SUBMISSION FROM MEDWAY NHS FOUNDATION TRUST

Health and Adult Social Care Overview and Scrutiny Committee

19 August 2026

Medway NHS Foundation Trust – Ear Nose and Throat service update

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Summary

This report outlines progress in resolving a significant backlog of referrals to the Trust's Ear Nose and Throat (ENT) service for patients from the Dartford and Gravesham area, summarises the findings of the independent review commissioned by NHS England, acknowledges the significant governance and operational issues identified, and outlines the extensive actions taken by Medway NHS Foundation Trust and partners to address them.

Since identification of the issue last year, all affected patients have now been reviewed and their pathways completed, national recovery milestones have been achieved, waiting times have significantly improved, and new governance, reporting and service management arrangements have been implemented to ensure safe and sustainable delivery of the service in future.

1. Background

1.1 This Ear Nose and Throat (ENT) service is provided by Medway NHS Foundation Trust (MFT) at Medway Maritime Hospital in Gillingham and Darent Valley Hospital (DVH) in Dartford, which is run by Dartford and Gravesham NHS Trust (DGT).

1.2 A validated backlog of 8,849 patients from the Dartford and Gravesham area was identified whose referrals to the service had not been managed in line with national NHS waiting time standards.

1.3 This included 4,279 adults and children awaiting a first outpatient appointment, and 4,570 existing patients awaiting a follow-up appointment, diagnostic test**,** or procedure. As a result, these patients experienced a significant and unnecessary delay to their care.

1.4 When these referrals were first received, they were reviewed by a clinician and assessed as routine, meaning that no urgent concerns, such as cancer, were identified at the time.

2. Progress and current position

2.1 Since identification of the backlog in May 2025, all affected patients have now been reviewed and their pathways completed.

2.2 National milestones to eliminate waits longer than 65 weeks and 52 weeks were achieved by December 2025 and March 2026 respectively.

2.3 More than 3,200 patients underwent clinical review for potential harm, with no cases assessed as moderate or severe harm.

2.4 ENT waiting times have significantly improved, with 74.8 per cent of patients treated within 18 weeks in June 2026 compared with 54.5 per cent in December 2025.

2.5 The service has received national recognition which noted the improvement from among the lowest-performing services nationally to one of the strongest performers for 18-week standards.

2.6 New governance arrangements, a single patient tracking list, strengthened performance oversight, a revised hosted service agreement and regular Board-level monitoring have been implemented to support sustainable improvement and reduce the risk of recurrence.

3. Review findings and recommendations

3.1 An external review, commissioned by NHS England South East, examined the key issues and events that led to the backlog, and set out a series of conclusions and recommendations on the actions required to address the issues identified.

3.2 The review concluded that a combination of governance weaknesses, incomplete data visibility, capacity constraints following the pandemic, and shortcomings in the management of the hosted service arrangement contributed to the development of a long-standing backlog within the ENT service delivered at DVH.

3.3 The absence of a visible, accurate Patient Tracking List (PTL), long term Referral to Treatment (RTT) data gaps, and a Service Level Agreement (SLA) that was not fit for purpose meant neither trust had reliable oversight of patient pathways or performance.

3.4 Clinical teams were aware of issues but constrained by capacity loss, clinic changes, and a focus on cancer and emergency work post-pandemic, while operational teams did not escalate concerns effectively.

3.5 Weak governance structures missed escalation opportunities, and limited professional curiosity across departments allowed problems to persist for years, compounded by gaps in oversight by the Integrated Care Board (ICB).

3.6 The recommendations include system integration, clear standard operating procedures, strengthened performance management, a new SLA, improved governance, cultural improvements, and an ICB-led redesign of the ENT model, all brought together under a single ENT Delivery Plan with Board level monitoring.

3.7 The Trust fully accepts the findings and is sincerely sorry for the impact on patients. The review's nine conclusions and 14 recommendations are set out in Appendix A.

4. Addressing the findings and recommendations

4.1 Once the issue was identified, teams at both trusts acted immediately – validating records, contacting patients in line with Duty of Candour requirements to explain what had happened, and increasing capacity to ensure patients could be seen at the earliest possible opportunity.

4.2 In June 2025 a new ENT referral process was introduced directing all ENT patients to MFT. This ensured full oversight of the backlog cohort and new referrals received for patients from the Dartford and Gravesham locality.

4.3 All open ENT pathways were transferred from DGT's Patient Administration System (PAS) and registered on the MFT PAS by the end of July 2025, with clinics at DVH built onto the MFT PAS, and all bookings now controlled by MFT staff. A Standard Operating Procedure now governs referrals, booking, scheduling and outcome management. As a result, all ENT activity is now administered consistently, transparently and in line with the future hosted service SLA.

4.4 As backlog patients were registered on the Trust's PAS, it became clear that of the 4,570 patients awaiting follow up, 2,870 were already on long term follow-up pathways. This left 5,979 patients to be seen, including 935 children. Of these, 2,352 had a waiting time of less than 52 weeks, 1,408 between 52 and 103 weeks, and 2,219 longer than 104 weeks.

4.5 Capacity was increased to ensure patients were seen at the earliest opportunity, while maintaining access for urgent and cancer patients. This included a combination of increased internal capacity, insourced weekend capacity at both hospitals, and additional community capacity.

4.6 The Trust prioritised the longest waiting patients for first appointment, unless clinically indicated otherwise. Within this, children were prioritised over adults, again unless otherwise indicated.

4.7 As a result, all affected patients were seen, treated, and discharged by the end of May 2026. The Trust also met national milestones to treat all patients waiting longer than 65 weeks by December 2025, and those waiting longer than 52 weeks by the end of March 2026.

4.8 ENT waiting times have also significantly improved. In June 2026 74.8 per cent of patients were treated within 18 weeks, up from 54.5 per cent in December 2025.

4.9 Professor Tim Briggs, National Clinical Lead for Getting it Right First Time (GIRFT), recently wrote to the Trust to praise the significant efforts to clear the backlog – noting that the service has moved from bottom of the country for treating patients within 18 weeks last year, to third best nationally by April this year. The national team will be visiting Medway soon to learn from this work and share learning across the NHS.

4.10 All patients waiting longer than 52 weeks were reviewed for potential harm during their clinic assessment. More than 3,200 adults and children were reviewed, with 88 cases assessed as low harm and none identified as moderate or severe harm.

4.11 Oversight and leadership of the service have also been strengthened. The divisional structure has been strengthened, with all previously acting leadership roles in the Surgery and Anaesthetics Division now substantively appointed. ENT now has its own dedicated Service Manager rather than a shared role, ensuring focused operational oversight.

4.12 Data quality and reporting have also improved. All ENT RTT activity for patients from both localities is managed and reported as a single, combined PTL, ensuring full visibility and consistent oversight. ENT performance, including Head and Neck cancer pathways, is reviewed weekly as one integrated service, with clear accountability residing with MFT for RTT, cancer reporting and national dataset submissions.

4.13 Weekly Director-level PTL reviews now provide strengthened oversight, with direct escalation to the Chief Operating Officer where required. Detailed demand and capacity modelling for 2026/27 has been completed across all specialties, and consultant job plans are being aligned to the activity needed to deliver sustainable performance.

4.14 Demand and capacity for ENT and Audiology are now balanced, including first appointments and diagnostics, with flexibility to manage fluctuations in urgent and cancer referral. This provides clear assurance that historic gaps have been addressed and the service is operating on a stable, well-governed footing.

4.15 A new hosted SLA with DGT will be implemented in August 2026. Led by MFT as the provider organisation for ENT, this provides clear governance, escalation routes, named operational and clinical contacts, and detailed expectations for productivity, utilisation, staffing ratios, accommodation, and equipment.

4.16 Both trusts have been engaged in shaping the agreement, and arrangements are in place to ensure regular joint performance meetings and a structured review cycle led by the accountable contract teams. This work provides strong assurance that future delivery of the hosted ENT service will be transparent,

well-governed, and consistently monitored.

4.17 A review of ENT commissioning arrangements across the ICB is under way with support from NHS England.

4.18 Further work is underway with system partners to act on the review's recommendations, and a detailed report about this will be presented to the Trust Board on Wednesday 2 September and published on the Trust website.

5. Risk management for MFT

5.1 The backlog described in this report has been resolved and significant actions have been taken to address the issues identified by the independent review. Ongoing implementation of the review recommendations is subject to regular monitoring and oversight through established Trust governance arrangements.

6. Financial implications for MFT

6.1 There are no financial implications arising from this update report.

7. Legal implications for MFT

7.1 There are no legal implications arising from this update report.

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Appendices

Appendix A – conclusions and recommendations of the external review commissioned by NHS England South East

Appendix A : **Conclusions and recommendations of an external review commissioned by NHS England South East.**

Conclusions

1. The absence of an MFT PTL for all their ENT activity hosted by DGT is seen as the central defining factor in the identified backlog issue. The inability to build any interim visible PTL solution to provide a patient safety net by the BI team at MFT is concerning, and there is no evidence that weekly, collated ASI information was consistently acted upon by operational teams.

2. Accurate recording and reporting of RTT data are central to meeting the RTT operational waiting times standards, delivering the maximum waiting times to all eligible patients and to the utilisation of Patient Choice Protocol. All parts of the NHS have a role to play in ensuring that waiting time data is recorded accurately. However, primary responsibility for accurate waiting time data sits with the Chief Executive of each organisation. There were known gaps in the external reporting of patient level RTT data for the ENT hosted patients at DGT, potentially dating back to 2014.

3. Medway ENT clinicians and operational managers from both trusts were aware, from 2020, that there was an issue with the ENT hosted service at DGT. There is evidence that formal or informal concerns were not acted upon either clinically or operationally.

4. There is no evidence that the internal reporting assumption at MFT about the true size of the total PTL was challenged. There is no evidence that concerns tabled at the Information Governance meetings chaired by the Chief Medical Officer were triangulated or escalated to the Trust Executive or Board level. The transfer of all hosted ENT activity onto the MFT PAS could have enabled meaningful business planning and regular demand and capacity reviews. Had this been the case, patient level information and oversight would have been possible, but discussions lacked impetus.

5. The SLA was not fit for purpose, meaning that there was a lack of process, performance levers were lost and escalation was not followed. From 2020 onwards, processes were designed to address known difficulties in costs, visibility, reporting, and capacity challenges.

6. From 2019 to 2025, outpatient capacity was lost at DGT due to the risk of aerosol-generating procedures and the repurposing of the area. Changes in clinic templates initiated by the ENT clinical body, in response to concerns regarding emergency workload and cancer referrals, together with the cessation of any additional capacity, significantly reduced the available capacity for general ENT new and follow-up pathways. Clinically, the ENT service authored two papers; one from the Clinical Director and another from the ENT GIRFT lead. The main body of the consultants focused their activity on the known issue of two-week waits, and the lack of visibility of the whole PTL meant that waits grew.

7. From 2020 onwards, it is stated in emails that escalation to the MFT Executive Team did take place, but until March 2024 did not appear to attract meaningful attention. The paper presented by the Deputy Chief Medical Officer was finally approved on April 2nd, 2024.

8. In February 2024, concerns raised within the ICB were not acted upon or followed up, and the opportunities for earlier review and resolution were missed. No meaningful business planning for ENT could take place due to the absence of DGT data in any planning methodology. However, the constraints experienced in the ENT service were already known by the ICB. ENT services had been in Service Development Plans (SDIPs) within the ICB contract since 2022/23. In May 2025, the COO at MFT established the extent of the backlog from an internal meeting at MFT and reported this directly to the ICB.

9. There was a perceived over-reliance on the ENT Secretariat at DGT by MFT, and whilst DGT sought a local response from MFT, they did not escalate the issue within their own Trust. There was a perceived lack of professional curiosity across all departments and disciplines associated with the service.

Recommendations

a) The ENT hosted activity delivered at DGT must be registered and administered by the MFT PAS. This needs to be documented in a standard operating procedure, communicated, and included as an appendix in the revised SLA document. Access to Diagnostics at DGT is provided through the existing SLA arrangement and will remain so.

b) Once all ENT activity is registered and administered by MFT, appropriate access and training must be provided for all staff. The responsibility for this delivery rests with MFT.

c) The process to record and outcome any activity delivered at DGT must be clear, concisely documented in a standard operating procedure and communicated to all staff at DGT and those who interface with the ENT service. This includes the audiology team and clinical ENT staff. Arrangements must be made to ensure that all new members of staff are aware of this process and that it is included in any PAS system training. The documented process must be included in the revised SLA. The responsibility for this delivery rests with MFT.

d) All ENT referrals must be visible on the Referral to Treatment (RTT) PTL at Medway Foundation NHS Trust and reviewed at the weekly performance meeting. The accountability for RTT cancer reporting and pathway management resides with MFT. The submission and compliance of all National Dataset returns for ENT must be the responsibility of the Information Team at MFT.

e) Performance oversight processes at MFT need strengthening and for the outcomes of PTL reviews directly reported to the COO. Robust demand and capacity modelling and planning is required across ENT and Audiology to prevent capacity gaps creating the potential for the growth in long waits. This

should be undertaken in partnership with the ICB and be reflected on and monitored through all consultant job plans. Given the known gaps in capacity as referenced to in the SDIP, any additional activity will need to be commissioned by the ICB.

f) A systematic review of the current commissioning arrangements and future clinical model for ENT across the wider ICB is urgently required. Led by the ICB and supported by NHSE colleagues, the review and future model need to take into account capacity constraints previously identified in the SDIP documents, and requirements to transform the service in line with any national recommendations.

g) A new hosted-service SLA is required. As commissioners of the service, the development will be led by MFT and agreed with representation from both NHS Trusts. The SLA hosted contract requires points of escalation, named contacts, detailed productivity and utilisation metrics, expected ratios of nursing and admin staff, an inventory of accommodation and equipment, and details of regular performance meetings between both trusts. The document must be signed and retained by the respective contracts departments. The cycle to review the SLA should be planned and led by the accountable contracts department.

h) The MFT managers accountable for the ENT service need to be visible on site at DGT to problem solve and build positive relationships with colleagues. At a minimum, this requires attendance on alternate weeks. Hosted contract performance meetings between MFT and DGT must be held monthly to discuss the agreed inventory of accommodation and staff in line with standard hosted-service arrangements led by the Divisional Director of Planned Care from MFT with the Divisional Director of Operations responsible for Outpatients at DGT.

i) A systematic review should be undertaken of the governance of all committees that feed into the Board Assurance Framework (BAF), namely Information Governance, Quality Assurance Committee (QAC), and Finance and Performance. A review of their Terms of Reference, lines of reporting, membership and basis of reports is a core requirement. This review should include reporting to Trust Board and the non-executive membership's understanding of all these committees.

j) The divisional structure for planned care at MFT needs to be reviewed, and appropriate action taken where gaps in personnel are evident. A systematic review of governance across the Division is an essential requirement of this, including revision of terms of reference for the Divisional Board and reporting of information on quality, safety, and risk. Consideration should be given to an Executive member providing oversight at all Divisional Board meetings until assurance is provided of their functioning.

k) The delivery of the actions from the Cultural Transformation Report must be central to building relationships between the ENT department at MFT, Division of Surgery, DGT and ICB. To enable this, consideration should be given to an external facilitator to lead any agreed sessions between the two acute Trusts.

This is to ensure staff escalate concerns appropriately, understand Trust Policies, and know how to raise issues through their line manager structures, Freedom to Speak Up Guardian, or a nominated senior. The Chief Operating Officers and other Executives at DGT, MFT, and the ICB must role-model a speak up culture and implement clear systems for doing so, support staff in raising their concerns, and use examples as an opportunity for continued improvement.

l) MFT was sighted to the known gaps in the external reporting of patient level RTT data of the hosted patients at DGT, potentially dating back to 2014. Consideration needs to be given with colleagues at NHSE to how reporting will be reinstated and the impact on the local and national position that these gaps have had.

m) DGT urgently requires a PAS which is compliant with the capture of information required for all national RTT data sets.

n) There needs to be one overarching ENT Delivery Plan, which incorporates accepted recommendations from this review, any transformational interventions, and which has oversight and monitoring against delivery from the ICB and Medway Trust Board.