East Kent Urgent Treatment Centre (UTC) Alliance

Chairs Report					
Meeting:	EKHUFT Board of Directors (BoD)				
Lead:	Dan Gibbs, Chief Operating Officer (COO)				
Reporting Officer & Contact Details:	Oena Windibank, UTC Alliance Chair oenawindibank@nhs.net				
Date of Board Meeting:	2 April 2026	**Agenda Item:**	26/10	**No. of pages:**	

The Report is provided for: (indicate with an "X" – you can populate more than one box)			
Approval		**Discussion**	
Assurance	X	**Information**	X

Key highlights
General issues: • The UTC contract has been extended as per the contract until August 2027. Discussions are underway across the Alliance led by the Deputy COO at EKHUFT to look at the model of care and progress work on the UTCs becoming the front door. Walk in patients will then be streamed into the acute pathway's including Emergency Department (ED), Same Day Emergency Care (SDECs) etc. This will be a phased approach over next four/six months and supports the corridor care improvement plan. Demand and capacity modelling is being undertaken to ensure that this model is resilient. • Discussions have commenced with the Integrated Care Board (ICB) to review the model at Kent & Canterbury Hospital (K&C), this is currently operating an Emergency Nurse Practitioner (ENP)/minor injury dominant model overnight. The numbers of attendees are very small and staffing this is both expensive and inconsistent. Given the current public interest in the K&C site this may require consultation if the ICB Executive agree to change the model. The ICB review of UTS's has not produced any findings to date so it is unclear what impact this have on Alliance led UTCs. Currently there is no ENP cover overnight on the co-located 24 hours sites which is part of the contract and the change to K&C would enable this to progress. • The telephone platform hosted by Integrated Care 24 (IC24) streams away significant numbers of patients who go through 111 to the UTCs sites, this has been raised with commissioners as a risk if they determine that they are stopping funding for this. Currently this sits within the UTC financial envelope and no indication has been given that this is reducing in 2026/27. **Key performance highlights**

Quality
Care Quality Commission (CQC) have now visited both Queen Elizabeth the Queen Mother Hospital (QEQM) and William Harvey Hospital (WHH) emergency floors, including the collocated UTCs. Feedback is awaited so any UTC specific actions can be taken forward.

Quality indicators for the period January to December 2025:

- 301 incidents were reported between January and December 2025. Weekly incident and complaint meeting is held by the alliance. No Patient Safety Incident Investigation (PSII) or After Action Reviews (AARs) reported in 2025.

- 61 new complaints were reported between January and December 2025. The highest number of compliant themes fall under the category of care needs not adequately met and attitude of clinician.

- Five complaints were fully upheld, ten partially upheld, 42 not upheld – resolved, the rest have either been withdrawn, resolved informally and others are awaiting EKHUFT signoff so outcome unknown.

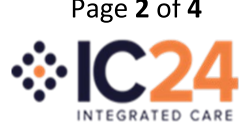
- Friends and family test data – yearly data continues to show a high recommend rate, with most patients rating their experience good or very good.

4-Hour target
Across the Alliance improvement seen on WHH, QEQM and Buckland sites with a slight downturn at K&C due to staffing gaps.

WHH is the site that has struggled to meet the 4-hour target and has had several breaches. Key issues relate to overnight on the co-located sites where the GP comes into a significant number of patients waiting meaning they struggle to get on top of the waits. This has been reviewed and as a result the Musgrove site is now closed and the GPs moved onto the WHH site and shift patterns reviewed.

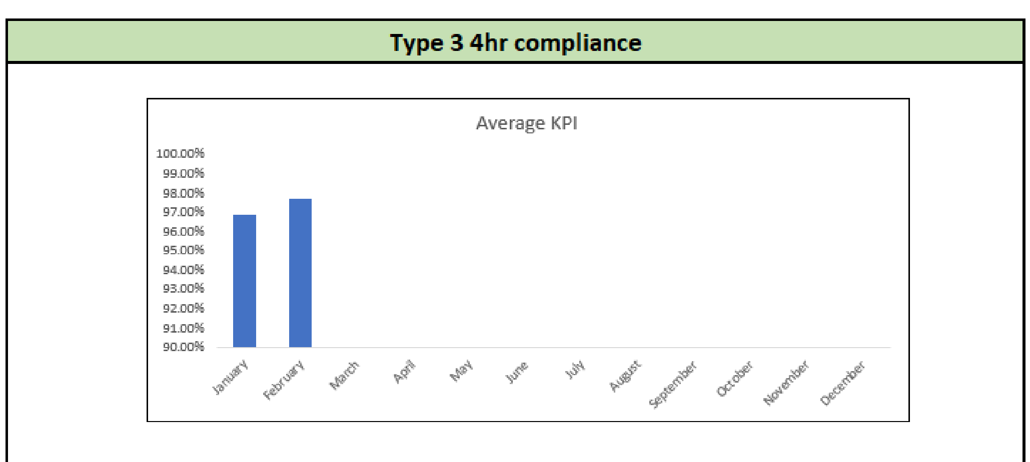
Work is continually in place with the Operations team and site clinical leads to review breaches and identify cause and address the issues

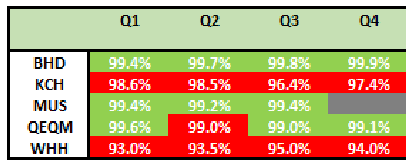
Work is underway to review the patient demand and map peak surges in demand; this will drive a conversation and plan around staffing/shift patterns.



UTC 4 Hour Compliance Data (Total)
Revised Key Performance Indicators (KPIs) – increased from 95% to 99% for 2025-26

Review of attendances underway at WHH to identify any reason for continued volume of breaches compared to QEQM.





	Q1	Q2	Q3	Q4
BHD	99.4%	99.7%	99.8%	99.9%
KCH	98.6%	98.5%	96.4%	97.4%
MUS	99.4%	99.2%	99.4%	
QEQM	99.6%	99.0%	99.0%	99.1%
WHH	93.0%	93.5%	95.0%	94.0%

	January	February	March	April	May	June	July	August	September	October	November	December
Type 3 4hr (99% target)												
BHD	99.80%	99.90%										
KCH	97.60%	97.20%										
QEQM	98.90%	99.30%										
WHH	92.90%	95.10%										
UTC	96.90%	97.70%										

UTC Breach volumes

	Jan					Feb				
	ED	UTC	Other	Total	KPI	ED	UTC	Other	Total	KPI
BHD	0	3	0	3	99.8	0	1	1	2	99.9
KCH	0	69	0	69	97.6	0	73	1	74	97.2
QEQM	0	32	3	35	98.9	0	17	0	17	99.3
WHH	2	238	10	250	92.9	13	130	11	154	95.1

Overnight breaches						
	QEQM	% of total	WHH	% of total	KCH	% of total
Jan	3	8.57%	112	44.80%	0	0.00%
Feb	0	0.00%	49	31.82%	1	1.35%

Streaming to Type 3
The UTC contract does not specify the streaming % required but the assumption has been that this should be Circa 35/40% and reflects other UTCs. The co-located sites achieve between 32 and 36% on average across the 24 hour period. An initial pilot to establish GP streaming at the front door at the WHH site has seen consistent increase in the numbers during the period this is in place (Monday to Friday 9 to 5) with a consistent level of 50% being achieved. This has now become Business as Usual and work is underway to move the streaming function into the UTC site to progress this. This will be tested in phased approach on the WHH site initially. The model on the QEQM site is currently Advanced Clinical Practitioner (ACP) driven so will need more detailed work to build on

the learning at WHH. Demand and capacity planning is commencing alongside this to review the workforce model and review the ability to expand this initiative and the operating hours.

Returns from UTC to ED

Work is routinely undertaken by UTC Ops Team revieiwng the data:
Awaiting report from Business Intelligence (BI) for January and February for both QEQM and WHH so that an Audit can be completed. A review of pathways from UTC to Acute Hospital departments will follow as the imprived SDECs pathways are established.

Finance

Q1 and Q2 reconciliations underway across the subcontracts.

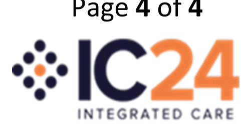
Predicted year end position is a £306 deficit, the key area of focus is drug and non-pay costs. The overspend in nursing is being targeted by other staffing gaps.

Staffing

No decision made as yet regarding the position of UTC General Manager. The role has not been advertised/filled since previous postholder left in March 2025.
Work continuing regarding sourcing overnight reception cover for QEQM UTC, therefore enabling the UTC to Remain in the Sarre Day unit, rather than relocation to ED overnight.
Recruitment freeze within EKHUFT for remainder of 2025/26 and for entirety of Q1 2026/27. Reviewing the impact of this on UTC staffing (ENP, Tech, admin).
GP rotas continue to have excellent fill rate.

Productivity

There is an ogoing programme of work for both GPs and ENPs led by the matrons and Clinical leads to review productivity, including review of the demand and individual staff performance. This has seen an improved position at the WHH particluarly. ENP dataset amended to include NHS Professionals (NHSP) staff and Physiotherapists (WHH only).



REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Integrated Performance Report (IPR)**

Meeting date: **2 April 2026**

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

Paper Author: **Ben Stevens, CSPO**

Appendices:

APPENDIX 1: IPR - February 2026

Executive summary:

Action required:	**Discussion**
Purpose of the Report:	The report provides the monthly update on Operational Performance, Quality & Safety, Workforce, Financial & Maternity organisational metrics. The metrics are directly linked to the Strategic and Annual objectives. The reported metrics are derived from: 1. Statutory reporting 2. Executive agreed key metrics The IPR is ordered into the following strategic themes: • Patients, incorporating operational performance metrics. • Quality and Safety (Q&S), incorporating Q&S metrics. • People, incorporating people, leadership & culture metrics. • Sustainability, incorporating finance and efficiency metrics. • Maternity, incorporating maternity specific metrics for quality and safety, Friends and Family Test (FFT) and engagement.
Summary of key issues:	Key performance points for February (reported month): **Patients** Urgent and Emergency Care (UEC) • 12-hour waits: 995 recorded in February; focus continues on reducing long stays across sites and specialties. • Patient flow: Increased numbers of patients with No Criteria to Reside (average 184.5) and >7-day stays, contributing to length of stay pressures. Planned Care: Referral to Treatment (RTT) • RTT performance: Incomplete performance reduced to 51.3%, below planned trajectory. • Long waits: 52-week waits increased to 2,016; 65-week waits increased to 88.

	Diagnostics • DM01 bottlenecks: CT and Non-Obstetric Ultrasound remain the primary areas of underperformance. • Operational constraints: Booking process delays linked to vacancies and sickness affecting use of available capacity. Cancer • 62-day standard: Performance at 65.8%, below target across several high-volume specialties. • Diagnostic delays: Backlogs in breast screening and extended diagnostic waits (including endoscopy) continue to affect pathway performance. **Quality** Patient Safety Incident Investigations • High volume of open investigations, including six nationally reportable cases, multiple After Action Reviews (AARs), and ten Local Patient Safety Incident Investigations (PSIIs) (seven previously overdue), requiring continued oversight to progress to completion. • Large number of overdue AARs and PSIIs, with 24 AARs overdue and several PSIIs still outstanding, indicating pressure on investigation capacity and workflow. Overdue Incidents • Increase in overdue incidents from 1,025 to 1,120 in February, despite month-on-month reduction in new overdue cases. • High number of unjustifiable overdue incidents (target of 300 by April 2026), requiring active management through QGBP oversight and handler support. Duty of Candour • Compliance below Key Performance Indicator (KPI) across all three elements: verbal (87%), written (87.5%), and findings (83.3%). • Multiple delays in communication timeframes, necessitating increased daily monitoring and strengthened escalation procedures. Never Events • Two new never events reported in February (wrong-site nerve block; retained epidural needle). • Data reporting discrepancy between Datix and StEIS causing apparent variation in monthly totals; flagged for correction in 2026 system update. Safeguarding • Safeguarding Level 3 training compliance below 85% (83.3% Children; 84.1% Adults), with medical and dental workforce identified as the lowest-compliance group. • Delays in digital transformation and backlog of safeguarding documentation, affecting timely access and updating of records. Mixed Sex Accommodation • 52 breaches in February, all in critical care. • Delays in transfer from critical care (>4 hours) remain the primary cause of breaches.

	Infection Prevention & Control (IPC) • Trust has exceeded year-end thresholds for C. difficile, E. coli, Pseudomonas and MRSA (three cases against zero tolerance). • Ongoing norovirus activity in February (six outbreaks), though with reduced operational impact compared to January. **People** Sickness Absence • Rates remain above threshold despite improvement: sickness reduced to 5.20%, with a 12-month rolling average of 4.93%. • High-variation across care groups: absence ranges from 2.51% to 21.26%, with notable levels in Queen Elizabeth the Queen Mother Hospital (QEQM) Operations Management and Risk, Governance & Patient Safety. Vacancies • Overall vacancy rate remains high at 9.3%, with significant variation between care groups (up to 13.3% in Kent & Canterbury Royal Victoria Hospital (KCRVH)). • Senior clinical gaps persist: 58 medical and dental consultant vacancies, alongside emerging supervisory-level pressure at Bands 4 and 6. Turnover • Turnover remains elevated in specific areas, particularly Corporate Services (8.4%), with 550 leavers in the last 12 months. • High-volume leaver groups include Band 5 nurses (145) and Band 3 staff (108), with relocation continuing as the primary reason for leaving. Appraisals • Compliance remains below the 80% threshold, standing at 76.5% with 1,766 overdue. • Largest gaps occur in Nursing & Midwifery and Admin & Clerical, driven by operational pressures. Statutory Training – Top Two Issues • Overall compliance slightly reduced to 93.8%, with 4,838 courses outstanding. • Safeguarding Children Level 3 remains the lowest-compliance module (90.4%), with activity concentrated in QEQM Theatres. **Sustainability** • Group deficit £77.3m Year to Date (YTD) (pre-Deficit Support Funding (DSF)), which is £14.4m adverse to plan, driven primarily by Cost Improvement Programme (CIP) under-delivery following the increased target in the second half of the year. • Trust position £11.7m adverse to plan, excluding deficit support funding.

	• Income £15.9m above plan, mainly due to Elective Recovery Fund (ERF) income (current and prior year), high-cost drugs and over-performance on rechargeable devices. • Pay costs £18.5m adverse YTD, with overspends in both substantive (£9.3m) and temporary staffing (£9.3m), reflecting unmet CIP expectations. • Non-pay £12.7m adverse, driven by overspends in general supplies, premises and drugs, partially offset by underspends elsewhere. • Post-DSF withdrawal, the Group is £33.6m adverse to plan, with a £23m DSF loss for quarters 3 and 4 (Trust impact £19.2m YTD). • Forecast year-end deficit £47.4m, which is £40.8m adverse to plan, primarily due to CIP under-delivery and loss of DSF (excluding DSF impact: £17.8m adverse). **Maternity** • Extended perinatal mortality rate remains below threshold at 4.44 (target 5.44). • Neonatal death rate continues below the MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK, target at 0.69, with no neonatal deaths in February and 4 in the past 12 months. • Stillbirth rate remains above threshold at 3.76 (target 3.60), with 22 stillbirths over 12 months but none in February. • Four moderate/severe incidents reported in February (drug error, Special Care Baby Unit (SCBU) admission, 3rd/4th degree tear, procedural complication). • Maternity overdue incidents increased to 211, with operational pressures affecting timely investigation and closure. • Targeted actions in place: “Stop the Clock” oversight meetings, focused support via NHS Professionals (NHSP) staff, incident data sheets to handlers, and trajectories set for overdue completion. • Eight complaints received in February; complaint response rate 87.5%, above the 85% threshold. • FFT response rate 40.8%, above average; recommendation rate achieved 90% target for the second consecutive month.
Key recommendations:	The Board of Directors is asked to **CONSIDER** and **DISCUSS** the metrics reported in the Integrated Performance Report.

Implications:

Links to Strategic Theme:	This report aims to support: • Quality and Safety • Patients • People • Partnerships • Sustainability

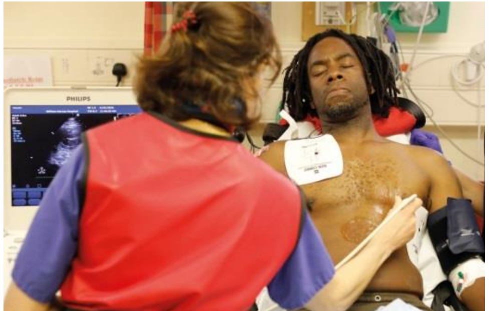
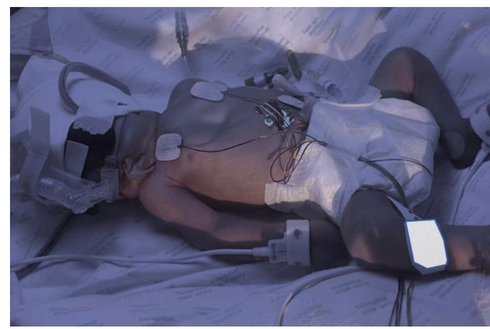
Link to the Trust Risk Register:	N/A
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: People and Culture Committee – 17 March 2026, Quality and Safety Committee – 24 March 2026, Finance and Performance Committee – 31 March 2026

Integrated Performance Report

FEBRUARY 2026

Integrated Performance Report

Statistical Process Control

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

What is statistical process control (SPC)?

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

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

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

Key Facts about an SPC Chart

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

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

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

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

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

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

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

Statistically significant improving variation	Statistically significant variation of concern	No significant change

Patients

Key Performance Indicator (KPI) Assurances

M

KPI's Statistically Improving | KPI's Indicating Concern

Consistently failing the target
Will consistently fail the target if nothing changes.

Failing Metrics	SPC Range
RTT 52w Breaches	
RTT 52w Performance	
12 Hr Total Time in Department	
12Hr Trolley Waits	
Cancer Over 104d on PTL	
Not Fit to Reside (pats/day)	
RTT 65w Breaches	
Super Stranded >21D	
Theatre Capped Utilisation	
Theatre Uncapped Utilisation	
RTT 1st OPA Performance	
RTT Incomplete Performance	

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

Common Cause Metrics	SPC Range
Ambulance Handovers within 30m	
RTT Total Incomplete Pathways	
% Beds Occupied 14+	
Cancer 28d Combined Performance	
Cancer 31d Combined Performance	
Cancer Over 62d on PTL	
Cancer Rapid Access Perf	
ED Compliance	
RTT 104w Breaches	
RTT 78w Breaches	
Theatre Session Opp.	
Type 1 Compliance 4hrs	
Cancer 62d Combined Performance	
DM01 Compliance	

Consistently passing the target
Will consistently pass the target if nothing changes.

Passing Metrics	SPC Range
Outpatient DNA Rate	

No set target
No set target.

Metrics	SPC Range
Endoscopy Backlog	

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

Patients

Scorecard View

Urgent & Emergency Care Metrics & Cancer Waiting Times

Key Performance Indicator (KPI)	Value	Ranges
ED Compliance FILTER: TOTAL RP07218 M_00093_ED_Compliance Updated: 16/03/2026 00:20	M | Feb 26 **74.9%** Num: 17K Denom: 23K	UCL: 78.3% Mean: 75.2% LCL: 72.0% Targ: 73.0%
Type 1 Compliance 4hrs FILTER: TOTAL RP07218 M_00093_Major_Comp Updated: 16/03/2026 00:20	M | Feb 26 **55.2%** Num: 7K Denom: 13K	UCL: 59.4% Mean: 53.5% LCL: 47.5% Targ: 57.0%
12 Hr Total Time in Department FILTER: TOTAL RP07218 M_00113_12hr Updated: 13/03/2026 06:12	M | Feb 26 **18.7%** Num: 2K Denom: 13K	UCL: 22.5% Mean: 19.9% LCL: 17.4% Targ: 16.1%
12Hr Trolley Waits FILTER: TOTAL RP07218 M_00384_Trolley_Waits Updated: 13/03/2026 13:46	M | Feb 26 **995**	UCL: 1,449 Mean: 1,188 LCL: 927 Targ: 0
Ambulance Handovers within 30m FILTER: TOTAL RP07218 M_00098_Ambulance_Handovers_30min Updated: 16/03/2026 00:16	M | Feb 26 **94.0%** Num: 5K Denom: 5K	UCL: 95.1% Mean: 91.1% LCL: 87.1% Targ: 95.0%
% Beds Occupied 14+ FILTER: TOTAL RP07218 M_01141_Beds_Occupied_14plus Updated: 13/03/2026 08:47	M | Feb 26 **33.8%** Num: 9K Denom: 28K	UCL: 36.6% Mean: 31.9% LCL: 27.1% Targ: 30.0%
Super Stranded >21D FILTER: TOTAL RP07218 M_00097_SuperStranded Updated: 13/03/2026 10:50	M | Feb 26 **225** Num: 6K Denom: 28	UCL: 255 Mean: 214 LCL: 173 Targ: 107

Key Performance Indicator (KPI)	Value	Ranges
Cancer 28d Combined Performance FILTER: TOTAL RP07218 M_00897 Updated: 13/03/2026 08:37	M | Feb 26 **75.8%** Num: 3K Denom: 4K	UCL: 82.4% Mean: 73.4% LCL: 64.5% Targ: 80.0%
Cancer Over 62d on PTL FILTER: TOTAL RP07218 M_00725 Updated: 13/03/2026 08:33	M | Feb 26 **213**	UCL: 254 Mean: 201 LCL: 148 Targ: 200
Cancer Rapid Access Perf FILTER: TOTAL RP07218 M_00217_2ww Updated: 13/03/2026 09:48	M | Feb 26 **95.9%** Num: 4K Denom: 4K	UCL: 102.1% Mean: 89.5% LCL: 76.9% Targ: 93.0%
Cancer 31d Combined Performance FILTER: TOTAL RP07218 M_01391 Updated: 13/03/2026 10:22	M | Feb 26 **95.2%** Num: 573 Denom: 602	UCL: 99.9% Mean: 95.8% LCL: 91.8% Targ: 96.0%
Cancer 62d Combined Performance FILTER: TOTAL RP07218 M_01390 Updated: 13/03/2026 10:08	M | Feb 26 **65.8%** Num: 244 Denom: 371	UCL: 81.1% Mean: 72.2% LCL: 63.3% Targ: 80.0%
Not Fit to Reside (pats/day) FILTER: TOTAL RP07218 M_01184_Not_F2R Updated: 13/03/2026 11:19	M | Feb 26 **184.5** Num: 5K Denom: 28	UCL: 195.4 Mean: 169.8 LCL: 144.2 Targ: 100.0
Cancer Over 104d on PTL FILTER: TOTAL RP07218 M_00715 Updated: 13/03/2026 08:36	M | Feb 26 **47**	UCL: 55 Mean: 40 LCL: 25 Targ: 0

Patients

Scorecard View

Referral to Treatment Waiting Times, Diagnostics & Productivity Measures

Key Performance Indicator (KPI)	Value	Ranges
RTT Incomplete Performance FILTER: TOTAL RP07218 M_01304_Incompletes Updated: 16/03/2026 02:51	M | Feb 26 51.3% Num: 38K Denom: 74K	UCL: 53.9% Mean: 52.5% LCL: 51.1% Targ: 58.8%
RTT 1st OPA Performance FILTER: TOTAL RP07218 M_01304_Incompletes_New_OP Updated: 16/03/2026 02:51	M | Feb 26 58.5% Num: 26K Denom: 44K	UCL: 62.0% Mean: 59.9% LCL: 57.9% Targ: 65.5%
RTT 52w Performance FILTER: TOTAL RP07218 M_01304_Incompletes_52_Perf Updated: 16/03/2026 02:51	M | Feb 26 2.7% Num: 2K Denom: 74K	UCL: 3.6% Mean: 3.1% LCL: 2.5% Targ: 1.1%
RTT Total Incomplete Pathways FILTER: TOTAL RP07218 M_01304_Total_Pathways Updated: 16/03/2026 02:51	M | Feb 26 73.9K	UCL: 81.7K Mean: 79.2K LCL: 76.7K Targ: 77.7K
RTT 52w Breaches FILTER: TOTAL RP07218 M_01304_RTT_52w Updated: 16/03/2026 02:51	M | Feb 26 2,016	UCL: 2,933 Mean: 2,457 LCL: 1,981 Targ: 852
RTT 65w Breaches FILTER: TOTAL RP07218 M_01304_RTT_65w Updated: 16/03/2026 02:51	M | Feb 26 88	UCL: 210 Mean: 119 LCL: 27 Targ: 0
RTT 78w Breaches FILTER: TOTAL RP07218 M_01304_RTT_78w Updated: 16/03/2026 02:51	M | Feb 26 5	UCL: 29 Mean: 11 LCL: -7 Targ: 0

Key Performance Indicator (KPI)	Value	Ranges
Theatre Session Opp. FILTER: TOTAL RP07218 M_00146_Theatres_Utilisation Updated: 13/03/2026 09:43	M | Feb 26 38	UCL: 55 Mean: 36 LCL: 18 Targ: 25
Theatre Uncapped Utilisation FILTER: TOTAL RP07218 M_00718_Theatre_Act_Utilisation Updated: 09/03/2026 13:14	M | Feb 26 78.7% Num: 174K Denom: 221K	UCL: 82.5% Mean: 79.1% LCL: 75.8% Targ: 85.0%
Theatre Capped Utilisation FILTER: TOTAL RP07218 M_01379_Theatre_Capped_Utilisation Updated: 16/03/2026 01:00	M | Feb 26 75.9% Num: 167K Denom: 221K	UCL: 78.8% Mean: 75.8% LCL: 72.7% Targ: 85.0%
RTT 104w Breaches FILTER: TOTAL RP07218 M_01304_RTT_104w Updated: 16/03/2026 02:51	M | Feb 26 2	UCL: 10 Mean: 3 LCL: -4 Targ: 0
DM01 Compliance FILTER: TOTAL RP07218 M_00190_DM01_Compliance Updated: 13/03/2026 11:49	M | Feb 26 63.9% Num: 21K Denom: 33K	UCL: 85.0% Mean: 76.9% LCL: 68.8% Targ: 78.0%
Outpatient DNA Rate FILTER: TOTAL RP07218 M_00185_DNA_OP_v4_ALL Updated: 16/03/2026 00:31	M | Feb 26 5.4% Num: 4K Denom: 81K	UCL: 6.9% Mean: 6.2% LCL: 5.5% Targ: 7.0%
Endoscopy Backlog FILTER: TOTAL RP07218 M_01063_Endo_BL Updated: 16/03/2026 02:28	M | Feb 26 694	UCL: 506 Mean: 354 LCL: 203 Targ:

East Kent Hospitals University NHS Foundation Trust

Executive Summary

Urgent and Emergency Care & Planned Care

Urgent and Emergency Care

- Overall four-hour compliance has increased and performance across all types of department at 74.9% and Type 1 also increasing at 55.2%. Compliance in Type 1 departments had been above the mean of the two-year period now for 12 months with performance consistently above 50%. Control limits on these metrics have been recalculated on the basis of this sustained improvement.
- The number of patients waiting in our emergency departments for over 12 hours in February decreased to 995. This remains a significant challenge and key operational focus for the Trust and system partners at 18.7%. Extensive analysis of the 12 hour waits by site, split by admitted and non-admitted, timelines and by speciality has been undertaken to support the hot sites for further steps and plans to be taken forward to reduce the number of our patients waiting over 12 hours.
- Ambulance handover performance was maintained at 94.0% of patients handed off to the Emergency Departments within 30 minutes. Performance is now positively alerting demonstrating continued improvements in this measure.
- The occupancy levels of patients spending >7 days on the RTS caseload increased in February. Patients recorded as having No Criteria to Reside (NCTR) and remaining in hospital at midnight was an average occupancy of 184.5 patients for February. Delayed discharges continues to contribute to the increased LOS observed and challenges in flow through the three main sites.

Planned Care

- Incomplete Performance has deteriorated to 51.3% from a peak of 55% at the end of Quarter 1 of patients waiting less than 18 weeks for treatment. This is against a target of 60% by March 2026. This is linked to reduced capacity to deliver activity against plan. Plans have been enacted to recover to 55% by the end of March with a stretch target of 57% with additional capacity being created under the Q4 Sprint funding from NHSE.
- At the end of February, the Trust saw a slight increase in the number of patients waiting greater than 52 weeks for treatment, from 2,006 in January to 2,016 at the end of February. This represents 2.7% of the PTL with a February target of no greater than 1.1%.
- There was also an increase in the number of patients waiting greater than 65 weeks from 69 at the end of January to 88 at the end of February.
- The Trust is in Tier 1 level support from NHS England for Elective Care.
- Plans have been enacted to increase activity and performance during Q4 through Waiting List Initiatives, procurement of an Insourcing Provider, Transfer of patients to the Independent Sector as well as Clinical Triage and Waiting List Validation to achieve >55% RTT Incomplete performance and reduce the volume of patients waiting greater than 52/65 weeks for treatment.

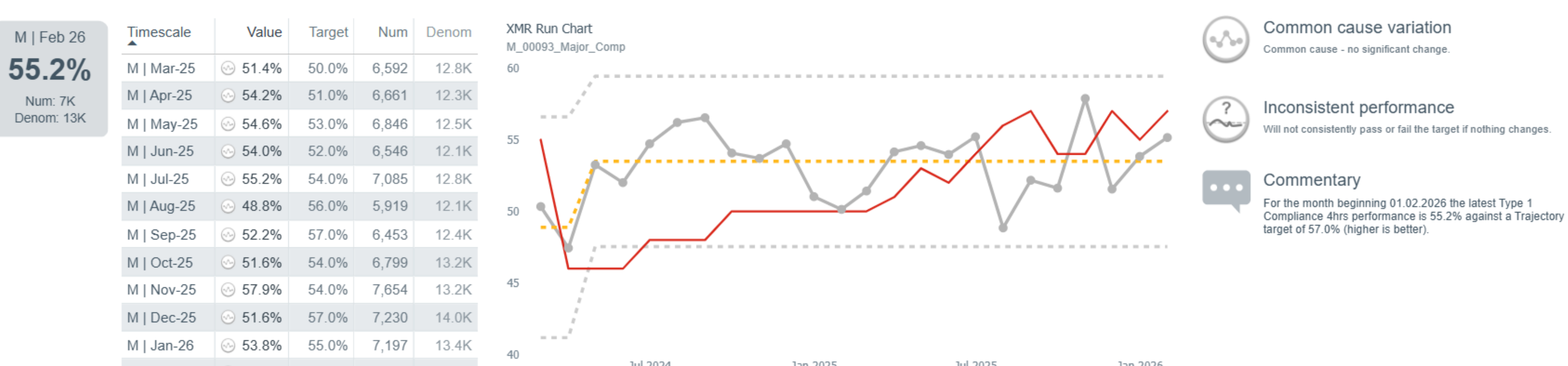
- Diagnostics DM01 performance has improved from 60.2% in January to 63.9%. CT and Non-Obstetric Ultrasound remain key areas of concern. There have been challenges related to booking processes that have been exacerbated by vacancies and increased sickness within the team. Additionally, a focus on the additional capacity required under the Q4 Sprint to expedite the treatment of long RTT waits has had an impact on DM01 recovery. An improvement plan is underway with a focus on driving bookings to make best use of capacity.

- FDS performance dipped to 66.3% in January, reflecting a decline in activity over the festive season, but recovered to 75.8% in February. Request-to-report times remain extended across most diagnostic modalities. Increased Breast Screening activity, supported by NHSE sprint funding, has delivered a clear improvement in the Breast pathway.
- 62-Day performance remains below target at 65.8% and is a statistically significant concern. February saw declines across several high-volume specialties: Breast (driven by screening backlogs, with expected improvement following sprint funding but with a two-month lag), Gynaecology (capacity constraints due to staff absence), and Upper/Lower GI (longer diagnostic waits throughout January, particularly endoscopy.
- Despite January–February deterioration, early March data shows strong signs of recovery for 62D across all major high-volume specialties.

Patients

Urgent & Emergency Care

Type 1 Emergency Department; Four Hour Compliance



M | Feb 26

55.2%

Num: 7K
Denom: 13K

Timescale	Value	Target	Num	Denom
M | Mar-25	51.4%	50.0%	6,592	12.8K
M | Apr-25	54.2%	51.0%	6,661	12.3K
M | May-25	54.6%	53.0%	6,846	12.5K
M | Jun-25	54.0%	52.0%	6,546	12.1K
M | Jul-25	55.2%	54.0%	7,085	12.8K
M | Aug-25	48.8%	56.0%	5,919	12.1K
M | Sep-25	52.2%	57.0%	6,453	12.4K
M | Oct-25	51.6%	54.0%	6,799	13.2K
M | Nov-25	57.9%	54.0%	7,654	13.2K
M | Dec-25	51.6%	57.0%	7,230	14.0K
M | Jan-26	53.8%	55.0%	7,197	13.4K
M | Feb-26	55.2%	57.0%	6,898	12.5K

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Type 1 Position Attendance Avoidance	• Working with partners to review the revised SPOA model for the impact and successes of the changes to ensure a 7-day service for maximum effectiveness and efficiencies for staff and patients. • Review of direct access pathways to be undertaken with partners.	• Dep COO/ UEC OPS	• Q1 to Q4 • Q1 to Q4	• Performance 55.2% increased in February to the previous levels for the year to date. Clinically lead Improvement Weeks for WHH and QEQM are scheduled across 25/26. Week 4 on both hot sites in March 2026 was focused around the Internal Professional Standards lenses whiich is a key part of the Eliminating Corridor Care action plan and reporting from March 2026 commencing 01/04/26. • As part of the SDEC steering group for the new capital builds on both sites, all direct access pathways will be reviewed in a workshop hosted by GIRFT in April. 111 pts on the DOS have been reviewed with the ICB and alliance UTC colleagues for direct attendances now implemented.
Safe and Effective ED	• Standards and quality indicators will be reviewed on both of the hot sites to ensure timely delivery of patient care within the constraints of the Department. • Review of CDU model on both sites.	• Dep COO UEC • MDs	• Q1 to Q4 • Q1 to Q4	• Internal professional standards have been reviewed and monitored at WHH by the improvement team following Improvement week 1. The outcome is scheduled to be reviewed with the Site Tri's and GIRFT in Q3 for further progression, TMC 03/26. • CDU walkaround at WHH has taken place and enabling changes have taken place in month 6. CDU SOP and timeline to UEC Programme Board end of October. Proof of concept changes trialled in November. CDU in place at WHH with a positive impact.
Admission Avoidance	Front door alternatives to ED: • SDEC capital plans being developed for WHH and QEQM with a steering group and workstream MDT approach, decants achieved. • Review UTC models and pathways with partners considering location and GP streaming 7 day service for all walk in patients.	• SiteTri • Dep COO UEC	• Q1 to Q4 • Q2	• Patient flow and pathways for emergency patients will be considered and reviewed as part of the Emergency Village capital development at WHH and QEQM, July & August 26. • UTC's to be co located within the SDEC plans at both sites for walk-in patients, completed successfully October 2025, streaming to be further developed to enable full utilisation of the emergency footprint for patient pathways .

Patients

Urgent & Emergency Care

12 Hour Total Time in Emergency Department

M | Feb 26
18.7%
Num: 2K
Denom: 13K

Timescale	Value	Target	Num	Denom
M | Mar-25	20.8%		2,669	12.8K
M | Apr-25	21.7%		2,664	12.3K
M | May-25	20.2%		2,529	12.5K
M | Jun-25	20.6%		2,499	12.1K
M | Jul-25	20.4%		2,625	12.8K
M | Aug-25	23.3%		2,820	12.1K
M | Sep-25	21.0%	21.3%	2,600	12.4K
M | Oct-25	21.2%	18.8%	2,789	13.2K
M | Nov-25	18.5%	18.1%	2,446	13.2K
M | Dec-25	20.2%	16.8%	2,841	14.0K
M | Jan-26	20.8%	17.0%	2,795	13.4K
M | Feb-26	18.7%	16.1%	2,346	12.5K

XMR Run Chart
M_00113_12hr

Common cause variation
Common cause - no significant change.

Consistently failing the target
Will consistently fail the target if nothing changes.

Commentary
For the month beginning 01.02.2026 the latest 12 Hr Total Time in Department performance is 18.7% against a Trajectory target of 16.1% (lower is better).

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Demand outstrips capacity	• Bed modelling to be developed for the sites around the management of peak demand and the full protocol plans for each site, for example within winter planning. • Patient flow within the Emergency Floor to be enhanced to reduce los with revised processes and equality of access to emergency and acute services. • In line with UEC plan, June 25, reduce 12h waits as per trajectories.	• Senior Ops teams • CG Tri WHH/Q EQM	Q1 to Q4 Q2 to Q4	• Acute sites to have agreed steps and plans in place for surge and/or excess demand with governance and transparency for space and staffing. Winter plan, approved by the Board September 2025, however from the modelling shows a negative bed position of 109 beds currently. Future modelling for 2026/27 is in progress. • Clinically led SDEC review of protocols for acute sites with SOP's for patient flow to reduce los and admissions has taken place, workshop 1 scheduled in line with GIRFT report and support for opportunities outlined. • Position for 12hrs is starting to show the required improvements following an Amber SDEC model introduced at WHH, implementation of action cards for ED and the site team to agreed escalation points for patients at a 8 hour and 10 hour perspective. Further discussion with site tri's and GIRFT support at WHH from August to review processes and modelling. Extensive additional analysis provided to sites of timelines and types for Tier 1 meeting discussions. GIRFT red lines and programme plan approach taken from the end of October and on-going.
Ambulance waiting times		• CG Tri WHH/Q EQM	Q1 to Q4	

Urgent & Emergency Care

12 Hour Total Time in Emergency Department

12h Total Time in EM Dept Actions

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
High number of Mental Health (MH) patients in ED with long waits	• Escalation SOP in place for delays in accessing MH capacity. • ICB support to EKMHT to manage OOA access. • Safe haven roll out underway. • Review framework for all MH patients around admission decision making with partners.	• CG Tri WHH/QEQM	Q1 to Q4	• ED internal processes in place to support patients. Plans in place with HCP/MH to put in 24/7 LPS to the sites/Safe havens to be co-located at QEQM with plans to be established fully by Q4. Plan for Safe Haven at WHH in development. • Focus for 25/26 on escalation and capacity to manage long stayers- SOP for escalation developed by MD for WHH and QEQM. • MH action cards taken forward via UEC Programme Board in October. • All long waits reported daily through system calls to ICB as key point of contact now. • New framework implementation from January 2026.

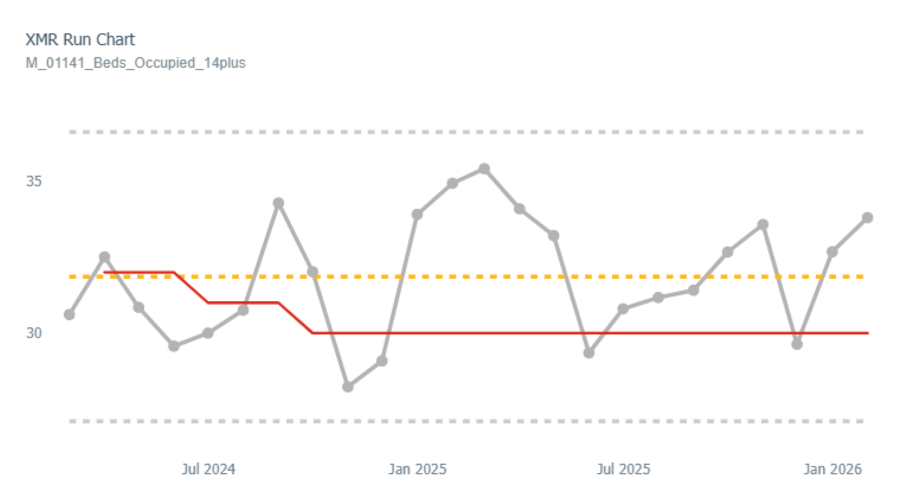
Patients

Urgent & Emergency Care

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

M | Feb 26
33.8%
Num: 9K
Denom: 28K

Timescale	Value	Target	Num	Denom
M | Mar-25	35.4%	30.0%	11.1K	31.5K
M | Apr-25	34.1%	30.0%	10.2K	30.0K
M | May-25	33.2%	30.0%	10.2K	30.6K
M | Jun-25	29.4%	30.0%	8,688	29.6K
M | Jul-25	30.8%	30.0%	9,533	31.0K
M | Aug-25	31.2%	30.0%	9,655	31.0K
M | Sep-25	31.4%	30.0%	9,475	30.2K
M | Oct-25	32.7%	30.0%	10.2K	31.2K
M | Nov-25	33.6%	30.0%	10.0K	29.9K
M | Dec-25	29.6%	30.0%	9,054	30.6K
M | Jan-26	32.7%	30.0%	10.1K	30.9K
M | Feb-26	33.8%	30.0%	9,382	27.8K



Common cause variation
Common cause - no significant change.

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

Commentary
For the month beginning 01.02.2026 the latest % Beds Occupied 14+ performance is 33.8% against a Trajectory target of 30.0% (lower is better).

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Alternatives to hospital and discharge with partners	••Develop board round SOP's ••Consider out of hospital alternatives for all patients within an acute bed on board rounds on a daily basis. ••Review current discharge staffing within the acute sites and partners for the numbers and range of roles and responsibilities together. ••Review the role of therapies in relation to discharge and hospital alternatives.	Dep COO, HCP and MD'S	• Q1 to Q4	•Community Business cases 1 and 2 focus upon additional P1 discharges and admision avoidance for a cohort pilot of frail patients through a neighbourhood health scheme are planned to commence from April 2026. •Implementation of the SOP's across the wards. •Joint discharge staffing review agreed with partners, option of an integrated team to be take forward from April 2026 at QEQM and KCH as a phased approach. •Range of alternative services and therapy in a community setting to be discussed. •nCTR patient numbers in total to be monitored and reported upon. P0 report set up and successfully embedded.
Patients not meeting the criteria to reside > 7 days	••Implement LOS biweekly meetings at QEQM, commencing with a four 4 pilot for >21 & 14 day pts. ••BAU at QEQM for > 7 day review biweekly ••Review current weekly LOS meeting at WHH and updated ••Escalation process to be in place for complex patients or spot purchasing.	• •Dep COO, HCP and MD'S	• Q1 to Q4	••Conclude outcome of the pilot and success as changes will be made as it progresses to resolve all issues arising by the group and resolved together. TOR to be provided. ••Implement at QEQM > 7 days review of patients biweekly with partners from month 4. ••Implement outcome of the WHH LOS Meeting review. ••Themes of community capacity to be compiled to be reviewed and considered, for example NWB beds and homeless pathway.
Discharge Lounge utilisation	••Review SOP's at both sites for opening hours and facilities, for example beds and chairs capacity. ••Golden patients to be identified and agreed daily for end of day bed meetings.	••Deputy COO-UEC ••MDs	• Q1 to Q4	••The Improvement Programme included a significant focus on the patent flow to the discharge lounge to gain before 10am utilisation. ••Build upon the changes and processes as part of the focus. ••Maintain and monitor the utilisation.

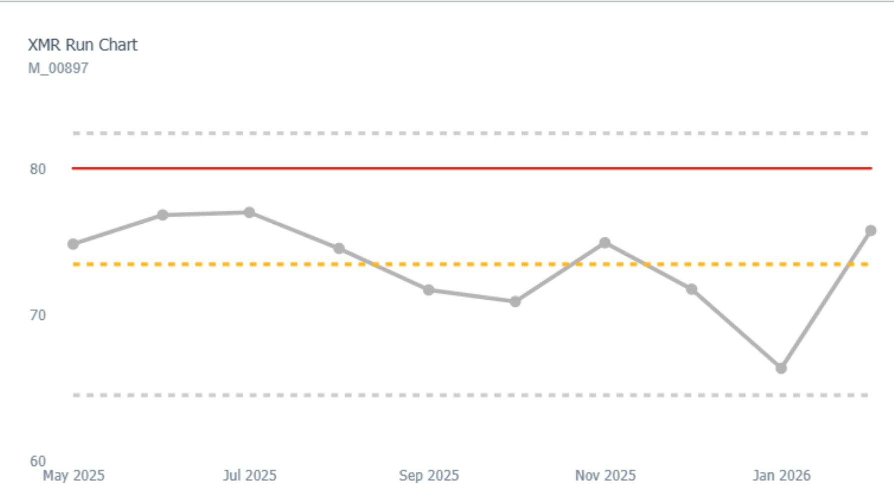
Patients

Cancer Care

Cancer 28 Day Performance

M | Feb 26
75.8%
Num: 3K
Denom: 4K

Timescale	Value	Target	Num	Denom
M | May-25	74.8%	80.0%	3,210	4,290
M | Jun-25	76.8%	80.0%	3,346	4,356
M | Jul-25	77.0%	80.0%	3,597	4,672
M | Aug-25	74.5%	80.0%	3,043	4,083
M | Sep-25	71.7%	80.0%	3,186	4,444
M | Oct-25	70.9%	80.0%	3,462	4,883
M | Nov-25	74.9%	80.0%	3,202	4,274
M | Dec-25	71.7%	80.0%	3,009	4,194
M | Jan-26	66.3%	80.0%	2,668	4,022
M | Feb-26	75.8%	80.0%	2,824	3,728



Common cause variation

Common cause - no significant change.

Inconsistent performance

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

Commentary

For the month beginning 01.02.2026 the latest Cancer 28d Combined Performance performance is 75.8% against a static target of 80.0% (higher is better).

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Access to timely diagnostic	• Extended request to report times observed across all radiological modalities • Increased Endoscopy booking out time frames	• Radiology • Endoscopy	• Ongoing	• Recovery space for CT Guided Biopsy at WHH has been secured within the radiology footprint following some minor works. Numerous lists were affected during January with lack of staff of recovery space used as ED escalation. • Extended request-to-report times have been observed across the majority of diagnostic modalities for 2ww and Urgent requests. Detailed and focussed escalation process are in place - Radiology (for vetting and reporting) and PSC (for booking) - to support patients through their diagnostics. • Reporting timeframes, particularly for MRI, are increasing. Whilst the position is being communicated and escalated, there is insufficient reporting capacity to meet the current demand due to long term vacancies. • Endoscopy timeframes have improved in month following a resolution estate issues at WHH that took down the Endoscopy suite for a number of weeks.
Benign Letter Backlog	• Timely consultant dictation of cancer letters to patients • Timely admin support to process dictated letters	• Cancer compliance • Admin • Consultant	• 25/26	• The trust regularly achieved its threshold target of having fewer than 250 benign letters in the backlog in the month of December. Despite efforts the current backlog is just shy of 400. Teams have been briefed via Operational Access meetings to review and support the processing of benign letters. • Lower GI – Results review inbox launched in February for WHH (aligned with MTW model) with support the faster turnaround for STT letters and follow up. Clinical engagement and team buy-in are complete. Job plan adjustments are required to allow specialist doctors to support consultant results review and admin. Planning continues to support the transition for QE.

Patients

Cancer Care

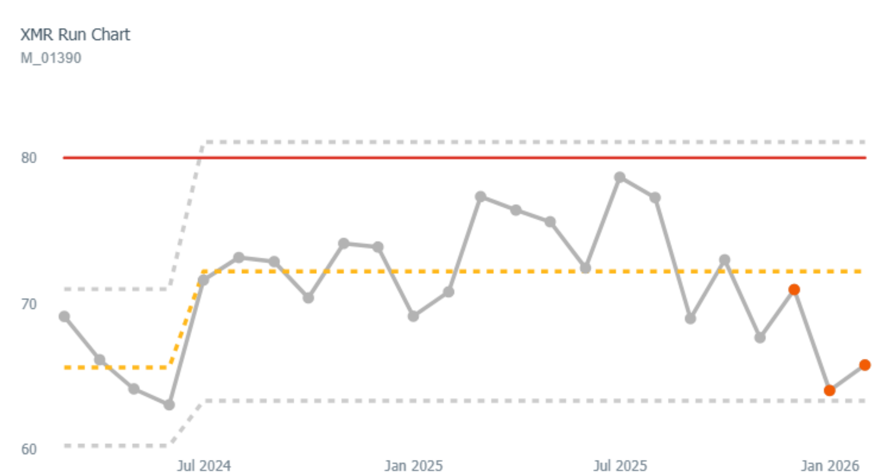
Cancer 62 Day Performance

Cancer 62d Combined Performance

FILTER: TOTAL | RP07218 | M_01390 | Updated: 13/03/2026 10:08

M | Feb 26
65.8%
Num: 244
Denom: 371

Timescale	Value	Target	Num	Denom
M | Mar-25	77.3%	80.0%	282	364
M | Apr-25	76.4%	80.0%	279	365
M | May-25	75.6%	80.0%	296	392
M | Jun-25	72.4%	80.0%	321	443
M | Jul-25	78.7%	80.0%	330	420
M | Aug-25	77.3%	80.0%	286	370
M | Sep-25	69.0%	80.0%	261	379
M | Oct-25	73.0%	80.0%	300	411
M | Nov-25	67.6%	80.0%	265	391
M | Dec-25	70.9%	80.0%	285	401
M | Jan-26	64.0%	80.0%	238	371
M | Feb-26	65.8%	80.0%	244	371



Special cause variation

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

Inconsistent performance

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

Commentary

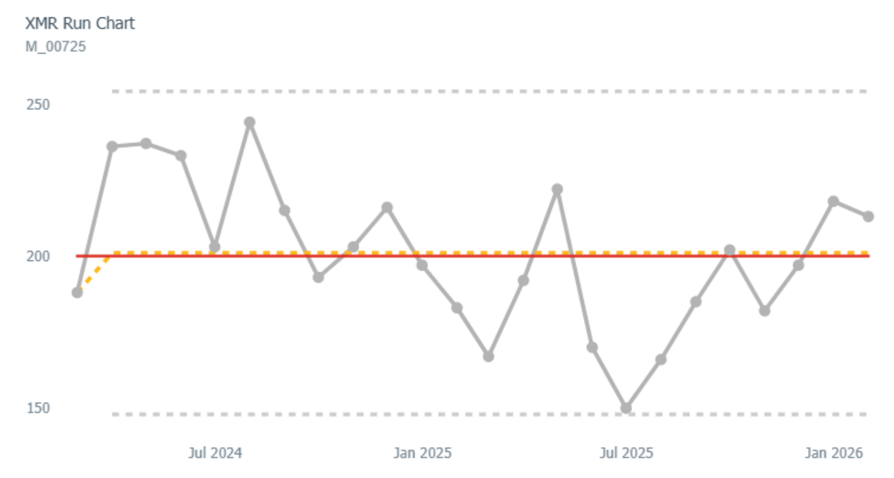
For the month beginning 01.02.2026 the latest Cancer 62d Combined Performance performance is 65.8% against a static target of 80.0% (higher is better).

Cancer Over 62d on PTL

FILTER: TOTAL | RP07218 | M_00725 | Updated: 13/03/2026 08:33

M | Feb 26
213

Timescale	Value	Target	Num	Denom
M | Mar-25	167	200	167	
M | Apr-25	192	200	192	
M | May-25	222	200	222	
M | Jun-25	170	200	170	
M | Jul-25	150	200	150	
M | Aug-25	166	200	166	
M | Sep-25	185	200	185	
M | Oct-25	202	200	202	
M | Nov-25	182	200	182	
M | Dec-25	197	200	197	
M | Jan-26	218	200	218	
M | Feb-26	213	200	213	



Common cause variation

Common cause - no significant change.

Inconsistent performance

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

Commentary

For the month beginning 01.02.2026 the latest Cancer Over 62d on PTL performance is 213 against a static target of 200 (lower is better).

Cancer Care

Cancer 62 Day Performance; Action Plan

Cancer 62d Performance & >62d PTL Patient Actions

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Grip and control of backlog position	• Clear actions outlined in PTL to progress patients. • Close monitoring of treatment booking times • Escalation through operational access meetings for areas of concern	• Cancer Operational lead/ compliance	• Ongoing	• Targeted escalation for patients against agreed thresholds for Histopathology, Radiology and Endoscopy. All diagnostics types now being escalated after a 7 day period. The majority of reporting is completed within 7 days. • 104 review now completed at operational access meetings with 63-104 watchlist being communicated. 104+ diagnostic reporting being escalated for 24 hour turnaround. • Additional monitoring measures have been input in place with radiology and the PSC to ensure clear actions against patients that are identified as not progressing through their diagnostic element of the pathway.
Urology treatment capacity	• Limited consultant robotic capacity • Limited oncology capacity	• Urology	• 26/27	• Urology demand and capacity exercise in progress to ensure capacity is right sized for the years ahead. • Current wait times for clinic appointments exceed 4 weeks post MDM. Current surgery timeframes extend past 62D. • Focus on reducing timeframes at the very start of the pathway – same day MRI reporting for example to ensure the majority of non-surgical patients can start treatment in a timely manner.
Chemotherapy provision	• Ensuring capacity to meet demand • Project planning Aseptic shutdown	• Cancer Services/ Oncology/ Pharmacy	• 26/27	• At present we are experiencing an increasing number of 31d and 62 breaches with new patient appointment extending to 2-3 weeks. • There is significant sickness across our nursing teams. • To support the expected 10% growth in 26/27 three business cases are in development. The business cases include nursing staff, HCAs, aseptic distribution, pharmacy screening, scheduling. • Pharmacy capacity also being reviewed as part of business planning to ensure pharmacy provision can meet demand. At present we have reached the daily aseptic order cap. The teams are exploring all options to support the increase in demand.
Breast screening	• Breast screening performance the primary driver to the Breast 62D decline	• Breast screening/ Breast	• Q4	• Breast insourcing commenced on the last weekend in January and the impact has been immediate. The screening backlog has now been cleared, and the Breast team are dating and advancing the influx of patients to the standard breast pathway.

Patients

Planned Care

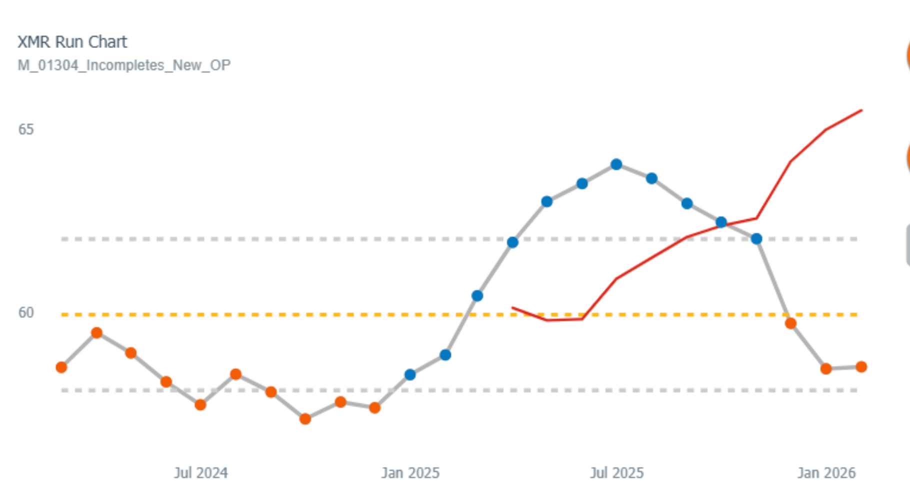
Referral to Treatment Waiting Times; 1st OPA and 52ww Performance

RTT 1st OPA Performance

FILTER: TOTAL | RP07218 | M_01304_Incompletes_New_OP | Updated: 16/03/2026 02:51

M | Feb 26
58.5%
Num: 26K
Denom: 44K

Timescale	Value	Target	Num	Denom
M | Mar-25	60.4%		30.3K	50.2K
M | Apr-25	61.9%	60.1%	32.0K	51.8K
M | May-25	63.0%	59.8%	31.7K	50.3K
M | Jun-25	63.5%	59.8%	31.2K	49.1K
M | Jul-25	64.0%	60.9%	31.2K	48.8K
M | Aug-25	63.6%	61.5%	31.3K	49.2K
M | Sep-25	63.0%	62.0%	30.2K	48.0K
M | Oct-25	62.5%	62.4%	30.0K	48.0K
M | Nov-25	62.0%	62.6%	29.1K	46.9K
M | Dec-25	59.7%	64.1%	27.2K	45.6K
M | Jan-26	58.4%	65.0%	26.5K	45.4K
M | Feb-26	58.5%	65.5%	25.8K	44.1K



Special cause variation

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

Consistently failing the target

Will consistently fail the target if nothing changes.

Commentary

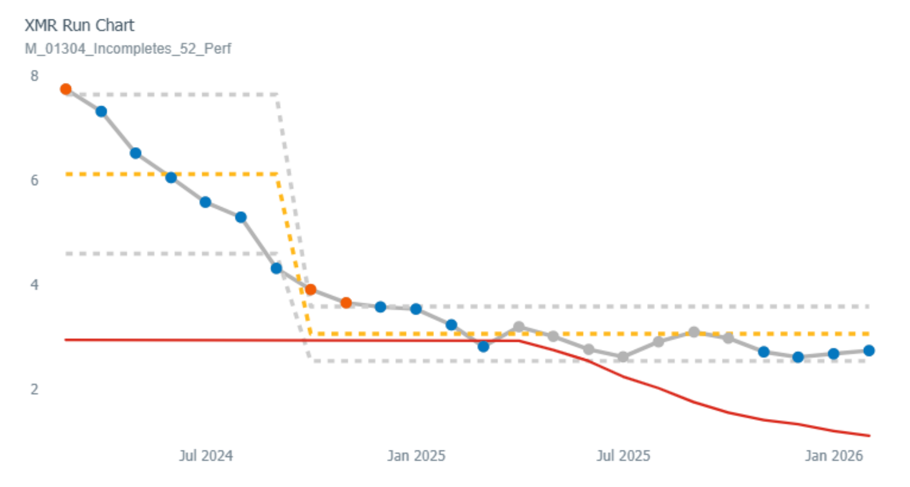
For the month beginning 01.02.2026 the latest RTT 1st OPA Performance performance is 58.5% against a Trajectory target of 65.5% (higher is better).

RTT 52w Performance

FILTER: TOTAL | RP07218 | M_01304_Incompletes_52_Perf | Updated: 16/03/2026 02:51

M | Feb 26
2.7%
Num: 2K
Denom: 74K

Timescale	Value	Target	Num	Denom
M | Mar-25	2.8%		2,272	81.0K
M | Apr-25	3.2%	2.9%	2,648	83.1K
M | May-25	3.0%	2.7%	2,466	82.1K
M | Jun-25	2.8%	2.5%	2,221	80.7K
M | Jul-25	2.6%	2.2%	2,087	80.0K
M | Aug-25	2.9%	2.0%	2,320	80.1K
M | Sep-25	3.1%	1.7%	2,435	78.9K
M | Oct-25	3.0%	1.5%	2,327	78.4K
M | Nov-25	2.7%	1.4%	2,078	76.9K
M | Dec-25	2.6%	1.3%	1,977	76.0K
M | Jan-26	2.7%	1.2%	2,006	75.2K
M | Feb-26	2.7%	1.1%	2,016	73.9K



Special cause variation

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

Consistently failing the target

Will consistently fail the target if nothing changes.

Commentary

For the month beginning 01.02.2026 the latest RTT 52w Performance performance is 2.7% against a Trajectory target of 1.1% (lower is better).

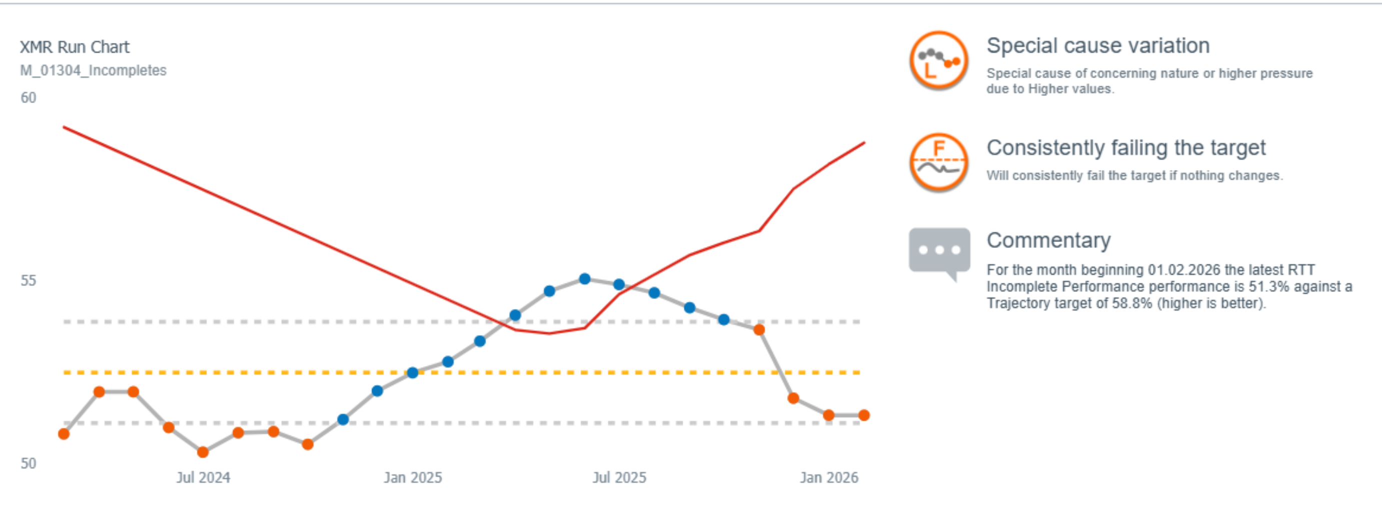
Patients

Planned Care

Referral to Treatment Waiting Times; Incomplete Pathways Performance

M | Feb 26
51.3%
Num: 38K
Denom: 74K

Timescale	Value	Target	Num	Denom
M | Mar-25	53.3%		43.2K	81.0K
M | Apr-25	54.0%	53.6%	44.9K	83.1K
M | May-25	54.7%	53.5%	44.9K	82.1K
M | Jun-25	55.0%	53.7%	44.4K	80.7K
M | Jul-25	54.9%	54.6%	43.9K	80.0K
M | Aug-25	54.7%	55.2%	43.8K	80.1K
M | Sep-25	54.3%	55.7%	42.8K	78.9K
M | Oct-25	53.9%	56.0%	42.3K	78.4K
M | Nov-25	53.6%	56.3%	41.2K	76.9K
M | Dec-25	51.8%	57.5%	39.3K	76.0K
M | Jan-26	51.3%	58.2%	38.6K	75.2K
M | Feb-26	51.3%	58.8%	37.9K	73.9K



KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Drive to eradicate 65 week waits and sustain as well as reduce the level of 52 week waits to <1% of PTL from a baseline of 3.6%. Trust enters Tier 1 Support from February 2026 for Elective Care and Tier 2 for Diagnostics and receives additional funding offers to increase activity and improve performance during the remainder of Q4	Seek written confirmation of available funds and eligibility criteria to receive	COO	February 18	Awaiting confirmation of funding available to EKHUFT and the criteria required for payment.
	Create further plan to increase activity and improve RTT performance for remainder of Q4	Dir Planned Care Recovery	February 18	Plans are in progress and will remain iterative until the 31st March.
	Request Independent Sector Capacity Offers and transfer patients	Dir Planned Care Recovery	February 18	Complete - Capacity offers received and suitable patients have been transferred
	Procure services of Insourcing Provider	Dir Planned Care Recovery	February 28	Complete – Insourcing provider has been appointed with appointments scheduled for Cardiology, Colorectal, Respiratory and Non-Obstetric Ultrasound
		MD DCB	March 31	Subject to funding confirmation
	Continue to create additional capacity to see further patients and improve RTT performance prior to the end of March	Dir Planned Care Recovery	March 31	In Progress
	Initiate Contract Performance meetings with CGs	COO	March 16	In Progress
	Create further Diagnostic Recovery plan to support RTT Q4 Sprint RTT and improve DM01 compliance	MD DCB	March 31	In Progress

Patients

Planned Care

Endoscopy Backlog; Overdue Surveillance and Routine Waits

M | Feb 26

694

Timescale		Value	Target	Num	Denom
M | Mar-25		206	0	206	
M | Apr-25		255		255	
M | May-25		268		268	
M | Jun-25		314		314	
M | Jul-25		258		258	
M | Aug-25		247		247	
M | Sep-25		257		257	
M | Oct-25		250		250	
M | Nov-25		374		374	
M | Dec-25		618		618	
M | Jan-26		715		715	
M | Feb-26		694		694	

XMR Run Chart

M_01063_Endo_BL

8K
6K
4K
2K
0K
Jul 2024
Jan 2025
Jul 2025
Jan 2026

Special cause variation

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

No set target

No set target.

Commentary

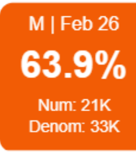
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Delay in triage of Gastro Referrals requiring straight to test scopes	• Regular triage time to be formalised into Consultant job pans	• John Bollas	February 26	• Action complete. Job plans updated.
Reduced Capacity due to booking utilisation and cessation of weekend (Sunday) lists	• Daily huddles to be implemented to ensure maximum utilisation of capacity and weekly oversight by Care Group Tri.	• Jade Pilcher	February 26	• Daily huddles and weekly oversight now in place. Utilisation improved from 86.6% to 91%
	• Delays in approval of booking posts by VCP to escalate and resolve	• Sunny Chada	January 26	• Vacant Booking posts all approved and out to advert / at interview stage. NHSP cover in place where required.
	• Sunday insourced lists reinstated to provide additional capacity until alternative pathways in place.	• Sunny Chada	January 26	• Additional Sunday lists reintroduced in January 26 and in place fro February 26
Unable to implement alternative pathways at pace due to recruitment delays	• Recruitment of nursing posts required to implement alternative pathways	• Jo Williams	February 26	• Alternative pathway nursing posts interviews February with initial implementation of capsule sponge from 1.4.26 , large and small bowel planned from 1.5.26 and TNE from 1.6.26

Detailed actions above result in full compliance and return of backlog to target (<200) by May 2026

Patients

Planned Care

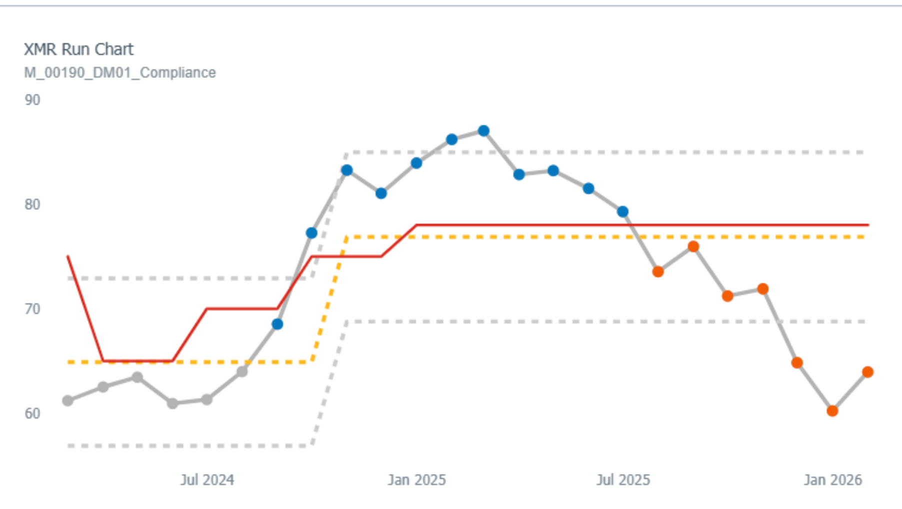
Diagnostics; DM01 Compliance % Patients Waiting less then 6 Weeks



M | Feb 26
63.9%
Num: 21K
Denom: 33K

Timescale	Value	Target	Num	Denom
M | Mar-25	87.0%	78.0%	15.5K	17.8K
M | Apr-25	82.8%	78.0%	14.5K	17.5K
M | May-25	83.2%	78.0%	15.0K	18.1K
M | Jun-25	81.5%	78.0%	15.9K	19.5K
M | Jul-25	79.3%	78.0%	16.7K	21.1K
M | Aug-25	73.5%	78.0%	14.9K	20.3K
M | Sep-25	76.0%	78.0%	16.8K	22.1K
M | Oct-25	71.2%	78.0%	18.1K	25.5K
M | Nov-25	71.9%	78.0%	19.0K	26.4K
M | Dec-25	64.8%	78.0%	18.5K	28.6K
M | Jan-26	60.2%	78.0%	18.5K	30.7K
M | Feb-26	63.9%	78.0%	21.1K	33.0K

XMR Run Chart
M_00190_DM01_Compliance



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

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

Commentary
For the month beginning 01.02.2026 the latest DM01 Compliance performance is 63.9% against a Trajectory target of 78.0% (higher is better).

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Cardiac MRI Backlog	• Recruitment to vacant consultant posts.	• Cardiology GM	• March 2026	• New consultant starts in May • Mitigations currently being put in place to sustain current capacity given the above. • Working with radiology to identify potential internal capacity and personnel to improve compliance. • Discussions ongoing around booking processes and chronology, and capacity use. • MTW undertaking non-stress lists to support. • Stress lists at OAH have now recommenced • Awaiting outcome of NHSE funding for an MRI scanner purely for CMRI – was due 16th March.

Planned Care

Diagnostics; DM01 Compliance % Patients Waiting less then 6 Weeks

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
MRI (exc. Cardiac) Booking Capacity Consultant Vetting; delays extending wait times & restricting patient flow Insufficient capacity for sedation & GA patients Current vacancy levels High Cancellation Rates @ Buckland & Deal Sites	• Training ongoing to increase the pool of staff with the knowledge and skills to book MRI • Review consultant job plans to ensure sufficient vetting time within job plans and explore options for radiographer led vetting. • Full demand capacity modelling to be undertaken to consider option for increased capacity • Establishment review requested to understand requirement. • Training for booking teams to manage messaging with patients to increase patient willingness to travel to satellite sites	• Head of Operations Radiology	• 8-12 weeks	• Booking utilisation continues to exceed 100% • Further review underway if pathway for complex MRI eg GA, sedation, pacemakers • Backfill with NHSP as available • Forecast trajectory to achieve 96% DM01 performance by April 2026 by improving booking utilisation and reducing cancellation rates. • Deep dive underway into DNA and cancellations
CT (exc. Cardiac) Booking Capacity Consultant Vetting; delays extending wait times & restricting patient flow High Cancellation Rates @ Buckland & downtime CT Biopsy capacity	• Training ongoing to increase the pool of staff with the knowledge and skills to book CT • Review consultant job plans to ensure sufficient vetting time within job plans and explore options for radiographer led vetting. • The downtime of CT's have contributed to a number of cancellations. Two CTs were due for replacement this year due to age but this has been delayed and both CTs have had downtime due to faults. Replacement programme has now commenced • CT Biopsy is an ongoing challenge due to consultant capacity. This is further impacted currently by the lack of recovery space at WHH following the SDEC moves. An urgent solution has been identified.	• Head of Operations Radiology	• 8 weeks	• Training Underway. Booking utilisation has declined in month due to high volumes of staff sickness • A dashboard has been created to monitor vetting performance which is monitored by the operational team and escalated to site leads as necessary. • Recovery space for CT Biopsy identified at WHH and increased capacity in place to manage backlog • CT replacement programme at QEQM commenced March 2026 • Vacancy rates within CT booking impacted by proposed recruitmenet freeze

Planned Care

Diagnostics; DM01 Compliance % Patients Waiting less then 6 Weeks

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
CT Cardiac Underlying capacity deficit	Demand & Capacity Analysis required Full review of Cardiac Pathways to be undertaken to understand capacity required to in-house all EK demand			• Demand capacity exercise has been undertaken which clearly demonstrates in house capacity is insufficient to meet the current demand. The service receives an average of 250 referrals per month. In house capacity is 140. We currently send 60 patients per month to the Chaucer leaving a monthly shortfall 50 slots. In 23/24 we sent 120 patients per month to the Chaucer but funding was reduced for 25/26 resulting in the worsening position. • In order to maintain current performance and prevent a worsening DM01 position additional funding is required of £380k for26/27 to increase Chaucer capacity back to 120 slots per month. This will maintain current performance. To clear the backlog and achieve DM01 compliance a further £500k would be required. • Deep dive underway into long term capacity requirements • Chaucer contacted regarding increasing capacity which has been secured for March 2026

NB The CT replacement programme is due to commence in January 2026. This presents a significant risk to cardiac CT capacity at both QEQM and WHH. A working group is currently meeting regularly to discuss mitigations. One option currently being reviewed is to move staff from QEQM/WHH to Buckland. The implications of this are being explored.

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Non-Obstetric Ultrasound Booking Capacity Consultant Rotas (delay to production) High Cancellation Rates Recruitment	• Training ongoing to increase the pool of staff with the knowledge and skills to book NOUS • Significant delays in the production of consultant rotas impacting on the ability of booking staff to book ahead eg December rotas published 29th November, January rotas not available as at 19th December • Training for booking teams to manage messaging with patients. • Current vacancies for RDAs not recruited to due to delays with approvals. A high number of NOUS lists require a chaperone. Backfill with NHSP as available. • Current vacancies for booking staff not recruited to due to internal vacancy approvals processes			• Training Underway. Booking utilisation and performance has significantly declined in moth due to staff vacancies and high sickness absence. Plan in place to support staffing gaps and deliver improvement. • Internal approval for external advertisement to fill band 2 booking staff vacancies unsuccessful. Approval for external advertising delayed due to proposed recruitment freeze • Insourced booking support secured for March 2026 to support improved booking utilisation • Implementation of Patchwork will support with addressing this issue. • Training underway. • Forecast trajectory to achieve 96% DM01 performance by June 2026 by improving booking utilisation, increasing establishment of RDAs and reducing cancellation rates.

Planned Care

Diagnostics; DM01 Compliance % Patients Waiting less then 6 Weeks

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
DEXA Field safety notice	The field safety notice that was in place for several months has been lifted for the KCH scanner and long waiting patients are being booked throughout December and January. Awaiting confirmation of part replacement at Buckland but likely to be February 2026. Booking utilisation of all scanners is consistently above 100% so no issues with booking and utilisation. DM01 performance remain consistent and in line with trajectory to deliver compliance by March 2026.			

Quality and safety

Key Performance Indicator (KPI) Assurances

M

KPI's Statistically Improving | KPI's Indicating Concern

Consistently failing the target
Will consistently fail the target if nothing changes.

Failing Metrics	SPC Range
PSII - Local	
AARs Overdue	
FFT Satisfaction Level - ED	
HSMR	
Overdue Incidents	
SHMI	

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

Common Cause Metrics	SPC Range
IPC: CDiff Infections	
Mixed Sex Breaches	
Never Events	
PSII - National	
Safeguarding Incidents	
Complaint Response	
Complaints Number	
Duty of Candour - Verbal	
Duty of Candour - Written 15wd	
Falls with Harm	
FFT Satisfaction Level - Inpatient	
IPC: EColi Infections	
IPC: Klebsiella Infections	
IPC: MRSA Infections	
IPC: MSSA Infections	
IPC: Pseudomonas Infections	
Patient Safety Incidents	
Pressure Ulcers	
Theatre recovery Mixed Sex Breaches	
Duty of Candour - Findings	
Patient Safety Incidents - Mod/Sev	

Consistently passing the target
Will consistently pass the target if nothing changes.

Passing Metrics	SPC Range
FFT Satisfaction Level - Outpatient	
NICE Compliance	
After Action Reviews (AARs)	
Safeguarding Adults Training	
Safeguarding Children Training	

No set target
No set target.

Metrics	SPC Range
SJRs Outstanding	

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

Quality and safety

Scorecard View

Incident Reporting, Compliments/Complaints & Safeguarding

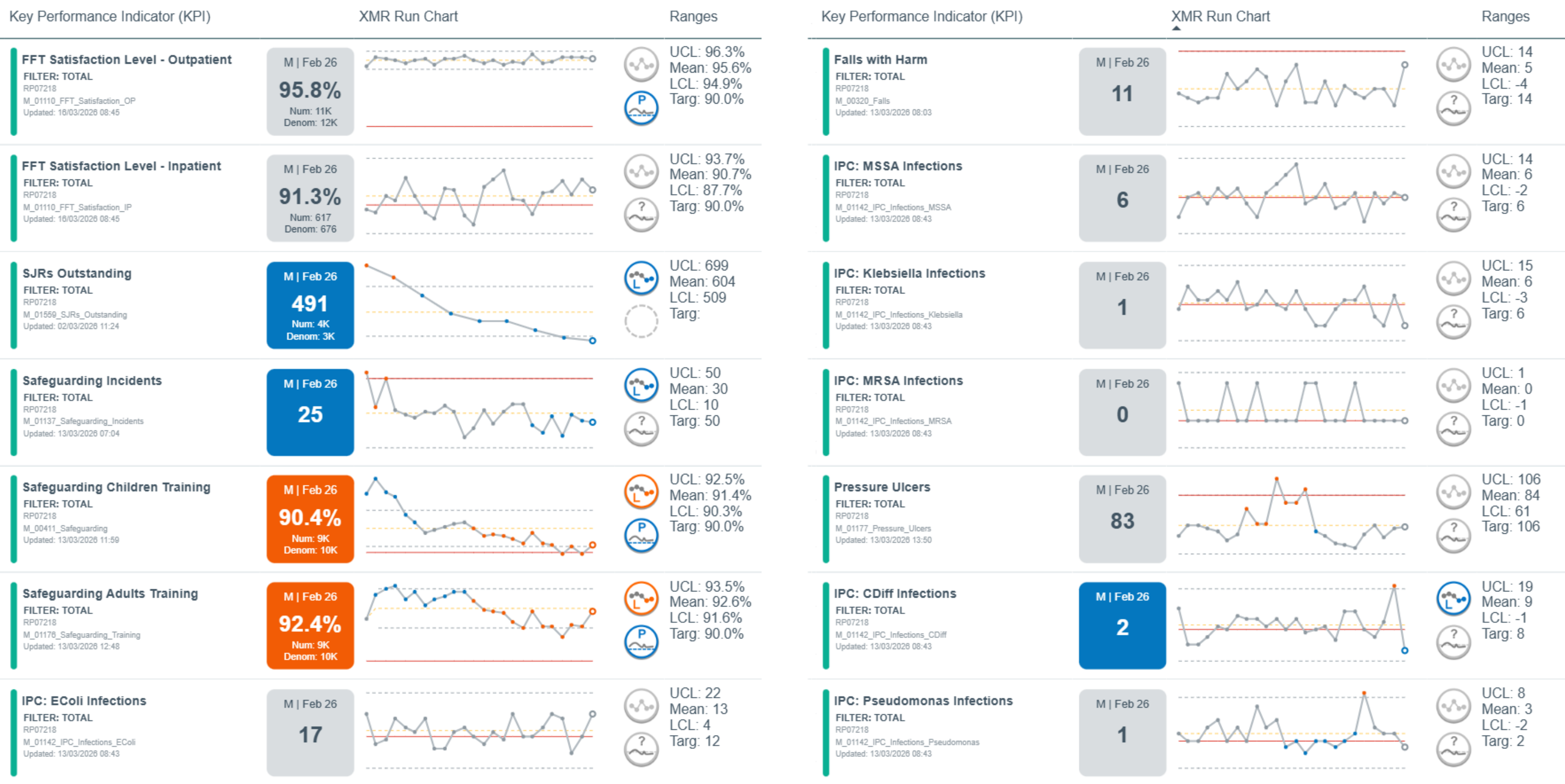
Key Performance Indicator (KPI)	Value	XMR Run Chart	Ranges
Patient Safety Incidents FILTER: TOTAL RP07218 M_00168_Patient_Incidents Updated: 16/03/2026 00:31	M | Feb 26 1,821		UCL: 2,395 Mean: 2,015 LCL: 1,634 Targ: 2,395
Patient Safety Incidents - Mod/Sev FILTER: TOTAL RP07218 M_00168_Patient_Incidents_Severe Updated: 16/03/2026 00:31	M | Feb 26 61		UCL: 67 Mean: 45 LCL: 23 Targ: 67
Overdue Incidents FILTER: TOTAL RP07218 M_01315_Overdue_incidents Updated: 16/03/2026 01:04	M | Feb 26 1,120		UCL: 1,203 Mean: 916 LCL: 629 Targ: 0
PSII - Local FILTER: TOTAL RP07218 M_01540_PSII_Internal Updated: 13/03/2026 09:19	M | Feb 26 0		UCL: 2 Mean: 1 LCL: 0 Targ: 0
PSII - National FILTER: TOTAL RP07218 M_01539_PSII_National Updated: 13/03/2026 09:16	M | Feb 26 0		UCL: 153 Mean: 43 LCL: -67 Targ: 0
After Action Reviews (AARs) FILTER: TOTAL RP07218 M_01541_After_Action _Reviews_(AARs) Updated: 13/03/2026 09:16	M | Feb 26 5		UCL: 15 Mean: 8 LCL: 0 Targ: 0
AARs Overdue FILTER: TOTAL RP07218 M_01542_Overdue_After_Action_Reviews_(AARs)_Snapshot Updated: 13/03/2026 09:27	M | Feb 26 24		UCL: 46 Mean: 34 LCL: 21 Targ: 0

Key Performance Indicator (KPI)	Value	XMR Run Chart	Ranges
Duty of Candour - Written 15wd FILTER: TOTAL RP07218 M_01043_DoC_Written_15_WD Updated: 13/03/2026 07:10	M | Feb 26 87.5% Num: 14 Denom: 16		UCL: 108.0% Mean: 88.3% LCL: 68.6% Targ: 100.0%
Duty of Candour - Verbal FILTER: TOTAL RP07218 M_01043_DoC_Verbal Updated: 13/03/2026 07:10	M | Feb 26 87.0% Num: 20 Denom: 23		UCL: 105.7% Mean: 93.6% LCL: 81.5% Targ: 100.0%
Duty of Candour - Findings FILTER: TOTAL RP07218 M_01043_DoC_Share_Findings Updated: 13/03/2026 07:10	M | Feb 26 83.3% Num: 20 Denom: 24		UCL: 106.8% Mean: 94.4% LCL: 81.9% Targ: 100.0%
Complaint Response FILTER: TOTAL RP07218 M_01255_Comp_30_45_days Updated: 13/03/2026 08:24	M | Feb 26 85.9% Num: 85 Denom: 99		UCL: 91.0% Mean: 85.1% LCL: 79.2% Targ: 85.0%
FFT Satisfaction Level - ED FILTER: TOTAL RP07218 M_01110_FFT_Satisfaction_ED Updated: 16/03/2026 08:45	M | Feb 26 83.7% Num: 2K Denom: 2K		UCL: 87.7% Mean: 83.9% LCL: 80.1% Targ: 90.0%
Never Events FILTER: TOTAL RP07218 M_00171_Never_Events Updated: 13/03/2026 08:54	M | Feb 26 4		UCL: 161 Mean: 45 LCL: -71 Targ: 0
Complaints Number FILTER: TOTAL RP07218 M_01255_Number_of_Complaints Updated: 13/03/2026 08:24	M | Feb 26 78		UCL: 145 Mean: 101 LCL: 58 Targ: 145

Quality and safety

Scorecard View

IPC, Patient Safety & Mortality



Quality and safety

Scorecard View

IPC, Patient Safety & Mortality

Key Performance Indicator (KPI)		XMR Run Chart	Ranges
Mixed Sex Breaches FILTER: TOTAL RP07218 M_00160_Mixed_Sex_Breach Updated: 13/03/2026 15:08	M | Feb 26 52		UCL: 132 Mean: 70 LCL: 7 Targ: 132
Theatre recovery Mixed Sex Breaches FILTER: TOTAL RP07218 M_00160_Mixed_Sex_Breach_Theatres Updated: 13/03/2026 15:08	M | Feb 26 0		UCL: 3 Mean: 0 LCL: -2 Targ: 3
HSMR FILTER: TOTAL RP07218 M_00133_HSMR_Index Updated: 13/03/2026 09:58	M | Oct 25 103.3 Num: 2K Denom: 1.7K		UCL: 103.7 Mean: 101.5 LCL: 99.2 Targ: 96.0
SHMI FILTER: TOTAL RP07218 M_00272_SHMI Updated: 13/03/2026 14:43	M | Oct 25 1.141		UCL: 1.145 Mean: 1.117 LCL: 1.089 Targ: 1.070
VTE Assessment Compliance FILTER: TOTAL RP07218 M_00297_VTE_Assessment_Compliance Updated: 13/03/2026 13:46	M | Feb 26 94.9% Num: 11K Denom: 11K		UCL: 95.7% Mean: 94.3% LCL: 92.8% Targ: 95.0%
NICE Compliance FILTER: TOTAL RP07218 M_01456_NICE_COMPLIANCE Updated: 10/03/2026 13:30	M | Feb 26 97.0% Num: 159 Denom: 164		UCL: 98.9% Mean: 95.8% LCL: 92.8% Targ: 90.0%

Key Performance Indicator (KPI)	XMR Run Chart	Ranges

Patient Safety Incident Investigations

Incidents are reviewed and investigated under the Trust's Patient Safety Incident Response Framework (PSIRF) Policy and Plan. There are national requirements for which a patient safety incident investigation (PSII) is required; and local requirements where the complexity and the potential learning is deemed to warrant a detailed systems analysis and is guided by the principle that people are well-intentioned and strive to do the best they can.

The Trust, at the end of February, had:

- Six (6) nationally reportable investigations ongoing: Two (2) PSII's (a retained swab never event, and a learning from deaths case), Three (3) AAR's (all never events- a retained needle, wrong breast wire insertion, and a wrong site block)
- One (1) Maternity and Neonatal Safety Investigations (MNSI)
- Twenty-five (25) other local response investigations (2 MDT reviews, 3 thematic reviews, and 20 AAR's). Approval will be via LRAP with Executive oversight.
- Ten (10) Local PSIIs (seven of which were overdue – one now signed off, one pending an extra-ordinary LRAP on 01/04/2026, one scheduled for LRAP 30/03/2026 and four (4) still outstanding)
- Three (3) externally led investigations which require Trust support.

There are currently forty (40) open AARs, with three (3) closed in February and five (5) new AARs commenced.

Twenty-four (24) AARs are overdue for completion, of which five (5) are awaiting Tri approval, six (6) are with executives to approve and two (2) are booked for LRAP by end of March.

Quality Governance staff continue to support handlers responsible for completion of the AARs. Progress with AARs is included in the weekly report to executives.

Overdue Incidents:

The number of overdue incidents increased from 1025 to 1120 at the end of February. A total of 523 incidents became overdue in February, which has decreased from 686 in January. The Care Group QGBP are addressing this as a matter of urgency with clinical teams, and the CNMO is meeting with Directors of Nursing and Midwifery weekly to ensure that we are able to meet the proposed trajectory of 300 incidents by April 2026.

The weekly overdue and anomalies report to QGBPs which is shared with the Care Group Leadership teams contains information about the number of incidents about to become overdue to support prioritisation within the care groups. The standard operating procedure (SOP) for Incident Management is in place, which aims to ensure that, where necessary, bottlenecks for handlers are identified and managed, and there is oversight (and action) at the appropriate level within the Care Group structures to facilitate timely closure. Governance staff are meeting regularly with handlers with high numbers of overdue incidents to support closure. A review of incidents overdue by 6 months or more has identified that there is a small proportion of incidents open for justifiable reasons, such as safeguarding reviews awaiting KCC outcomes and AAR or PSIIs that are being undertaken.

In terms of monitoring via the PRM the aim is to see a month-on-month reduction for incident closure to reduce to 300 unjustifiable overdue incidents by the end of March 2026. It is reasonable for an organisation with a high volume of incident reporting to always have some open incidents and the teams are clear that this is an agreed expectation.

Quality and safety

Executive Summary

Systems Update, Safeguarding & Patient Privacy

Duty of Candour:

In February Duty of Candour compliance was below the KPI of 100% for all three components:

- Verbal compliance was 87% due to three (3) conversations being carried out after day 10 (by day 15) (WHH, WCYP and KCVH incidents)
- Written compliance was 87.5% due to two (2) letters being sent after the 15-day KPI timeframe (CCASS and WCYP incidents).
- Findings compliance was 83.3% due to three (3) KCVH letters being sent after day 10 (but completed prior to day 15) and one (1) WCYP obstetrics letter still awaiting completion.
- A daily review of the DoC will be undertaken to ensure continuous oversight
- A DoC working group has been set up to improve compliance and understand the barriers to completion chaired by Deputy Head of Patient Safety. All triumvirates have been invited to the weekly meeting to support improvements. The weekly reports on the DoC due and current compliance continues to be sent out to QGBPs and Director of Quality Governance to maintain oversight. Monitoring of compliance continues to be shared in the weekly report to executives to provide assurance.
- A new Duty of Candour (DoC) escalation procedure has been developed implemented to standardise the SBAR process and escalation pathways, ensuring consistent expectations and practices across all care groups

Never Events:

There were four reported never events in February.

- Wrong site surgery: One patient had the wrong oral lesion biopsied. The patient has now had the correct lesion biopsied. The case was presented at IRP and an AAR investigation has commenced which will be approved via LRAP. The other patient was a nerve block.
- Wrong implant: During an elective c-section a patient that had consented for a copper coil intrauterine device (IUD) to be inserted, had a hormonal coil IUD inserted instead. A SWARM was completed and presented at IRP with actions identified. For assurance, the action plan will be reviewed at LRAP for approval in 12 weeks.
- Retained foreign object post-surgery (epidural needle).

Safeguarding :

The Trust benchmarks safeguarding training compliance against the national standard of **85%**. Current compliance for **Adult and Child Safeguarding Levels 1, 2, and 4** exceeds this benchmark. However, compliance for **Safeguarding Level 3** is **83.3%** for Children and **84.1%** for Adults.

- **Training** Capacity**:** Adequate capacity exists for all staff to complete required courses current DNA rate for refresher training 15%
- Weekly List and booking shared with Care Group Triumvirates against a clear improvement trajectory, reporting monthly at Care Group Performance Review Meetings(PRMs)and Safeguarding operational Group(SOG)

The professional group with the highest level of non-compliance is the **medical and dental workforce**. This risk is recorded on the **Corporate Risk Register(CR3733)**

- **Supervision:** Compliant across the Safeguarding team Levels of specialist safeguarding supervision monitoring progress limited CMW improvement
- **Digital transformation of safeguarding consultations**, delayed which is impacting efficiency and accessibility of safeguarding information. New Safeguarding additions On Datix . Initial Sunrise and CITO options discussed

Backlog of transfer of safeguarding information onto records, national alerts ,conference minutes, DoLs list is tracked weekly to assess progress.

Mixed Sex Breaches
52 breaches occurred in the month of February.

- There has been a small increase in the number of patients sharing the same sex accommodation, with all occurring within the critical care units. Breaches in critical care units are predominantly related to patients waiting more than 4 hours for transfer to a ward bed after being stepped down.

Infection Prevention and Control:

All infections decreased in February 2026, except E-coli, with a significant drop in both klebsiella and C-diff cases, believed to be that true cases were identified earlier and reported in January, brought forward by norovirus outbreaks and co-infections (many patients would not have been tested for c-dif if they didn't have symptoms, but due to norovrius symptoms, all patients tested immediately) The E-coli cases were all reviewed, and no new learning identified, main source –Urinary tract, and hepatobiliary.

Norovirus outbreaks continued, with 6 outbreaks in February, but significantly reduced impact , with sporadic cases only by the end of the month.

There were 2 Clostridium difficile cases, 17 cases of E.coli with no obvious linked cases, 1 case of Klebsiella and pseudomonas, 6 MSSA's and 0 MRSA's.
Currently the Trust has breached the end of year thresholds for C-dif, E-coli, and Pseudomonas, but remain under for Klebsiella and E-coli, there have been 3 MRSA bacteraemia's – against a 'zero' tolerance. As identified below the external thresholds for the year for E-Coli and C-dif were particularly challenging –with the C-dif threshold reducing by over 30% compared to the previous years threshold, over 10% lower for E-coli.
Currently, compared to last year, we are seeing higher rates of E-Coli, MRSA and C-dif, but lower rates of pseudomonas , MSSA and Klebsiella.

As well as norovirus the Trust saw some sporadic Flu and COVID in February but no outbreaks.

The healthcare associated infection (HCAI) objectives for 2025/26:

- C difficile 98 (145 in 2024/25)
- E. coli 141 (160 in 2024/25)
- Klebsiella 76 (77 in 2024/25)
- Pseudomonas 24 (24 in 2024/25)
- MSSA 83 (5% reduction on cases in 2024/25 at 87)
- MRSA zero tolerance

Quality and safety

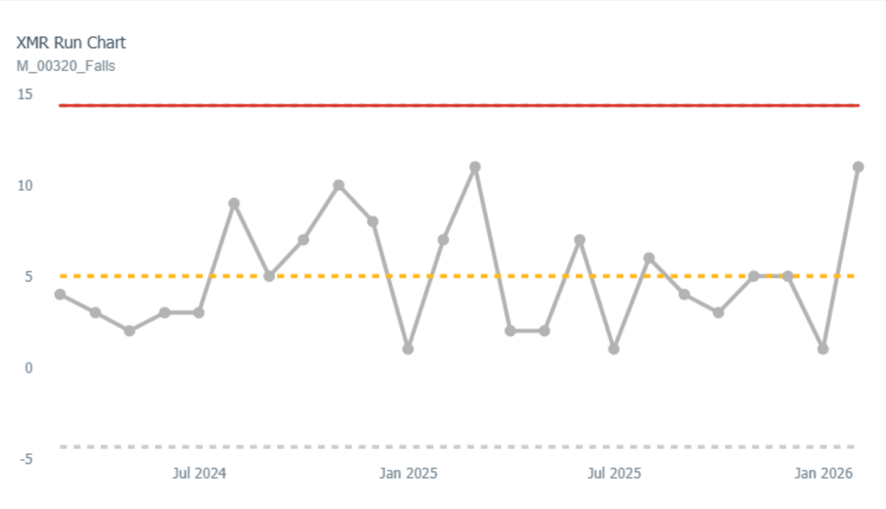
Safe Care

Patient Falls with Moderate or Above Harm Recorded

M | Feb 26

11

Timescale		Value	Target	Num	Denom
M | Mar-25		11	14	11	
M | Apr-25		2	14	2	
M | May-25		2	14	2	
M | Jun-25		7	14	7	
M | Jul-25		1	14	1	
M | Aug-25		6	14	6	
M | Sep-25		4	14	4	
M | Oct-25		3	14	3	
M | Nov-25		5	14	5	
M | Dec-25		5	14	5	
M | Jan-26		1	14	1	
M | Feb-26		11	14	11	



Common cause variation

Common cause - no significant change.

Inconsistent performance

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

Commentary

For the month beginning 01.02.2026 the latest Falls with Harm performance is 11 against a (6 Sigma Threshold) target of 14 (lower is better).

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
10% trajectory for reduction in falls for 2025/26 – 11 falls in February resulting in moderate and above harm. 9 moderate and 2 severe harm.	• In depth MDT review for falls in hot spot areas for February undertaken.	Falls Lead	April 2026	• Data analysis undertaken in respect of areas with increased fall rates. Meetings with matron and ADON for Kent ward held, action plan agreed for taking learning forward. Report to be delivered at Quality board by DCN.
	• Supporting clinical areas with actions within the Trust Wide Improvement Plan.	Falls lead	April 2026	• Specialised review with advice for patients who repeatedly fall. • Development of a Dynamic Risk Management Tool to support staff in real time practice in continuous assessment. • Deputy Chief Nursing Officer to ascertain which documents remain to avoid duplication. • DRMT to be taken through NMEC April to represent in view of introduction TW.
	• Themes discussed at Falls Stakeholder event, January 2026	Falls lead	April 2026	• New TWIP developed following MDT stakeholder event, being presented for approval at Falls Steering Group in March and FoCC in April.

Quality and safety

Safe Care

Falls with Harm; Actions Table

Falls with Harm (con't)

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Increase in falls resulting in low and no harm in ward areas where the focus is to encourage patients to sit out of bed and get moving.	• Co creation of a newly constituted 'patient care and deconditioning' working group. • Increase awareness of the risk of deconditioning- related falls	AHP Lead/Therapy Leads Trust Wide/ Falls Lead/ Manual Handling Lead	April 2026	• Patient Care and Deconditioning working group established, MDT Stakeholder event to be held 17th April 2026. We Care team to support improvement methodology. • Enablement bays across care groups having positive impact, we care projects improving functional movement post operative, plan to triangulate projects within the patient care and deconditioning model. • Break out group formed to review functional competency for mobility aids. Plan to incorporate into manual handling mandatory training for train the trainer model. Link workers to attend BHD. • Manual Handling team to revisit staff competencies in real time ward environment to support confidence with patient mobility assistance eg, sit to stand. • TOR and objectives to be agreed with AHP Lead and Therapies.
MASA risk assessments are not always fully completed in a timely manner.	• Falls dashboard to be created to include MASA completion, including time of medical reviews, radiology reports and status of clinician completing review.	Falls Lead	July 2026	• IT agreed and for Sunrise amendments, latest update regarding care plans delayed until July 2026.
	• Simplify the risk assessment process through triangulation of FOC services within one document to enable fluid streamline documentation into the risk assessment.	FOC lead nurses/IT sunrise	April 2026	• Meeting took place on the 2nd October 2025 between Sunrise team and FOC lead nurses. Sunrise advise a 6-month timeline due to other workstreams. Plan to discuss the relevant information being pulled into Drs notes. • Trialling risk assessment FOC workshop if successful to role out TW. • FOC champion identified across care groups first meeting to be held in March 2026.
	• Review white boards to create live boards for information and updated assessment information to be pulled through to the white board.	IT transformation team/Falls lead WDET	May 2026	• Second stake holder meeting held on 24th February 2026 plan to co create white boards trust wide with live information. ADON IIT proposed to be discussed at matrons forum to have an understanding of requirements for whiteboard icons. Further meeting awaited Date TBC. From IT ADON and Head of information and data.
Identified gap in knowledge regarding undertaking Dynamic Risk Assessments and redeployment of staff as patient's acuity and dependency changes during shift	• Implementation of the Dynamic risk assessment tool developed	Falls Lead/ADoN FoC/ADON WDET	April 2026	• Partial overlap of assessment tools and audits in place noted as a key issue. Plan to build on previous review undertaken by Associate Chief Nurse of nursing audit tool. • Nursing audit work to be agreed/confirmed prior to implementation. • DRMT to be taken back to NMEC April to agree timeline of a proposed role out.
	• DRMT to be accessed and completed digitally	Falls Lead/ADoN FoC/ADON WDET	March 2026	• DRMT currently in paper format discussed with ADON IT standalone document. Awaiting feedback as for discussion with CN. IT report waiting times for work streams, document will present as a standalone document for IT with priority. Need to ascertain which documents will be discontinued to avoid any duplication.

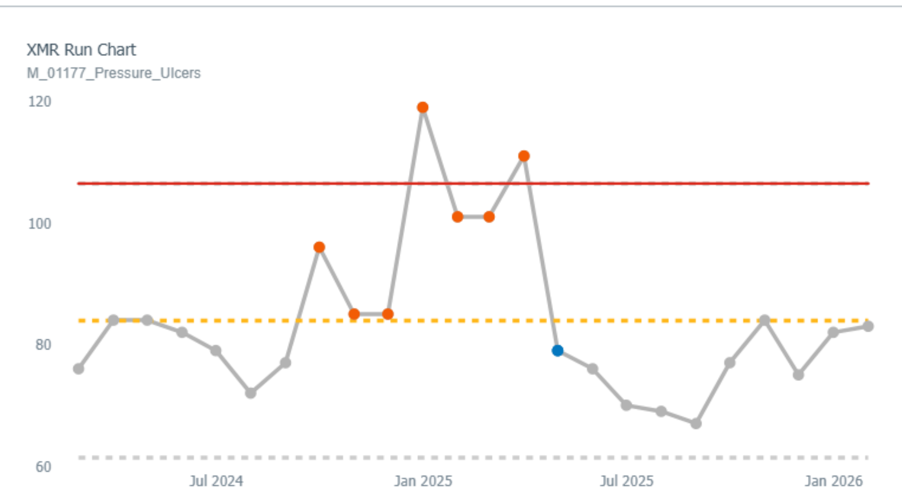
Quality and safety

Safe Care

Pressure Ulcers; Hospital Associated

M | Feb 26
83

Timescale		Value	Target	Num	Denom
M | Mar-25		101	106	101	
M | Apr-25		111	106	111	
M | May-25		79	106	79	
M | Jun-25		76	106	76	
M | Jul-25		70	106	70	
M | Aug-25		69	106	69	
M | Sep-25		67	106	67	
M | Oct-25		77	106	77	
M | Nov-25		84	106	84	
M | Dec-25		75	106	75	
M | Jan-26		82	106	82	
M | Feb-26		83	106	83	



Common cause variation

Common cause - no significant change.

Inconsistent performance

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

Commentary

For the month beginning 01.02.2026 the latest Pressure Ulcers performance is 83 against a (6 Sigma Threshold) target of 106 (lower is better).

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Known seasonal risk of increase in tissue viability incidents across winter months in hospital owing to increasing occupancy.	• Increased TVN presence in ED across winter months to support	Tissue Viability Lead	March 2026	• FoC team members regularly visit EDs to review care from a whole FoC lens.
	• Restructure of TV team to allow more site-based working, to include timely reviews in all clinical areas.	Tissue Viability Lead	April 2026	•First vacancy filled within TV team, current vacancy shortlisted but now on hold whilst moving through new QEIA process

Pressure Ulcers (con't)

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
The accuracy, completeness & dynamic nature of risk assessments remain critical challenges with a consistent theme in audits & incidence data demonstrating that risk assessments are incomplete or inaccurate leading to delayed pressure ulcer prevention strategies.	• A full documentation review is taking place with the Sunrise team to simplify & streamline the documentation process for all clinical staff. • Review the Risk assessment process on Sunrise to simplify & reduce duplication. • Simplify the risk assessment process through triangulation of FOC services within one document to enable fluid streamline documentation into the risk assessment. • To improve the compliance with risk assessment & SKINS bundle completion within Maternity.	TV lead/Chief Nursing Information Officer FOC Lead Nurse/Sunrise team Maternity Unit Managers/ TV Team	March 2026 April 2026 June 2026 June 2026	• Sunrise team advised work will take 6-months due to other workstreams. Also discussed the relevant information being pulled into Drs notes. • Met with Sunrise team to amalgamate PURPOSE T risk assessment into SKINS bundle, to reduce duplication, inconsistencies with risk assessment and to easily identify when review is required. • Ongoing discussions are being had with Sunrise teams, latest update regarding care plans delayed until April 2026. • Icon for PTL boards has been added to review list at part of rebuild of whiteboards by IT team. Discussion at recent working group was that it would be added to the agenda of the matron's forum to clarify the most useful icons on the whiteboard. • There is an increased focus on a multi-disciplinary risk assessment with increased discussion at huddles and handovers. Recent discussions at TV Stakeholder event regarding joint FoC risk assessment workshop, trial workshop arranged for 8/4/26 at WHH. • Maternity to transfer documents to Sunrise. • To arrange study sessions to update on the changes & support on the completion of the documents. Date extended due to current situation of TV team linked with staffing and workload demand.
Increased pressure damage noted due to long gaps in repositioning. Contributing to the development of unstageable and moderate harm pressure damage.	• To review the current provision of Hybrid mattresses trust wide • To review equipment to assist staff in repositioning complex patients, meaning fewer staff are required to reposition these patients appropriately . • Repositioning as a theme discussed at TV Stakeholder event, January 2026. • To reduce the risk of pressure ulcer development by preventing patient deconditioning.	Manual Handling & TV Leads Manual Handling Team Tissue Viability Team Associate Director of Therapy Services	August 2026 July 2026 April 2026 April 2026 April 2026	• Discussed at MDG working group, TV & Manual Handling leads to review current specification & to the proceed to tender. • Training and evaluating under way. Feedback is very positive, manual handling lead to seek assistance for funding. • Stakeholder event took place 14.1.26, new trust wide improvement plan to be approved at TVSG in March 2026 and at FoCC in April 2026. • Trust wide improvement plan has been circulated and to be finally approved at TVSG on 26/3/26. • Multi-disciplinary stakeholder event planned for 17th April 2026. We Care team have been asked to support with improvement methodology.

Quality and safety

Safe Care

Pressure Ulcers; Action Table

Pressure Ulcers (con't)

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Ineffective heel offloading continues to be a recurrent theme in the development of hospital acquired pressure ulcers.	• Trust wide heel offloading campaign as part of National Stop the Pressure Awareness week & Site based study days (Sept & Oct) to highlight appropriate offloading techniques.	Tissue Viability Team	April 2026	• Heel offloading compliance and technique to be captured in the annual tissue viability audit taking place 27th-29th April 2026. Question added to measure effectiveness of heel offloading.
	• To continue to raise awareness of the appropriate techniques for offloading heels	Tissue Viability Steering Group	April 2026	• Reviewing new guidance from EPUAP & NPIAP to align trust wide policy and best practice. • PAG asked to review current pillow supplier to provide a more effective product. Some samples available for TV team to review & feedback.
Medical device related pressure ulcers continue to be a recurrent theme trust wide.	• Provide a targeted approach based on learning from incidents involving face to face training in the appropriate clinical areas	Tissue Viability Team	April 2026	• Analysis of causative factors were presented at Tissue Viability Stakeholder event in January and an updated trust wide improvement plan has been developed to be presented at TVSG in March 2026. • Monitoring for reduction in MDRPU.
	• In response to an increased in nasal damage due to NG tubes, current securing devices being reviewed.	Procurement Assurance Group	April 2026	• New NG securing device being trialled in areas at QEQM & K&C. • TV team to work with industry to create QR codes on the management of medical devices. An initial meeting has been held with the Aspen representative who will lead a workshop at upcoming TV champion study day. • Information leaflets from other trust being reviewed & evaluated.
Missed opportunities for earlier skin inspection and escalation of pressure damage.	• Focus on reporting of category one damage. • ED working group to review initial skin inspection in Emergency Departments	Lead Tissue Viability Nurse	April 2026	• Newly updated TWIP includes action for matrons/ward managers to role model categorising of 1 & 2 pressure ulcers. • Virtual awareness workshops on Decision Tool completion & skin inspection to commence. • ED now have pressure ulcer risk assessment icon on tracker board to evidence early identification of risk.
	• TV team looking at individual actions from recent hospital acquired incidents for shared learning across the trust.	ED	July 2026	• Due to pressures in the ED Tissue Viability Team meeting with ED senior nurses in person.
	• Dynamic risk assessment to be developed to support staff with managing shift and mitigation	Falls Lead/ADoN FoC/ADON WDET	June 2026	• Tool to be digitalised meeting held with ADON IT plan for standalone document to be developed. In queue with IT.

Quality and safety

Safe Care

Patient Safety Incidents

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Patient Safety Incident Response (PSIR) Framework.	• Annual review of PSIRF policy approved and updated on Policy Centre completed • Patient safety training programme in place: PSIRF, Swarm, AAR, Incident Investigation, Engagement/Duty of Candour, Human Factors. • The Patient Safety Partners policy has been approved and is available on Policy Centre. One (1) post has been recruited to, with further applications having been received a second interview date will be scheduled for April to recruit to the second PSP post. • Training compliance with level 1 of the patient safety syllabus was 93.8% Trust wide in February, which is above the 85% KPI. Specialties that are non-compliant have been escalated to Care Group Triumvirates and QGBPs.	• Head of Patient Safety and Improvement .	30/03/2026	• Weekly report to Executives includes details of all learning responses. • Training Needs Analysis in place. A review of training content has been completed to align with the patient safety syllabus. Annual patient safety training content review due in April 2026. • Incident Investigation, Swarm, DoC and AAR training dates are available on to book on ESR • PSIRF Plan updated and has been published on the external Trust website along with the policy. • Duty of Candour (DoC) updated policy has been made available on Policy Centre in January. All template letters and resources have been updated.
Investigations commenced in February	PSII (Local): Delayed management of an acute ischemia of lower limb contributed to patients' death. Identified through learning from Deaths panel. AAR: Never event- Wrong site surgery. Needle inserted into wrong site for nerve block, however not injected as wrong location identified. Wrong site marking process, as marker intentionally marked opposite side so as not to affect sterile field. SEIPs Analysis: Never event- Retained epidural needle found under site dressing the day after surgery. AAR: A 70year old patient suffered a cardiac arrest whilst sat in the speciality waiting room (SPEC) overnight. Resuscitation unsuccessful. AAR: Vascular patient is in a side room, due to having c-diff and norovirus. Deterioration of patient not appropriately acted upon and patient died. Lack of recognition of the acute abdomen. AAR: Patient with a recent community acquired C.Diff attended due to infective COPD. Prolonged antibiotics and potentially inappropriate treatment led to recurrence of C.Dff and death.	• Head of Patient Safety and Improvement	15/05/2026	• Explore if there is an existing Acute Ischaemic Limb pathway. If not, one needs to be developed that encompasses ensuring when an acutely ischaemic limb is suspected by the ambulance crew the patient is transferred to K&CH and the vascular team directly for emergency management. • Review current Trust pathway, agreed with SECAmb, for ischaemic limb (to include timely transfer to appropriate site) • AAR to explore why stop before you block process not followed • Incident discussed at M&M and theatre huddles • Staff discussions completed and support provided • IRP: For SEIPs analysis with action plan to be signed off at LRAP • Anaesthetist attended and removed needle • Discussed in morning briefs, at audit day and M&M • IRP: For AAR, 12 weeks with LRAP sign off • All extra chairs found in SPEC removed. • Rapid huddle with ADoN, HoN and matron to establish facts of incident and formulate areas of interest to investigate. • Pre-IRP: For AAR, 12 weeks with LRAP sign off • Discussed at Vascular M&M • meeting with the POPS team to review the management of acutely unwell vascular patients. • Pre-IRP: AAR, 12 weeks with LRAP sign off. Highlighted at IRP. • IPC completed a rapid review however there were aspects of management as an outpatient not reviewed therefore for AAR to identify learning. • Linked complaint being managed via process

Quality and safety

Safe Care

Infection Prevention Control & Patient Privacy

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Themes and Trends from patient safety events		• Head of Patient Safety and Improvement	31/03/2026	
IPC processes across all sites to focus on the reduction of avoidable infections. Thresholds for 25/26 have challenging trajectories, with no more than 98 C. diff cases.		IPC Team	Ongoing and measured against monthly trajectories to achieve below 25/26-year end.	
Mixed sex breaches	• Work is continuing at QEQM and WHH to improve step down from critical care	• QEQM & WHH triumvirate	• April 2026	• System wide conversations are ongoing regarding removing 'exit block'

Quality and safety

Safe Care

Patient Experience; Friends & Family Test (FFT)

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
FFT ED: satisfaction levels remain below the Trust target of 90% satisfaction. Not all patients currently have their communication needs met	• All ED, AMU, SDEC and UTC staff to undertake the AIS e-learning • All ED, AMU, SDEC and UTC staff to learn to use the BSL video on demand service.	• Associate Directors of Nursing for UEAM at QEQM and WHH / Operational Managers	• By September 2026	**Benchmark data:** • UEAM staff who have completed AIS e-learning between 2021 and 2025: **8 (eight).** • Data on use of BSL video on demand in UEAM: No BSL video on demand used between April 2025 and end of December 2025. • **January 2026:** one BSL video remote interpreting at QEQM ED • **February 2026**: No BSL interpreting – neither video nor face to face
Patients' communication needs are not always shared by ED staff with the receiving ward / SDEC or when they are sent for a diagnostic test	• ED must add the patient's communication needs to Sunrise when the patient books in.	• Associate Directors of Nursing for UEAM at QEQM and WHH / Operational Managers	• By end of June 2026	**Benchmark:** Number of patients whose communication needs are recorded on Sunrise – 10,392 as of 1st December 2025
Limited use of telephone interpreters by ED (concerns that family are being used to interpret)	• Staff to be made aware of the importance of using interpreters, especially to gain consent, explain diagnosis and treatment. Patients' family / friends must not be used unless the issue the patient presents with is clinically urgent or life threatening.	• ED Managers with support from Trust interpreting lead	• By September 2026	**Benchmark data:** • Current level of use of interpreting in ED and UTC – from April 2025 to end of December 2025: WHH 279, QEQM 247, K&CH 115, Buckland 71. TOTAL: 698 interpreting sessions (spoken languages) • **Use in February 2026**: WHH -14, QEQM – 33, K&CH – 8, Buckland - 2
Care of patients in escalation areas increases the risk to patient safety and leads to a poor patient and carer/family experience	• Patients in escalation areas receive adequate food and drink, including having their dietary needs met.	• ED Matrons and senior nurses	• By June 2026	**Benchmark data:** • Food and drink: 64 positive comments (55%) and 53 negative comments (45%) in FFT for Jan/Feb 2026. • FFT comments about corridor care: 6 positive comments (18%) and 27 negative comments (82%) in Jan/Feb 2026.
	• Carers / family say they were sign-posted to the Carers Support Hospital Service. • Carers were offered the Carers Leaflet.	• Assoc Directors of Nursing for UEAM / Heads of Nursing, plus, ED teams to signpost to support for carers	• July 2026	**Benchmark data: New question to be added to the carers survey.**

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Quality and safety

Safe Care

Patient Experience; Friends & Family Test (FFT)

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Inpatient care: Patients are able to get meals that meet their dietary and cultural needs.	• Patient feedback via our in-house inpatient survey shows an improvement in patients saying their dietary and cultural needs are being met. From 77% (CQC inpatient survey 2024) to 85% by March 2027.	• Directors of Nursing / Associate Directors of Nursing	• By end of March 2027	Inpatient Survey: as of end of February 2026: 86% of patients who had their dietary needs had these; 83% K&C, 81% QEQM, 97% WHH
	• Improved score in next CQC adult inpatient survey	• Directors of Nursing / Associate Directors of Nursing	• September 2026	**TBC**
Patients say they were involved in decisions about their care and treatment	• Improve the use of shared decision-making tools (e.g. BRAN) – evidence of use in five specialisms (clinical audit)	• Care Group Medical Directors • Audit team	• December 2026	Results of 2024 survey shared with site senior nursing teams, along with areas requiring improvement.
	• Develop a training package for doctors on shared decision making and pilot	• Medical Education team / Patient Voice and Involvement	• End of June 2026	**Not started yet**
Patients / carers say the carer / family were involved in the discharge of their loved one	**Implement the NHSE Carers and Hospital Discharge toolkit:** • Establish a task and finish group	• Deputy COO / Associate Director of Patient Experience / Heads of Nursing / Ward staff	• February 2026	**Not started yet**
	• FFT additional question	• Lead for Patient Voice and Involvement	• April 2026	Initial discussion with Deputy COO and ADofPE taken place and DoNs asked for information on any checklists currently in use. No information received to date.
	• Carers survey promoted by ward staff and through social media / posters	• Matrons / Ward Managers / Communications team	• From April to November 2026	**Not started yet**
Patients say that their communication needs were met whilst in hospital	• Roll out 'What Matters to me' communication posters behind patient beds on each site.	• Associate Directors of Nursing across the three sites / Lead for Patient Voice and Involvement	• February to April 2026	Start delayed due to lack of resources to print posters and to distribute.
Patients say their spiritual needs were met whilst they are an inpatient	• Ward Accreditation audits • CQC inpatient survey 2025 / inhouse inpatient survey	• QIWA team • Patient Voice and Involvement team	• September 2026	**Benchmark data from Trust inpatient survey:** 41% of patients with spiritual needs said these needs were met as an inpatient; 36% K&C, 33% QEQM, 63% WHH
	• Chaplaincy service profile and data on patient contacts	• Chaplaincy team	• Six-month report to Patient Exp Cttee	**Due in May and November 2026**

Quality and safety

Safe Care

Safe Staffing

Staff Type	Vacancy Rate Feb 26 (Target 10%)	Sickness Rate Feb 26 (Target 5%)	Safe Care Red Flags Feb 26
Registered Nursing & Midwifery	2.1%	5.49%	
Registered Nursing Associate	N/A	N/A	539
Health Care Support Worker	%	N/A	

Staff Type	Care Hours Per Patient Day (CHPPD) Feb 26	Avg Fill Rate Day Feb 26	Avg Fill Rate Night Feb 26
Registered Nursing & Midwifery	6.1	85%	93%
Registered Nursing Associate	0.1	100%	100%
Health Care Support Worker	2.8	76%	100%

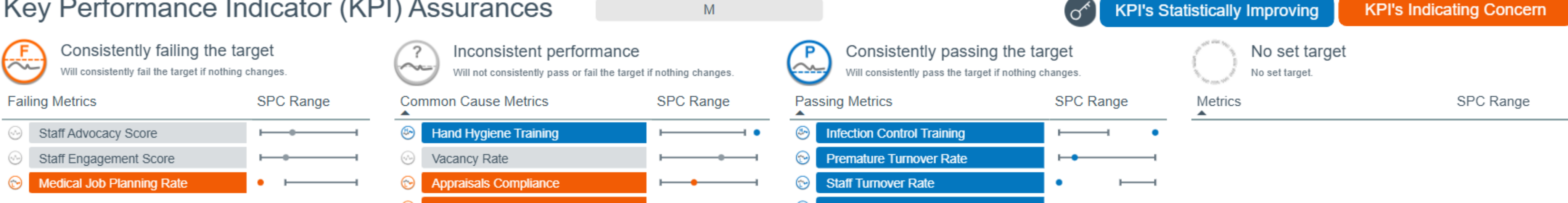
Safe Staffing:

CHPPD is calculated by dividing the number of actual nursing (both registered and HCSW) hours by the number of patients on the ward at 23:59; this advises of the 'nursing' or care hours that are available to each patient per day.

The average fill rates for February 2026 are still at an acceptable level overall. Staff are redeployed across the sites daily to mitigate staffing based on dynamic risk assessment of patient acuity and dependency levels, with ward managers working clinically as required. Operational meetings are held throughout the day to support safe staffing levels. St Augustine's QEQM remains closed with staff being redeployed to other areas to provide support and mitigate staffing shortfalls. Invicta continues to see fluctuating elective electivity and Mount McMaster continues to see fluctuating bed occupancy and patient acuity. Cambridge K has seen a change in function to a short stay frailty ward, with the frailty assessment unit also relocated to this area. Bishopstone had previously removed the escalation beds, reducing the bed base to 22 beds from 24 beds.

Several areas did work on amber shifts, as defined within our organisation. There were three red shifts; ED QEQM (2.5hrs night shift & 2hrs day shift) and Quex QEQM (12.5hrs day shift). Shift review meetings were completed to recognise real time escalation and to support ongoing learning.

People



Understanding the Data

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

People

Scorecard View

Workforce Metrics

Key Performance Indicator (KPI)	Value	Ranges
Sickness FILTER: TOTAL RP07218 M_00874_Sickness Updated: 13/03/2026 09:42	M | Feb 26 **5.2%** Num: 13.3K Denom: 256.7K	UCL: 5.4% Mean: 4.9% LCL: 4.3% Targ: 5.0%
Vacancy Rate FILTER: TOTAL RP07218 M_00872_Vacancy_Rate Updated: 13/03/2026 07:59	M | Feb 26 **9.3%** Num: 938.5 Denom: 10.1K	UCL: 10.2% Mean: 9.0% LCL: 7.8% Targ: 10.0%
Staff Turnover Rate FILTER: TOTAL RP07218 M_00240_Staff_Turnover_Rate Updated: 13/03/2026 12:03	M | Feb 26 **6.4%** Num: 549.8 Denom: 8.5K	UCL: 8.4% Mean: 8.0% LCL: 7.7% Targ: 10.0%
Premature Turnover Rate FILTER: TOTAL RP07218 M_00240_Premature_Turnover Updated: 13/03/2026 12:03	M | Feb 26 **13.1%** Num: 109.6 Denom: 838.3	UCL: 14.5% Mean: 13.7% LCL: 12.8% Targ: 25.0%
Appraisals Compliance FILTER: TOTAL RP07218 M_00127_Appraisals_Completed Updated: 13/03/2026 10:23	M | Feb 26 **76.5%** Num: 6K Denom: 8K	UCL: 80.3% Mean: 77.4% LCL: 74.5% Targ: 80.0%
Staff Engagement Score FILTER: TOTAL RP07218 M_01146_Staff_Engagement Updated: 13/03/2026 09:10	M | Feb 26 **5.88**	UCL: 6.27 Mean: 6.01 LCL: 5.74 Targ: 6.80
Staff Advocacy Score FILTER: TOTAL RP07218 M_01146_Staff_Advocacy Updated: 13/03/2026 09:10	M | Feb 26 **5.34**	UCL: 5.75 Mean: 5.44 LCL: 5.14 Targ: 6.70
Statutory Training FILTER: TOTAL RP07218 M_00411_Statutory_Training_Compliance Updated: 13/03/2026 11:59	M | Feb 26 **93.8%** Num: 73K Denom: 78K	UCL: 93.4% Mean: 92.9% LCL: 92.5% Targ: 91.0%
Infection Control Training FILTER: TOTAL RP07218 M_00411_Infection_Control Updated: 13/03/2026 11:59	M | Feb 26 **95.4%** Num: 9K Denom: 10K	UCL: 94.2% Mean: 93.5% LCL: 92.8% Targ: 90.0%
Hand Hygiene Training FILTER: TOTAL RP07218 M_01176_Hand_Hygiene Updated: 13/03/2026 12:48	M | Feb 26 **90.5%** Num: 6K Denom: 7K	UCL: 89.7% Mean: 86.7% LCL: 83.8% Targ: 85.0%
Medical Job Planning Rate FILTER: TOTAL RP07218 M_01311_Job_Planning Updated: 12/03/2026 11:04	M | Feb 26 **0.3%** Num: 2 Denom: 755	UCL: 55.8% Mean: 35.2% LCL: 14.6% Targ: 90.0%

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People

Executive Summary

Workforce Metrics & Statutory Training

Sickness absence has reduced again, falling from 5.28% to **5.20%**, with a significant easing in overall sickness activity. Episodes dropped to **2,080** (from 2,455), affecting 1,935 colleagues compared with 2,337 last month. The rolling 12-month average is now 4.93%, continuing its gradual downward trend. Seasonal illness continues to drive the profile, though volumes have fallen. Cough, cold and flu episodes fell to 564 (from 817), and gastrointestinal illness reduced to 368 (from 405). Stress, anxiety, depression-related absence also declined, albeit more subtly, to 251 episodes from 265. The long-term to short-term ratio remains stable at 55:45. The highest levels of sickness absence were seen in Care Group Operations Management QEQM (21.26%) and Risk, Governance and Patient Safety (16.93%). Across care groups, rates range from 2.51% in Strategy & Partnerships to 5.83% in CCASS, with DCB (5.72%) and WCYP (5.64%) remaining above threshold. Overall, winter-related pressures are beginning to ease, though pressures linked to mental health remain a consistent feature of the profile.

The vacancy rate has improved slightly to **9.3%** (from 9.4%), with 939 vacancies reported in February. This reflects a subtle improvement and continued plateauing since December, following the sustained rises seen through 2025. Care group vacancy rates range from 5.9% in Strategy & Partnerships and 6.0% at QEQM to 13.3% in KCRVH, the highest rate. The largest volume of vacancies remains in DCB (220). By staff group, the highest volumes sit within Additional Professional, Scientific & Technical (528) and Admin & Clerical (223) roles. The vacancy profile continues to be dominated by hands-on clinical roles, with 835 vacancies at Band 2, 231 at Band 4 and 132 at Band 6, indicating emerging pressure at supervisory level. There are also 58 medical and dental consultant vacancies, signalling key gaps in senior clinical leadership and service delivery. Alongside the headline figure, the 'true' vacancy position – which accounts for vacancies, offers and starters, is 425. This reflects areas where we are over-established, most notably at Band 3, where we are 369 WTE above establishment. This provides a more accurate view of underlying workforce gaps and highlights where establishment and workforce supply are not yet aligned.

Turnover has reduced again to **6.4%** (6.43%), down from 6.55% last month, with 550 leavers over the past 12 months. Rates range from 3.8% in Strategy & Partnerships to 8.4% in Corporate Services, reflecting the continued impact of organisational change. The highest volume of leavers remains in DCB (148). By staff group, turnover includes 143 staff nurses, equating to 145 total Band 5 leavers, and 108 Band 3 leavers, consistent with the transient nature of some early-career roles. The most common reason for leaving continues to be relocation (168 leavers), which reflects both the challenge of our peninsula geography and the ongoing impact of staff experience on retention. Premature turnover has improved slightly to 13.1% (from 13.2%). Nursing turnover stands at 6.4%, broadly consistent with last month's 6.3%. The financial exposure remains significant. If turnover were to return to the 10% threshold, the Trust faces a £3.5m risk envelope, reinforcing the link between staff experience, leadership investment and financial sustainability.

Appraisal compliance remains broadly unchanged at **76.5%** (76.6% last month), leaving the Trust 3.5% below the 80% threshold. There are 1,766 outstanding appraisals, with a further 223 due next month. Compliance ranges from 59.0% in Strategy & Partnerships to 79.6% at WHH, with no care group currently at threshold. Outstanding activity remains concentrated in Nursing and Midwifery (641) and Admin & Clerical (583), reflecting both scale and operational pressures.

Statutory training compliance is **93.8%**, a slight decrease from 94.0%. Over the past 12 months 73,072 courses have been completed, with 4,838 outstanding. Rates range from 92.1% in KCRVH to 94.7% in Strategy & Partnerships. The lowest-compliance module remains Safeguarding Children at 90.4%, though improved from 89.8% last month, with outstanding activity concentrated in QEQM Theatres (130).

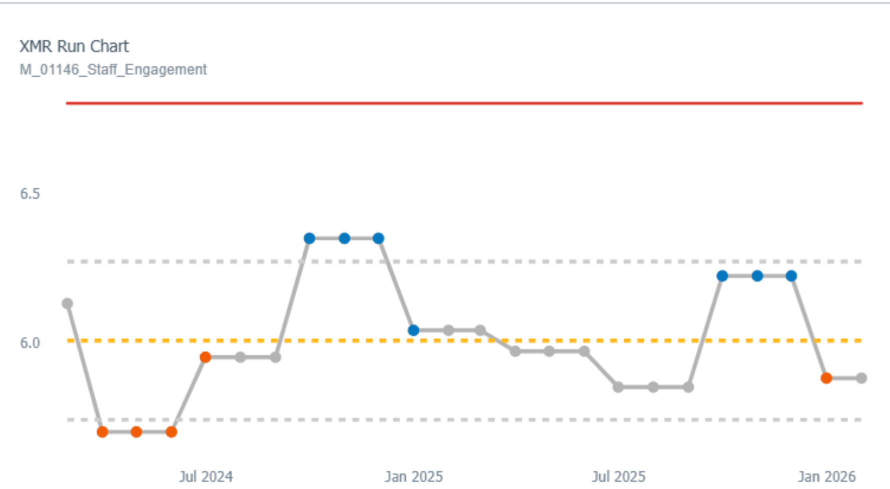
People

Integrated Improvement Plan (IIP)

Staff Engagement Score

M | Feb 26
5.88

Timescale	Value	Target	Num	Denom
M | Mar-25	6.04	6.80	6	
M | Apr-25	5.97	6.80	6	
M | May-25	5.97	6.80	6	
M | Jun-25	5.97	6.80	6	
M | Jul-25	5.85	6.80	6	
M | Aug-25	5.85	6.80	6	
M | Sep-25	5.85	6.80	6	
M | Oct-25	6.22	6.80	6	
M | Nov-25	6.22	6.80	6	
M | Dec-25	6.22	6.80	6	
M | Jan-26	5.88	6.80	6	
M | Feb-26	5.88	6.80	6	



Common cause variation

Common cause - no significant change.

Consistently failing the target

Will consistently fail the target if nothing changes.

Commentary

For the month beginning 01.02.2026 the latest Staff Engagement Score performance is 5.88 against a static target of 6.80 (higher is better).

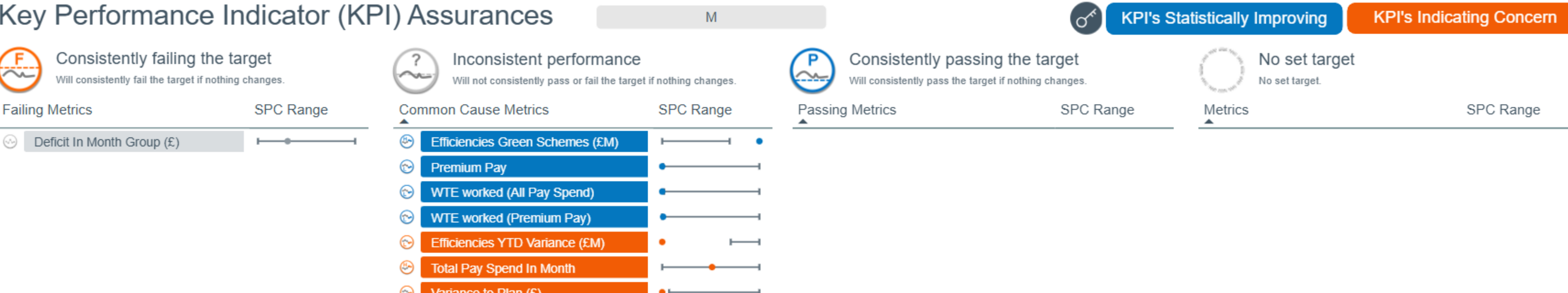
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Staff Engagement levels (6.22) are below the national average (6.71).	• Priorities identified through NSS have been acted on, with a wide variety of actions initiated	Head of Culture & Inclusion	End Sept 26	• The latest results indicate that staff engagement has deteriorated, following a downward trend over the past five years. Results show a more pronounced decline this year, reinforcing the need for a coordinated Trust response. • Findings have shaped proposed Trust-wide actions that centre around the importance of leadership, team climate and personal/ professional development as core determinants of the staff experience. • Eliminating corridor care and ensuring dignified care sits at the heart of plans to make the Trust somewhere staff feel proud to work, with care groups encouraged to identify their role in driving this forward.
Actions/ interventions initiated to improve staff engagement	• Activity taking place across People & Culture Strategy delivery plans and local Care Group people plans	Head of Culture & Inclusion	End Sept 26	• Results have been shared with EMT, TMC, P&CC along with Care Group leadership triumvirates. Care Groups are being provided with data packs and our organisational response has been drafted. The corporate focus centres around better leadership, stronger teams and kinder people. Care Groups are being provided with suggested areas of focus, and encouraged to explore 1-2 specific themes along with services, wards or departments that have expressed significant concerns. They are also encouraged to celebrate and learn from the 61 areas that exceed the national standard.
2025 NHS Staff Survey	• Driving response rates across the 2025 NSS is key to improving engagement and the credibility of results	Head of Culture & Inclusion	End Nov 25	• **Action Closed.** This action is now closed, with the survey achieving a majority response rate (53%) and the second-highest participation in the Trust's history (*n* = 5,379). The sample is representative, credible and reflects strong engagement from staff across all care groups, staff groups and areas. Our focus has now shifted to synthesising what almost 5,500 colleagues told us, and drafting an evidence-based, person-centred plan that will underpin our response.

People Integrated Improvement Plan (IIP)

Workforce Metrics

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Ensuring vacancy rate remains below the Trust threshold of 10%.	• Monthly monitoring of vacancies across Care Groups, ensuring that active recruitment is taking place. • Focus on hard to recruit areas and supporting new ways of working to reduce reliance on temporary staffing.	Heads of P&C P&CBPs	• Ongoing	• HCSW vacancies improving following the B2 to B3 uplift. • Working with Finance, Temporary Staffing and the CMO office to target areas of long-term and high-cost medical agency, and alternative ways of working. • Vacancies in maternity are at **7.6%** following the recruitment of student midwives and other positive recruitment.
Keeping Anxiety & Stress related absence to a minimum, and below 15% of all absences.	• Support from Health & Wellbeing Team and Occ Health to focus on areas of high stress related sickness. Improved Return To Work interviews to support intervention.	Heads of P&C, P&CBPs, OH	• Ongoing	• **3,895** face to face counselling sessions have been delivered to-date to 885 individual. 85% of staff demonstrated clinically reliable improvement, improving CORE-OM scores by 4.19 points – from 16.40 (moderate clinical distress) to 12.21 (mild non-clinical). The counselling service will continue, albeit in a reduced capacity following reduced funding from Charitable Funds Committee.
Maintaining **Staff Turnover** against a gold standard of 10%	• Improving HCSW, Nurse & Premature retention which are the main contributors to overall turnover	Head of Culture & Inclusion	• Ongoing	• Staff Turnover remains below 10% (**6.4%**) and has achieved the gold standard (10%) for over a year. It is currently at the lowest rate the Trust has seen in 2 years. While the overall trend is encouraging, we remain mindful that the current economic climate may be artificially suppressing movement – and that if conditions shift, turnover could rise more sharply.
Update calculation used to denote premature turnover as acutely sensitive to improvements in total turnover	• New method of calculation agreed bringing PT in-line with other methods of measure & reducing sensitivity to wider improvements	Head of Culture & Inclusion	• Complete	• Premature turnover (**13.1%**) remains stable, inflecting upwards slightly month-on-month, though this is more a result of reduced overall turnover than any material change in new starter turnover.
Staff Engagement levels (5.85) are below the national average (6.78)	• Priorities identified through NSS have been acted on, with a wide variety of actions initiated. • Focus on improving engagement and response rate for 2025 staff survey.	Head of Culture & Inclusion	• Dec 26	• Staff survey results indicate that staff engagement and experience have continued to deteriorate, following a downward trend over the past five years. Our organisational response has been proposed to TMC and P&CC in March following the embargo lifting. Care groups are being provided with data packs to support their local activity.
Medical staff levels of statutory training compliance are consistently low at an average of 75%. Has been below 80% for 4 years.	• Identifying those staff who are not compliant, and working with GMs and Clinical Leads to address compliance. • Care Groups contacting individuals directly to support improvement of compliance, particularly with trainee doctors.	CMO	• Dec 25	• Compliance for medical staff has reached **89.0%** - the highest level in the past 18 months and now within touching distance of the required threshold for the first time in years. All Care Groups are targeting improvement within medical staff compliance – with compliance lowest in the Corporate Care Group (77.8%).

Sustainability



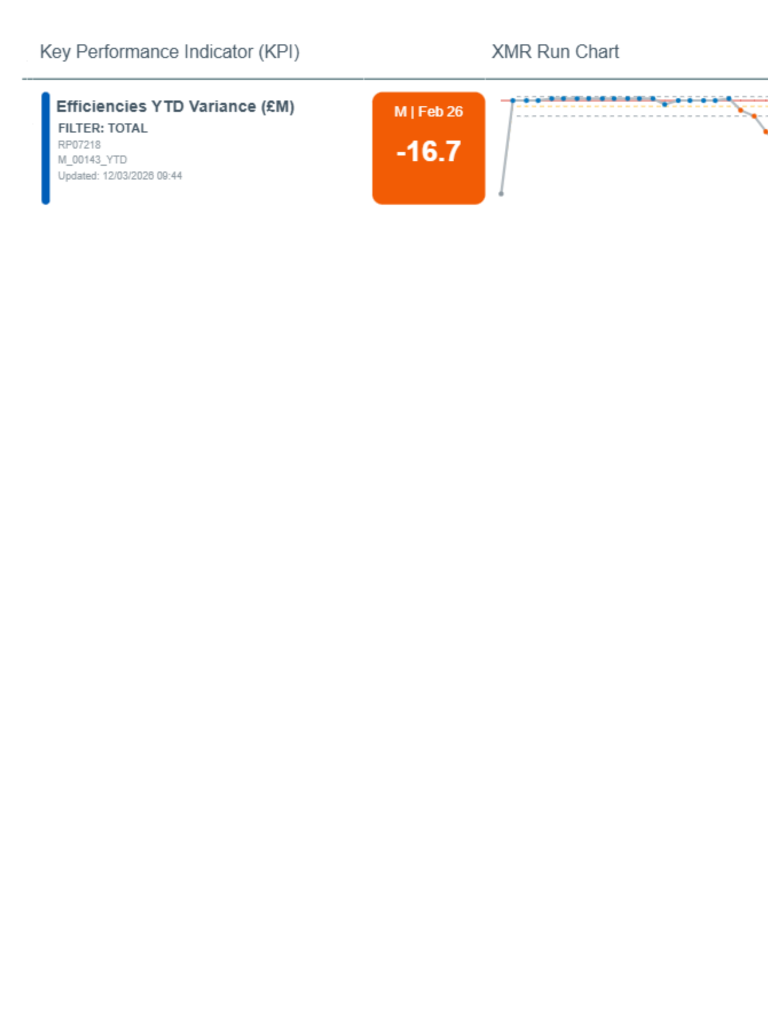
Understanding the Data

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

Sustainability

Scorecard View

Financial Metrics



Executive Summary

Financial Position

The month 11 YTD position achieved by the Group (Pre deficit support funding) was a £77.3m deficit; £14.4m adverse to plan. This is predominantly due to CIP under-delivery, following the step up in the CIP target in the second half of the year.

As at month 11, the Trust is £11.7m adverse to plan (Pre deficit support funding).

The Trust's income from patient care is £15.9m higher than plan YTD. This is predominantly driven by additional Specialised Commissioning income for Elective Recovery Fund (ERF) performance (£3.4m), prior year ERF (£2.9m), prior year high cost drugs (£1.9m) and over performance on rechargeable high cost drugs and devices (£6.0m).

Trust other operating income is £0.3m favourable to plan YTD. Above plan income for education and training of £2.0m is offset by below plan income for car parking and non-patient care services totalling £1.7m.

Trust employee expenses are £18.5m adverse to plan YTD. Substantive staffing is £9.3m adverse YTD, and temporary staffing costs £9.3m adverse YTD. There was a stepped increase in the CIP target in the second half of the year, which is not currently being delivered.

Other operating expenses are £12.7m adverse to plan YTD, predominantly driven by overspends in general supplies and services, premises and drugs, partly offset by underspends in clinical supplies and services, purchase of healthcare, clinical negligence and consultancy.

To note Post deficit support funding, the Group is £33.6m adverse to plan YTD. DSF has been withdrawn from K&M ICS for Quarters 3 and 4 (£23.0m impact for the Trust). This had an adverse impact of £3.8m in month and £19.2m YTD.

The year end forecast, as submitted to NHS England on 08/01/26, is a £47.4m year end deficit; £40.8m deficit to plan. The 2 key drivers being CIP under-delivery and loss of DSF (excluding DSF, £17.8m deficit to plan). The revised forecast for month 11 was achieved in month.

Sustainability

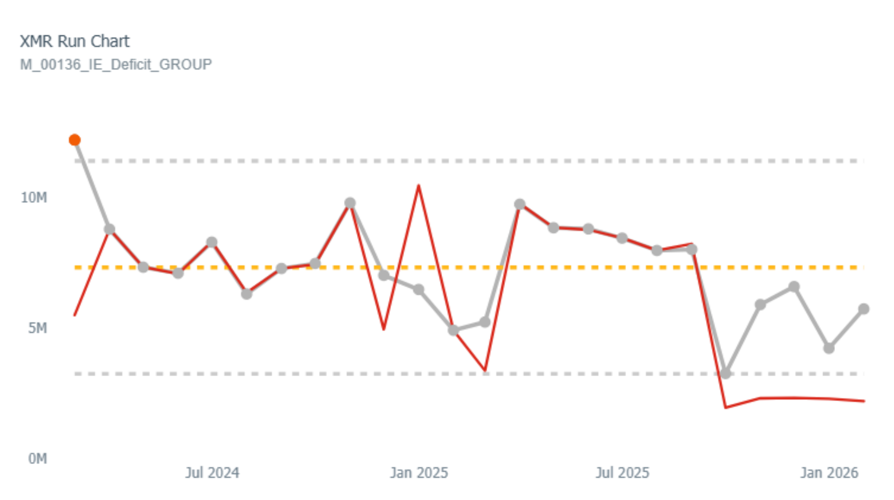
Financial Measures

Income & Expenditure Monthly Deficit (Group)

M | Feb 26

5.7M

Timescale		Value	Target	Num	Denom
M | Mar-25		5.2M	3.3M	5.21M	
M | Apr-25		9.7M	9.7M	9.73M	
M | May-25		8.8M	8.8M	8.82M	
M | Jun-25		8.8M	8.7M	8.78M	
M | Jul-25		8.4M	8.4M	8.42M	
M | Aug-25		7.9M	8.0M	7.95M	
M | Sep-25		8.0M	8.2M	7.99M	
M | Oct-25		3.2M	1.9M	3.23M	
M | Nov-25		5.9M	2.3M	5.88M	
M | Dec-25		6.6M	2.3M	6.57M	
M | Jan-26		4.2M	2.3M	4.20M	
M | Feb-26		5.7M	2.2M	5.71M	



Common cause variation

Common cause - no significant change.

Consistently failing the target

Will consistently fail the target if nothing changes.

Commentary

For the month beginning 01.02.2026 the latest Deficit In Month Group (£) performance is 5.7M against a Trajectory target of 2.2M (lower is better).

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Achievement of financial plan for 25/26	• Achievement of a revised £47.4m year end deficit; £40.8m deficit to plan (as advised to NHS England on 8th January 2026 as part of the NHSE Financial protocol for reforecasting). • A revised CIP delivery of £60m is needed (as part of delivering the revised yearend revenue re-forecast).	• Theme leads • PMO	• On-going	• As at month 11 the Group's financial position (excluding DSF) is adverse to plan by £14.4m YTD. • The year end forecast, as submitted to NHS England 08/01/26, is a £47.4m year end deficit; £40.8m deficit to plan. The 2 key drivers being CIP under-delivery and loss of DSF (excluding DSF, £17.8m deficit to plan). • The revised forecast for month 11 was achieved in month. Work is continuing with the Care Groups and Corporate areas to deliver the reforecast with a monthly line by line analysis and escalation to Executive Sponsors • Regular COO and CFO led meetings with Care Groups on financial delivery are in place since November, focusing on specific areas of delivery to reduce our run-rate expenditure, identifying variances to plan and implementing mitigations, and maintaining close alignment between operational and financial performance requirements. Trust-wide communications on Grip and Control requirements was circulated mid-November. • Increased levels of reporting are being requested from NHSE including reporting greater level of CIP delivery, workforce triangulation and underlying run rate data.

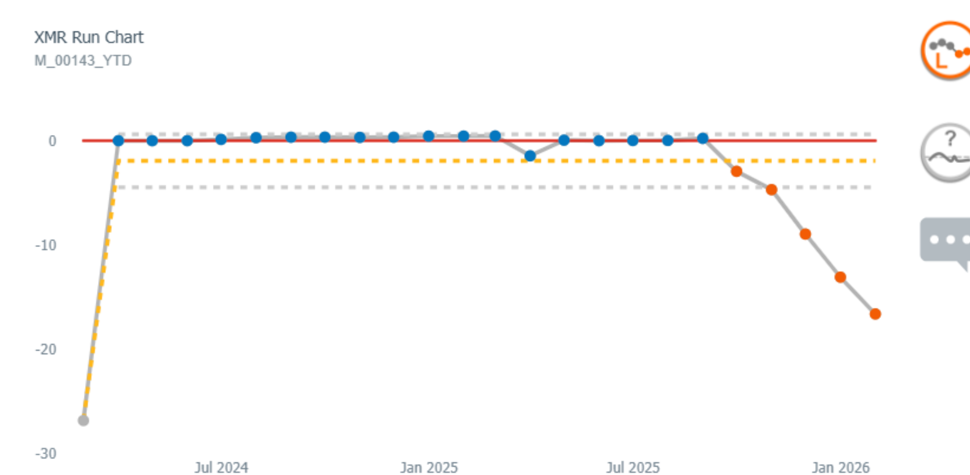
Sustainability

Financial Measures

Financial Efficiencies; YTD Variance

M | Feb 26
-16.7

Timescale	Value	Target	Num	Denom
M | Mar-25	0.5	0.0		
M | Apr-25	-1.5	0.0	-1	
M | May-25	0.0	0.0		
M | Jun-25	0.0	0.0		
M | Jul-25	0.0	0.0		
M | Aug-25	0.0	0.0		
M | Sep-25	0.2	0.0		
M | Oct-25	-2.9	0.0	-3	
M | Nov-25	-4.7	0.0	-5	
M | Dec-25	-9.0	0.0	-9	
M | Jan-26	-13.1	0.0	-13	
M | Feb-26	-16.7	0.0	-17	



Special cause variation

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

Inconsistent performance

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

Commentary

For the month beginning 01.02.2026 the latest Efficiencies YTD Variance (£M) performance is -16.7 against a static target of 0.0 (higher is better).

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Ensure identification of CIP opportunities sufficient to reach the required £80m cash out, recurrent CIP target for 2025/26 To note – this has been revised to £60m CIP delivery in-year as part of the year end I&E reforecast submitted to NHSE 08/01/26.	• New substantive Director of Financial Sustainability in post 1st September. • Resourcing to support in-year delivery identified	Financial Sustainability Director	• On-going	• YTD, £53.3m has been delivered, of which YTD 59% recurrent: 41% non-recurrent split (the target is 75% recurrent) • The revised CIP forecast for month 11 was achieved in month • Emerging risks to delivery of the year end £60m CIP delivery are being regularly tracked.
Ensuring robust CIP reporting of achievement	• Streamlined reporting process • Robust CIP Methodology	Financial Sustainability Director	• On-going	• CIP Methodology defined • CIP reporting process streamlined • Internal audit on Efficiencies commenced Sept'25 and recommendations shared • PMO has transitioned to the Finance team as of the 1st Dec'25 to strengthen alignment of financial management and project delivery • Analysis of lessons learned for CIP in 25/26 has been completed and shared at FPC • Review of Grip and Control measures has been completed and shared at FPC • Further infrastructure to support CIP delivery has been agreed and is being mobilised.

Sustainability

Financial Measures

Agency & Temporary Workforce Spend

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
The Temporary Workforce team are finding it challenging to swap out high pay premium medical workers and/or negotiate alternative terms, such as becoming Direct Engagement (DE). Many of the high cost agency have been working with the Trust long term and embedded in the organisation.	• The Temporary Workforce/MTW team are meeting with each Care Group following the change to the agency managed service in December 2025. Working with the CMO, Managing Directors and Medical Directors to highlight the issues and gain support to reduce premium pay workers. • Need to increase DE workers, making the savings on VAT payments.	CPO	Ongoing	• Agency spend continues to reduce across all staff groups, with the largest decrease in AfC, down 29% in December 2025. • Joint sessions held with the MTW team and NHSP, CG MDs, Temp Workforce and PMO to review agency usage, agree exit plans and discuss recruitment plans following the transition to Patchwork agency manager in December 2025. The number of active agency locums has increased to 58. All agency locums to be reviewed with exit plans to be agreed. • Monthly meetings are now scheduled with all Care Groups. The MTW team and currently undertaking a review of current rates paid against the rate caps and discuss plans to reduce these to improve our compliance. • Our DE throughput decreased in December 2025 to 89%. This was partly due to the transition away from the ID Medical managed service and it is expected that this will return to 95% once all bookings have fully migrated. Plans are now in place to remove/replace the long-term standard placement locums. We now have four standard placement locums remaining with exit plans agreed. • Notice was served for 7x long-term agency locums in December who are looking to migrate to the bank. This is due to be completed in January, taking the total to 40 for the financial year to date. • New agreed processes are now in place following the transition to Patchwork agency manager. • Bank and Agency trackers tools shared with CG's; to be monitored weekly and monthly via PMO and CG finance meetings. • March 26 – Agency continues to reduce.
Agency management across the South East NHS Region means disparity across Kent and Medway Trusts for AfC rates.	• Sign up to the Kent and Medway Collaborative AFC Rate Card • Areas above cap to work with Temp Staffing & South East Temp Staffing Collaborative team to reduce inline with stepping down timescales.	CPO	•Ongoing	• Agency Hours (all staff groups) continued to see a decrease in December 2025, down 68% when compared to April 2025. Overall medical agency hours also continue to reduce in line with exit plans (down 67% compared to April 2025). • A new AfC rate card (agency) was implemented on the 1st April 2025. The only areas above the new caps are Maternity and Paediatrics. A plan is now in place to remove all agency usage (AfC). This has led to a number of agency staff migrating to the bank, with a further 4 joining in December 2025. • The South East Temporary Staffing Programme has published their next step down rates for both agencies and bank. These have now been approved and were implemented in October 2025. • On the 1st March 2025, the Trust implemented a restriction on the use of agency staff for bands 2 and 3. Agency hours (AfC bands 2-3) has reduced 100% since this was implemented. • Working with the ICB, a number of new controls/processes have been implemented to support controlling overall demand and reduce our reliance on agencies. This will also support the Trust in achieving our objectives in relation to the workforce CIP schemes. We are now looking to implement similar controls for the bank. • The Next stage of AFC rate card step down was applied in October 2025. • Weekly meeting with the Care Groups and NHSP and MTW. ICB are handing over the project to align AFC bank rates to the South East Temp Collaborate • April will see K&M Trust's all moving to the lowest level rate card across the region.

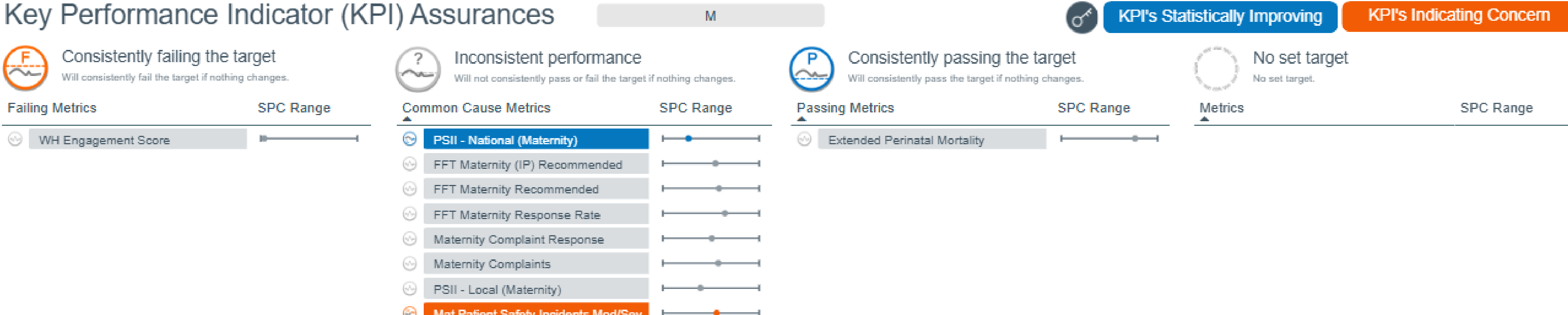
Sustainability

Financial Measures

Agency & Temporary Workforce Spend

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Agency management across the South East NHS Region means disparity across Kent and Medway Trusts for Medical rates.	• Sign up to the Kent and Medway Collaborative Medical Rate Card • Areas above cap to work with the Temp Staffing team & South East Temp Staffing Collaborative team to reduce inline with stepping down timescales. • Regular meetings now held across the collaborative to current issues as we worked towards rate parity across the region.	CPO	•Ongoing	• Temp Staffing, PMO & South East Collaboration; monthly meetings scheduled, to progress and implement actions against CIPs. • To date, we have successfully reduced the hourly rates of 30 long-term agency locums. Plans are now being established ahead of the transition to the new service. • As a result of tighter controls, a number of agency locums are now considering migrating to the bank or joining the Trust substantively. 7x agency locums and 4x AfC agency staff served notice in December with their transition to the bank to be completed in January. A further 6x agency locums and 5x AfC agency staff are currently starting the application process. • Agreed exit plans discussed and in place for the majority of the remaining agency locums. Regular meetings are continuing, now being led by the MTW team following their implementation in December 2025. • A regional meeting was held with the South East Collaborative to review the current bank position with the intention of aligning our rate cards. When reviewing our medical rate card, only the Consultant rate was above the new cap. Analysis has now been completed and should the consultant rate be reduced to the new cap, this would save the Trust approximately £33k per month. • Plans are also now being established to reduce our bank rates (medical), which contributes an additional spend of approximately £130k per month. • CMO signing off communications to reduce medical bank rates by 5 per hour on escalated rates, with reviews every 4 weeks until rate card ceiling is met. Due to be implemented beginning of March 2 • South East Collaborative are working on sharing all current medical bank rates for comparison with agreement due to be reached around 3rd April 26 to step down together.

Maternity



Understanding the Data

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

Maternity: Scorecard View

Maternity Metrics

Key Performance Indicator (KPI)		XMR Run Chart	Ranges
Mat Patient Safety Incidents Mod/Sev FILTER: TOTAL RP07218 M_00168_Actual_Harm_Mat_Pat Updated: 16/03/2026 00:31	M | Feb 26 **4**		UCL: 9 Mean: 3 LCL: -2 Targ: 9
PSII - National (Maternity) FILTER: TOTAL RP07218 M_01539_PSII_National_MNSI_only Updated: 13/03/2026 09:18	M | Feb 26 **0**		UCL: 2 Mean: 1 LCL: -1 Targ: 0
PSII - Local (Maternity) FILTER: TOTAL RP07218 M_01540_PSII_Internal_Maternity Updated: 13/03/2026 09:19	M | Feb 26 **0**		UCL: 2 Mean: 0 LCL: -1 Targ: 0
Maternity Complaints FILTER: TOTAL RP07218 M_01255_Maternity Updated: 13/03/2026 08:24	M | Feb 26 **8**		UCL: 16 Mean: 7 LCL: -3 Targ: 16
Maternity Complaint Response FILTER: TOTAL RP07218 M_01255_Comp_30_45_days_Mat Updated: 13/03/2026 08:24	M | Feb 26 **87.5%** Num: 7 Denom: 8		UCL: 150.1% Mean: 86.4% LCL: 22.7% Targ: 85.0%
Extended Perinatal Mortality FILTER: TOTAL RP07218 M_01206_Perinatal_Death_Rate Updated: 16/03/2026 00:55	M | Feb 26 **4.44** Num: 26 Denom: 6K		UCL: 4.81 Mean: 4.02 LCL: 3.22 Targ: 5.44
FFT Maternity Response Rate FILTER: TOTAL RP07218 M_01110_FFT_MAT_response Updated: 16/03/2026 08:45	M | Feb 26 **40.8%** Num: 170 Denom: 417		UCL: 56.7% Mean: 34.3% LCL: 12.0% Targ: 15.0%

Key Performance Indicator (KPI)		XMR Run Chart	Ranges
FFT Maternity Recommended FILTER: TOTAL RP07218 M_01110_FFT_Extract_MAT_fft Updated: 16/03/2026 08:45	M | Feb 26 **91.2%** Num: 333 Denom: 365		UCL: 96.3% Mean: 90.2% LCL: 84.2% Targ: 90.0%
FFT Maternity (IP) Recommended FILTER: TOTAL RP07218 M_01110_fft_Mat_IP Updated: 16/03/2026 08:45	M | Feb 26 **93.4%** Num: 199 Denom: 213		UCL: 101.0% Mean: 92.7% LCL: 84.4% Targ: 90.0%
WH Engagement Score FILTER: TOTAL RP07218 M_01146_Mat_Engagement Updated: 13/03/2026 09:10	M | Feb 26 **5.89**		UCL: 6.34 Mean: 6.11 LCL: 5.87 Targ: 6.90

East Kent Hospitals University NHS Foundation Trust

Maternity: Executive Summary

Maternity Mortality Measures

The extended perinatal rate remains below the threshold of 5.44 per 1,000 births, with the 12 month rate performance at 4.44 in February. This rate includes both stillbirths and neonatal deaths.

In February, the neonatal death 12 month remained below the MBRRACE target of 1.84 for the 10th time in the 12 month rolling reporting period, at 0.69. The service reported no neonatal deaths in month, and a total of 4 in the past 12 months.

The stillbirth rate remains above threshold of 3.60, at 3.76 in February. The service reported 0 stillbirths in month and a total of 22 in the past 12 months.

MBRRACE Ext Perinatal Rate 12m

FILTER: TOTAL | RP05230 | M_01206 | Updated: 16/03/2026 00:47

M | Feb 26
4.44
Num: 26
Denom: 6K

Timescale	Value	Target	Num	Denom
M | Mar-25	4.44	5.44	26	5,861
M | Apr-25	3.93	5.44	23	5,847
M | May-25	3.76	5.44	22	5,855
M | Jun-25	3.73	5.44	22	5,891
M | Jul-25	4.06	5.44	24	5,916
M | Aug-25	3.39	5.44	20	5,899
M | Sep-25	3.55	5.44	21	5,923
M | Oct-25	4.07	5.44	24	5,895
M | Nov-25	4.58	5.44	27	5,890
M | Dec-25	4.39	5.44	26	5,924
M | Jan-26	5.11	5.44	30	5,868
M | Feb-26	4.44	5.44	26	5,851

XMR Run Chart
M_01206

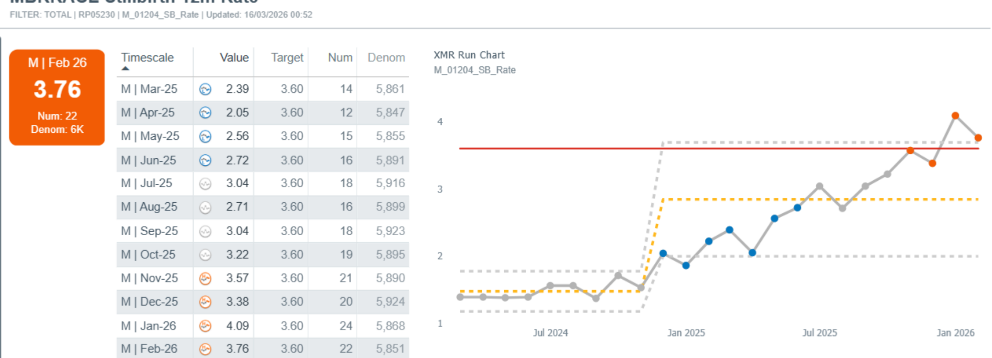
MBRRACE NND Rate 12m

FILTER: TOTAL | RP05230 | M_01205_NND_Rate | Updated: 16/03/2026 00:47

M | Feb 26
0.69
Num: 4
Denom: 6K

Timescale	Value	Target	Num	Denom
M | Mar-25	2.05	1.84	12	5,847
M | Apr-25	1.89	1.84	11	5,835
M | May-25	1.20	1.84	7	5,840
M | Jun-25	1.02	1.84	6	5,875
M | Jul-25	1.02	1.84	6	5,898
M | Aug-25	0.68	1.84	4	5,883
M | Sep-25	0.51	1.84	3	5,905
M | Oct-25	0.85	1.84	5	5,876
M | Nov-25	1.02	1.84	6	5,869
M | Dec-25	1.02	1.84	6	5,904
M | Jan-26	1.03	1.84	6	5,844
M | Feb-26	0.69	1.84	4	5,829

XMR Run Chart
M_01205_NND_Rate



MBRRACE Stillbirth 12m Rate

FILTER: TOTAL | RP05230 | M_01204_SB_Rate | Updated: 16/03/2026 00:52

M | Feb 26
3.76
Num: 22
Denom: 6K

Timescale	Value	Target	Num	Denom
M | Mar-25	2.39	3.60	14	5,861
M | Apr-25	2.05	3.60	12	5,847
M | May-25	2.56	3.60	15	5,855
M | Jun-25	2.72	3.60	16	5,891
M | Jul-25	3.04	3.60	18	5,916
M | Aug-25	2.71	3.60	16	5,899
M | Sep-25	3.04	3.60	18	5,923
M | Oct-25	3.22	3.60	19	5,895
M | Nov-25	3.57	3.60	21	5,890
M | Dec-25	3.38	3.60	20	5,924
M | Jan-26	4.09	3.60	24	5,868
M | Feb-26	3.76	3.60	22	5,851

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

Maternity: Executive Summary

Maternity Investigations

Current open MNSI investigations	Progress
Neonatal Therapeutic cooling MI-049910	Investigation in progress
Neonatal Therapeutic cooling	Investigation in progress

Current open local PSSI's	Progress
Twin birth – 31/40 – Twin 1 admission to NICU	Investigation complete – to LRAP
Term IUD	Investigation in progress
Maternal bladder injury and unexpected neonatal admission to NICU	Investigation approaching completion – to LRAP
Management of pre-term labour and maternal DVT	Investigation approaching completion, report in process of approval – to LRAP
Joint neonatal/maternity case. Medical gases availability	Investigation in progress

4 moderate /severe patient safety incidents were reported in February under the following categories:

- 1 Drug error – administering
- 1 unanticipated admission to SCBU
- 1 3rd/4th degree perineal trauma
- 1 complication during operation/procedure

Maternity: Maternity Care

Patient Experience, Incident Reporting & Complaints

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
FFT scores	• Review existing process in relation to the promotion of the FFT	• Patient Experience Team		FFT response rate remains higher than average, at 40.8% The recommended rate has achieved the target of 90% for the second month, following 7 months below target and below average.
Overdue Incidents	• Email and communication with individual overdue incident and action owners with ongoing monitoring of expected completion date • Agreed with corporate team an understanding that some maternity incidents will remain open for longer than 6 weeks, given the complex nature of some investigations.	• Head of Governance		• The number of maternity overdue incidents in February was 211 – an increase of 7 compared to last month • Continued monitoring of incident management with increased surveillance and support through weekly 'Stop the clock' meetings. Performance impacted by need for Matrons and ward managers to work clinically due to high activity and acuity to maintain safety and vacancy / absence within the governance team. • Focus on management of open incidents approaching 6 week threshold to prevent them becoming overdue • NHSP provided for staff able to support the incident investigation process with a particular focus on overdue and soon to be overdue incidents. • Incident data sheets emailed to incident handlers to support them to target their overdue incidents when they are time constrained • Meeting with incident handlers and line managers to set trajectories for completion of overdue incident reports and standard work to ensure Datix management proceeds in line with Trust policy and expected timeframes
Complaints		• Head of Governance		• Total of 8 maternity complaints received in February • Complaint response rate was 87.5% in February for Obstetrics against a threshold of 85%.

FFT Maternity Recommended

FILTER: TOTAL | RP07218 | M_01110_FFT_Extract_MAT_ffi | Updated: 16/03/2026 08:45

M \| Feb 26 — 91.2% — Num: 333 Denom: 365

Timescale	Value	Target	Num	Denom
M | Mar-25	90.5%	90.0%	286	316
M | Apr-25	90.9%	90.0%	239	263
M | May-25	89.9%	90.0%	303	337
M | Jun-25	86.2%	90.0%	281	326
M | Jul-25	89.4%	90.0%	446	499
M | Aug-25	86.5%	90.0%	415	480
M | Sep-25	84.9%	90.0%	400	471
M | Oct-25	85.4%	90.0%	292	342
M | Nov-25	87.9%	90.0%	319	363
M | Dec-25	88.7%	90.0%	313	353
M | Jan-26	90.2%	90.0%	248	275
M | Feb-26	91.2%	90.0%	333	365

XMR Run Chart
M_01110_FFT_Extract_MAT_ffi
95
90
85
Jul 2024
Jan 2025
Jul 2025
Jan 2026

Maternity Complaints

FILTER: TOTAL | RP07218 | M_01255_Maternity | Updated: 13/03/2026 08:24

M \| Feb 26 — 8

Timescale	Value	Target	Num	Denom
M | Mar-25	7	16	7	
M | Apr-25	7	16	7	
M | May-25	4	16	4	
M | Jun-25	5	16	5	
M | Jul-25	6	16	6	
M | Aug-25	3	16	3	
M | Sep-25	16	16	16	
M | Oct-25	10	16	10	
M | Nov-25	7	16	7	
M | Dec-25	7	16	7	
M | Jan-26	5	16	5	
M | Feb-26	8	16	8	

XMR Run Chart
M_01255_Maternity
20
10
0
Jul 2024
Jan 2025
Jul 2025
Jan 2026

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Month 11 (M11) Finance Report**

Meeting date: **2 April 2026**

Board sponsor: **Angela van der Lem, Chief Finance Officer (CFO)**

Paper Author: **Julie Wells, Deputy Chief Finance Office - Performance (DCFO)**

Appendices:

Appendix 1: M11 Finance report

Executive summary:

<table>
<tr><td>Action required:</td><td>Information</td></tr>
<tr><td>Purpose of the Report:</td><td>The report is to update the BoD on the financial performance for February 2026 (M11).</td></tr>
<tr><td>Summary of key issues:</td><td>The M11 Year to Date (YTD) position achieved by the <u>Group</u> (Pre-Deficit Support Funding (DSF)) was a deficit of £77.3m, £14.4m adverse to plan, as illustrated below.
<table>
<tr><th>£000</th><th>YTD Plan</th><th>YTD Actual</th><th>YTD Variance</th></tr>
<tr><td>Patient care income</td><td>£866,210</td><td>£884,066</td><td>£17,856</td></tr>
<tr><td>Other income</td><td>£69,467</td><td>£58,600</td><td>(£10,867)</td></tr>
<tr><td>Employee Expenses</td><td>(£646,821)</td><td>(£666,250)</td><td>(£19,429)</td></tr>
<tr><td>Other operating expenses</td><td>(£344,852)</td><td>(£347,600)</td><td>(£2,748)</td></tr>
<tr><td>Non-operating expenses</td><td>(£7,487)</td><td>(£6,655)</td><td>£832</td></tr>
<tr><td>Operating Surplus / (Deficit)</td><td>(£63,483)</td><td>(£77,839)</td><td>(£14,356)</td></tr>
<tr><td>Technical Adjustments</td><td>£648</td><td>£569</td><td>(£79)</td></tr>
<tr><td>TECHNICALLY ADJUSTED SURPLUS / (DEFICIT) EXCL DEFICIT SUPPORT</td><td>(£62,835)</td><td>(£77,270)</td><td>(£14,435)</td></tr>
</table>
The <u>Trust's</u> Month 11 YTD position was a deficit of £77.9m, £11.7m adverse to plan, as illustrated below.
<table>
<tr><th>£000</th><th>YTD Plan</th><th>YTD Actual</th><th>YTD Variance</th></tr>
<tr><td>Patient care income</td><td>£849,780</td><td>£865,695</td><td>£15,915</td></tr>
<tr><td>Other income</td><td>£60,537</td><td>£60,806</td><td>£269</td></tr>
<tr><td>Employee Expenses</td><td>(£596,709)</td><td>(£615,247)</td><td>(£18,537)</td></tr>
<tr><td>Other operating expenses</td><td>(£373,293)</td><td>(£386,000)</td><td>(£12,707)</td></tr>
<tr><td>Non-operating expenses</td><td>(£7,206)</td><td>(£3,719)</td><td>£3,487</td></tr>
<tr><td>Operating Surplus / (Deficit)</td><td>(£66,891)</td><td>(£78,464)</td><td>(£11,573)</td></tr>
<tr><td>Technical Adjustments</td><td>£648</td><td>£569</td><td>(£79)</td></tr>
<tr><td>TECHNICALLY ADJUSTED SURPLUS / (DEFICIT) EXCL DEFICIT SUPPORT</td><td>(£66,243)</td><td>(£77,895)</td><td>(£11,652)</td></tr>
</table>
</td></tr>
</table>

	The Trust's income from patient care is £15.9m higher than plan YTD. This is predominantly driven by additional Specialised Commissioning income for Elective Recovery Fund (ERF) performance (£3.4m), prior year ERF (£2.9m), prior year high cost drugs (£1.9m) and over performance on rechargeable high cost drugs and devices (£6.0m). Trust other operating income is £0.3m favourable to plan YTD. Above plan income for education and training of £2.0m is offset by below plan income for car parking and non-patient care services totalling £1.7m. Trust employee expenses are £18.5m adverse to plan YTD. Substantive staffing is £9.3m adverse YTD, and temporary staffing costs £9.3m adverse YTD. There was a stepped increase in the Cost Improvement Programme (CIP) target in the second half of the year, which is not currently being delivered. Other operating expenses are £12.7m adverse to plan YTD, predominantly driven by overspends in general supplies and services, premises and drugs, partly offset by underspends in clinical supplies and services, purchase of healthcare, clinical negligence and consultancy. 2gether Support Solutions (2gether) reported a YTD surplus of £3.6m, £0.5m ahead of plan. This overperformance is mainly driven by an improvement in retail catering profits and higher bank interest received. Spencer Private Hospitals (SPH) reported a YTD surplus of £0.04m, £0.3m below plan. This variance is primarily due to increased theatre rates and the high cost of agency theatre staffing, which have reduced the overall theatre surplus. Measures are in place to eliminate agency theatre staff by the start of the new financial year, and savings have already started to materialise. The Trust cash balance (excluding subsidiaries) at the end of February was £19.0m. The appendix provides the full cash flow forecast for the year.
Key recommendations:	The Board of Directors is asked to review and **NOTE** the financial performance of M11.

Implications:

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

Assurance route:

Previously considered by: Finance and Performance Committee – 31 March 2026

Finance Performance Report 2025/26

February 2026

Chief Finance Officer
Angela van der Lem

Group Summary

Month 11 (February) 2025/26

	Trust			2gether Support Solutions			Spencer Private Hospitals			Consolidation Adjustments			Group		
	Year to Date			Year to Date			Year to Date			Year to Date			Year to Date		
(£'m)	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
NHS Income From Commissioners - exc. D&D	788.953	798.914	9.961	0.000	0.000	0.000	19.063	20.485	1.422	(0.959)	(2.114)	(1.155)	807.057	817.285	10.228
NHS Income From Commissioners - Drugs	53.851	57.608	3.756	0.000	0.000	0.000	0.000	0.000	0.000	(1.673)	0.000	1.673	52.178	57.608	5.430
NHS Income From Commissioners - Devices	6.976	9.173	2.198	0.000	0.000	0.000	0.000	0.000	0.000	(0.001)	0.000	0.001	6.975	9.173	2.198
Other Income	60.537	60.806	0.269	154.109	179.779	25.670	0.052	0.040	(0.012)	(145.231)	(182.025)	(36.794)	69.467	58.600	(10.867)
Total Income	**910.317**	**926.501**	**16.184**	**154.109**	**179.779**	**25.670**	**19.115**	**20.525**	**1.410**	**(147.864)**	**(184.139)**	**(36.275)**	**935.677**	**942.666**	**6.989**
Substantive Staff (inc. Apprenticeship Levy)	(540.644)	(549.926)	(9.282)	(40.957)	(42.148)	(1.191)	(7.102)	(9.331)	(2.229)	0.663	1.812	1.149	(588.040)	(599.593)	(11.553)
Bank Staff	(39.782)	(48.075)	(8.293)	0.000	0.000	0.000	0.000	(0.152)	(0.152)	0.003	0.153	0.150	(39.779)	(48.074)	(8.295)
Agency/Contract	(16.283)	(17.246)	(0.963)	(1.971)	(1.041)	0.930	(0.748)	(0.296)	0.452	0.000	(0.000)	(0.000)	(19.002)	(18.583)	0.419
Total Employee Expenses	**(596.709)**	**(615.247)**	**(18.537)**	**(42.928)**	**(43.189)**	**(0.261)**	**(7.850)**	**(9.779)**	**(1.929)**	**0.666**	**1.965**	**1.298**	**(646.821)**	**(666.250)**	**(19.429)**
Drugs	(95.553)	(96.235)	(0.682)	0.000	(0.013)	(0.013)	(2.427)	(2.314)	0.113	2.240	1.996	(0.244)	(95.740)	(96.566)	(0.826)
Rechargeable Devices	(6.976)	(9.173)	(2.198)	0.000	0.000	0.000	0.000	0.000	0.000	0.001	0.000	(0.001)	(6.975)	(9.173)	(2.198)
Supplies and Services - Clinical	(48.177)	(44.991)	3.186	(52.803)	(60.574)	(7.771)	(2.042)	(1.491)	0.551	1.797	9.747	7.950	(101.225)	(97.309)	3.916
Supplies and Services - General	(122.385)	(142.614)	(20.228)	(30.529)	(45.475)	(14.946)	(0.228)	(0.243)	(0.015)	137.905	166.072	28.166	(15.237)	(22.260)	(7.023)
Clinical negligence	(34.621)	(33.240)	1.381	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	(34.621)	(33.240)	1.381
Depreciation and Amortisation	(24.493)	(22.665)	1.828	(0.474)	(0.920)	(0.446)	(0.210)	(0.303)	(0.093)	0.000	(0.001)	(0.001)	(25.177)	(23.889)	1.288
Other non pay	(41.088)	(37.083)	4.005	(24.134)	(26.145)	(2.011)	(5.888)	(6.306)	(0.418)	5.233	4.371	(0.862)	(65.877)	(65.163)	0.714
Total Other Operating Expenses	**(373.293)**	**(386.000)**	**(12.707)**	**(107.940)**	**(133.127)**	**(25.187)**	**(10.795)**	**(10.657)**	**0.138**	**147.176**	**182.184**	**35.008**	**(344.852)**	**(347.600)**	**(2.748)**
Non Operating Expenses	(7.206)	(3.719)	3.487	(0.173)	0.109	0.282	(0.116)	(0.045)	0.071	0.008	(3.000)	(3.008)	(7.487)	(6.655)	0.832
Profit/Loss	**(66.891)**	**(78.464)**	**(11.572)**	**3.068**	**3.572**	**0.504**	**0.354**	**0.044**	**(0.310)**	**(0.014)**	**(2.991)**	**(2.977)**	**(63.483)**	**(77.839)**	**(14.356)**
Less Technical Adjustments	0.648	0.569	(0.079)	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.648	0.569	(0.079)
Technically Adjusted Profit/Loss	**(66.243)**	**(77.895)**	**(11.652)** 1	**3.068**	**3.572**	**0.504** 2	**0.354**	**0.044**	**(0.310)** 3	**(0.014)**	**(2.991)**	**(2.977)** 4	**(62.835)**	**(77.270)**	**(14.435)** 5
Non Recurrent Deficit Support Revenue Allocation	53.770	34.567	(19.203)	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	53.770	34.567	(19.203)
Deficit Support Adjusted Profit/Loss	**(12.473)**	**(43.328)**	**(30.855)**	**3.068**	**3.572**	**0.504**	**0.354**	**0.044**	**(0.310)**	**(0.014)**	**(2.991)**	**(2.977)**	**(9.065)**	**(42.703)**	**(33.638)**

1. Trust

It was agreed in the planning process, at the outset of this financial year, that non-recurrent Deficit Support Funding (DSF) totalling £57.6m would be received in 2025/26. This non-recurrent allocation reduced the Group's planned deficit from £64.2m to £6.6m. Since this allocation is non-recurrent, the finance report will focus on the deficit prior to the DSF, with DSF shown below the line to maintain emphasis on the recurrent position. However, it should be noted that due to the System being off plan in their Month 6 reporting, DSF has been withdrawn from K&M ICS for Quarters 3 and 4 (£23.0m impact for the Trust).

The Trust's YTD position as at month 11 is £30.9m adverse, primarily driven by the aforementioned loss of DSF income in October to February (£19.2m), together with CIP under-performance, following the stepped increase in CIP targets from October. Excluding the impact of DSF, the Trust is £11.7m adverse to plan YTD.

- Income from patient care is £15.9m higher than planned YTD. This includes additional income for delegated Specialised Commissioning ERF performance of £3.4m, prior year ERF £2.9m, prior year high cost drugs £1.9m and overperformance of £6.0m in rechargeable high cost Drugs and Devices. Furthermore there is overperformance in Chemotherapy of £0.5m as well as overperformance from the Compensation Recovery Unit of £0.5m and GUM Pathology of £0.5m.
- Other operating income is £0.3m favourable to plan YTD, mainly due to higher than expected education and training income.
- Employee expenses are £18.5m over plan YTD, reflecting overspends across all staff groups excluding administrative and clerical. This position is predominantly attributable to under-delivery of CIP.
- Other operating expenses are £12.7m above plan YTD, driven by overspends in general supplies, drugs and premises costs. These pressures are partly offset by underspends in clinical supplies, purchased healthcare, clinical negligence, and consultancy.

2. 2gether Support Solutions

2gether Support Solutions reported a £3.6m YTD surplus, £0.5m ahead of plan. This overperformance is mainly driven by improvement in retail catering profit and higher bank interest received.

3. Spencer Private Hospitals

Spencer Private Hospitals reported a YTD surplus of £0.04m, £0.3m below plan. The adverse variance is primarily due to increased theatre rates and the high cost of agency theatre staffing, resulting in a reduced theatre surplus. Measures are in place to eliminate agency theatre staff by the start of the new financial year, and savings have already started to materialise.

4. Consolidation Adjustments

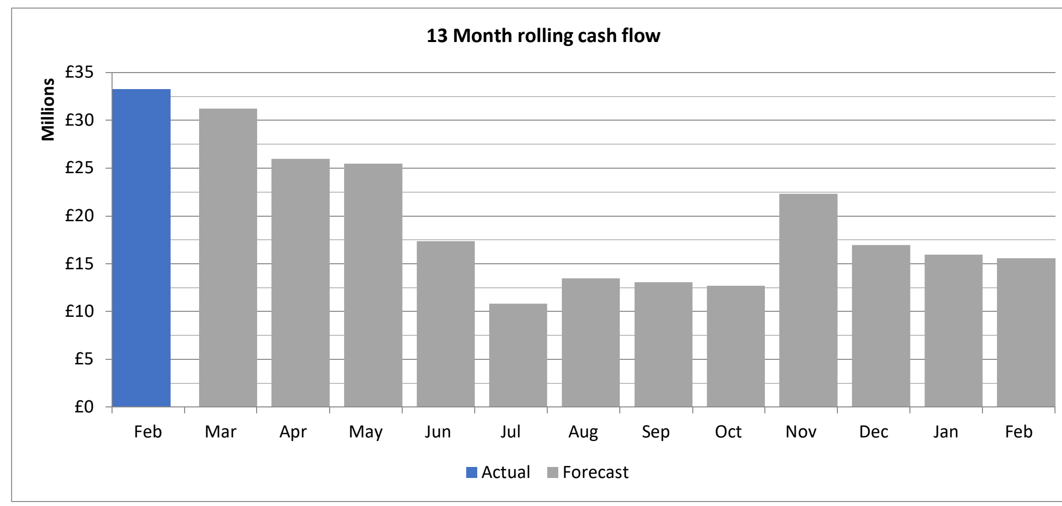
Consolidation adjustments are applied to eliminate all inter-company income and expenditure transactions.

5. Group

The YTD deficit for the Group as at Month 11 stands at £77.3m (excluding the non-recurrent DSF allocation), which is adverse to plan by £14.4m.

Cash Flow

Month 11 (February) 2025/26



Unconsolidated Cash balance was £19.0m at the end of February 2026, £17.0m below plan.

Cash receipts in month totalled £107.4m (£12.3m above plan)

- K&M ICB paid £74.1m in February (above plan by £0.8m)
- NHS England paid £13.1m in February, £2.2m above plan
- No VAT reclaims were received in month, £3.5m below plan. February VAT reclaim was received in early March.
- £13.8m Capital PDC was received in month. (£9m above plan)
- £3.5m of Revenue Support PDC was received in month.
- Other receipts totalled £2.8m, £0.3m above plan (this includes £1.1m from other NHS organisations and £1.7m from other Non NHS debtors)

Cash payments in month totalled £100.3m (£11.3m above plan)

- Creditor payment runs were £26.8m (£5.5m above plan)
- £22.8m payments to 2gether (£2.5m above plan)
- Total payroll was £50.8m (£3.3m above plan in month 11)

2025/26 Cash Plan

The revised plan submitted to NHSE in May 2025 shows a Trust deficit position at the end of 2025/26 of £10.27m. The cash plan assumes full delivery of £80m cash releasing efficiencies and a £42m Capital PDC programme.

Full receipt of Deficit support funding, £57.6m, was planned into the cashflow from Kent and Medway ICB in the year. Deficit support funding was to be received by the ICB on a quarterly basis contingent on continued delivery of the System plan.

Risk to the cashflow

Deficit Support Funding (DSF) - DSF is dependant upon the ICS delivery of the system plan. Funding was received in Quarters 1 and 2. Notification that DSF will not be received in H2 has been received. Q3 and Q4 DSF has therefore been removed from the cashflow forecast. The impact of this is seen in reduced payments to creditors and a decline in the Better Payment Practice Code (BPPC) compliance.

PDC Revenue Support - The Trust received £11.5m support in December 2025, £10.2m in January 2026 and a further £3.5m in February 2026. The Trust has also received confirmation from NHS England that £19.7m PDC Revenue Support can be drawn in March 2026 (to be received by the Trust on the 16th March).

The efficiency delivery - The reforecast in January reduced the expected efficiencies from £80m to £60m. The £20m of unrealised savings has been mitigated by an increase in PDC Revenue support requested in March. If the remaining in-year efficiencies are not realised, or are non-cash releasing, this will result in reduced payments to creditors and a further decline in BPPC compliance.

Creditor Management

The Trust paid to 55 day creditor terms for non NHS suppliers in month 11. At the end of Febuary 2026, the Trust was recording 40 creditor days (Calculated as invoiced creditors at 28th February/Forecast non-pay expenditure x 365).

Statement of Financial Position

Month 11 (February) 2025/26

	Trust			2gether Support Solutions			Spencer Private Hospitals			Consolidation Adjustments			Group		
(£'m)	**Opening**	**To date**	**Movement**	**Opening**	**To date**	**Movement**	**Opening**	**To date**	**Movement**	**Opening**	**To date**	**Movement**	**Opening**	**To date**	**Movement**
Non Current Assets	**360.773**	**382.831**	**22.058**	**64.913**	**63.057**	**(1.856)**	**4.349**	**4.069**	**(0.280)**	**(141.301)**	**(138.930)**	**2.371**	**288.734**	**311.027**	**22.293**
Inventories	7.546	7.428	(0.118)	6.022	6.022	0.000	0.060	0.025	(0.035)	0.000	0.000	0.000	13.628	13.475	(0.153)
Trade Receivables	34.729	43.601	8.872	17.299	18.055	0.756	4.056	6.593	2.537	(21.540)	(25.059)	(3.519)	34.544	43.190	8.646
Accrued Income and Other Receivables	(3.870)	(3.697)	0.173	(0.115)	(0.261)	(0.146)	(0.083)	(0.082)	0.001	0.000	0.000	0.000	(4.068)	(4.040)	0.028
Assets Held For Sale	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Cash and Cash Equivalents	47.695	18.972	(28.723)	24.189	36.150	11.961	3.048	2.610	(0.438)	0.000	0.000	0.000	74.932	57.732	(17.200)
Current Assets	**86.100**	**66.304**	**(19.796)**	**47.395**	**59.966**	**12.571**	**7.081**	**9.146**	**2.065**	**(21.540)**	**(25.059)**	**(3.519)**	**119.036**	**110.357**	**(8.679)**
Payables and Accruals	85.542	86.439	0.897	23.409	34.773	11.364	4.421	6.339	1.918	(17.889)	(22.153)	(4.264)	95.483	105.398	9.915
Deferred Income and Other Liabilities	6.262	19.571	13.309	0.000	0.002	0.002	0.000	0.000	0.000	0.000	(0.008)	(0.008)	6.262	19.565	13.303
Provisions	10.424	4.357	(6.067)	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	10.424	4.357	(6.067)
Borrowing	4.244	4.538	0.294	2.468	2.187	(0.281)	0.079	0.022	(0.057)	(4.485)	(4.629)	(0.144)	2.306	2.118	(0.188)
Current Liabilities	**106.472**	**114.905**	**8.433**	**25.877**	**36.962**	**11.085**	**4.500**	**6.361**	**1.861**	**(22.374)**	**(26.790)**	**(4.416)**	**114.475**	**131.438**	**16.963**
Provisions	3.724	3.590	(0.134)	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	3.724	3.590	(0.134)
Borrowing	67.533	64.629	(2.904)	48.231	46.277	(1.954)	1.887	0.986	(0.901)	(111.229)	(106.888)	4.341	6.422	5.004	(1.418)
Non Current Liabilities	**71.257**	**68.219**	**(3.038)**	**48.231**	**46.277**	**(1.954)**	**1.887**	**0.986**	**(0.901)**	**(111.229)**	**(106.888)**	**4.341**	**10.146**	**8.594**	**(1.552)**
Net Assets	**269.144**	**266.011**	**(3.133)**	**38.200**	**39.784**	**1.584**	**5.043**	**5.868**	**0.826**	**(29.238)**	**(30.311)**	**(1.073)**	**283.149**	**281.352**	**(1.797)**
Public Dividend Capital	609.877	650.640	40.763	30.267	30.267	0.000	0.048	0.048	(0.000)	(30.315)	(30.315)	0.000	609.877	650.640	40.763
Retained Earnings	(394.090)	(437.986)	(43.896)	9.008	9.510	0.502	2.185	3.006	0.821	0.000	0.009	0.009	(382.897)	(425.461)	(42.564)
Revaluation Reserve	53.355	53.355	0.000	0.000	0.000	0.000	2.812	2.812	0.000	0.000	0.000	0.000	56.167	56.167	0.000
Taxpayers Equity	**269.142**	**266.009**	**(3.133)** 1	**39.275**	**39.777**	**0.502** 2	**5.045**	**5.866**	**0.821** 3	**(30.315)**	**(30.306)**	**0.009** 4	**283.147**	**281.346**	**(1.801)**

1. Trust:

Non-Current Assets - Values reflect in-year additions less depreciation charges. Non-Current assets also includes the loan and equity that finances 2gether Support Solutions.

Current Assets - Current assets have decreased by £20m compared to 2024/25, primarily due to reductions of £29m in cash and receivable increased by £8m. Further details provided on the cash and working capital pages.

Current Liabilities - Current liabilities have increased by £8.4m YTD, primarily driven by a rise in deferred income, which will be recognised next month. This increase has been partially offset by a £6.1m reduction in provisions (refer to the Working Capital schedule).

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

Public Dividend Capital - YTD movement in Public Dividend Capital (PDC) was £40.7m of which £25.2m relates to Revenue Support and £15.5m was Capital PDC.

2. 2gether Support Solutions:

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

Current Assets - Current assets have increased by £12.6m, primarily driven by a £12m increase in cash balances.

Current Liabilities - Current liabilities increased by £11m, primarily driven by a £11.4m rise in payables, partially offset by a £0.3m reduction in borrowing.

3. Spencer Private Hospitals:

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

Current assets increased by £2m, driven by higher trade receivables offset by slight reduction in cash and inventories**.**

Current Liabilities: Increased by £1.9m, primarily due to an increase in invoice payables.

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

Capital Expenditure

Month 11 (February) 2025/26

2025/26 Capital Programme £000	Annual Plan	Actual M11 YTD	FOT M12	FOT Year-end
Robotic Assisted Surgery	0	32	4,288	4,320
2025/26 National UEC Programme	23,765	11,170	4,276	15,446
2025/26 National CIR Programme	12,637	9,224	4,008	13,232
IDG (IT Hardware and Systems Replacement)	2,300	3,162	3,034	6,196
Vanguard Mobile Theatres Lease	0	0	2,963	2,963
MDG (Medical Devices Replacement)	3,000	1,790	2,111	3,901
2025/26 National CIR Programme - Phase 2	0	919	1,836	2,755
GB Energy NHS Solar	0	81	1,722	1,803
PEIC (Critical Estates Priorities)	4,000	3,700	1,161	4,861
ERP (Equipment Replacement Programme)	3,800	1,848	1,107	2,955
WHH Cardiac Catheter Lab	1,190	480	520	1,000
2025/26 National Diagnostics Programme	1,218	62	418	480
Digital Pathology Projects	0	1,508	411	1,919
Fire Safety Remedy Works all sites	0	5	295	300
Subsidiaries - 2Gether Suport Solutions (2SS)	450	203	247	450
Hyper Acute Stroke Unit (HASU)	3,580	1,043	239	1,282
NHSE Maternity Scheme (Early Release Fees) - 2025/26 (Year 2)	800	574	226	800
2025/26 Critical Estates Infrastructure - Design Works	0	1	149	150
Thanet CDC	4,340	356	138	494
Maternity Improved Signage and POC Haematology Analysers	0	0	88	88
Fire Compartmentation Strategy	4,930	3,398	79	3,477
Block and Beam replacement - WHH - 2025/26 (Year 2)	350	449	51	500
Subsidiaries - Spencer Private Hospitals (SPH)	64	39	48	87
Patients Experience Portal (PEP) integration with NHS App	0	205	45	250
Maternity Information System (MIS)	125	124	1	125
Aseptic Suite Remedial Works	750	595	0	595
Right of Use Assets (RoUA) - IFRS16 Leases	758	700	0	700
Pharmacy Automation Replacement at KCH	0	804	0	804
Endoscopy Lease Equipment purchase	0	943	0	943
Donated Assets	600	836	0	836
All Other	0	(148)	0	(148)
Nursery Major Refurbishment Works	300	0	0	0
Pathology Pneumatic Tubes - System Replacement	100	0	0	0
Procurement of 2x Mobile CT Scanners - 2025/26 (Year 2) - Enabling W	60	0	0	0
Maternity (CQC) Urgent Works	0	4	0	4
CDC Liver Surveillance Pathway	0	99	0	99
Diagnostics Imaging (QEQM MRI) - 2025/26 (Year 2)	2,050	1,786	(0)	1,786
	71,167	**45,991**	**29,462**	**75,453**
Expenditure as a percentage of Year-End Forecast		**61%**	**39%**	**100%**

Funding	Annual Plan	FOT Year-end
Operational Capital	29,175	29,698
Donations	600	836
PDC	38,420	44,919
Total Funding	**68,195**	**75,453**
Funding Under/(Over) utilisation	**(2,972)**	-

At Month 11, the **year-end forecast of £75.453m is fully compliant with the available capital funding** envelope. The position includes the following adjustments to the previously-reported forecast (of £79.026m).

- 2025/26 National UEC Programme – WHH SDEC Expansion – a **£3.754m reduction in the expected PDC funding**, to align the year-end forecast to the actual funding issued in the latest MOUs by DHSC/NHSE. The reduction occurred as a result of the National Team mistakenly issuing a lower funding amount in 2025/26 than requested within the approved Business Case. To offset this reduction, the programme has been re-profiled and a corresponding level of expenditure (£3.754m) has been deferred into 2026/27, with an expectation that the balance to the originally approved funding amount for 2025/26 will be uplifted accordingly within the 2026/27 allocation.

- An **increase in the level of Charitable Funding in-year expenditure of £0.183m** (has a net neutral impact on the bottom-line reported position).

The Group's gross capital **YTD spend to the end of Month 11 was £46m**, which represents circa 61% of the total year-end forecast. The remaining **39% (£29.5m) is expected to be delivered in M12** and so an **inherent degree of risk** remains. However, this is being monitored by the the Capital Working Group that continues to meet on a weekly basis to recieve regular updates and assurance from all scheme leads on the delivery and to provide a forum where any risks can be swiftly escalated to Execs and/ or dealt with immediately. **The £29.5m profiled for delivery in Month 12 is broken down into two main areas:**

- £17.4m (circa 59%) relates to externally funded schemes, some of which have been contingent on the timely external approval of their respective business case. In most cases, this resulted in a revised phased implementation than what was originally anticipated when the original 2025/26 capital plan (and associated spend profile) was submitted in April 2025.

- £12.1m profiled into M12 relates to internally funded schemes, most of which have been reprofilied throughout the year to accommodate emergent risks arising (i.e. reductions due to anticipated slippage within the respective schemes or actual increases as mitigating options for other schemes that were at risk of slippage).

All reasonable steps have been taken (particularly for those schemes involving equipment purchasing) by the Procurement team to ensure delivery within the agreed timelines, though there remains significant reliance on timely delivery by suppliers.

Full cash draw down requests have been submitted to NHSE for all approved capital funding streams in 2025/26, noting that some of the externally funded schemes have had varying levels of internal brokerage as a means of mitigating slippage across financial years for multi-year schemes. Where internal brokerage has been required, a corresponding level of internally-funded capital will be re-provided in 2026/27 to complete the respective schemes.

Cost Improvement Summary
Month 11 (February) 2025/26

Delivery Summary

Programme Themes £000	This Month Plan	This Month Actual	This Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	Annual Plan	Annual Forecast	Annual Variance
01. Estate Utilisation & Rationalisation	151	53	(98)	2,342	938	(1,404)	2,489	983	(1,506)
02. Procurement	593	450	(143)	4,301	4,016	(285)	4,897	4,403	(494)
03. Digital Utilisation & Rationalisation	104	27	(77)	612	185	(427)	715	225	(490)
05. Medical Workforce	783	173	(610)	4,994	1,176	(3,818)	5,803	1,363	(4,440)
06. AHP | Nursing | Midwifery Workforce	199	273	74	1,304	525	(779)	1,506	678	(828)
07. Non-Clinical Workforce	315	543	228	2,013	3,944	1,932	2,333	4,288	1,955
08. Diagnostics	92	164	72	643	1,018	375	734	1,122	388
09. Integrated Urgent and Emergency Care	257	106	(151)	1,741	962	(779)	2,000	1,058	(942)
10. Theatre Utilisation	165	34	(131)	1,098	129	(969)	1,263	155	(1,108)
11. Outpatients	44	53	9	299	254	(44)	343	306	(37)
12. Medicines Management and Devices	59	289	230	644	1,918	1,274	703	2,153	1,451
13. Subsidiaries - 2gether	416	37	(379)	4,583	122	(4,461)	5,000	158	(4,842)
14. Subsidiaries - Spencer	44	105	61	256	105	(151)	300	135	(165)
15. Service Efficiency Review	-	-	-	-	-	-	-	-	-
16 to 23 Care Group Led Schemes	6,719	1,124	(5,595)	45,149	12,692	(32,456)	51,914	13,652	(38,262)
25. Central	-	2,973	2,973	-	25,338	25,338	-	29,320	29,320
26. Miscellaneous	-	-	-	-	-	-	-	-	-
27. System	-	-	-	-	-	-	-	-	-
Grand Total	**9,941**	**6,403**	**(3,538)**	**69,978**	**53,322**	**(16,656)**	**80,000**	**60,000**	**(20,000)**

Delivered £000

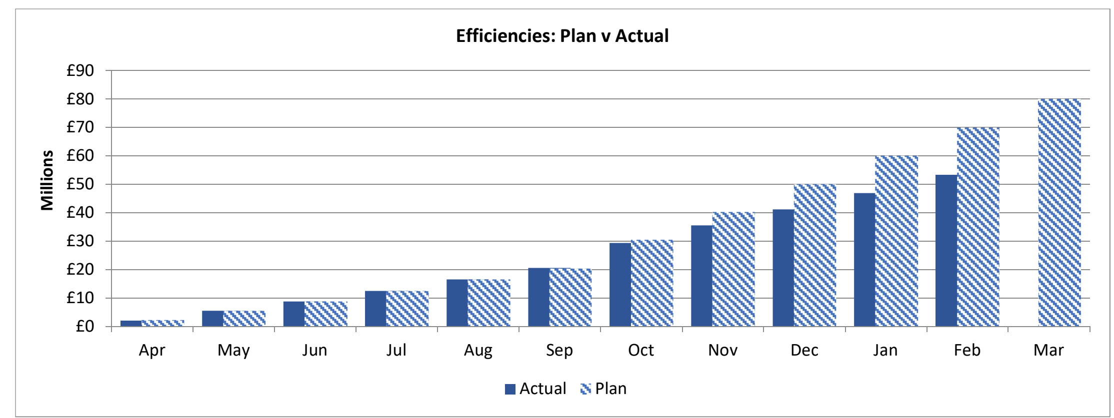
Month	Target	Actual
April	2,290	2,040
May	3,252	3,549
June	3,308	3,263
July	3,594	3,608
August	4,074	4,082
September	3,803	4,000
October	10,152	8,839
November	9,810	6,193
December	9,845	5,575
January	9,909	5,769
February	9,941	6,403
March	10,022	
	80,000	**53,322**
		66.7%

The Efficiencies plan for 2025/26 is £80.0m. CIP delivery is adverse of plan in Month 11 by £3.5m and £16.7m YTD.

Total savings of £53.3m have been delivered to month 11; £18.7m from Pay schemes, £27.3m from Non-pay schemes and £7.4m from income schemes.

The recurrent/non-recurrent delivery YTD is 59% Recurrent, 41% non-recurrent, an improvement due to the reclassification of some schemes in month.

The Trust has re-forecasted CIP delivery of £60.0m savings in year, with the revised CIP target delivered in month.



REPORT TO BOARD OF DIRECTORS (BoD)

Report title:	**Significant Risk Register (SRR) Report**
Meeting date:	**2 April 2026**
Board sponsor:	**Sarah Hayes, Chief Nursing and Midwifery Officer (CNMO)**
Paper Author:	**Emma Kelly, Associate Director of Quality Governance (on behalf of Director of Quality Governance)**

Appendices:

None

Executive summary:

Action required:	**Assurance**
Purpose of the Report:	This paper presents the current Significant Risk Report (SRR) to ensure Board oversight of those risks rated as high and above (15>). All have an assigned Executive Director and are required to be updated monthly and reported through Trust Management Committee (TMC) and the appropriate Board Sub Committees to Board. This paper demonstrates movement in month, details those risks that have been de-escalated from the SRR due to the mitigations in place and new risks.
Summary of key issues:	The majority of the risks contained in the SRR report have had a 'review' within the last four weeks. As of 23 March 2026, when the SRR was extracted there were 39 risks on the SRR. There are four risks with associated overdue actions. This is an improved position on the last report. These have been escalated with risk owners and delegates via the Risk Review Group and Accountable Executives informed. There have been two existing risks escalated to the SRR since the last report. Five risks have been de-escalated. Full details are within Section 4. Monthly meetings are in place with the Executive leads for each significant risk (and their deputy/wider team as requested) to ensure regular monthly oversight and scrutiny. This month's report contains a forecast (where known) of when the risk is likely to be de-escalated due to mitigations. The remaining risks will be reviewed by the end of March 2026 - with a particular focus on aged risks (two years and older) and progress monitored with additional scrutiny of static aged risks via the Risk Review Group. There are currently 19 risks on the

	SRR that have been on the Risk Register for more than two years (although they will not have had a residual rating of high or above for all of this time). A number relate to both local and national system wide issues (for example hospital flow, lack of capital investment in infrastructure and hard to recruit to areas). In some cases, these risks may remain but require rearticulating by Risk Owners. The last Risk Review Group meeting was held on 17 March. A deep dive was received from Corporate Finance. There were no escalations from the meeting but Care Group and Corporate leads were asked to ensure that all risks are up to date – with significant risks reviewed at a minimum monthly. Care Groups were also asked to ensure they are reviewing the monthly emerging risk report via their Care Group governance meetings.
Key recommendations:	The Board of Directors is asked to receive and **NOTE** the Significant Risk Report for assurance purposes and for visibility of key risks facing the organisation.

Implications:

Links to 'We Care' Strategic Objectives:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Trust Risk Register:	This paper provides an update on the significant risks (to be known as the 'significant risk report') to the Trust which replaces the Corporate Risk Register (CRR).
Resource:	Yes. Additional resource will be required to mitigate some of the significant risks identified. The position of Head of Risk Management is currently vacant and essential cover is being provided by the Associate Director for Quality Governance ahead of a review and restructure of work within the wider team. At present there is reduced corporate support for risk although some temporary support (two days per week) is due to commence on 26 November 2025.
Legal and regulatory:	Yes. The Trust is required to comply with the requirements of a number of legal and regulatory bodies including but not limited to: • NHS England • Care Quality Commission • Health and Safety Executive
Subsidiary:	2gether Support Solutions Spencer Private Hospitals

Assurance route:

This was previously considered by:

A report was received by Trust Management Committee (TMC) on Wednesday 4 March 2026 (verbal update as reduced agenda due to financial discussions).

Reporting is also received monthly at the Finance and Performance Committee, and bi-monthly at Quality and Safety Committee and People and Culture Committee.

It should be noted that as the Risk Register is a live document the supporting information was extracted on 23 March 2026.

SIGNIFICANT RISK REPORT

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1. Purpose of the report

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

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

1.3 The last Risk Review Group took place on 17 March 2026. A deep dive presentation was provided by Corporate Finance. Two new risks were discussed at the meeting but require review outside of the meeting by the Chair due to non-quoracy.

2. Background

2.1 A comprehensive review and refresh of the Corporate, Care Group and Specialty level risk registers was launched in November 2023. This followed an initial review and recommendations made by an External Consultant on behalf of the Trust in October 2023. Phase 1 of this work was concluded at the end of March 2024. Phase 2 will involve embedding the processes and governance improvements introduced and continuing to develop the risk culture in the organisation.

2.2 One of the outputs of the Trust Risk Review was the creation of a Significant Risk Report. The latest is summarised in Section 3 of this report.

2.3 The Risk Review Group was established in early February 2024. The Group, which meets monthly and is chaired by the CNMO. Deep dives are presented by all Corporate and Clinical Care Groups twice a year.

3. Current Significant Risk Register

3.1 There are currently 39 risks in total on the Significant Risk Report. This is four less risks than when the last report was received by the Board.

3.2 There has been two existing risk escalated to the Significant Risk Register since the last report. Five further risks have been de-escalated. The remainder of the residual risk ratings remain the same. The details are at Section 4.

3.3 There are overdue actions associated with four of the risks (marked in bold for clarity on the attached Appendix). This is an improved position on the last Board report. These have been escalated for immediate attention with the Risk Owners and Delegates and Accountable Executives informed.

3.4 This month's report contains a forecast (where known) of when the risk is likely to be de-escalated due to mitigations. The remaining risks will be reviewed by the end of March 2026 - with a particular focus on aged risks (two years and older) and progress monitored with additional scrutiny of static aged risks via the Risk Review Group. There

are currently 19 risks on the Significant Risk Register that have been on the Risk Register for more than two years (although they will not have had a residual rating of high or above for all of this time). A number relate to both local and national system wide issues (for example hospital flow, lack of capital investment in infrastructure and hard to recruit to areas). In some cases, these risks may remain but require rearticulating by Risk Owners.

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to February report	Target Risk Score	Actions summary
678	Care Group - Diagnostics, Cancer and Buckland Accountable Executive: Chief Medical Officer (CMO) **Forecast: Risk to be reviewed after External Review (June 2026) with consideration of whether the risk is accepted and should be closed.**	Insufficient Pharmacy support for the safe (and secure) use of medicines on wards	High (15)	⟺	Low (4)	Request purchase of Sunrise medicines app for use by pharmacy staff with aim of improving processes on the system which have been impacted when switching to epma e.g. ordering and screening (Home function is required to improve MR process) Awaiting outcome of decision. Note new version will be introduced in 2026 – unclear on impact to pharmacy team Person Responsible: Deputy Lead CS Pharmacist Due: 31 March 2026 **Identify causes of late nights for clinical pharmacy staff and identify strategies to reduce the commitment (clinical staff provide a late-night commitment which is Time Off In Lieu (TOIL) based which reduces clinical capacity).**

						Person Responsible: Lead Pharmacist for Clinical Operations **Due: 28 February 2026** Propose a new model of working to support review of most at risk patients. Proposal to include impact on other patients for Care Quality Commission (CQC) and Trust to review Person Responsible: Lead General Specialist Medicine Pharmacist Due: 31 March 2026 (due date extended as significant work embedding the Standard Operating Procedure (SOP) and evaluating).
679	Care Group – Diagnostics, Cancer and Buckland Accountable Executive: CMO **Forecast: Risk score to be reviewed following completion of works (for April Risk Review Group)**	Failure to supply, from Pharmacy, scheduled chemotherapy treatments to patients	Extreme (20)		High (15)	Remedial works on Air Handling Unit (AHU) to be completed and confirmed as closed. Comprehensive update provided by the Director of Pharmacy but awaiting confirmation to enable closure of risk action. Person Responsible: Pharmacy Quality Assurance & Quality Control Lead/Director of Pharmacy Due: 31/03/26
1350	Care Group – Diagnostics,	Failure to provide ward stock medicines	High (15)		Very Low (3)	Person Responsible: Chief Pharmacy Technician

	Cancer and Buckland Accountable Executive: CMO **Forecast: Business Case (BC) approved at Business Case Scrutiny Group (BCSG) on 17/10/25. To be presented at Finance and Performance Committee (FPC) and tender process to commence.**	in a timely fashion due to obsolescence of Pharmacy TWS Distribution robot				Due: 31 March 2026 Discuss finances with DCB finance lead again to ensure we are clear on costs, cost benefits and savings Person Responsible: Chief Pharmacy Technician Due: 31 March 2026 Develop internal project plan for robot project Person Responsible: Chief Pharmacy Technician Due: 31 Mar 2026 Update: Previous outstanding actions implemented. New actions added action for next stage.
1679	Corporate People and Culture **Accountable Executive: Chief People Officer (CPO)** **Forecast: Not expected to be de-escalated in short term. For review alongside Delivery Plan implementation. Links to**	There is a risk of failure to address poor organisational culture	High (15)		Low (4)	The People and Culture Strategy has been drafted and will be approved in conjunction with the Trust Strategy. The due date has been amended to reflect this. In the meantime, the Delivery Plan is progressing with regular update to Trust Management Committee. Person Responsible: Norman Blissett, CPO Due: 31 July 2026

	BAF FPC002.					
1814	Corporate – Strategic Development & Capital Planning Accountable Executive: Chief Strategy & Partnerships Officer (CPSO) **Forecast: Not expected to be de-escalated in short term as external risk evolves but work underway to strengthen controls and response.**	Loss of access to key operational / clinical systems from threats (cyber air con, break of external circuits, fire, floods etc) for a protracted period	High (15)	⟷	Moderate (10)	Following the review of the role of cyber responsibilities within the IT team a further action is to review and update Job Descriptions (JDs) to ensure they reflect post holders responsibilities. Person Responsible: Head of Infrastructure, Cyber and Frontline Services Due: 30 April 2026 **Training needs analysis to be undertaken for IT staff in relation to cyber.** **Person Responsible: Head of Infrastructure, Cyber and Frontline Services** **Due: 23 Feb 2026** Review privileged access rights to key infrastructure systems (as per DocIT) Person Responsible: Head of Infrastructure, Cyber and Frontline Services Due: 31 Mar 2026 Review of external facing systems that currently do not support Multi-Factor Authentication (MFA) Person Responsible: Head of IT Applications Due: 31 Mar 2026

						Review and update current IT incident and cyber response plans Person Responsible: Head of Infrastructure, Cyber and Frontline Services Due: 30 April 2026 (extended).
1891	Corporate Operations Accountable Executive: Chief Operating Officer (COO) **Forecast – not expected to de-escalate in short term (linked to BAF FPC002**	Misalignment between Demand and Capacity across the Trust's urgent and emergency care pathway	Extreme (20)		Low (6)	Conduct a comprehensive review of current Emergency Department (ED) processes and identify areas for improvement - focussing initially on the opportunity to reduce the number of patients spending 12+ hour in ED. Refresh of Clinical Decision Unit (CDU) model as part of Same Day Emergency Care (SDEC) capital build process as an enabler. Colocation of Urgent Treatment Centre (UTC) to fully utilise Emergency Floor footprint. Review from September with Emergency Care Improvement Support Team (ECIST) support is underway at William Harvey Hospital (WHH) and areas of good practice with be transferred to Queen Elizabeth the Queen Mother Hospital (QEQM). to be included and referenced in Urgent and Emergency Care (UEC) Improvement Plan that now has structure and governance within the

						Programme Board to Trust Management Committee (TMC). CDU estates changes in progress and nearly complete with a Standard Operating Procedure (SOP) for utilisation. Extensive bed modelling has taken place as part of the winter planning process for Board review in October. New SDEC capital builds at both sites are on schedule for July 2026 at QEQM and September 2026 WHH. New SDEC clinical modelling session in place with Getting it Right First Time (GIRFT) at WHH end of February 2026. Person Responsible: Alison Pirfo, Deputy COO Due: 31 Jul 2026 (Review: 06/02/2026- implementation date extended from 28/02/2026)
2123	Care Group – Diagnostics, Cancer and Buckland Accountable Executive: CPSO **Forecast: Meeting to be held with Managing Director**	Health and Safety Risk to staff and the potential unavailability of records at the point of need due to lack of storage space for Health Records.	High (15)		Low (4)	Intention to move health records under digital team (Corporate Strategy Development (SD) – Director of Information) pending consultation. This will enable alignment with digital strategy Person Responsible: Alison Mitchell-Hall, MD DCB Due: 01/04/2026

	(MD) Diagnostics, Cancer, Buckland (DCB) w/c 23/03/26 to review risk scoring and forecast					February update – delay in the above transfer happening and enactment of strategy regarding reducing the number of paper health records. Strategy to be developed and agreed regarding the creation of new paper records Person Responsible: Helen Mackie, Acting CMO Due: 01/04/2026
2234	Care Group – Diagnostics, Cancer and Buckland Accountable Executive: CMO **Forecast: Not expected to close or be de-escalated in short term as relates to hard to recruit area. Mitigations in place and digital and AI solutions being implemented where appropriate** Review 12/03/26 February much improved	Failure to meet national histopathology Turnaround Time (TAT's) to support cancer pathway	High (16)	⟺	Moderate (8)	Kent and Medway Pathology Network (KMPN) Digital Histopathology & AI project to improve performance & resilience. NB: this is an adjunct to maintaining service delivery and performance and NOT all histology cases can be reported using AI. Person Responsible: Head Biomedical Scientist Cellular Pathology Due: 31 Dec 2026 Update 26 Feb 26: Digital pathology is being rolled out however validation is still in progress therefore not yet UKAS accredited. Trust involved in discussions regarding a Kent & Medway Joint Venture. Trust to ensure areas of pressure are highlighted and worked up.

	histology reporting – 74% inside 10 days (78% for urgents) but reduced demand and increased reporting capacity					Person Responsible: Helen Mackie, Acting CMO. Due: April 2027(extended from 31 Jan 26) Update 26 Feb 2026: Moved to Phase 2 on 2 Feb 2026 - involves implementing the new single governance structure and single management team above Head BMS level to create the joint venture.
2599	Corporate – Medical Accountable Executive: CMO **Forecast: Not expected to close or be de-escalated in short term as relates to hard to recruit areas.**	There is a risk of inadequate medical staffing levels and skills mix to meet patients' needs	High (15)		Moderate (9)	The Trust is currently undertaking a medical establishment review for acute and general medicine. This is being led by the Deputy CMO and supported by internal Programme Management Office (PMO), 1 Whole Time Equivalent (WTE) of consultant support (4 consultants) and an external expert workforce consultancy team. Person responsible: Helen Mackie, Acting CMO. Due: 31 March 2026. Conversion of full-time agency and bank into fixed term locally employed contracts whilst we complete an establishment review for all medical teams. Person responsible: Helen Mackie, Acting CMO.

						Due: 31 March 2026. QEQM Business Case has been submitted for 2 additional acute physicians who will have either CCT or CESR. 3 month timeframe to recruit. Person responsible: Sunny Chada, MD, QEQM. Due: 30 April 2026.
2808	Care Group – QEQM Accountable Executive: CMO Action – review with Care Group and agree thresholds for de-escalation (with oversight and involvement from Deteriorating Patient workstream).	There is a risk of patient harm occurring due to delays in recognising and escalating deteriorating patients in ED due to capacity	High (15)	NEW (escalation)	Low (6)	Participation in relevant audits relating to deteriorating patients and development and implementation or robust actions to address gaps and identified areas where improvement is needed. Person Responsible: Specialist Nurse Practitioner Due:31/03/2026 Focus on ensuring full compliance with resus training (paediatric and adult) for all remaining staff that require it within department - in particular medical staff. ILS and PILS compliance will be complete by end of March 2026 so action date extended. Person Responsible: Consultant Due: 30/04/2026
2844	Care Group – Diagnostics, Cancer and Buckland	Inability to take on new patients for homecare for medicines due	High (15)	⟺	Very low (3)	Halt new oral oncology patients progressing to homecare via dispensary. Base on

	Accountable Executive: CMO	to the service exceeding its capacity to support patients and the processes involved				assessment of ability to attend the hospital regularly to collect prescription. Long implementation time due to time to accrue impact Person Responsible: Chief Pharmacy Technician Due: 31/03/2026 Review income and team size in line with NMHC guidance Person Responsible: Lead Cancer Services Pharmacist Due:31/03/2026 Repatriate some homecare services in house Lead time extended because repatriation of patients is a significant amount of work Person Responsible: Pharmacy Medicines Value Team Lead Due: 31/03/2026 Consider moving staff from dispensary telemeds to homecare and bring capacity into balance as well as assess impact of so going in dispensary Person responsible: Chief Pharmacy Technician Due: 30/06/2026 NHS Professionals (NHSP) to support outsourced screening. Person Responsible: Chief Pharmacy Technician

						Due: 30/06/2026 Outsource screening Person Responsible: Person Responsible: Pharmacy Medicines Value Team Lead Due: 31/08/2026
3105	Care Group - Critical Care, Anaesthetics and Specialist Surgery Accountable Executive: CMO **Forecast: Risk to be closed in April 26 once equipment in use.**	Patient harm to Head and Neck cancer operations delayed or aborted due to aged Leica microvascular microscope breakdown	High (16)		Low (4)	A new microscope procured. Installation and training during March. Person Responsible: Procurement Facilitator – Decontamination Contract Manager Due: 31/03/2026
3354	Queen Elizabeth Queen Mother Care Group Accountable Executive: CSPO **Forecast: Review of Estates risks has been completed by Director of Strategy which may impact on**	Inability to deliver adequate care in clinical environment due to infrastructure deficiencies	High (16)		Moderate (9)	Working with 2gether Support Solutions (2gether) to create a clear targeted investment list of areas required to improve environment. Currently focussed on ventilation in core areas and awaiting proposal. Managed through Health & Safety (H&S) committee Person Responsible: General Manager

	Care Group estates risks. Work remains in progress, presented to Risk Review Group. **Relates to SRR risk 3384 and Board Assurance Framework (BAF)**					Due:1 April 2026 (action owner updated and due date from 26 Feb 2026) Review of all Fire Risks fed back from WHH Fire and Rescue visit. Sub-group to be formed to ensure immediate actions are delivered. Visit now scheduled for 16th-24th April. Person Responsible: Sunny Chada, MD QEQM Due: 31 Mar 2026 Creation of a transparent system to see open estates requests and to be prioritised by triumvirate with 2gether. Reporting to be created and submitted through H&S committee into Board once produced. Person Responsible: General Manager Due: 26 March 2026 (due date and action owner updated from 26 Feb 26) Pilot of handyman role approved by 2gether to focus on patient and staff environment improvements. Handyman now in place with weekly sign off of jobs.

						Review effectiveness in Q4 2025/26. Person Responsible: Sunny Chada, MD QEQM Due: 03 April 2026 (updated from 06 Mar 2026) Site Security review completed and to be presented to corporate Security Group to secure 5 year improvement plan for funding deficiencies. Immediate doors for security breaches locked e.g. by Spencer Person Responsible: Sunny Chada, MD QEQM Due: 01 Apr 2026 Consider external review of 2gether cleaning service to enhance standards and gain best value for money. Person responsible: Ben Stevens, CSPO Due: 31 March 26
3367	Corporate Medical **Accountable Executive: CMO**	Lack of timely review of diagnostic test results	Extreme (20)	⟷	Low (6)	Full risk review to be undertaken including actions with CMO and Transformation Team lead (PSP Senior Support Practitioner). Meetings booked for w/c 16 March 26 and w/c 30 March 26.

3384	Corporate – Strategic Development & Capital Planning Accountable Executive: CSPO **Forecast: Not expected to be de-escalated in short term. Linked to BAF FPC003 and SRR 3700.**	The ability to deliver safe and effective services & implement improvements across Trust estate is compromised due to financial constraints for capital funding and assets replacement	High (16)		Moderate (12)	Business case to be approved by NHS England (NHSE) following approval at Trust Board Person Responsible: Nicky Bentley (NB), Director of Strategy & Business Development Due: 30 Apr 2026 23 Feb 2026: Actions updated by NB, Director of Estates
3386	Care Group – Women, Children and Young People Accountable Executive: CNMO **Forecast: A new Kent wide Maternity Information System is being procured (led by Dartford). Planned rollout winter 2026. Still an open CAS alert. To understand if the**	Potential risk of inaccurate records due to Euroking back copying	High (16)		Low (4)	Work continues to implement MSR 2.1.1 into the Euroking Test environment to then be tested. If the testing is successful, then Trust to decide whether to move this into the live Euroking environment or stick with the current bespoke MSR. End date of Magentus support as part of NPSA project unclear. Person Responsible: Clinical Information Systems (CIS) Manager Due: 30/07/2026 Procurement of new Maternity IT system to ensure adequate reporting integration with current systems and patient accessibility Person Responsible: Head of Operations Due: 15/09/2026

	mitigations in place will reduce risk ahead of mobilisation of new system.					
3449	Corporate Medical Accountable Executive: CMO **Forecast: Not expected to reduce imminently but to be informed by Plus 24 SOP audit and harm reviews. Links to SRR 1891 and BAF FPC002**	There is a risk that patients who stay in ED for over 24 hours may not receive appropriate assessment and review	High (16)		Low (6)	Plus 24 SOP in place and action to develop and audit tool and audit compliance with this, including quality of and documentation of plans of care and time patient reviewed Person Responsible: Operations Director – UEC QEQM Due: 31 Mar 2026
3553	William Harvey Hospital Care Group Accountable Executive: CSPO **Forecast: Risk will close following completion of capital works – which will**	Failure of Cardiac Catheter Suite equipment (Lab 1, 2 & 3) WHH	Extreme (20)		Moderate (10)	Working on solution for a new lab that will act as a decent lab initially, to be implemented by end of financial year. Further lab replacements will then be reviewed once this is completed Person Responsible: General Manager Due: 30 Apr 2026 Capital across 25-26 and 26-27 capital programmes with expected completion of scheme Aug 26. Action

	be completed in a phased approach					and due date extended to reflect comments from Director of Strategy Person Responsible: Nicky Bentley, Director of Strategy & Business Development Due: 31 Aug 2026 Action update 26 Feb 2026: Works have commenced and will be completed in 2026/27. The equipment has been purchased and will be on site by 31 March 2026.
3556	Corporate Nursing Accountable Executive: CNMO Priority action: Review risk with owners and WHH Care Group	Risk to patient safety, privacy and dignity and experience due to overcrowding and delivery of care in non-care spaces in the Emergency Departments	High (15)	⟺	Low (6)	**Assess progress of clinical harm reviews and associated learning. Remains ongoing** **Person Responsible: Jonathan Purday, Associate Medical Director** **Due: 31/01/2026** March 26 – non care space SOP in place on both sites and escalation process.
3557	William Harvey Hospital Care Group Accountable Executive: COO **Forecast: Improved pathways but not**	Increased length of stay for mental health patients awaiting inpatient community beds	High (16)	⟺	Moderate (9)	Senior ED leads to review a good practice Discharge to Assess (DTA) framework with Deputy COO that could be used for deciding whether a patient with mental health needs (and no physical health needs) should be admitted into an inpatient bed whilst awaiting a Mental Health

	expected to de-escalate imminently due to shortage of acute MH Inpatient (IP) beds. Continued partnership work with external provider. **06/02/2026, DRO review New MH framework in place**					(MH) inpatient bed. There are some circumstances where this might be appropriate, therefore having a best practice framework would be helpful. Person responsible: Alison Pirfo, Deputy COO Due: 31 Mar 2026
3662	Diagnostics, Cancer and Buckland Care Group Accountable Executive: CNMO **Forecast – Weekly Improvement Plan meetings in place. Not expected to decrease imminently as requires recruitment into vacant posts. Following a Kent & Medway (K&M) review chemothera**	There is a risk of poor patient experience and quality of care when receiving SACT treatment due to the volume of treatments, staff skill mix and pharmacy aseptic pressures leading to delays on the day	High (16)	NEW	Low (6)	To review staffing/skill mix element of the risk. Person responsible: Clinical Matron Due: 31 Mar 2026 Review of themes from patient safety incidents in last 6 months Person Responsible: Head of Nursing – Governance Due: 31 Mar 2026 Review of policies that support the chemotherapy unit Person responsible: Associate Director of Nursing Due: 31 Mar 2026 Reconstitution by nursing staff using closed systems for selected SACT drugs Person Responsible: Clinical Matron

	py capacity being reviewed including relocating non chemo therapy work from the units.					Due: 30 April 2026 Implementation of SACT improvement plan Person Responsible: Danielle Mackenzie Due: 31 August 2026
3700	Corporate – Finance & Performance Management Accountable Executive: Chief Finance Officer (CFO) **Forecast: Risk may de-escalate pending agreement of the Plan**	Failure to agree a Medium-term Financial Recovery Plan with System / Region and National Partners	Extreme (20)		Moderate (12)	Agreement of the Medium Term Financial Plan (MTFP) with Board, Integrated Care Board (ICB) & NHSE, and update due to March 26 FPC. Person Responsible: Angela Van der Lem, CFO To be implemented by: 30 Apr 2026 Action reviewed and due date updated by DRO, LG
3702	Care Group – Critical Care, Anaesthetics and Specialist Surgery Accountable Executive: COO **Forecast: Work-ongoing but not expected to be de-escalated in short term as relates to system wide**	Delayed discharge of patients from Critical Care when medically fit to be transferred to the ward	High (16)		Moderate (8)	Work with site triumvirate on priority for critical care wardables to be discharged from Critical care Person Responsible: Director of Nursing (DoN) To be implemented by: 27 Mar 2026 Risk and action reviewed and updated by GO - implementation date extended. Workplan continues.

	flow and emergency and elective demand. **Linked to BAF FPC002 and SRR risk 1891.**					
3719	Care Group – Diagnostics, Cancer and Buckland Accountable Executive: CMO **Forecast: Not within Trust control as Alliance wide procurement but risk to be updated once timeframes established.**	There is a risk of patient harm from availability, delays and errors in Systemic Anti-Cancer Therapy (SACT) prescribing for adults due to system failures with the ARIA medonc system being out of date at Kent and Medway Cancer Collaborative (KMCC)	High (15)	↔	Low (5)	New E-prescribing system to be procured and implemented across the Cancer Alliance Person Responsible: Head of Operations Due: 30/04/2026 Action update: Matter raised at Cancer Delivery Group meeting 10/12/2025 – Senior Responsible Officer (SRO). Business case nearly complete and meetings to be scheduled - IT Project Manager has emailed Leads nurses.
3725	Corporate Nursing Accountable Executive: CNMO **Forecast: recruitment progressing and will be closed when all posts recruited to (anticipated by June 2026)**	Risk of inadequate legal services support due to vacancies and resignations	High (16)	↔	Moderate (12)	Legal structure agreed and approved. Recruitment progressing. Person Responsible: Director of Quality Governance Due: 31 March 2025

3752	Corporate – Nursing Accountable Executive: CNMO **Forecast: Risk remains but discussions and decision making via TMC and Q&SC as to away forward**	There is a risk that the Trust is non-compliance with HBN 04-01 2009 as additional beds have historically been put in permanently into four bedded bays to create six bedded bays	High (15)		Low (4)	Paper to be discussed at TMC (March 26) regarding current risk vs risk of reducing bed capacity and impact on care in non-care spaces/flow. Following this a paper will be brought to the next Q&SC (May 26) Person Responsible: Kim Perry, Deputy Chief Nurse
3782	Corporate – Operations Accountable Executive: COO **Forecast: Aligns with Risk 3874. Pending decision regarding business case investment required.**	Overdue Appointments for Patients on the Diabetes and Endocrine Outpatients Patient Tracking List (PTL)	Extreme (20)		Moderate (9)	For action please see Risk 3874 (Trust wide non RTT risk)
3799	Care Group – William Harvey Accountable Executive: COO **Forecast: To be kept under review until performance**	Insufficient capacity to deliver gastro OPA in a timely manner	High (15)		Very Low (2)	Continuation of ID Medical gastro clinics being held at the weekend until December 25. Positive impact but vacancies also be filled within team & reduction of capacity (5 to 4 clinic rooms) due to SDEC build. Person Responsible: Head of Operations

	is at acceptable stage to de-escalate.					Due: 31 March 26 (Review 21/01/26, implementation date extended from 31/12/25)
3803	Care Group – Diagnostics, Cancer and Buckland Accountable Executive: CSPO **Forecast: Review risk scoring with leads now Apex Viewer is live**	Risk of total failure of DartOCM	Extreme (20)		Moderate (8)	Project plan in place – Trust IT, Path IT and KMPN PMO team supporting to deliver Tactical solution. Apex Viewer is now live. DART support to be extended until December 26. Person Responsible: General Manager - Pathology Due: 01/12/2026
3810	Corporate – Nursing Accountable Executive: CNMO **Forecast: Risk likely to be static but with regular review of assurance** **Relates to SRR risk 3384 and BAF**	Lack of capital funding to adequately maintain the estate it is not always possible to comply fully with Health Technical Memoranda (HTM) and Health Building Note (HBN) standards which enable prevention control measures including cleaning and ventilation	High (16)		Low (4)	Report through the Quality & Safety Committee to Board to ensure oversight of existing controls and gaps in assurance- quarterly and annually Person Responsible: Sarah Hayes, CNMO Due: 31/07/2026
3830	Care Group – Women, Children and Young People	Demand for maternity services will exceed the current environmental	High (16)		Low (4)	Rotation of midwifery staff into community settings.

	Accountable Executive: CNMO **Forecast: Review current position with Director of Midwifery (DoM).**	and community capacity required				Person Responsible: Head of Midwifery and Gynaecology Due: 31 March 2026 Review of community staffing rotas. Person Responsible: Head of Midwifery and Gynaecology Due: 31 March 2026
3833	Care Group – QEQM Accountable Executive: CSPO **Forecast: Audit scores improving. Review of residual risk score with MD.**	Lack of Health and Safety Oversight Impacting Safety Culture	High (16)	⟺	Low (6)	Site wide H&S audit to determine investment plan for 2026. Person Responsible: Sunny Chada, MD QEQM Due: 30/04/2026 Site security walkaround completed and investment plan to be submitted to Trust Security Group for discussion/agreement Person Responsible: Sunny Chada, MD QEQM Due: 31/03/2026 Bed proposal completed and review at Capital Investment Committee on 18/11/25 and supported for BCSG presentation in 26. Person Responsible: Sunny Chada Due: 31/03/26
3836	Care Group – Women, Children and Young People	There is a quality and financial risk that due to the gaps in the QEQM medical grade rota,	Extreme (20) (Risk rating to be reviewe	⟺	Low (4)	To continue to explore the company BDI to provide UK trained middle grades Person responsible: General Manager Due: 31 March 2026

	Accountable Executive: CMO **Forecast: Risk expected to be de-escalated in May 2026 by when 4 additional doctors will have**	there will be clinical and financial implications for the Trust	d with leads)			Recruitment of 2 paediatric middle grade doctors in progress. to be in post by 30 April Person Responsible: General Manager Due: 30 Apr 2026 SW - action update & forward view: 4 Specialty doctors have been recruited for CYP at QEQM utilising BDI recruitment agency. 2 will commence at the end of March, 1 in April and 1 in May. The risk will remain until all applicants have been recruited.
3837	Corporate Finance and Performance Management Accountable Executive: CFO	25-26 System delivery of the Financial Position	Extreme (20)	⟺	Moderate (12)	Twice monthly Financial Improvement Programme Board Person responsible: Lorna Gibson, Director of Financial Sustainability Due: 31 Mar 2026 Monthly reporting into the Trust's Finance and Performance Committee & Trust Board Person Responsible: Angela Van der Lem, CFO Due: 31 Mar 2026 Trust unlikely to receive Deficit Support Funding (DSF) for Q3 and 4 from ICB. Trust is submitting a cash support return (to value of outstanding DSF and residual deficit) and await feedback

						Person Responsible: Julie Wells, Deputy Director of Finance Due: 31 March 26
3838	Corporate Finance and Performance Management Accountable Executive: CFO Review 12 Feb: Forward view: Further Grip and Controls in place to support agreed delivery of Cost Improvement Programme (CIP) of £60m for 25/26. Additionally, lessons learned from CIP Programme to inform next year's Programme has been completed.	Failure to deliver the Trust Financial Plan for 25/26	High (16)	⟷	Moderate (12)	Mitigating actions will need to be taken if the Trust moves away from plan mid-year Person Responsible: Lorna Gibson, Director of Financial Sustainability Due: 31 Mar 2026 Delivery of workforce headcount reductions (25/26) Person Responsible: Norman Blissett, CPO Due: 31 Mar 2026
3840	Care Group – Kent & Canterbury and Royal Victoria	There is a risk that patients are coming to harm, dying and having cancer treatment delayed or not	High (15)	⟷	Low (5)	**Patients on a non-Referral to Treatment (RTT) pathway Working Group - AI solution to be explored.**

	Accountable Executive: COO	commenced due to a breakdown in the surveillance, monitoring and escalation through the urology cancer pathways.				**Person Responsible: General Manager** **Due: 20 Nov 2025** **Business case/bid for urology pathway coordinator 3x band 3s, 2x Clinical Nurse Specialist (CNS) and 1x pathway navigator.** **Person Responsible: General Manager** **Due: 20 Nov 2025** **Development of oncology tracker identified to assist with staging and follow-up.** **Person Responsible: General Manager** **Due: 20 Nov 2025** **Recruitment of urology secretaries to meet the demands of the service may need to be taken to BCP.** **Person Responsible: General Manager** **Due: 20 Dec 2025**
3874	Corporate – Operations Accountable Executive: COO **Forecast: Mitigation will involve significant investment.**	Risk of patient harm and poor patient experience due to non-RTT follow up backlog	High (15)		Low (6)	Business Case being produced for significant investment required for validation and mitigation of the risk. Person Responsible: Dan Gibbs, COO Due: 30/06/26

	Pending BC review.					
3866	Corporate – People and Culture Accountable Executive: CPO update – external vacancy freeze in place) **Forecast – not expected to close but to be kept under review as linked to SRR 3838 above.**	Risk of inability to deliver CIP due to not achieving planned workforce reductions	High (16)		Moderate (9)	Delivery of planned workforce headcount reductions 25-26 Person Responsible: Norman Blissett, CPO Due: 31 Mar 2026
3890	Critical Care, Anaesthetics and Specialist Surgery Accountable Executive: CSPO **Forecast – risk to be de-escalated upon replacement of microscope or use of loan device (July 2026)**	WHH ENT Operating Microscope at risk of failure due to age	High (16)	NEW	Low (4)	Replacement of existing microscope. Procurement exercise to select clinically approved replacement. Person Responsible: Procurement Facilitator – Decontamination Contract Manager Due: 01 July 2026

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

	Residual Risk Score				
Care Group	**15**	**16**	**20**	**25**	**Total**
CCASS CG		3			3
DCB CG	5	2	2		9
K&C CG	1				1
QEQM CG	1	2			3
WHH CG	1		2		3
WCYP CG		1	1		2
Corporate Medical	1	1	2		4
Corporate Nursing	2	2			4
Corporate Operations	1	1	1		3
Corporate Strategic Development	1	1			2
Corporate Finance		1	2		3
Corporate Services					
Corporate People and Culture	1	1			2
TOTAL	**14**	**15**	**10**	**0**	**39**
CHANGE SINCE LAST REPORT	**-2**	**-5**	**-3**	**0**	**-4**

Heatmap Type: Residual Risk Score Update

5. Extreme	Low (5)	Moderate (10)	High (15) 5	Extreme (20) 5	Extreme (25)
4. Significant	Low (4)	Moderate (8)	Moderate (12)	High (16) 16	Extreme (20) 4
3. Moderate	Very Low (3)	Low (6)	Moderate (9)	Moderate (12)	High (15) 9
2. Low	Very Low (2)	Low (4)	Low (6)	Moderate (8)	Moderate (10)
1. Negligible	Very Low (1)	Very Low (2)	Very Low (3)	Low (4)	Low (5)
	1. Rare	2. Unlikely	3. Possible	4. Likely	5. Almost Certain

4. Changes since the last report

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

The below risks were escalated to the Significant Risk Report since the last report:

- There is a risk of poor patient experience and quality of care when receiving SACT treatment due to the volume of treatments, staff skill mix and pharmacy aseptic pressures leading to delays on the day (risk ref: 3662). DCB Care Group. Residual risk rating 16 (high). Risk escalated from 12 (moderate) on 27/02/26.

- WHH ENT Operating Microscope at risk of failure due to age (risk ref: 3890). CCASS Care Group. Residual risk rating 16 (high). Escalated 20/10/25 but an emerging risk. Risk reviewed and made open on 12/03/26.

4.2 Closure of risk or de-escalation from the Significant Risk Report

The below risks have been de-escalated from the Significant Risk Register since the last Board report due to the mitigations in place:

- There is a risk that the lung function equipment will stop working due to its age and servicing history (risk ref: 3743) QEQM Care Group. Previous residual risk rating high (15) reduced to moderate (9) on 09/03/26. Kit installed at Thanet Community Diagnostic Centre (CDC) and Buckland Hospital Dover (BHD) so score reduced to 9. Following remaining kit installation (x2) risk will be closed.

- There is a risk to deteriorating patients at K&C due to the lack of appropriate medical cover (risk ref: 3691). KCRVH Care Group. Previous residual risk rating high (16) reduced to moderate (12). Locum Consultant cover in place.

- Unable to safely staff theatres across the three sites due to high vacancy levels (risk ref: 3875). CCASS Care Group. Previous residual risk rating high (16) reduced to moderate (12) on 23/02/26 due to posts being approved and in process of recruitment.

- Inability to safely staff all three critical care units due to current vacancies within the nursing establishment (risk ref: 3867) CCASS Care Group. Previous residual risk rating high (16) reduced to moderate (12). Posts recruited to.

- Inappropriate medicines use within Surgical Specialities (includes variety of care groups) and insufficient supervision and support to junior pharmacy staff (risk ref: 2982) DCB Care Group. Previous residual risk rating high (16) to moderate (12). Posts recruited to and will be in post/have had induction period by June 26.

5. Escalations from Risk Review Group

5.1 There were no escalations from the meeting but Care Group and Corporate leads were asked to ensure that all risks are up to date – with significant risks reviewed at a minimum monthly. Care Groups were also asked to ensure they are reviewing the monthly emerging risk report via their Care Group governance meetings

6. Conclusion

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

End.