undertook its annual review of the Standing Financial Instructions and Scheme of Delegation. Members were assured that appropriate governance and financial control arrangements remained in place. The Committee recommends them to the Board for approval.	Advise

Agenda item	Key points to note	Assure/alert/advise the Board
Treasury Management Policy and Compliance Review	The Committee undertook its annual review of the Treasury Management Policy and its compliance. Members were assured that appropriate governance and financial control arrangements remained in place. The policy was approved.	Advise

Olu Odeniyi
Chair, Finance Business and Investment Committee
22 July 2026

PEOPLE COMMITTEE CHAIR'S ASSURANCE REPORT

This report is founded on the People Committee meeting held on 26 August 2026.

Agenda items

- Mann Review update
- Updates on legislation, regulations and national changes
- Future Workforce Solution / People Portal update
- Workforce metrics, including areas of concern
- Board Assurance Framework (BAF) and Corporate Risk Register (CRR)
- Significant Employee Relations report
- Operational workforce update
- Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES), including disciplinary data deep dive
- Staff Engagement Report and Staff Survey actions
- Education Group minutes
- Pre-employment and in post checking standards
- Medical Appraisal Annual Report
- Approval of Freedom to Speak Up Policy
- Forward plan
- Review of BAF and CRR implications arising from Committee discussions
- Evaluation of the meeting

Agenda item	Key points to note	Assure/ Alert/ Advise
Future Workforce Solution / People Portal update	The Committee identified a significant delivery risk arising from the scale and complexity of the Future Workforce Solution transformation programme (now renamed the People Portal). The Committee was alerted to uncertainty about the system's functions and the direct overlap of timings for the transformation programme with the Medway Community Healthcare (MCH) integration. The Committee assessed assurance as limited and agreed that programme readiness, capacity pressures and associated risks should be escalated to the Board.	Alert
Operational workforce update	The Committee heard that workforce anxiety had increased in the context of organisational change, the MCH integration and the move to the neighbourhood health model. Community nursing pressures continued and while the recruitment of newly qualified nurses was positive, newly recruited nurses would require significant preceptorship and team support. The Committee recognised the cumulative impact of change and operational workload on staff and leaders and cross referenced the Staff Engagement report and the associated recommendations.	Alert
Action log	Members considered progress with robotic process automation and deployment of Copilot licences. Whilst noting encouraging progress, concern was expressed regarding staff awareness of available licences and the adequacy of training support. The IT training team would be engaged regarding the provision of additional, live and practical support for Copilot skills development. This action has been added to the People Committee action log.	Advise
Mann Review	The Committee was advised that implementation of the Mann Review recommendations would be embedded within the Trust's Nobody Left Behind approach and aligned with existing work on unacceptable behaviours.	Advise
Workforce metrics, including areas of concern	The Committee noted a small reduction in appraisal compliance linked to the appraisal pilot and received assurance that appraisals had been completed despite technical recording issues. Short-term stress-related absence had increased and agency expenditure had moved slightly above the ceiling due to pressures in community hospitals. These areas continue to require oversight.	Advise
Significant Employee Relations Issues	The Committee noted that the number of open employment tribunals was at the highest level experienced by the Trust, largely because national listing delays have created a cumulative backlog rather than because of a substantial increase in new claims . Police involvement was also delaying some internal cases. The Committee recognised the impact of complex cases on individuals, teams and workforce capacity and supported the view that informal early resolution through management intervention was an action they fully supported.	Advise

Agenda item	Key points to note	Assure/ Alert/ Advise
WRES and WDES, including disciplinary data deep dive	The Committee approved the annual WRES and WDES reports and the Committee recommended the reports to the Board for approval. The disciplinary data deep dive provided assurance that decisions to commence formal investigations had generally been appropriate, while identifying an opportunity to strengthen pre-investigation fact-finding. A focused piece of work will assess whether this reduces the number of cases progressing to formal investigation and improves the disparity metric. The result will be reported back in 6 months.	Advise
Medical appraisal and revalidation report	The Committee approved the report and recommends to the Board for approval.	Advise
Approval of Freedom to Speak Up Policy	The Committee approved the policy and recommends to the Board for approval.	Advise
Board Assurance Framework (BAF) and Corporate Risk Register (CRR)	The Committee approved closure of the issue relating to the withdrawal of funding for Level 7 apprenticeships, as the anticipated impact had not materialised. Members welcomed the improvement in the BAF but requested further testing of whether listed controls and assurances demonstrably reduce risk. A focused review will take place after development of the post-integration shadow BAF.	Assure
Staff Engagement Report and Staff Survey actions	Insight from more than 800 staff contacts indicated that staff broadly understood the direction of travel, but were experiencing workload pressure and uncertainty about what change would mean for them. The Committee welcomed the triangulated approach and work to strengthen leadership communication, wellbeing conversations and hotspot analysis. Progress and impact against the recommendations will return to the next Committee.	Assure

Kim Lowe
Chair, People Committee
26 August 2026

Freedom to Speak Up Policy Review 2026

Meeting:	Board Meeting - Part 1 (Public)
Date of meeting:	16 September 2026
Agenda item no:	Item 13
Report title:	Freedom to Speak Up Policy
Executive sponsor(s):	Pauline Butterworth, Deputy CEO and Chief Operating Officer
Report author(s):	Pauline Butterworth, Deputy CEO and Chief Operating Officer
Action this paper is for:	Approval
Public/non-public	Public

Executive summary

Background

The Freedom to Speak Up (FTSU) Policy has undergone its scheduled review to ensure continued alignment with national guidance and organisational requirements. The policy adopts the national FTSU Policy for the NHS and sets out how colleagues, volunteers, contractors and others working with or on behalf of Kent Community Health NHS Foundation Trust can raise concerns about patient care, safety, workplace practices or behaviours, and how the Trust will respond.

As part of this review, the policy has been updated to reflect the Trust's current policy framework, ensure key information remains accurate and accessible, and support the Trust's commitment to creating an open and transparent culture where colleagues feel safe and confident to speak up

Summary of Changes:

The review has resulted in several administrative and formatting updates, including:

- Transfer of the policy onto the Trust's new organisational policy template to provide a refreshed, consistent and accessible format in line with current document standards.
- Review and update of all key contact details throughout the policy to ensure that colleagues have access to accurate and current sources of support and advice.
- Completion of a full Equality Impact Assessment (EQIA) as part of the review process, demonstrating the positive impact of the policy and ensuring consideration of equality, diversity, inclusion and human rights requirements.
- Replacement of the term "worker" with "colleague" throughout the document to align with Trust terminology and support a more inclusive and people-centred approach.
- No substantive changes have been made to the underlying principles, processes or arrangements for raising concerns. The policy continues to reflect the national Freedom to Speak Up Policy for the NHS and the Trust's commitment to supporting colleagues who speak up

Recommendation from People Committee:

The People Committee reviewed the revised Freedom to Speak Up Policy and recommends its approval to the Board.

The Board is invited to note that the amendments are primarily administrative in nature and improve the presentation, accessibility and accuracy of the document while maintaining compliance with national FTSU requirements.

Next Steps:

Following Board approval, the policy will be published and implemented in accordance with the Trust's policy governance arrangements, with a review date of September 2029 unless earlier review is required due to legislative or organisational change.

The policy is available to Board members within the Diligent library.



QUALITY COMMITTEE CHAIR'S ASSURANCE REPORT

This report is founded on the Quality Committee meeting held on 3 September 2026.

Agenda items

- Improvement project – Improving Communication for the Looked After Children and Community Paediatrics Service
- We Care action plan: Safe Domain
- National Audit of Care at the End of Life (NACEL) action plan and progress
- Feedback from non-executive director service visits
- Quality risk report
- Eliminating corridor care
- Infection Prevention and Control Board Assurance Framework
- Strategic priorities update on Better Patient Experience and Putting Communities First
- Quality report
- Divisional report – Pharmacy; including Medicines Optimisation Group assurance report
- Learning from Experience Council chair's assurance report
- Clinical Effectiveness Group chair's assurance report
- Patient Safety and Clinical Risk Group chair's assurance report (including the patient safety incident response report)
- Quality priorities progress report
- Learning from Deaths report – Quarter Four
- Community hospitals and community services mortality deep dive report

Agenda item	Assurance and key points to note	Assure/alert/advise the Board
Improvement project: Improving Communication for the Looked After Children and Community Paediatrics Service with patients, families and carers	The project was developed in response to recurring themes identified through complaints, patient feedback and staff experience and has delivered measurable improvements, including a reduction in communication-related complaints and improved staff wellbeing. There has been increased use of digital solutions, standardised information and clearer communication pathways to support families who were waiting for assessment and diagnosis. Members noted the wider applicability of the learning across the Trust, particularly given communication continues to be a common theme within patient feedback and complaints.	Assure
Matters arising - We Care action plan: Safe domain For those services rated as requiring improvement through the We Care programme	Improvement actions are subject to regular monitoring and escalation processes and services receiving a requires improvement rating are revisited as part of the ongoing review programme. Mandatory training compliance in some community hospital services where compliance with basic life support training in particular had fallen below expected levels. This has been linked in part to the implementation of revised resuscitation training requirements. All affected teams had been reviewed, training needs had been identified, and staff had been scheduled onto the required programmes. The Committee will receive a further update at its November meeting.	Assure
Matters arising National Audit of Care at the End of Life (NACEL) action plan and progress	Improvements continue to be embedded across community hospitals. Positive progress was reported in the recognition of the deteriorating patient, communication with patients and families, documentation of patients' wishes and holistic assessments. Work to strengthen documentation of spiritual, religious and cultural needs within the inpatient clinical record is progressing. Regular audit arrangements are now in place to monitor compliance and support ongoing improvement. There is continued focus on quality improvement and the Trust is contributing to national discussions regarding future development of NACEL measures and bereavement feedback arrangements.	Assure

Agenda item	Assurance and key points to note	Assure/alert/advise the Board
Feedback from non-executive director service visits	There are consistently positive reports regarding team culture, leadership and staff commitment despite significant operational pressures. Recurring workforce themes include recruitment and retention challenges, maternity leave cover arrangements and increasing complexity of patient need. Concerns regarding maternity leave cover will be considered further by the People Committee.	Assure
Quality risk report	The risk ratings for the cybersecurity and resuscitation training had reduced following the implementation of additional controls and mitigating actions. The Committee was concerned that the reduction in the cybersecurity rating from 16 to 12 was premature, although members recognised that the latest controls had reduced the likelihood of a cyber incident occurring but had not reduced the potential consequence should such an incident take place. Because of the potentially significant impact a major cyber incident could have on patient care, operational delivery and service resilience, members asked for the completion of the cybersecurity deep-dive through the Audit and Risk Committee before any reduction in the current risk rating of 16 is considered.	Advise
Eliminating corridor care	There has been a reduction in the number of hours patients spend in non-care spaces with no recorded incidents of corridor care in east Kent in July 2026. The earlier identification of patients requiring discharge support and improved coordination through the Trust's Transfer of Care Hub has contributed to this improved patient flow and reductions in delays. Increasing patient complexity, frailty, homelessness, dementia and learning disability needs continue to be important contributors to delayed discharge and require strong multi-agency working across the health and care system. Progress is being made but the delivery of planned winter capacity and ongoing system collaboration will be critical to sustaining improvements and reducing reliance on non-care spaces.	Assure
Infection Prevention and Control Board Assurance Framework (IPCBAF)	Compliance remains strong, with no deterioration identified since the previous report to the Board. There has been continued improvement in MRSA screening compliance and strengthened assurance provided through antimicrobial	Advise

Agenda item	Assurance and key points to note	Assure/alert/advise the Board
	stewardship arrangements and ongoing quality improvement activity. The Committee recommends it to the Board for approval.	
Strategic priorities update on breakthrough objectives monitored by the Committee Better Patient Experience	There has been progress in the expansion of Home First services, implementation of seven-day rehabilitation at West View Integrated Care Centre and the development of discharge-to-assess pathways. These initiatives support the Trust's ambition to provide more care closer to home and improve patient flow through the system. There is progress in the development of a future neighbourhood-based intermediate care model designed around patient outcomes, independence and recovery whilst responding to increasing levels of frailty and complexity within the population.	Assure
Strategic priorities update on breakthrough objectives monitored by the Committee Putting Communities First (Did Not Attend metrics (DNA))	To meet this objective, progress has been made in strengthening the underlying data, identifying priority services and establishing a targeted improvement approach. The next phase of work will focus on understanding the factors contributing to higher DNA rates within the most deprived communities and evaluating interventions that improve access and engagement. The Committee welcomed the use of data, service-level engagement and shared learning to inform future improvement activity across the Trust.	Assure
Quality report	There is evidence of improving workforce wellbeing within community nursing services, where sustained reductions in sickness absence are beginning to demonstrate measurable benefit, alongside early indications of improvement in deferred visits. The Committee also noted the recent Care Quality Commission inspection at Deal Hospital, where initial feedback identified no immediate concerns, with formal feedback expected in due course.	Advise
Pharmacy Divisional report and Medicines Optimisation Group assurance report	There is ongoing work to strengthen medicines governance arrangements, particularly in relation to medicines safety culture, controlled drugs, and antimicrobial stewardship. Further work will be undertaken to improve service level audit arrangements outside community hospitals and provide assurance	Advise

Agenda item	Assurance and key points to note	Assure/alert/advise the Board
	that any risks associated with medical gases and medicines management are identified and escalated appropriately. This proactive approach will improve assurance processes and audit arrangements. Work is underway to develop the workforce, governance arrangements and operating model required to support the changes resulting from future neighbourhood health models, including closer integration with primary care, frailty services and the sexual health service.	
Learning from Experience Council chair's assurance report	The forum is an important mechanism for patient and public involvement and the positive contribution made by participation partners, who continue to provide constructive challenge and feedback on a range of quality, safety and patient experience matters is noted. Participation partners plan to bring their own reports and intelligence into the Council, further strengthening the role of community voice in shaping and co-designing services.	Assure
Clinical Effectiveness Group chair's assurance report	The group is becoming more established and providing improved oversight of clinical audit, research, patient outcomes and clinical effectiveness. There is increasing visibility of themes emerging from clinical audit, medical claims and service-level reporting and further work is planned to improve the consistency of outcome measurement across services. This work will become increasingly important as the Trust develops neighbourhood health models and seeks to better demonstrate the effectiveness and impact of care.	Assure
Patient Safety and Clinical Risk Group including the patient safety incident response report	Beyond its core function to review incidents, the Patient Safety Incident Review Group is increasingly focussing on triangulating safety intelligence from multiple sources. There remains some concern about overdue investigation actions, but these are being actively managed and monitored.	Assure
Quality priorities progress report	All priorities remain on track. Members noted that delivery of the health inequalities projects had been delayed due to an internal service consultation process, but appropriate adjustments had been made to the programme timetable and delivery is expected to commence during quarter three.	Advise

Agenda item	Assurance and key points to note	Assure/alert/advise the Board
Learning from Deaths report – Quarter Four	The Learning from Deaths process continues to mature, with improved communication and documentation evident within clinical records and increasing triangulation between mortality reviews, patient safety incidents, complaints and medico-legal information. Members also noted the importance of maintaining oversight of mortality trends as services evolve and more complex care is delivered within community settings. The Committee recommends the report to the Board.	Assure
Community hospitals and community services mortality deep dive report	Following concerns by the Committee regarding an apparent increase in deaths within East Kent, a deep dive was undertaken. The review found that the increase was attributable to changes in review methodology and case selection rather than evidence of deteriorating quality of care or unsafe practice. There were no significant quality concerns but there is a need for greater consistency in service models, continued improvement in communication across providers and stronger use of mortality intelligence to support quality improvement. The Committee welcomed the strengthening of the mortality review processes and ongoing work to align learning from deaths, patient safety and quality improvement activity.	Alert

Dr MaryAnn Ferreux, Non-Executive Director
Chair, Quality Committee
3 September 2026

Front Sheet – Integrated Performance Report

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

Meeting:	Board Meeting - Part 1 (Public)
Date of meeting:	16 September 2026
Agenda item no:	Item 15
Report title:	Integrated Performance report
Executive sponsor(s):	Gordon Flack, Chief Finance Officer
Report author(s):	Nick Plummer, Associate Director – Systems and Analytics
Action this paper is for:	Discussion
Public/non-public	Public

Executive summary

Overview:

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

In month performance against target:

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

	This month		Previous Month	Trend
Targets	42		42	
Met	23	55%	24	
Marginally Off Target	8	19%	5	
Missed	11	26%	13	

For this report, **23** of the **42** key performance indicators (KPIs) (one fewer than last month) are meeting or exceeding target for the month (**55%**). **Eight** KPIs are marginally off target (amber) and **11** are further off target (red).

Two red KPIs are also in special cause variation (declining): **KPI 2.5b Inpatient Care Hours Per Patient Day (CHPPD) – Unregistered Staff** and **KPI 4.7 Community No Criteria to Reside (NCTR)**.

The key positive movement this month is that KPI 2.1 Inpatient Medication errors has moved from red last month to green this month. To offset this, KPIs 1.1b Health Visiting - Antenatal Visits (Specialist and Targeted) and 2.6b Children and Young People Did Not Attend/Was Not Brought (CYP DNA/WNB) rate have moved from green last month to amber this month.

The remaining red KPIs are experiencing either common cause variation or special cause variation (improving).

Performance remains mixed, but the reduction in red measures and the sustained improving variation across a broad group of indicators provide evidence of positive movement alongside the identified areas requiring continued oversight.

Variation and Assurance:

27.9 percent (12) of the KPIs are in special cause variation (improving) with seven (16.3 percent) in special cause variation (declining) and the remaining 22 (51.2 percent) in normal variation:

In terms of assurance there are **five** KPIs that have negative assurance due to the target being outside control limits: KPIs 1.1a Health Visiting Antenatal Visits Offered (Universal), 2.12 Allied Health Professional (AHP) Access Waiting Times – however in special cause variation (improving), 3.2 Sickness (Stress), 4.7 No Criteria to Reside in a Community Hospital Bed and 4.8 No Criteria to Reside in a Community Hospital bed (West Kent).

Sustained improving performance is particularly evident in Health Visiting antenatal offers, School Health screening, adult and children's DNA rates, AHP access waits, turnover, vacancy rate, temporary staffing spend and community activity.

	Variation/Assurance	Consistently Hitting Target	Hit and Miss target	Consistently Missing Target	Trend
Putting Communities First	Improving Special Cause Variation	0	2	1	
	Normal Variation	1	4	0	
	Deteriorating Special Cause Variation	0	0	0	
	Trend				
	Variation/Assurance	Consistently Hitting Target	Hit and Miss target	Consistently Missing Target	Trend
Better Patient Experience	Improving Special Cause Variation	1	1	1	
	Normal Variation	2	9	0	
	Deteriorating Special Cause Variation	3	1	1	
	Trend				
	Variation/Assurance	Consistently Hitting Target	Hit and Miss target	Consistently Missing Target	Trend
Great Place to Work	Improving Special Cause Variation	1	2	0	
	Normal Variation	1	2	1	
	0	0	0		
	Trend				
	Variation/Assurance	Consistently Hitting Target	Hit and Miss target	Consistently Missing Target	Trend
Sustainable Services	Improving Special Cause Variation	2	1	0	
	Normal Variation	0	2	0	
	Deteriorating Special Cause Variation	0	1	1	
	Trend				

Performance Vs National Benchmarks (where available):

The Trust is performing favourably against available benchmarks in 12 KPIs.

Performance is adverse to benchmark in four KPIs: **KPI 2.3a Falls** (7.96 against 5.13), **KPI 2.3b Falls with harm** (1.33 against 1.30), **KPI 2.8 Urgent Community Response** (82.8% against 87.1%) and **KPI 3.3 Turnover** (12.73% against 8.50%).

Items of concern:

KPI 4.7 Community No Criteria to Reside is in special cause variation (declining) at 35.2%, materially above the 15% target. The position reflects both operational-flow and data-quality issues. Weekly escalation, a formal action plan, revised recording controls, an NCTR standard operating procedure and local tests of change remain in progress.

Significant improvements in previous areas of concern:

KPI 2.12 AHP Access within 12 weeks continues to show special cause variation (improving). As at 18 August, overall service-level performance was **92.0%** (98.9% within 18 weeks), excluding Community Paediatrics, with 14 of 19 services achieving 92% or above.

KPI 3.7 Vacancy Rate continues to show special cause variation (improving). The July gross vacancy factor was **3.36%**, better than the 6.00% target and the 5.60% benchmark.

DNA performance (KPIs 2.6a and 2.6b) remains in special cause variation (improving), supported by targeted improvement work, a digital-first approach and planned NHS App implementation from September 2026.

Items of excellence:

National Oversight Framework performance remains strong. The Trust is in **Segment 1**, with an average metric score of **1.53**, ranked **1st** among Community and Mental Health providers, **8th of 205** nationally and **1st of 28** in the South East.

Key national standards include School Health screening at **94.8%**, Urgent Community Response at **83.4%**, Urgent Treatment Centre (UTC) four-hour performance at **99.5%**, consultant-led Referral to Treatment (RTT) incomplete pathways at **99.7%**, and GUM access within 48 hours at **100%**.

Temporary staffing performance remains favourable: external agency spend was **0.1%** of clinical pay and staff bank spend was **5.3%**, with both measures showing special cause variation (improving).

Financial and productivity performance remains positive. The Trust reported a year-to-date surplus of **£57k** to the end of July after adjustment for donated-asset depreciation. Cost Improvement Programme (CIP) delivery was **£5.369m**, £49k ahead of plan, although 51% was non-recurrent. Community activity was **108.2%** of plan and continued to show special cause variation (improving).

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

N/A

Recommendation(s)

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

Link to CQC domain				
☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well-led

Assurance level	Reasonable
Rationale for assurance level	Majority of metrics meeting target with low levels of negative variation.

Implications		
Links to BAF risks / CRR	☒ BAF	☐ CRR
Equity, diversity and inclusion	Yes (provide a brief sentence describing the issue) White candidates were 1.44 times as likely to be appointed from shortlisting as BAME candidates, an improvement of 0.13 points month on month. Adult DNA rates were significantly higher for White other, Mixed, Asian/Asian British and Black/Black British groups than for White British patients; the White Irish rate was significantly lower. Children's DNA rates were significantly higher for White Irish, White other and Mixed groups than for White British children; the Black/Black British rate was significantly lower. AHP 12-week access was also significantly lower for Mixed, Asian/Asian British and Other ethnic groups compared with White British patients.	
Legal and regulatory	No	

Executive sponsors sign off
Gordon Flack, Chief Finance Officer
Date: 08 September 2026

Integrated Performance Report

2026/27 Month 4 report
September 2026

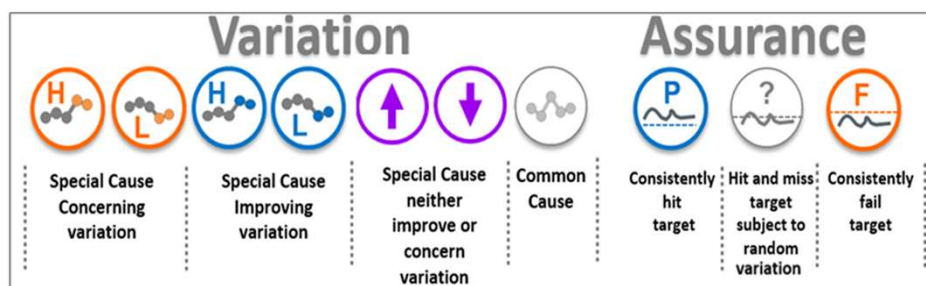
Overall CQC Rating – Outstanding  (July 2019)

Safe	Good 
Effective	Outstanding 
Caring	Outstanding 
Responsive	Good 
Well-led	Good 
Community health services for adults	2 September 2014 Good 
Community health services for children, young people and families	2 September 2014 Good 
Community dental services	24 July 2019 Good 
Community health inpatient services	2 September 2014 Good 
Community end of life care	24 July 2019 Good 
Community urgent care services	24 July 2019 Outstanding 
Community health sexual health services	24 July 2019 Outstanding 



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Pages 12-22	– A Better Patient Experience
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Pages 31-35	– Population Equality Summary
Pages 37-41	– Workforce EDI Summary
Page 42	– Community Services Subcontractor Performance
Pages 43-44	– Appendix 2 (RTA by Service)



Executive Summary



Kent Community Health

NHS Foundation Trust

National Oversight Framework (as at 18th August – Q4)

Our overall segment is segment **1 (no change from Q3)**, with an average metric score of **1.53 (1.56 in Q3)**. This places us **1st** for Community and Mental Health (same as Q3), **8th out of 205** nationally (down from 7th in Q3) and **1st of 28** (2nd in Q3) in the southeast region.

For individual domains and metrics we are:

Access to Services (2.39 – slight decline from 2.18 in Q3)

Percentage of people waiting over 52 weeks for community services score – 2.39 (down from 2.18 in Q3)

Effectiveness and Experience of Care (2.06 – slight decline from 1.71 in Q3)

Percentage of Urgent Community Response patients seen within two hours score 2.06 (down from 1.71 in Q3) due to the response rate within 2 hours moving from 88.43% in Q3 to 86.02% in Q4.

Patient Safety (1.1 – same as Q3)

NHS Staff Survey - raising concerns sub-score score – 1.1

People and Workforce (1.37 - good improvement from 1.75 in Q3)

Sickness absence rate score – 1.44 (good improvement from 1.85 in Q3)

NHS staff survey engagement theme score - 1.3 (improvement from 1.65 in Q3)

Finance and Productivity (1.21 – Same as Q3)

Planned surplus/deficit score – 1 (same as Q3)

Variance year-to-date to financial plan score – 1 (same as Q3)

Relative difference in costs score – 1.43 (same as Q3)



Executive Summary



Kent Community Health

NHS Foundation Trust

Summary

For this report, 23 of the 42 KPIs (one less than last month) are meeting or exceeding target for the month (55%), while 8 KPIs are marginally off target (amber) and 11 are further off target (two fewer than last month). Of the red KPIs, two are also in special cause variation (declining): KPI 2.5b Inpatient Care Hours Per Patient Day (CHPPD) – Unregistered Staff and KPI 4.7 Community No Criteria to Reside (NCTR). The remaining red KPIs are currently experiencing either common cause variation or special cause variation (improving).

	This month		Previous Month	Trend
Targets	42		42	
Met	23	55%	24	
Marginally Off Target	8	19%	5	
Missed	11	26%	13	

Variation

There are twelve metrics with special cause variation (improving), with highlights being sustained improving performance for KPIs 1.1a Health Visiting – Antenatal Visits Offered (Universal), 1.1b Health Visiting – Antenatal Visits Offered (Specialist and Targeted), 1.2 School Health – Year R and Year 6 Children Screened for Height and Weight, 2.6a Adults DNA Rate, 2.6b CYP DNA/WNB Rate, 2.12 AHP (Non-Consultant Led) Access Waiting Times (12 week target), 3.3 Turnover (All), 3.4 Turnover (Voluntary), 3.7 Vacancy Rate, 4.2 External Agency Spend % of Pay (Clinical), 4.3 Staff Bank Spend % of Pay (Clinical) and 4.5 Community Activity (YTD as % of YTD Plan).

Putting Communities First

ASSURANCE			
VARIATION	Consistently Hit Target 	Hit and Miss Target subject to random variation 	Consistently Fail Target 
	Special Cause Variation (improving)  	KPI 1.1b Health Visiting - Antenatal Visits Offered (Specialist and Targeted) KPI 1.2 (N) School Health - Year R and Year 6 Children Screened for Height and Weight	KPI 1.1a Health Visiting - Antenatal Visits Offered (Universal)
	Common Cause Variation 	KPI 1.4 (N) Percentage of child BCG vaccinations given within 28 days KPI 1.5 (N) Looked After Children - Initial assessments completed within 28 days KPI 1.6 (N) Looked After Children - Review assessments completed within timescale KPI 1.7 (N) Education and Health Care Plan (EHCP) - Completed within 6 weeks	
	Special Cause Variation (declining)  		

Better Patient Experience

ASSURANCE			
VARIATION	Consistently Hit Target 	Hit and Miss Target subject to random variation 	Consistently Fail Target 
	KPI 2.6a ADULTS DNA Rate: DNAs as a % of total activity	KPI 2.6b CYP DNA/WNB Rate: DNAs as a % of total activity	KPI 2.12 AHP (Non-Consultant Led) Access Waiting Times (12 week target)
	Common Cause Variation 	KPI 2.1 Inpatient Medication Errors Per 1000 bed days KPI 2.2 Community Medication Errors Per 1000 WTE KPI 2.3a Rate of Falls per 1000 Occupied Bed Days KPI 2.3b Rate of Falls with harm per 1000 Occupied Bed Days KPI 2.4 Pressure Ulcers - Lapses in Care KPI 2.5a Inpatient Care Hours Per Patient Day (CHPPD) - Registered Staff KPI 2.7 (N) 6 Week Diagnostics (DM01) KPI 2.13 (N) Access to GUM: within 48 hours KPI 2.14 Average Length of Community Hospital Inpatient Stay (Mean)	
	Special Cause Variation (declining)  	Combined CHPPD	KPI 2.5b Inpatient Care Hours Per Patient Day (CHPPD) - Unregistered Staff

A Great Place to Work

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

Sustainable Care

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

Executive Summary



Kent Community Health

NHS Foundation Trust

Benchmarking

Benchmarks are available to give national context to KCHFT performance. The trust are performing **favourably** in KPIs 2.1 Inpatient Medication Errors per 1,000 bed days, 2.2 Community Medication Errors per 1,000 WTE, 2.6a DNA Rate for Adults, 2.6b DNA/Was Not Brought Rate for CYP services, 2.14 Community Hospital Mean Length of Stay, 3.1 Sickness Rate, 3.6 Mandatory Training, 3.7 Vacancy Rate, 4.2 External Agency Spend % of Pay (Clinical), 4.3 Staff Bank Spend % of Pay (Clinical), 4.4 Cost Improvement Plans (CIP) and 4.6 Bed Occupancy.

We are currently **adverse** to the benchmark in only four KPIs: 2.3a Rate of Falls per 1,000 Occupied Bed Days (7.96 against a benchmark of 5.13), 2.3b Rate of Falls with harm per 1,000 Occupied Bed Days (1.33 against a benchmark of 1.30), 2.8 2-Hour Urgent Community Responses Met (82.8% against a benchmark of 87.1%) and 3.3 Turnover (All) (12.73% against a benchmark of 8.50%).

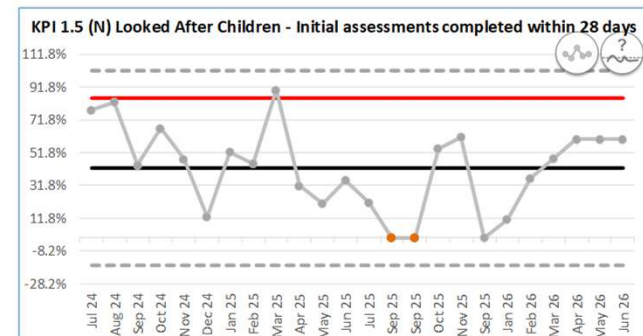
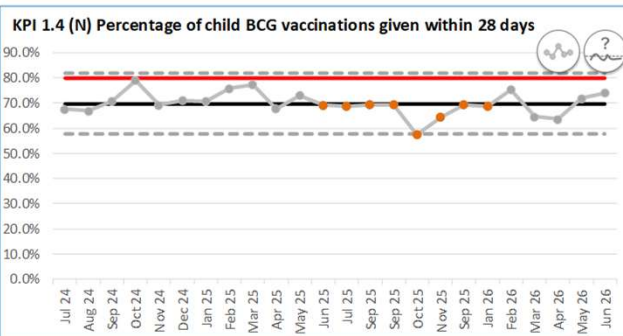
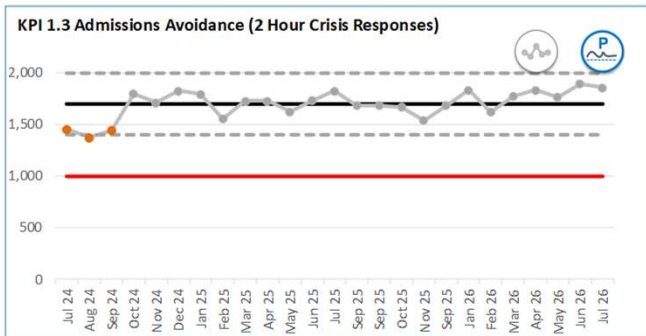
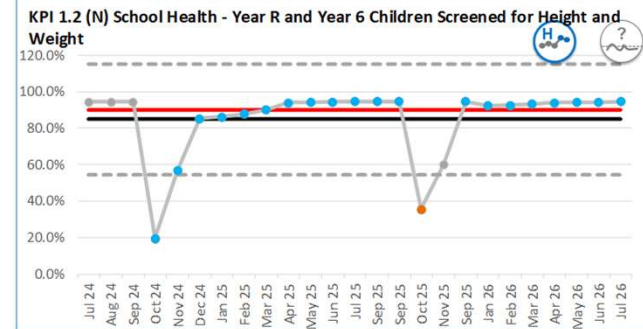
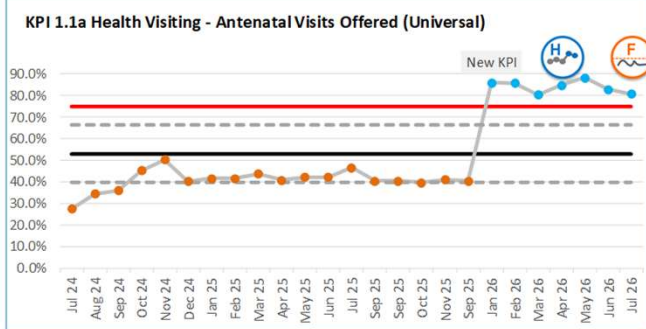
National Targets

Indicator	Detail	2026/27 Target	2026/27 Actual
National targets	KPI 1.2 School Health - YrR and Yr6 Height and Weight Screening	90%	94.8%
	KPI 1.4 Child BCG Vaccinations given within 28 days	80%	69.9%
	KPI 1.5 Looked After Children Initial Health Assessments	85%	60.0%
	KPI 1.7 Education and Health Care Plan (EHCP) Completed within 6 weeks	70%	71.1%
	KPI 2.7 6 week Diagnostic Tests (DM01)	85%	76.1%
	KPI 2.8 2-Hour Urgent Community Response	80%	83.4%
	KPI 2.9 Total Time in MIU/UTCs: Less than 4 hours	95%	99.5%
	KPI 2.10 Consultant Led 18 Week RTT - Incomplete Pathways	92%	99.7%
	KPI 2.13 Access to GUM within 48 hours	100%	100%

Putting Communities First

KPI	Variation				Assurance			Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit	Benchmark
	Special Cause Concerning variation	Special Cause Improving variation	Special Cause neither improve or concern variation	Common Cause	Consistently hit target	Hit and miss target subject to random variation	Consistently fail target									

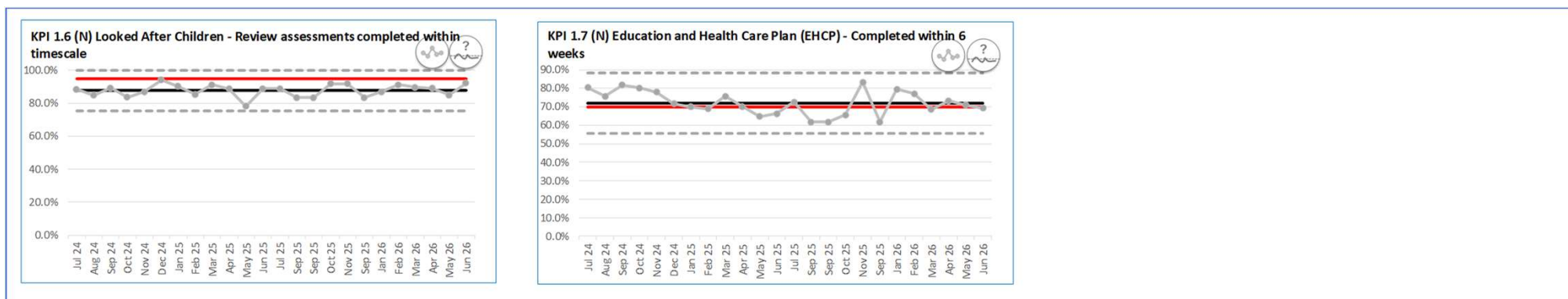
KPI 1.1a Health Visiting - Antenatal Visits Offered (Universal)	Jul 26	80.8%	75.0%	H	F			53.0%	39.7%	66.3%	N/A
KPI 1.1b Health Visiting - Antenatal Visits Offered (Specialist and Targeted)	Jul 26	83.5%	85.0%	H	?			79.3%	73.1%	85.4%	N/A
KPI 1.2 (N) School Health - Year R and Year 6 Children Screened for Height and Weight	Jul 26	94.8%	90.0%	H	?			84.8%	54.6%	115.1%	N/A
KPI 1.3 Admissions Avoidance (2 Hour Crisis Responses)	Jul 26	1858	1000		P			1697	1400	1995	N/A
KPI 1.4 (N) Percentage of child BCG vaccinations given within 28 days	Jun 26	74.1%	80.0%		?			69.8%	57.8%	81.9%	N/A
KPI 1.5 (N) Looked After Children - Initial assessments completed within 28 days	Jun 26	60.0%	85.0%		?			42.4%	-16.8%	101.7%	N/A



Putting Communities First

KPI	Variation				Assurance			Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit	Benchmark
	 Special Cause Concerning variation	 Special Cause Improving variation	 Special Cause neither improve or concern variation	 Common Cause	 Consistently hit target	 Hit and miss target subject to random variation	 Consistently fail target									

KPI 1.6 (N) Looked After Children - Review assessments completed within timescale	Jun 26	92.2%	95.0%			87.8%	75.5%	100.2%	N/A
KPI 1.7 (N) Education and Health Care Plan (EHCP) - Completed within 6 weeks	Jun 26	69.2%	70.0%			72%	56%	88%	N/A



Putting Communities First Summary



Kent Community Health
NHS Foundation Trust

Focus for Improvement Work

KPI 1.1a Health Visiting – Antenatal Visits (Universal) continues to show special cause variation (improving). Performance was 80.8% in July 2026, above the 75.0% target, following the step change from January 2026 when all families began to be offered an antenatal review appointment under the new contract.

KPI 1.1b Health Visiting – Antenatal Visits (Specialist and Targeted) also shows special cause variation (improving). July 2026 performance was 83.5%, slightly below the 85.0% target. The service continues to work with commissioners to review uptake of the antenatal offer, particularly within the 28–34 week reference period, as many clients access support outside this timeframe.

KPI 1.4 Percentage of BCG vaccinations given within 28 days remains in common cause variation. Performance improved to 74.1% in June 2026, below the 80.0% target but above the 69.8% mean. Locality performance remains mixed, with DGT improving from 67.0% in May to 77.9% in June, while EKHUFT reduced from 75.8% to 69.0% over the same period. Overall vaccination uptake remains high at 85% in DGT and 81% in EKHUFT, indicating that delays primarily affect timeliness rather than access.

The overall position reflects external factors and parent-led scheduling decisions rather than clinic capacity constraints. Contributing factors include parent-led postponements, appointments chosen outside the KPI window, SCID screening delays, and babies remaining in hospital. The EKHUFT decline rate (15.9%) remains notably higher than DGT (8.8%).

Controls in place to maintain performance include weekly breach reviews, active demand and capacity management, revised non-contact protocols, SMS reminders and BCG information videos, and workforce expansion.

Putting Communities First Summary



Kent Community Health
NHS Foundation Trust

Stable Metrics

KPI 1.2 School Health Screening continues to show special cause variation (improving), with performance at 94.8% in July 2026, above the 90.0% school-year target and reflecting sustained improvement.

KPI 1.5 Looked After Children Initial Health Assessments – Health services have a statutory responsibility to complete an Initial Health Assessment (IHA) and circulate the report to the responsible officer within 28 days from date of the child becoming looked after. To comply with the statutory regulation, 85% of children need to be seen within this time frame. KCHFT, the local authorities (KCC and Medway council) have a target to send the referral within five working days.

Latest reported performance for KPI 1.5 was 60.0% in June 2026, below the 85.0% target but above the 42.4% mean. The metric remains in common cause variation. The team continues to use the appointment search tool on RIO, alongside work with local authority partners, to support improvement.

Ongoing work is taking place regards the deep dive into late cancellations/WNB. This is being jointly undertaken with the local authorities.

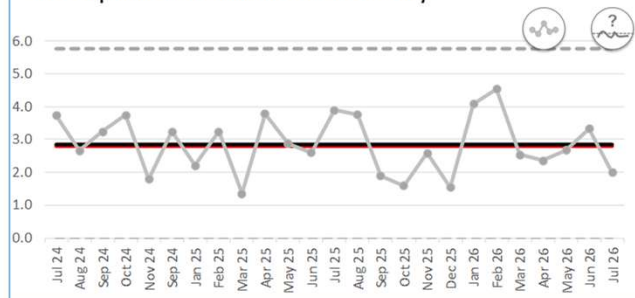
KPI 1.6 Looked After Children Review Health Assessments – performance was 92.2% in June 2026, below the 95.0% target but above the 87.8% mean. The metric remains in common cause variation.

KPI 1.7 Education and Health Care Plans (EHCP) – statutory health services are required to provide advice or complete assessment within six weeks of notification by the local authority. Demand remains high and continues to affect delivery within current resources. Compliance was 69.2% in June 2026, slightly below the 70.0% target and the 72.0% mean, with performance in common cause variation. KCHFT also monitors the 20-week response time; the most recently stated figure remains 85% for January referrals.

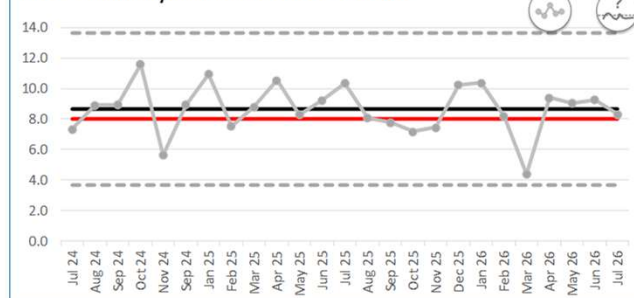
Better Patient Experience

KPI	Variation			Assurance			Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit	Benchmark
	Special Cause Concerning variation	Special Cause Improving variation	Special Cause neither improve or concern variation	Common Cause	Consistently hit target	Hit and miss target subject to random variation									
KPI 2.1 Inpatient Medication Errors Per 1000 bed days							Jul 26	2.0	2.8			2.9	-0.1	5.8	2.8
KPI 2.2 Community Medication Errors Per 1000 WTE							Jul 26	8.3	8.0			8.7	3.7	13.6	14.0
KPI 2.3a Rate of Falls per 1000 Occupied Bed Days							Jul 26	7.96	7.00			7.93	3.52	12.33	5.13
KPI 2.3b Rate of Falls with harm per 1000 Occupied Bed Days							Jul 26	1.33	1.50			1.40	-0.54	3.34	1.30
KPI 2.4 Pressure Ulcers - Lapses in Care							Jul 26	6	1			3	-2	7	N/A
KPI 2.5a Inpatient Care Hours Per Patient Day (CHPPD) - Registered Staff							Jul 26	4.28	4.00			4.02	3.57	4.47	N/A
Combined CHPPD							Jul 26	7.81	8.00			8.17	7.66	8.68	N/A

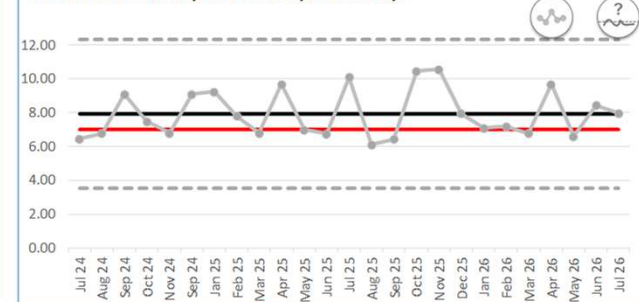
KPI 2.1 Inpatient Medication Errors Per 1000 bed days



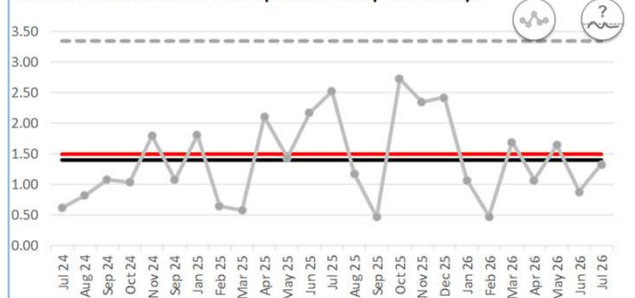
KPI 2.2 Community Medication Errors Per 1000 WTE



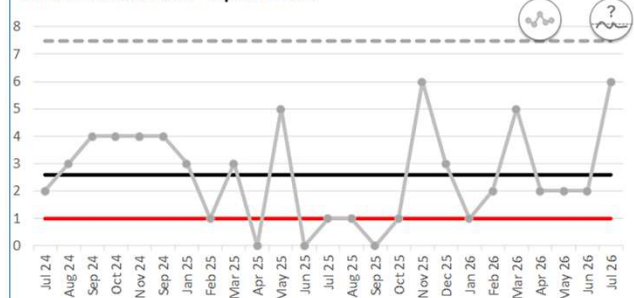
KPI 2.3a Rate of Falls per 1000 Occupied Bed Days



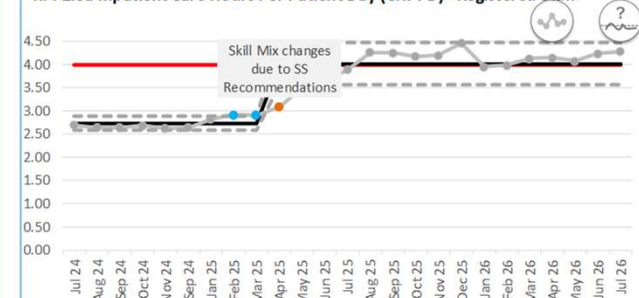
KPI 2.3b Rate of Falls with harm per 1000 Occupied Bed Days



KPI 2.4 Pressure Ulcers - Lapses in Care

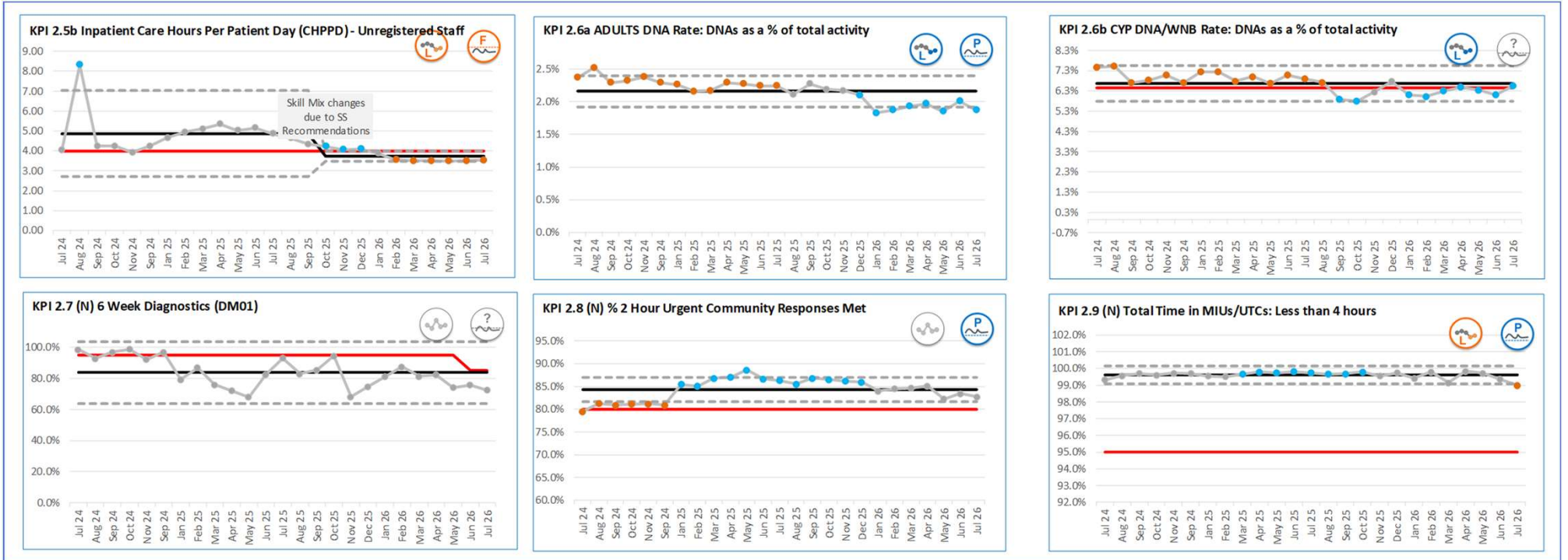


KPI 2.5a Inpatient Care Hours Per Patient Day (CHPPD) - Registered Staff



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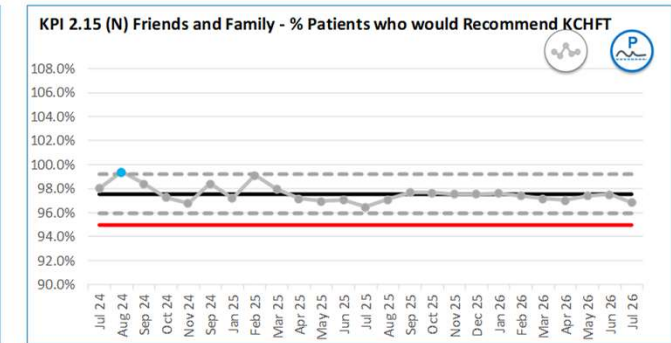
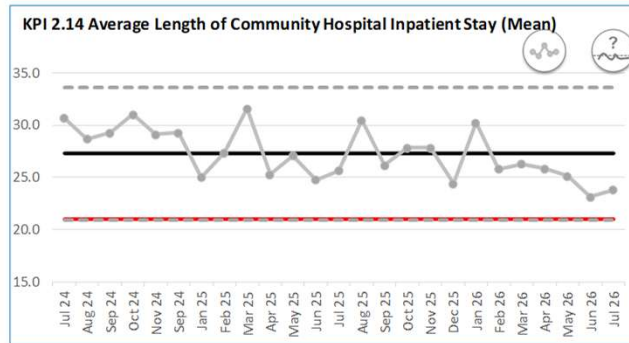
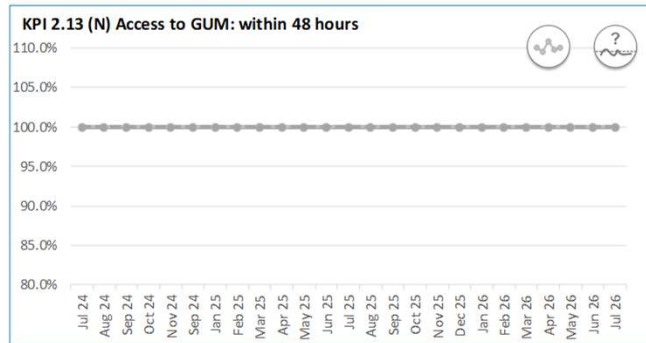
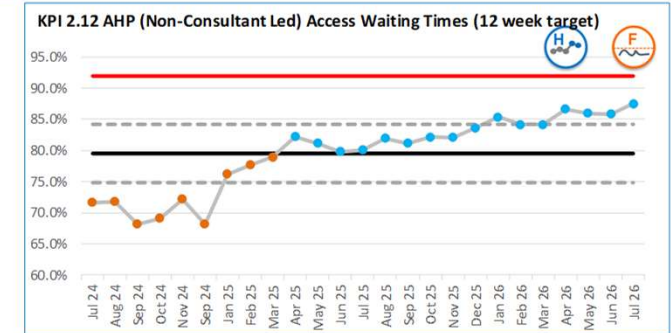
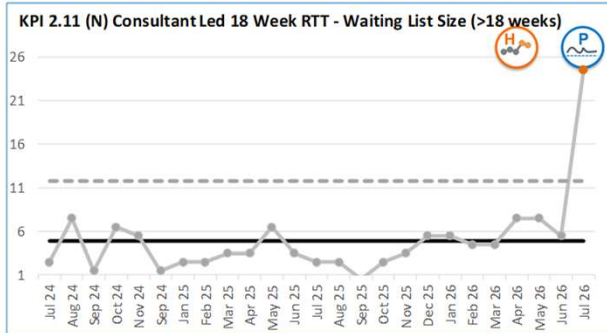
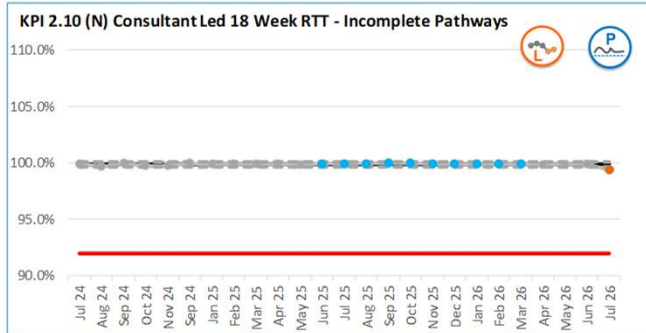
KPI	Variation Assurance							Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit	Benchmark
	H L Special Cause Concerning variation H L Special Cause Improving variation U D Special Cause neither improve or concern variation C Common Cause P Consistently hit target ? Hit and miss target subject to random variation F Consistently fail target															
KPI 2.5b Inpatient Care Hours Per Patient Day (CHPPD) - Unregistered Staff								Jul 26	3.53	4.00	U	?	3.73	3.48	3.98	N/A
KPI 2.6a ADULTS DNA Rate: DNAs as a % of total activity								Jul 26	1.9%	3.0%	P	P	2.2%	1.9%	2.4%	3.7%
KPI 2.6b CYP DNA/WNB Rate: DNAs as a % of total activity								Jul 26	6.6%	6.5%	U	?	6.7%	5.8%	7.6%	7.3%
KPI 2.7 (N) 6 Week Diagnostics (DM01)								Jul 26	72.5%	85.0%	C	?	83.7%	63.9%	103.5%	N/A
KPI 2.8 (N) % 2 Hour Urgent Community Responses Met								Jul 26	82.8%	80.0%	C	P	84.3%	81.6%	87.0%	87.1%
KPI 2.9 (N) Total Time in MIUs/UTCs: Less than 4 hours								Jul 26	99.0%	95.0%	U	P	99.6%	99.1%	100.1%	N/A



Better Patient Experience

KPI	Variation						Assurance						Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit	Benchmark
	Special Cause Concerning variation	Special Cause Improving variation	Special Cause neither improve or concern variation	Common Cause	Consistently hit target	Hit and miss: target subject to random variation	Consistently fail target	Consistently hit target	Hit and miss: target subject to random variation	Consistently fail target											

KPI 2.10 (N) Consultant Led 18 Week RTT - Incomplete Pathways	Jul 26	99.4%	92.0%	  		99.9%	99.6%	100.1%	N/A
KPI 2.11 (N) Consultant Led 18 Week RTT - Waiting List Size (>18 weeks)	Jul 26	24	100	  		4	-2	11	N/A
KPI 2.12 AHP (Non-Consultant Led) Access Waiting Times (12 week target)	Jul 26	87.5%	92.0%	  		79.5%	74.9%	84.1%	N/A
KPI 2.13 (N) Access to GUM: within 48 hours	Jul 26	100.0%	100.0%	  		100.0%	100.0%	100.0%	N/A
KPI 2.14 Average Length of Community Hospital Inpatient Stay (Mean)	Jul 26	23.8	21.0	  		27.3	20.9	33.6	28.5
KPI 2.15 (N) Friends and Family - % Patients who would Recommend KCHFT	Jul 26	96.9%	95.0%	  		97.6%	95.9%	99.2%	N/A



Better Patient Experience Summary



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Focus for Improvement Work

KPI 2.6a Adults DNA Rate continues to show special cause variation (improving) due to ongoing targeted improvement work such as use of a digital first approach. This will be further enhanced through the implementation of the NHS App (due from September 2026 and additional enhancements to communication pathways throughout 2026-27. **KPI 2.6b CYP DNA/WNB Rate** is also in special cause variation (improving).

Breakthrough Focus

Out of 19 services with more than 150 DNAs in the most deprived populations, ten have been identified as high priority. The focus is on reducing the quintile 1 (highest deprivation) DNA rate towards the quintile 2 DNA rate.

We Care Strategy Refresh & Breakthrough Objectives

The Inequalities Intelligence Managers are:

Re-baselining the 19 chosen services using data extracted from the Data Warehouse and checking for a statistically significant difference between quintile 1 and quintile 2 DNA rates.

Holding meetings with each of the ten priority services to discuss what they know and have done already to tackle DNAs, provide tailored support and identify areas for further data analysis.

Undertaking additional data analysis, informed by meetings above.

Providing recommendations to services for further improvement work

Better Patient Experience Summary

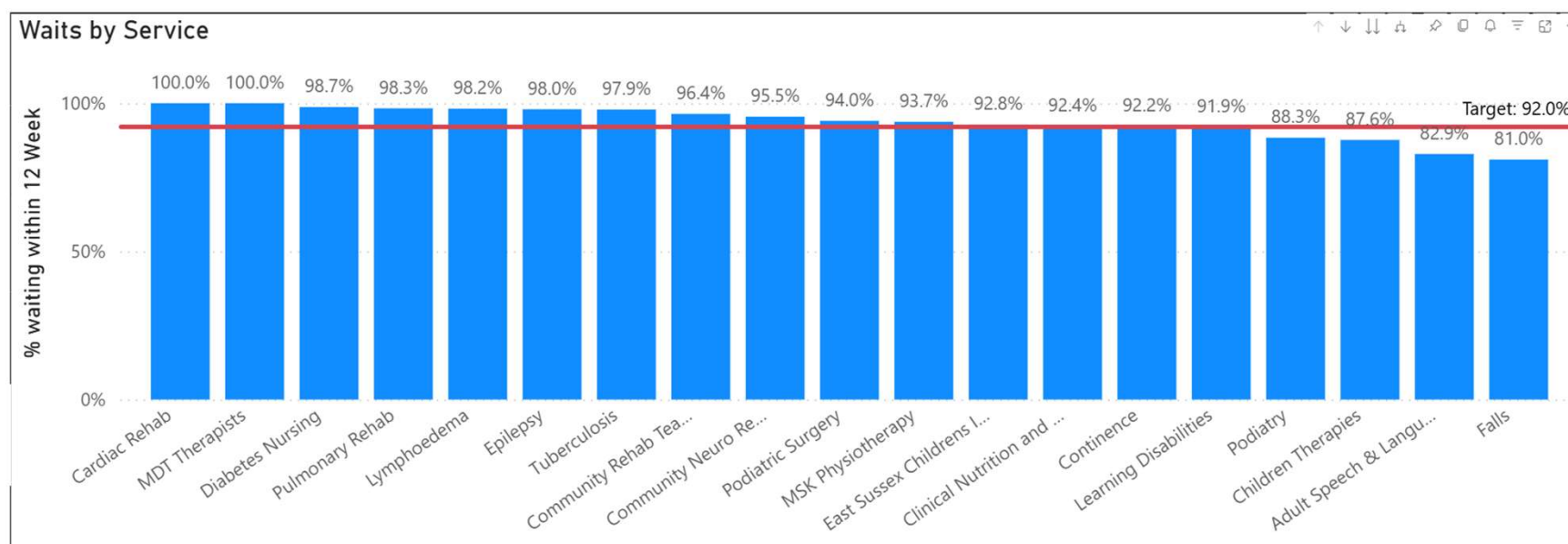


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Focus for Improvement Work

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

The overall position at service level as of 18th August is 92.0% (98.9% within 18 weeks). This excludes Community Paediatrics which is subject to separate reporting oversight under BP1b (see slide 19). Of the 19 services, 14 are achieving 92% and above.



Better Patient Experience Summary

Current Situation – Patient Tracking and wait times



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Revised Breakthrough targets for 2026/2027 have been agreed to focus on five services measuring first to follow up against clinician led standards and for services to use Patient Initiated Follow Up. Children Therapies, Falls Service, Adult Speech and Language, Community Neuro Rehabilitation and Podiatry have been identified. Children Therapies, MSK Physiotherapy have been identified for PIFU reporting. 12 and 18 week reporting will continue for all services.

Current 12-week reporting shows 14 out of 19 services are within target with 3 remaining services within 5% of target. ASLT and Falls services are above 80%. Many services particularly children's services have variation in activity throughout the year caused by annual leave and school holidays.

Podiatric surgery has been added as a service focus. We are expecting delays in this service due to ongoing operating theatre refurbishment. All surgery is currently paused with staff focusing on pre-surgery preparation so when the theatre is back on-line we can focus on those patients who have been waiting longest. Waiting lists have been validated and harm reviews undertaken as a precaution. Trajectories have been prepared to project impact to wait times once capacity is focused on theatre sessions and POA activity.

The 92% 12-week RTA target remains with the expectation that improvement will continue. Meetings with the five focused services are taking place to ensure compliance and that clinicians set the first to follow up target on RIO. Reporting on F2FU against target has begun with targets for the five focused services staged in year so that by end of March 2027 they will achieve 75% of First to Follow Up within the clinical standards set.

The key recent areas of learning are;

- Continued monthly PTL review meetings to share learning and provide progress on service initiatives and action plans and review progress against objective targets. Reviewed at each PTL meeting through service A3s.
- Review and revision of Trust Access Policy against new National Guidance on managing RTT waits in Elective Care. Policy agreed
- Introduction of a community demand/capacity model with job plans being agreed in all services. This is in progress with help offered to Business managers to implement the model.
- F2FU training and expectations against the Breakthrough target.



Better Patient Experience Summary



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Community Paediatrics – BP1b

The service focus had been to reduce the number of long waiters with an improvement trajectory (We Care Breakthrough metric BP1b). As of the 26th August there are no children over 52 weeks. The 2026-27 target is to further reduce number of children waiting from 52 weeks to 36 weeks by March 2027. Performance has been impacted by an increase in demand within the Southeast locality, resulting in a higher number of children exceeding the 36-week threshold. Currently, 270 children are waiting between 36 and 52 weeks, of whom 98 have appointments booked during September 2026. The team is actively working to increase capacity and manage new referrals. The service is currently booking appointments at approximately 44 weeks.

The overall 12-week RTA within 12 weeks is 43.7%. The average waiting time is 18.63 weeks.

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

In July 2026, combined CHPPD increased to 7.85. Registered staffing delivered 19,362 actual hours against 19,982 planned (97% fill), while unregistered staffing delivered 15,948 hours against 13,172 planned (121% fill). The report continues to flag KPI 2.5b as below target and in special-cause variation (declining). However, in reality this shows that the staffing has reached a steady state and the target metric for HCAs should now be reset at 3.5 CHPPD.

Registered shift fill remained close to plan across the community hospitals, ranging from 93% to 99% by site. Unregistered fill remained above plan overall and varied from 90% to 140%, reflecting continued additional staffing demand. Revised establishments and successful recruitment into registered nurse posts continue to support stable registered staffing levels.

Jul-26	Registered Staff			Unregistered Staff			Combined CHPPD
	Shift Fill Rate	Planned Hours	Actual Hours	Shift Fill Rate	Planned Hours	Actual Hours	
Victoria Hospital, Deal	93%	2176	2022	96%	1689	1614	6.98
Faversham Cottage Hospital	95%	2151	2047	115%	1127	1295	7.90
Westview Hospital (Benenden East)	98%	1782	1745	129%	1070	1375	7.29
Westview Hospital (Benenden West)	99%	1778	1755	115%	1412	1631	8.38
Westbrook House (Stroke)	98%	2131	2085	135%	1539	2082	9.25
QVMH, Herne Bay	97%	2146	2087	140%	1085	1519	7.30
Whitstable & Tankerton Hospital	97%	2137	2068	123%	1205	1480	7.42
Hawkhurst Hospital	97%	2134	2078	122%	1466	1788	6.50
Tonbridge Goldsmid (NOF)	97%	1778	1716	121%	1160	1407	8.33
Tonbridge Primrose (Stroke)	99%	1771	1759	124%	1421	1758	10.51
ALL Sites	97%	19982	19362	121%	13172	15948	7.85

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

Unregistered hours remained above plan in July 2026: 15,948 actual hours against 13,172 planned, equivalent to 121% fill and a variance of 2,776 hours. The report continues to attribute this pressure to Enhanced Therapeutic Observations and Care (ETOC). The ratified ETOC policy, along with ongoing work with system partners, strengthens governance and provides clearer decision-making for deploying additional staffing across community hospitals.

Better Patient Experience Summary



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Stable Metrics

Latest July 2026 data show the following KPIs remain in common cause variation. Performance is mixed: several measures are meeting target, while others require continued monitoring.

KPI 2.1 Inpatient Medication Errors was 2.0 against a 2.8 target; KPI 2.2 Community Medication Errors was 8.3 against 8.0; KPI 2.3a Falls was 7.96 against 7.00; KPI 2.3b Falls with Harm was 1.33 against 1.50; KPI 2.4 Pressure Ulcers was 6 against 1; KPI 2.7 Diagnostics was 72.5% against 85.0%; KPI 2.8 Urgent Community Response was 82.8% against 80.0%; KPI 2.13 GUM Access was 100.0%; KPI 2.14 Length of Stay was 23.8 days against 21.0; and KPI 2.15 Friends and Family was 96.9% against 95.0%.

KPI 2.14 Average Length of Community Hospital Inpatient Stay improved to 23.8 days in July 2026, from 25.1 days in month 2, but remains 2.8 days above the 21-day target. The metric remains in common cause variation, with a mean of 27.3 days.

The 21-day target is an average: rehabilitation placements, including stroke, may require longer stays, while targeted intervention should support shorter stays and timely discharge home.

Home First commenced support with Pathway 1 discharges from community hospitals, primarily in EK and recently WK whilst the Home First model is expanding. WK Home First continues to ramp up, with increased staffing, weekend working and closer integration with KEAH translating into increased Pathway 1 activities and improved responsiveness.

WK Home First activity has progressively increased as the service has mobilised. Accepted referrals averaged 19.2 per week in June, increasing to 21.0 in July (+9%) and 22.3 per week in August to 17 August (+16% vs June). The latest week reached 25 accepted referrals, 30% above the June weekly average. Importantly, increased activity has been accompanied by improved responsiveness, with 96% (24/25) of referrals w/c 17 August starting the same or next day. Caseload remains controlled at approximately 45–53 patients, while discharge throughput has reached 28–31 patients in the strongest weeks, with LOS generally maintained at 10–15 days. The service has also supported 3 discharges from Community Hospitals recently (2 in July + 1 in August)

Better Patient Experience Summary



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Stable Metrics continued...

Seven-day working: Weekend working has now commenced, increasing capacity to support Friday/weekend discharges and reducing reliance on weekday-only Pathway 1 starts.

KEAH/Home First interface: Revised joint triage arrangements will target patients where KEAH start dates exceed 48 hours, reducing to 24 hours when in OPEL 4, with Home First providing bridging or full acceptance where capacity allows.

Other variation for highlighting

KPI 2.15 Friends and Family - % Patients who would recommend KCHFT is now in common cause variation. July 2026 performance was 96.9%, above the 95.0% target, although below the 97.6% mean. The current process range remains above target, providing continued assurance of strong performance.

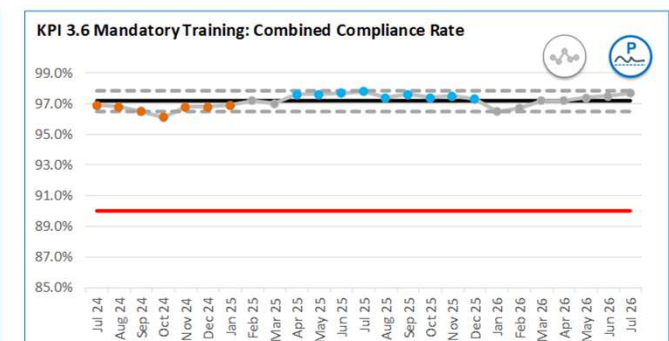
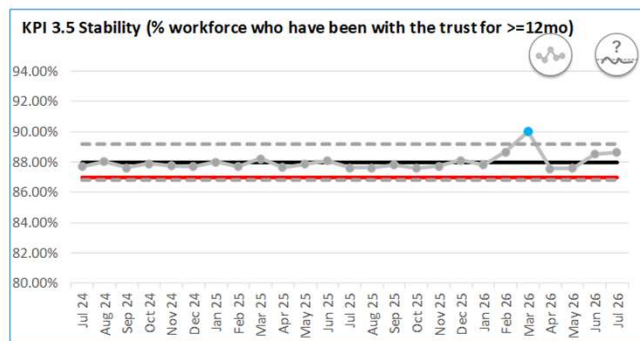
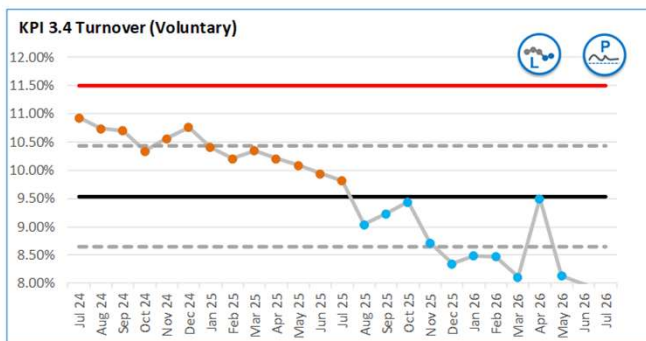
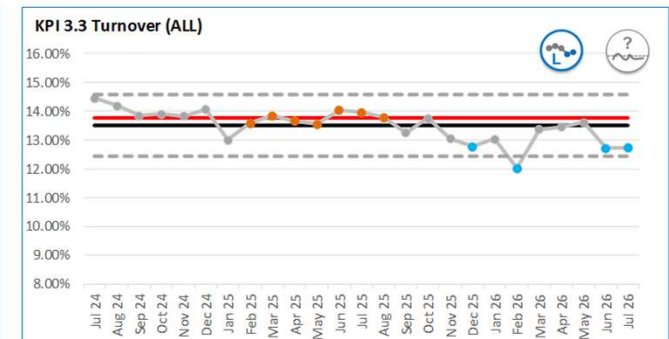
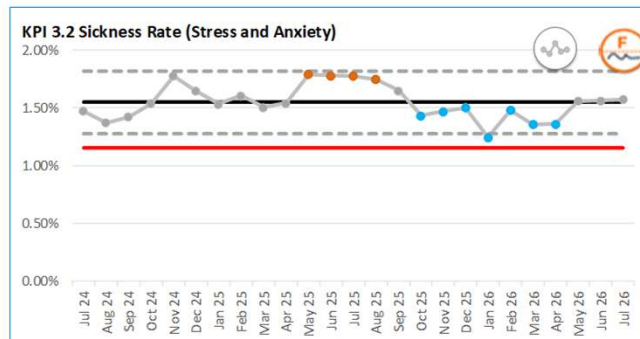
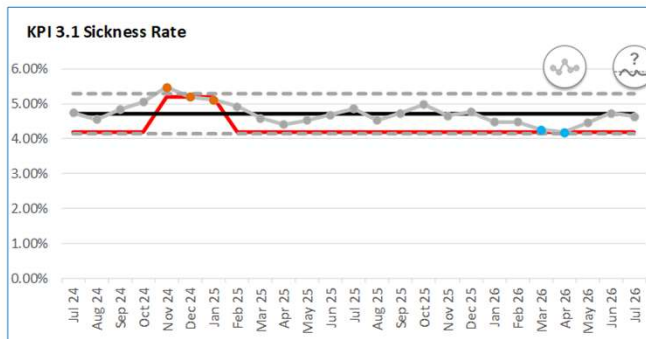
KPI 2.7 6 Week Diagnostics - The NHSE compliance target has been 85% since April 2026. July 2026 compliance was 72.5%, below both the target and the 83.7% mean. The metric remains in common cause variation and does not yet provide consistent assurance of meeting target. Babies who fail the newborn hearing screening must be seen by Audiology within 4 weeks and in July 100% of babies were seen within target time.

A short period of structured engagement has been undertaken with the Audiology team to explore alternative service delivery models, which will feed into a DM01 recovery plan. A plan has been developed to release clinical capacity while maintaining an appropriate level of service provision for patients requiring critical follow-up reviews. This will run for a period of six weeks, and by October 2026 the service should be compliant with the DM01 target.

A Great Place to Work

KPI	Variation				Assurance			Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit	Benchmark
	H	L	H	L	U	D	C									
KPI 3.1 Sickness Rate	Special Cause Concerning variation	Special Cause Improving variation	Special Cause neither improve or concern variation	Common Cause	Consistently hit target	Hit and miss: target subject to random variation	Consistently fail target	Jul 26	4.64%	4.20%			4.72%	4.15%	5.29%	5.53%
KPI 3.2 Sickness Rate (Stress and Anxiety)								Jul 26	1.57%	1.15%			1.55%	1.27%	1.82%	N/A
KPI 3.3 Turnover (ALL)								Jul 26	12.73%	13.78%			13.50%	12.43%	14.58%	8.50%
KPI 3.4 Turnover (Voluntary)								Jul 26	7.84%	11.50%			9.53%	8.64%	10.43%	N/A
KPI 3.5 Stability (% workforce who have been with the trust for >=12mo)								Jul 26	88.63%	87.00%			87.99%	86.80%	89.18%	N/A
KPI 3.6 Mandatory Training: Combined Compliance Rate								Jul 26	97.7%	90.0%			97.2%	96.5%	97.8%	92.6%

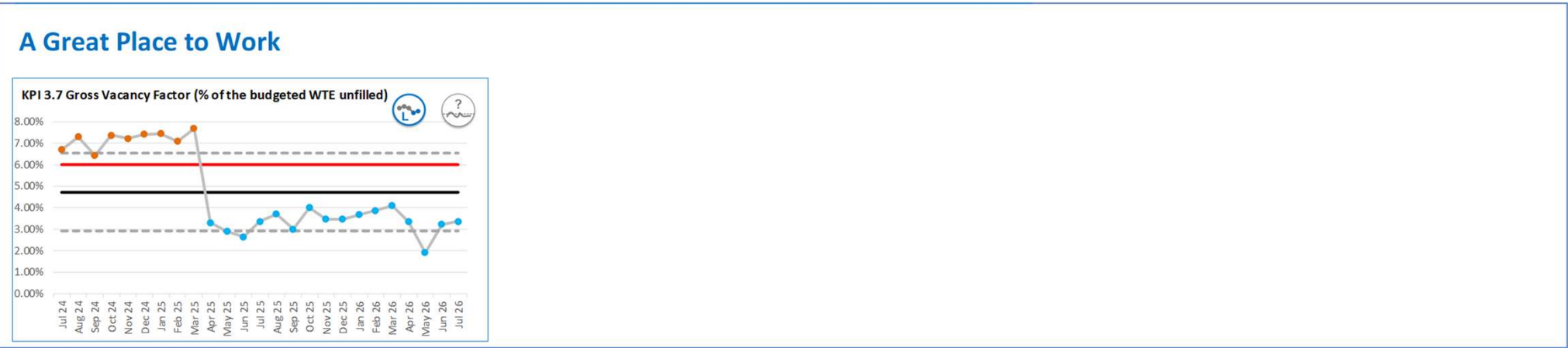
A Great Place to Work



A Great Place to Work

KPI	 Special Cause Concerning variation  Special Cause Improving variation  Special Cause neither improve or concern variation  Common Cause  Consistently hit target  Hit and miss: target subject to random variation  Consistently fail target Latest month Measure Target Variation Assurance Mean Lower process limit Upper process limit Benchmark
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KPI 3.7 Gross Vacancy Factor (% of the budgeted WTE unfilled)	Jul 26	3.36%	6.00%	 	4.72%	2.91%	6.53%	5.60%
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A Great Place to Work Summary

Focus for Improvement Work



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KPI 3.1 Sickness Absence was 4.64% in July 2026 and remains a Breakthrough objective watch metric, against a target of 4.20%. The measure remains in common cause variation, is slightly below the 4.72% mean, and is below the national benchmark of 5.53%. Stress and anxiety absence was 1.57%, above the 1.15% target and slightly above the 1.55% mean.

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

The recent refresh of the Managing Absence Policy seeks to further improve absence rates by clearly and compassionately outlining managers' responsibilities for holding early, supportive conversations with absent colleagues. This is also supported by monthly check and challenge meetings by PODBPs at service governance meetings, the recent launch of an engagement campaign to support colleagues experiencing burnout, and development of manager confidence sessions to manage sickness absence which has been well received. A piece of work to re-frame presentation of metrics, impact, and ensure focussed check and challenge of long/ short term absence at a divisional and service level is being trialled by business partners, clinical service directors and the employee relations team.

KPI 3.3 Turnover (All), at 12.73% in July 2026, improved from the previous month and remains in special cause variation (improving). Performance is below both the 13.50% mean and the 13.78% target, while remaining above the 8.50% benchmark. This continues to reflect positive retention performance, while wider system workforce changes remain a relevant context.

KPI 3.4 Turnover (Voluntary) remains a Breakthrough objective watch metric because it is more directly controllable and is an indicator of engagement and morale. At 7.84% in July 2026, it continues to show special cause variation (improving) and remains well below both the 9.53% mean and the 11.50% target.

A Great Place to Work Summary



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Stable Metrics

Mandatory Training (KPI 3.6) continues to perform strongly at 97.7% in July 2026, against a 90.0% target. It remains in common cause variation and is above both the 97.2% mean and the 92.6% benchmark.

Whilst the overarching metric is stable the Education Group receive a monthly report highlighting areas of concern and excellence. The one element of moving and handling level 4 that was a concern has improved; this will continue to be monitored. Equity, Diversity and Inclusion is a recently mandated topic, the feedback from colleagues has been positive, and compliance is 22.5% above the expected trajectory.

Stability (KPI 3.5) remains in common cause variation at 88.63% in July 2026, above both the 87.00% target and the 87.99% mean.

Other variation for highlighting

Vacancy Rate (KPI 3.7) continues to show special cause variation (improving). The July 2026 gross vacancy factor was 3.36%, against a 6.00% target, and remains below both the 4.72% mean and the 5.60% benchmark. The latest point is just above the 2.91% lower process limit.

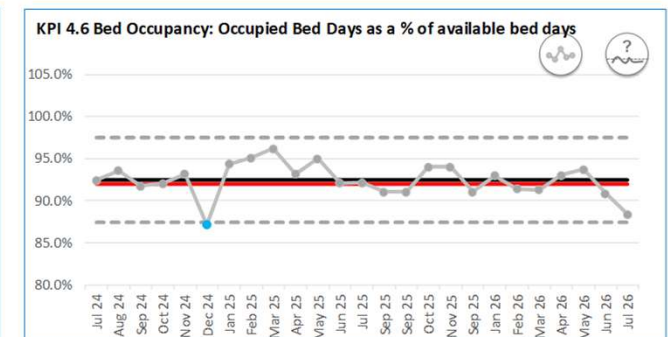
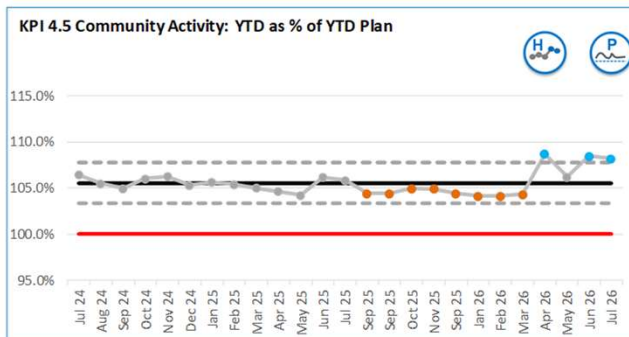
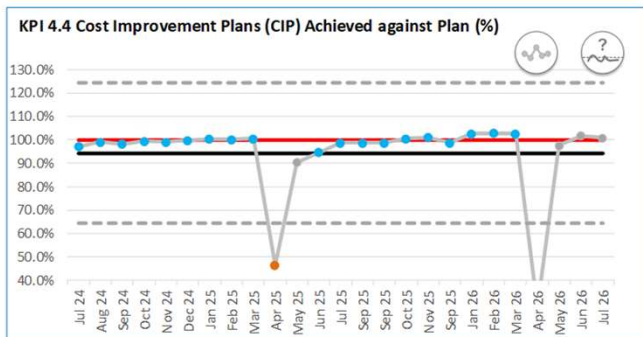
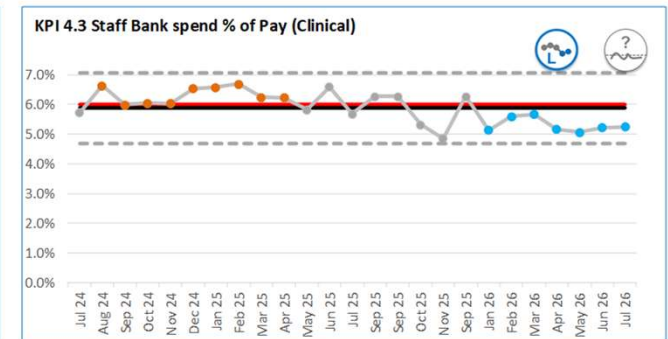
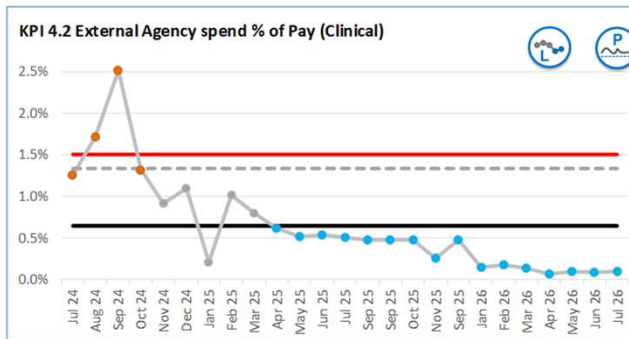
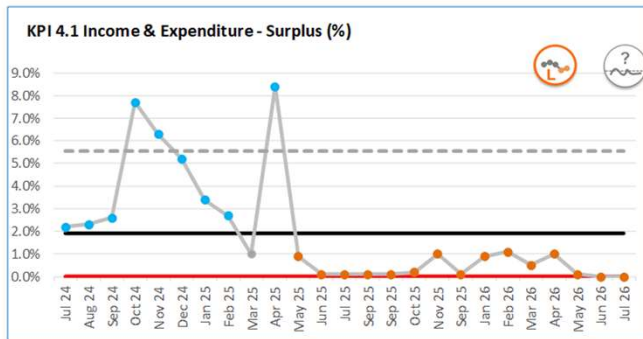
Although the vacancy rate increased from the previous month, performance remains materially better than target and benchmark and continues the improving pattern evident since April 2025.

Sustainable Care

KPI	H L Variation H L Special Cause Concerning variation L L Special Cause Improving variation U D Special Cause neither improve or concern variation C Common Cause P ? F Assurance Consistently hit target Hit and miss: target subject to random variation Consistently fail target						Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit	Benchmark

KPI 4.1 Income & Expenditure - Surplus (%)	Jul 26	0.0%	0.0%				1.9%	-1.7%	5.6%	N/A
KPI 4.2 External Agency spend % of Pay (Clinical)	Jul 26	0.1%	1.5%				0.6%	-0.1%	1.3%	0.8%
KPI 4.3 Staff Bank spend % of Pay (Clinical)	Jul 26	5.3%	6.0%				5.9%	4.7%	7.1%	5.6%
KPI 4.4 Cost Improvement Plans (CIP) Achieved against Plan (%)	Jul 26	100.9%	100.0%				94.4%	64.5%	124.3%	97.2%
KPI 4.5 Community Activity: YTD as % of YTD Plan	Jul 26	108.2%	100.0%				105.5%	103.3%	107.8%	N/A
KPI 4.6 Bed Occupancy: Occupied Bed Days as a % of available bed days	Jul 26	88.4%	92.0%				92.4%	87.4%	97.5%	90.0%

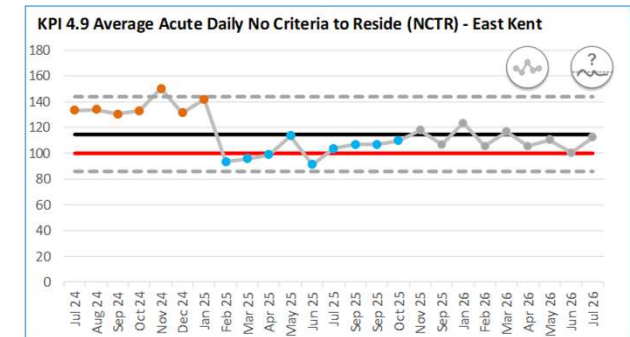
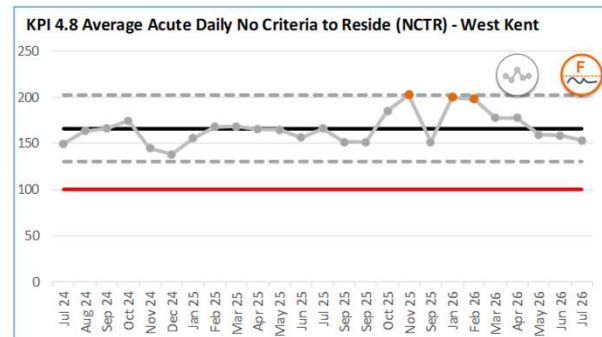
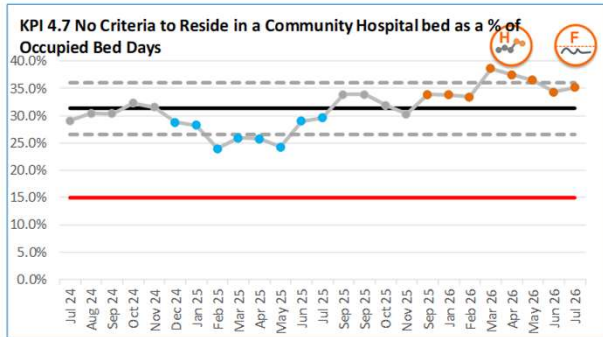
Sustainable Care



Sustainable Care

KPI	Variation				Assurance			Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit	Benchmark
	Special Cause Concerning variation	Special Cause Improving variation	Special Cause neither improve or concern variation	Common Cause	Consistently hit target	Hit and miss target subject to random variation	Consistently fail target									
KPI 4.7 No Criteria to Reside in a Community Hospital bed as a % of Occupied Bed Days					Jul 26	35.2%	15.0%			31.3%	26.5%	36.1%	N/A			
KPI 4.8 Average Acute Daily No Criteria to Reside (NCTR) - West Kent					Jul 26	153	100			166	130	202	N/A			
KPI 4.9 Average Acute Daily No Criteria to Reside (NCTR) - East Kent					Jul 26	112	100			115	86	144	N/A			

Sustainable Care



Focus for Improvement Work

KPI 4.7 Community No Criteria to Reside (NCTR) is in special cause variation (declining) at 35.2% and remains significantly above target level (15%). The east Kent position continues to impact the KCHFT NCTR rate but being aware that there are a higher number of beds with the east Kent geographical patch – 59%:41%.

NCTR remains an ongoing operational-flow issue with discharge pathway and system delays, however a deep dive into the assessment and reporting of NCTR status has identified site level variation and coding inconsistencies and variation.

The improvement plan has several strands:

- Weekly NCTR meetings and escalation continue as business as usual.
- Ongoing structured engagement with team members to identify and progress change ideas
- Revision of the board round reporting template and a new NCTR SOP to improve coding accuracy and consistency
- The enablement approach adopted at Deal has been implemented at Tonbridge, with Whitstable and Tankerton and QVMH beginning small tests of change.

Sustainable Care Summary



Kent Community Health
NHS Foundation Trust

Stable Metrics

KPIs 4.1 Income and Expenditure Surplus - The Trust is in a surplus position of £57k to the end of July once adjusted for £12k of depreciation on donated assets. The YTD surplus position is comprised of underspends on pay and depreciation / interest of £1,191k and £96k partly offset by an overspend on non-pay costs of £1,087k and an under-recovery on income of £143k. The adverse variance for non-pay is driven by £926k shortfall in CIP (offset by an over delivery in pay schemes), and extra high cost drug charges which are offset by additional income. There are underspends in other non-pay areas including premises costs and training.

4.6 Bed Occupancy, 4.8 Acute No Criteria To Reside West Kent and 4.9 Acute No Criteria To Reside East Kent are in common cause variation with little month to month change. However, they don't provide full assurance of meeting target given the process control limits are above the target level.

KPI 4.4 CIP is in common cause variation, having achieved CIP savings of £5,369k to the end of July against a plan of £5,320k which is £49k (0.9%) ahead of target. Of the YTD achievement, £2,807k (51%) has been achieved on a non-recurrent basis. Whilst delivery remains slightly ahead of target YTD, a significant proportion relates to non-recurrent or non-scheme-based savings and continued focus is required to secure recurrent delivery for the full year. The total savings for the year are forecast to be £20,255k in-line with the plan.

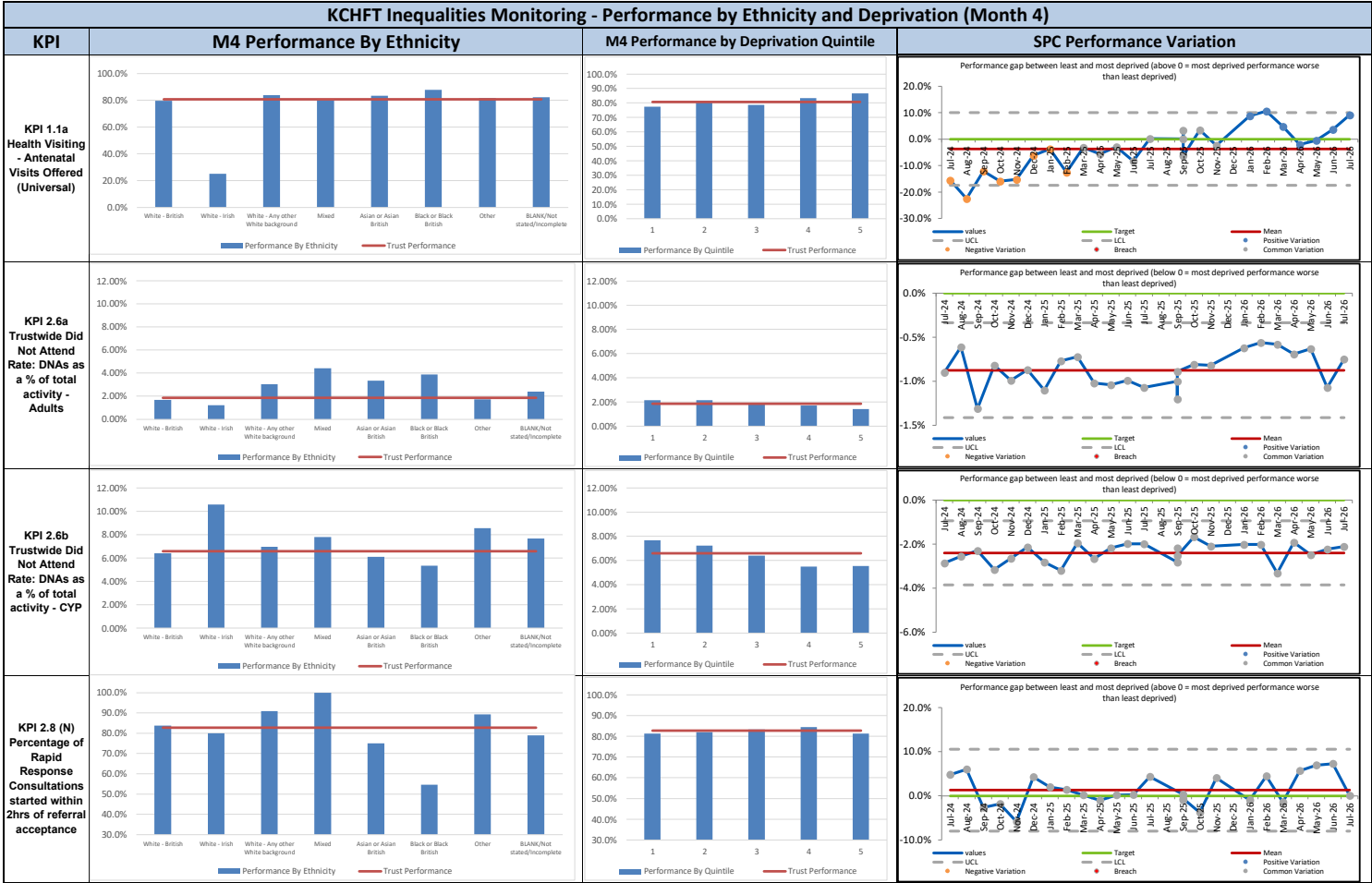
Other variation for highlighting

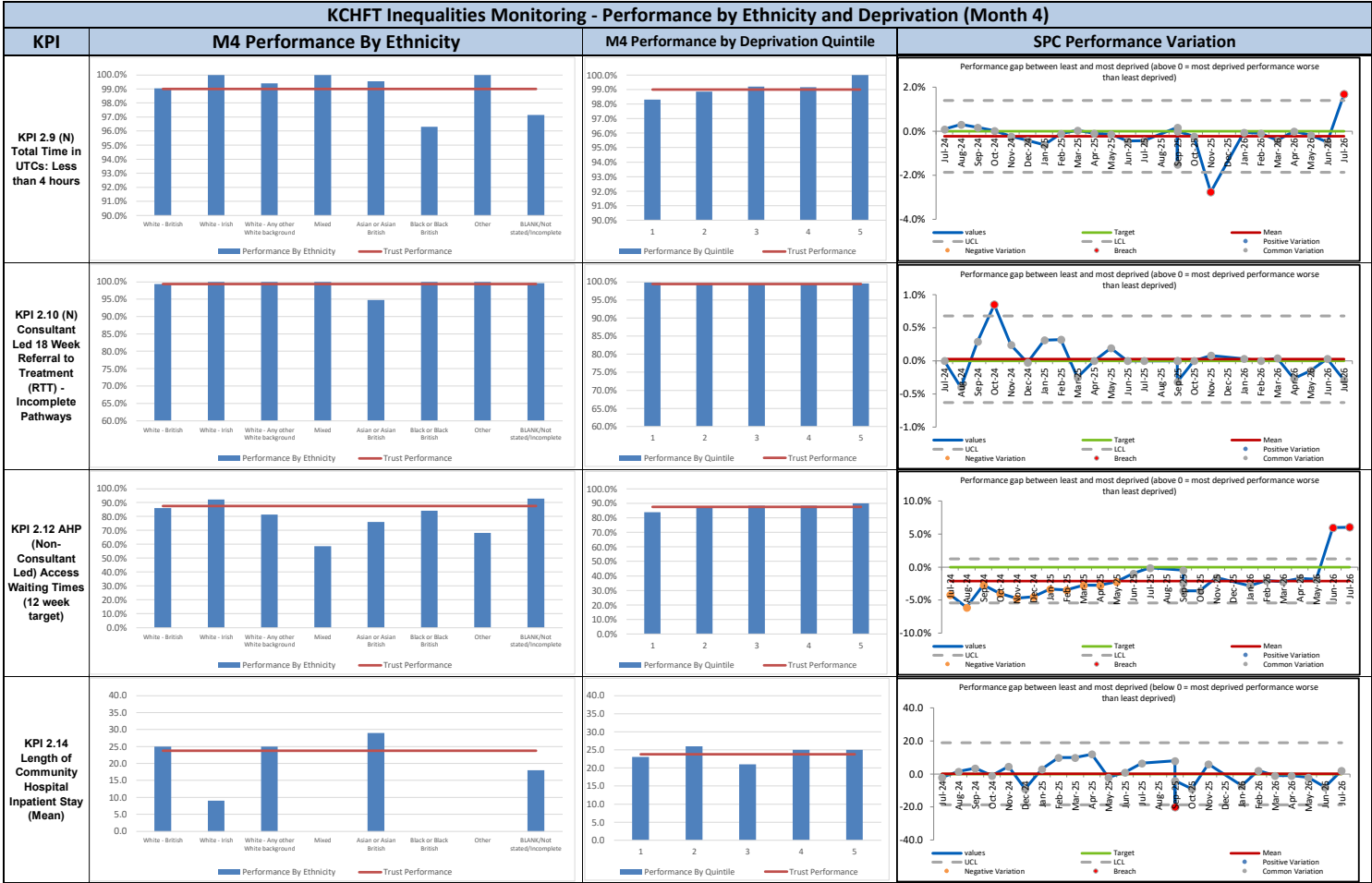
KPI 4.5 Activity levels are showing a special cause variation (improving), remaining in a positive position against the 26/27 plan at 108.2%.

KPI 4.2 External Agency Spend % of Pay (Clinical) and KPIs 4.3 Staff Bank Spend % of Pay (clinical) are in special cause variation (improving) following a positive shift below the mean, standing at 0.1% and 5.3% for the month respectively. Of the temporary staffing usage in July, £16k related to external agency which was 0.1% of the pay bill. The agency ceiling for the month was £14k meaning costs were £2k over the maximum.

KCHFT Inequalities Monitoring - Performance by Ethnicity and Deprivation (Month 4)

	KPI 1.1a Health Visiting - Antenatal Visits Offered (Universal)		KPI 2.6a Trustwide Did Not Attend Rate: DNAs as a % of total activity - Adults		KPI 2.6b Trustwide Did Not Attend Rate: DNAs as a % of total activity - CYP		KPI 2.8 (N) Percentage of Rapid Response Consultations started within 2hrs of referral acceptance		KPI 2.9 (N) Total Time in UTCs: Less than 4 hours		KPI 2.10 (N) Consultant Led 18 Week Referral to Treatment (RTT) - Incomplete Pathways		KPI 2.12 AHP (Non-Consultant Led) Access Waiting Times (12 week target)		KPI 2.14 Length of Community Hospital Inpatient Stay (Mean)	
Trust Performance	80.8%		1.9%		6.6%		82.8%		99.0%		99.4%		87.5%		23.8	
Target	75.0%		3.0%		6.5%		80.0%		95.0%		92.0%		92.0%		21.0	
Performance by Ethnicity																
	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	Days	No.
White - British	79.6%	643	1.68%	107846	6.39%	32509	83.7%	1365	99.0%	6396	99.4%	1572	86.0%	9530	25.0	150
White - Irish	25.0%	8	1.21%	752	10.57%	136	80.0%	10	100.0%	3	100.0%	13	92.1%	76	9.0	1
White - Any other White background	83.8%	80	3.04%	2645	6.96%	2675	90.9%	55	99.4%	163	100.0%	91	81.3%	583	25.0	4
Mixed	80.0%	25	4.41%	758	7.78%	2578	100.0%	3	100.0%	42	100.0%	68	58.6%	391	N/A	0
Asian or Asian British	83.3%	90	3.34%	1545	6.10%	2452	75.0%	12	99.6%	221	94.7%	31	76.1%	343	29.0	1
Black or Black British	87.9%	66	3.88%	804	5.34%	2208	54.6%	11	96.3%	81	100.0%	9	84.2%	202	N/A	0
Other	81.5%	27	1.72%	2361	8.55%	876	89.3%	28	100.0%	2	100.0%	13	68.2%	22	N/A	0
BLANK/Not stated/Incomplete	82.3%	96	2.40%	25387	7.67%	4479	78.9%	383	97.1%	140	99.6%	2152	92.8%	4924	18.0	30
% Completeness	90.7%	1035	82.1%	142098	90.7%	47913	79.5%	1867	98.0%	7048	45.5%	3949	69.4%	16071	83.9%	186
Performance by Deprivation Quintile																
	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	Days	No.
Quintile 1 - Most Deprived	77.5%	160	2.16%	21778	7.66%	9850	81.3%	171	98.3%	1121	99.8%	544	83.9%	2842	23.0	21
Quintile 2	80.9%	204	2.16%	26020	7.24%	10015	82.0%	306	98.9%	1741	99.6%	800	87.2%	3487	26.0	27
Quintile 3	78.7%	281	1.94%	33976	6.39%	12275	83.3%	534	99.2%	1981	99.4%	1026	88.4%	4139	21.0	52
Quintile 4	83.4%	217	1.70%	34913	5.50%	9098	84.4%	469	99.2%	1550	99.4%	817	88.4%	3259	25.0	41
Quintile 5 - Least Deprived	86.6%	142	1.41%	24489	5.55%	5557	81.3%	380	100.0%	312	99.5%	634	89.9%	2072	25.0	43





Population Equality Summary

KCHFT measures equity by ethnic group and deprivation against 7 key KPIs



Kent Community Health

NHS Foundation Trust

Ethnicity Analysis

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

Five KPIs have sufficient data for ethnic group:

KPI 1.1a Health Visiting – The proportion of antenatal visits (Universal) undertaken for White Irish patients was **significantly lower** than White British patients.

KPI 2.6a DNA Rate Adults – White any other, Mixed, Asian/Asian British and Black/Black British ethnicity patients had **significantly higher** DNA rates compared to patients with White British ethnicity. The DNA rate for White Irish patients was **significantly lower** than White British.

KPI 2.6b DNA Rate Children – DNA rates for children from White Irish, White any other or Mixed ethnic backgrounds were **significantly higher** compared to White British children. Black/Black British children had a **significantly lower** DNA rate than White British children.

KPI 2.9 UTC 4 Hour Wait – 99.0% of patients waited in UTCs for less than 4 hours. There were **no statistically significant** differences between ethnic groups.

KPI 2.12 AHP Access waiting time – The 12-week access target was met for a **significantly lower** proportion of patients with Mixed, Asian/Asian British or Other ethnicity compared to White British.

Population Equality Summary

Deprivation Analysis



Kent Community Health
NHS Foundation Trust

KPI 1.1a Health Visiting – There were **no statistically significant differences** between deprivation quintiles in the proportion of new birth visits undertaken within 14 days (Universal).

KPI 2.6a DNA Rate Adults & 2.6b Children – The DNA rate for adults living in the most deprived quintile was **significantly higher** than those from quintiles 3 to 5. For children, the DNA rate for those living in the most deprived quintile was **significantly higher** than those from quintiles 2 to 5. The variation by month in the difference in DNA rates for people living in the most and least deprived areas remained within common cause variation limits.

KPI 2.8 Rapid Response Consultations – There were **no statistically significant** differences between deprivation quintiles in the proportion of consultations that started within 2 hours. The difference between the least and most deprived quintiles was within common cause variation limits.

KPI 2.9 Total time in UTC – There were **no statistically significant differences** between deprivation quintiles in the proportion of patients that waited less than 4 hours in UTC. The difference between the least and most deprived quintiles breached common cause variation limits.

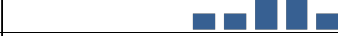
KPI 2.10 Consultant Led 18 Week RTT Incomplete Pathways – There were **no statistically significant** differences in attainment by deprivation quintile. The gap between the least and most deprived areas was within common cause variation limits.

KPI 2.12 AHP Access Waits – The proportion of patients from quintile 1 that met the 12 week access target was significantly lower than patients from quintiles 2 to 5. The SPC chart shows that the gap between the most and least deprived quintiles breached common cause variation limits.

KPI 2.14 Mean Length of Community Hospital Inpatient Stay (LOS) – The SPC control limits are wide due to the small number of patients in each quintile. The difference in mean LOS between the most and least deprived quintiles was within common cause variation limits.

Summary

For this report, 4 of the 6 EDI metrics are meeting or exceeding target for the month (67%), one is marginally off target (amber) and one is further off target (red). Of the red KPIs, there are no KPIs that are also in special cause variation (declining). Five of the six KPIs are all currently experiencing special cause variation (improving).

	This month		Previous Month	Trend
Targets	6		6	
Met	4	67%	3	
Marginally Off Target	1	17%	2	
Missed	1	17%	1	

Variation

The red KPI; Relative Likelihood of BAME staff entering the formal disciplinary process compared to white staff, is showing special cause variation (improving).

Four other metrics are also showing special cause variation (improving), with those being Disability Declaration Rate, BAME Voluntary Turnover Rate, Relative Likelihood of White staff being appointed from shortlisting compared to BAME staff and % BAME Representation – Non-Clinical Band 8a+ Roles.

EDI Dashboard

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

Workforce EDI Dashboard



Kent Community Health

NHS Foundation Trust

The EDI Dashboard is provided to support the ambitions of the Nobody Left Behind Project.

Explanations of the graphs are as follows:

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

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

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

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

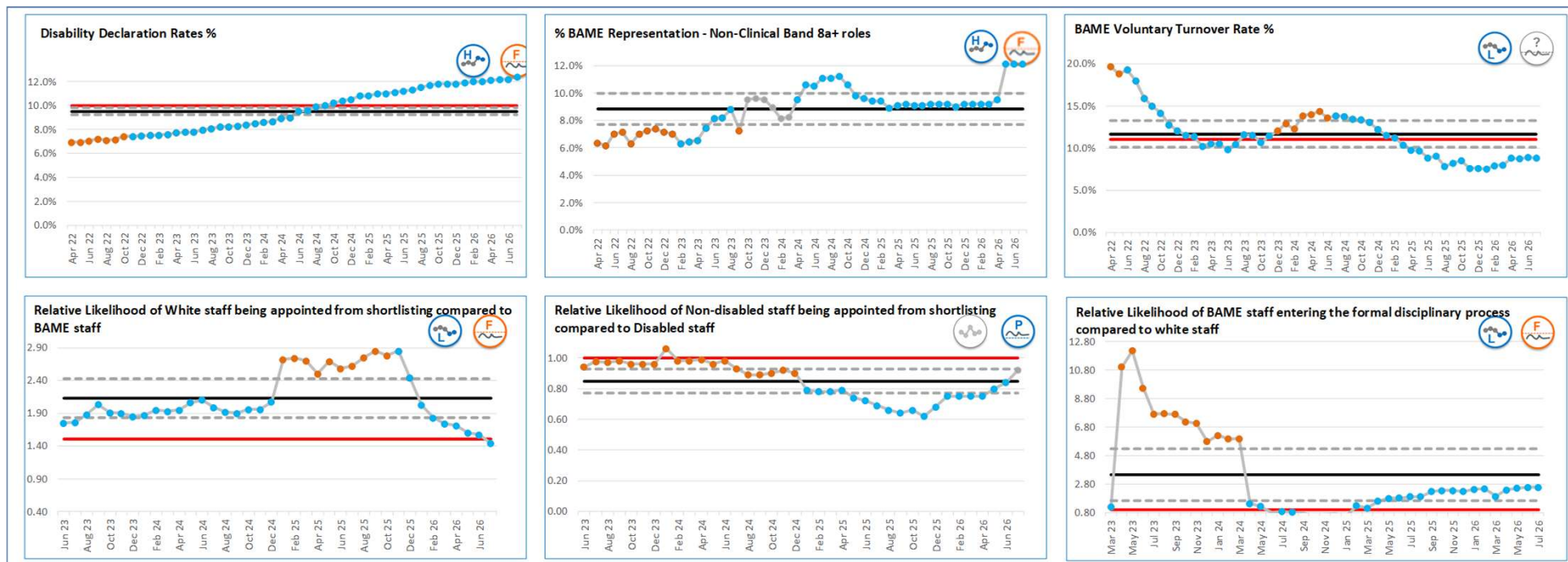
Relative Likelihood of non-disabled staff being appointed from shortlisting compared to disabled staff: This shows the relative likelihood of non-disabled applicants being appointed from shortlisting compared to disabled applicants. A figure above 1 indicates that non-disabled candidates are more likely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

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

Workforce EDI Dashboard



Kent Community Health NHS Foundation Trust



Disability Declaration Rates %

12.4% – 0.2% increase. The Trust continues to excel in disability declaration both locally and nationally. It is one of the areas that we receive most attention for when presenting to other organisations and attending industry events.

% BAME Representation – Non-Clinical Band 8a+ roles

12.1% [no change month / month] – Whilst this metric has not changed in this reporting period there has been a significant increase in the overall metric when compared to a twelve-month rolling data set. This is indicative of the impact our NLB programmes of work are having since the launch of the NLB action plan in summer 2025.

BAME Voluntary Turnover Rate % (2023-24 target, BAME voluntary turnover rate = White voluntary turnover rate)

8.8% [0.1% decrease month / month] – Whilst a small decrease has been observed in this reporting period, over the course of several months now there has been a net gradual increase in this metric. Despite this increase the overall representation both Trustwide but also within senior leadership continues to increase over a 12-month rolling period. With change occurring across Kent and Medway, in line with national NHS changes, it is to be expected that voluntary turn over may temporarily increase.

Relative Likelihood of white staff being appointed from shortlisting compared to BAME staff

1.44 [0.13 point improvement month / month] – significant work has been undertaken by the EDIH&Wb team to address the disparity this metric highlights. We are now starting to see these the impact of these efforts in our quantitative data, having previously heard qualitatively that said work was having a positive impact. This drop below 2x more likely is positive. Work is still needed to continue reducing the disparity as far as is possible, but it is reassuring to observe the measurable impact of our interventions. This also reiterates the actions being the correct actions for the change we needed to see.

Relative Likelihood of non-disabled staff being appointed from shortlisting compared to disabled staff

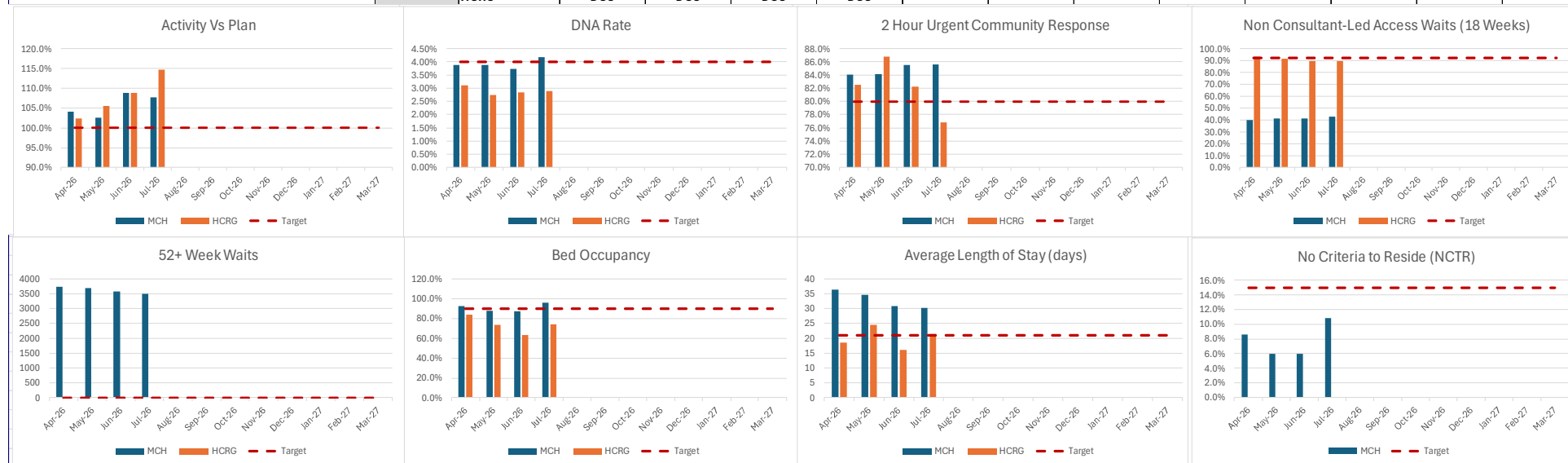
0.92 [0.08 point change month / month, technical worsening but moving nearer to parity, recruitment remains in favour of interviewees with disabilities] – this metric has historically been in favour of candidates declaring a disability. Further analysis is available in our annual WDES reports, in summary this is indicative of the positive culture at the Trust to ensuring inclusion of colleagues and applicants with additional access needs, health conditions and declared disabilities.

Relative likelihood of BAME staff entering the formal disciplinary process compared to white staff

2.56 – following a request from the People Committee for further analysis on this metric was completed and was presented at the August People Committee with a follow up being agreed in 6 months. The committee supported all the recommendations. As part of this analysis, it was established there were several cases which were not appropriate to report per the definitions of this metric and has subsequently been removed. We have also further defined the entry gate for cases being reportable per this metric to ensure minimal risk of further inappropriate cases entering our data sets. The Assistant Director of People (ER, Business Partnering and Recruitment) and Head of EDIH&Wb will meet monthly to review the data prior to formalisation to ensure all cases are appropriate for reporting and to ensure early identification of any thematic concerns.

Community Services sub-contractor performance

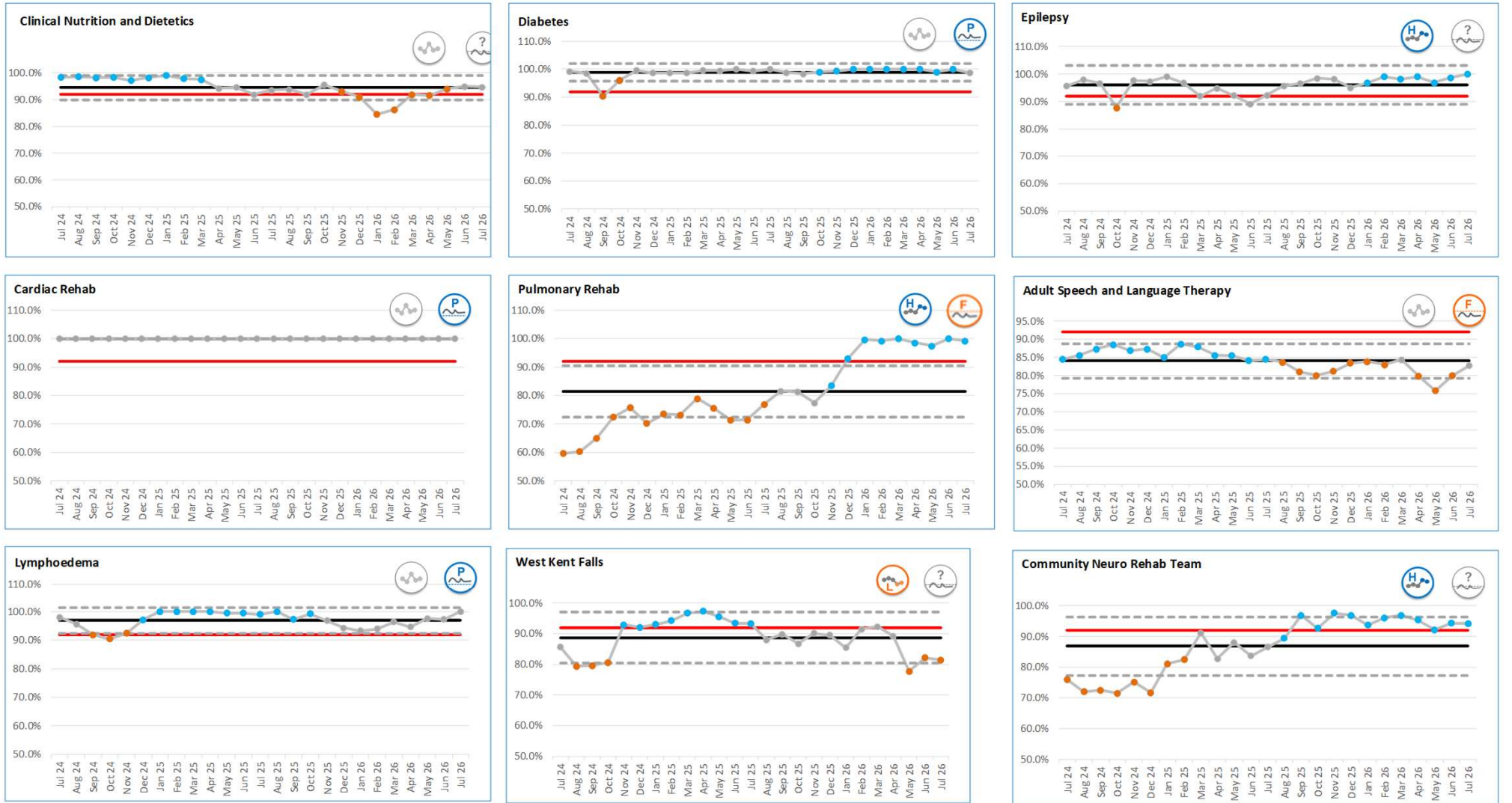
	Target	Sub-Contract	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Activity Against plan	100%	MCH	104.1%	102.6%	108.8%	107.7%								
		HCRG	102.4%	105.5%	108.8%	114.8%								
DNA Rate	4.0%	MCH	3.89%	3.89%	3.73%	4.18%								
		HCRG	3.10%	2.73%	2.84%	2.90%								
2 Hour Urgent Community Response	80.0%	MCH	84.1%	84.2%	85.5%	85.6%								
		HCRG	82.5%	86.9%	82.3%	76.9%								
Non Consultant-Led Access Waits (18 Weeks)	92.0%	MCH	40.1%	41.4%	41.5%	42.7%								
		HCRG	93.5%	91.6%	89.4%	89.7%								
52+ Week Waits	0	MCH	3724	3682	3572	3489								
		HCRG	0	0	0	1								
Bed Occupancy	90%	MCH	92.4%	87.6%	87.2%	96.1%								
		HCRG	83.6%	73.7%	63.5%	74.3%								
Average Length of Stay	21	MCH	36.26	34.63	30.79	30.29								
		HCRG	18.5	24.5	16.2	21.4								
No Criteria to Reside	15%	MCH	8.6%	5.9%	5.9%	10.8%								
		HCRG	DCU	DCU	DCU	DCU								



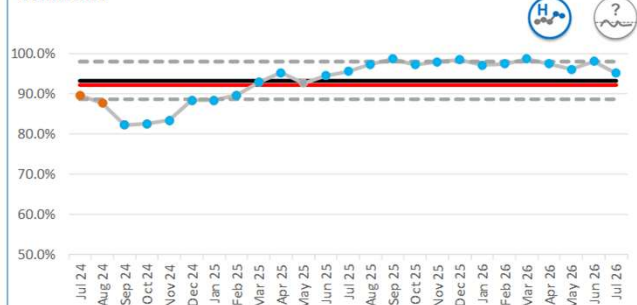
July performance is mixed across access and responsiveness. Activity remained above plan for both providers (MCH 107.7%; HCRG 114.8%). DNA performance was within the 4% threshold for HCRG (2.9%) but slightly above it for MCH (4.18%). MCH continued to meet the 2-hour Urgent Community Response standard at 85.6%, while HCRG fell below target to 76.9%. Neither provider met the 92% 18-week access standard (MCH 42.7%; HCRG 89.7%). MCH's 52+ week waits reduced to 3,469, while HCRG reported one wait.

Capacity and flow pressures remain concentrated in MCH. Bed occupancy rose to 96.1%, above the 90% target; HCRG remained below target at 74.3%. Average length of stay remained above the 21-day standard for both providers: MCH improved slightly to 30.29 days, while HCRG increased to 21.4 days. MCH's No Criteria to Reside rate increased from 5.9% to 10.8%, but remained below the 15% threshold; HCRG data remains under collection. Overall, activity is strong, but urgent response, access waits and inpatient flow remain key areas for attention.

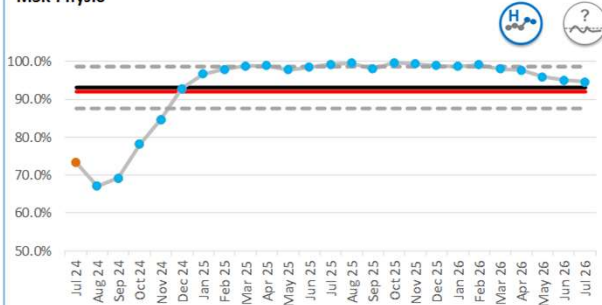
Appendix 1: RTA By Service



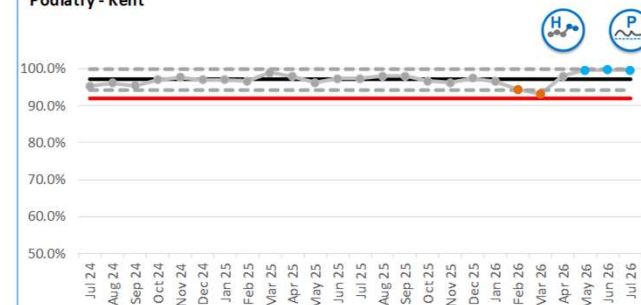
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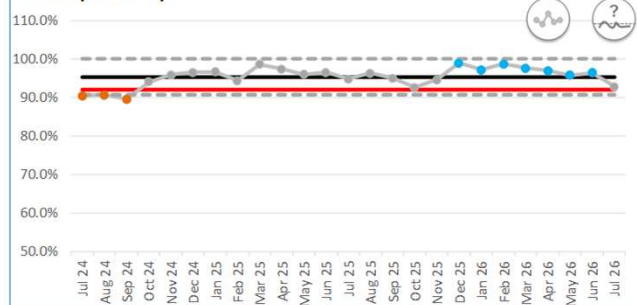
MSK Physio



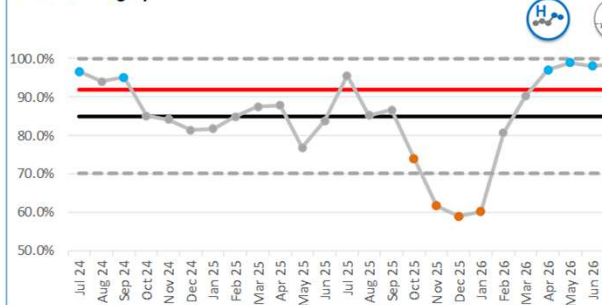
Podiatry - Kent



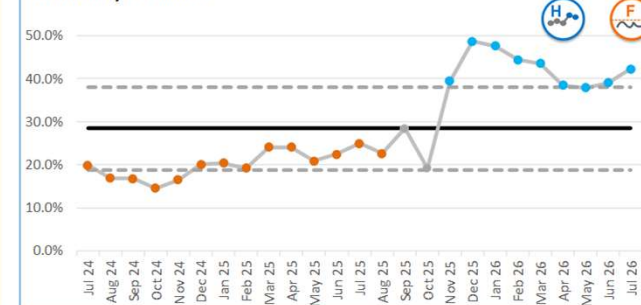
Podiatry - Medway



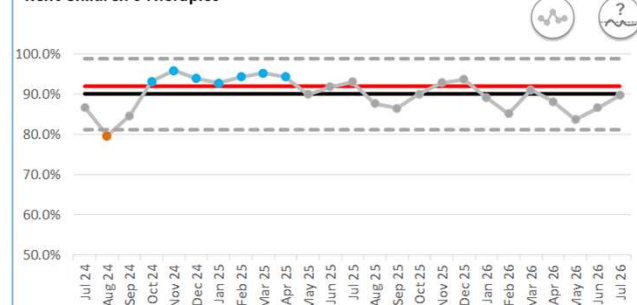
Podiatric Surgery



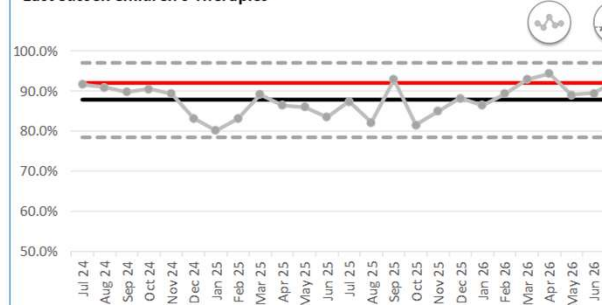
Community Paediatrics



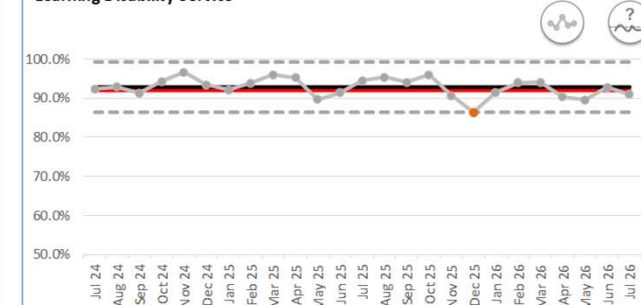
Kent Children's Therapies



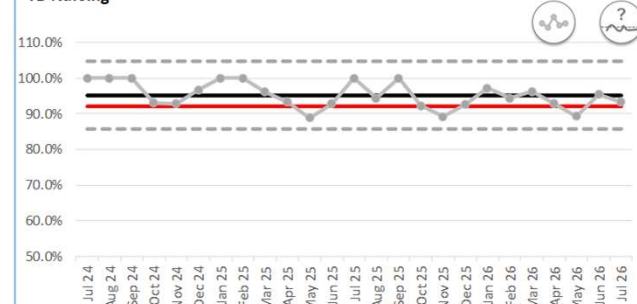
East Sussex Children's Therapies



Learning Disability Service



TB Nursing



Front Sheet – Standing Financial Instructions and Scheme of Delegation

The Standing Financial Instructions and Scheme of Delegation are presented to the Board for final approval.

Meeting:	Board Meeting - Part 1 (Public)
Date of meeting:	16 September 2026
Agenda item no:	Item 16
Report title:	Standing Financial Instructions and Scheme of Delegation
Executive sponsor(s):	Gordon Flack, Chief Financial Officer
Report author(s):	Debra Ody, Deputy Chief Financial Officer
Action this paper is for:	Approval
Public/non-public	Public

Executive summary

Overview:

The Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD) are presented to the Board for final approval, following the review and endorsement undertaken by the Finance, Business and Investment Committee on 22 July 2026.

This paper presents the proposed amendments to the Trust's SFIs and SoD identified through a review undertaken by the Finance and Procurement teams to ensure compliance with current legislation, including the Procurement Act 2023, and to reflect the Trust's transition to electronic procurement processes.

The proposed changes include amendments to procurement thresholds, clarification of quotation requirements, revisions to delegated authority wording, an addition to the allowable exemptions for a single tender waiver, and updates to tender receipt and opening processes. The changes are intended to improve clarity, consistency and legislative compliance whilst aligning governance documents with current operational practice.

Items of concern:

None.

Significant improvements in previous areas of concern:

The proposed amendments provide greater clarity around procurement requirements, remove ambiguity in delegated financial limits and ensure governance documentation reflects the Trust's current electronic procurement arrangements.

Items of excellence:

The review demonstrates proactive governance by ensuring that key financial governance documents remain current, compliant with legislation.

Appendices

The SFIs and SoD (see Appendix A and Appendix B respectively) are available to Board members within the Diligent library.

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

Finance, Business and Investment Committee, 22 July 2026 – Review and endorsement for approval of the SFIs and SoD.

Recommendation(s)

The Board is asked to **Approve** the report

Link to CQC domain

☐ Safe ☒ Effective ☐ Caring ☐ Responsive ☒ Well-led

Assurance level

Significant

Rationale for assurance level

The assurance level is significant, reflecting the detailed review, committee approval and alignment with current legislation and procurement processes.

Implications

Links to BAF risks / CRR	☐ BAF	☒ CRR
Equity, diversity and inclusion	No	
Legal and regulatory	Yes (provide a brief sentence describing the issue) Achieve the financial duties set by NHS England and alignment to the Procurement Act 2023.	

Executive sponsors sign off

Gordon Flack, Chief Finance Officer

Date: 17 August 2026

STANDING FINANCIAL INSTRUCTIONS AND SCHEME OF DELEGATION

1. Introduction

The standing financial instructions (SFIs) are designed to ensure regularity and propriety of financial transactions. SFIs define the purpose, responsibilities, legal framework and operating environment of the Trust. All executive members, non-executive members and all officers should be aware of the existence of these documents and be familiar with their detailed provisions. The SFIs should be used in conjunction with the scheme of delegation (SoD) which sets out the arrangements for the delegation of functions within the Trust.

The SFIs and SoD are reviewed regularly to ensure compliance with relevant legislation and to follow the Trust's transition to electronic processes. The current SFIs have been reviewed by the Finance and Procurement teams, and several proposed updates are listed below, this follows a major review in 2024 and routine annual update in 2025.

The proposed SFIs and SoD are set out in appendices A and B with tracked changes to highlight the proposed differences.

2. Proposed changes to the standing financial instructions

The proposed changes to the SFIs are:

- 7.11: updated thresholds from £139,688 to £135,018 and dates. These changes ensure compliance with updated legislation under the Procurement Act 2023 where the threshold is updated every two years.
- 7.11: specified the number of suppliers required when assessing contract values over £10,000, previous wording said a sufficient number, proposed change specifies three suppliers. This is to ensure clarity and consistency.
- 7.18.2.4: Changed from Chief Executive or their nominated officer to just nominated officer.
- 7.9.17: additional exemption for a single tender waiver inserted as follows; where the use of a product, supplier, or procurement route is mandated by NHS England.

3. Proposed changes to the scheme of delegation

The three proposed changes to the scheme of delegation that all fall under the tendering, quotations and contracting section, are:

- Receipt of tenders: changed from Chief Executive nominated representative to via the electronic procurement portal. This reflects the change from receipt of hard copies to electronic submissions in-line with current processes. The electronic

procurement portal maintains a full audit trail, role-based access controls and segregation of duties, ensuring governance arrangements remain robust despite the move away from manual tender opening processes.

- Opening of tenders: changed from two executive directors (one of which must not be from the originating department) to by the Procurement team via the electronic procurement portal. This also reflects the change from receipt of hard copies to electronic submissions in-line with current processes.
- Formal authorisation and awarding of a contract changed to add per annum to the values for the Chief Finance Officer, Chief Executive and Chief Executive and Finance, Business and Investment Committee. This removes ambiguity in the delegated limits.

4. Authorisation of changes

The proposed amendments strengthen clarity and alignment with current procurement legislation and practices.

The Board is asked to approve the revised Standing Financial Instructions and Scheme of Delegation as set out in Appendices A and B. The changes would take place with immediate effect from the date of Board approval.

5. Appendix A – updated standing financial instructions

This document is available to Board members within the Diligent library.

6. Appendix B – updated scheme of delegation

This document is available to Board members within the Diligent library.

Front Sheet – Annual Medical Appraisal and Revalidation Report 2025/26

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

Meeting:	Board Meeting - Part 1 (Public)
Date of meeting:	16 September 2026
Agenda item no:	Item 17
Report title:	Annual Medical Appraisal and Revalidation Report 2025/26
Executive sponsor(s):	Dr Sarah Phillips Chief Medical Officer
Report author(s):	Dr Satvinder Kaur Lall, Deputy Chief Medical Officer
Action this paper is for:	Approval
Public/non-public	Public

Executive summary

Overview:

The purpose of this annual report is to provide assurance to the Board and is mandated by NHS England. The report provides a summary of the policies and systems in place within Kent Community NHS Foundation Trust (KCHFT) to meet the requirements of medical revalidation.

Items of concern:

- Completion and ratification of the revised Medical Appraisal and Revalidation Policy: The revised Revalidation and Appraisal Policy, together with the accompanying EQIA, has been drafted and feedback from the Local Negotiating Council (LNC) incorporated. The policy is awaiting ratification through the Trust's governance processes.
- Embedding the revised General Medical Council (GMC) Good Medical Practice standards across appraisal processes continues to be a priority.

Significant improvements in previous areas of concern:

- Enhanced quality assurance arrangements have been introduced, including individual quality assurance and development reviews for appraisers led by the Deputy Chief Medical Officer.
- Successful integration of doctors transferring into the Trust while maintaining appraisal compliance and governance standards.

Items of excellence:

- Effective support provided for 71 doctors through the Trust's annual appraisal and revalidation programme, including the successful integration of 20 doctors transferring from East Kent Hospitals University NHS Foundation Trust (EKHUFT) while maintaining appraisal and governance oversight.
- Continued investment in the appraisal workforce through appraiser development, refresher training and enhanced quality assurance reviews.

- During the 2025/26 reporting year, the Trust maintained a pool of 14 trained appraisers. Although one appraiser left during the year, leaving 13 active appraisers at year end, appraisal capacity remained sufficient to support the medical workforce. Looking ahead, capacity will be strengthened through three doctors undertaking appraiser training, the addition of one experienced appraiser to the Trust's appraiser pool, and the development of a mentoring programme for newly appointed appraisers.

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

Reviewed and approved by the People Committee on 26 August 2026.

Recommendation(s)

The Board is asked to

- Note** the contents of the Annual Medical Appraisal and Revalidation Report 2025/26 and the assurance provided regarding the Trust's arrangements for medical appraisal and revalidation.
- Approve** the Annual Medical Appraisal and Revalidation Report 2025/26 for submission to NHS England.

Link to CQC domain

☒ **Safe** ☐ **Effective** ☐ **Caring** ☐ **Responsive** ☒ **Well-led**

Assurance level

Reasonable

Rationale for assurance level

The report provides reasonable assurance that effective arrangements are in place to meet medical appraisal and revalidation requirements, with identified areas for improvement being actively managed through established governance processes.

Implications

Links to BAF risks / CRR	☐ BAF	☐ CRR
Equity, diversity and inclusion	No	
Legal and regulatory	Yes (provide a brief sentence describing the issue) Appraisal and revalidation of doctors in line with NHS England (NHSE) regulation is mandatory	

Executive sponsors sign off

Executive Sponsor: Dr Sarah Phillips

Date: 08 September 2026

ANNUAL MEDICAL APPRAISAL AND REVALIDATION REPORT 2025/26

1. Purpose

The purpose of this report is to provide assurance to the Board that Kent Community Health NHS Foundation Trust has robust and effective arrangements in place to support medical appraisal and revalidation and is meeting its statutory obligations under the General Medical Council (GMC) revalidation framework. The report also highlights key achievements, risks, areas of good practice and priorities for the forthcoming year.

2. Executive Summary

The Trust continues to maintain effective systems and processes for the annual appraisal and revalidation of doctors with a prescribed connection to the organisation.

During the 2025/26 appraisal year:

- The Trust supported 71 doctors requiring appraisal.
- Four revalidation recommendations were submitted by the Responsible Officer to the GMC.
- One revalidation deferral was made.
- There were no overdue appraisals recorded during the reporting period.
- The Trust maintained a sufficient pool of trained appraisers to deliver its appraisal programme.
- No significant concerns arose relating to appraisal processes, patient safety or professional standards that affected assurance regarding doctors' fitness to practise.

The Responsible Officer is satisfied that the Trust remains compliant with NHS England appraisal and revalidation requirements and that processes continue to provide assurance regarding the quality and safety of medical practice within the organisation.

3. Strategic Context

Medical revalidation was introduced by the GMC in December 2012 to assure patients, employers and the public that licensed doctors remain up to date and fit to practise.

The Trust has a statutory responsibility to:

- Ensure all eligible doctors participate in annual appraisal.
- Maintain effective appraisal and revalidation systems.
- Provide governance oversight of professional standards.
- Support doctors in maintaining continuing fitness to practise.

- Make recommendations to the GMC through the Responsible Officer.
- Participate in NHS England assurance processes and organisational audits.

The appraisal process supports:

- Professional development.
- Patient safety.
- Clinical governance.
- Workforce wellbeing.
- Organisational learning and improvement.

4. Key Assurance Indicators

Indicator	2025/26 Position
Doctors requiring appraisal	71
Revalidation recommendations	4
Revalidation deferrals	1
Doctors discussed through revalidation review processes	All due for revalidation
Overdue appraisals (>3 months)	0
Active trained appraisers	14 during the year, 13 at year end
Annual appraiser refresher training completed	Yes

5. Medical Appraisal Performance

The Trust achieved high levels of appraisal compliance throughout the reporting period. All doctors with a prescribed connection to the organisation were supported through an established appraisal process consistent with GMC and NHS England requirements.

A total of 71 doctors required appraisal during the year, including doctors transferring to KCHFT through organisational transfer arrangements. The appraisal programme successfully accommodated these changes whilst maintaining compliance and assurance standards.

The Trust undertakes regular monitoring of appraisal activity and there were no overdue appraisals during the reporting period.

6. Revalidation Activity

Revalidation recommendations are made by the Responsible Officer following review of appraisal outcomes, supporting information, governance intelligence and evidence demonstrating continued fitness to practise.

During 2025/26:

Revalidation Outcome	Number
Positive Recommendations	4
Deferrals	1
Non-Engagement Recommendations	0

All doctors due for revalidation were reviewed through formal multidisciplinary review arrangements chaired by the Responsible Officer and involving appraisal and governance representatives.

The Responsible Officer is satisfied that recommendations submitted to the GMC were supported by appropriate evidence and governance processes.

7. Quality Assurance

The Trust maintains a comprehensive quality assurance system for appraisal and revalidation including:

- Appraisal quality review.
- Appraiser peer support.
- Audit of appraisal outcomes.
- Annual appraisal reporting.
- Appraiser refresher training.
- Monitoring of appraisal timeliness.
- Integration with wider clinical governance systems.

An advanced appraisal refresher programme was delivered in October 2025 and all appraisers have undertaken appropriate training and quality assurance activities.

The Deputy Chief Medical Officer (DCMO) has commenced individual quality assurance and development reviews with appraisers to support consistency of decision-making and appraisal quality across the Trust.

8. Appraiser Workforce and Capacity

During the reporting year the Trust had 14 trained appraisers. One appraiser left the organisation during the year, leaving 13 active appraisers at year end. This was considered sufficient to support the current medical workforce.

To strengthen future resilience:

- Three doctors have booked new appraiser training.
- One experienced appraiser will join the Trust appraiser pool.
- A mentoring programme is being developed for newly appointed appraisers.
- Additional quality assurance activities are being implemented.

The DCMO provides assurance that future appraisal capacity remains adequate for anticipated workforce growth.

9. Governance, Patient Safety and Professional Standards

The appraisal and revalidation process forms part of the Trust's wider clinical governance arrangements.

Appraisal discussions incorporate:

- Patient safety incidents.
- Complaints and compliments.
- Quality improvement activity.
- Continuing professional development.
- Reflection against GMC Good Medical Practice standards.

The Trust reported no significant patient safety events associated with appraisal processes and no concerns arose that required escalation through professional standards procedures.

All doctors continue to contribute to the Patient Safety Incident Response Framework (PSIRF) and Duty of Candour processes as part of ongoing professional development and organisational learning.

10. Equality, Diversity and Inclusion

The Medical Appraisal and Revalidation Policy requires equality monitoring and reporting to ensure fair and equitable access to appraisal and revalidation processes.

No significant equality concerns were identified during the reporting period.

The appraisal framework supports:

- Inclusive professional development.
- Fair access to appraisal opportunities.
- Equitable treatment of all medical staff.
- Compliance with the Equality Act 2010.

11. Risks and Mitigations

Risk	Current Mitigation
Appraiser succession planning	Recruitment and training of additional appraisers
Increasing appraisal demand	Expansion of appraiser pool and mentoring model
Compliance with evolving GMC requirements	Ongoing policy review and appraiser development
Transfer of appraisal records during organisational changes	Robust governance oversight and multidisciplinary review processes

Current Risk Rating: Low

The Responsible Officer does not identify any significant unmanaged risks that would compromise delivery of the appraisal and revalidation process.

12. Assurance Against External Standards

The Trust participates in NHS England assurance processes including:

- Annual Organisational Audit.
- Responsible Officer Networks.
- Appraisal lead Networks.
- Quality Assurance of Medical Appraisers processes.

The appraisal process has also been updated to reflect the revised GMC Good Medical Practice standards introduced in 2024.

13. Priorities for 2026/27

The key priorities for the coming year are:

1. Finalise and ratify the revised Medical Appraisal and Revalidation Policy.
2. Continue recruitment and development of medical appraisers.
3. Ensure that 0.25 Pas are recognised in the job plan for 8 appraisals per year.
4. Expand mentoring arrangements for new appraisers.
5. Continue quality assurance reviews using established appraisal quality tools.
6. Maintain compliance with NHS England and GMC requirements.
7. Further embed the revised GMC Good Medical Practice standards within appraisal processes.

14. Conclusion

The Trust continues to demonstrate strong compliance with GMC and NHS England appraisal and revalidation requirements. Effective governance arrangements, supported by a trained appraiser workforce and robust quality assurance processes, provide assurance that doctors remain engaged in appraisal and continue to demonstrate fitness to practise.

The Responsible Officer is satisfied that the Trust maintains an effective appraisal and revalidation system that supports patient safety, professional development and organisational assurance.

15. Recommendations

The Board is asked to:

1. Note the contents of the Annual Medical Appraisal and Revalidation Report.
2. Receive assurance that effective appraisal and revalidation arrangements are in place across the Trust.

3. Support submission of the Responsible Officer's annual assurance statements to NHS England and the General Medical Council.
4. Endorse the priorities identified for 2026/27.

Dr Sarah Phillips
Chief Medical Officer
&
Dr Satvinder K Lall
Lead Appraiser

Front sheet - Infection Prevention and Control Board Assurance Framework.

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

Meeting:	Board Meeting - Part 1 (Public)
Date of meeting:	16 September 2026
Agenda item no:	Item18
Report title:	Infection Prevention and Control (IPC) Board Assurance Framework
Executive sponsor(s):	Caroline Bates, Chief Nursing Officer
Report author(s):	Dorothy Chakani, Assistant Director Infection Prevention Control
Action this paper is for:	Noting
Public/non-public	Public

Executive summary

The Infection Prevention and Control Board Assurance Framework (IPCBAF) provides quarterly assurance against the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections (Hygiene Code). It assesses organisational compliance across the ten Code of Practice criteria, identifying areas of compliance, assurance gaps and mitigating actions.

Overall compliance against the Hygiene Code remains high, with 92% of applicable indicators assessed as compliant, no indicators assessed as non-compliant, and all areas of partial compliance subject to active mitigation and governance oversight.

A list of acronyms and definitions is appended to the end of the document.

Across the 10 criteria there are 150 Key Performance Indicators

Green	Compliant	139	92%
Amber	Partially compliant	8	5%
Red	Not compliant	0	0%
White	Not applicable	4	3%

Key areas requiring continued oversight:

The principal areas of partial compliance relate to decontamination governance, water safety, contractor assurance, antimicrobial stewardship, ANTT competency assurance and MRSA screening compliance. Mitigating actions are in place and progress is monitored through the IPC governance framework.

Governance and Estates Assurance (1.1g, 1.1h, 1.5d): Further work is required to strengthen organisational decontamination governance through establishment of a Decontamination Safety Group, address succession planning for the Authorised Person (Water) role, and improve assurance from NHSPS and PFI partners regarding cleaning and water safety compliance.

Decontamination Assurance (2.4): A revised dental procurement process has been developed to ensure reusable medical devices are assessed for compatibility with approved decontamination pathways prior to purchase. The associated standard operating procedure (SOP) is awaiting final approval through IPC governance processes.

Antimicrobial Stewardship (AMS) (3.6, 6.2): The Trust remains partially compliant with antimicrobial stewardship training requirements. A nationally recognised NHS AMS training package has been identified, and consideration is being given to its incorporation within the Trust training framework. In the interim, assurance continues through local service arrangements, prescribing governance and specialist pharmacy oversight.

Workforce Competency Assurance (6.3): ANTT policies, procedures and competency documentation are in place; however, a Trust-wide training, competency assessment and assurance framework has not yet been established. Implementation of the established Medway Community Healthcare (MCH) ANTT training and competency programme is planned from 1 October 2026 to support a standardised Trust-wide approach.

MRSA Screening Compliance (8.4): Community hospital MRSA admission screening compliance remains below the 95% target, although performance has improved compared with the previous year. Enhanced monitoring arrangements, including twice-weekly IPC review and RIO handover prompts, are in place to support improvement.

Significant improvements since the previous Board Assurance Framework review:

- Patient-facing antimicrobial stewardship information **(4.2k)** has improved from partially compliant to compliant following implementation of TARGET *patient resources. (*Treat Antibiotics Responsibly, Guidance, Education, Tools)
- A Trust-wide Decontamination Safety Group is being established to strengthen organisational oversight of decontamination risks, with the inaugural meeting scheduled for November 2026.
- MRSA screening performance has improved, although remains below the Trust target.
- No areas have deteriorated.

Overall, the Board can take assurance that the Trust remains substantially compliant with the Hygiene Code, continues to strengthen IPC assurance arrangements, and has no areas of non-compliance.

The Hygiene Code is available to Board members within the Diligent library.

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

Presented to Quality Committee on 3 September 2026 and assurance received. .

Recommendation(s)

The Board is asked to

- Note the current IPC Board Assurance Framework compliance position
- Note the areas of partial compliance and associated mitigation plans
- Take assurance that identified gaps are subject to active monitoring and improvement through established governance arrangements

Link to CQC domain

☒ **Safe** ☒ **Effective** ☒ **Caring** ☒ **Responsive** ☒ **Well-led**

Assurance level

Significant

Rationale for assurance level

Significant assurance is provided as the Trust remains substantially compliant with the Hygiene Code, with no areas of non-compliance and robust mitigating actions in place for all areas of partial compliance.

Implications

Links to BAF risks /
Corporate Risk Register

☒ BAF

☐ CRR

Equality, diversity and
inclusion

No

Legal and regulatory

Yes (provide a brief sentence describing the issue)
Care Quality Compliance (CQC) compliance with Health
and Social Care Act 2008: code of practice on the
prevention and control of infections

Executive sponsors sign off

Name and designation:

Caroline Bates, Chief Nursing Officer

Date: 08 September 2026

Infection Prevention and Control Board Assurance Summary

Organisation:	Kent Community Health NHS Foundation Trust
Reporting Period:	January 2026 - August 2026
Prepared by:	Dorothy Chakani
Role:	Assistant Director Infection Prevention Control
Date of Report:	19/08/2026

Executive Summary

This report provides assurance on the Trust's compliance with the National IPC Manual and the Health and Social Care Act 2008 Code of Practice. Overall compliance remains good, with no significant IPC risks to patients or staff. A small number of areas are partially compliant; these are subject to active mitigation and oversight through the IPC governance structure.

1. Purpose of the IPC Board Assurance Framework

The IPC Board Assurance Framework (BAF) is a live document, reviewed quarterly (or sooner if guidance changes), to assess the Trust's compliance with the *Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections*. It provides structured assurance against:

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

The framework is aligned to the ten Code of Practice criteria and supports systematic identification of risks, gaps in assurance, and required mitigation. It underpins continuous improvement and responsiveness to emerging threats.

2. Governance and Leadership

Director of Infection Prevention and Control (DIPC): Caroline Bates

Board Oversight: IPC is a standing agenda item at Quality Committee and reported to Board bi-annually.

Strategy: A Kent and Medway system IPC strategy, reviewed annually and aligned to national guidance.

IPC Work and Improvement Plan: Produced annually and reviewed quarterly; includes defined workstreams and an IPC BAF action plan.

Training Compliance: Compliance with mandatory IPC training remains high and stable. FFP3 fit testing compliance continues to be monitored through the IPCG, with targeted improvement work in progress.

3. Compliance with NIPCM and Code of Practice

The table outlines the compliance criteria the Trust is required to demonstrate under the Code of Practice, alongside its current compliance position. The Trust is compliant with the majority of the indicators assessed, with a small number partially compliant; partial compliance reflects areas where assurance processes require strengthening rather than absence of IPC controls. Four indicators are not applicable to the organisation.

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

6. Non-compliance and Mitigation for partially compliant key lines of enquiry.

The following areas are partially compliant. Risks are recorded on the appropriate risk registers and are subject to active mitigation. There are no significant patient safety risks arising from these issues.

1. **1.1g.** Decontamination leadership arrangements remain in place, supported by external Authorising Engineer oversight and quarterly decontamination assurance meetings with Sexual Health, Podiatry and Dental services. Whilst a formal Decontamination Safety Group is not yet established, governance arrangements are being strengthened through the development of a dedicated Trust-wide Decontamination Safety Group. Draft Terms of Reference are in development, and the inaugural meeting in November 2026. The action remains under active management to strengthen organisational assurance and oversight of decontamination risks.
2. **1.1h.** The Trust does not currently have an Authorised Person (AP) for water safety. Interim mitigation continues through external Authorised Engineer (Water) oversight and strengthened Water Safety Group scrutiny. Following the Trust consultation in October 2026, Estates team capability and capacity will be reviewed to inform the longer-term approach. In relation to the Swaleside Dental Services water safety concerns, the Ministry of Justice is coordinating a multi-agency workshop and KCHFT representatives have provided their availability to support this work.
3. **1.5d.** Assurance from NHS Property Services (NHSPS) and PFI facilities contractors regarding cleaning standards, compliance and audit outcomes remains incomplete. This risk remains recorded on the Estates risk register. Local partnership working and escalatory processes are in place where concerns are identified; however, full assurance from outsourced providers has not yet been achieved and the action remains ongoing.
4. **2.4.** A pre-purchase decontamination review process has been developed by Dental Services to ensure reusable medical devices are assessed for compatibility with IHSS or approved local decontamination pathways prior to procurement. Devices that cannot be safely reprocessed are not introduced into patient care. Final approval of the associated SOP is awaited through the IPC governance process.
5. **3.6.** Non-medical prescribers are competency assessed, and medical prescribers work in line with Trust AMS policies and NICE guidance, with consultant representation on the AMS Group. The Trust remains non-compliant with the IPC BAF requirement for antimicrobial stewardship training. Whilst a nationally recognised training package has been identified, approval has not been granted to incorporate AMS training into the Trust's mandatory training programme.
6. **6.2.** IPC is embedded within job descriptions, induction programmes and the mandatory training schedule, with role-specific IPC training and compliance monitored through governance structures. However, antimicrobial stewardship (AMS) training is not formally incorporated within the Trust-wide induction or mandatory training matrix. A nationally recognised NHS AMS training package has been identified; however, approval has not been granted to include this within the Trust's mandatory training programme. As a consequence of AMS training not being

incorporated within the Trust's mandatory training programme, the Trust remains partially compliant with this criterion.

7. **6.3.** An ANTT Policy, supporting SOP and competency documentation are in place, having been developed jointly by the IPC Team and IV Specialist Teams. Competency assessment is undertaken through local service arrangements; however, there is currently no standardised Trust-wide ANTT training, competency or assurance framework. Development of a standardised training and competency framework is being explored as a future quality improvement initiative. Until these arrangements are established and embedded, the Trust remains partially compliant with Criterion 6.3.

8. **8.4.** MRSA admission screening compliance within inpatient units remains below the 95% target. Performance has improved compared to the previous year; however, compliance remains inconsistent. Improvement actions include proactive IPC review processes and implementation of an MRSA screening prompt within the RIO handover process. Further improvement work is ongoing with the Lead Matron for Community Hospitals to strengthen the reliability and timeliness of screening. Non-compliance is predominantly attributable to delayed screening rather than failure to screen, although the relatively small number of eligible patients means that individual omissions can have a disproportionate impact on overall performance. Until sustained compliance is consistently achieved, the Trust remains partially compliant with this requirement.

7. Improvement Plan

The IPC Board Assurance Framework is embedded within the IPC annual work plan, with focused actions in place to address the remaining areas of partial compliance. Priorities for 2026/27 include strengthening decontamination and water safety governance, improving assurance from outsourced facilities providers, implementing enhanced decontamination procurement controls, progressing antimicrobial stewardship compliance, strengthening ANTT assurance arrangements, and improving MRSA screening compliance. Delivery of these actions is expected to reduce the number of partially compliant criteria and strengthen organisational assurance during 2026/27.

8. Progress Update

Criterion	Change since last report	Status
4.2k AMS patient information	Improved to compliant	↑ Improved to Compliant
Dental procurement process (2.4)	Process developed, SOP awaiting approval	↗ Progress
Decontamination Safety Group (1.1g)	Inaugural meeting scheduled	↗ Progress
MRSA screening (8.4)	Compliance improving but below target	↗ Progress
AMS training (3.6/6.2)	No change – work ongoing	→ Unchanged
Water AP (1.1h)	No change, AE mitigation remains	→ Unchanged
Contractor assurance (1.5d)	No material change Assurance from NHSPS and PFI providers regarding cleaning standards, compliance and audit outcomes remains incomplete. The action remains ongoing.	→ Unchanged

9. Conclusion

IPC systems and governance arrangements are well established and aligned with national standards. Overall, the Trust demonstrates good compliance with the *Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections*. Areas of partial compliance remain and are subject to active monitoring, risk management and improvement plans. There are currently no significant IPC-related risks resulting in immediate patient safety concerns.

Acronyms and Definitions

The attached paper includes specialist Infection Prevention and Control, governance, assurance and clinical terminology. This section is provided to improve readability, reduce ambiguity, and support consistent interpretation by meeting attendees and readers. **Reporting convention:** all new acronyms should be written in full at first use in the body of the paper and included in the table below, where relevant.

Acronym / Term	Full wording	Brief definition / context for reader
AE	Authorised Engineer	External specialist adviser providing technical assurance in areas such as decontamination or water safety
ANTT	Aseptic Non-Touch Technique	Standard approach used to prevent contamination during clinical procedures
AP	Authorised Person	Designated competent person with operational responsibility in a specialist safety area
BAF	Board Assurance Framework	Framework used to identify principal risks, controls, assurances and gaps
CAUTI	Catheter-associated urinary tract infection	Urinary tract infection associated with use of a urinary catheter
CDI	<i>Clostridioides difficile</i> infection	Infection caused by <i>Clostridioides difficile</i>
COCA	Community onset, community associated	Case identified in the community and attributed to community acquisition
COIA	Community onset, indeterminate association	Case identified in the community where attribution is not fully clear
DIPC	Director of Infection Prevention and Control	Executive lead with responsibility for IPC assurance and oversight
FFP3	Filtering face piece 3 respirator	Respiratory protective equipment for specific infection risks
HOUDINI	HOUDINI catheter review tool	Prompt used to assess whether a catheter remains necessary H - Haematuria / blood clots requiring catheterisation O - Obstruction / urinary retention U - Urology surgery or specific urological reason D - Decubitus ulcer / severe pressure damage where catheter supports healing I - Input and output monitoring, when accurate hourly measurement is essential N - Nursing end-of-life care / comfort in terminal care I - Immobility or instability where toileting is not feasible and catheter use is clinically justified
Hygiene Code	Health and Social Care Act 2008 Code of Practice on the	Statutory code for IPC compliance

Acronym / Term	Full wording	Brief definition / context for reader
	Prevention and Control of Infections	
ICB	Integrated Care Board	NHS body responsible for planning and funding services locally
IHSS	Independent Healthcare Sterilisation Services	External sterilisation and reprocessing service provider
IPC	Infection Prevention and Control	Policies and practices used to prevent and manage infection risks
IPCG	Infection Prevention and Control Group	Group overseeing IPC governance, assurance and improvement
MRSA	Methicillin-resistant <i>Staphylococcus aureus</i>	Antibiotic-resistant organism monitored as a key safety measure
NHSPS	NHS Property Services	Organisation managing parts of the NHS estate
NICE	National Institute for Health and Care Excellence	National body producing evidence-based guidance and standards
NIPCM	National Infection Prevention and Control Manual	National manual setting out IPC practice requirements
PFI	Private Finance Initiative	Contractual arrangement for some estate and facilities services
PIR	Post-infection review	Structured review undertaken after an infection incident to identify learning and actions
RCA	Root Cause Analysis	Structured review to identify contributory factors and learning
RiO	RiO electronic patient record	Clinical electronic record system used for documentation and prompts
TWOC	Trial without catheter	Planned catheter removal to assess ongoing need

Front Sheet – Use of the Trust Seal report

The report sets out the detail of the process in place for the custody and use of the Trust Seal between 27 March 2026 and 7 September 2026

Meeting:	Board Meeting - Part 1 (Public)
Date of meeting:	16 September 2026
Agenda item no:	Item 19
Report title:	Use of the Trust Seal report
Executive sponsor(s):	Tony Saroy, Interim Trust Secretary
Report author(s):	Gina Baines, Assistant Trust Secretary
Action this paper is for:	Noting
Public/non-public	Public

Executive summary

Overview:

The report sets out the detail of the process in place for the custody and use of the Trust Seal between 27 March 2026 and 7 September 2026

Items of concern:

There are no areas of concern to be brought to the Board's attention.

Significant improvements in previous areas of concern:

There are no significant improvements to report to the Board.

Items of excellence:

To strengthen compliance with the Trust's Standing Orders, unique reference numbers have been introduced for each entry in the register, providing a clear audit trail for all uses of the Trust Seal.

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

This report has not been presented at any other meetings.

Recommendation(s)

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

Link to CQC domain

☐ Safe
 ☐ Effective
 ☐ Caring
 ☐ Responsive
 ☒ Well-led

Assurance level

Significant

Rationale for assurance level

There is full compliance with the Trust's Standing Orders for the custody and use of the Trust Seal. Appropriate controls are in place, a comprehensive register is maintained, and no instances of non-compliance or governance concerns were identified during the reporting period.

Implications		
Links to BAF risks / CRR	☐ BAF	☐ CRR
Equality, diversity and inclusion	No	
Legal and regulatory	Yes (provide a brief sentence describing the issue) The Trust's standing orders sets out the arrangements for the sealing of documents including the recording of each sealing in a register. Each entry in the register includes details of the sealing describing the document and the date of sealing.	

Executive sponsors sign off
Tony Saroy, Interim Trust Secretary
Date: 07 September 2026

USE OF THE TRUST SEAL REPORT

1. Introduction

The purpose of this report is to assure the Board that there are processes in place to record the use of the Trust Seal.

2. Assurance

The custody of the Seal of the Trust, sealing of documents and signature of documents is set out in the Trust's standing orders.

The custody of the Seal of the Trust is kept by the Corporate Governance team in a secure place. Access is only available to authorised personnel.

A register is maintained by the Assistant Trust Secretary which records those occasions when the official Seal of the Trust is affixed to documents. To strengthen compliance with the Trust's Standing Orders, unique reference numbers have been introduced for each entry in the register, providing a clear audit trail for all uses of the Trust Seal.

In addition, reporting arrangements have been enhanced and future reports on the use of the Trust Seal will be presented to the Board twice yearly rather than annually, providing more regular oversight and assurance.

In the period from 27 March 2026 to 7 September, three documents have been sealed. Mairead McCormick, Chief Executive and Gordon Flack, Chief Finance Officer attested the seal on each occasion.

Date of sealing	Description	Signatures
17.06.2026	Underlease relating to part of the Barkantine Centre, Isle of Dogs, London	Mairead McCormick Gordon Flack
17.06.2026	Engrossed TR1 (HM Land Registry form) relating to College Road Clinic, College Road, Margate, Kent	Mairead McCormick Gordon Flack
18.08.2026	Deed of variation relating to Unit 1D, Jubilee Way, Whitstable Road, Faversham, Kent	Mairead McCormick Gordon Flack

3. Recommendation

The Board is asked to receive the report and note the assurances provided.

Gina Baines
Assistant Trust Secretary
8 September 2026