REGISTER OF DIRECTOR INTERESTS – 2025/26 FROM JANUARY 2026

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
BLISSETT, NORMAN	Chief People Officer	Director and sole shareholder of Gallanach Enterprises Ltd **(1) (3)**	20 January 2025
CATTO, ANDREW	Non-Executive Director	Group Chief Executive Officer, Integrated Care 24 (IC24) **(1)** (including Director of Cleo Systems 24 Ltd, Brightdoc 24 Limited, Idental Care 24 Ltd.) Board Member of east Kent Health and Care Partnership (HCP) **(1)** Director of Transforming Primary Care **(1)**	1 November 2022 (Second term)
DESAI, KHALEEL	Director of Corporate Governance	Non-Executive Director/Trustee of The Mines Advisory Group (MAG) Charity **(4)**	29 April 2024
DOHERTY, ANNETTE	Chair	Chair of Maidstone and Tunbridge Wells NHS Trust **(1)** President (Chair) of the Royal Society of Chemistry **(4)** Member of Tonbridge Grammar School Academy **(4)**	1 May 2025
FLETCHER, TRACEY	Chief Executive	None	4 April 2022
GIBBS, DAN	Chief Operating Officer	Equity holder in Ignite Data Ltd. **(2)**	7 February 2025
GRIFFITH, FFION	Non-Executive Director	Non-Executive Director, Nexus Infrastructure Plc **(1)**	1 May 2025 (First term)
HAYES, SARAH	Chief Nursing and Midwifery Officer	Charity Trustee, The 1930 Fund for Nurses (Charity) **(4)**	18 September 2023
HOLDEN, DES	Chief Medical Officer	International Advisor, Public Intelligence (Denmark) **(5)** (2018) Advisor/Non-Executive Director, South East Health Technology Alliance **(4)** (2017) Visiting Professor, Clinical and Experimental Medicine, University of Surrey **(5)** (2023 to 2026)	2 January 2024

REGISTER OF DIRECTOR INTERESTS – 2025/26 FROM JANUARY 2026

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
HOLLAND, CHRISTOPHER	Associate Non-Executive Director	Director of South London Critical Care Ltd **(1)** Shareholder in South London Critical Care Ltd **(2)** Dean of Kent and Medway Medical School, a collaboration between Canterbury Christ Church University and the University of Kent **(4)** South London Critical Care solely contracts with BMI The Blackheath Hospital for Critical Care services **(5)**	13 December 2019 (Second term)
MUSGROVE, ROBERT	Non-Executive Director	Employee of IBM UK Ltd **(1)** Non-Executive Director In-Common, 2gether Support Solutions **(1)**	1 May 2025 (First term)
OIRSCHOT, RICHARD	Non-Executive Director	Non-Executive Director, Puma Alpha VCT plc (July 2019) **(1)** Director, R Oirschot Limited (August 2010) **(3)** Trustee, Camber Memorial Hall (June 2016) **(4)**	1 March 2023 (First term)
OLASODE, OLU	Senior Independent Director (SID)/Non-Executive Director	Executive Chairman, TL First Group (started 9 May 2020) **(3)** Chairman, Governance and Leadership Academy UK (started 11 September 2018) **(1)** Non-Executive Director, Priory Care Group (started 1 June 2022) **(1)** Independent Chair of Audit and Governance, London Borough of Croydon (started 1 October 2021) **(4)**	1 April 2021 (Second term)
STEVENS, BEN	Chief Strategy and Partnerships Officer	None	1 June 2023 (substantive) (20 March 2023 interim)
SYKES, CLAUDIA	Non-Executive Director	Director, Cloudier Skies Ltd **(1)** (started 21 December 2022) Chair, East Kent Health and Care Partnership (HCP) (**1**) (1 January 2024) Chair, Kent and Medway VCSE Alliance **(5)** (September 2022)	1 March 2023 (First term)

REGISTER OF DIRECTOR INTERESTS – 2025/26 FROM JANUARY 2026

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
van der LEM, ANGELA	Chief Finance Officer	Board Member, NHS Commercial Solutions Management Board **(1)**	6 November 2024
WALKER, CATHERINE	Non-Executive Director	Chair of Advisory Appointments Committee, Kings College NHS Foundation Trust **(1)** Tribunal Member, Ministry of Justice **(1)** Panel Member/Chair, High Speed 2 **(1)** Panel Member/Chair, East West Rail **(1)**	25 October 2024 (First term)

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

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

Categories:

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

UNCONFIRMED MINUTES OF THE ONE HUNDRED AND FOURTY EIGHTH MEETING OF THE BOARD OF DIRECTORS (BoD) THURSDAY 5 FEBRUARY 2026 AT 1.00 PM HELD IN SEMINAR ROOMS 1 & 2, BUCKLAND HOSPITAL, COOMBE VALLEY ROAD, DOVER, CT17 0HD AND BY WEBINAR VIDEOCONFERENCE

PRESENT:

Dr A Doherty	Trust Chair (Chair)/Nominations and Remuneration Committee (NRC) Chair	AD
Mr N Blissett	Chief People Officer (CPO)	NB
Dr A Catto	Non-Executive Director (NED)/Quality and Safety Committee (Q&SC) Chair/Integrated Audit and Governance Committee (IAGC) Member/ NRC Member	AC
Mr D Gibbs	Chief Operating Officer (COO)	DG
Ms F Griffith	NED/NRC Member/People and Culture Committee (P&CC) Member/ NED Maternity Safety Champion	FG
Ms S Hayes	Chief Nursing and Midwifery Officer (CNMO)	SH
Dr D Holden	Acting Chief Executive Officer (CEO) (*joined by Webinar*)	DH
Dr H Mackie	Acting Chief Medical Officer (CMO)	HM
Mr R Musgrove	NED/Finance and Performance Committee (FPC) Member/ NRC Member/NED In-Common (2gether Support Solutions (2gether))	RM
Mr R Oirschot	NED/FPC Chair/Charitable Funds Committee (CFC) Member/ IAGC Member/NRC Member	RO
Dr O Olasode	NED/Senior Independent Director (SID)/IAGC Chair/NRC Member (*joined by Webinar*) (*left meeting at 2.30 pm*)	OO
Mr B Stevens	Chief Strategy and Partnerships Officer (CSPO)	BS
Ms C Sykes	NED/CFC Chair/P&CC Chair/FPC member/IAGC Member/ NRC Member	CS
Ms A van der Lem	Chief Finance Officer (CFO)	AvdL
Mrs C Walker	NED/NRC Member/P&CC Member/Q&SC Member	CW

ATTENDEES:

Family Members	Sister and Stepdaughter of Patient - Family Story *(minute number 25/112)*	
Ms M Cudjoe	Director of Midwifery (DoM) *(minute number 25/118)*	MC
Mr K Desai	Director of Corporate Governance (DCG) (non-voting Board member)	KD
Dr M Farr	Chief Analytical Officer *(minute number 25/117)*	MF
Professor C Holland	Associate NED/NRC Attendee/P&CC Attendee/Q&SC Attendee (non-voting Board member)	CH
Ms C Maynard	Associate Director of Nursing, Cancer, Clinical Haematology and Haemophilia *(minute number 25/112)*	CM
Ms L Rudd	Nurse Consultant, Supportive and Palliative Care & Clinical Ethics Committee Chair *(minute number 25/112)*	LR
Ms E Sharp	Guardian of Safe Working (GoSW) *(minute number 25/119)*	ES

IN ATTENDANCE:

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

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

Mr L Arterton	Governor
Ms M Bonney	Governor
Ms S Landers	Member of Staff
Ms S Mahmood	Staff Governor
Ms B Mayall	Governor
Ms A Stepanian	Member of the Public
Mr M Taylor	Member of the Public

MINUTE NO.		ACTION
25/107	**CHAIR'S WELCOME AND APOLOGIES FOR ABSENCE** The Chair opened the meeting, welcomed everyone present, and noted apologies received from Ms T Fletcher (TF), CE. The Acting CEO, Dr Holden, was joining remotely due to commitments at an NHS England (NHSE) meeting in London; the NED, Dr Olasode, was also joining remotely.	
25/108	**CONFIRMATION OF QUORACY** The Chair **NOTED** and confirmed the meeting was quorate.	
25/109	**DECLARATION OF INTERESTS** The Chair **NOTED** there were no new interests declared.	
25/110	**MINUTES OF THE PREVIOUS MEETING HELD ON 4 DECEMBER 2025** **DECISION:** The BoD **APPROVED** the minutes of the previous meeting held on 4 December 2025 as an accurate record.	
25/111	**MATTERS ARISING FROM THE MINUTES ON 4 DECEMBER 2025** **Action B/22/25 – Deep Dive Review Friends and Family Test (FFT) Feedback** The CSPO verbally confirmed the review of FFT data was now complete, reported through the Patient Experience Committee, noting the recommendation for agreement for closure of this action. **Action B/24/25 – Review new NHS Oversight Framework (NOF) and metrics, alignment with Integrated Improvement Plan (IIP) and Integrated Performance Report (IPR) reporting** The CSPO verbally confirmed completion of this work and IIP progress provided in the IPR, noting recommendation for agreement for closure of this action. **Action B/27/25 – Progress update on implementation of outstanding actions from 2022 Higher Level Responsible Officer (HLRO) visit** The Acting CMO verbally confirmed improvements to appraisal processes following the review including a quality and assessment assurance process, noting recommendation for agreement for closure of this action. **Action B/30/25 – Update on Trust's Capital Programme** The CSPO reported a verbal update would be provided within the Finance Report agenda item later in the meeting. **Action B/35/25 – Update on review of stillbirths increase** The CNMO reported a verbal update would be provided within the Maternity and Neonatal Assurance Board (MNAB) Chair's Report agenda item later in the meeting. The Board of Directors **NOTED** the action log, **NOTED** the updates on actions, actions for future meeting, and **APPROVED** the twelve actions recommended for closure.	

25/112 **FAMILY STORY**

The Board received an extremely emotional and powerful family experience regarding the end of life (EoL) care provided to their brother and stepfather, Pete, who died in the William Harvey Hospital (WHH) in September 2023.

The Chair thanked the family for their courage in attending and sharing their experience with the Board, and apologised on behalf of the Trust for the unacceptable failings in Pete's care.

The Family highlighted the following key points from their experience:

- Described a series of concerns, including:
  - Poor communication;
  - Limited involvement of the family in key decisions;
  - Lack of compassion;
  - Missing or incomplete medical records;
  - Delays in issuing a hospice referral;
  - Misunderstanding over available hospice beds;
  - Inconsistent visiting arrangements;
  - Inadequate symptom management;
  - Absence of an EoL plan.
- Highlighted distress caused by avoidable delays and failures in the complaints process, which took over a year to progress.

The Board acknowledged Pete's preferred place of death, a hospice, had not been respected, largely due to human error, poor co-ordination between hospital teams and the hospice, system pressures and missed clinical communication. The Clinical Executive Directors and the Nurse Consultant, Supportive and Palliative Care recognised missed opportunities to intervene earlier. This was around supporting staff in identifying patients approaching EoL, and to initiate timely 'Respect' conversations, emphasising these should centre on a patient's values, fears, and preferences. The Nurse Consultant, Supportive and Palliative Care confirmed mitigation of these gaps in future, emphasising new systems, including enhanced EoL pathways and introduction of dedicated palliative care beds across Trust sites, intended to strengthen staff confidence, clarity of roles and communication.

The Board reiterated learning from this case must directly inform improvements in practice and culture, including scrutiny of learning by the Q&SC. It was noted the complaints process continued to be improved, ensuring timeliness, clarity, and compassionate communication with families.

The Board noted the significant actions already taken since 2023, including:

- Introduction of Patient and Family Liaison staff in Emergency Departments (EDs);
- Extended visiting hours (now 7am–8pm);
- Dedicated palliative care beds;
- Improved on site carer support, development of a Carers Policy and leaflet, strengthened processes for issuing death certificates, and implementation of Martha's Rule to provide families with a rapid escalation route if concerned about deterioration of patient.
- Further planned improvement actions were noted, Trust wide adoption of the NHSE Carers and Discharge Toolkit, standardisation of discharge checklists including carer involvement, improved identification and recording of carers in the electronic patient record, and Trust wide rollout of 'What matters to me' bedside posters to improve communication and personalisation of care.

Board members expressed deep gratitude for Pete's family in being open and honest, reiterated sincere apologies for their experience, and confirmed that their contribution would have a lasting impact on driving improvements to ensure compassionate, safe and dignified EoL care for all patients.

Post meeting note provided by Family in respect of whether there had been any communication with the Hospice and at the meeting reported no. 'After the weekend, on Monday 11 September 2023 (morning), palliative nurses were in communication with hospice, trying to get Pete transferred, that was his wish. Aim and focus was to find a bed available in any of the hospices. Family were not aware of any communications with the hospice regarding Pete's care. After Pete died, Family asked if someone had contacted the hospice about Pete's wishes concerning how he would like to die, 'Respect' document hospice had on file. The Family was told that hadn't happened, and was told there was a bed available at the Canterbury hospice. An hour and a half later, Family was informed due to miscommunication, there was no bed available at Canterbury. On Tuesday 12 September (morning), a bed became available in Ashford hospice and although Pete said he would like to be transferred there, Family knew he was too ill for transfer. The team went to arrange the transfer, sadly Pete died shortly afterwards. The Family felt although they knew Pete was very near EoL, the medical staff did not realise this, probably due to Pete seeming so lucid, and were surprised at how quickly he passed away that morning.'

The Board of Directors discussed the Family Story and **NOTED** the actions and improvements taken to date and those planned.

25/113 **CHAIR'S REPORT**

The Chair highlighted the following key points:

- Significant winter pressures affecting Trust, including critical incident declared (first time in over two years) at Queen Elizabeth the Queen Mother Hospital (QEQM) on 12 January due to bed pressures and norovirus cases, as well as sustained operational strain across all sites. Declaring this enabled whole system focus that remained in place for seven days;
- Care Quality Commission (CQC) unannounced inspections of Urgent and Emergency Care (UEC) and the medical pathway at QEQM, as well as that week at WHH, with formal feedback expected in due course.

The Chair commended Trust staff for their resilience and acknowledged the difficulty this critical incident and winter period posed for patients.

The Chair reflected on the Family Story, raising the need to strengthen staff training and support for EoL, particularly given the ageing population and increasing number of patients in hospital at EoL. The NEDs recommended undertaking a focussed deep dive on this topic, it was agreed to add this as an item for presentation and discussion at a future Q&SC meeting, to include scoping communication pathways between hospices and the hospital teams.

ACTION: Present at future Q&SC meeting for discussion a deep dive report around strengthening staff training and support for EoL, particularly in response to ageing population and increasing number of patients in hospital at EoL, including scoping communication pathways between hospices and the hospital teams. — CNMO

Board members sought an update on the national maternity inquiry led by Baroness Amos. The Chair and Acting CEO reported they had taken part in interviews at the end of 2025 and the national timeline for findings had been extended as the inquiry widened engagement with families. The Trust had provided dates for future visits and awaited confirmation from the inquiry team.

The Chair recognised staff efforts during the recent CQC visits to QEQM and WHH, and reaffirmed all external feedback welcomed as part of the Trust's commitment to improving UEC.

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

25/114 **ACTING CHIEF EXECUTIVE OFFICER'S (CEO's) REPORT**

The Acting CEO highlighted the following key issues:

- Considerable operational pressures across Trust during December and January;
- ED performance deteriorated due to rising demand, norovirus outbreaks and winter pressures, with only 73% of patients admitted, transferred or discharged within four hours an increase in 12 hour stays to just over 20%;
- Ongoing challenges around high bed occupancy and delayed discharges, with partners engaged to improve patient flow;
- Elective and diagnostics performance fallen behind trajectory, with recovery plans in place for Quarter four and into June 2026;
- Financial performance at month nine reported £9m adverse to plan, impacted by under delivery of Cost Improvement Programme (CIP) and withdrawal of Deficit Support Funding (DSF);
- Need for intensified cost containment activity;
- Immediate actions in response to concerns raised at CQC inspections had already been implemented, and further information requests were being processed. Positive feedback received about staff compassion. Board would receive ongoing updates as formal outcome letters were received;
- In respect of maternity and neonatal services, repeat visits and staff focus groups would be arranged as part of the national investigation led by Baroness Amos, Trust awaiting further details of scope and timing;
- Impact of the Trust wide norovirus outbreaks, particularly at QEQM where up to 23 bays were affected at the peak, resulting in 35 empty beds and major flow disruption. Cases were now declining, community transmission remained high, noting estates related constraints on side room capacity, with further review work underway.

The Board welcomed positive developments, including securing £4.7m capital investment for two additional surgical robots, strong flu vaccination uptake with coverage exceeding 54%, stroke services achieving the only national Grade A in the latest Sentinel Stroke National Audit Programme (SSNAP) audit, and the launch of a new satellite maternal medicine clinic at Kent and Canterbury Hospital (K&C) to improve access for women with complex pregnancies. The Board congratulated these team achievements.

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

25/114.1 **UPDATE ON COLLABORATION ACROSS KENT & MEDWAY (K&M) INTEGRATED CARE SYSTEM (ICS)**

The Acting CEO provided a verbal update on strengthening collaboration across the K&M ICS highlighting the following key elements:

- In line with K&M Integrated Care Board's (ICB's) priorities and local ambitions, regular Executive to Executive meetings had begun between acute trusts moving away from working in silos, exploring opportunities for shared working, greater consistency of access, and improved sustainability;

- Productive discussions already underway in areas including operations, research and education, with Kent Community Health NHS Foundation Trust (KCHFT) also seeking to establish similar formal links;
- Further engagement with Kent and Medway Mental Health NHS Trust (KMPT) expected, with shared ownership of pathways identified as vital to improving patient flow at both the front and back doors of hospitals, mental health interface challenges and overall patient experience.

The NEDs welcomed the shift towards genuine collaboration but stressed the importance of turning intentions into measurable actions, noting the earlier presentation at its Closed meeting on deficit drivers and the need for outcome based system conversations rather than high level dialogue. The Acting CEO confirmed all K&M providers, including community and mental health partners, were receiving the same analytical insight and the ICS was working on scaling successful smaller projects into system wide improvements. He emphasised the need to progress models such as discharge to assess, earlier pre-hospital pathways for frail patients and improved alternatives to ED attendance for people with mental health needs.

The Board raised concerns regarding the persistent challenge of medically fit patients remaining in hospital due to lack of social care capacity. NEDs sought assurance the system was engaging with social care providers. The Acting CEO confirmed he had been invited to speak with local Councillors and that this was an opportunity around joint problem solving. The Board agreed the Trust must play a stronger role in influencing the ICS on this issue, and that lobbying efforts, both locally and nationally, including through MPs should be strengthened. A further suggestion was made that Governors could support lobbying activity, and the Chair requested this be added as an item for a future Council of Governors (CoG) meeting.

ACTION: Progress engagement with local Councillors regarding social care capacity, as well as raising social care pressures with MPs and at ICS level. — Acting CEO

ACTION: Add social care related collaboration and lobbying for discussion at a future CoG meeting for Governors to support raising social care pressures with MPs. — DCG

The Board of Directors received and **NOTED** the verbal report on collaboration and partnership across NHS K&M ICS.

25/115 **PERFORMANCE AND FINANCE REPORTING:**

25/115.1 **INTEGRATED PERFORMANCE REPORT (IPR)**

The Executive team highlighted the following key performance against metrics reported in the IPR for the month of December 2025, noting this also tracked progress against the Integrated Improvement Plan (IIP) milestones:

- Operational performance: remained significantly challenged, particularly in UEC, with overall four hour compliance down to 73% and 1,276 patients waiting over 12 hours in the ED. Total number of excess 12 hour waiting hours was around 10,000 fewer than the previous winter, indicating some improvement amidst heavy system pressures;
- Quality and Safety (Q&S): Norovirus outbreaks continued to impact patient flow and bed capacity across sites. One never event in December (wrong

breast wire insertion) and increase in overdue incidents (rose to 950). Work to reduce incident backlogs and strengthen Duty of Candour compliance ongoing. Improvements in falls and harm reduction, alongside ongoing infection control challenges linked to norovirus and increased C. difficile detection due to expanded testing. Safeguarding Level 3 compliance at 82.8% for Children and for Adults 82.1%. Mixed sex accommodation breaches of 50 (8% increase) with actions in place to improve both these areas. Maternity metrics remained stable overall;

- Patients: ongoing participation in national programmes including the Planned Care Sprint, Getting it Right First Time (GIRFT) initiatives and Same Day Emergency Care (SDEC) improvement work supporting recovery trajectories;
- Planned care: progress reducing long waits, including drop in 52 week waits from 2,078 in November to 1,977 in December, reduction in 65 week waits to 46. Referral to Treatment (RTT) performance fallen to 51.8% against 60% target, diagnostics performance deteriorated to 64.8%. Detailed recovery plans for DM01 underway, including recruitment, increased vetting capacity, and improved booking utilisation. Cancer performance remained below trajectory, 62 day performance 70.2%. Improvement plans for breast screening, histopathology reporting and pathway co-ordination, with escalation processes in place for overdue diagnostics;
- People: workforce indicators showed increased sickness absence at 5.67% driven by seasonal pressures, slight rise in vacancy rate to 9.4%, and a continued historically low turnover rate of 6.6%. Appraisal compliance remained static at 75.6% (despite introduction of a new anniversary based appraisal system) with targeted work required to increase compliance above 80%. Statutory training compliance remained high at 93.9%;
- Financial performance: continued to be adverse, strengthened grip and control measures, CIP methodology improvements, and Care Group level financial performance meetings.

The Board endorsed the continued operational focus on restoring diagnostic performance by June 2026 and supported the Trust's actions to maximise capacity through independent sector usage, national Sprint schemes and internal productivity measures.

The Board acknowledged the operational pressures contributing to patient care in escalation corridors and commended staff for their continued hard work and commitment maintaining safety.

The Board noted recruitment challenges remained concentrated in Band 2 and 4 roles, new measures to reduce agency reliance beginning to take effect, including rate card alignment and exit plans for long term locums. The Board supported continued scrutiny through the P&CC.

The Board stressed the need for visible progress on reducing run rate expenditure and achieving the revised £60m CIP forecast. The Trust's segmentation under the National Oversight Framework remained at segment 3, with updated national data expected later in the quarter.

The Board of Directors **NOTED** the metrics reported in the December 2025 IPR.

25/115.2 **MONTH 9 (M9) FINANCE REPORT**

The CFO reported on the following key issues:

- Materially adverse financial position driven by withdrawal of DSF, CIP under delivery, and non-recurrent cost pressures;
- Year to Date (YTD) position including loss of DSF £20.5m adverse to plan, £11.5m related to DSF, excluding DSF Trust remained £9m adverse to plan;
- CIP under delivery of £7.3m YTD against a challenging full year efficiency requirement of £80m, increased significantly from £49m the previous year;
- Additional cost pressure arising from reversal of a £1.7m VAT reclaim following Supreme Court ruling on car parking VAT.

The Board discussed the Trust's reforecast year end (YE) deficit submitted to NHS England (NHSE) in January. The CFO confirmed work continued to mitigate the position whilst protecting safe patient care. Actions underway included reducing temporary staffing expenditure, using national benchmarking data to target opportunities in outpatient productivity, back office costs, estates and medicines management, and reviewing pay bill efficiency. It was emphasised that transformational change would be required in some areas to deliver sustained financial improvement in 2026/27, and learning from high performing providers would be built into next year's plan.

The Board noted that, despite in year challenges, CIP delivery was on track to exceed prior year savings, and that every effort would be made to close the gap to the original £80m target, although full delivery remained unlikely.

The CSPO provided a capital update, noting the unusually back loaded capital programme, with £28m forecast to be spent in Month 12, largely due to national programme timelines. Assurance was provided that business cases for major developments had progressed, supporting confidence in delivery.

The Board noted failure to spend capital allocation would result in loss of funds and cost pressure in 2026/27. The CSPO confirmed mitigations in place, including bringing forward schemes from the next year and securing additional capital from regional slippage, reflecting NHSE's confidence in Trust's delivery capability. It was noted capital bids for 2026/27 had been submitted and outcomes were awaited.

The Board of Directors **NOTED** the financial performance of Month 9.

25/116 **SIGNIFICANT RISK REGISTER (SRR) REPORT**

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

- 43 risks;
- Number of overdue actions reducing, reflecting improved grip and oversight;
- Risks reviewed within last four weeks, with monthly risk oversight meetings with Executive Directors ensuring actions progressed;
- One new risk approved since last report (risk 3836), one risk de-escalated, and one risk closed following mitigations.

NEDs queried the newly escalated risk regarding medical rota gaps at QEQM and asked for greater clarity on the clinical and financial context, including implications for training and service delivery. The CNMO advised that whilst the high level risk position was clear, further detailed information would be provided outside the meeting, as the risk was still being progressed through the Trust's governance

structure. The Acting CMO confirmed the issue formed part of a wider Trust level risk relating to gaps in middle grade medical staffing across several specialties, affecting patient flow, continuity of care and consultant workload. Work was underway to improve recruitment and retention, including strengthening training offers for locally employed doctors and expanding Certificate of Eligibility of Specialist Registration (CESR) pathways. It was noted specific details on this new risk would be reported for discussion at the P&CC for further scrutiny. The NED (Mrs Walker) agreed to raise this risk for detailed discussion and clarity around its impact at the next P&CC meeting.

ACTION: Raise at next P&CC meeting the new risk (risk 3836 - medical rota gaps at QEQM) for detailed discussion, scrutiny and clarification in respect of its impact around training, rota resilience, service delivery, clinically and financially. — NED (Mrs Walker)

The Board noted assurance of processes for identifying, escalating and reviewing significant risks were functioning, Care Groups required to keep risks updated monthly and review emerging risks through their governance structures. It was also acknowledged ongoing work to improve the dynamic nature of the register, including tightening risk descriptions, strengthening controls, and improving cross Board Committee visibility.

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

25/117 **ACCESSING THE IMPACT OF APPOINTMENT SCHEDULING ON INEQUALITIES IN DEPRIVED AREAS**

The Chief Analytical Officer presented the following key points on the Trust's work to understand and address inequalities in access, experience and outcomes, with a particular focus on how appointment scheduling affected patients in deprived areas:

- Emphasised whilst headline population level data routinely reviewed through the IPR, essential to interrogate variation beneath this to understand whether patients from more deprived communities could access services in a timely and equitable way;
- Trust developed sophisticated analytical approaches, beyond routinely recorded demographic information to better identify and understand population sub groups. This included through linguistic and name origin classification, enabling more nuanced insight into communities such as the Nepalese population in Ashford that might not be fully visible in census data;
- Governance arrangements supporting work, through the Inequalities and Unwarranted Variation Committee. Chaired by the COO and CMO, meeting bimonthly providing 'critical friend' function to identify patterns of difference in access or outcomes across demographic groups;
- Across metrics such as ED waiting times, hospital outcomes and mortality indicators, few statistically significant differences had been found when cut by deprivation or ethnicity. However, national patterns of later presentation and delayed diagnosis in more deprived groups were also reflected locally and required continued scrutiny.

The Board focused on the Trust's pioneering use of data science and predictive modelling to reduce inequalities in outpatient attendance. It was noted the team had successfully developed algorithms to identify patients at higher risk of Did Not Attend (DNA) or cancellation, enabling differentiated communication and appointment strategies. For example, patients with a high likelihood of attending might simply receive letters, those with moderate risk may additionally receive texts, and those at greatest risk might be telephoned or supported more actively

(an approach analogous to tailored marketing strategies). A pilot demonstrated substantial reduction in DNA rates for the targeted cohort, the Board welcomed plans to expand this into additional specialties and explore automation to allow real time anomaly detection and proactive intervention.

NEDs emphasised the importance of embedding the work into routine governance and assurance, noting current Board reports did not yet routinely present disaggregated inequalities data despite national expectations that they should. The COO and CSPO confirmed work was underway to ensure this became part of business as usual reporting, including through the Q&SC and Trust Management Committee (TMC), noting the Inequalities Committee formally reported through the Executive governance structure.

The Board discussed the potential need for strategic policy decisions, for example whether differential waiting times might be justified where earlier treatment demonstrably improved outcomes for specific population groups.

The CFO asked that inequalities analysis be explicitly incorporated into the development of upcoming cost improvement and financial sustainability plans to ensure future service transformation did not inadvertently widen inequalities.

ACTION: Chief Analytical Officer to work with CFO to integrate inequalities analysis into CIPs, long term financial sustainability planning, and future service transformation. — CFO

The Acting CMO highlighted cultural and communication challenges in designing equitable services, stressing the need for co-designed interventions that genuinely resonated with different communities, drawing on successful examples from other regions.

The Board welcomed the innovative analytical approach, its national significance, and supported the continued expansion and embedding of the work.

The Chair requested the following two follow ups:

- Chief Analytical Officer to provide a presentation at the next CoG meeting on equity of access and experience for neurodiversity patients, building on any existing analytical work;
- Further work on analysis of equity of cancer diagnosis in younger people, in light of recent national cases of late diagnosis where symptoms were not recognised early, with an interest in understanding the role of education, health literacy and demographic bias in symptom recognition and referral.

ACTION: Include provision of presentation from Chief Analytical Officer at next CoG meeting on equity of access and experience for neurodiversity focused inequalities for patients, building on any existing analytical work. — DCG

ACTION: Present at a future Board meeting the further work (led by the Chief Analytical Officer) on analysis of equity of cancer diagnosis in younger people, in light of recent national cases of late diagnosis where symptoms were not recognised early, with an interest in understanding the role of education, health literacy and demographic bias in symptom recognition and referral. — CSPO

The Board of Directors:

- **NOTED** the report and presentation:
- The analytical skills available at the Trust and considered the highest priority areas that could be deployed;

- Sought regular assurance EKHUFT's patients had the same access, experience and outcome irrespective of their background and demographics.

25/118 **MATERNITY AND NEONATAL ASSURANCE BOARD (MNAB) CHAIR'S REPORT**

The DoM highlighted the following key points:

- Clinical Negligence Scheme for Trusts (CNST) Compliance:
  - Continued progress toward full compliance with all ten CNST Year 7 safety actions;
  - Perinatal Mortality Review Tool (PMRT): Quarter 3 (Q3) reporting 100% compliance with PMRT standards, timely reporting to MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK;
  - Serious Incidents (SIs)/Duty of Candour (DoC)/Early Notification Scheme (ENS): Full use of external reviewers, as well as 100% reporting to NHS Resolution's ENS and the Maternity and Newborn Safety Investigations (MNSI) programme. Two cases referred to MNSI (one case accepted and one case currently being triaged). One case presented to Trust's Incident Review Panel (IRP);
  - Update on Manchester homebirth Prevention of Future Deaths (PFD) report and subsequent national request for urgent homebirth safety review:
    - Service completed full benchmarking exercise, assessing 55 recommendations: 51 fully compliant, one not applicable, and three partially met (of which one (transfer audit)) now completed. Work underway on remaining two actions, ensuring separation of site specific outcome data in Perinatal Quality Oversight Monitoring (PQOM) reporting, already addressed, and full review of homebirth service model, registered as part of the Maternity and Neonatal Improvement Programme (MNIP) (completion December 2026). Over 90 evidence documents submitted to Integrated Care Board (ICB) for external review.
  - PQOM: Supernumerary status compliance 100% (at both sites in October and November 2025). 100% compliance of 1:1 in Labour (at both sites). Neonatal death (NND) rate increased to 0.85 (two NNDs in October);
  - MNIP: Progress with restorative work, series of values based away days, improved Maternity CQC patient satisfaction survey results. Positive progress recruiting Band 5s completing preceptorship, progressing Band 6.
  - Update on National Maternity Review: following site visits and focus groups across all maternity units in November. In response to a provider information request, Trust submitted over 560 documents and subsequently met with regional teams to provide further assurance. National team to undertake follow up site visits, and preparations underway to ensure staff supported and positive progress showcased;
  - Increase in stillbirth rate: although numbers remained below national outlier thresholds, internal aggregate review undertaken identifying themes relating to deprivation and smoking. Following repeated triggers from the new Maternity Outcomes Signalling System (MOSS), independent aggregate review commissioned, mirroring approach taken to the neonatal deaths review. One safety action identified through the MOSS critical checklist (appointment of a consultant fetal monitoring lead at QEQM, already completed).

The Board requested the independent stillbirth review report be presented at a future Board meeting on completion.

ACTION: Present independent stillbirth review report at a future Board meeting when completed. CNMO

The Board noted improvements in training compliance, patient experience metrics, workforce progress (including cessation of maternity agency usage), positive achievements from the MNIP, alongside areas requiring continued focus such as culture, complaints, and infrastructure needs.

The Board formally recognised and thanked the DoM for her leadership, contribution to the transformation of maternity services and her continued support to the Trust and its staff. Acknowledging her hard work and wished her well in her new role (leaving the Trust the following month).

The Board of Directors **NOTED** the MNAB Chair Assurance Report from the 8 December 2025 and 13 January 2026 MNAB meetings.

25/119 **GUARDIAN OF SAFEWORKING (GoSW) QUARTERLY REPORT (QUARTER 4: 1 OCTOBER TO 31 DECEMBER 2025)**

The GoSW highlighted the following key elements:

- Appointment of a second Guardian, positive development for capacity and oversight;
- Update on implementation of the national Framework Agreement for exception reporting (came into effect 4 February 2026). Significant changes, such as confidential reporting routes, simplified processes, new evidence requirements, and removal of supervisors from initial review stages would require adaptation, Trust well prepared, with a new Standard Operating Procedure (SOP) drafted for Local Negotiating Committee (LNC) approval. Virtual briefing session for resident doctors scheduled to support implementation;
- Ongoing challenges with exception reporting for Locally Employed Doctors (LEDs), not covered by 2016 contract and could not formally exception report. Pilot at QEQM indicated under reporting and continued workload pressures. Many LEDs felt reluctant to escalate concerns despite existing informal mechanisms. The Joint LNC would consider options for establishing an equivalent reporting route;
- Exception reporting overall risen in acute and surgical specialties, reflecting high patient acuity, with Foundation Year 1 doctors continuing to submit majority of reports. It was explained the apparent variation in reporting by department (e.g. rises within Emergency Medicine was influenced by the structure of combined rotas, making raw comparison less meaningful);
- Future reports may contain less granular data due to confidentiality requirements under the new reforms;
- Ongoing concerns in Vascular Surgery and Urology, where national education quality reviews identified mandatory actions relating to exception reporting encouragement. GoSW attended induction sessions to reinforce reporting expectations that would continue to be monitored closely.

The NEDs stressed the importance of aligning LED experience with Trust's aspiration to be an employer of choice.

The Board noted the 10 Point Plan to improve resident doctors' working lives, appointment of a resident doctor representative leading surveys across peer groups. The Acting CMO confirmed compliance reporting against the plan would be brought back to the Board. It was noted the national plan was co-designed with resident doctors, and implementation locally should actively improve experience and wellbeing.

The Board of Directors **NOTED** the GoSW report, and improving working lives of resident doctors with good rostering practices and promoting the use of exception reporting for resident doctors.

25/120 **EQUALITY DELIVERY SYSTEM (EDS) REPORT 2025**

The CPO highlighted the following key findings:

- Trust continued to be rated Developing, reflecting progress made whilst acknowledging significant work remained to reach the next level;
- Although organisation had improved across several areas, further scrutiny was required.

The Board noted the Trust was celebrating Equality Week, with the Ethnic Diversity Engagement Network (EDEN) undertaking activity across the sites and thanked the network for its contribution.

The Board approved the report for submission subject to the following correction:

- Page 8 – Domain 3: first bullet point should read 'As part of the NHS England EDI Improvement Plan High Impact Action of Board and Executives requirement to have EDI objectives, the Executive Team have these in place as part of their appraisals as do the non-executives from the start of the 2025/2026 appraisal year.'

The Board noted the final version of the report had not been reviewed by P&CC and agreed this would be presented at the next P&CC meeting for a detailed deep dive review to assess compliance and provide assurance of this. It was emphasised the importance of sustained focus on the actions identified within the report. Board members reflected positively on the improvements and welcomed continued strengthening of Equality, Diversity and Inclusion (EDI) work across the Trust, whilst noting a number of elements would need updating as work progressed.

ACTION: Present final version of EDS Report 2025 to next P&CC meeting for a detailed deep dive review discussion to assess compliance and provide assurance of this, along with regular monitoring and evaluation by P&CC. CPO

DECISION: The BoD **APPROVED** the EDS Report 2025 for submission, and **NOTED** the following:

- Strengthening data collection and reporting by protected characteristics across patient and workforce metrics;
- Conduct deep dive into Accessible Information Standard (AIS) compliance, interpreter use, and translated patient information;
- Promote carers' rights, increase feedback via carers survey, and embed Systematized Nomenclature of Medicine (SNOMED) codes;
- Increase visibility and impact of staff networks through Executive sponsorship and protected time;
- Use staff survey and EDI dashboards to monitor disparities and escalate persistent inequalities to Board level;
- Deliver targeted interventions to reduce disproportionality in disciplinary processes and improve advocacy.

25/121 **UPDATE ON KENT FIRE AND RESCUE SERVICE (KFRS) REGULATORY AUDIT**

The CSPO highlighted the following key points:

- Audit of WHH undertaken in November and December 2025, inspection resulted in Notice of Deficiencies, identifying 92 breaches of the Regulatory Reform (Fire Safety) Order 2005 across eight thematic areas, including:
  - Issues in compartmentation;
  - Fire alarm equipment;
  - Blocked or wedged fire doors;
  - Storage obstructing escape routes;
  - Placement of bariatric patients in challenging areas of evacuation;
  - Weaknesses in evacuation planning, oversight and culture.
- Some immediate actions already taken following audit, including minor infrastructure repairs and engagement with KFRS regarding Trust's £16m four year fire compliance investment programme, now in second year;
- Experienced Fire Safety Improvement Director brought in to accelerate progress, review plans and liaise directly with KFRS;
- Clinical and Estates teams briefed and interim oversight strengthened;
- Not all deficiencies could be resolved by 18 March 2026 deadline for KFRS's return visit, particularly those involving major infrastructure works. KFRS indicated if Trust could demonstrate meaningful progress and credible delivery plans, an extension may be granted, failure to do so may lead to enforcement action;
- Similar site wide audit at QEQM scheduled for April 2026 and lessons from WHH already being applied to preparations.

The NEDs raised non infrastructure issues, particularly fire drills, evacuation awareness, inappropriate door wedging, and local risk management highlighting these as symptomatic of a wider fire safety culture challenge. The Board discussed culture and leadership visibility, as well as the necessity of staff empowerment to act when they saw unsafe practice. The NEDs emphasised compliance with e-learning (currently 92%) was insufficient without practical training and consistent reinforcement. The Executive Directors confirmed a strengthened communications plan and leadership engagement approach was being developed.

The NEDs raised concern about long standing weaknesses in oversight, emphasising some issues identified should have been detected internally rather than by external regulators. It was confirmed fire safety assurance currently reported through TMC and Board, oversight processes and effectiveness of training were being reviewed in light of the audit findings.

ACTION: Fire Safety Improvement Director complete a review of resourcing, training requirements and effectiveness, cultural interventions, oversight processes and present a further report with recommendations to the Board. CSPO

The Board of Directors **NOTED** the update on Kent Fire and Rescue Service Regulatory Audit report.

25/122 **NURSE STAFFING ESTABLISHMENT REVIEW FOR INPATIENT WARDS, ACUTE MEDICAL UNITS (AMUs) AND EDs (JUNE – SEPTEMBER 2025)**

The CNMO highlighted the following key elements:

- Review fulfilled statutory requirement under the Developing Workforce Safeguards (evidence based recommendation on safe nursing staffing levels);
- Thanks to the Workforce and Education Nursing team for their expertise and national level contribution to training others;
- Review applied triangulation of Safer Nursing Care Tool (SNCT) data, quality and safety indicators, professional judgement and Care Hours Per Patient Day (CHPPD). CHPPD continued to show improvement, supported by ongoing work to realign budgets and Electronic Staff Record (ESR) coding to better distinguish inpatient from clinic activity;
- Establishment changes recommended in earlier reviews (January 2024 and January 2025) informed this cycle, although not all had yet been fully processed through ESR and the financial ledger;
- Current review proposed a balanced set of establishment adjustments across inpatient wards, AMUs, EDs and children's services, including both increases and reductions where appropriate. Most areas remained unchanged and selected wards progressing targeted skill mix changes (e.g. Cambridge L (WHH), Kingston (K&C), QEQM Coronary Care Unit, and Fordwich (QEQM);
- Areas where quality or leadership concerns identified, enhanced monitoring or organisational development support to be put in place.

Committee Chairs confirmed scrutiny of the review through Q&SC and P&CC, not required to be presented to FPC as no approval needed due to net financial impact being neutral, any increases offset by reductions elsewhere. The Board noted the continued need to separate inpatient and outpatient budgets in several areas (e.g. Birchington, Padua, Rotary and Marlowe) to ensure accurate CHPPD and operational visibility.

DECISION: The Board of Directors:

- **NOTED** the content of the Nurse Staffing Establishment Review report as well as the processes and methodology underpinning the review;
- Received **ASSURANCE** the Safer Staffing Review had been undertaken in accordance with national guidance;
- **APPROVED** the recommendations made within the review.

25/123 **BOARD COMMITTEE – CHAIR ASSURANCE REPORTS**

25/123.1 **NOMINATIONS AND REMUNERATION COMMITTEE (NRC) – CHAIR ASSURANCE REPORT**

The NRC Chair reported on the following key issues:

- Approved salary ranges for Very Senior Manager (VSM) or equivalent roles, including DoM; Managing Director for Women, Children and Young People Care Group; Acting CMO; and Acting CEO;
- Assurance on the revised VSM Pay Policy, approved with additional requirements for clarity on pay uplift eligibility and conduct/capability;
- Succession planning required significant further work aligning Trust's planning with the NHS South East Region template. Key gaps remained in

'ready now' successors for Executive Director roles. Strengthened developmental approach agreed, including personalised development plans, stretch assignments, coaching and leadership programme access. Further report to be presented at next meeting (to also become a standing agenda item for future meetings), as well as being added to P&CC annual work plan to oversee the broader leadership pipeline;

- 360 degree feedback process reviewed, agreeing refreshed approach for 2026 appraisal cycle, to incorporate structured follow up, coaching check ins and alignment with NHSE Management and Leadership Framework. Work underway and further report to be presented at next meeting;
- Approval of Board development priorities for 2026, including repeating the GGI Board Assurance Matrix self-assessment, progressing Well Led review at pace, updating Board member Insights profiling, and continuing to embed EDI principles (report presented to IAGC for further review and discussion);
- Reviewed for assurance annual objectives for 2gether's Managing Director;
- Assurance on CE's mid-year performance review;
- NED term renewals taken forward to CoG recommending Claudia Sykes for a second term;
- Discussion about arrangements identifying Board Committee Deputy Chairs with proposals to be put forward to the Trust Chair.

The Board of Directors **NOTED** the 8 and 16 December 2025 NRC Chair assurance report.

25/123.2 **QUALITY AND SAFETY COMMITTEE (Q&SC) – CHAIR ASSURANCE REPORT**

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

- Professional Standards work, significant progress capturing accurate data on time to first consultant review and on understanding activity of specialist teams at 'front door', supporting improved decision making and commissioning;
- Ongoing development of Learning Disability strategy, strengthened since previous discussions supporting improved outcomes and data quality across the sites;
- Substantial improvement over past two years in managing patients on medical escalation lists, area previously considered a major risk. Whilst progress recognised, emphasised renewed focus was required, particularly around the virtual ward model. A fuller update on utilisation, refusal rates, benchmarking and impact on bed stock had been requested;
- Wide range of Q&S matters scrutinised, including risk escalation from WHH Care Group. This included improvements in patient safety training and National Institute for Health and Care Excellence (NICE) compliance, harm free care metrics, deteriorating patient pathways, safeguarding, emergency planning, infection prevention and control, and maternity safety indicators;
- Key issues included a Prevention of Future Deaths (PFD) notice relating to a discharge from QEQM;
- Continued work reducing harm from falls and pressure ulcers, and concerns regarding surgical site infection rates in elective orthopaedics.

The Board noted the Committee's assurance improvements continued across several domains, including National Early Warning Score (NEWS2) compliance, sepsis pathways, Respect training, and monitoring of mortality review processes. Emerging risks were also noted, including ED ventilation concerns and demands on specialist outpatient services.

The Board of Directors **NOTED** the 18 November 2025 Q&SC Chair assurance report.

25/123.3 **FINANCE AND PERFORMANCE COMMITTEE (FPC) – CHAIR ASSURANCE REPORT**

The FPC Chair reported on the following key issues:

- Most of Committee's discussion, particularly Trust's financial position, reforecasting, performance pressures and capital programme had already been covered earlier in the meeting;
- Scrutiny of SRR, multiple overdue actions required urgent updating, notably relating to cyber reporting, training needs assessment and targeted investment programme. Full written update requested ahead of next meeting;
- Month 8 IPR reviewed, noting deteriorating performance in emergency access and elective pathways, driven by infection control outbreaks, bed closures and system wide pressures, alongside impact of industrial action;
- Financial performance remained significantly adverse, with £12.4m variance including DSF and a residual £2-£2.5m gap to reach the planned £20m YE deficit;
- Capital programme continued to show large underspend due to slippage in major schemes, further update requested to understand implications and lessons learned;
- Detailed scrutiny of Trust's CIP, noting under delivery, recurrency at only 44%, and significant slippage within 2gether's schemes. Lessons learned review requested and also consideration of an external peer review to strengthen future delivery;
- Workforce transformation essential to meeting wider financial sustainability targets;
- Approval of the Same Day Emergency Care (SDEC) business cases for WHH and QEQM, and the Healthex loan transfer (approved at an Extra-ordinary Closed Board meeting on 8 January).

The Board of Directors **NOTED** the 6 January 2026 FPC Chair assurance report.

25/123.4 **PEOPLE AND CULTURE COMMITTEE (P&CC) – CHAIR ASSURANCE REPORT**

- **10 POINT PLAN TO IMPROVE RESIDENT DOCTORS' WORKING LIVES**

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

- Deep dive into quality of appraisals, noting significant variation across departments and reaffirming poor appraisal completion not driven by staffing shortages or operational pressures, reflecting differences in line management capability and organisational culture. High performing areas such as Day Surgery and Occupational Health demonstrated robust, structured appraisal processes could be delivered even in pressured environments. Developing targeted support to low performing departments;
- Draft Communications and Engagement Strategy reviewed, to be presented at a future Board meeting for input;
- Staff voice updates included work led by Trust's Neurodiversity Network to strengthen awareness and reduce stigma;
- Early staff survey findings discussed ahead of formal publication in March;
- Workforce planning remained a significant concern, noting 2025/26 workforce savings were forecast to fall substantially short of plan (£16m achieved against a target of £45m). Drivers include slower than expected

reduction in temporary staffing, particularly for medical rotas. Detailed 2026/27 workforce plan requested for next P&CC meeting, incorporating Zero Based Review (ZBR) outputs and K&M system wide workforce pressures;
- GoSW quarterly report raised specific concerns about training environment and workload in vascular surgery and urology at K&C, where Foundation doctors were routinely working beyond contracted hours and struggling to take breaks. Action plan in place, Committee highlighted doctor numbers remained insufficient to manage patient acuity safely, a continued priority for oversight. Progress on resolving historical annual leave underpayment (2020-24) and objective to complete all payments for current staff by YE;
- Update on NHSE's 10 Point Plan to improve resident doctors' working lives, following initial presentation to P&CC:
  - Newly appointed Resident Doctor Peer Lead (in December 2025) undertaken extensive engagement (surveys, forums, British Medical Association (BMA) liaison and face to face feedback), reviewed each domain, identifying issues with parking for on call doctors, annual leave booking processes, and consistency of wellbeing support during rotations, and clearer guidance needed on study leave;
  - Some improvements already implemented through rostering changes and enhanced GoSW oversight;
  - Trusts must appoint both a senior lead for resident doctor issues and a peer representative, develop Board Assurance Framework (BAF), and formally report progress to NHSE as part of the Oversight Framework;
  - 10 Point Plan to return to Board with full BAF.

ACTION: Present developed 10 Point Plan BAF to Board once finalised. — Acting CMO

The Board of Directors **NOTED** the:

- 27 January 2026 P&CC Chair assurance report;
- Presentation on the 10 Point Plan initially presented through P&CC and intention to return with report and BAF.

25/123.5 **INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC) – CHAIR ASSURANCE REPORT**

The Vice-Chair/NED (IAGC NED member) on behalf of the IAGC Chair provided the following verbal report on key points from the meeting:

- External audit activity progressing to plan, with early testing underway and no delays anticipated in meeting the statutory June 2026 deadline for signing the annual accounts, an improvement compared with previous years when deadlines were missed;
- The following three final internal audit reports reviewed:
  - 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;
  - Findings noted as directly relevant to current discussions on financial management and patient safety oversight.
- SRR and BAF reviewed and discussed, with no new issues of concern;
- 2024/25 Annual Reports and Accounts received, from Spencer Private Hospitals (SPH) and 2gether;

- Annual reports received for assurance on policy compliance and Subject Access Requests (SARs), highlighting continued monitoring of governance performance.

The Board of Directors **NOTED** the verbal IAGC Chair assurance report from the IAGC meeting held on 30 January 2026.

25/124 **ANY OTHER BUSINESS**

There were no other items of business raised.

25/125 **QUESTIONS FROM THE PUBLIC**

The Board noted one question received.

The Chair reported the Trust had received further correspondence from Mr John Newington in relation to his ongoing complaint to the Trust, noting below his question in full:

Question from Mr Newington
'Question to be formally recorded in full and unedited in the Board of Directors meeting of 5 February 2026.

I have emailed a copy of this question to the CEO and Chair of EKHUFT, please can a copy of this question be formally sent to each Director of EKHUFT, CEO and Chair so they can in future be held personally responsible and accountable.

Staff at the Trust can do some wonderful work, but from the objective documented evidence in my case, the Directors and CEO of EKHUFT, from the evidence have not learnt from the findings of the Kirkup report written on the engrained culture at this Hospital Trust.

The Parliamentary Health Service Ombudsman, (PHSO) has upheld my complaint and yet the Directors of EKHUFT, CEO and from her lack of action, knowing the facts, also the Chair Dr Annette Doherty are all fully complicit in continuing the culture that was documented in the Kirkup report into this Trust, as a default culture of denial, deflection and concealment to any criticism.

Putting the corporate reputation above being open and honest.

The Trust are now outstanding the timescales laid down by the PHSO to reply what went wrong and why in the mistreatment of my hand injury and that their investigation completed was fundamentally flawed and not evidence based.

The Trust still have not answered my Freedom of Information (FOI) request into the name of the Doctor who the consultant blames for incorrectly recording in the consultants own hand written medical notes, that my hand injury was an old injury, when it was not, when in fact my fractured hamate and dislocated metacarpals had already been correctly reported on by the radiographer at my original admittance to A&E.

I have repeatedly raised this directly to the present CEO and I have repeatedly raised to be recorded in the Board of Directors minutes. So, from the objective evidence and their lack of any corrective action, the leadership of this Trust need to be held personally fully accountable and responsible for being complicit and allowing a cover up culture, where dishonesty and covering up is still positively tolerated.'

The Chair responded to Mr Newington's question, as noted below.
After our complaints processes, Mr Newington, took his complaint to the PHSO and we have been waiting for their assessment.

We now have that and it is with the Acting CEO and CNMO. I have asked to see the full report but understand it makes clear the Trust should have handled the complaint better. I am very sorry about that Mr Newington.

I have asked the Acting CEO and CNMO to meet with you to follow up the PHSO findings.

I will also ask the Q&SC to receive lessons learned from your case, which will include the recommendations of the PHSO.

ACTION: Present to Q&SC for review and discussion around lessons learned and the PHSO recommendations about Mr John Newington's (complaint) case. — Acting CEO/ CNMO

I know this has taken a long time for you to get to this point. I am grateful to you for persisting. I am also sorry on behalf of the Trust. We will follow up with you directly.

The Chair closed the meeting at 4.20 pm.

Date of next meeting: Thursday 2 April 2026

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Matters Arising from the Minutes on 5 February 2026**

Meeting date: **2 April 2026**

Board sponsor: **Annette Doherty, Chair**

Paper Author: **Board Support Secretary**

Appendices:

None

Executive summary:

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

Implications:

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

Assurance route:

Previously considered by: None

MATTERS ARISING FROM THE MINUTES ON 5 FEBRUARY 2026

1. Purpose of the report

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

2. Background

2.1. An open action log is maintained of all actions arising or pending from each of the previous meetings of the BoDs. This is to ensure actions are followed through and implemented within the agreed timescales.

2.2. The Board is asked to note the updates on the action log as noted below:

Action No.	Action summary	Target date	Action owner	Status	Latest Progress Note (to include the date of the meeting the action was closed)
B/27/25	Revisit and provide progress update on implementation of the outstanding actions from the 2022 Higher-Level Responsible Officer (HLRO) visit.	~~Feb-26~~/ Apr-26	Acting Chief Medical Officer (CMO)	To Close	**February 2026:** improvements to appraisal processes following review including a quality and assessment assurance process. **March 2026:** Update report attached to actions table (Appendix 12). **Action for agreement for closure at 02.04.26 BoD meeting.**
B/31/25	Look at revising Significant Risk Register (SRR) report format to include target dates for risk score reduction, clearer distinction between historic and current actions/mitigations and whether these were, and refresh risk descriptions ensuring these were relevant and accurate.	~~Feb-26~~/ Apr-26	Chief Nursing and Midwifery Officer (CNMO)	To Close	**February 2026:** In progress, continues to be worked on. **March 2026:** The risk system reporting is very manual, Trust is constantly working to improve the data quality of what is presented and will ensure for the April BoD report there is increased clarity on current open actions and the forecast for risk reduction as well as the descriptions. **Action for agreement for closure at 02.04.26 Board meeting.**
B/34/25	Share findings with Board members of the patient and family experience Picker survey feedback results on maternity services when not embargoed.	~~Feb-26~~/ Apr-26	CNMO	To Close	**February 2026:** Embargo expected to be lifted in March 2026. **March 2026:** Care Quality Commission (CQC) Maternity Survey 2025 report attached to actions table (Appendix 13). **Action for agreement for closure at 02.04.26 BoD meeting.**
B/40/25	Present at future Quality & Safety Committee	May-26	CNMO	To Close	Added to the Q&SC work planner for a report to be presented at the 19.05.26

	(Q&SC) meeting for discussion a deep dive report around strengthening staff training and support for End of Life (EoL), particularly in response to ageing population and increasing number of patients in hospital at EoL, including scoping communication pathways between hospices and the hospital teams.				Q&SC meeting. **Action for agreement for closure at 02.04.26 Board meeting.**
B/41/25	Progress engagement with local Councillors regarding social care capacity, as well as raising social care pressures with MPs and at Integrated Care System (ICS) level.	Apr-26	Acting Chief Executive (CE)	Open	Acting CE to provide a verbal update at the April 2026 BoD meeting.
B/42/25	Add social care related collaboration and lobbying for discussion at a future Council of Governors (CoG) meeting for Governors to support raising social care pressures with MPs.	Apr-26	Director of Corporate Governance (DCG)	To Close	Added to April 2026 CoG agenda. **Action for agreement for closure at 02.04.26 Board meeting.**
B/43/25	Raise at next People & Culture Committee (P&CC) meeting the new risk (risk 3836 - medical rota gaps at Queen Elizabeth the Queen Mother Hospital (QEQM)) for detailed discussion, scrutiny and clarification in	Apr-26	Non-Executive Director (Mrs Walker)	To Close	Added to agenda for the P&CC meeting in January 2026, unfortunately due to unavailability of Executive Directors to discuss at the Committee, this has been deferred to the March P&CC meeting for discussion. **Action for agreement for closure at 02.04.26 Board meeting.**

	respect of its impact around training, rota resilience, service delivery, clinically and financially.				
B/44/25	Chief Analytical Officer to work with Chief Finance Officer (CFO) to integrate inequalities analysis into Cost Improvement Programme (CIPs), long term financial sustainability planning, and future service transformation.	Jun-26	Chief Finance Officer (CFO)	To Close	Chief Analytical Officer working with Director of Financial Sustainability on how to incorporate into CIP planning. Will be monitored through FPC. **Action for agreement for closure at 02.04.26 Board meeting.**
B/45/25	Include provision of presentation from Chief Analytical Officer at next Council of Governors meeting on equity of access and experience for neurodiversity focused inequalities for patients, building on any existing analytical work.	Apr-26	DCG	To Close	Added to the CoG work plan. **Action for agreement for closure at 02.04.26 Board meeting.**
B/46/25	Present at a future Board meeting the further work (led by the Chief Analytical Officer) on analysis of equity of cancer diagnosis in younger people, in light of recent national cases of late diagnosis where symptoms were not recognised early, with an interest in understanding the role of education, health literacy and demographic bias in symptom recognition and referral.	Jun-26	Chief Strategy and Partnerships Officer (CSPO)	To Close	Discussed at the Inequalities and Unwarranted Variation Committee. Team of analysts working on analysis, ready to be presented at June 2026 Board. Included on BoD annual work programme to receive a presentation at the June 2026 Board. **Action for agreement for closure at 02.04.26 Board meeting.**
B/47/25	Present independent stillbirth review report at a future	Apr-26	CNMO	Open	Verbal update to be provided by CNMO at 02.04.26 Board meeting.

East Kent Hospitals University NHS Foundation Trust

	Board meeting when completed.				
B/48/25	Present final version of Equality Delivery System (EDS) Report 2025 to next P&CC meeting for a detailed deep dive review discussion to assess compliance and provide assurance of this, along with regular monitoring and evaluation by P&CC.	Apr-26	Chief People Officer (CPO)	To Close	EDS report provided in Reading Room for information at 17.03.26 P&CC meeting, noting near final draft report considered by Committee previously (with minor comments), and approved by the Board at its 05.02.26 meeting. Any final comments from P&CC members to be shared outside of P&CC meeting. **Action for agreement for closure at 02.04.26 Board meeting.**
B/49/25	Fire Safety Improvement Director complete a review of resourcing, training requirements and effectiveness, cultural interventions, oversight processes and present a further report with recommendations to the Board.	Jun-26	CSPO	Open	Item for future BoD meeting.
B/50/25	Present developed 10 Point Plan Board Assurance Framework (BAF) to Board once finalised.	Apr-26	Acting CMO	To Close	Regular updates included on BoD annual work plan (4 monthly). Update report presented at April 2026 BoD. **Action for agreement for closure at 02.04.26 Board meeting.**
B/51/25	Present to Q&SC for review and discussion around lessons learned and the Parliamentary Health Service Ombudsman (PHSO) recommendations about Mr John Newington's (complaint) case.	Apr-26	Acting CE/CNMO	To Close	Direct communication with Mr Newington by both CE and Chair, proposal to re-open investigation offered. **Action for agreement for closure at 02.04.26 Board meeting.**