UNCONFIRMED MINUTES OF THE COUNCIL OF GOVERNORS PUBLIC MEETING HELD ON TUESDAY 03 FEBRUARY 2026 AT 10:00 – 12:00HR BOARDROOM, KENT AND CANTERBURY HOSPITAL

PRESENT:

Dr Annette Doherty	Trust Chair, Chair	AD
Bernie Mayall	Lead Governor	BM
Olubunmi Akinnawonu	Elected Governor - Staff	OA
Laurence Arterton	Elected Governor – Thanet	LA
Sarah Barton	Elected Governor – Ashford	SB
Monique Bonney	Elected Governor – Swale	MB
Linda Judd	Partnership Governor	LJ
Kieran Leigh	Elected Governor - Folkestone & Hythe	KL
Paul Schofield	Elected Governor – Thanet	PS
Dr Andrew Catto	Non-Executive Director	AC
Khaleel Desai	Director Corporate Governance	KD
Dan Gibbs	Chief Operating Officer	DG
Ffion Griffiths	Non-Executive Director	FG
Sarah Hayes	Chief Nursing and Midwifery Officer	SH
Dr Des Holden	Acting Chief Executive Officer	DH
Robert Musgrove	Non-Executive Director	RM
Richard Oirschot	Non-Executive Director	RO
Claudia Sykes	Non-Executive Director	CS

IN ATTENDANCE:

Nataliya Reckling	Executive Assistant *(Minutes)*	NR
Sylvia Robson	Board Secretary	SR

MINUTE NO. Conf.CoG/25		ACTION
25/033	**CHAIRMAN'S INTRODUCTIONS** Chair welcomed everyone to the meeting and offered her thanks to the group for taking the time to be present. Chair confirmed that no members of the public were present.	**AD**
25/034	**CONFIRMATION OF QUORACY** The Chair confirmed the meeting was quorate.	**AD**
25/035	**APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS** Apologies were received from: – Governors - Alex Ricketts, Carl Shorter and Russell Wyles – NEDs – Prof Chris Holland, Dr Olu Olasode and Catherine Walker There were no declarations of interests in respect of the agenda items.	**AD**

	The Chair informed the Council that CQC had conducted two inspections of QEQM in January 2026 and were currently inspecting WHH. Therefore, a number of Executives could not be present at the Council meeting today.	
25/036	**MINUTES OF PREVIOUS MEETING HELD ON 29 OCTOBER 2025** The minutes from the previous meeting held on the 29 October 2025 were **APPROVED** as a true and accurate record of the meeting subject to correcting of two spelling errors.	**AD**
25/037	**MATTERS ARISING FROM THE MINUTES** The Chair noted that all outstanding actions were included in the agenda and will be addressed at this meeting. SB referred to the previous action log item noted as exploring a possibility of information boards in public areas of EDs. SB clarified that the original intention was not specifically about information boards, but rather about providing information to help patients manage their expectations. During her visit to the ED at WHH SB observed that patients and visitors often did not know where to go, and improved signage and wayfinding across ED would help patients navigate to the correct areas more easily. The Council discussed that the signage could be improved at all sites and that volunteers also helped patients and visitors to find their way in the hospitals. Additionally, SB commented that the removal of reception desk at WHH could potentially create issues for 2gether staff who will occupy this area as patients and visitors might approach them for directions.	**AD**
25/038	**RATIFICATION OF VIRTUAL VOTES SINCE THE LAST MEETING** Chair confirmed that since the last meeting, there were no virtual votes to ratify.	**AD**
25/039	**CHAIR'S REPORT** Chair confirmed that her report would be verbal and wanted to highlight the following: – **Unannounced CQC Inspections** AD expressed thanks and appreciation to the Executive team for their significant efforts throughout January 2026 in responding to the CQC engagement and follow-up activity, noting it has been an intense period. Staff were recognised for working incredibly hard, staying focused, and being open and transparent about areas requiring improvement. A robust action plan has been developed by Chief Nursing and Midwifery Officer and the Executive team, and that this plan is actively being followed after the recent visit to QEQM.	

- **Infection Prevention and Control**

A significant norovirus outbreak in the QEQM has required the closure of beds, which has increased operational pressure across the organisation. Flu was noted as less of an issue at present. These pressures have had a notable impact on Emergency Care, adding to an already challenging period. AD emphasised that teams have been working collaboratively and transparently throughout the outbreak response.

- **Update on Contract and Commissioning**

A number of system-wide meetings have taken place involving Trust Chairs and CEOs across Kent and Medway. These meetings focused on the future commissioning approach being developed by the ICB, which includes significant changes to how services will be commissioned and how contracts will be structured. The Trust is currently in a period of negotiation regarding the commissioning offer. Two versions have been received so far, with a final offer expected shortly. The Trust's Chief Finance Officer have dedicated extensive time to understanding and responding to the emerging commissioning proposals.

A key strategic direction shaping these discussions is the "left shift" – moving appropriate services from acute hospitals into primary care and community settings and development of integrated neighbourhoods designed to deliver certain services closer to home. These initiatives aim to ensure that people who do not need to attend EDs are supported elsewhere, especially frail elderly patients, who often arrive in EDs when alternative care settings would be more suitable.

- **Finance Update**

AD highlighted that all acute provider Trusts in Kent and Medway are expected to fall short of their original financial delivery plans for the year. The Trust is targeting £60m in savings for the financial year, with only two months remaining. Despite the challenge, the Chair expressed confidence that the Trust will meet the £60m target, though it requires intense focus and discipline. The system-wide savings element, approximately £22 million, will not be delivered this year, which is consistent across neighbouring acute Trusts.

Achieving the £60m Trust-level savings would represent the largest CIP improvement plan ever delivered by the organisation. Maintaining quality and patient safety alongside such significant savings has been difficult, but remains the top priority.

The Council was made aware that the ICB had commissioned Ernst & Young (EY) to analyse the underlying causes of the deficit, to identify future system-wide opportunities for improved collaboration and financial efficiency across Kent and Medway. The Board will receive an update from EY representatives this week.

- **NEDs Update**

It was confirmed that CS had agreed to serve a second term as a NED, and this had been ratified by the Governors. The Chair commended CS as a dedicated NED and a valuable Vice Chair.

	RO was offered a second term, but due to significant work commitments, including overseas travel, he was unable to accept a full additional term. However, RO has agreed to extend his role for four months to allow continuity through the end of the financial year and to provide time to safely transition responsibilities to a new NED. AD recognised the challenge of replacing RO's significant expertise and leadership. RO expressed that he has enjoyed his time with the organisation. As a consequence of RO's upcoming departure, the Trust will need to appoint a new NED. This process will be brought to the NRC for agreement and next steps. MB raised a about whether there will be improvements to new GP surgeries and local services. AD confirmed that one of the system - level business cases focused on increasing investment in GP services across Kent and Medway. Current provision is highly variable, and additional services cannot be placed into GP practices without extra funding and capacity within community settings. The Council heard that there was also a system-wide business case around increasing provision within Mental Health Services, acknowledging national challenges and the high number of mental health patients who present to ED in crisis, which often is not the right place for them to be cared for. AD informed the Council of two other system-wide business cases around developing Integrated Neighbourhood Teams to deliver more services in the community, including outpatient follow-up, diagnostics, and other aspects that do not require hospital attendance, and improving discharge pathways, recognising delayed discharges as one of the biggest barriers to hospital flow. Additionally, all Kent and Medway CEOs have signed up to the system-wide transformation plan, which aims to reduce reliance on acute hospitals for activity that could be managed elsewhere. The reduced contract offers to acute providers reflect a deliberate system push to encourage this shift. AD acknowledged that this transformation journey was likely to take three to five years as the level of change cannot be implemented within a single financial year. DH added that business cases mentioned above must demonstrate at least a 2% financial benefit relative to overall spending which is a formal qualifier for approval. These business cases focus on providing better, faster responses for patients with the emphasis on designing pathways that work for all population groups recognising that standard models may not meet the needs of every group and that people access health services in different ways. In particular, the proposal for improved access to mental health services seeks create alternative provision through partnership with social care to reduce avoidable ED attendances and provide more appropriate, timely support.	

	Elective referral management proposals focus on improving how referrals for elective care are handled, with emphasis on early interventions such as therapies and lifestyle advice to prevent unnecessary referrals to specialist pathways. However, success would depend on consistently high capacity in primary care. In relation to the recent CQC inspection of emergency pathway at QEQM, DH noted that the inspectors had observed strong focus on patient safety and high levels of compassion in care delivery. CQC staff spoke to a wide range of clinical teams and patients, and reported a generally favourable impression. CQC team raised concerns regarding overcrowding in ED; six patients were found in an area the CQC felt was too congested for safe care. Concern was also raised about how staff managed situations where physical space is insufficient, and whether the nurse in charge had clear and ultimate responsibility in these conditions. CQC inspectors also noted that there were significant numbers of corridor patients over a two-day period, particularly, concern was raised regarding patients receiving oxygen in the corridor which was felt to be outside SOP. In relation the medical pathway inspection at QEQM, the CQC approach was more collaborative and solution-focused. Only a small number of concerns were raised in this round of inspection.	
25/040	**ACTING CHIEF EXECUTIVE OFFICER'S REPORT** This was highlighted in the previous agenda item.	
25/041	**LEAD GOVERNOR REPORT** BM expressed her gratitude to CS and RO for their contributions to the Trust. BM noted that the Trust was experiencing ongoing movement, development, and organisational change. Change, though sometimes unsettling, often leads to positive improvements and the Governors have a key role in supporting the Trust and its leadership; maintaining a calm, rational approach; avoiding and addressing speculation, and reassuring and supporting colleagues during transitions. The Council is entering the election period, which naturally brings some uncertainty. BM wished good luck to all current governors who were standing again, and offered thanks to those stepping down, recognising their service and commitment. BM informed the Council that Alex Ricketts was stepping down after thoughtful consideration, he will be greatly missed, both professionally and personally. Neville Daw has also stepped down after over four years of support. Neville is known for his strong understanding of systems and processes and is a hard act to follow. A refreshed Governor support team is now in place, some members know the Council well; others are still settling in. Khaleel Desai (KD) will act as the	**BM**

	interim bridge between the Council and the support team and all Governor queries should initially go to KD. BM expressed thanks to the Acting CEO for his steady leadership during a challenging period and for providing a sense of safety and stability. BM also noted that, in her view, the Trust had the strongest group of NEDs and Executives it has ever had, and that the Trust leadership were working cohesively and effectively. BM highlighted the need to remember the Trust's difficult history, including serious challenges and scandals such as Maternity Review. However, the progress has been made and everything remains a work in progress, with some improvements taking more time than others. BM emphasised that the Council was made up of dedicated and capable individuals and expressed genuine pleasure and privilege in serving as part of the Council and the Trust.	
25/042	**TRUST SECURITY UPDATE** KD provided Trust security update in BS's absence. The Council heard that a Trust-wide security review had taken place in August 2024 due to post-Covid transition as many existing arrangements still reflected pandemic needs, and rising number of security incidents, particularly in the EDs. As a result of the review, new security arrangements were implemented. At QEQM and WHH one additional 24/7 security officer has been added to each ED. This improved response times to incidents and resulted in earlier and more effective de-escalation. ED staff reported feeling more supported and safer. Body-worn camera trials have been successful and well-received. At RVH, the review led to the removal of one 24/7 security officer, returning to pre-COVID staffing levels. However, concerns were raised locking and unlocking procedures and general security arrangements. Planned improvements included new door access control systems, enhanced exterior lighting and improved perimeter fencing. In addition, the security team conducted risk assessment and provided advice on lone working, violence and aggression, and emergency response. KD noted that the net change across the Estates had equated to an additional 14 hours of daily security coverage, equivalent to one full additional security officer per day. Some concerns were raised regarding CCTV management and Police access to footage; these are currently under investigation. All security officers are now SIA-licensed to Supervisor level, which allows them to support clinically-led physical interventions. In conclusion, the new security contract provides better ability to respond to emerging risks across sites and enhanced capacity to support patient and staff safety.	**KD**

	LA clarified that at the previous meeting, Governors sought clarification on whether the Trust's security staff operated under a "zero-contact" contact, meaning they were not permitted to have any physical contact with individuals causing disturbances. This issue was acknowledged as a key concern and part of the broader discussion about the scope of security officers' responsibilities and limitations. Additionally, LA noted that during a Governor site visit to Radiology, staff raised concerns around theft in the department and the absence of CCTV coverage in certain areas. Staff reported that installing CCTV could reduce the number of theft incidents and would increase staff confidence and help them feel more secure in their working environment. **Action: KD to follow-up on concerns around theft incidents in Radiology and clarify the situation around additional CCTV in the areas of the department that currently do not have CCTV coverage. KD to provide update at the next Council meeting.**	**KD**
25/043	**UPDATE ON CURRENT POSITION OF PHARMACIES STRATEGIC APPROACH** AC provided a verbal update and highlighted the following points: – Pharmacy remains a key area of focus for the Council in view of the aging Pharmacy estate, condition and reliability of key equipment such the Pharmacy robot, and workforce pressures. – Over the past two years, the Pharmacy governance structures have strengthened and there is now a reliable "ward-to-board" flow of information, supported by Pharmacy-specific Performance Review Meetings and regular reporting into the Quality & Safety Committee. – Improvement examples include a reduction in controlled drug utilisation and harm incidents. However, there remain resourcing challenges for the Controlled Drugs Accountable Officer but overall governance processes are robust – Current priorities areas are: o Replacement of the Pharmacy Robot, which requires significant planning and transition work to avoid disruption. o Aseptic Unit refurbishment and compliance – the unit was previously non-compliant; further work is needed to return the service to full operational capacity and to ensure full compliance with regulatory standards. o Radiopharmaceuticals (radioactive medicines used for diagnosis and some treatments) are an area of heightened risk. There is a regulatory compliance issue currently under review. Approximately 5,000 patients per year rely on radiopharmaceuticals, making compliance critical for patient safety. o Ongoing work to optimise pharmacy services, including better use of digital medicines tools. DH added that an external review of the pharmacy service was underway, being conducted by NHSE Deputy Chief Pharmacists supported by the	**AC**

	regional team. The purpose of this review is to assess whether the Trust has the right number of pharmacy staff, examine how staff are deployed across services, review whether staff are working at the appropriate level of practice and evaluate the leadership and management structure within pharmacy. DH also provided further details around radiopharmaceuticals issues. Essential work has been completed to address compliance gaps, which includes creating conditions suitable for sterile preparation of radiopharmaceuticals. DH stressed that the Trust must re-establish full capability for sterile manufacturing processes. Currently, the Trust is purchasing expensive chemotherapy products externally because in-house sterile preparation is not fully operational, which is costly and not sustainable. It is uncertain whether full radiopharmacy compliance and internal manufacturing could be restored within this financial year. MB reiterated concerns about the location of the WHH Pharmacy, which is at the back of the hospital. This area is far from areas where patients most commonly need immediate medication (e.g., UTC and ED). In other hospitals pharmacies or collection points are often located near the front entrance for patient convenience. Current arrangements at WHH mean that some patients are unable to obtain medicines on site and are directed to local supermarkets or external pharmacies. This is especially problematic for parents with unwell children or for patients attending A&E who expect on-site dispensing. MB also emphasised that timely dispensing was critical to avoid delays in patient discharge. This can be an issue at weekends when only one pharmaceutical round takes place and porters do not have access to the iPad, meaning they cannot track or manage requests. AD thanked MB for her observations and noted that these issues were not unique to East Kent but agreed that the matters raised must be closely monitored.	
25/044	**OUTPATIENT BOOKING ISSUES** KD presented the update on outpatient booking process review which had been requested by SB. The Council was made aware that although the Outpatients General Manager could not be present at this meeting, she had offered to meet with SB individually to discuss any concerns. The Council heard that the outpatient booking review was part of the Outpatient Transformation Group workplan, recognising that many existing processes are outdated and inefficient. KD informed the Council that outpatient booking covered new referrals and follow-up appointments - 65% of bookings are new bookings, 8% - are follow-ups, and remaining bookings are managed directly by specialty teams, resulting in a split, inconsistent system. The service involves a large multidisciplinary team including around 75 booking staff, also receptions teams, access to records staff and a nursing team. Many processes remain manual and paper-heavy. Staff currently check 189 results	**KD**

per day, often switching between systems repeatedly to make booking decisions.

There is a significant potential for AI and automation to reduce manual work, improve sorting/triaging, and streamline workflows, and the discussions around this are taking place at the Trust and at the system and national levels.

KD reminded the Council that SB raised the issue that patients could not cancel and instantly rebook appointments. System limitations mean data does not update in real time; a cancellation must be processed before a new slot becomes available leading to delays and a poor user experience. These issues are being looked at as part of the Outpatients Transformation work.

KD also addressed SB's second query about the long wait times when calling the Outpatients Booking telephone line. These waits are acknowledged as a genuine and common patient experience. Long waits are due to vacancies within the booking team and historical telephony setup issues. Previously, staff could only log into one dedicated telephone line and would receive calls only from that line. This meant staff were not able to support calls from other specialties, leading to bottlenecks and uneven call-handling capacity. This issue has now been fixed — staff can log into the system and receive calls from any relevant specialty line, improving flexibility and reducing delays. The Trust is exploring AI-supported call handling, particularly for simple or frequently asked questions.

The Council was made aware that the maximum eight-week booking window is linked to doctors' leave management. If appointments were booked much further ahead, then subsequently booked leave could result in large numbers of cancelled patient appointments. Patients would then return to the bottom of the queue, worsening waiting time inequalities.

AD commented that while the explanations given clarify why the current system operates as it does, they do not sufficiently describe what the Trust is actively doing to change it. Many industries have already modernised booking and scheduling systems; healthcare should not lag behind. Investment will be required, but other acute providers appear to have already made progress with similar challenges.

In response to AD's comment, DH highlighted that multiple factors influenced how quickly the outpatient booking experience could be improved. For example, the Trust must ensure it has an appropriate number of phone lines and adequate telephony capacity for the volume of calls received. Staffing levels also influence how quickly calls can be answered and appointments booked.

DH acknowledged that the Trust could make greater use of online self-booking

and digital options to reduce pressure on the phones but this shift to online booking depends partly on patient confidence and willingness to use those tools. By increasing digital and self-service options, staff time can be focused more effectively on patients who require direct support.

SB thanked KD and DH for taking time to investigate the issues she had raised and for providing explanations, but emphasised the need for clearer detail, realistic timeframes, and a greater sense of urgency around patient safety.

SB also noted that AI might help streamline processes but it cannot replace the need for system redesign, workforce and operational planning.

SB emphasised that her biggest concern was the patient safety impact of delays in follow-up booking as some patients were not receiving follow-up appointments and were getting lost to follow-up. This creates risks around clinical deterioration. There are many patients who do not know how to escalate issues.

SB reported that when she attempted to resolve her own follow-up issues by calling the outpatient booking line, she was unable to book an appointment. Patients in similar situations may be reaching out appropriately but still finding no route to resolve their problem.

RM queried if the Trust needed to re-evaluate the existing policy around eight - week annual leave notice for doctors if someone else could cover their clinics and continuing with a specific clinician is not essential for that appointment type. Some patients may be willing to accept an appointment 12 weeks or more in advance if this means that they gain certainty, the slot meet their needs, and they understand that they may not see their usual clinician.

DH provided explanation on the operational realities linked to the eight-week booking policy and how these factors impact both rebooking capacity and patient safety risks. In particular, DH noted that for Two-Week Wait referrals delays carry potential high-risk implications.

DH acknowledged the connection between the eight-week booking restriction and SB's earlier concern about patients being lost to follow-up. If routine follow-ups (e.g. in Diabetes, Ophthalmology and Urology) are scheduled for three months or more, the current eight-week booking limit means patients cannot be given an appointment at the point of clinic. This increases the likelihood that patients lose visibility within the system, risking long delays or missed follow-ups.

DH stressed that the Trust needs a clearer understanding of the scale of the problem and suggested that changes to how clinical leave is planned could

	support more flexible booking. MB asked if there was data as to how many patients were waiting for their follow-up appointments and how long they were waiting. DH confirmed that the Trust held this data. MB highlighted that delays in follow-ups could result in clinical harm and avoidable A&E attendances. AD commented that many Trusts were undertaking outpatients transformation and suggested benchmarking as an important next step to identify which cute providers are delivering this most effectively and what models they use. AC confirmed that issues around outpatient follow-up and booking timelines will be formally monitored by the Quality & Safety Committee (Q&SC). **Action: AC to ensure that outpatient follow-up and booking timelines are monitored by the Q&SC.**	**AC**
25/045	**NED OVERVIEW REPORT** **<u>Quality and Safety Committee</u>** AC presented the Quality and Safety Committee report noting that the Committee continued its approach of involving Care Group leaders directly in the Quality & Safety Committee to improve triangulation of information across operational and executive levels. AC highlighted the following matters: – Complaints have increased by approximately 23.7% in the last quarter with clinical management remaining the most common theme. Despite this, compliments still significantly outweigh complaints. Complaints continue to be viewed as an important source of learning, with good examples provided to the Committee on how learning is being translated into service improvements. – Legal Services have seen improvement in the past 12 months and there is a better relationship with the HM Coroners which is a positive development. – The Trust continues to demonstrate some of the best stroke performance in the country, which should be celebrated. – Mental Health leadership remains strong and the current focus includes mental health presentations in ED, particularly training needs. – Learning Disability and Autism (LDA) – recent discussion at the Quality and Safety Committee highlighted increased resourcing within the Mental Health team to support LDA patients. – The Cancer Board's multidisciplinary, multi-professional approach—bringing together managers and clinicians—is seen as a positive development for improving cancer outcomes. – The Association of Perioperative Practice has provided external scrutiny of theatres and over the last year, improvements have been observed across all theatre areas. – Patient Safety Incident Response Framework (PSIRF) processes were	**AC**

recently subject to internal audit, with a reasonable level of assurance.

- The annual Human Tissue Authority report provided assurance that learning from the Fuller Review had been implemented. AC reminded that NEDs and Governors had undertaken Mortuary visits and were impressed with the rigour of access controls and the respectful culture demonstrated.
- Clinical audit showed significant improvements over the last year. Over 40 medical students are now involved in audit projects, which is a positive development.

Action: AC to provide more detail / data around difference increased resourcing for LDA patients made to improving their outcomes at the next CoG. **AC**

CS

People and Culture Committee

CS brought these key matters to the Council's attention:

- Appraisal completion has fallen below the 80% target, and even 80% is not considered sufficient by the Board. A deep dive in January 2026 revealed significant variation across departments in both the quality and completion of appraisals. Data indicates a clear correlation between high appraisal completion and higher staff morale, engagement, and advocacy. Areas with low completion tend to rely on one manager undertaking all appraisals, whereas higher-performing areas distribute the responsibility more effectively. Targeted action plans will be developed, drawing on learning from teams with strong appraisal outcomes.
- Early themes from the most recent staff survey indicate the Trust remains in a very challenging position. Some emerging improvements noted, particularly around EDI, though the Trust is still significantly below average overall.
- Ongoing work continues around culture, including line manager capability, handling of issues, and creating a more positive work environment.
- The FTSU Guardians now provide regular reports every other People and Culture Committee meeting. Engagement across the Trust with The Guardian Service is increasing, with staff welcoming the service and guardians targeting areas of concern. An internal audit review of FTSU effectiveness has been commissioned and will be reported at the next Integrated Governance Committee meeting.
- Workforce remains a major challenge, significantly affecting delivery of the cost improvement targets. The Trust continues to be an outlier in bank and agency usage, which remains high due to waiting-list initiatives and the need to maintain safe staffing levels.

AD noted that although nationally many Trusts had seen decline in their staff survey results due to financial and workforce pressures, the People and Culture Committee agreed not to use this as a rationale or excuse. The Committee emphasised the need to be open and transparent about what staff are telling the organisation and how leadership is responding. A key area of focus will be to identify which interventions over the past year have not delivered results, and what new or revised actions are required for the coming year.

AD added that the Trust leadership acknowledged that without significant

	improvement in staff morale and engagement, the Trust would not make progress in productivity, innovation and sustainable transformation. The executive team expressed a clear desire for governor input and support as the Trust works to address the cultural and engagement challenges highlighted. OA raised concerns regarding recent changes to staff catering, particularly their impact on morale and wellbeing. Hot meals are no longer available at weekends. Staff working 12-hour shifts have reported that arriving in the canteen to find no hot food available has been demoralising and contributes negatively to wellbeing. AD agreed and noted that these changes, while seemingly small, have a disproportionately large impact on how valued staff feel and whether they perceive the Trust as caring for their basic needs. Improving access to appropriate food and basic comforts is essential to creating a workplace that staff would recommend to others. MB highlighted the poor condition of staff accommodation, observed during a previous site visit to WHH, such extremely poor quality of matrasses, outdated and inadequate furnishings, including curtains being purchased at disproportionately high procurement costs despite cheaper, more suitable alternatives being available through retail outlets. The condition of accommodation was described as demoralising, particularly for doctors working long shifts and relying on the facilities for adequate rest. A concern was raised regarding heating systems running 24/7, even during summer, causing accommodation to be uncomfortably hot. This results not only in poor staff comfort but also in unnecessary cost to the Trust. **Action: People and Culture Committee to review the catering changes, and accommodation issues given their impact on morale, engagement and overall staff experience. The Council to be provided with an update once the review has been undertaken and areas for improvement have been identified.** **<u>Finance and Performance Committee</u>** RO provide the following update: – At Month 7, year-to-date position: £9m adverse to plan excluding Deficit Support Funding (DSF). – CIPs underdelivered by £7.3m and in January 2026 the Trust submitted the revised CIP forecast of £60m. Although the Trust is on track to meet the revised £60m CIP target, the recurrent vs non-recurrent split is a major concern – only 45% CIPs are recurrent and 55% - non-recurrent. The target for recurrent CIPs is 75%. his creates run-rate pressure going into 2026/27 and increases the challenge for the next financial year. – Total deficit increased from £6.6m to £26.6m. There are concerns that CIPs identified so far are still at a low level, and significant additional work is required before year-end. – CIP requirement for 2026/27 is £72m, based on a 6% efficiency	**CS** **RO**

	expectation similar to other Trusts. – Urgent and Emergency Care – 4hr standard compliance decreased to 73% in December 2025 compared to 77.2% in November 2025. There were 1,276 patients who waited over 12hr in ED in December 2025. This remains a major operational challenge and focus for the Trust. – Patients not meeting the criteria to reside remain high at 168, despite improvement work before Christmas. – Small improvements are noted in RTT performance in December 2025, but this is still below required levels. – Capital spend for 2025/26 is currently higher than planned. Mitigations are in place to utilise underspends by bringing forward relevant projects from the 2026/27 capital plan. MB raised concern that the Trust and wider system were not keeping pace with demand generated by a rapidly growing local population. In Swale, for example, current representation is for 68,000 households, with a further 17,000 projected under local housing growth targets. This expansion is expected to place significant additional pressure on health services unless capacity is increased. A merger of the two main GP practices in Faversham has led to difficulties for elderly and vulnerable patients in accessing GP services and this will lead to increased ED attendances. A query was raised about whether the Trust had data to confirm increases in attendances from specific localities affected by primary care access challenges. AD commented that the Trust could not continue expanding physical estate indefinitely to absorb demand growth and emphasised the importance of embedding the left-shift strategy. Additionally, AD informed the Council that the Board was actively reviewing the long-term clinical strategy recognising that the Trust cannot continue to deliver £60 of efficiency savings annually through incremental cuts. Strategic priorities under consideration include service reconfiguration, consolidation of services where clinically appropriate, and accelerating system-wide models that support the left shift. It is crucial to have clinical strategy as soon as possible. The Council discussed the forthcoming official opening of Thanet Community Diagnostic Centre (CDC), which is a new joint partnership diagnostic and GP services hub. This CDC will enable diagnostics to be completed without patients needing to attend ED. In addition, GP services to operate on-site, supporting earlier intervention. It was suggested that Governors may benefit from a site visit to understand CDC role in the left-shift model and the range of services offered. **Action: to include CDCs deep dive in one of the Council meetings to understand what CDCs would deliver, their scope and capacity and how their visibility and utilisation can be maximised.** **Action: Governors to consider Thanet CDC site visit.**	**KD** **CoG**
25/046	**ANY OTHER BUSINESS** – Communication Strategy KD informed the Council that the initial draft of the Trust's Communication	

	Strategy will be presented to the Council sub-Committees next week for formal Governor engagement. It was acknowledged that the Trust's current communications approach has been reactive, particularly in response to negative media coverage. Members emphasised the importance of building stronger stakeholder relationships and communicating positive stories more proactively. It was noted that despite East Kent's challenging media environment, there is significant opportunity to reposition the Trust through consistent, strategic communication. LD shared examples of positive patient and community feedback, particularly from volunteer-supported initiatives and fundraising activities. Despite widespread local praise for patient care, such positive feedback rarely reaches the media. The view was expressed that journalists are often more interested in negative stories; however, reference was made to other Trust such as MTW that have successfully increased the visibility of positive communications through stronger stakeholder engagement and a deliberate shift in communication methods.	

Date of the next meeting: Friday 17 April 2026 at 09:00 – 14:00 HR, Conference Room, Education Centre, William Harvey Hospital

Signed _____

Date _____

Chair's initials ……..

EKHUFT Council of Governors (CoG) Action Log

Date	Minute number	Description	Owner	Status	Due date	Progress Update
03/02/2026	25/042	KD to follow-up on concerns around theft incidents in Radiology and clarify the situation around additional CCTV in the areas of the department that currently do not have CCTV coverage. KD to provide update at the next Council meeting.	KD	Open	17/04/2026	Update is attached as an appendix to the Action Log
03/02/2026	25/045	Mark Anderson to provide more detail / data around difference increased resourcing for LDA patients made to improving their outcomes at the next CoG.	MA	Open	17/04/2026	Agenda item for the CoG meeting on the 17 April 2026
03/02/2026	25/045	P&CC Chair to update on the outcome of the review of catering changes and accommodation issues including areas for improvement	CS	Open	17/04/2026	Included in the PCC Chair's Report

Sort order - ID

Action ID	Area	Description	Progress Update	Start date	Due date	Owner	Status

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

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

Meeting date: **2 April 2026**

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

Paper Author: **Des Holden, CEO**

Appendices:

N/A

Executive summary:

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

Implications:

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

Assurance route:

Previously considered by: N/A

We care

CHIEF EXECUTIVE OFFICER'S (CEO'S) REPORT

1. PURPOSE OF THE REPORT

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

2. INTERNAL UPDATE

2.1 Performance update

Our Emergency Department (ED) performance improved in February, with overall four hour compliance increasing to 74.9% and Type 1 performance rising to 55.2%. The number of patients waiting more than twelve hours reduced to 995, representing 18.7% of attendances. Pressures remain significant, driven by capacity constraints, site level flow issues and delays associated with mental health pathways.

Ambulance handover performance remained strong at 94% within 30 minutes, supported by improvements in Same Day Emergency Care (SDEC), the Clinical Decision Unit (CDU) and revised streaming models.

A Rapid Improvement Plan aimed at eliminating corridor care by the end of the first quarter of 2026/27 is now underway, focusing on the implementation of clinical operating standards, enhancing ED streaming and decompression, strengthening pull based internal flow, reducing the number of patients who no longer meet the criteria to reside, and delivering a structured improvement programme.

Cancer performance remains challenged, although there are early indications of recovery in some areas. The Faster Diagnosis Standard (FDS) improved to 75.8%, supported by increased breast screening activity. However, 62 day performance declined to 65.8%, reflecting ongoing pressures within diagnostic pathways and workforce limitations. Work continues to improve radiology reporting capacity, increase endoscopy availability and strengthen oversight of the cancer backlog. Diagnostic performance under the DM01 standard improved marginally to 63.9%, though this position remains fragile. Capacity issues in CT and non obstetric ultrasound continue to restrict progress, and Trust wide action is underway to improve booking efficiency, reduce cancellations, expand diagnostic capacity and enhance vetting processes.

Elective performance deteriorated in February, with the proportion of patients treated within 18 weeks falling to 51.3%. Long wait numbers increased to 2,016 for 52 week waits and 88 for 65 week waits. As a result, the Trust has entered NHS England's Tier 1 support framework for Elective Care and Tier 2 support for Diagnostics. A recovery plan for quarter four is being delivered, supported by Sprint funding and involving increased insourcing, greater use of the independent sector, extended internal operating capacity and strengthened governance structures. The Trust achieved improved performance in March, and expects further increase to better than 55% by close down of this quarter's activity.

2.2 Finance update

As at Month 11 (February), the Group's financial position is £14.6m adverse to plan, with an actual deficit of £77.3m before the application of deficit support funding.

Deficit Support Funding (DSF) for the Kent and Medway (K&M) system has been withdrawn for quarters three and four, resulting in a further adverse impact of £23.0m, of which £19.2m relates to Month 11.

Year to date (YTD) financial performance continues to be heavily influenced by under delivery of the cost improvement programme (CIP), where the efficiency target included a significant stepped increase during the second half of the year.

Despite the challenging financial context, the Trust delivered an in-month position in line with the agreed reforecast and remains on track to deliver the revised year end position.

The Trust's financial plan for 2026/27 has now been submitted and, with the inclusion of DSF, delivers a breakeven position. This plan includes a cost improvement requirement of £75.9m for the coming year.

Detailed finance information is available in the finance report.

2.3 People update

Analysis of the 2025 NHS Staff Survey is now complete, with more than 5,300 colleagues having participated across all staff and Care Groups.

Staff engagement, which remains a strong indicator of organisational performance, shows further decline this year, continuing the downward trend observed over recent years. The findings reflect the ongoing pressures within the organisation and highlight the impact of operational pressures, such as corridor care, on how colleagues experience the workplace.

Through detailed analysis of these results, including year on year changes and comparison to national benchmarks, three priority outcome areas have been identified: advocacy (particularly in relation to corridor care), compassionate culture and development. The analysis also confirms that achieving sustained improvements in these areas will require strengthening leadership capability, enhancing team climate and improving access to growth and development opportunities.

In response to these results, we are implementing a refreshed leadership and management curriculum, expanding the Team Engagement and Development (TED) programme to support team development, and working to improve, and make for equitable, access to personal and professional development offers.

Care Groups have received detailed data packs and have been asked to identify one or two priority areas within their direct control to support focused, consistent improvement.

3. EXTERNAL UPDATE

3.1 Meningitis community outbreak

The Trust responded to the meningitis community outbreak in March, alongside the Integrated Care Board (ICB), UK Health Security Agency (UKHSA), Kent Community Health NHS Foundation Trust (KCHFT) and other partner organisations.

Our thoughts are with everyone who has been affected by the outbreak, and the families and loved ones of the two young people who have sadly died.

The first patient presented to the ED at the Queen Elizabeth the Queen Mother Hospital (QEQM) on the evening of Wednesday 11 March. The Trust has publicly recognised that there was an opportunity prior to diagnosis being confirmed on Friday 13 March to notify UKHSA of this case and has reminded all staff of the requirement to inform UKHSA of suspicion of any notifiable disease within 24 hours, even if sometimes it may be shown later not to have been necessary. We are also developing additional visual reminders for wards and EDs.

The Trust has been in close contact with UKHSA since Friday 13 March to discuss the management of patients presenting with suspected meningitis.

In order to manage the incident, clear case definitions were produced and shared, to identify 'strongly suspected' and 'possible' cases and ensure timely, appropriate and safe management. Patients meeting the 'possible' case definition were all tested and given antibiotics. In addition, there were a significant number who were referred to ED for routine prophylaxis. Individuals also attended Urgent Treatment Centres (UTCs) and were either discharged or referred to EKHUFT. Between Friday 13 March and Friday 26 March, over 500 people attended the William Harvey Hospital (WHH) and QEQM EDs with possible or strongly suspected meningococcal disease.

The Trust attended UKHSA National Incident Management meetings daily, and internal Incident Management meetings.

I want to thank all the staff who worked so hard for all the patients. A huge effort has been made by our urgent and emergency care (UEC) teams, paediatric teams, critical care, ward isolation areas, microbiology, pharmacy, infection prevention and control (IPC), and many other frontline and support teams, all working together to care for patients and create capacity within the EDs and across our busy hospitals. As we were in an unprecedented situation, we brought in extra staff, including nursing staff, to help wards and the UEC teams. We have increased our wellbeing support for the wards and departments most affected. Staff were advised on appropriate Personal Protective Equipment (PPE) in line with national guidance and our Occupational Health team have also been supporting staff.

Appropriate follow-ups are being arranged for patients.

3.2 National Oversight Framework (NOF) and segmentation

The Trust has recently been informed that it has been moved from segment 3 to segment 4 of the NHS NOF.

This change reflects our challenges with patients waiting for a bed in ED, waiting times for elective patients and finance; This is a disappointing but accurate indication of our overall performance against national expectations and relative to other acute Trusts.

We know some of our challenges are deep-rooted and we will continue to work closely with NHS England (NHSE) to strengthen delivery, rebuild financial stability and accelerate improvement.

3.3 National Investigation into Maternity and Neonatal Services

Baroness Valerie Amos has made further visits to both the WHH and QEQM as part of the National Maternity and Neonatal Investigation.

The Trust welcomes the publication of the interim findings and remains committed to sharing learning and supporting the continued improvement of maternity services across east Kent.

Staff across maternity services have delivered significant improvements, and the Trust remains committed to providing safe, high quality and compassionate care to women, birthing people and families.

4. OTHER AREAS TO NOTE

4.1 Relaunch of internal professional standards

On 9 March, the Trust relaunched its Internal Professional Standards (IPS), a set of ten operating standards that form a shared professional contract across clinical and operational teams to support safe and timely care for emergency patients.

The relaunch included professionally designed materials that are now displayed across key locations, an all staff communication with a video message reinforcing expectations, and the implementation of a new dashboard designed to provide timely performance feedback.

Two relaunch weeks took place across the WHH and QEQM, supported by presentations, senior leader walk arounds and focused work in the Acute Medical Units (AMUs), which helped improve understanding of specialty review delays. The WHH ED also tested revised escalation processes.

Ten wards reinstated improvement boards and daily huddles, with all showing progress against target measures. The Seabathing Ward achieved particularly strong performance, consistently completing 100% of electronic discharge summaries by 1pm on the day of discharge.

This work is at the heart of our integrated system plan, supported by community and mental health trusts, Getting it Right First Time (GIRFT) and the ICB, to get out of the care people experience in corridors.

4.2 Robotic Assisted Surgery

Following the award of £4.7m of capital funding for two additional surgical robots, the new robots will be delivered during the final week of March and installed shortly thereafter, increasing the total number of surgical robots in the Trust to five.

Robotic assisted procedures have already commenced on the systems recently installed at both the QEQM and WHH, including the first robotic hysterectomies at QEQM as part of the NHS National Cancer Plan.

The expansion of the robotic programme is expected to support improved productivity by reducing post-operative complications, shortening length of stay, reducing readmissions and, in some cases, shortening operating times.

Once the two new robots are installed, the Trust will be able to offer an expanded range of robotic procedures, further improving outcomes and patient experience.

4.3 Refurbishment project starts at Buckland Hospital

A refurbishment programme to install state-of-the-art X-ray equipment has begun at Buckland Hospital in Dover and will continue until late April. During this period, X-ray services will be temporarily unavailable at the site, and patients requiring imaging will be redirected elsewhere, although the UTC, dental X-ray service and CT imaging will continue to operate. I would like to apologise for any inconvenience this causes to our patients and their families during this time.

4.4 Cath lab at William Harvey Hospital (WHH)

Work has begun on the £2.8m project to create a new catheter laboratory at the WHH. The new facility, due to open in the autumn, will provide improved clinical space for cardiac procedures and a dedicated recovery area, enabling more patients to be treated and improving the working environment for staff.

4.5 European Association of Urology Nurses Conference

I am pleased to share that Urology Stone Nurse Specialist Brenda McConnell recently represented the Trust at the European Association of Urology Nurses Conference in London, where she delivered a presentation on dietary, metabolic and fluid related factors in stone disease. This provided a valuable opportunity to showcase the work of our urology service on an international stage.

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

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**COUNCIL OF GOVERNORS**				
REPORT TITLE:	**LEARNING DISABILITY & AUTISM PROVISION AND CARE**				
MEETING DATE:	**17 APRIL 2026**				
BOARD SPONSOR:					
PAPER AUTHOR:	**ASSOCIATE DIRECTOR OF NURSING FOR MENTAL HEALTH**				
APPENDICES:	*n/a*				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	**Information**	Assurance	Discussion
Purpose of the Report:	The purpose of this report is to provide an update of resources and workstreams related to the care and provision of patients with a learning disability and/or autism.				
Summary of Key Issues:	• Additional funding has been sought to increase specialist learning Disability & Autism (LDA) support. • Requirements to meet compliance of statutory LD+A training is an ongoing challenge.				
Key Recommendation(s):	• LDA recruitment and service improvement workstreams ongoing. • Continue working with the ICB and system partners in finding solutions to improve performance and standards.				
Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients	**Our people**	Our future	Our sustainability	**Our quality and safety**	
Link to the BAF:					
Link to the Corporate Risk Register (CRR):	Risk 3835 - statutory LD+A training compliance [risk score 12]				
Resource:	Y	Financial, cost of course and attendance of staff			
Legal and regulatory:	Y	Statutory training requirements			
Subsidiary:	N				
Assurance Route:					
Previously Considered by:	.				

LEARNING DISABILITY & AUTISM PROVISION AND CARE

1. Purpose of the report

1.1 The purpose of this report is to provide an update of resources and workstreams related to the care and provision of patients with a learning disability and/or autism.

2. Background

2.1 People with learning disabilities and/or autism (LDA) often have difficulty in accessing timely healthcare, experience greater levels of inequalities, longer hospital stays, and delays in leaving hospital. They may also present with very complex clinical presentations, increased risk of harm to self or others, and communication difficulties. It is nationally recognised that LDA patients require specialist assessment and intervention, along with effective care coordination, advocacy, and clinical leadership.

3. LDA Liaison Nurse/Practitioner

3.1 In 2025, EKHUFT had 1.5 whole time equivalent (wte) contracted Learning Disability and Autism Specialist Practitioners (Band 7) to support clinical staff with LDA patients. A review of staffing and skill mix involving benchmarking against other acute Trusts has resulted in the approval of a further 1.5 wte Band 7s to be added to the service to increase specialist support across all hospital sites.

3.3 Recruitment has already progressed, although there have been other changes within the team, meaning that full establishment has not, as yet, been realised. An outline of workforce changes is illustrated below.

Staff	wte	Prof.	Covers	Started	Comments
EGa	1.0	RNLD	WHH	Sep-21	Leaving 14/04/26
EGr	0.5	RNLD	QEQM	Mar-25	Maternity leave (Feb-26)
CHi	0.5	OT	KCH / all (OT)	Jan-26	
CHu	1.0	RNLD	QEQM	Apr-26	
TAM	1.0	RNLD	WHH	Apr/May-26	

3.4 The addition of an Occupational Therapist will help with holistic approaches and enabling independent living skills.

4. LDA SOP

4.1 A Standard Operating Procedure has been developed for LDA specialist support, to outline roles, responsibilities and expectations of the team.

4.2 As part of the SOP, a LDA Strategy has been created, this is outlined below:

EKHUFT LDA Strategy 2026-2028

- **Enhanced Care and Support:**
  Promoting person-centred care, addressing individual needs, and managing risk to promote safe, inclusive and equitable care within the acute setting.
- **Clear processes and pathways:**
  Development of patient pathways within Emergency Departments and inpatient ward settings, highlighting referral criteria for specialist support, and enabling ward staff to promote safe and timely discharge.
- **Promoting safety and quality:**
  Thematic analysis and reporting of key performance indicators, incident reports and patient experience/carer feedback, which will help highlight positive practice, identify areas of improvement, and enable sharing of lessons learned.
- **Evidence-based practice:**
  Using national guidance, national audits, and relevant directives to drive clinical effectiveness and promote best practice.
- **Addressing inequalities:**
  Upholding the human rights of individuals with learning disabilities/autism, and reducing barriers to access timely services and support as required.
- **Skilled Workforce:**
  Ensuring that people with learning disability/autism are adequately supported by a trained and competent workforce.
- **LD/Autism-friendly environments:**
  Creating supportive environments and services that enable people with learning disability/autism whilst being in hospital.
- **Multi-agency working:**
  Strengthening communication and relationships with multi-professional/multi-agency partners, and working with commissioners and others to highlight and develop system-wide objectives.

4.3 Other workstreams in development includes:

- Developing a local procedure to support processes for complex admissions for investigations.
- Development of working with palliative services, and also with cancer services.
- Ask, Listen, Do.
- Carer survey analysis.
- Thematic review of discharge processes for patients with complex needs (related to a PSIRF investigation).

5. Statutory Learning Disability and Autism training

5.1 There is a statutory requirement for all CQC-registered providers to train staff in LDA, in accordance with the Health & Care Act. Health and social care providers are expected to set out of plan for training for the 2026/27 financial year. However, there is no local funding allocated to this training.

5.2 NHSE funding will only be provided to those ICBs that have hit the 30% target for both Tier 1 and Tier 2. The ICB is predicted to reach around 15% compliancy by the end of this month without additional sessions.

5.3 The current position (18/03/26) –

- Tier 1 (general awareness) total staff requiring training 1,872, completed 108 (5.8%)

- Tier 2 (enhanced) total staff requiring training 8,200, completed 1,049 (12.8%)

5.4 Compliance with statutory Learning Disability and Autism training has been added to the corporate risk register.

5.5 This is being discussed at an Executive level to assess whether this is business critical, given the current financial pressures.

6. Recommendations

6.1 Continuing to progress with the development of the workforce establishment, as identified above, as well as other key workstreams.

6.2 Continuing to work with other providers within Kent & Medway to explore solutions to address training compliance.

7. Conclusion

7.1 This paper provides an overview of the steps being taken to promote safe and effective provision of care for LDA patients.

East Kent Hospitals University NHS Foundation Trust

COUNCIL OF GOVERNORS
MEMBERSHIP ENGAGEMENT AND COMMUNICATIONS COMMITTEE
TERMS OF REFERENCE

Constitution
The Committee is a committee of the Council of Governors. It has no delegated power to make decisions on behalf of the Council.

Purpose:

1. The Committee is responsible to the Council of Governors for the following:

Develop the Communications and Membership Strategy for approval by the Council of Governors, in consultation with the Director of Communications, and review annually.

The Communications and Membership Strategy will include plans and objectives for:

- Membership recruitment
- Communication with Members
- Membership engagement
- Promoting the role of FT Governors;

2. Oversee the implementation of the Membership Strategy and monitor progress.

3. Provide a report on the business of the Committee to the Council of Governor meetings.

Frequency of Meetings:
Meetings of the Committee will be held on a quarterly basis.

Membership and attendance:
The Committee will consist of four Governor members appointed every March for a three - year period. Membership will be voluntary and based on skills and interest. Committee members will agree the Chairmanship of the Committee each year at their first meeting after appointment.
All governors will have the right to attend Committee meetings and participate in discussions. Only members of the Committee will have voting rights.

Attendees:
Director of Communications and Engagement, or nominated representative

Quorum:
The Committee shall be quorate when at least two Governor members of the Committee are present plus the Director of Communications. Virtual attendance at meetings is accepted.

Support:
The Committee will be supported administratively by the Corporate Secretariat. It shall receive advice from the Trust Secretary, or their representative, and the Director of Communications and Engagement, or their representative.

Ratified at Full Council on 20 May 2021

East Kent Hospitals University NHS Foundation Trust

REPORT TO COUNCIL OF GOVERNORS (CoG)

Report title: **Membership Engagement and Communications Committee (MECC) Terms of Reference (ToR)**

Meeting date: **17 April 2026**

Board sponsor: **Bernie Mayall, Lead Governor**

Paper Author: **Khaleel Desai, Director of Corporate Governance**

Appendices:

Appendix1: MECC ToR

Executive summary:

Action required:	**Approval**
Purpose of the Report:	To formally notify CoG of the updated ToR.
Summary of key issues:	MECC reviewed and updated ToR at the meeting on the 26 February 2026, in particular, membership and quoracy. MECC agreed that the Committee will be held quarterly and have the workplan.
Key recommendations:	CoG is asked to **APPROVE** the ToR. Governors are invited to nominate themselves as MECC members.

Implications:

Links to Strategic Theme:	• *People* • *Partnerships*
Link to the Trust Risk Register:	
Resource:	Y/N
Legal and regulatory:	Y/N
Subsidiary:	Y/N

Assurance route:

Previously considered by: MECC – 26 February 2026

We care

East Kent Hospitals University NHS Foundation Trust

COUNCIL OF GOVERNORS'

PEOPLE AND GOVERNANCE ENGAGEMENT COMMITTEE

PROPOSED TERMS OF REFERENCE

Constitution

The Audit and Governance Committee is a committee of the Council of Governors. It has no delegated power to make decisions on behalf of the Council.

Purpose:

The Committee is responsible to the Council of Governors for the following:

- Working with the Board of Directors' Integrated Audit and Governance Committee (IAGC) to establish the criteria for the appointment, re-appointment or removal of the Trust's external auditors, including the method for monitoring the quality of the external audit as set out in HEFMA NHS Audit Committee Handbook.
- Presenting to the Council of Governors the procurement process that it has followed for the
- Appointment of the external auditors, the results of the procurement processes and
- recommendations.
- Receiving the external auditor's plan and work timetable for the year, to review the external auditor's performance and review any year end audit recommendations.
- Receiving the internal auditors plan, work timetable and annual report, for information only.
- Seek assurance from the Chair of the IAGC that internal control processes are in place.
- Working with the Trust Secretary to ensure the Trust's Constitution complies with latest legislation and NHS I guidance.
- Considering any locally proposed amendments to the EKHUFT Constitution.
- Reviewing the effectiveness of NED engagement with Council Committees and Working Groups and report conclusions to the Council.
- Consider proposals for changes to policies relating to the Council of Governors and make recommendations to Council.
- issues of Quality raised by Governors or their constituents to identify trends and themes;
- Look at the Board assurance framework; and quarterly performance against the annual quality objectives and identified risk. Use this information to inform the development of a draft of the Council commentary on the Trust's Quality report to take to Council for agreement.
- Propose to Council a topic for the Governor Indicator for audit by external auditors

Frequency of Meetings:

Meetings of the Committee will be held quarterly.

East Kent Hospitals University NHS Foundation Trust

Membership and attendance:

The Committee will consist of five Governor members appointed every May for a one year period.

Membership will be voluntary and based on skills and interest. Committee members will agree the Chairmanship of the Committee each year at their first meeting after appointment.

All governors will have the right to attend Committee meetings and participate in discussions. Only members of the Committee will have voting rights.

Quorum:

The Committee shall be quorate when at least three members are present. Virtual attendance at meetings is accepted.

Support:

The committee will be supported administratively by the Corporate Secretariat and receive professional advice from the Group Company Secretary.

East Kent Hospitals University NHS Foundation Trust

REPORT TO COUNCIL OF GOVERNORS (CoG)

Report title: **People and Governance Engagement Committee (PAGE) Terms of Reference (ToR)**

Meeting date: **17 April 2026**

Board sponsor: **Bernie Mayall, Lead Governor**

Paper Author: **Khaleel Desai, Director of Corporate Governance**

Appendices:

Appendix1: PAGE ToR

Executive summary:

Action required:	**Approval**
Purpose of the Report:	To formally notify CoG of the updated ToR.
Summary of key issues:	PAGE reviewed and updated ToR at the meeting on the 19 February 2026, in particular, membership and quoracy. PAGE agreed that the Committee will be held quarterly and have the workplan.
Key recommendations:	CoG is asked to **APPROVE** the ToR. Governors are invited to nominate themselves as PAGE members.

Implications:

Links to Strategic Theme:	• *People* • *Partnerships*
Link to the Trust Risk Register:	
Resource:	Y/N
Legal and regulatory:	Y/N
Subsidiary:	Y/N

Assurance route:

Previously considered by: PAGE– 19 February 2026

East Kent Hospitals University NHS Foundation Trust

BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)

Committee: **Quality and Safety Committee (Q&SC)**

QSC Meeting: **3 February 2026 presented to the Board of Directors on 2nd April 2026**

Chair: **Dr Andrew Catto, Non-Executive Director (NED)**

Paper Author: **Amy Golder, Executive Assistant**

Quorate: **Yes**

Appendices:

None

Declarations of interest made:

None

Assurances received at the Committee meeting - focus on learning and improvement:

Agenda item	Summary
SPENCER PRIVATE HOSPITAL QUALITY DEEP DIVE	The Committee received the report and **NOTED** the following key updates: • A significant amount of work has taken place in relation to the governance arrangements with Spencer incorporated into the Trust's governance arrangements. • All Spencer meetings and policies have been reviewed, and an assurance framework has been developed. • Changes have been made to the Medical Advisory Committee (MAC) and corporate days were established for all key meetings. • The Team was working through a competency framework and training matrix for managers. • Quality Oversight meetings were now taking place with the Trust

EMERGENCY DEPARTMENT CARE QUALITY COMMMISSION (CQC) INSPECTION	The Committee received the report and **NOTED** the following key updates: **QEQM Emergency Department CQC inspection.** • The inspection was unannounced and took place 6-7 January 2026, within a very complex situation being managed at QEQM. This related to the number of norovirus patients, high numbers of not fit to reside patients and a significant influx into the department. • CQC were positive about the culture and hard work of the team but did identify areas for improvement. They identified issues related to leadership, medical cover, medical intervention for some patients and corridor care. • The team were working closely with CQC, and weekly updates: against the action plan were being provided. • The Trust had submitted all the information requested by the CQC and were now awaiting their report. **CQC inspection of the Medical Pathway at QEQM.** • The Trust received positive feedback from the inspection, with concerns regarding boarding and possible misinformation in relation to a Deprivation of Liberty Safeguards (DOLS) assessment. • There was also an **unannounced inspection of the WHH Emergency Department between the 2-3 February** 2026, the verbal, initial, feedback received was broadly positive (although as is the case with all inspections further feedback will arise from triangulation of data sources in coming weeks).

RENAL DEEP DIVE	The Committee received the report and **NOTED** the following key updates: • NHSE Dialysis Quality Review was prompted by capacity and infrastructure pressures (2019/20-2022/23) growth) • There was £1.27M NHSE recurrent funding for increased dialysis activity. • Equipment Replacement had been completed at Margate, Dover and Ashford sites, but Medway and Maidstone required urgent investment. • There was a rolling replacement program for Haemodialysis (HD) machines. • There was improved resilience with contingency and in-house water testing in case of breakdowns. • Mortality Outlier Review had taken place and coding corrected. • Infection Control, dialysis associated infections improving, although dialysis access surgery delays were noted as a potential increasing risk. **Key Incidents** • There was a Hepatitis B exposure incident (which had no onward transmission). • There had been persistent Legionella at Maidstone HD unit, the pipe replacement business case was progressing. Following the move of vascular to K&CH, there was increased competition for theatre space. It was confirmed that additional support was being provided to increase vascular access In summary, there had been significant progress in relation to the NHSE actions and there had been significant investment in the dialysis infrastructure, however there remained notable risks around capacity, estates, IT system fragility and access to surgery delays.
QUALITY GOVERNANCE REPORT (PATIENT EXPERIENCE, INQUESTS, CLAIMS, INCIDENTS AND CAS).	The Committee received the report and **NOTED** the following key updates: • Security incidents were now in the top 5 types of incidents reported, 56 of those related to patients leaving the Emergency Department without waiting to be seen and 15 related to assaults to our staff. • A Never Event occurred in December 2025, related to a breast marker coil within radiology, and After-Action Review (AAR) had occurred which identified additional learning. • The Duty of Candor (DoC) policy has now been approved. Two written and 2 verbal DoC notifications had fallen out of our agreed KPI, (but had since been completed). • The Patient Safety Policy has been ratified. • There had been a dip in inquest activity during November and December 2025, but the team had seen a notable increase in activity at the beginning of the year.

EFFECTIVENESS OF SCREENING PROGRAMMES (INC CERVICAL.) ANNUAL REPORT	The Committee received and **NOTED** the following key updates: • Clear actions were in place in relation to the screening programs. • There were issues regarding the recall times for breast screening, the target was 3 weeks, however we were currently around 10 weeks. An action plan was in place to address this, and a new director of breast screening had been recruited. • The antenatal screening service was running well.
QUALITY ACCOUNT PLAN FOR COMPLETION AND SIGN OFF AND 2025/26 QUALITY STRATEGY AND Q1-Q3 UPDATE ON QUALITY PRIORITIES	The Committee **NOTED** the following key updates: • It was confirmed that the Quality Account was on track for completion within the agreed timeframe and it would be brought to the Council of Governors meeting for consultation.
NON-RTT QUARTERLY UPDATE	The Committee **NOTED** the following key updates: • It was important that our patients received the right care, especially within specialties such as diabetes and ophthalmology. • A recovery plan was being delivered by the Chief Operating Officer and it had been discussed at the Executive Team meeting. • It was important that Quality and Safety Committee continued to have oversight and regular updates: were provided. • Work remained ongoing to validate the waiting lists, to fully understand the risk to patients and, a consistent approach to validating needed to be adopted across all specialties.
ASSOCIATION FOR PERIOPERATIVE PRACTICE (AFPP) PROGRESS UPDATE	The Committee **NOTED** the following key updates: • All 3 of the Trust's theatres had now received AFPP accreditation, which was a cause for celebration.
MONTHLY STRATEGIC RISK REGISTER UPDATE	The Committee received and **NOTED** the report. • There were several overdue actions associated with some of the risks, which were in the process of being addressed.
CARE QUALITY COMMISSION (CQC) UPDATE	The Committee received and **NOTED** the report. • The ward accreditation scheme was progressing well and there was a task force to support specific wards. • There were only 2 remaining "must do" and "should do" actions, and these related to pharmacy and mandatory training, which was now improving.
DATA QUALITY AND ACCOUNTABILITY ASSURANCE	The Committee received the report and **NOTED** the following key update. • Information Assurance Committee met regularly and coordinated accurate data quality collection. This Committee is an example of good practice. • There was interest nationally on the Hospital Standarised Mortality Ratio (HSMR) and the work of Same Day Emergency Care (SDEC).

	• A Digital, Data and Technology Group had recently been established, which reported directly into the Trust Management Committee. • The Team was exploring how AI could improve data quality and collection going forward
COST IMPROVEMENT SCHEME QUALITY IMPACT ASSESSMENTS (QIA)	The Committee received the report and **NOTED** the following key updates: • A robust governance process had been established for QIAs. • 79 QIAs had been considered by the panel between July and December 2025, which was an increase. • The next step from April 2026 was the review of existing schemes and how they were functioning within the clinical environment and how they had impacted on quality and safety.
PATIENT DOCUMENTATION AUDIT UPDATE	The Committee received and **NOTED** the report. • The Consent Policy had been revised and approved • Further training for clinical staff had been taking place. • The Documentation Audit was included within the Annual Audit Programme.
CONTROLLED DRUGS ANNUAL REPORT	The Committee received the report and **NOTED** the following key updates: • The Trust continued to prescribe many controlled drugs. • The number of incidents recorded had reduced over the last year. • Remote prescribing was increasing through electronic prescribing solutions. • Compliance with the CQC self-assessment reportedly remained good, and the actions identified had been addressed. The CQC were keen that pain management plans were in place and followed. • There was a focus on the management of controlled drugs when patients were being cared for on corridors. • Further work was required regarding training on how to treat the use of synthetic opiates and raising awareness of the risk these drugs hold to our community. • There needed to be consideration regarding whether the Trust should have Opioid stewardship group and the QSC were supportive of this proposal.
SAFE STAFFING ESTABLISHMENT REVIEW	The Committee received the report and **NOTED** the following key updates: • The report had also been considered by the People & Culture Committee. • Reviews had taken place against the safe care model and there had been involvement from ward managers and matrons. • The Committee agreed that the report would be submitted to Trust Board for their consideration.
MATERNITY & NEONATAL BOARD	The Committee received the report and **NOTED** the following key updates:

	• Clinical Negligence Scheme for Trusts (CNST) was discussed at length at the Maternity and Neonatal Board. The representatives from anaesthetics had concerns regarding how the requirements were going to be met going forward, with the current staffing. • A CNST challenge session with the ICB was planned for early February 26. • Restorative work continued with the families and feedback would be fed into national discussions. • The Trust was anticipating the Baroness Amos Enquiry revisit soon. • Annual CQC maternity survey, noted areas of positive change, but with the need for ongoing improvement.
INTEGRATED PERFORMANCE REVIEW (IPR)	The Committee received and **NOTED** the IPR.
PATIENT EXPERIENCE COMMITTEE ASSURANCE REPORT	The Committee received and **NOTED** the Patient Experience report.
OPERATIONAL QUALITY GOVERNANCE UPDATE (OQG) CHAIR'S REPORT	The Committee received and **NOTED** the Operational Quality Governance Report.
SAFEGUARDING COMMITTEE ASSURANCE REPORT	The Committee received and **NOTED** the Safeguarding Committee report.
MORTALITY STEERING & SURVEILLANCE GROUP (MSSG) CHAIR'S REPORT	The Committee received and **NOTED** the Mortality Steering & Surveillance Group report.
CLINICAL AUDIT AND EFFECTIVENESS GROUP (CAEG) CHAIR'S REPORT	The Committee received and **NOTED** the Clinical Audit and Effectiveness Group report.

Referrals from other Board Committees:

The Committee asks the BoD to discuss and **NOTE** this Q&SC Chair Assurance Report and the following; • Safe staffing Review	Assurance	

• Non-RTT risk		

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BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)

Committee: People & Culture Committee

Meeting date: 17th March 2026

Chair: Claudia Sykes

Paper Author: Claudia Sykes

Quorate: Yes

Appendices: none

Declarations of interest made: none

Assurances received at the Committee meeting: see below

Agenda item	Summary
BAF risk: recruitment and retention **CPO Report and IPR**	The Committee reviewed the CPO report which covered updates on disciplinaries, tribunal cases, sickness absence, vacancies and recruitment. Appraisal compliance has risen to **76.6%.** Compliance continues to vary across the organisation, with rates ranging from 62.5% in Strategy & Partnerships to 78.7% within the William Harvey Care Group. This continues to be closely monitored by the People and Culture team, but requires more prioritisation from operational managers to reach the target of 80%.
BAF risk: recruitment and retention **Sickness deep-dive**	Following a request from the Committee, a report was presented with an analysis of sickness at the Trust: The report highlighted that sickness levels remain consistently high across the Trust, driven mainly by Anxiety/Stress/Depression, musculoskeletal conditions, and seasonal respiratory illness. Over the period 1 February 2025 – 31 January 2026, the Trust has lost a total of 131,496 working days, of which long term sickness (71,933 days) now exceeds short term sickness (59,564 days). Sickness is not evenly distributed across the Trust. It is heavily concentrated in high pressure clinical environments such as: • Theatres • Emergency Departments (ED) • Maternity Services • Critical Care • Therapies Inpatient Teams The report also included Return to Work statistics. Within long term sickness hotspots such as QE Theatres, WH Critical Care A, and WH A&E, Return To

	Work completion is particularly low (12–20%), suggesting gaps in follow up, early intervention, and consistent use of support pathways. The Committee welcomed the report, the first time members could recollect that this has come to a Board assurance committee. The report included a range of specifc actions needed. It was vital that line managers had the confidence to discuss sickness absence, and help staff return to work with reasonable adjustments where needed. Executive members commented that this was another indication of a culture where line managers avoided having difficult conversations, often due to lack of training or a concern that this might be difficult or appear uncaring.
BAF risk: Recruitment and retention **Accommodation**	The Committee received an update from 2gether on staff accommodation. It was clear that there is urgent work to be done between the Trust and 2gether on an agreed understanding of roles and responsibilities. The update highlighted changes effective from 1st May under the Renters Rights Act. The Trust is the landlord for staff accommodation. There were also concerns about the quality of staff accommodation, with William Harvey being a high priority. The Committee has requested an urgent short and long term plan for staff accommodation; to receive assurance that staff accommodation meets all health, safety and fire requirements and clarity on roles and responsibilities between the Trust and 2gether. The Committte was NOT ASSURED that Staff accommodation is meeting all required legislation
BAF risk: culture and values **Staff survey**	The Committee reviewed the detailed findings from the staff survey. It was extremely disappointing that, despite focused efforts to tackle deep-rooted cultural issues over the last 12 months, the Trust had not made progress and remained in the bottom 3 Trusts in England. The Committee heard examples from the People & Culture team where they had struggled to have engagement from senior managers at the Trust when tackling cultural issues. In some cases, managers were wary of having difficult conversations; in others it did not seem to be treated as a priority when departments were facing operational pressures. The Committee noted the action plan presented, but commented that similar plans had been presented in previous years and had not made any difference. More discussion was required at Board, to ensure there was full buy in and visible leadership. The Committee was NOT ASSURED of improvements in staff culture, as reflected by the staff survey

BAF risk: culture and values **Freedom to Speak up**	The Freedom to Speak Up Guardian presented the latest report for the Trust. It was noted that the reporting format needed to include more themes and narrative highlights. There was a discussion on some of the specific comments being raised by staff, which raised questions around how line managers were communicating changes to their teams. Executive members were aware of the comments and concerns, and were working with the line managers to support with improved communication and answers. The Committee also reviewed the Freedom to Speak up report which had been commissioned from an external consultant, Helen Buckingham, responding to concerns raised by consultant anaesthetists (CCASS). The report included a number of useful recommendations. The Chair noted that this, and other reports commissioned into the CCASS concerns, would be presented and discussed by the full Board. This area would need dedicated attention to resolve a range of issues emerging from the various concerns and reports.
BAF risk: culture and values **Staff Congress**	The Director of Corporate Governance and Director of Culture, Inclusion and Organisational Development presented a proposal on merging the Staff Congress with the Trust's Change Ambassadors. There was acknowledgement that the Staff Congress was not working as planned, due to issues with staff availability, resources and engagement. The Change Ambassador Programme had been continuing well, as part of the Trust's People Strategy. The Committee supported the outline proposal and noted that it was important to acknowledge when things were not working. It was important to consider staff engagement and communication on the next steps.
BAF risk: organisational development and resilience **Workforce planning**	The Committee reviewed the 2026/27 workforce planning update. This set out the work being done on the Zero Based Reviews. The Committee also heard from the Acting Chief Medical Officer on the implementation of job planning, and how this would support improved consultant rostering. The Committee noted: - There was a lack of clarity and detail about the information presented, and how this would lead to specific workforce savings in 26/27. - The Finance and Performance Committee had reviewed specific workforce (WTE) savings and financial targets in its last meeting, but there seemed to be nothing to back this up - There was a lack of pace about the activities, which raised risks of delivery of any savings within the 26/27 financial year The Committee noted that there remained opportunities within temporary staffing, specifically bank. However this had been the same in 2025/26 and had not been delivered. It was acknowledged that the Trust had delivered substantial savings over the last 2 years, £49m and an expected £60m in this financial year. However workforce savings targets had not been met. Some departments like ED relied heavily on bank pay to be able to address workforce and performance challenges. However every single care group had overspent

	on almost every area of staffing in 25/26. The Committee requested more assurance on the controls in place – especially preventative controls – over temporary staffing spend. The Committee requires a further update, addressing these concerns and with a detailed plan, at its next meeting. The Committee was NOT ASSURED on 26/27 workforce plans
BAF risk: organisational development and resilience	Dr Syed Gilani, the Acting Director of Medical Education, gave an update on the challenges in the Medical Education department. Key highlights: - The department had struggled with considerable vacancies in the year. This was being addressed, and only 3 vacancies now remained. However the vacancies had severely affected operational effectiveness and morale - Work was being done with the Finance team to report on training spend in the year Feedback from all medical school students highlight these main issues: i) Poor accommodation at William Harvey ii) Timetable issues culminating in students being turned away from clinics due to lack of oversight from block leads, regular block lead meetings with medical education and oversight of timetables from the medical education department due to staffing gaps Recommendations: - That the trust is aware of changes, i.e. Education Quality Review (new process from NHS E on quality inspections) and is prepared for how the intervention takes place and has executive and multi-disciplinary input. - The 10 Point Plan is a Trust wide piece of work that needs full Trust engagement in order to meet the full standards. - Consider if there are any more training places that can be converted into national training posts as per the national recommendation. - All-encompassing job plan processes to actively record and report all training activities and supervisioncarried out by our clinical staff. - Induction – ensuring the right resource, personnel, premises, content and IT suites to facilitate this The Committee thanked Dr Gilani for his leadership, and welcomed the update. The Committee had not received updates from Medical Education for over a year, and this would be a regular item to be monitored.

Other items of business: None

Actions taken by the Committee within its Terms of Reference: none

Items to come back to the Committee outside its routine business cycle: none

Items referred to the BoD or another Committee for approval, decision or action: none

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BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)

Committee: **Finance and Performance Committee (FPC)**

Meeting date: **24 February 2026**

Chair: **Richard Oirschot, Non-Executive Director (NED)**

Quorate: **Yes**

Appendices: **None**

Declarations of interest made:

No declaration of interest was made outside the current Board Register of Interests.

Assurances received at the Committee meeting:

Agenda item	Summary
Significant Risk Register (SRR)	The Committee received and **NOTED** the updated SRR relevant to its remit. The Committee noted there were 43 risks on the corporate risk register, with 15 sitting within its remit, the largest number assigned to any Committee, and overdue actions had reduced. Despite this assurance, ongoing high-risk infrastructure and digital issues continued to present significant exposure. **Assurance:** Partial assurance — there a large number of high risks with little movement down.
Capital Update	The Committee received and **NOTED** the capital update. The Trust remained on track to deliver its £79m capital spend by year-end (YE). Queen Elizabeth the Queen Mother Hospital (QEQM) Same Day Emergency Care (SDEC) had been approved by NHS England (NHSE) and additional capital had been secured for robotics, solar panel installation and safety-critical infrastructure. Risks included the potential PDC pressures and the complexity of managing multiple capital funding pots. Members requested a simplified capital summary sheet and a future report modelling the planned reduction in infrastructure risk. **Assurance:** Partial assurance — capital project delivery remains complex and has multiple dependencies which create high risk. Requires regular and careful oversight.
Capital Investment Group (CIG) Assurance Report	The Committee received and **NOTED** CIG Assurance Report.
Virtual Ward review and update	The Committee received and **NOTED** the Virtual Ward review and update.

	The Committee received assurance that improvements had been made to the Heart Failure and Acute Virtual Wards, and that the Hospital at Home service had been transferred and restructured under the Virtual Ward model. A business case for recurrent funding is scheduled for submission on 13 March. Risks included the reliance on non-recurrent funding, duplication of community services and a lack of standardisation across Kent & Medway (K&M). Benchmarking and financial impact analysis were requested and the programme will remain as a standing agenda item. **Assurance:** Partial assurance — good progress but funding and variation in models creates uncertainty.
We Care Integrated Performance Report (IPR) (M10): National Constitutional Standards for Emergency Access, Referral to Treatment (RTT), Cancer and Diagnostics	The Committee received and **NOTED** the M10 IPR. Urgent care performance had improved in January and February, supported by a newly implemented mental health escalation framework. However, significant risks were identified: continuing delays for mental health patients due to external bed shortages, absence of appropriate assessment facilities, and pressures arising from reduced police support in the Emergency Department (ED). Members requested a dedicated paper from the Mental Health Steering Group. **Assurance:** Limited assurance — multiple variables create performance risks.
2gether Support Solutions (2gether) Subsidiary indicative Budgets	Assurance was provided that the Stage 1 2gether budget for 2026/27 incorporated all relevant inflation, Terms & Conditions (T&Cs) and system Cost Improvement Programme (CIP) expectations. Recent peer learning with Northumbria Trust was beneficial. Risks included the sizeable £3.75m CIP requirement, the need for rapid agreement on FM-related change notices, and back-office efficiency savings requiring agreement on how benefits would be shared. A further update is due next month. **Assurance:** Committee received partial assurance but recognised more work was being done and would be shared.
Spencer Private Hospitals (SPH) Subsidiary indicative Budgets	Assurance was provided that agency usage was reducing through transition to NHS Professionals (NHSP) and improved procurement processes for prostheses. Risks discussed included major uncertainty regarding Integrated Care Board (ICB) commissioning intentions (representing 80% of Spencer's income), previous incorrect NHSP rate information causing a £355k cost pressure, and discrepancies between Trust and Spencer theatre utilisation data. A joint review and updated proposals will return in two months. **Assurance:** Committee received partial assurance but detail was missing at this stage.

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M10 Finance Report	The Committee received the M10 Finance Report and **NOTED** its content. The Committee was assured that the Trust remained on track to deliver its revised YE plan, barring any unexpected adverse issues. However, significant external oversight was acknowledged as a resource pressure on team bandwidth.
Business Planning Position 2026/27	The Committee received and **NOTED** the Business Planning updates. The Trust submitted its financial plan on time, supported by bottom-up modelling requiring a 3.6–3.8% productivity uplift and a CIP target of £75.9m for next year. The Committee noted substantial risks due to the scale of workforce reductions required, pressures from emerging capital schemes and the need to rapidly establish deliverables across care groups. A new contract monitoring committee will provide monthly reporting to FPC. The Committee received assurance on the Business Planning Process and positioning.
Business cases: over £1.75m Requiring Investment £2.5m for Self-Funding. Capital Business Cases Over £1m	The Committee received and **NOTED** the Business Case Scrutiny Group Assurance Report. The Committee approved the business case for two new obstetric theatres and refurbishment of the delivery suite, subject to confirmation of equipment assumptions, correction of depreciation figures, modelling of how freed-up main theatre capacity will be used and assessment of temporary staffing efficiencies. The Committee **APPROVED** the Maternity business case.
Feedback to Board of Directors	There was no specific feedback to the Board of Directors from this meeting.
Referrals to Other Board Committees	The Committee noted no referrals to other Board Committee.

Items referred to the BoD or another Committee for approval, decision or action:

Item	Purpose	Date
The Committee asks the BoD to discuss and **NOTE** this assurance report from FPC.	Assurance	To Board on 2 April 2026.

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BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)

Committee: Charitable Funds Committee (CFC)

Meeting date: 3 March 2026

Chair: Claudia Sykes, Non-Executive Director (NED)

Paper Author: Claudia Sykes, NED

Quorate: Yes

Appendices: None

Declarations of interest made: None

Assurances received at the Committee meeting: See below

Agenda item	Summary
Cazenove update	The charity has £1.2m invested with Cazenove as the fund manager, and received an annual update from the Cazenove team. The fund has achieved a return of 13.1% over the 2025 calendar year; the benchmark set is 3% above Consumer Price Index (CPI). The Cazenove team highlighted – as in previous years – the unpredictability of the markets due to the Trump factor. At the date of the meeting, the impact of the Iranian war was not fully known. The investment portfolio had an unrealised gain of £228k; as at 23 March this is now £181k.
Devereux property	The charity was generously left a property in Margate several years ago, with a lifetime tenant in situ. This property is now available to be sold. The Chief Strategy and Partnerships Officer, Ben Stevens, is leading on this for the Trust and charity.

Other items of business: None

Actions taken by the Committee within its Terms of Reference: None
Items to come back to the Committee outside its routine business cycle: None
Items referred to the BoD or another Committee for approval, decision or action: none

Item	Purpose	Date
CFC asks the BoD to discuss and **NOTE** this CFC Chair Assurance Report.	Assurance	2 April 2026

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BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)

Committee: **Integrated Audit and Governance Committee (IAGC)**

Meeting date: **30 January 2026**

Chair: **Dr Olu Olasode, Non-Executive Director (NED)**

Paper Author: **Board Support Secretary**

Quorate: **Yes**

Appendices:

None

Declarations of interest made:

No additional declarations of interest were made

The Purpose of the Committee Terms of Reference (ToR) extracts:

The IAGC is the high-level committee with overarching responsibility for risk. The role of the IAGC is to scrutinise and review the Trust's systems of governance, risk management, and internal control. It reports to the Board of Directors (herein shown as the Board) on its work in support of the Annual Report, Quality Report, Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness of risk management arrangements, and the robustness of the self-assessment against Care Quality Commission (CQC) regulations.

Assurances received at the Committee meeting:

Internal Audit

Assurances received on the effectiveness of the Trust's internal audit function and counter-fraud arrangements:

Internal Audit – Progress Report	• The Committee received **Assurance** noting the Internal Audit progress report and the following three final internal audit reports:
	  • **Financial Efficiency Planning and Governance:** received partial assurance;
	  • **Grip and Control follow up:** received reasonable assurance;
	  • **Patient Safety Incident Response Framework (PSIRF):** received reasonable assurance. Committee members welcomed evidence of improved learning processes, raised concerns about inconsistent escalation and documentation of serious incidents (highlighting a specific case). It was agreed this to be reviewed by the Quality and Safety Committee (Q&SC) and the outcome reported at the next IAGC meeting.
	  • Audit findings noted in respect of financial management and patient safety oversight.
	• The Committee highlighted financial efficiency work continues to face substantial challenges, raised concern around delayed identification and delivery of required schemes, inconsistent use of trackers, and insufficiently developed action plans for

	underperforming initiatives. The Executive team acknowledged the concerns, further work was required to strengthen accountability, ownership, and governance arrangements through the strengthened governance structure (including the Financial Improvement Performance Board (FIPB) as well as the Finance and Performance Committee (FPC). Internal Audit will continue to examine financial controls, including bank and agency expenditure and non-pay controls. • The Committee discussed the follow-up audit review on Grip and Control, noting the strong progress with most actions implemented and improved visibility with a single tracker consolidating the audit and counter fraud actions. • Committee members reiterated the need to ensure overdue audit actions were progressed and timely completed. • The Committee received assurance of continuity of Finance resources with the provision of interim arrangements in respect of the annual audit, following the departure of the Deputy Chief Finance Officer (CFO). It was noted successful recruitment of a substantive Deputy CFO commencing early March 2026, key responsibility will include liaison with internal and external audit.

Counter Fraud

Assurances received on the adequacy of the Trust's arrangements for counter fraud and as required by NHS Counter Fraud Authority.

Local Counter Fraud Specialist (LCFS) RSM Risk Assurance Services LLP - Progress Report • **Declarations of Interest**	• The Committee received **Assurance** noting the LCFS Progress Report update and continued delivery against the work plan. LCFS work included proactive exercises, fraud awareness training, cyber-fraud sessions, and bespoke training for Finance staff. • The Committee noted six new referrals received, five ongoing, and continued monthly liaison with HR ensuring cases closed by LCFS with ongoing internal processes and appropriately tracked. • Committee members raised concern about the relatively low number of sanctions or criminal outcomes despite the volume of referrals. It was agreed the need to strengthen deterrence, ensure follow through of cases at greater pace, and better understanding of thresholds for escalating cases to criminal investigation. It was highlighted the importance of benchmarking Trust's profile against other organisations and reviewing whether the threshold for pursuing criminal sanctions was set appropriately. It was also raised the long length of time some cases remained open, that was a concern in respect of the negative impact on staff and organisational culture. It was agreed to review opportunities to improve timeliness, escalation routes, reporting transparency, and provide recommendations at the next IAGC meeting. • The Committee received **Limited Assurance** noting a verbal update on declarations of interest, previous management actions not being completed, and the further work underway to improve compliance.

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External Audit

Assurance received on the effectiveness of the external audit process and the work of external auditors.

External Audit Grant Thornton (GT) - External Audit Progress Report and Sector Update	• The Committee received **Assurance** from the External Audit Progress Report and Sector update. • The Committee noted external audit activity progressing to plan, early testing underway, no significant issues to date, and no delays anticipated in meeting the June 2026 statutory deadline for approval and signing of the annual accounts. • Committee members noted the sector update, acknowledging the helpful overview of financial sustainability pressures and the role of NEDs in supporting value for money arrangements. • The Committee discussed how Boards nationally are balancing financial pressures against maintaining quality outcomes, noting increasing political focus on this area. It was noted continued audit review work looking at how this was being managed by the Trust, to ensure financial grip and control does not undermine care and quality. The BoD will continue to review and have oversight of risks, quality and financial sustainability. • The Committee emphasised the importance of robust Quality Impact Assessment (QIA) processes, noting the next BoD Strategic Session in March will include discussion on risk appetite, clinical priorities and the revised Board Assurance Framework (BAF).

Financial Reporting

Assurances received on the integrity of the financial statements of the Trust and formal announcements relating to the Trust's financial performance.

Financial Sustainability Plan (FSP)/Cost Improvement Programme (CIP)	• The Committee received **Limited Assurance** from a verbal update on FSP, noting current position pending national guidance and ongoing contract negotiations with the Integrated Care Board (ICB). Trust required to restore financial balance over three years, recognising the significant financial challenges and impact in being able to reduce its deficit and achieve financial balance. • Trust's CIP requirement for upcoming financial year remains highly challenging. The Committee discussed the feasibility and credibility of delivery. Committee members emphasised risks surrounding pace, planning certainty, and the capacity to reduce cost quickly should demand not fall as assumed through the system 'left-shift' initiatives. The CFO provided assurance around CIP resources, and delivery being strengthened that included recruitment to new posts. Committee members highlighted concern with delays in securing these posts and the impact to progress the CIP. • The Committee considered and discussed the broader system context, in relation to external review of the drivers of the Kent &

	Medway (K&M) system deficit and Trust level opportunities. Committee members stressed the need to significantly strengthen the governance of system savings programme. There also needed to be a clear risk sharing arrangement with the ICB, particularly if 'left shift' assumptions did not materialise at the required pace.
Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD)	• The Committee received **Limited Assurance** from a verbal update briefing on SFIs and SoD. It was noted the SoD had been updated the previous year, and that further review work was required, particularly in respect of the implemented grip and control measures, and the need to clarify spend authorisation levels. This had also been recently discussed at FPC. • The CFO confirmed the newly appointed Deputy CFO once established in post will lead the work to complete the review and present a revised version for consideration at a future IAGC meeting for approval.

Losses and Special Payments Report to 31 December 2025	• The Committee received **Assurance** on Losses and Special Payments, noting no issues for escalation and the following key highlights:
	  • Total losses and special payments for period amounted to £143k across 136 cases, representing reduction of £85k and 22 cases compared with same period in previous financial year;
	  • Key categories include, bad debt write-offs (£132k) largely relating to staff debt, overseas visitor debt and accommodation charges, along with small numbers of ex gratia payments for loss of personal effects.

Single Tender Waiver (STW) Report	• The Committee received **Limited Assurance** on STWs, noting a marked increase in both the volume and value of STWs in 2025/26. This was driven in part by a single high-value STW as well as challenges with sudden capital opportunities, operational capacity constraints, and continuity of service requirements, acknowledging the element around cultural factors. On a positive note around a quarter of STW requests were being rejected, demonstrating strengthened challenge processes, but that further improvement still required. • The CFO highlighted the trend reflected ongoing issues in procurement to payment processes and broader organisational pressures. It was confirmed strengthened escalation with STW activity now presented to the Trust Management Committee (TMC) on a rolling basis to improve visibility and accountability. • The Committee discussed the challenge posed by retrospective STWs, forward planning failures, the need for earlier engagement with procurement, and current pressures on procurement resourcing. Committee members emphasised the importance of aligning procurement behaviour to SFIs and the Procurement Act 2023. A review of procurement resourcing was needed to ensure benchmarking of staffing levels and resources are fit for purpose.

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Governance

Assurances received on the effectiveness of the Trust's system of integrated governance, risk management, and internal control (clinical and non-clinical) across the whole of the organisation's activities that support the achievement of the Trust's objectives.

2gether Support Solutions (2gether) Annual Report and Accounts 2024/25	• The Committee received **Assurance** from the 2gether Annual Report and Financial Statements for the year ended 31 March 2025. This had been reviewed and approved by 2gether's Board and Audit and Risk Committee. External Auditor (Grant Thornton) issued an unqualified audit opinion with no significant findings. • The Committee highlighted and noted process matters raised in the report affected both the Trust and 2gether, and these will be taken forward through the Trust and 2gether Joint Oversight meeting.
Spencer Private Hospitals (SPH) Annual Report and Financial Statements 2024/25	• The Committee received **Assurance** from the 2024/25 SPH Annual Report and Financial Statements. Noting this had already been reviewed and approved through SPH's Audit and Finance Committee and Board. • SPH confirmed its financial position remained healthy, with no material audit concerns identified. There was only an outstanding issue relating to the classification of a historic group loan, which following auditor review was determined to be a non-basic financial instrument requiring fair-value treatment rather than recognition at residual value. Completion of the necessary recalculation, agreement with auditors, and to be incorporated into the final accounts. Companies House granted a filing extension to 31 March 2026, with final submission expected in February.
Annual Accounts process and timetable 2025/26 and Review of Accounting Policies 2025/26	• The Committee received **Assurance** from the report outlining the production process followed the Department of Health and Social Care (DHSC) timetable. Interim audit work beginning late January 2026 and draft accounts due for submission on 27 April 2026. The final audit commencing on 28 April, with IAGC meeting scheduled on 23 June to review and recommend approval to the Board for sign-off at its meeting on 24 June, for submission to DHSC by the deadline of 26 June 2026. • Committee members discussed the Going Concern statement, confirming the approach used in the previous year's accounts remained appropriate given similar financial challenges. • The Committee reviewed and approved the draft Accounting Policies 2025/26, noting no significant changes proposed. Updates mainly reflected Group Accounting Manual (GAM) 2025/26 requirements and the anticipated completion of Healthex dissolution during the year. It was noted should the dissolution not be completed, relevant disclosures will revert to prior year's wording.

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Quality Account process 2025/26	• The Committee received **Assurance** from the draft Project Plan to deliver the 2025/26 Quality Account, noting the statutory requirement for publication by 30 June 2026. The proposed governance pathway through TMC, Q&SC, IAGC, Council of Governors (CoG) and BoD. • The Chief Nursing and Midwifery Officer (CNMO) highlighted the process had significantly improved over the previous 12 months, with previous year's Account completed on time and with strong engagement from internal and external stakeholders. Noting there will be detailed review and consultation with the Governors. • The Q&SC NED Chair acknowledged the improved process and confirmed Q&SC's ongoing oversight monitoring production of this annual document.
Annual Report 2025/26 – process and timeline for production and sign-off	• The Committee received **Assurance** from the report outlining the process and timetable for the production and sign-off of the 2025/26 Annual Report. • Responsibility for co-ordinating the updated sections and production of this annual document now with the Deputy Director of Communications and Engagement. This document will be in line with the statutory requirements set out in the NHS Foundation Trust Annual Reporting Manual (ARM). The proposed timetable was noted, with early drafts to be presented to FPC, CoG, and IAGC, prior to the final presented to IAGC at its meeting on 23 June, and BoD on 24 June for approval for submission.

Risk Management and Internal Control

Assurances received on the adequacy of the Trust's internal controls (clinical and financial) and risk management systems, and all risk and control related disclosure statements (in particular the Annual Governance Statement, regular reports on the activities of the Executive Risk Assurance Group, self-certification statements to the Regulator, and Care Quality Commission declarations), together with any accompanying Head of Internal Audit statement, External Auditor opinion or other appropriate independent assurances.

Significant Risk Register (SRR) Report	• The Committee received **Assurance** noting the SRR report. There are currently 45 risks meeting the threshold for inclusion on the SRR. Twelve risks with overdue actions escalated to Executive Directors for immediate attention, and scheduled for discussion at the Risk Review Group. • The CNMO highlighted ongoing work to strengthen oversight, including monthly Executive level meetings for each significant risk, improvements in action tracking, and alignment of the risk register with the Board Assurance Framework (BAF). • The Committee noted newly approved risks relating to the Children's Diabetes Team and Pharmacy Procurement, and an escalated risk relating to Queen Elizabeth the Queen Mother Hospital (QEQM) medical rota gaps.

	• The Committee agreed a governance review of associated reputational risks to be undertaken, with consideration whether this may be incorporated into future BAF refresh discussions. • There was discussion regarding deeper Committee involvement, it was agreed a programme of deep dives into selected significant risks to be developed and brought back to IAGC.

Board Assurance

Assurances received on the Trust's underlying assurance processes that underpin the achievement of corporate objectives, and compliance with relevant regulatory, legal and code of conduct requirements, any related reporting, and self-certifications.

Board Assurance Framework (BAF)	• The Committee received **Assurance** from the revised BAF, following its request this be refreshed. Noting the document was more strategic, standalone, set out risks, controls, mitigations and assurance routes mapped clearly against Trust's strategic objectives. • The Director of Corporate Governance (DCG) confirmed this review included looking at BAF approaches across other trusts to design a model bringing together best practice, alignment with Trust's emerging Clinical Strategy, and integration with Trust's developing risk appetite framework (expected to be moved forward collectively at the March BoD Strategic Session). • Committee members welcomed the refreshed approach, emphasising the importance of ensuring the narrative avoided optimism bias and realistically reflected both strengths and areas of concern. • The Committee noted the need to avoid excessive detail within the assurance and control sections to ensure the document remained manageable and focused.

Other Assurance Functions and Regulatory Compliance

Other significant assurance received, both internal and external to the Trust, that may affect governance of the organisation. These will include, but not be limited to, any review by Department of Health arms-length bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Resolution, NHS England/NHS Improvement etc.), and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies etc.), and arrangements by which staff within the Trust may raise confidentially concerns over financial control, reporting, clinical quality and patient safety and other matters.

Policy Compliance	• The Committee received **Assurance** from the annual report presented on policy compliance and the continued monitoring of this key governance performance. • The Committee noted overall compliance continues to improve now approaching the regulatory benchmark of 90%, with 26 of 241 policies (10.8%) currently past their review date, down from 13.4% at the previous report. Some policies remain overdue, including the Quality Impact Assessment Policy, where progress has been

	delayed due to competing priorities and additional support has been secured to expedite completion. • The CNMO stated the current report covered Trust-wide policies only, and work was underway to incorporate policies from its subsidiaries (2gether and SPH) into a full Group-wide compliance report within the next reporting cycle. • Committee members recognised the significant improvement in policy governance over recent years, with thanks given to the teams involved.
Subject Access Requests (SARs)	• The Committee received **Limited Assurance** from the annual report presented on SARs, emphasising the importance of continuing to robustly monitor performance against this governance requirement. • The Committee noted SAR performance remained significantly challenged, with 53% compliance against the statutory 30 day requirement, with an increasing volume of both patient and staff Data Subject Access Requests (DSARs). Key operational issues included inadequate triage, inconsistent use of complex extensions, inefficient clinician review processes, and limited patient signposting to alternative access routes such as the NHS App and Trust's patient portal. Planned improvement measures include strengthened communications, updated website guidance, enhanced triage and scoping, application of Data (Use and Access) Act 2025 (DUAA) provisions.
EKHUFT Board Developmental Priorities for 2026 including update on Well Led	• The Committee received **Assurance** from the update report on the Trust's Board Developmental Priorities for 2026 and the planned Well-Led developmental review. • The Committee noted the Nominations and Remuneration Committee (NRC) had agreed a refreshed Board Development Programme. This will include updated Insights profiling, repeat assessment against the Good Governance Institute (GGI) Board Assurance Matrix, and targeted development sessions focusing on risk appetite, lessons learned from other trusts, and embedding Equality, Diversity and Inclusion (EDI) considerations. • Committee members raised concerns about NED visibility of the Executive development activity. The Chief Executive confirmed a dedicated session scheduled for the week commencing 2 February to define the Executive Team's development needs, with alternative external support being explored.

Relationships With Other Committees

Assurances from the Committee's review of Chair reports from the Quality and Safety Committee, Finance and Performance Committee and People and Culture Committee to consider findings of significant assurance and the implications on the Trust's governance.

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Other items of business

- The Committee noted the 2026/27 IAGC Annual Work Programme.
- The Committee Chair recognised the significant operational pressures, extending thanks to the Executive team and staff for their continued hard work and dedication looking after patients.
- The Committee discussed the current arrangements for Governors observing Board Committee meetings to improve Governor engagement, and to look at and understand barriers to participation (e.g. travel difficulties for in-person attendance) noting ways to make engagement easier and more meaningful will be explored.

Items referred to the BoD or another Committee for approval, decision or action:

Item	Purpose	Date
The Committee asks the BoD to discuss and **NOTE** this assurance report from IAGC.	Assurance	To Board on 2 April 2026.

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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

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	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

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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.

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SIGNIFICANT RISK REPORT

1. Purpose of the report

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

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

1.3 The last Risk Review Group 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 route 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

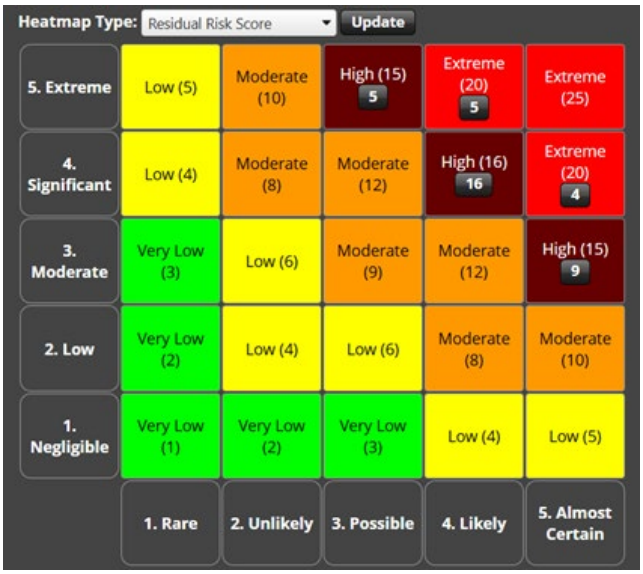
						Person Responsible: Julie Wells, Deputy Director of Finance Due: 31 March 26
3838	Corporate Finance and Performance Management Accountable Executive: CFO Review 12 Feb: Forward view: Further Grip and Controls in place to support agreed delivery of Cost Improvement Programme (CIP) of £60m for 25/26. Additionally, 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**



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.