

1 AGENDA

Title of Meeting	Trust Board Meeting (Public)
Date	24 th September 2026
Time	09.30 to 12.45
Venue	Meeting Rooms 2 and 3, Farm Villa, Hermitage Ln, Maidstone ME16 9PH

Agenda Item	DL	Description	FOR	Format	Lead	Time
TB/26-27/63	1.	Welcome, Introductions & Apologies		Verbal	Chair	09.30
TB/26-27/64	2.	Declaration of Interests		Verbal	Chair	
BOARD REFLECTION ITEMS						
TB/26-27/65	3.	Personal Experience - Southwest Kent clinic pathway in Highlands House	FD	Verbal	DHS	09.35
STANDING ITEMS						
TB/26-27/66	4.	Minutes of the previous meeting	FA	Paper	Chair	09.50
TB/26-27/67	5.	Action Log & Matters Arising	FA	Paper	Chair	
TB/26-27/68	6.	Chair's Report	FN	Paper	CL	09.55
TB/26-27/69	7.	Chief Executive's Report	FN	Paper	SS	10.05
TB/26-27/70	8.	Board Assurance Framework	FA	Paper	JK	10.15
STRATEGY, DEVELOPMENT AND PARTNERSHIP						
TB/26-27/71	9.	Governance Improvement Plan	FD	Paper	SS	10.25
TB/26-27/72	10.	Integrated Quality and Performance Report	FD	Paper	SS	10.40
TB/26-27/73	11.	Neighbourhood Health Collaborative Board Progress Report	FN	Paper	SS	10.55
TB/26-27/74	12.	Kent and Medway ICB Draft Commissioning Intentions	FD	Paper	NB	11.05
Break – 10 mins						
SUB-BOARD COMMITTEE REPORTS						
TB/26-27/75	13.	Report from Quality Committee	FD	Paper	MD	11.25
TB/26-27/76	14.	Report from People Committee	FD	Paper	PC	
TB/26-27/77	15.	Report from Audit and Risk Committee	FD	Paper	KC	
TB/26-27/78	16.	Report from Finance, Business and Investment Committee	FD	Paper	JC	
TB/26-27/79	17.	Report from CYP / AAED Committee	FD	Paper	SW	
OPERATIONAL ASSURANCE						
TB/26-27/80	18.	Triangulated Culture, Performance and Quality Deep Dive	FD	Paper	KH	11.45
TB/26-27/81	19.	Finance Report – Month 5	FN	Paper	NB	12.00
TB/26-27/82	20.	Medical Revalidation	FA	Paper	AQ	12.10
TB/26-27/83	21.	Business Continuity and Emergency planning report	FN	Paper	AR	12.20
TB/26-27/84	22.	Winter planning 2026/27 – expectations and assurance	FA	Paper	DHS	12.30
TB/26-27/85	23.	Register of interests	FN	Paper	TS	12.35
TB/26-27/86	24.	Standing Orders Amendment (Partnership Committee)	FA	Paper	TS	

CLOSING ITEMS						
TB/26-27/87	25.	Any Other Business Reflection of values			Chair	12.45
TB/26-27/88	26.	Questions from the Public			Chair	
	Date of Next Meeting: Thursday, 26 th November 2026					
Members:						
Colin Lynch	CL	Trust Chair				
Stephen Waring	SW	Non-Executive Director and Trust Senior Independent Director				
Julius Christmas	JC	Non-Executive Director and Trust Vice Chair				
Kim Lowe	KL	Non-Executive Director				
Susan Baker	SB	Non-Executive Director				
Kevin Corrigan	KC	Non-Executive Director				
Margaret Dalziel	MD	Non-Executive Director				
Dr Julie Hammond	JH	Associate Non-Executive Director				
Pam Creaven	PCr	Non-Executive Director				
Sheila Stenson	SS	Chief Executive				
Donna Hayward-Sussex	DHS	Chief Operating Officer and Deputy Chief Executive				
Dr Afifa Qazi	AQ	Chief Medical Officer				
Julie Kirby	JK	Acting Chief Nursing Officer				
Nick Brown	NB	Chief Finance and Resources Officer				
Ali Layne-Smith	ALS	Chief People Officer				
Dr Adrian Richardson	AR	Director of Partnerships and Transformation				
In attendance:						
Kindra Hyttner	KH	Director of Strategy and Engagement				
Tony Saroy	TS	Trust Secretary				
Lucia Barnes	LB	Interim Deputy Trust Secretary				
Hannah Stewart	HS	Deputy Trust Secretary				
James Read	JR	Personal Story				
Apologies:						

Kent and Medway Mental Health NHS Trust Board of Directors (Public)
Minutes of the Public Board Meeting held at 09.30 to 12.00 on Thursday 30th July 2026
Meeting Rooms 2 and 3, Farm Villa, Hermitage Ln, Maidstone ME16 9PH

Members:			
	Colin Lynch	CL	Joint Chair KCHFT and KMMH
	Stephen Waring	SW	Non-Executive Director (Senior Independent Director)
	Kim Lowe	KL	Non-Executive Director
	Julius Christmas	JCh	Non-Executive Director (Deputy Chair) [from item TB/26-27/53]
	Kevin Corrigan	KC	Non-Executive Director
	Sean Bone-Knell	SBK	Non-Executive Director
	Mickola Wilson	MW	Non-Executive Director
	Margaret Dalziel	MD	Non-Executive Director
	Dr Julie Hammond	JH	Associate Non-Executive Director
	Pam Creaven	PC	Associate Non-Executive Director
	Sheila Stenson	SS	Chief Executive
	Nick Brown	NB	Chief Finance and Resources Officer
	Donna Hayward-Sussex	DHS	Chief Operating Officer/Deputy Chief Executive
	Julie Kirby	JK	Acting Chief Nursing Officer
	Ali Layne-Smith	ALS	Interim Chief People Officer
	Dr Afifa Qazi	AQ	Chief Medical Officer
	Dr Adrian Richardson	AR	Director of Partnerships and Transformation
Attendees:			
	Kindra Hyttner	KH	Director of Strategy and Engagement
	Daryl Judges	DJ	Deputy Trust Secretary
	Lucia Barnes	LB	Interim Deputy Trust Secretary (Minutes)
	Tony Saroy	TS	Trust Secretary [until item TB/26-27/54]
	The Board was joined by members of the public and members of staff.		
Apologies:			

Item	Subject	Action
TB/26-27/37	Welcome, Introduction and Apologies The Chair welcomed all to the meeting and noted the apologies which had been received. All written reports were taken as read. The Chair reminded members of the importance of ensuring that the Trust values remained at the forefront of both Board discussions and written reports.	
TB/26-27/38	Declarations of Interest No interests were declared.	
TB/26-27/39	Personal Experience – My experience within KMMH services, including inpatient rehabilitation The Board received a personal experience presentation from a service user who reflected on their experiences of mental health services following significant trauma and deterioration in their mental health.	

Item	Subject	Action
	The presenter highlighted: • The importance of being listened to and treated with compassion and humanity. • Concerns regarding perceived discrimination and the need for services to fully consider underlying trauma experiences. • Challenges experienced within inpatient environments, including noise and sensory impacts. • The importance of meaningful therapeutic interventions and social engagement opportunities. • Interest in alternative therapeutic approaches and ensuring patients are involved in decisions about their care. Board members explored: • The impact of inpatient ward environments on recovery. • The importance of trauma-informed practice. • The relationship between psychiatrists, nurses and service users within decision-making processes. • Opportunities to improve patient involvement and experience. Members reflected on several learning points arising from the presentation, particularly regarding therapeutic relationships, listening to lived experience and environmental factors affecting recovery. Action: By September 2026, DHS and JK to consider the learning from the Personal Experience presentation within relevant service improvement programmes, including patient voice, therapeutic relationships, trauma-informed care and the inpatient environment. The Board thanked Mark for sharing their experiences and noted the Personal Experience Story.	
TB/26-27/40	Minutes of the previous meeting The Board approved the minutes of the meeting held in May 2026.	
TB/26-27/41	Action Log & Matters Arising The Board reviewed the action log and confirmed that all actions should be closed, with the following exception: • TB/25-26/9 action to be replaced with: By September 2026, TS and CL to finalise and implement the revised Non-Executive Director Visit and Assurance Framework, including arrangements for consistent reporting to support triangulation of assurance information	
TB/26-27/42	Chair's Report The Chair presented his first report to the Board and thanked colleagues across the Trust for the warm welcome and support received since taking up post. Appreciation was also expressed to the former Chair for their leadership and contribution to the organisation.	

Item	Subject	Action
	The Chair welcomed recent changes to the Non-Executive Director team, noting that a Sue Baker a Non-Executive Director has been appointed from 1 August 2026. The Chair also highlighted the appointment of Julius Christmas as Deputy Chair. The Chair also recognised the significant contribution of Mickola Wilson and Sean Bone-Knell, whose terms of office as Non-Executive Directors were coming to an end. On behalf of the Board, the Chair thanked them for their commitment, support and leadership during their tenure and acknowledged the valuable contribution they had made to the Trust's governance and development. The Chair highlighted three key themes emerging from recent engagement activities, Board discussions and site visits: • Quality and Culture: The Chair emphasised the strong relationship between organisational culture, staff experience and the quality of patient outcomes. He reflected that quality improvement could not be seen solely as the responsibility of clinical teams, but required a whole organisation approach involving all Directorates. Board members agreed that quality, culture and leadership were increasingly interdependent and that future discussions should focus more explicitly on these links. • Consistency of Service Delivery: The Chair highlighted the need to ensure that high quality services and outcomes are delivered consistently across all services and localities. He emphasised the balance required between local ownership and accountability and greater organisational consistency in expectations, standards and improvement methodologies. Members discussed the importance of identifying and addressing unwarranted variation and ensuring that all Directorates contribute to organisation-wide quality improvement. • System Leadership: The Chair reflected on the Trust's significant role within Kent and Medway and highlighted the responsibility to be an effective system partner. Discussion included the Trust's contribution to wider system outcomes, neighbourhood development and partnership working, together with the need to assure itself that its system leadership role was translating into tangible benefits for patients and communities. The Chair also emphasised the importance of organisational resilience, leadership development and Board effectiveness in supporting delivery of the Trust's strategic ambitions. To that end, the Board Development programme will place significant emphasis on improving the quality and consistency of our Board assurance and ensuring that management colleagues engaged in the assurance process are better equipped and more confident in this area. Members agreed that delivery of these themes would require greater cross-cutting discussions across Board and Committee structures rather than consideration through individual organisational silos. During discussion of the Chair's Report, Board members reflected on feedback from the Personal Experience Story and recent Non-Executive Director visits regarding the impact of ward environments and estate capacity on patient experience. The Board sought assurance regarding the monitoring of clinical environments and space utilisation across the Trust.	

Item	Subject	Action
	Action: By September 2026, NB to provide assurance regarding the monitoring and utilisation of clinical environments and estate capacity, including consideration of issues relating to ward environments, space utilisation and patient experience. The Board noted the Chair's Report.	
TB/26-27/43	Chief Executive's Report The Chief Executive presented key updates, including: • Continuing development of the Clinical Strategic Plan. • Preparations for publication of the forthcoming national mental health strategy. • Engagement with regional and national partners. • Progress in implementing neighbourhood-based approaches. • System architecture developments across Kent and Medway. • Recent discussions with regional NHS leadership. The Board discussed: • Alignment between local strategic plans and emerging national policy. • The Trust's leadership role within the wider system. • Opportunities arising from neighbourhood-based delivery models. • The importance of maintaining focus on operational performance whilst delivering transformation. The Board received an update regarding the Lord Mann Review and the Trust's response to the recommendations arising from it. Members noted that a significant proportion of the review recommendations were already reflected within existing Equality, Diversity and Inclusion workstreams, People Plan priorities and associated organisational programmes. Board members discussed the importance of ensuring that alignment with existing workstreams translated into demonstrable delivery and impact and noted that ongoing oversight would be required through established governance arrangements to provide assurance that all recommendations had been appropriately addressed. The Board welcomed the opportunity to continue monitoring progress through future reports. The Board agreed to support adoption of the International Holocaust Remembrance Alliance definition of antisemitism in line with NHS England expectations. The Board noted the Chief Executive's Report.	
TB/26-27/44	Board Assurance Framework (BAF) The Board received the updated Board Assurance Framework. Discussion focused on: • Board ownership of strategic risks. • The importance of assurance being owned collectively by the Board rather than solely by Executive Directors. • Development of the future assurance framework. • Clarity regarding performance trajectories, risk appetite and delivery plans.	

Item	Subject	Action
	The Board acknowledged that significant development work on the Board Assurance Framework had been required and that Board development work would be needed so as to make it a truly embedded , well-understood tool. Members welcomed progress made since the previous Board meeting and noted ongoing work to strengthen assurance arrangements. The Board agreed that further detailed consideration would take place through Board development sessions during the autumn. Action: By October 2026, TS to support further development of the Board Assurance Framework and wider assurance model through Board Development Sessions, ensuring clear Board ownership of strategic risks and assurance. The Board approved the Board Assurance Framework.	
TB/26-27/45	Neighbourhood Alliance Progress Report. The Board received an update on progress in delivering the Neighbourhood Alliance model and noted the continued development of neighbourhood-based working across Kent and Medway. Members heard that national and local system changes provided a significant opportunity to further strengthen partnership working and support more integrated models of care. The report outlined the transition towards four locality-based footprints across Kent and the work underway to ensure that Trust structures remain aligned with wider system arrangements. Discussion focused on: • Alignment between Trust structures and system structures. • Maintaining focus on patient outcomes throughout transformation. • The importance of clear governance and accountability arrangements. The Board acknowledged that transformation on this scale would require sustained collaboration across organisations and that future reporting should continue to demonstrate the impact of neighbourhood working on service delivery, patient experience and population outcomes. The Board noted the Neighbourhood Alliance Progress Report.	
TB/26-27/46	Improvement Collaborative - Impact Report 2025/26 The Board received the Impact Report, which reflected on the improvements achieved across the Trust through continuous improvement activity over the previous year. The report demonstrated how improvement methodologies had been applied across a range of services to support better outcomes for patients, carers and staff. Members welcomed the evidence of positive change and reflected on the importance of ensuring that learning from successful improvement initiatives is shared consistently and promptly across the organisation. Discussion focused on the link between service quality, staff engagement and organisational culture, with Board members highlighting the need to continue embedding improvement	

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	approaches as part of day-to-day practice rather than viewing them as standalone projects. Members reflected on: • Progress achieved through improvement methodologies. • Benefits arising from continuous improvement initiatives. • The importance of embedding learning across services. • Opportunities to further strengthen organisational culture and outcomes. The Board also recognised the contribution that improvement activity makes towards delivery of the Trust's strategic objectives and the development of a culture of learning, innovation and accountability. Members emphasised the importance of understanding not only whether initiatives had been delivered, but also the measurable impact they had achieved for patients and services. The Board welcomed the progress demonstrated through the Improvement Collaborative and noted that improvement methodology was becoming increasingly embedded across the organisation. Members discussed the importance of ensuring that improvement activity was not considered in isolation but was explicitly connected to quality improvement, organisational culture, leadership and management development. The Chair observed that these programmes represented key strategic enablers and that the organisation needed to understand how they interacted and reinforced one another. Board members considered whether current arrangements were sufficiently joined-up and whether the organisation was deriving maximum benefit from the interaction between improvement, leadership, quality and cultural development programmes. Action: By September 2026 a deep dive will be brought to the Public Board meeting to consider how improvement activity, organisational culture programmes and leadership and management development work align, whether they are mutually reinforcing and what further organisational changes may be required. The Board noted the Impact Report.	
TB/26-27/47	Report from Quality Committee The Committee Chair reported that assurance had been received in a number of areas, including safeguarding, mortality governance and elements of the quality governance framework. However, limited assurance remained in relation to aspects of operational performance and the pace of improvement in some areas, including waiting times and patient experience measures. Ongoing scrutiny and monitoring arrangements remain in place through the Committee. During discussion, Board members reflected on the wider issue of assurance maturity across the organisation and acknowledged that further work was required to develop a more consistent understanding of what constitutes high-quality assurance. Members discussed the relationship between performance reporting, risk management, committee oversight and the Board Assurance Framework and	

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	agreed that forthcoming Board development work would provide an opportunity to strengthen collective understanding in these areas. The Board noted the importance of moving from reassurance based reporting towards evidence-based assurance supported by triangulated information. The Board received and noted the Quality Committee Chair's Report.	
TB/26-27/48	Report from People Committee The Committee Chair reported that the Committee had scrutinised workforce culture, staff experience, equality, diversity and inclusion, and strategic workforce planning. Assurance was provided regarding the Trust's response to the Lord Mann Review and implementation of national workforce standards. The Committee noted that workforce culture and staff survey outcomes remained key areas of focus, with further improvement required to address variation in staff experience and ensure that actions delivered measurable impact. The Board received and noted the People Committee Chair's Report.	
TB/26-27/49	Report from Mental Health Act Committee The Committee Chair reported that assurance had been received regarding Mental Health Act compliance and ongoing preparations for forthcoming legislative changes. Whilst assurance was received regarding statutory compliance arrangements, the Committee continued to monitor recurring concerns relating to documentation and administrative compliance. Members noted that these did not necessarily indicate poor care but did represent recurring assurance concerns. The Board heard that improvement work was underway and that future Mental Health Act oversight would transition into revised governance arrangements, principally through the Quality Committee. The Board received and noted the Mental Health Act Committee Chair's Report.	
TB/26-27/50	Report from Finance, Business and Investment Committee The Committee Chair reported that assurance had been received regarding the Trust's financial position and progress against the Cost Improvement Programme. The Committee noted continued financial pressures relating to agency expenditure, external bed usage and workforce costs. Whilst financial control arrangements remained in place, limited assurance remained against delivery of all cost improvement targets and continued focus would be required throughout the year. Limited assurance remained in relation to delivery of the Cost Improvement Programme and achievement of agency expenditure expectations. The Board received and noted the Finance, Business and Investment Committee Chair's Report.	

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TB/26-27/51	Report from Charitable Funds Committee The Committee Chair reported that assurance had been received regarding the governance and management of the Trust's charitable funds. The Committee noted continued progress in charitable activities and opportunities to maximise benefits for patients, carers and staff through charitable and volunteering initiatives. The Board received and noted the Charitable Funds Committee Chair's Report.	
TB/26-27/52	Report from CYP / AAED Committee The Committee Chair reported that the Committee had received assurance regarding the ongoing integration of CYP and All Age Eating Disorder Services into the Trust. Particular focus had been given to service performance, workforce challenges and waiting times. Limited assurance remained in relation to neurodevelopmental waiting times and some reporting and data quality issues following service transfer, although improvement plans were in place and progress was being closely monitored. The Board discussed neurodevelopmental waiting times, workforce issues, data and digital limitations and the need for more assurance-based reporting. Members discussed the phased handover of digital functions from NELFT and noted the associated risks relating to reporting, data quality and system dependencies during the transition period. Assurance was provided that transition arrangements and mitigation plans were in place; however, the Board agreed that this would remain an area for ongoing scrutiny through the Committee until the transfer was fully completed and sustainable arrangements had been embedded. The Board received and noted the CYP / AAED Committee Chair's Report.	
TB/26-27/53	Integrated Quality and Performance Report (IQPR) The Board received the Integrated Quality and Performance Report and noted the continued development of the revised reporting framework, which was intended to provide clearer performance oversight and greater alignment with the Trust's strategic priorities. Assurance was provided in a number of areas, including safeguarding, mortality governance, patient safety and progress in reducing waiting times across several services. Members welcomed the continuing development of the IQPR and noted the increased level of commentary and contextual information provided within the report. Board members discussed the need for the report to evolve further from a retrospective performance summary towards a more strategic and forward-looking document. Members noted that the IQPR should provide a clearer assessment of the Trust's progress against its strategic objectives and assist the Board in understanding future risks, opportunities and anticipated performance trajectories. It was recognised that the report represented a key mechanism through which the Board could assess both current performance and future organisational positioning.	

Item	Subject	Action
	Board members also discussed the importance of ensuring that areas of limited assurance are clearly articulated, including the actions being taken, expected timescales for improvement and indicators that would demonstrate progress. Action: By September 2026, SS and NB to bring forward proposals to strengthen the front-end narrative of the IQPR, including greater emphasis on strategic delivery, future trajectory and progress against strategic objectives. The Board noted the Integrated Quality and Performance Report.	
TB/26-27/54	CQC Community Survey The Board received the results of the Care Quality Commission Community Mental Health Survey and noted that, whilst some positive results had been achieved, the findings highlighted a number of areas where patient experience was not where the organisation would wish it to be. The Board agreed that as an organisation we need to 'own' this survey outcome, there being several aspects within our control to improve upon. Members expressed concern regarding aspects of patient involvement, communication, responsiveness and patients' confidence that they had been listened to throughout their care and treatment. The Board noted that the results represented an area of limited assurance, need to improve and warranted continued oversight. Discussion focused on understanding the underlying causes of the survey outcomes and ensuring that learning was triangulated with other sources of intelligence, including complaints, compliments, patient stories, Freedom to Speak Up themes, local service feedback, executive and non-executive service visits and clinical insight. Whilst members welcomed the improvement actions developed in response to the survey findings, emphasis was placed on assurance needing to demonstrate measurable impact rather than solely reporting activity. The Board sought assurance that progress would be monitored through the Quality Committee and that future reporting would clearly demonstrate whether patient experience outcomes had improved. Action: By September 2026, AQ and JK to ensure that learning from the Community Mental Health Survey is triangulated with feedback from clinicians and incorporated into the Trust's improvement plan. The Board noted the CQC Community Survey Report.	
TB/26-27/55	Finance Report – Month 3 The Board received the Month 3 Finance Report and noted that the Trust remained focused on delivering its financial plan in a challenging operating environment. Assurance was provided regarding financial controls and oversight arrangements. However, the Board recognised ongoing risks relating to delivery of the Cost Improvement Programme, agency expenditure, workforce pressures and out-of-area bed usage.	

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	Members noted that approximately £6m of planned savings had been delivered against a target of £10m and that failure to achieve the remaining savings could result in a financial deficit position. The Board also discussed the impact of agency expenditure, particularly within specialist and CYP services, and the challenges associated with the national agency expenditure cap. Whilst recognising the contextual workforce challenges, members expressed concern regarding continued reliance on agency staffing and emphasised the importance of achieving expenditure levels within the national agency ceiling. The Board sought assurance regarding the trajectory for agency reduction and the sustainability of the associated workforce plans. Additional context was provided regarding agency expenditure, noting particular pressures associated with specialist services, children's services and inherited workforce challenges linked to service transfers. Members acknowledged these factors whilst emphasising the need to maintain focus on reducing agency reliance as part of both the Trust's financial sustainability and workforce strategy. The Board agreed that delivery against agency expenditure expectations and wider Cost Improvement Programme objectives should continue to receive detailed scrutiny through the Finance, Business and Investment Committee until greater assurance could be provided. The Board noted the Month 3 Finance Report.	
TB/26-27/56	Workforce Deep Dive – Workforce Activity The Board received the Workforce Deep Dive, which focused on the development of the Trust's strategic workforce planning approach. Members were advised that work had commenced on a long-term workforce strategy to ensure the Trust has the right workforce capacity, capability and skill mix to support delivery of its strategic objectives and respond to future service demand. The Board discussed workforce challenges, including clinical workforce capacity, recruitment and retention, agency expenditure and the opportunities presented through digital innovation and new models of care. Members emphasised the importance of ensuring the workforce plan was aligned with service transformation programmes and developed in collaboration with system partners. Assurance was provided that strategic workforce planning was being embedded across the organisation, with a focus on leadership development, workforce productivity, staff experience and future workforce sustainability. The Board noted that further work was required to refine assumptions, strengthen workforce data and ensure clear links between workforce planning, operational delivery and quality outcomes. The Board noted the Workforce Deep Dive.	
TB/26-27/57	Freedom to Speak Up Annual Report	

Item	Subject	Action
	The Board received the Freedom to Speak Up Annual Report and welcomed the continued increase in concerns being raised, recognising this as evidence of growing confidence in speaking up arrangements across the organisation. A detailed discussion was held regarding the themes emerging from Freedom to Speak Up activity and how organisational learning was being translated into improvement. Members highlighted the importance of ensuring that concerns raised by staff are not only captured and analysed but also result in visible action and feedback. The Board reflected that responsibility for identifying themes appropriately sits with the Freedom to Speak Up function; however, responsibility for responding to those themes, delivering improvement and addressing cultural issues rests with operational and executive leaders across the organisation. Members discussed the extent to which Directorates were consistently incorporating Freedom to Speak Up learning within directorate improvement plans and cultural development activity. It was agreed that strengthening the feedback loop and demonstrating the impact of actions taken remained important priorities. Action: By September 2026, SS, in conjunction with the Executive Team, to strengthen arrangements for closing the feedback loop for staff raising concerns through Freedom to Speak Up and demonstrate how concerns raised have informed learning and improvement. The Board noted the Freedom to Speak Up Annual Report.	
TB/26-27/58	System Governance and Joint Committee Alignment The Board received a report on proposed changes to governance arrangements and was advised that: • A Partnership Committee would be established in shadow form from October 2026. • The changes would support closer system working whilst retaining clear accountability and Board oversight. Partnership Committee The Board received a report outlining proposed system governance arrangements, including establishment of a Partnership Committee in shadow form from October 2026. Members discussed the purpose of the proposed Committee and agreed that its role extended beyond governance simplification. The Board noted that the new arrangements would provide enhanced oversight of the Trust's responsibilities as a lead contractor, strengthen assurance regarding partnership and supply chain management arrangements and support greater visibility of the Trust's contribution to wider system outcomes. Discussion focused on how the effectiveness of partnership working could be measured in future. Members recognised that traditional organisational performance measures alone would be insufficient and reflected on the need for meaningful metrics	

Item	Subject	Action
	that demonstrated the effectiveness of collaboration and the impact of system-wide working for patients, partners and local populations. The Board welcomed the direction of travel and agreed that the proposed arrangements would support greater focus on partnership effectiveness whilst maintaining clear accountability and Board oversight. Joint Committee The Board received the Joint Committee paper and noted the strong emphasis on system benefit as a core responsibility for all NHS providers. Members recognised that delivery of organisational objectives must increasingly be considered alongside delivery of wider system objectives and reflected on the important role NHS providers play in supporting system transformation. The Board welcomed the direction of travel outlined within the Joint Committee report and both noted and supported its contents The Board approved the proposed governance arrangements and noted the report.	
TB/26-27/59	Governance Improvement Plan Members discussed the ongoing development of the Governance Improvement Plan and welcomed the progress being made in strengthening assurance arrangements, board effectiveness and organisational oversight. The Board noted that Mental Health Act governance responsibilities would be incorporated into revised governance arrangements and discussed how assurance would continue to be maintained through the Quality Committee and wider governance framework. Discussion focused on the need to improve the quality of assurance received by Committees and Board through stronger triangulation of quality, performance, workforce, culture and risk information. Members agreed that the programme provided an important opportunity to strengthen organisational governance arrangements and support more effective Board oversight of strategic priorities and risks. The Board noted progress against the Governance Improvement Plan and approved the programme of work.	
TB/26-27/60	Reflection on delivery of the Trust values in reports and discussions Members reflected that the discussions throughout the meeting aligned strongly with the Trust's values of Caring, Inclusive, Curious and Confident. The Chair emphasised that future consideration should move beyond retrospective reflection and become more actively embedded in Board behaviours, reports, discussions and decision-making.	

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	Members were encouraged to consider whether the Board and wider organisation were consistently demonstrating the Trust's values through the way discussions were conducted, priorities were set and decisions were taken. The Chair invited Board members and colleagues attending Board to provide any post-meeting reflections on Values, Board effectiveness or any other aspect of the meeting directly to himself and/or the Chief Executive.	
TB/26-27/61	Any Other Business No additional business was raised.	
TB/26-27/62	Questions from Public A member of the public reflected on the importance of ensuring that patient feedback leads to visible and meaningful change. Concerns were raised regarding survey fatigue and whether traditional feedback mechanisms always capture patients' experiences effectively. The Board discussed the value of alternative approaches, including focus groups and more direct engagement with service users, and reiterated its commitment to listening to patient feedback and using it to inform service improvements. The Board noted the question and response provided.	
	Date of Next Meeting The next meeting of the Board will be held on Thursday 24th September 2026.	

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 09/2026

Key	DUE	IN PROGRESS	NOT DUE	CLOSED
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Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
ACTIONS DUE IN SEPTEMBER 2026								
28/05/2026	TB/25-27/9	Board Assurance Framework (BAF)	TS to finalise and implement the revised Non-Executive Director Visit and Assurance Framework, including arrangements for consistent reporting to support triangulation of assurance information	TS	September 2026		Revised NED Visit and Assurance Framework drafted and aligned to the Trust Strategy and Board Assurance Framework, with updated visit, reporting and escalation arrangements developed to support consistent reporting and triangulation of NED observations with committee assurance, quality and performance information. To be closed	In progress
29/01/2026	TB/25-26/125	Sustainable Communities Provider Collaborative Progress Report	Present a 'broader health inequalities' update for the Board	AR	July 2026	September 2026	Addressed in the Alliance paper. To be closed.	In progress
28/05/2026	TB/26-27/14	Workforce Deep Dive - Workforce Race Equality Standard and Workforce Disability Equality Standard	Explore what support can be provided by the transformation team to improve workforce race and disability data, to enable clear linkage between workforce metrics, analysis and actions	AR	September 2026		Discussions are ongoing, including how this work aligns with PCREF progress, protected characteristic training and the breakthrough objective to recommend KMMH as a place to work. To be closed.	In progress
30/07/2026	TB/25-27/39	Personal Experience – My experience within KMMH services, including inpatient rehabilitation	DHS and JK to consider the learning from the Personal Experience presentation within relevant service improvement programmes, including patient voice, therapeutic relationships, trauma-informed care and the inpatient environment.	DHS/JK	September 2026		This has been addressed through the rehabilitation work. To be closed.	In progress
30/07/2026	TB/25-27/42	Chair's Report	NB to provide assurance regarding the monitoring and utilisation of clinical environments and estate capacity, including consideration of issues relating to ward environments, space utilisation and patient experience.	NB	September 2026		Estates work is ongoing, with existing arrangements providing assurance on specific aspects of condition and capacity. Further detail is needed to triangulate wider issues, with a proposal	In progress

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 09/2026

Key	DUE	IN PROGRESS	NOT DUE	CLOSED
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Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
							due to the Finance, Business and Investment Committee in November.	
30/07/2026	TB/25-27/46	Improvement Collaborative - Impact Report 2025/26	AR to bring a deep dive will be brought to the Public Board meeting to consider how improvement activity, organisational culture programmes and leadership and management development work align, whether they are mutually reinforcing and what further organisational changes may be required.	AR	September 2026		Joint paper with KH and ALS on the agenda. To be closed.	In progress
30/07/2026	TB/25-27/53	Integrated Quality and Performance Report (IQPR)	SS and NB to bring forward proposals to strengthen the front-end narrative of the IQPR, including greater emphasis on strategic delivery, future trajectory and progress against strategic objectives.	SS/NB	September 2026		Work is underway it will be a report rather than a proposal. To be closed.	In progress
30/07/2026	TB/25-27/54	CQC Community Survey	AQ and JK to ensure that learning from the Community Mental Health Survey is triangulated with feedback from clinicians and incorporated into the Trust's improvement plan.	AQ/JK	September 2026		The Chief Medical Officer liaised with the AHP Lead, who agreed to triangulate feedback from the staff and patient surveys. To be closed.	In progress
30/07/2026	TB/25-27/57	Freedom to Speak Up Annual Report	SS, in conjunction with the Executive Team, to strengthen arrangements for closing the feedback loop for staff raising concerns through Freedom to Speak Up and demonstrate how concerns raised have informed learning and improvement.	SS	September 2026		FTSU concerns are reviewed and monitored through Executive and SDR oversight, with themes and learning used to improve practice and communicated to staff. Unresolved concerns are escalated through the appropriate leadership route. To be closed.	In progress
ACTIONS NOT DUE OR IN PROGRESS								
30/07/2026	TB/25-27/44	Board Assurance Framework (BAF)	By October 2026, TS to support further development of the Board Assurance Framework and wider assurance model through Board Development Sessions, ensuring clear Board ownership of strategic risks and assurance.	JK	October 2026			Not Due

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 09/2026

Key	DUE	IN PROGRESS	NOT DUE	CLOSED
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Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
CLOSED AT LAST MEETING OR COMPLETED BETWEEN MEETINGS								
29/01/2026	TB/25-26/119	Continuous Improvement Story – Standardising Medication Storage in Allington Centre	Produce a Trust-wide scale-up plan with measurable safety metrics and report it to the Finance, Business and Investment Committee	AR	July 2026		Covered in the impact report. To be closed.	CLOSED
29/01/2026	TB/25-26/128	Integrated Quality and Performance Review	Provide a refined complaints improvement trajectory including complexity categorisation and bottleneck analysis	JK	March 2026	July 2026	Revised date agreed at the May 2026 Trust Board meeting	CLOSED
29/01/2026	TB/25-26/127	Trust Quality and Safety Agenda	Finalise the NED Visit Insight Framework	TS	May 2026	July 2026	A new system of NED visit feedback will be implemented over the next quarter, with digital submission of NED visit feedback	CLOSED
26/03/2026	TB/25-26/153	Five-year trust strategy 2026-2031	At its June seminar, SS to present the strategic workplan which shows how the strategy will have operational effect.	SS	June 2026		A seminar session on the Trust's Strategic Workplan was held in June 2026. To be closed.	CLOSED
28/05/2026	TB/25-27/3	Personal Experience – The Acute ward and its patient's journey	Review post discharge medication and follow-up processes, to ensure continuity of care and sufficient reviews	AQ	July 2026		This is being picked up as part of work around discharge processes via Acute Directorate. To be closed.	CLOSED
28/05/2026	TB/25-27/10	Sustainable Communities Provider Collaborative Progress Report	Ensure that future Sustainable Communities Provider Collaborative Progress Reports include revised timelines and narrative explanation for those milestones where delivery was 'off-track'	Jha	July 2026		All milestones have been reviewed with revised timelines added, where known and explanations added to exception reporting. To be closed.	CLOSED
28/05/2026	TB/25-27/12	Integrated Quality and Performance Report (IQPR)	Provide clarification regarding the increase in the "perinatal assessments (against annual target)" metric in April 2026	DHS	July 2026		NHSE count when patients have the first face to face or video contact. If they are seen in a subsequent financial year, they are counted again at that point. This is why the in-month figures for April and May are higher than other months, as	CLOSED

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 09/2026

Key	DUE	IN PROGRESS	NOT DUE	CLOSED
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Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
							patients already on the caseload receiving their first contact of the new financial year are counted along with new patients. To be closed.	
28/05/2026	TB/25-27/13	Finance Report – Month 1	Explore with MW and KC alternative approaches to the presentation of the Trust's financial data, to first be considered by the Finance, Business and Investment Committee	NB	July 2026		This has been discussed in FBI committee and will be developed over the coming months. To be closed.	CLOSED
28/05/2026	TB/25-27/17	Governance Improvement Plan	Discuss the scheduling of a presentation of best practice for delivering assurance to the Board and its sub-committees at a future Board Seminar	TS / JC / SS	July 2026		A verbal update will be given at the meeting.	CLOSED
28/05/2026	TB/25-27/18	Co-creation strategic plan: implementation update	Liaise with Trust Secretariat to confirm the scheduling of the underlying action plan for the Co-creation strategic plan at the Quality Committee	KH	July 2026		A six-monthly update on the Co-creation strategic plan will be considered at the Quality Committee in May and November annually. To be closed.	CLOSED

Title of Meeting	Board of Directors (Public)
Meeting Date	24 September 2026
Title	Chair's Report
Author	Colin Lynch, Trust Chair
Presenter	Colin Lynch, Trust Chair
Purpose	For noting

1. Introduction

Since the previous Kent and Medway Mental Health NHS Trust ("the Trust") Board meeting, I have continued to meet colleagues, visit services and engage with partners across Kent and Medway. My report focuses on matters of significance to the Trust and my activity over the past two months. It remains aligned to the three themes set out in my first report and to the five *Doing Well Together* strategic ambitions: timely access, safe care, positive experiences, smarter working and staying well.

The consistent thread is delivery. The Board must be able to see how colleague and service-user insight, operational evidence and constructive challenge lead to accountable action and sustained improvement. The revised approach to Chair and Non-Executive Director visits described below is intended to strengthen that connection.

2. Key themes and initial reflections

KMMH colleagues and team engagement, development and service improvement

On 11th August, our executive director team, Chief Executive and me met with NHS England and Kent and Medway ICB representatives for the Trust's 6 monthly Provider Oversight Meeting. It was a fair, well-balanced and constructive session. The focus was on service quality improvement, financial balance, cultural and leadership development and system partnership collaboration, including on integrated neighbourhood care. The follow-up from NHS England has been similarly constructive, setting out clear expectations for delivery against our Quality and Governance Improvement Plans.

On 5th August I had the pleasure of visiting colleagues in our South West Kent Mental Health Together service at Highlands House, Tunbridge Wells. Colleagues were really open and constructive with their feedback, and it was great to hear of the effective local improvement work, for instance, with service user physical health checks. I was told of appetite within the Trust for more nurse-led research work. Constructive feedback was given on how we might best support local managers to be effective.

On 11th August, I was also most pleased to visit our Psychiatry Liaison service based in Medway Maritime Hospital. It was good to hear of the effective joint working with the recovery house VCSE partner and smoother referral pathways. Colleagues had some progressive and constructive views in relation to clinical risk management and how that can be optimised for the benefit of service users and system partners.

On 25th August, I was very happy to join the Speak to Sheila webinar and have the opportunity to share why I'm so motivated to have joined the Trust and outline some of the themes in this and my previous Chair's report. In particular, my and our Board's view about the close links between effective colleague engagement and communication, cultural development work and maximising the quality of our services. The importance of being able to share our improvement work and best practice generally right across the Trust came up as a theme.

On 9th September, I visited our Children and Young Person Community service team in George's Turle House, Canterbury. Colleagues who worked previously for North East London NHS FT have felt warmly welcomed and integrated. We had an excellent wide-ranging discussion with colleagues having plenty of ideas and suggestions on neighbourhood working and collaborations with KCHFT and internal matters, including how we might reduce the number and increase the effectiveness of our meetings and recruitment-related frustrations. I heard of some fantastic achievements in our schools working teams and some great feedback on what is working well culturally in that team and which directly relates to that consistently high achievement.

On 9th September, I also visited our Mental Health Together and Mental Health Together Plus teams in Laurel House, Canterbury. Again, constructive working with a VCSE partner – this time Invicta – came through as a strength, as did colleagues covering for each other and 'going the extra mile'. In a similar vein to the CYP team meeting, constructive feedback for improvement was given about internal meetings, recruitment issues, the need for clearly genuine colleague consultation and also communication with GP colleagues.

All feedback from my visits on 9th September will be included in the thematic analysis for the Trust Board in November.

At the time of writing this Report, I'm much looking forward to the Trust's Long Service Awards on 17th September.

System leadership for sustainable patient and partner benefit

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

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

There is a meeting of the Kent and Medway Joint Committee scheduled for 21st September and I will report on that verbally in this Board meeting.

On 1st September, I was happy to represent our Trust and KCHFT on the stakeholder panel for the recruitment of the Kent and Medway ICB permanent Chair. We met with three very credible and engaged candidates. At the time of writing this report, the outcome of that recruitment process is as yet unknown.

On 18th August, with our Chief Executive I visited the Chief Executive of Alzheimer's and Dementia Support Services (ADSS). It was an excellent discussion covering matters such as the forthcoming Mental Health Services Review, our ongoing partnering and joint working arrangements and ADSS interface with physical community health services. The meeting was a very good reminder that our system VCSE partners are essential to the removal of barriers to effective care and for the sustained improvement - including via single and multi-neighbourhood integrated care arrangements – of health and care outcomes.

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

Board effectiveness, resilience and being fit for the future

The Board met for a seminar on 6th August. The session supported further consideration of the Trust's strategic risk and assurance work and has informed the continuing development of our Board Assurance Framework ("BAF"). A revised BAF is being developed for Board consideration, with clearer risk terminology, traceability from the previous framework and stronger evidence of control effectiveness. This is important and will help make our forthcoming programme of assurance-focussed Board development work more effective. Work on our Board development plan, including how learning from audits, reviews, feedback and committee discussions is used to improve Board effectiveness, has also progressed.

The Governance Improvement Programme has continued through regular review meetings and focused work on committee terms of reference and workplans, escalation routes, Board and committee reporting, triangulation and governance expectations. This continues the work to develop a more forward-looking, priority-based Board development programme and a stronger shared understanding of high-quality assurance. Our Chief Executive and me are keen to ensure that, from the outset, our work on improving Board assurance is meaningful and impactful for management colleagues well beyond those who sit on the Trust's Board.

I much look forward to engaging with Board and other colleagues on all aspects of our Board development work. Including notably the cultural development priorities workshop taking place in October.

3. New NED visit process

Following work with the Governance team and our Chief Executive, I am pleased to report that a revised approach to Chair and Non-Executive Director (“NED”) visits has been agreed. The process is designed specifically for the Trust and is aligned to *Doing Well Together* and its five ambitions. It provides a more coordinated programme of NED visits, a standard form for capturing feedback and a consistent method for mapping findings to strategic priorities, assurance themes and committee routes.

Visit insight will be triangulated with quality, workforce, finance, performance, risk and patient-experience information. This will help strengthen management actions and Board assurance, identify recurring concerns and make good practice more visible across the Trust.

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

The revised process places the five *Doing Well Together* ambitions at the centre of analysis and reporting. Each substantive observation from historic or future visit feedback should be assigned one primary ambition, a controlled sub-theme, an evidence scope, an assurance level and a principal committee route. A secondary ambition or committee should be used only where the issue is genuinely cross-cutting.

Stage	Expected treatment
1. Capture	Record the substantive observation, source, service context and whether it reflects good practice, an improvement opportunity, a concern or an escalation.
2. Map	Assign one primary <i>Doing Well Together</i> ambition, the relevant sub-theme, evidence scope and proposed committee route.
3. Apply escalation rules	Identify whether the finding should be shared, monitored, escalated or immediately escalated. Current safety, safeguarding, legal rights, probity or serious speaking-up concerns should not wait for routine reporting.

4. Validate and act	Share material findings with the relevant Executive and service leads; identify ownership, action, timescale and evidence of outcome.
5. Triangulate and assure	Test the observation against formal quality, workforce, finance, performance, risk, patient experience and other relevant evidence before drawing a wider conclusion.
6. Report and close the loop	Route focused assurance to the lead committee and provide Board-level insight on recurring themes, good practice, risks, outcomes and feedback to colleagues.

Thematic assurance through *Doing Well Together*

Executive summary

The five visits provide strong positive local assurance on frontline care, visible local leadership, multidisciplinary working, medicines safety, physical-health monitoring, risk assessment, recruitment and development, and partnership working. The Pharmacy Team and Southwest Kent Mental Health Together provided particularly strong examples of positive team culture and improvement.

The positive findings are not isolated examples. Taken together, they suggest that the strongest services share several characteristics: visible and accessible local leadership; strong multidisciplinary relationships; clarity of purpose; colleagues who feel supported to contribute ideas; active investment in development; effective partnership working; and practical changes that release time for care or improve safety. Recurring concerns remain around communication, colleague voice, management autonomy, digital interoperability, estates and the consistent spread of learning. No visit reported an issue requiring rapid escalation.

Headline assurance position

Theme	Positive assurance	Concern or assurance gap	Assessment
Patient experience and clinical effectiveness	Good frontline, crisis and liaison care; improved medicines safety; 100% physical-health monitoring reported; full MDT assessments within four hours in liaison.	Sustainability and wider consistency require routine validation.	Reasonable

Communication engagement and colleague voice	Positive communication and psychological safety within local teams.	Repeated concern that corporate messages do not land well, staff feel “done unto”, and feedback does not consistently influence decisions.	Limited
Leadership, workforce and culture	Visible local leadership, recruitment success, development, inclusive teams and good supervision.	Reported blame-culture legacy, slow or variable workforce support, limited local autonomy, research-access concerns and night staffing pressure.	Limited to Reasonable
Digital, estates and productivity	Innovative pharmacy app; local improvement ideas; service-level problem solving.	IT systems do not interoperate effectively; liaison assessment space, telephone access and avoidable escalation to senior managers affect efficiency and care.	Limited
Partnership and integrated care	Strong GP, VCSE, acute and multidisciplinary relationships; Recovery House working well.	Some issues depend on partner estates and operational arrangements.	Reasonable
Learning and spread	Strong examples of improvement and innovation.	Repeated concern that KMMH does not consistently celebrate, promote or spread successful practice.	Limited

Thematic assurance analysis

Communication, engagement and colleague voice

Gregory House colleagues described communication, listening and engagement as weak and said that colleagues in the East can feel that change is done to them. The Pharmacy Team reported that messages from senior leaders can be lost, not passed on or interpreted differently. Southwest Kent Mental Health Together said that earlier consultation on the model had not sufficiently reflected concerns about clinical-supervision capacity. The Psychiatric Liaison Service similarly requested earlier engagement with local managers so that organisational messages can be explained and adapted appropriately.

This is a recurring Trust-wide concern across the four visits. The Board should seek evidence that two-way communication, consultation and visible feedback loops are improving, rather than relying solely on the volume of communication issued.

Organisational culture, leadership and management support

Local leadership was a clear strength. Gregory House described visible joint working between service, nursing and operational leaders. The Pharmacy Team reported strong leadership, psychological safety, excellent multidisciplinary relationships and active professional development. Southwest Kent colleagues described a caring, inclusive and resilient team, while the Psychiatric Liaison Service reported visible and approachable managers.

This positive local evidence sits alongside wider concerns. Gregory House reported a residual perception of blame culture and reluctance to raise ideas based on past experience. Southwest Kent described slow and variable workforce support for flexible working and difficult management issues. The liaison visit raised concern that decisions are escalated to service directors when they could be taken locally. These findings suggest a gap between strong local cultures and the wider organisational conditions experienced by managers and colleagues.

Quality, patient experience and safety

The five visits produced strong positive clinical evidence. Gregory House reported good frontline care and positive emergency and crisis responses. Pharmacy colleagues described improved medicines safety in community mental health teams and training to reduce overmedication of autistic people and people with learning disabilities. Southwest Kent reported 100% physical-health monitoring compliance following focused improvement, an equipped room and colleague training. The Psychiatric Liaison Service described full multidisciplinary assessment and treatment planning within four hours of referral and a person-centred approach to risk management.

Specific assurance gaps remain. Pharmacy reported that poor IT interoperability can create avoidable errors and inefficiency. The liaison assessment environment was described as unsuitable for confidential assessment and triage, and the night shift could feel understaffed, although additional recruitment was reported as approved. These matters require validation of current controls and follow-up through the relevant quality, digital, workforce and estates routes.

Smarter working, digital and local autonomy

The Pharmacy Team highlighted an app giving rapid access to consultants across 21 specialties, potentially avoiding unnecessary GP referrals. Southwest Kent described a focused approach to physical-health monitoring and Friday debriefs. The liaison visit identified smoother pathways with Medway NHS Foundation Trust and the Recovery House as a positive alternative to admission.

Against this, digital interoperability was reported as creating error and efficiency risks. The liaison service also described time lost because accessible telephones were limited, and raised a wider concern that excessive central control and escalation can reduce productivity and confidence in local decision-making. The Board should seek

assurance that decision rights, digital systems and support processes enable teams to work effectively while maintaining proportionate controls.

Learning, research and spread of improvement

The visits identified a substantial pipeline of learning: pharmacy medicines-safety practice, recruitment and career development; physical-health monitoring at Highlands House; partnership working and co-location; crisis and risk-management practice; and ideas for wider quality-improvement briefings using colleagues to share local stories.

However, Gregory House and Pharmacy both reported that KMMH does not consistently celebrate or spread success. Southwest Kent also reported perceived barriers and inequity in access to research opportunities, particularly for nursing colleagues. This supports a more systematic Share, Adopt, Scale or Evaluate process, with named ownership and evidence of benefit.

The Cherry Tree House visit provided positive assurance about the transition from NELFT to KMMH, particularly the people-focused aspects of the transition and proactive support from the estates function. Strong partnership working with schools, social care, GPs and acute services was identified as important to early intervention, preventing escalation and delivering effective care.

Good practice Themes

What the strongest services appear to have in common

The strongest positive evidence is associated with visible local leadership, professional trust, multidisciplinary working, active support for development, effective partnership relationships and practical improvement led close to the point of care. These characteristics provide a useful starting point for management consideration of how successful practice can be supported and replicated elsewhere.

Visible and enabling local leadership

Several visits demonstrated the value of visible, accessible and joined-up local leadership. Gregory House described effective joint working between service, nursing and operational leaders. The Pharmacy Team reported strong leadership, psychological safety and effective relationships across professional groups. The Psychiatric Liaison Service similarly described managers as visible, available and approachable.

Multidisciplinary and holistic care

Strong multidisciplinary working was evident across services. The Mother and Baby Unit demonstrated integrated clinical and operational leadership and strong relationships with acute and voluntary-sector partners. At Broughton Ward, compassionate multidisciplinary care and meaningful therapeutic activity supported recovery. Priority House colleagues identified opportunities for earlier engagement between physical and mental health professionals so that care planning better reflects the needs of the whole person.

Safety and clinical improvement

Visits identified practical improvement approaches producing positive clinical assurance. Pharmacy colleagues described strengthened medicines safety in community mental health teams and training to reduce overmedication of autistic people and people with learning disabilities. South West Kent Mental Health Together reported 100% physical-health monitoring compliance following focused improvement, an equipped room and colleague training. The Psychiatric Liaison Service described multidisciplinary assessment and treatment planning within four hours and a person-centred approach to risk management.

Workforce development, recruitment and retention

The Pharmacy Team provided positive evidence of career development, professional support and successful recruitment, including rotational pharmacists choosing to join the Trust. Littlebrook Hospital reported stable staffing and recruitment progress for the new female psychiatric intensive care unit. South West Kent Mental Health Together described positive recruitment activity and perceived improvement in retention despite a difficult labour market. The Mother and Baby Unit reported no vacancies and little use of bank or agency colleagues.

Colleague wellbeing and psychological safety

Positive local approaches included South West Kent Mental Health Together's informal Friday debrief, effective supervision and supportive management within Pharmacy, and psychologically safe local team cultures in which colleagues reported no barriers to raising concerns. These examples may offer practical learning for local leadership and wellbeing arrangements.

Partnership working across organisational boundaries

Highlands House benefited from co-location and positive relationships with GPs and voluntary-sector partners. Cherry Tree House described collaboration with schools, social care, GPs and acute services to support prevention and early intervention. The Psychiatric Liaison Service highlighted improved working with Medway NHS Foundation Trust and Recovery House as an alternative to admission. The Mental Health Learning Disability Service also described strong partnership working and support for mainstream services around autism and reasonable adjustments.

Innovation that releases time or improves access to expertise

Pharmacy's specialist-advice application provides rapid access to consultants across 21 specialties and may avoid unnecessary GP referrals. Littlebrook Hospital was developing approaches to understand ward-manager workload and reduce administrative burden. Gregory House colleagues proposed quality-improvement briefings through which colleagues could share improvement stories locally. These examples show that practical innovation can improve access to expertise, release time for care and support the spread of learning.

Spotlight:

Area	Example	Suggested treatment
Clinical quality	Pharmacy-led medicines safety in community teams and training to reduce overmedication.	Adopt / Scale
Physical health	Reported 100% monitoring compliance supported by an equipped room and trained colleagues at Highlands House.	Evaluate / Adopt
Culture and development	Pharmacy leadership, psychological safety, recruitment and career development.	Share / Adopt
Integrated care	Recovery House, acute-provider collaboration and strong GP and VCSE relationships.	Share
Risk and access	Psychiatric Liaison MDT assessment and treatment planning within four hours of referral.	Evaluate / Share
Improvement spread	Quality-improvement briefings using colleagues to tell improvement stories locally.	Test / Evaluate
Early intervention and partnership	Cherry Tree House collaboration with schools, social care, GPs and acute services.	Share / Evaluate

Emerging risks and issues for Board attention

- Repeated communication and consultation concerns across all four visits, including whether colleagues can see how feedback influences decisions.
- A reported gap between positive local cultures and wider perceptions of blame, limited staff voice and insufficient local autonomy.
- Digital interoperability concerns with potential medicines-safety and productivity implications.
- An unsuitable liaison assessment environment affecting confidentiality, assessment and triage, together with inefficient access to partner staff by telephone.
- Workforce concerns involving night staffing, central support to managers, retention of newly qualified nurses and access to research opportunities.
- Inconsistent organisational arrangements for identifying, celebrating, evaluating and spreading good practice.
- Access and capacity pressures in South Kent CAMHS, including geography, limited sites, the reported 26% non-attendance rate and high ADHD review demand.
- Loss of operational business intelligence and complex IT access at Cherry Tree House pending migration to a single RiO instance.

Recommendations

The Board is asked to:

- **Note** the Chair's activity and reflections since the previous meeting;
- **Note** the five-ambition, True North-aligned framework for analysing historic and future Chair and NED service-visit feedback;
- **Consider** the proposed route of validation with Executive and service leads before thematic findings are presented for committee or Board assurance; and
- **Consider** the consistent use of Share, Monitor, Escalate and Immediate Escalation thresholds.

Conclusion

The revised framework gives the Trust a clear and strategy-aligned method for converting qualitative visit feedback into proportionate management action and Board assurance. Its credibility will depend on maintaining the distinction between evidence and interpretation, protecting confidentiality, escalating urgent concerns promptly and avoiding Trust-wide conclusions where the evidence remains local or incomplete.

Chief Executive's Board Report

Date of Meeting: 24th September 2026

Introduction

It has been a busy summer for the NHS with exceptionally nice weather for people taking some much-needed relaxation time with friends and family. Our new Chair and I have undertaken several visits together internally in the Trust and externally meeting our partners. Thanks to all who made us so welcome. There continues to be a lot of work in the Kent & Medway system that we are a fundamental part of shaping the future of services for our population. By the time we meet as a Board I will also have attended the national Chief Executives meeting, on which I will provide a verbal update.

National Update

National Oversight Framework (NOF), Quarter 1 segmentation

At the beginning of the month, NHS England published its latest National Oversight Framework (NOF) results, which provide a national view of how NHS organisations are performing against national priorities. We remain in Segment 3 and are ranked 53 out of 58 in the mental health and community trust league table.

There is important context to this result. NHS England has significantly changed the way organisations are assessed which means changes in scores do not necessarily mean changes in performance. NHS England has been clear that this quarter's data should not be directly compared with previous quarters. This is effectively a new baseline and new way of measuring performance.

There are known data-quality and measurement challenges affecting some indicators, and we are carrying out a detailed review to fully understand our position so that we can assure ourselves that the plans we have in place will improve our position. We will keep the Board informed.

NHS England South Region Oversight meeting

We had our first oversight meeting with NHS England (NHSE) in August, which for us was the start of the transition of provider oversight back to NHSE from the Integrated Care Board (ICB). It was a good opportunity for the Trust to be able to update NHSE on our improvement directly.

NHSE provided positive feedback. They recognised the quality of the information provided, the openness of discussions, and the Board's clear understanding of the Trust's priorities, risks and improvement journey through the *Doing Well Together* strategy.

Key strengths highlighted included:

- Strong Board leadership, governance and oversight, with recognition of improvements needed to the Board Assurance Framework (BAF), committee structures, quality governance and organisational learning.
- Effective integration of the All-Age Eating Disorder and Children and Young People's Mental Health Services transferred from NELFT, with services maintaining performance and staff reporting a positive experience of the transition.
- Progress in strengthening patient safety arrangements, including implementation of Patient Safety Incident Reporting Framework (PSIRF), learning from incidents and delivery of the Quality Improvement Plan (QIP).
- Continued development of the Trust's culture, workforce initiatives and refreshed People Plan, with a strong focus on inclusion, wellbeing and staff engagement.
- Significant improvement in dementia services, with waiting times reducing from 28 weeks to 13.1 weeks and diagnosis rates reaching their highest level to date.
- Positive leadership of neighbourhood health development and system partnership working across Kent and Medway.

NHS England also acknowledged a number of ongoing challenges requiring continued focus from the trust, including patient flow and delayed discharges, out-of-area placements, temporary staffing expenditure, workforce inequalities, sickness absence, patient experience improvements and the need to sustain progress in quality and culture.

The Trust has been asked to provide continued assurance and evidence of impact in relation to:

- Delivery of governance, quality and cultural improvement programmes
- Actions arising from the Community Mental Health Survey
- Reducing reliance on external beds and improving discharge pathways
- Delivery of workforce transformation and equality objectives
- Implementation of the revised Mental Health Together model and neighbourhood-based approaches

Our feedback letter concludes that the Trust has made encouraging progress across governance, culture, workforce and quality improvement, supported by strong Board engagement and a willingness to learn and improve. NHS England emphasised that continued focus on delivery, assurance and partnership working will be important in maintaining momentum and improving outcomes for patients, carers and staff.

National mental health priorities

NHS England and mental health chief executives have agreed three stretch targets for the sector: a 95% reduction in out-of-area placements by March 2027, reducing 12-hour waits for mental health patients in emergency departments, and ensuring 50% of children and young people are seen within four weeks. We are working with NHSE to further understand the baselines and measurement requirements, and to discuss known data-quality

challenges, and will review our improvement plans against each of these areas with executive oversight.

Investment to strengthen urgent and emergency mental health care

Last month the government announced additional funding to open mental health centres and improve urgent and emergency mental health care, giving people earlier local support and specialist crisis care outside A&E. We are pleased that the investment will support enhanced crisis assessment and care in Medway Maritime Hospital, Queen Elizabeth The Queen Mother Hospital and William Harvey Hospital. It will build on existing services, including Safe Havens, mental health crisis teams and specialist mental health support within emergency departments.

New national Mental Health Strategy

Publication of the new Mental Health Strategy has been delayed and is now expected in December 2026, which impacts timings of our strategic clinical plan. In the meantime, we are continuing to engage clinicians, patients and communities in further development of our clinical strategic plan.

Kent & Medway System Update

Provider Alliance

Progress continues to be made with the Provider Alliance board and the two system alliances (Neighbourhood and Acute). All system Chief Executives and Chairs agreed that we would recruit a Chief Executive for the Provider Alliance. The postholder will be appointed on a fixed term 18-month basis, reporting to a Trust Chair and hosted by our Trust along with the alliance team. The new Chief Executive will be critical in taking the large provider transformation agenda forward. Two Managing Director posts will also be recruited, one for each alliance. We look forward to working with the new postholders to transform services for our population.

System Leadership Group (SLG)

I attended the Kent and Medway System Leadership Group (SLG) where we reviewed progress across the Provider Alliance, neighbourhood transformation programme and system financial position. Members noted that the Provider Alliance has completed its initial transition phase and now has the key foundations in place, including established acute and neighbourhood collaboratives, strengthened governance arrangements and plans to recruit dedicated Alliance leadership. The group also considered the emerging medium-term financial plan for Kent and Medway, recognising the scale of the financial challenge facing the system and the need for accelerated transformation, stronger collaboration across organisations and continued focus on delivering current-year financial plans.

We also reviewed progress on neighbourhood health development, commissioning intentions and wider system transformation. Emphasis was placed on advancing neighbourhood-based care, improving patient flow and discharge arrangements, integrating mental and physical health services, developing shared digital capabilities and strengthening partnership working with local government ahead of local government reorganisation.

Members endorsed a continued focus on prevention, population health, financial sustainability and service transformation, with a commitment to delivering improved outcomes for the population of Kent and Medway through collaborative system leadership.

Trust Update

Welcome to Lee Williams, Director of Programme Delivery

I am pleased to update that Lee Williams joined the Trust on 10 August 2026 as Director of Programme Delivery on a 12-month fixed-term contract. Lee's appointment reflects the Trust's strategic decision to strengthen internal programme delivery capability and bring expertise in-house following support from external partners.

Lee will provide leadership and oversight for the below four key programmes:

- Mental Health Together (MHT)
- Supporting delivery of the Trust's Quality Improvement Plan (QIP)
- The Operational Model Reset Programme
- Embedding Children and Young People's Services

As we continue to implement our five-year *Doing Well Together* strategy, Lee's appointment represents an important investment in programme leadership and delivery expertise required to support long-term organisational improvement and the delivery of better outcomes for patients, staff and partners. I am sure you will join me in welcoming Lee to the Trust.

NHS England Regional Financial Oversight meeting

I attended an NHS England regional financial oversight meeting last month with Nicola George, our Deputy Chief Finance Officer. NHSE acknowledged the Trust's strong start to 2026/27, recognising that the organisation is delivering its financial plan and remains on track at Month 4 despite significant system-wide financial pressures. The Trust's compliant financial plan and robust financial management were positively recognised.

The discussion focused on maintaining financial delivery while continuing to improve patient flow, reduce clinically ready for discharge delays and minimise reliance on external beds. NHS England welcomed the Trust's proactive management of operational pressures and highlighted the importance of continued collaboration across Kent and Medway to support neighbourhood development and the wider "left shift" agenda.

The meeting also considered the transfer of Children and Young People's Mental Health Services and All Age Eating Disorder Services, with ongoing work underway to ensure long-term financial sustainability and resolve outstanding asset and capital matters. NHS England confirmed its support in progressing these issues.

NHS England noted that the Trust's year-to-date performance provides confidence in delivery of the agreed financial plan and encouraged continued focus on cost improvement opportunities, workforce sustainability and planning for 2027/28. The Trust was thanked for its constructive engagement and transparent approach, with NHS England confirming that

existing assurance arrangements will continue and that progress will be reviewed following Quarter 2 reporting.

Alzheimer's & Dementia Support Services (ADSS) Visit: Working with Partners

The Trust Chair Colin Lynch and I visited the ADSS service in Northfleet last month. Our visit was an opportunity to introduce Colin to Katie Antill, Chief Executive of ADSS and reflect on the positive work we have undertaken together to date and how we can build on our partnership moving forward to further improve services for patients with dementia.

A massive thank you to Katie and Denise for making us so welcome. We look forward to working closer with you and other partners in the future.

New Director of Adult Social Care for Kent Council: Working with Partners

I met with the new Director of Adult Social Care for Kent Council in August. It was a fantastic opportunity to start new relationships with the council and discuss how we can work closer together moving forward. There was recognition from both sides that this needs to be a different relationship moving forward and the importance of how we work together is critical to support our patients to continue to live well in the community. We have agreed to meet monthly, and I will keep the Board sighted on the future improvement programme for our teams.

The Beacon Service Visit

I visited our Thanet based community teams this month. Adam Doyle, Chief Executive of K&M ICB, joined me on the visit. Staff were very open and shared how it currently feels for them during the staff consultation for the redefined clinical model of our community teams. Staff had some excellent suggestions for us to consider as part of the consultation feedback. Adam was curious with staff regarding how the commissioners could further support the development and improvement of our services and how digital could support our staff moving forward. I would like to thank staff for their openness and honesty.

NHS Graduate Management Training Scheme

We were pleased to host the Kent cohort of NHS Graduate Management Training Scheme (GMTS) trainees as part of their system-wide orientation programme. During their week with the Trust, trainees gained insight into a range of services, including volunteering and charity initiatives, inpatient care, and community crisis services. They also spent time with Board members, providing valuable insight into the role of the Trust Board, leadership responsibilities, governance, and decision-making within a mental health trust. The programme highlighted the strength of partnership working across Kent and Medway and our shared commitment to developing the next generation of NHS leaders.

Mental Health Together continued improvement

Mental Health Together has reached a significant transition point. We are moving from programme design into implementation, with the refreshed model of care agreed, workforce consultation underway, locality planning progressing, and key foundations in workforce, finance, digital and partner mobilisation now in place.

The programme's key risks relate to locality implementation, workforce transition, partner mobilisation, programme capacity and maintaining service continuity; these are being mitigated through strengthened governance, integrated locality plans, active dependency management, robust staff engagement and consultation, partner readiness planning, enhanced performance oversight, and a refreshed critical path to ensure safe and coordinated delivery while continuing to improve waiting times and access to care.

Over the coming months, focus will be on completing consultation, finalising locality implementation plans, mobilising partners and rolling out the refreshed model in a safe and phased way. Progress, performance, risks and benefits realisation will continue to be closely monitored through programme governance and Executive Management oversight to ensure delivery remains on track and achieves the intended improvements in access, experience and outcomes.

A full update is provided in the Neighbourhood Alliance Progress Report. However, I would like to recognise here the progress our community teams and partners are making to reduce the number of people waiting over 38 weeks for support, as part of our Trust 'timely access' strategic ambition. We have significantly reduced waits across the county and our East Kent teams have made the most significant improvement. Well done to everyone for their continued focus and hard work.

Trust Leadership Event

This month, we brought together key leaders from across the Trust for our regular Leadership Day. We explored our role in the changing health and care system, including developments across neighbourhood and acute care, and reflected on progress since the launch of our new strategy in July. We also focused on our collective leadership role in achieving a 65% NHS staff survey response rate and explored the new NHS staff standards, linking these to our cultural transformation work. It was a valuable opportunity to align leaders around our priorities and the role we all play in delivering meaningful change to improve health outcomes and in driving a consistent, values-led culture across the Trust.

Long Service Awards

On 17 September, we welcomed long-serving colleagues to Castle Westenhanger in Kent for our annual Long Service Awards. The event celebrated the dedication, commitment and professionalism of staff who have given many years of service to the Trust and NHS. The atmosphere throughout the day was warm, positive and uplifting, with a strong sense of pride as colleagues and friends came together to recognise those who have made such a lasting contribution to patients, services and communities. It was a privilege to recognise so many colleagues for their service and to thank them for the difference they make every day.

Awards and recognition

Since the last Board meeting, colleagues have continued to receive regional and national recognition for excellence in clinical care, quality improvement and collaboration. Most notably, Dr Lucia Laskowski and Dr Suresh Thapaliya secured first place in the Royal College of Psychiatrists Resident Doctor in Core/Higher Training Poster Prize for their service evaluation work. Our Southern Counties Children and Young People Mental Health Provider Collaborative has been shortlisted for Provider Collaborative of the Year at the HSJ Awards 2026. And Shannon Paine, Head of Nursing, Dr Ishaq Pala and Dr Shantala Satisha

have all been shortlisted for national awards recognising outstanding leadership, innovation and clinical contribution. These achievements reflect the talent, dedication and improving culture across the organisation. Well done to all our colleagues.

KMMH in the news

Since July, the trust has continued to strengthen its external profile through proactive media activity focused on quality improvement, innovation, research and patient outcomes. Positive coverage has included national and regional stories on [reduced waiting times](#), quality [improvement initiatives](#), research, [community partnerships](#) and recovery-focused services.

In September, we were delighted to showcase [Coleman House](#) in Dover, which received a £680,000 refurbishment. The launch of the refreshed mental health hub was hosted by Acting Chief Nurse, Julie Kirby, and attended by the Mayor of Dover, Councillor Bekah Dawes. A huge thank you to: our estates team who led the refurbishment; our Charity for funding some beautiful art on the walls to make it welcoming for patients and staff; and to our Nursing and Quality team for making sure the space was safe and compliant.

Value in Practice Awards

We continue to receive lots of nominations for our trust Value in Practice Awards. Please see the appendix for the latest winners – a massive congratulations to you all. Please keep nominating, I know the difference this makes for our staff to be recognised for their hard work and dedication to the trust, our patients and the families.

Summary and Conclusion

It has been a busy period since we last met as a Board. We have had two assuring oversight meetings with NHSE South East where they have recognised the positive progress we are making, the grip we have over the areas where we need to improve, and our continued commitment to do this openly and transparently. This has set a strong foundation as we move into the autumn for us to continue to build on the good progress we have made. We must continue to be more curious and confident in our approach, and believe in our role as the experts for mental health care in our system.

Sheila Stenson

Chief Executive

24th September 2026

Executive Team Visits

Sheila Stenson:

Gregory House
East Kent Pharmacy Team
The Beacon, Ramsgate

Donna Hayward-Sussex

CYPMHS & AAEDS at Maidstone Hub (Community CYPMHS Teams, Neurodevelopmental, All Age Eating Disorder)
CYPMHS & AAEDS Community Services at Castleside
Mental Health Plus services at Coleman House
Community Services at Orchard House

Julie Kirby

TGU
CHBPOS
Female PICU, Littlestone Lodge
Coleman House opening
Ashford & Canterbury MHT and MHT+

Kindra Hyttner

Gregory House
Coleman house & Ash Eton

Value in Practice Awards

Directorate	June	July
North	Bosede Oladeji, Support Worker	Neema Mwemezi Community Mental Health Practitioner
East	Ruby Hook, Occupational Therapist	Ian Janes, Occupational Therapist
West	Laura Meyers, Administrator	Charlotte Carver, Clinical Manager
Forensic	Amber O'Neill, Nurse	Rosemary Nicholson, Administrator MHL D
Support services	Danielle Anderson, Recruitment Manager	Cathryn Twyman, Project Manager
Acute	Sabina Pieper, Art Therapist, Sevenscore Ward	Megan Coomber, Matron
Children & Young Persons and All Age Eating Disorders	Hayley Coffey, Senior Psychotherapist	Sara Lane, Medical Secretary, South Kent Coast

Trust Board meeting

Meeting details

Date of meeting:	24 September 2026
Title of paper:	Board Assurance Framework: Current Position and Transition to the New Framework
Author:	Louisa Mace, Risk Manager, supported by Andrew Hughes, ANHH
Executive Director:	Julie Kirby, Acting Chief Nurse

Purpose of paper

Purpose:	Assurance and Approval
Submission to Board:	Regulatory Requirement

Overview of paper

Part A reports the current Board Assurance Framework (BAF), updated on 9 September 2026, and the assurance it gives. Part B reports progress on the new framework since the Board Seminar on 6 August, including sessions with each committee in September.

The Board is asked to approve the current BAF as the interim framework, approve the design of the new framework, and approve the move to it from the October 2026 committee cycle. The recommendations are at Section 10.

Issues to bring to the Board's attention

The current BAF holds 14 risks, five extreme and nine outside tolerance. Culture (ID 08337) has risen from 9 to 16 and inpatient flow (ID 08065) remains highest at 20. Seven risks show no update this period and all 17 red actions are past their date with no revised date. The BAF provides limited assurance.

The Board is asked to decide on an eighth strategic risk on the new BAF framework for operational resilience, and to accept a Cautious appetite for financial risk as a departure from the Open position set at the Seminar on 6 August.

Governance

Implications/Impact:	Patient safety / Legal / Regulatory / Financial
Assurance:	Limited assurance (see Section 4)
Oversight:	Audit and Risk Committee

Board Assurance Framework

Current Position and Transition to the New Framework

1. Purpose and structure of this paper

This paper is in two parts. **Part A** reports the current Board Assurance Framework (BAF), updated on 9 September 2026, and the level of assurance it gives the Board. **Part B** reports progress on the new framework since the July Board, including the outcomes of the Board Seminar on 6 August and of the working sessions held with each committee chair and executive lead between 7 and 15 September. It sets out what the Board is asked to approve so that the new framework goes live in the October committee cycle.

The July paper set a timeline of a Board Seminar on 6 August, approval in September and embedding from October. This paper reports against that timeline. The BAF is Theme 6 of the Governance Improvement Programme, whose progress is reported separately on this agenda.

The recommendations are set out in full at Section 10.

Part A: The current Board Assurance Framework

2. The current risk profile

The BAF was updated on 9 September 2026. It holds the same 14 open risks reported in July. Five are rated extreme (a current score of 15 or above), seven are scored 12 and two are scored 9. Nine of the fourteen are recorded as outside tolerance, four as in tolerance and one as in appetite.

The number of extreme risks is unchanged at five, but the composition has changed. Organisational culture (ID 08337) has risen from 9 to 16 and cyber attack (ID 04673) has fallen from 15 to 12. Inpatient flow (ID 08065) remains the highest-rated risk at 20.

Summary of the current BAF risks

Risks are ordered by current (residual) score. Red shading shows an extreme score of 15 or above, amber a score of 12 and yellow a score of 9. Direction compares each score with the July report, because the trend column in the BAF itself is still blank.

ID	Risk	Executive lead	Now	Target	Target date	Appetite	Direction
08065	Inpatient flow	Chief Medical Officer	20	3	Mar 2027	Outside tolerance	Static
08157	Delivering the Community Mental Health Framework through Mental Health Together	Chief Operating Officer	16	6	Oct 2026	Outside tolerance	Static
02290	Delivery of safe, high-quality care	Chief Nurse	16	6	Mar 2027	Outside tolerance	Static
07960	Self-harm among female patients on acute wards	Chief Nurse	16	6	Sep 2026 (passed)	Outside tolerance	Static
08337	Organisational culture and delivery of strategic ambitions	Director of Strategy and Engagement	16	6	Mar 2027	In tolerance	Up from 9
00580	Meeting Memory Assessment Service demand	Director of Partnerships and Transformation	12	12	Dec 2026	In tolerance	At target

ID	Risk	Executive lead	Now	Target	Target date	Appetite	Direction
07891	Management of violence and aggression	Chief Nurse	12	6	Mar 2027	Outside tolerance	Static
04673	Cyber attack	Chief Finance and Resources Officer	12	9	Mar 2027	Outside tolerance	Down from 15
07557	Trust agency usage	Chief Medical Officer	12	9	Oct 2027	In appetite	Up from 9
08174	Delivery of financial targets	Chief Finance and Resources Officer	12	8	Mar 2026 (passed)	Outside tolerance	Static
08175	Delivery of underlying financial sustainability	Chief Finance and Resources Officer	12	6	Mar 2026 (passed)	Outside tolerance	Static
08480	Stakeholder confidence	Director of Communications and Engagement	12	9	Mar 2027	Outside tolerance	Static
08173	Delivery of a fit-for-purpose estate	Chief Finance and Resources Officer	9	6	Mar 2027	In tolerance	Static
08146	Maintenance of a sustainable estate	Chief Finance and Resources Officer	9	6	Apr 2027	In tolerance	Static

3. Movements and pressures this period

Organisational culture (ID 08337), increased from 9 to 16. Ownership has moved to the Director of Strategy and Engagement, and the description, controls and actions have been rewritten with the culture and staff experience leadership team. The score rose as a result of that review. Seven of the eight actions fall due in November or December 2026. The action on the Leading Well Together programme, due in May 2026, is red. Two actions appear to duplicate each other, a cultural transformation strategic plan and a Board-approved cultural transformation plan, both due on 26 November 2026 with different owners. The Board agreed on 6 August that this risk will be developed further at the October Board workshop.

Inpatient flow (ID 08065), static at 20. The number of patients clinically ready for discharge has improved to 56, of whom 48 were in Trust beds and 8 in Ticehurst as at 4 August. High admission rates mean occupancy has not fallen, with demand running at around ten more patients a day. The recovery houses action, recorded in July as blocked, now carries a date of December 2026 following ICB plans for a further recovery house in Thanet before winter. The early discharge action has moved to the end of September because the internal audit report arrived late. The target score of 3 by March 2027 has not been tested against these plans, and the most recent data in the update is six weeks old.

Community Mental Health Framework (ID 08157), static at 16. The Trust is seeing 77% of people within 18 weeks, and the risk owner will decide in September whether the score can reduce to 12. Formal consultation on the refined Mental Health Together model closes on 8 October, with a decision due by 31 October. The recorded target of 6 by 31 October 2026 would need a ten-point reduction in six weeks and should be reset.

Cyber attack (ID 04673), reduced from 15 to 12. The risk has been reassessed against the national and county risk assessments. The narrative describes a rating of likelihood 5 and impact 3, which does not match the scores recorded in the framework (current likelihood 3,

consequence 4, giving 12). The two need to be reconciled. The target of 9 is reached by reducing consequence.

Trust agency usage (ID 07557), increased from 9 to 12. The increase reflects recruitment needed for children and young people's services transferred from NELFT, and a recruitment strategy is now reflected in the actions. The target date of October 2027 falls beyond the latest date the Risk Management Process Standard Operating Procedure permits.

Memory Assessment Service demand (ID 00580), at its target of 12. The community model continues to roll out, with a level 2 pilot agreed for the neighbourhood site in Folkestone and Hythe. Two actions are red and past their dates (optimisation of the phase 1 model, due May 2026, and scoping the effect of the improved diagnosis rate, due April 2026), and two phase 2 actions are parked with no status. The Quality Committee noted on 15 September that the risk does not yet cover what happens after diagnosis. The Risk Manager is discussing with the risk owner whether to close this risk and open a new one.

Self-harm on female acute wards (ID 07960), static at 16. The target date of 12 September 2026 has passed with the risk ten points above its target of 6. Three of the five actions are red: the clinical risk forum terms of reference (due June), the self-harm formulation tool (due May) and information for patients and families (due July). The data analysis and CAPLET training actions are complete.

Risks with no update this period. Seven of the fourteen risks show no update on InPhase: violence and aggression (07891), safe, high-quality care (02290), both finance risks (08174 and 08175), stakeholder confidence (08480) and both estate risks (08173 and 08146).

4. Assurance offered by the current framework

What the framework does well

The framework remains a standing item at committees and at the Board, and its scoring is honest: nine of the fourteen risks are recorded outside tolerance, and the Trust is not lowering scores to appear within appetite. Some improvements have been made since July. The estate risk previously recorded as in appetite at a score of 9 (08146) has been corrected to in tolerance. The recovery houses action on the highest-rated risk now has a date. The culture risk has been fully reviewed. The Risk Manager has checked the whole framework line by line for this report.

What limits the assurance it gives

- **Currency.** Half of the risks carry no update this period, including the Trust's most inspected risk (02290, scored 16) and both finance risks.
- **Actions.** The framework carries 56 actions: 10 complete, 27 amber, 17 red and 2 parked with no status. All 17 red actions are past their target date and none carries a revised date. The number of red actions is the same as in July. Six actions across the two finance risks were due on 31 March 2026 and remain open.
- **Targets.** The two finance risks still carry target dates of 31 March 2026, which the July paper asked to be updated. The self-harm target date has passed. Two target dates (07557 and 08146) fall beyond the date the Standard Operating Procedure permits, and the targets for inpatient flow and community mental health sit below the values its Appendix C allows.

- **Evaluation.** The assurance column lists forums and reports and does not state the level of assurance obtained. The entry for safe, high-quality care (02290) still records actions in place of assurance, and stakeholder confidence (08480) records a single general line. Five of the fourteen risks refer to independent assurance, and none of the six risks on quality, safety and access does.
- **Missing fields.** Four fields that the Standard Operating Procedure makes mandatory, and that InPhase holds for every risk, are still not reported to the Board: adequacy of controls, gaps in control, gaps in assurance and risk mitigation indicator status. These are the fields that show where the Trust is not yet in control and where it does not yet know.
- **Appetite.** The framework does not record which appetite category each risk is aligned to, so the appetite verdicts cannot be checked from the document. Three risks scored 12 carry three different verdicts (in appetite, in tolerance and outside tolerance). The verdicts reflect the positions recorded on InPhase; the appetite positions set on 6 August will be applied when committees score causes in October.
- **Strategic alignment.** The framework is still structured under the 2023 to 2026 objectives. It holds no workforce risk, no partnership risk and no digital risk other than cyber attack.

Level of assurance

Using the Trust's four-point scale of substantial, reasonable, limited and no assurance, **the current BAF provides limited assurance.** The July paper described the position as limited to moderate. The evidence above does not support a grade of reasonable, which the Risk Management Framework sets as the lowest level the Trust will tolerate.

This judgement concerns the framework and the reliability of the information it gives the Board. Where narrative updates have been made, they show active management of the major risks. The work needed to close the gaps is not lost at transition: each current risk becomes a scored cause in the new framework, and its controls, assurances and actions carry across.

Risk owners will therefore complete the following before the October committee meetings:

1. update the seven risks that show no update this period;
2. give every red action a revised date, or close it with a record of why;
3. rebaseline the target dates that have passed or that fall outside the permitted period; and
4. reconcile the cyber attack narrative with its recorded scores.

Part B: Transition to the new framework

5. Progress against the timeline

The table sets the timeline approved in July against the position now.

Milestone	Planned in July	Position at September
Board Seminar	6 August: test the seven risks and confirm risk appetite	Held. Outcomes at Section 6.
Committee chairs and executive leads agree their risks	July to August	Held in September: Finance, Business and Investment (7 September), Partnership (14 September), Quality (15 September), Audit and Risk (15 September) and People (15 September). Outcomes at Section 7.
Board approval	September	This meeting.
Go-live and embedding	October onwards	Proposed from the October committee cycle. Plan at Section 9.

The overall timeline holds. One design question needs a Board decision (Section 7.2), and the culture risk (SR6) will be completed after the October Board workshop, as the Board agreed on 6 August.

6. What the Board Seminar concluded

The Board tested the seven strategic risks and set its risk appetite and maturity targets. Its conclusions were:

- **Risk statements.** SR1 should capture timely access and a positive experience for patients and staff. SR2 should be restated as maintaining financial sustainability, with value for money and productivity treated separately. SR3 should reflect the opportunity for innovation and the trade-offs involved. SR5 should reflect the need to recruit the right people. Governance should be removed from SR6, which sits with the People Committee alone. SR7 should consider collaboration across the system as well as the Trust's own part, with health inequalities and their determinants placed under it.
- **Risk appetite.** All five appetite domains were set at Open, with a comply or explain approach for Patients. All level 2 categories remain Open except Counter Fraud (Averse) and Information Security (Cautious). Each committee is to say whether its risks depart from Open, with the Audit and Risk Committee holding the overview.
- **Maturity targets for September.** Developing for SR1, SR2, SR4, SR5 and SR7. Emerging for SR3, which was not agreed and was referred to the Finance, Business and Investment Committee. SR6 to be set after the October workshop.
- **Scoring.** Committees review scores and the Board signs them off.
- **Medium Term Financial Plan.** The effects of out of area beds, inpatient nursing, the Agenda for Change Band 5 evaluation and sickness absence are to be reflected in the BAF.

7. What the committee sessions concluded

Each session brought together the committee chair, the Acting Chief Nurse, the Chief Finance and Resources Officer, the executive lead (if not one of the two mentioned), the Risk Manager

and external support. Each tested the risk statement, the causes, the appetite and the maturity target for the committee's own risks. The Audit and Risk Committee session considered that committee's oversight role and the audit trail from the current framework to the new one.

7.1 Revised strategic risk statements

Each statement is fixed for the life of the framework. The causes beneath it change as pressures change. Wording shown in bold italics is proposed drafting that follows the committee discussion and has not previously been seen by the board.

Ref	Proposed risk statement	Owning committee	Change and reason
SR1	There is a risk that the Trust will not consistently <i>provide timely access to</i> safe, high-quality and compassionate care.	Quality	Timely access added, as the Board asked on 6 August. Experience is captured in the causes and effects.
SR2	There is a risk that the Trust will not maintain financial sustainability.	Finance, Business and Investment	Value for money removed. The committee noted that value for money is assessed through the external audit report received by the Audit and Risk Committee.
SR3	If an eighth risk is created: There is a risk that the Trust will not <i>develop and use digital systems, data and technology to improve care and productivity.</i> If not: There is a risk that the Trust will not maintain secure, resilient and interoperable digital systems <i>and use them to improve care and productivity.</i>	Finance, Business and Investment	Reflects the innovation opportunity the Board asked for. Final wording depends on the decision at Section 7.2.
SR4	There is a risk that the Trust will not maintain a safe, therapeutic and fit-for-purpose estate.	Finance, Business and Investment	No change. Causes revised (Section 7.5).
SR5	There is a risk that the Trust will not attract, recruit, retain and develop <i>the right people to sustain its workforce.</i>	People	Reflects the Board's request to focus on recruiting the right people.
SR6	There is a risk that the Trust will not develop <i>the leadership and organisational culture needed to deliver its strategy.</i>	People	Governance removed. Interim wording, to be completed after the October Board workshop.
SR7	There is a risk that the Trust will not work effectively <i>as a partner to deliver integrated care and reduce health inequalities.</i>	Partnership (shadow from October)	Moves from system collaboration to the Trust as a partner, which the committee felt was clearer and more accurate. Health inequalities placed here, as the Board asked.
SR8	Subject to decision: There is a risk that the Trust will not <i>maintain operational resilience against disruption, including cyber attack, loss of critical systems and failures of information governance.</i>	Audit and Risk	See Section 7.2.

7.2 Decision required: an eighth strategic risk for operational resilience

At the Finance, Business and Investment Committee session, members questioned whether cyber security belongs inside the digital risk. Three reasons were given. First, oversight of cyber security, business continuity and emergency preparedness, and information governance and data protection sits with the Audit and Risk Committee under current arrangements, so the Finance, Business and Investment Committee cannot take assurance on it. Second, the Board set a Cautious appetite for information security on 6 August and an Open appetite for digital development, which would place two appetite positions inside one risk. Third, members with experience elsewhere observed that discussion of cyber risk tends to crowd out discussion of digital opportunity when the two share an agenda item.

The Chair of the Audit and Risk Committee took a different initial view on 15 September. Cyber, artificial intelligence, digital and data are closely connected, and the case for separating them needs to be made. The Chair asked that the question be put to the Board with the rationale, and will offer a view as Chair once the rationale has been seen. The Finance, Business and Investment Committee will also discuss the question on 22 September, and a verbal update will be given at this meeting.

	Option A: retain seven risks	Option B: create an eighth risk
Design	Cyber, business continuity and information governance remain causes under SR3.	SR8 covers operational resilience, owned by the Audit and Risk Committee. SR3 covers digital development, owned by the Finance, Business and Investment Committee.
For	Keeps the discipline of seven risks. Keeps cyber and digital in one conversation, reflecting how closely they are connected.	Matches where oversight already sits. Gives each risk one appetite position. Lets the digital risk focus on opportunity, as the Board asked.
Against	One risk carries two appetite positions and is split across two committees for assurance.	The Audit and Risk Committee would own one risk while overseeing the whole framework. This can be managed by the committee reporting its assurance on SR8 directly to the Board, and by internal audit testing SR8 independently.

The executive sponsor recommends Option B. The deciding factors are that appetite is set at risk level, and that a risk should be owned by the committee that already oversees its causes.

7.3 Risk appetite

On 6 August the Board set all domains at Open and asked each committee to say whether its risks depart from that position. The committees have now done so. One departure is proposed.

Risk	Proposed appetite	Committee view
SR1	Open	Quality Committee confirmed Open. Options will be considered through a clinical lens that includes professional judgement, regulatory standing and legal duties, which reflects how clinical decisions are already made.
SR2	Cautious (departure from Open)	Finance, Business and Investment Committee proposes Cautious for financial risk. Limited financial impact is accepted where there is a benefit for patient care, but material unplanned overspends are not. Small investments to test an opportunity remain possible within this position. The committee noted that a Cautious financial appetite acts as a check on the Open appetite for estate and digital.
SR3	Open	Open for digital development. Information Security remains Cautious, and sits under SR8 if the Board chooses Option B.
SR4	Open	Open, with the committee noting that large investment in estate the Trust owns calls for a more careful approach than leased estate.
SR5	Open	People Committee confirmed Open, moving from the previous Seek. The committee noted that decisions in practice are often more cautious than this, and that work is needed for the Trust to operate at Open.
SR6	To be confirmed	After the October Board workshop.
SR7	Open	Partnership Committee confirmed Open for an initial period while the committee establishes how it will work. The Board also agreed a review of the level 2 categories under Partners.
SR8	Cautious	Subject to the decision at Section 7.2. Reflects the Information Security position set on 6 August.

7.4 Risk maturity targets

Risk	Set on 6 August	Committee view
SR1	2 Developing	2 Developing, with an aim of reaching 3 Established. The committee chair would not set Established without evidence of control effectiveness, which has not yet been presented.
SR2	2 Developing	3 Established proposed.
SR3	1 Emerging (not agreed)	3 Established proposed. Members described the management of digital risk as between Developing and Established, with known gaps in third-party management and interoperability.
SR4	2 Developing	2 Developing.
SR5	2 Developing	2 Developing.
SR6	To be confirmed	After the October Board workshop.
SR7	2 Developing	The working group discussed 1 Emerging because it has not yet met. To be confirmed.

The committees applied different tests. The Quality Committee declined to set Established without evidence, while the Finance, Business and Investment Committee raised SR2 to match SR3. At Developing, risk, cause and effect are separated and controls are described but not yet assessed. Established requires control effectiveness to be assessed, and the new framework will first do that in the October committee cycle. No strategic risk can therefore evidence Established in September.

To keep the ambition and the scale meaningful, it is proposed that all risks are recorded at Developing for September, that Established is recorded as the target for SR1, SR2 and SR3 at the March 2027 reassessment, and that the Audit and Risk Committee applies a single evidence test to every risk at that point.

7.5 Changes to causes

The draft framework reviewed by the BAF Revival Group held 63 causes under the seven risks, 19 of them under SR1. The committee sessions agreed the following changes, which will be made before the October committee meetings. This table is the audit trail of how the draft has changed.

Risk	Changes agreed
SR1	Add causes on access to children and young people's services and to all-age eating disorder services, held by the Children and Young People's Committee until it stands down. Make the out of area placements cause cover children and adults. Narrow the cause on under-identification of autistic people to people accessing or referred to Trust services. Take in matters previously held by the Mental Health Act Committee as it is disbanded. The temporary staffing provider cause is expected to close once new arrangements are contracted.
SR2	Widen the agency cause to temporary staffing, covering bank and agency. Replace the cause on variation in demand with out of area placements, where the financial effect of that demand appears. Consider a cause on the financial position of the wider system and its investment in mental health. Keep the underlying and medium-term position as a distinct cause.
SR3	Depends on the decision at Section 7.2. If Option B is chosen, cyber, business continuity and information governance move to SR8, and SR3 causes are redrafted around digital capability, data and innovation.
SR4	Reword the ligature cause as environmental safety in inpatient areas, covering fixed and non-fixed ligature risks, with ligature named explicitly. Add causes on the location of services for neighbourhood working and on tenure (owned or leased). Add the Green Plan and environmental sustainability. Review the causes when the draft estates plan reaches the committee this month.

Risk	Changes agreed
SR5	Clarify the cause on competition for staff as competition from other providers, including pay differences across the county boundary, and keep it at a low score while evidence is gathered. Reframe the cause on inclusive working environments as the Trust being a good employer, covering equality, diversity and inclusion and the national workforce equality standards, leaving values and psychological safety to SR6. Add a cause on the absence of a strategic workforce plan. Keep clinical staffing and children and young people's medical staffing as separate causes for now.
SR6	To be developed after the October Board workshop.
SR7	Keep the cause on dependencies following the transfer of services from NELFT, including digital systems and inquests, as a time-limited cause. Consider the Trust's role in the forensic provider collaborative. The question of whether the Trust's commissioning role needs its own risk or a separate commissioning view remains open.

Three principles were confirmed across the sessions. Causes move on and off the framework as pressures change. A cause number is never reused once a cause is removed, so the audit trail is preserved. Causes are listed separately so that a committee can see which specific issue needs attention, even where several relate to the same theme.

7.6 How the new framework will operate

The BAF is the unitary Board's document. The sessions confirmed the following arrangements.

- **Roles.** Executive leads shape each risk, its causes and scores. The owning committee tests them and makes a recommendation. The Board takes the decision and signs off the scores.
- **What each forum receives.** Each committee receives only the strategic risks it owns. The Audit and Risk Committee and the Board receive the whole framework.
- **Reporting to the Board.** Each owning committee reports to the Board through a short assurance statement on each of its risks, giving the level of assurance on the Trust's four-point scale, the causes that have moved, the gaps in control and assurance, and what the committee has required.
- **Audit and Risk Committee.** Beyond any risk it owns, the committee reviews how the framework is working across all committees. It looks for inconsistency, for causes that span committees and may fall between them (for example health inequalities, out of area placements, violence and aggression, and workforce), and for emerging issues to refer to the right committee.
- **Committee business.** Committee work plans and agendas are built around the causes. Each paper states which cause it addresses, and a paper that relates to no cause should prompt a question about whether the causes are right.
- **Committee questions.** Committee chairs will use a common set of questions: is this control working, and what is the evidence; what has changed since the last meeting; and what would it take to bring this cause within appetite.
- **Accountability.** Each strategic risk has an accountable executive owner. Each cause has a named lead who is responsible for delivery and for the evidence that controls are working.
- **Single source of data.** InPhase remains the single record. The Risk Manager is linking each InPhase risk to the cause it sits under.

8. Transition from the current framework

The Chair of the Audit and Risk Committee asked for a clear trail from the current framework to the new one. The table shows where each current risk will sit. No current risk is lost: each becomes a scored cause, and the operational detail stays on the Trust and directorate risk registers.

Mapping to be confirmed against InPhase by the Risk Manager before the October committee meetings.

ID	Current risk	New risk	Position in the new framework
08065	Inpatient flow	SR1	Cause on patient flow. Its financial effect appears under the SR2 out of area placements cause.
08157	Community Mental Health Framework	SR1	Cause on timely access to community services.
02290	Delivery of safe, high-quality care	SR1	Absorbed into the strategic risk itself. Its components become causes.
07960	Self-harm on female acute wards	SR1	Cause on self-harm, with environmental ligature risk under SR4.
07891	Violence and aggression	SR1	Cause under SR1, with its effect on staff noted under SR5.
00580	Memory Assessment Service demand	SR1	Cause on access, subject to the review of what follows diagnosis.
08337	Organisational culture	SR6	Cause under SR6, to be developed at the October Board workshop.
07557	Trust agency usage	SR5 and SR2	Temporary staffing cause under SR5 for supply, and under SR2 for cost.
04673	Cyber attack	SR8 or SR3	Depends on the decision at Section 7.2.
08174	Delivery of financial targets	SR2	Cause on the in-year financial position.
08175	Underlying financial sustainability	SR2	Cause on the underlying and medium-term position.
08480	Stakeholder confidence	SR7	Cause on external scrutiny. Reputational effects are recorded across each strategic risk.
08173	Fit-for-purpose estate	SR4	Cause on investment in the estate.
08146	Sustainable estate	SR4	Cause on a safe and compliant estate.

The current framework remains in force until the Board receives the first full framework in the new format. After that, the current spreadsheet extract is retired.

The Risk Management Framework, the Non-Clinical Risk Management Policy and the Risk Management Process Standard Operating Procedure all define the BAF as a subset of the risk register. They need to change to reflect the new model, and the scoring conventions need to be settled before causes are scored. So that October committees score on a consistent basis, the Risk Manager and external support will issue a single written scoring guide ahead of the October meetings. The revised documents, with the refreshed risk appetite statement, will go to the Audit and Risk Committee in December.

9. Go-live plan and risks to delivery

Go-live plan

1. **Before the October committee meetings.** Each committee receives its strategic risks in the new format, with the scoring guide and the common question set. Risk owners complete the updates listed in Section 4.
2. **October committee meetings.** Each committee confirms its causes, scores them, confirms any departure from Open appetite at level 2, records controls, assurances and gaps, and agrees its first assurance statement. The same support attends every meeting so that the approach is consistent.
3. **October Board workshop.** The Board develops SR6 and sets its appetite and maturity target.
4. **November Board.** The Board receives the first full framework in the new format, with committee assurance statements.
5. **December Audit and Risk Committee.** First review of how the framework is working across committees.
6. **March 2027.** Maturity reassessed against a single evidence test, ahead of the annual appetite review.

The Audit and Risk Committee meets quarterly, so it will not review the new framework before the November Board. The Chief Finance and Resources Officer raised whether that rhythm is right during launch, and whether the committee may need to meet more often while the Trust responds to the CQC report. The committee chair has noted the question for further discussion.

Risks to delivery

- **Capacity and continuity.** External support is close to the end of its contracted time. The framework has depended heavily on the Risk Manager, which the Quality Committee described as a single point of success/failure. The October cycle needs named support in each committee's secretariat. It is proposed this is the exec lead.
- **Consistency.** Five committees adopting the framework at once could develop different practices, a concern the People Committee chair raised. The written scoring guide, the common question set, consistent support at October meetings and the Audit and Risk Committee's oversight are the controls.
- **Volume.** Around 70 causes, each with several controls, is a large amount of material. The risk is that committees describe activity instead of judging whether controls work. Committees will need to remove causes and controls that no longer apply.
- **New and temporary committees.** The Partnership Committee has not yet met, and its causes are expected to change substantially in the first six months. The Children and Young People's Committee holds some causes only until it stands down.
- **Competing demands.** The launch coincides with the response to the CQC report, the integration of transferred services and the restructuring of committees, which draw on the same executive and non-executive time.

How the Board will know the new framework is working

At the July Board, members asked what would show that the new framework is more than a rewording. By March 2027 the Board should expect to see:

- an assurance statement from each owning committee at each Board meeting, with an assurance grade for each strategic risk;
- every committee agenda item linked to a named cause;
- every action within its date or formally re-dated, and no red action without a revised date;
- an explanation for every change in score;
- independent assurance identified for every strategic risk, with the 2027/28 internal audit plan aligned to the framework;
- decisions recorded as arising from the framework, such as investment, escalation to partners or a commissioned deep dive; and
- maturity reassessed against a single evidence test.

10. Recommendations

The Board is asked to:

1. **RECEIVE** the current Board Assurance Framework as at 9 September 2026 and note the risk profile: 14 risks, five rated extreme and nine outside tolerance, with organisational culture increased to 16 and inpatient flow the highest-rated risk at 20.
2. **NOTE** that the current framework provides limited assurance, and **REQUIRE** risk owners to complete the updates set out in Section 4 before the October committee meetings.
3. **APPROVE** the current framework as the Trust's interim Board Assurance Framework until the Board receives the first full framework in the new format.
4. **APPROVE** the strategic risk statements at Section 7.1, noting that SR6 will be completed after the October Board workshop and that SR7 will be refined while the Partnership Committee operates in shadow form.
5. **DECIDE** whether to create an eighth strategic risk for operational resilience owned by the Audit and Risk Committee (Option B, recommended) or to retain seven strategic risks (Option A).
6. **APPROVE** the risk appetite positions at Section 7.3, including the Cautious appetite for financial risk proposed by the Finance, Business and Investment Committee.
7. **APPROVE** the maturity targets at Section 7.4, with all risks recorded at Developing for September and Established as the March 2027 target for SR1, SR2 and SR3.
8. **APPROVE** the move to the new framework from the October 2026 committee cycle, on the operating arrangements at Section 7.6 and the transition set out at Section 8.
9. **NOTE** the risks to delivery and the measures the Board will use to judge whether the new framework is working.

Trust Board meeting

Meeting details

Date of meeting:	24 th September 2026
Title of paper:	Governance Improvement Programme
Author:	Tony Saroy, Trust Secretary
Executive Director:	Sheila Stenson, Chief Executive

Purpose of paper

Purpose:	Discussion
Submission to Board:	Board requested

Overview of paper

A paper setting out an update on the Governance Improvement Programme.

Issues to bring to the Board's attention

The programme is assessed as Amber-Green overall. Five of the six programme themes are on track, with the 'Assurance, Escalation and Information Flow' theme requiring targeted recovery action.

Since the programme was established in May 2026, key governance changes include the refreshed Board Assurance Framework, revised committee arrangements, clarification of Non-Executive Director responsibilities within Terms of Reference and incorporation of programme reporting into the Board forward plan.

Early impact includes stronger alignment between Doing Well Together 2026-2031, strategic risks and Board assurance; clearer committee accountability; and a more structured basis for Board and committee oversight.

The principal programme risk is the pace and coherence of the Assurance, Escalation and Information Flow theme. Delivery is interdependent with the revised Integrated Quality and Performance Report (IQPR) and Strategy Deployment Review (SDR) arrangements.

The next phase will focus on formal approval, implementation, routine use and evidence of impact, rather than completion of governance documents alone.

The appended delivery report (*71.1 in reading room*) sets out the detailed status, ownership, due dates, commentary and evidence for all programme deliverables.

Governance	
Implications/Impact:	Legal, regulatory and organisational effectiveness impact
Assurance:	Reasonable assurance on programme direction and governance, with limited assurance on delivery of the Assurance, Escalation and Information Flow theme until recovery actions and implementation evidence are confirmed.
Oversight:	Trust Board

1. Introduction

The Governance Improvement Programme was established following external review findings (commissioned independently by the trust late last calendar year) and wider organisational feedback about the complexity, duplication and clarity of the Trust's governance arrangements. The programme is intended to simplify governance, clarify accountability and delegation, strengthen escalation and information flow, improve the Board Assurance Framework and embed consistent governance discipline and behaviours.

This report provides the first formal progress and assurance update to the Board. The detailed Output Delivery Report (which is appended to this report) records the position as at 7th September 2026. It reports progress against 70 output measures across six programme themes, identifies supporting evidence and highlights matters requiring further action. Future updates will be aligned to the Board's meeting cadence and will distinguish clearly between completion of outputs, implementation and demonstrated impact.

2. Overall programme assurance

The programme is assessed as Amber-Green overall. Five of the six programme themes are on track. The remaining theme, Assurance, Escalation and Information Flow, is at risk because key escalation, triangulation and reporting arrangements are not yet implemented. This risk requires active management but does not outweigh the progress and control evident across the wider programme.

The programme has moved beyond initial planning and is producing revised governance arrangements, Terms of Reference, workplans, reporting materials and a strengthened Board Assurance Framework. Reasonable assurance can be taken that the programme has clear executive oversight and a defined delivery framework. Limited assurance remains in relation to the Assurance, Escalation and Information Flow theme until revised arrangements are implemented, routinely used and shown to operate as intended. Early impact includes clearer alignment between strategy, risk and assurance, more explicit committee accountabilities and a more structured basis for Board oversight.

3. Progress since the previous update

The most significant progress is within the Board Assurance Framework programme theme. The new BAF format, revised strategic risks, alignment to Doing Well Together 2026-2031 and revised risk articulations are reported as complete following the Board workshop on 6th August 2026. Work continues with Committee Chairs and Executive Leads on controls, mitigating actions, assurance narratives and assurance gaps. This work has strengthened the connection between strategic objectives, principal risks and the assurance required by the Board.

The Governance Structure and Committee Documentation programme themes are also progressing. Revised Quality Committee arrangements incorporate the transfer of Mental Health Act Committee responsibilities, while the Partnership Committee Terms of Reference and draft workplan remain under active review. The action to clarify Non-Executive Director roles and responsibilities within Terms of Reference has been completed, providing greater clarity about committee accountability and contribution.

Supporting governance materials are being standardised and strengthened. A revised committee workplan, branded committee cover sheet and agenda guidance have been drafted to improve consistency and the quality of information presented to committees. A structured Governance Improvement Programme reporting schedule has also been incorporated into the

Board forward plan. These materials now require approval, testing and consistent use so that their impact can be evidenced.

4. Principal risks and dependencies

The principal risk remains within the Assurance, Escalation and Information Flow programme theme. The escalation pathway map, communication of escalation routes to operational leaders and formal testing using real examples have not started. The design of triangulated reporting also remains incomplete and requires confirmed ownership, decision-making routes and implementation milestones.

Delivery of this programme theme is interdependent with the revised Integrated Quality and Performance Report (IQPR), which is intended to provide a clearer focus on strategy, quality, performance and assurance, and with the associated Strategy Deployment Review reporting arrangements. Delay to the IQPR milestone has consequential impact on the redesign and implementation of SDR packs. A single recovery plan will bring these linked actions together, confirm executive and delivery ownership, set revised milestones and provide a phased route through design, approval, implementation and testing. Progress will be monitored through the programme delivery report and escalated through the Chief Executive's oversight arrangements.

Across the wider programme, the central delivery challenge is the transition from drafting and agreement to implementation, embedding, and routine use. Several actions are currently on track because governance materials are being developed, while evidence of formal approval, adoption, consistent application and effectiveness remains outstanding. Future reporting will therefore distinguish between output completion, implementation and outcome or impact, using the planned Watch and Outcome tiers.

5. Next phase

- Agree, implement and monitor a recovery plan for the Assurance, Escalation and Information Flow programme theme, including the linked IQPR and SDR dependencies.
- Complete the approval and implementation of revised committee Terms of Reference, workplans and governance materials.
- Complete the delegation and escalation model and progress the Scheme of Delegation once the committee architecture is confirmed.
- Embed the BAF within Board and committee workplans and complete the review of controls, assurances and gaps.
- Introduce the Watch and Outcome tiers so that reporting demonstrates impact and sustained embedding, as well as output completion.

6. Governance and oversight

The programme remains under Chief Executive's oversight, with delivery coordinated by the Trust Secretary and led through the named executive and corporate leads. Detailed progress will continue to be monitored through the programme delivery report. Matters requiring changes to committee responsibilities, Terms of Reference, the Scheme of Delegation or constitutional documents will follow the appropriate committee and Board approval route.

7. Conclusion

The programme has made good progress in establishing the foundations for more effective governance and is moving from design into implementation. Progress is evident in the strengthened Board Assurance Framework, clearer committee arrangements and accountability, and more structured governance reporting.

The overall Amber-Green assessment reflects delivery across five programme themes while recognising the continuing risk within Assurance, Escalation and Information Flow. The immediate priority is to recover this theme and ensure that revised governance arrangements are approved, implemented, routinely used and demonstrably improving the quality of assurance and decision-making available to the Board.



Kent and Medway
Mental Health
NHS Trust



Kent and Medway Mental Health NHS Trust

Governance Improvement Programme

Reporting period	Prepared for	Prepared by	Programme RAG
Q2	Trust Board	Trust Secretariat	Amber-Green

How to use this report

What this tracks. This report covers only the Output (‘Delivered’) metrics, the first column of the Metrics Framework: the deliverables produced, meetings held and documents agreed. It confirms the work is done. The Watch (Impact) and Outcome (Embedded) tiers are added once initial delivery is complete.

Status rating logic

Complete	Deliverable produced, agreed or in use exactly as specified, with objective evidence recorded.
On track	Underway (or a start is scheduled) and on programme to deliver by its due date. The healthy in-progress state: not yet done, but no concern.
At risk	Underway but delivery by the due date is in doubt: slippage is emerging or a risk needs active management. Early flag.
Off track	Has missed, or will miss, its due date, or is blocked. Triggers the framework escalation route, meaning that the named lead owns a recovery plan.
Not started	Not yet begun and not yet due. A neutral baseline, not an alarm: commentary notes scheduled start.

Completed weekly. Set each deliverable’s Status, add a one-line Commentary (progress, blocker or next step), and cite objective Evidence on completion (minute, register entry, dispatch record). Keep to evidence the Trust already holds. Anything Off track is reported to the relevant committee chair and the named executive lead.

Programme summary

Roll-up across the six themes. Set a theme status from the deliverable detail on the pages that follow.

#	Theme	Output deliverables	Theme status	Lead
1	Governance Structure	9	On track	Trust Secretary
2	Terms of Reference and Delegation	13	On track	Trust Secretary
3	Assurance, Escalation and Information Flow	16	At risk	CNO / CFO
4	Governance Discipline and Capability	13	On track	Trust Secretary
5	Board Oversight and Continuous Improvement	6	On track	Trust Sec / Chair
6	Board Assurance Framework (BAF)	13	On track	CNO
	Total	70		

Complete

On track

At risk

Off track

Not started

1

Governance Structure

Theme 1 of 6 · Output ('Delivered') metrics

The architecture of the Trust’s committees and forums: their number, purpose and design.

Deliverable (output)	Owner	Due	Status
End-to-end governance map produced and agreed by Board	Trust Secretary	Jul 26	On track
Executive leads engaged and signed off the structure review	CEO / Trust Sec	Jul 26	On track
All sub-committees reviewed against their stated purpose	Trust Secretary	Aug 26	On track
Forums for closure / merger / redesign agreed with Executive	Trust Secretary	Aug 26	On track
Revised EQIA ToRs, process and forms agreed	Trust Sec / CMO / CNO	Sep 26	On track
EQIA embedded in new structure with clear assurance route	Trust Secretary	Oct 26	On track
Baseline equality data published; proportionate approach agreed	CMO / CNO	—	On track
Sub-Board meeting map produced (purpose + assurance route)	Trust Secretary	Aug 26	On track
Decision log agreed: meetings retained / redesigned / closed	Trust Secretary	Sep 26	Not started

2

Terms of Reference and Delegation (1 of 2)

Theme 2 of 6 · Output ('Delivered') metrics

Who has authority to decide what, and how that authority is documented and understood.

Deliverable (output)	Owner	Due	Status
Gap analysis of ToRs vs actual practice — all committees	Trust Secretary	Aug 26	On track
Revised ToRs drafted, agreed and ratified by Board	Board / Trust Sec	Sep 26	On track
Revised Executive attendee matrix agreed by CEO and Chair	CEO / Chair	Aug 26	On Track
Attendee changes implemented ahead of NED recruitment	Trust Secretary	Sep 26	Complete
Delegation and escalation model documented and agreed by CEO	CEO	—	Not started
Delegation model ratified by Trust Board	Board	—	Not started
Review of lead provider governance structure	CFO / Trust Sec	—	On track

Complete

On track

At risk

Off track

Not started

2

Terms of Reference and Delegation (2 of 2)

Theme 2 of 6 · Output ('Delivered') metrics

Who has authority to decide what, and how that authority is documented and understood.

Deliverable (output)	Owner	Due	Status
Time-bound governance set for each transitional programme	Exec lead	—	Not started
Exit criteria agreed, published and assigned to a named lead	Exec lead	—	Not started
Legacy forums formally closed or ToRs formally amended	Trust Secretary	Oct 26	On track
Forum closures / ToR changes endorsed by ARC	ARC	Oct 26	On track
Scheme of delegation reviewed, updated and published	CFO	—	Not started
Secretariat maintenance process for the scheme established	Trust Secretary	Oct 26	Not started

Complete

On track

At risk

Off track

Not started

3

Assurance, Escalation and Information Flow (1 of 2)

Theme 3 of 6 · Output ('Delivered') metrics

Whether escalation routes work in practice, and whether data genuinely informs decisions.

Deliverable (output)	Owner	Due	Status
Escalation pathway map produced, agreed by CNO, integrated	CNO	—	Not started
Escalation map shared with operational leaders and forums	CNO	—	Not started
Formal escalation test completed using real examples	CNO	—	Not started
Escalation-test gaps documented; remediation assigned	CNO	—	Not started
BI team remit realigned to decisions, assurance, data quality	CFO	—	Not started
Revised BI strategy agreed by CFO	CFO	—	On Track
Triangulated dashboard and report templates produced	CFO / CNO / CPO	—	Not started
Quality & People Committees receiving triangulated reports	CFO / CNO / CPO	—	Not started

Complete

On track

At risk

Off track

Not started

3

Assurance, Escalation and Information Flow (2 of 2)

Theme 3 of 6 · Output ('Delivered') metrics

Whether escalation routes work in practice, and whether data genuinely informs decisions.

Deliverable (output)	Owner	Due	Status
New IQPR format agreed by CEO	CEO	Sep 26	At Risk
New IQPR in use at July Board	CFO	Sep 26	At Risk
New SDR pack format agreed by Dir. Transformation & Perf.	DofTP	Sep 26	Not started
New SDR format in use across all divisions and services	DofTP	Sep 26	Not started
New Quality Digest format agreed; to July Quality Committee	CNO	Jul 26	Complete
Quality Digest triangulated from multiple sources at launch	CNO	—	Complete
Minimum reporting standards issued to all Executives	Trust Secretary	Oct 26	On track
Secretariat monitoring process for report standards set	Trust Secretary	Oct 26	Not started

Complete

On track

At risk

Off track

Not started

4

Governance Discipline and Capability (1 of 2)

Theme 4 of 6 · Output ('Delivered') metrics

Whether the people who operate the framework have the right tools, roles and habits.

Deliverable (output)	Owner	Due	Status
Expectations document for chairs / members / attendees shared	Trust Secretary	Sep 26	On track
Chairs, members and attendees acknowledged receipt	Trust Secretary	Jun 26	Not started
Revised sub-committee Board-update template agreed	Trust Secretary	Sep 26	On track
New Board-update template in use	Trust Secretary	Sep 26	At Risk
Revised Board / sub-committee front sheets in use	Trust Secretary	Sep 26	On track
Insight-driven report-writing training designed; cohort 1 run	Trust Secretary	Sep 26	On track
Ongoing training schedule for new report authors established	Trust Secretary	Nov 26	Not started

Complete

On track

At risk

Off track

Not started

4

Governance Discipline and Capability (2 of 2)

Theme 4 of 6 · Output ('Delivered') metrics

Whether the people who operate the framework have the right tools, roles and habits.

Deliverable (output)	Owner	Due	Status
Standard committee workplan template agreed	Trust Secretary	Aug 26	On track
All committees operating against refreshed workplans	Committee Chairs	Sep 26	Not started
Agenda protocols agreed with chairs and Executive leads	Trust Sec / Chairs	Nov 26	On track
Maximum agenda-item guidance agreed and published	Trust Secretary	Nov 26	Not started
Governance-behaviours presentation delivered to TLT	Trust Secretary	—	Not started
Cascade plan agreed and delivered via the leaders' event	Trust Secretary	—	Not started

Complete

On track

At risk

Off track

Not started

5

Board Oversight and Continuous Improvement

Theme 5 of 6 · Output ('Delivered') metrics

Whether the Board holds itself to account and makes improvement self-sustaining.

Deliverable (output)	Owner	Due	Status
First governance improvement update to September Board	Trust Secretary	Sep 26	On track
Quarterly reporting cycle embedded in Board forward plan	Trust Secretary	Sep 26	Complete
Well-Led self-assessment approach agreed and ratified by Board	Chair / CEO	—	Not started
Annual review cycle of structures and ToRs ratified by Board	Board	Sep 26	On track
Annual review cycle embedded in forward plans	Trust Secretary	Sep 26	On track

Complete

On track

At risk

Off track

Not started

6

Board Assurance Framework (BAF) (1 of 2)

Theme 6 of 6 · Output ('Delivered') metrics

Whether the BAF has become the living connective tissue of the Trust’s risk oversight.

Deliverable (output)	Owner	Due	Status
New BAF format agreed and signed off by Board	CNO	Sep 26	Complete
Revised BAF strategic risks agreed and presented	CNO	Sep 26	Complete
BAF risks aligned to five-year strategy milestones	CNO	Sep 26	Complete
Risk articulations revised for all BAF risks	CNO	Sep 26	Complete
Standard risk-articulation template adopted across all risks	CNO	Oct 26	On track
Controls and mitigating actions reviewed for all BAF risks	CNO	Sep 26	On track
Assurance narrative revised for all BAF risks	CNO / Execs	Oct 26	On track

Complete

On track

At risk

Off track

Not started

6

Board Assurance Framework (BAF) (2 of 2)

Theme 6 of 6 · Output ('Delivered') metrics

Whether the BAF has become the living connective tissue of the Trust’s risk oversight.

Deliverable (output)	Owner	Due	Status
Assurance gaps explicitly identified and tracked per risk	CNO / Execs	—	On track
Committee-to-BAF mapping completed	Trust Secretary	Sep 26	On track
Each BAF risk assigned a primary assurance committee	Trust Secretary	Sep 26	Complete
BAF established as standing item at Board and sub-committees	Trust Secretary	Sep 26	On track
Revised risk register format agreed and implemented	CNO / Trust Sec	Oct 26	On track
Operational register aligned to BAF and documented	CNO / Trust Sec	Nov 26	Not started

Complete

On track

At risk

Off track

Not started

Trust Board meeting

Meeting details

Date of meeting:	24th September 2026
Title of paper:	Integrated Quality and Performance Report (IQPR)
Author:	All Executive Directors
Executive Director:	Sheila Stenson, Chief Executive

Purpose of paper

Purpose:	Discussion
Submission to Board:	Standing Order

Overview of paper

The IQPR provides an integrated assessment of performance against our Doing Well Together strategy and broader quality and performance measures requiring greatest Board attention.

Overall assurance remains partial. There is evidence of improvement across several areas, including some elements of access and quality and safety, alongside delivery of the financial plan. However, improvement is not yet consistent across services and patient flow remains our most significant operational and strategic constraint.

Issues to bring to the Board's attention

The Board is asked to NOTE:

- Overall assurance remains limited: Root causes, mitigating actions and credible recovery plans are not yet sufficiently developed for a number of performance indicators, particularly within access. And where improvements are being seen we are not yet able to demonstrate that these are embedded and sustainable.
- Access and flow: We cannot yet provide assurance that the trust is consistently taking the right actions or that current interventions are delivering the required impact trust wide.
- Principal risk: Flow is our most significant risk. An urgent and measurable recovery and stabilisation plan is required, with particular focus on discharge processes and implementation of the new national discharge pathway guidance.
- Improvement is happening but not yet sustained: The Quality Improvement Plan and reduction in community waits are beginning to show positive progress, but there is not yet sufficient assurance that improvements are fully embedded or sustainable.
- Leadership and delivery: Stronger local leadership and ownership are required to ensure actions are implemented consistently and sustained across all services.
- The three new national mental health priorities reinforce existing areas of focus and challenge in relation to flow and access. The commitment is to reduce inappropriate out-of-area placements, improve children's waiting times and reduce long waits in

emergency departments. Current performance and data quality challenges mean continued executive oversight is required.

- The 2026 Quarter 1 National Oversight Framework presents a mixed position, with stronger performance in finance, productivity and innovation, and greater challenge across access, people, experience and effectiveness. A detailed review is underway to ensure organisational priorities and assurance arrangements remain aligned to the framework.
- DIALOG+ has been introduced as an important outcome measure. Establishing a robust baseline and improving utilisation will help the trust move beyond measuring activity alone and better understand the impact of care on people's lives, supporting our longer-term ambitions around prevention, neighbourhood health and helping people live well and stay well.

Governance

Implications/Impact:	Regulatory oversight by CQC and NHSE/I
Assurance:	The Board can take limited assurance from the report. The Trust understands its principal areas of performance challenge, but root-cause analysis, mitigating actions and recovery plans are not yet consistently developed or sufficiently mature to demonstrate that the right actions are being taken and are delivering the required impact, particularly across access and flow. The immediate priority is to strengthen recovery planning, local ownership and oversight, and to demonstrate sustained and measurable improvement.
Oversight:	Oversight by Trust Board and all Committees

Chief Executive Summary

The IQPR demonstrates both progress and challenge for us as an organisation. We recognise we are on an improvement journey and there is evidence of improvement activity beginning to deliver positive results in several areas - including community access, elements of quality and safety, and delivery of our financial plan. The Quality Improvement Plan is also starting to show encouraging signs of progress. However, improvement is not yet sufficiently consistent, embedded or sustainable for the Board to take full assurance.

The report also highlights why our current position remains one of limited assurance. In a number of areas, particularly within the access domain, we are not yet able to demonstrate consistently robust root-cause analysis, mitigating actions and recovery plans. As a result, we cannot yet be assured that we are always focusing on the right actions or that those actions are delivering the impact required. Strengthening this line of sight between performance, improvement activity and measurable outcomes must now become a key focus.

Patient flow remains our most significant organisational risk and a multifaceted one. The impact is felt across patient experience, quality, safety, access, productivity and financial performance. Whilst some factors require a whole-system response, there is a significant element that sits within our own control, particularly the consistency and effectiveness of discharge processes. We therefore need to move with urgency to stabilise and recover the position, supported by a clear delivery plan and implementation of the new national discharge pathway guidance. A 60-day accelerated flow recovery and stabilisation plan will be stood up from this month, with executive oversight of delivery and impact, reported through our strategy reporting programme measures.

The external environment further reinforces where our attention must be focused. The new national priorities for mental health services, together with the first quarter National Oversight Framework assessment, align closely with the strategic areas already identified through *Doing Well Together*. Whilst there are known data-quality and measurement challenges affecting some indicators, both local and national intelligence point to the need for us to ensure organisational priorities and assurance arrangements are aligned. We are carrying out a detailed review against both and will keep the Board informed.

As we move into the second half of the year, our priority is not simply to demonstrate improvement activity, but to demonstrate impact. This will require stronger local leadership, clearer ownership of actions, greater consistency of delivery and a sharper focus on whether the changes we are making are resulting in timely access, safer care, improved flow, and better experiences for the people who use our services and work for us. The Board can therefore take assurance that the organisation understands its principal challenges and is taking action, but only limited assurance regarding the maturity, consistency and impact of those actions at this stage.

A further change within this report is the inclusion of DIALOG+ as an emerging measure of outcomes and impact. Whilst access, activity and flow remain critical indicators of performance, they do not in themselves tell us whether people's lives are improving as a result of the care and support we provide. DIALOG+ has the potential to become an important organisational measure because it captures outcomes that matter to the people using our services, and which are also reported in the CQC community mental health survey which is a key measure with the NOF. It also provides a more meaningful assessment of whether

individuals are living well and staying well, which is our trust ambition and aligns with national priorities around prevention and neighbourhood health.

At present, utilisation is not yet sufficiently consistent for us to use the measure strategically or derive meaningful assurance from it. Our immediate priority is therefore to improve adoption, establish reliable baselines and begin benchmarking performance across services. As our strategy matures and improvements become embedded, this will enable us to move beyond measuring access and activity alone and develop a stronger understanding of the impact our interventions are having on people's lives, helping inform future service design, improvement priorities and investment decisions.

Whilst overall assurance remains partial, we are increasingly clear about where we need to focus our efforts and how we will measure success. The combination of our strategic delivery plans and improvement programmes strengthened focus on flow and discharge, alignment with national priorities and the development of outcome measures such as DIALOG+ will help us move beyond measuring activity alone and provide stronger evidence of the difference we are making for the people and communities we serve.

Integrated Quality & Performance Report (IQPR)

September 2026
(July Data)

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1.Doing Well Together



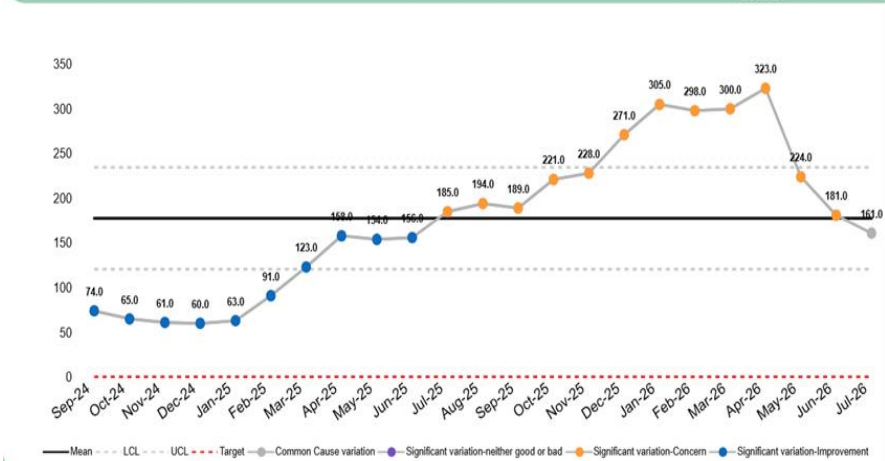
People can get the right mental health support at the right time, close to home wherever they live.

Executive Sponsor: Donna Hayward-Sussex, Chief Operating Officer & Deputy CEO

True North

Ref.02: MHT patients waiting for treatment for 38 weeks or more
SPC Chart: Trust Wide

Target	Actual	UCL	Mean	LCL	Variation	Assurance
0	161	235	178	121		



Assurance level: Partial Assurance, improving trajectory

Direction of travel: Improving, but there is variation across the directorates.

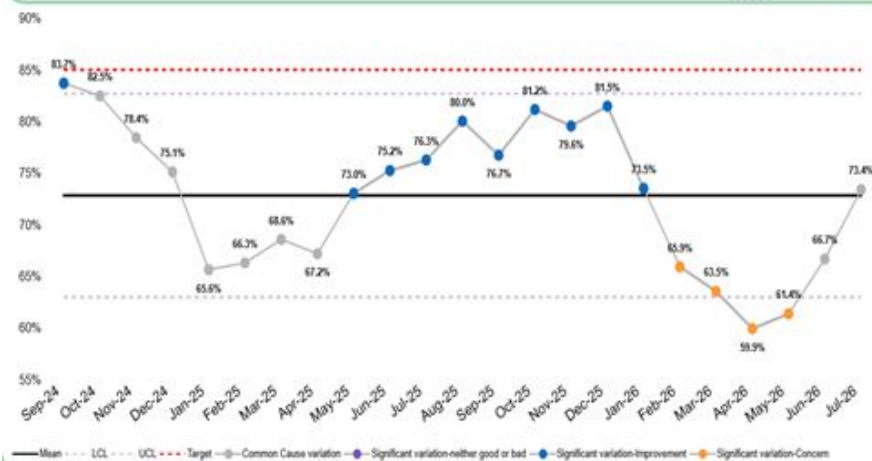
Key Assurance Challenge: Assurance depends on demonstrating that current actions deliver sustained improvement, reduce variation and release measurable capacity across all directorates.

Current: The reported position provides evidence of progress towards the 85% 18-week True North goal, with 75% of patients starting treatment within 18 weeks. The number waiting over 38 weeks reduced by 50% between April and July 2026, from 323 to 161, and the current average wait from referral to treatment commencement is 44 days. Improvement is concentrated, with East Kent accounting for 86% of the reduction, and performance remains variable between directorates. The improvement in East Kent is anticipated as the directorate is the largest contributor to long waits, due to the highest monthly contact volumes based on geography size.

Breakthrough

Ref.01: % Mental Health Together patients receiving treatment in 18 weeks
SPC Chart: Trust Wide

Target	Actual	UCL	Mean	LCL	Variation	Assurance
85.0%	73.4%	82.7%	72.8%	63.0%		



Looking ahead: We are on track to achieve our year-one breakthrough objective by March 2027. We are consulting on our revised clinical model, which aims to build on the positive results seen in our Medway & Swale pilot, with the ambition for timely access to our services. The redefined model will deliver further reductions in long waits and greater consistency across teams. We recognise organisational change can temporarily affect performance and may see some short-term variation in our performance over the coming months.

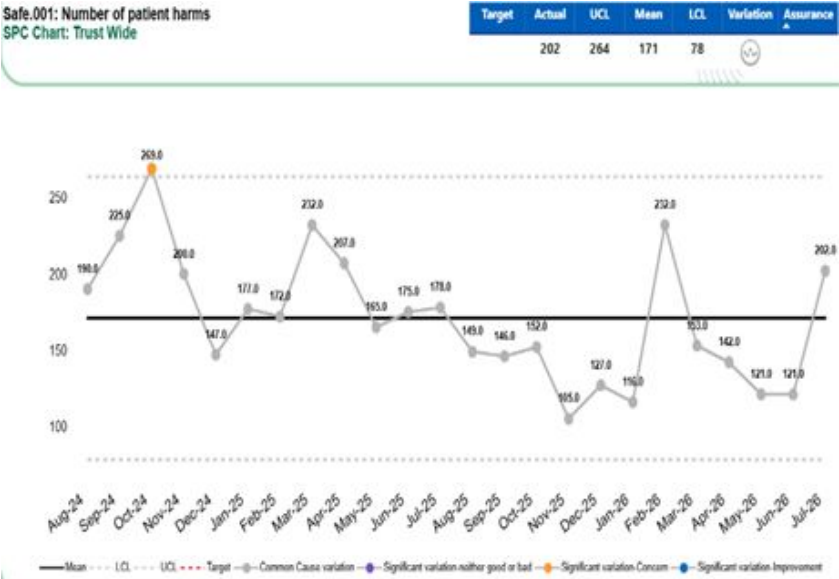
Our focus for the remainder of the year is on sustaining improvements already made, stabilising performance and embedding consistent practice across all directorates. We will continue to monitor increasing community demand, particularly where this creates pressure on capacity, waiting times and patient flow. Alongside this, we are aligning our care with the ICB's new commissioning model, which moves towards an outcome focused, neighbourhood led approach that strengthens workforce planning and supports consistent delivery across all neighbourhoods. Our new Neighbourhood Mental Health programme working group which is part of the Neighbourhood Alliance will maintain a strong focus on three areas; a coordinated crisis prevention and flow improvement model, transforming dementia support closer to home through a neighbourhood and VCSE delivered post diagnostic pathway, and expanding primary care mental health capacity through a sustainable, well supervised practitioner workforce to support delivery this year and the longer-term shift towards more integrated, neighbourhood-based care.

Next assurance point: sustained reduction in long waits across all directorates, reduced variation and evidence that the revised clinical model is releasing capacity and improving treatment commencement access.

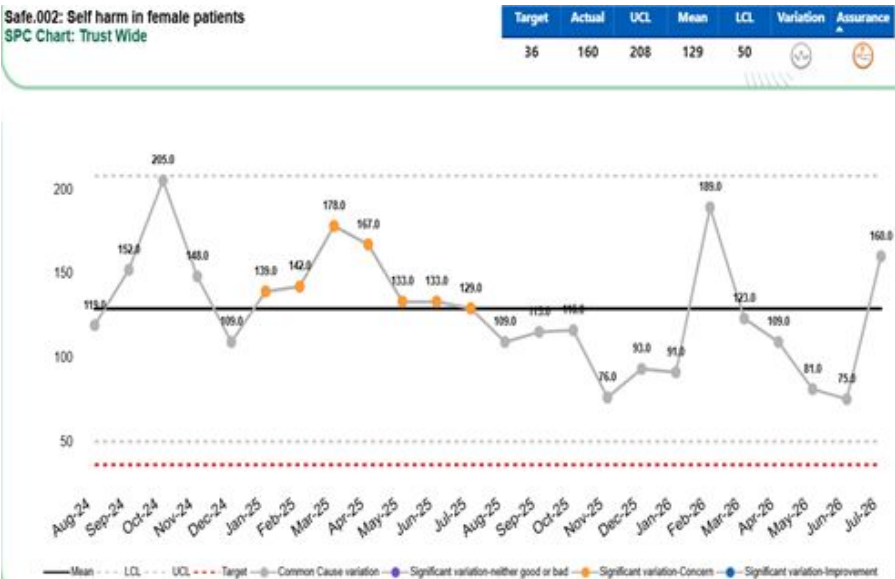


People are safe when they receive care from us, whether in our wards or communities.
Executive Sponsor: Julie Kirby, Interim Chief Nurse

True North



Breakthrough



Assurance level: Partial

Direction of travel: Improving overall, with material variation, normally driven by a small number of complex high need cases.

Key Assurance Challenge: The reduction in reported harms is positive but does not yet provide assurance that avoidable harm is reducing consistently or that current interventions are driving the change. Further evidence is required on severity, repeat incidents, ward variation and patient outcomes.

Current: Reported harms reduced by 24.4% in the last 12 months compared with the previous 12 months, but ward-level incidents remain variable and are often concentrated among a small number of people with complex needs. Self-harm remains the most frequently cited reason for referral to Liaison services, accounting for 540 referrals. The trust is seeing a reduction in reported harms, establishment of a Trust-wide Self-Harm Reduction Programme and targeted review of high-intensity pathways.

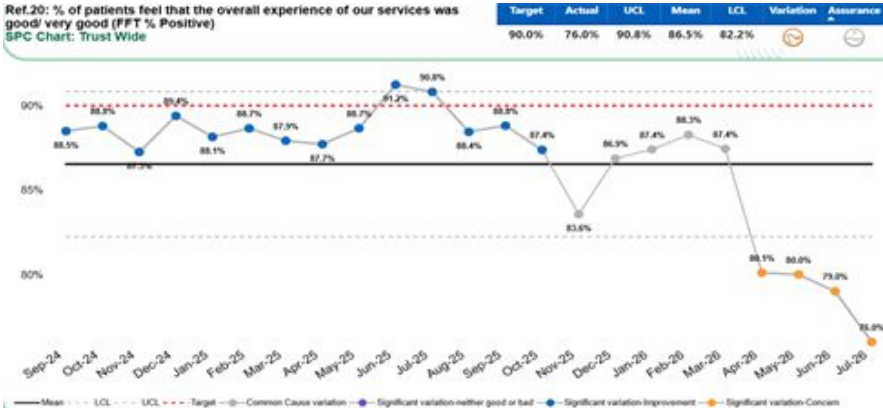
Looking ahead: we expect to see greater consistency between wards and a reduction in avoidable harm as these interventions become embedded. Recognising that not all self-harm is preventable or within the direct control of our services, we will also broaden how we assess progress beyond incident numbers alone, including severity of harm, repeat presentations and patient experience, and community outcomes. A doctor-led Community Liaison audit will further help identify unmet need, pathway gaps and opportunities for earlier intervention across acute, liaison and neighbourhood teams.

Next assurance point: evidence that incident severity and repeat presentations are reducing, that ward variation is narrowing and that learning and clinical controls are reliably embedded.



People feel listened to, involved in decisions and supported by a culture that reflects our values.
Julie Kirby, Interim Chief Nurse & Ali Layne-Smith, Chief People Officer

True North



Exp.002: Trust Staff Engagement Score
(annual figure from NHS staff survey)
Target: 6.8
March 2026: 6.7

Breakthrough

Measure Name	Target	V	A	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Ref.22: % of patients feel that we are good/ very good at including them in decisions about their care	95.0%											80.0%	79.6%	79.4%	78.7%
Ref.23: 60% of surveyed staff recommend us as a place to work	60.0%								33.0%		54.0%	50.7%			45.6%

(Insufficient data points to produce SPC analysis)

Assurance level: Partial

Direction of travel: Deteriorating for reported patient experience; uncertain for staff experience.

Key Assurance Challenge: Interim staff feedback is positive but is not directly comparable with the annual NHS Staff Survey and does not yet establish an improving trend. Assurance will increase when directorate-level evidence from the cultural dashboard and annual survey demonstrates sustained improvement.

Current: Patient experience was 79% in July, with directorate results ranging from 66% to 93%. Response volumes have almost doubled from March 26 to July 26, strengthening the evidence base, but scores have declined and feedback continues to identify concerns about involvement in discharge planning, treatment decisions, care coordination and transitions between services. Improvement action has not yet translated into a sustained increase in patient experience.

Staff experience is showing early signs of improvement with data, captured from staff through mandatory training, suggesting 85% of respondents would recommend the Trust as a place to work. Engagement activity has increased and our first cultural dashboard will provide richer insight at directorate level. The annual NHS Staff Survey will take place this month alongside a significant organisation consultation (Mental Health Together), and we recognise that this period of change may influence both participation and how colleagues report their experience.

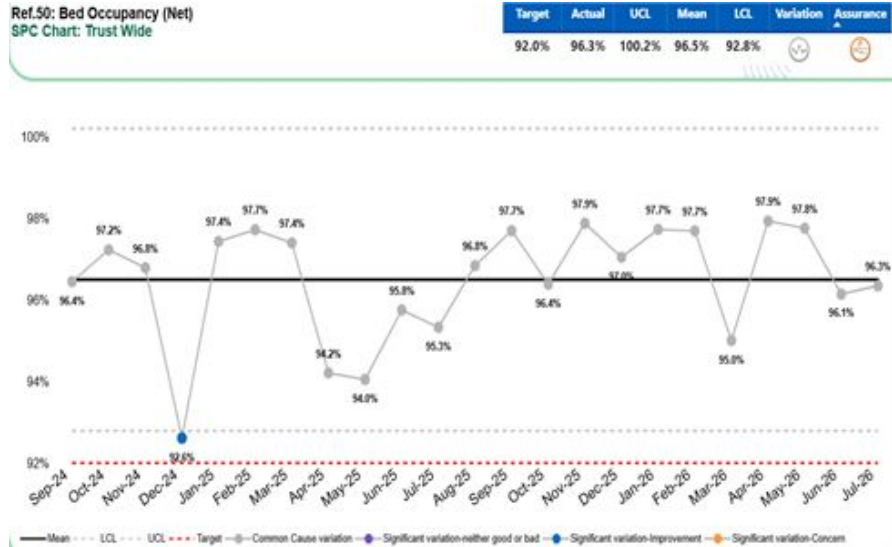
Looking ahead: Our priority now is to strengthen local leadership ownership of both patient and staff experience. Leaders will be expected to actively encourage feedback; understand what people are telling us and demonstrate how this is being used to improve services and staff experience. Over the next six months, we will strengthen directorate-level ownership, use the cultural dashboard to target support and continue to improve the quality and reach of patient and staff feedback.

Next assurance point: evidence that directorate actions improve involvement scores, reduce variation and show how feedback has changed services.



People with mental illness are supported to recover, stay well and live well in their communities.
Executive Sponsor: Afifa Qazi, Chief Medical Officer

True North



Breakthrough

(Insufficient data points to produce SPC analysis)

Measure Name	Target	V	A	Apr-26	May-26	Jun-26	Jul-26
Ref.51: Number awaiting bed (monthly average)				19.0	20.4	17.0	17.2

Assurance level: Limited

Direction of travel: Deteriorating overall, improving position on Clinically ready for discharge.

Key Assurance Challenge: The flow actions need to be strengthened, but sustained impact is not yet evident in occupancy, delayed discharge, out-of-area use or length of stay (LOS). Assurance will increase when these measures improve against agreed trajectories.

Current: Bed occupancy remains above the 90% target, currently at 96%; inappropriate out-of-area placement days increased sharply to 716 in July; and discharge delays continue to consume substantial inpatient capacity. Although the number of people clinically ready for discharge has reduced from a peak of 79 to 42, CRfD delays still accounted for a significant number of bed days (1,650 in June; 1,724 in July). The number of people awaiting a bed remains relatively stable at 17–20 each month. The urgent need to improve our internal discharge processes is a priority, as part of this we will be able to make an informed decision regarding how we improve flow.

Looking ahead: Over the six months the Supporting Recovery & Living well Trust Initiative will align the command centre, ward-rigour (timely discharge), CRFD standardisation and other initiatives. We expect these actions to translate into lower occupancy, fewer delayed discharges and reduced reliance on out-of-area beds. This is particularly important given the new national mental health priorities to reduce inappropriate out-of-area placements by 95% by March 2027 and reduce 12-hour ED breaches. Our current position means further improvement is required and recovery plans will need to be developed to ensure these are delivered.

Next assurance point: sustained improvement in bed occupancy, CRFD and out of area use, with clear evidence that discharge rigour and pathway controls are impacting on length of stay and readmissions, supported by the bed modelling exercise due for completion at the end of September 2026.



People benefit when we use our time, skills and resources well so more goes into care.

Executive Sponsor: Nick Brown, Chief Finance and Resources Officer

True North

Measure Name	Target	V	A	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Ref.65: Productivity Increase Year on Year	2.0%			5.5%	4.0%	4.6%	4.3%	4.4%	5.8%	7.2%	6.1%

(Insufficient data points to produce SPC analysis)

Breakthrough

% of Medics and Psychologists adhering to patient facing workplan (Target 90%)

Finalisation of measure and testing with clinical leads ongoing prior to publication

Assurance level: Partial

Direction of travel: Not yet established.

Key Assurance Challenge: Reported productivity and workforce indicators are positive, but the measure and baseline are not yet sufficiently mature to demonstrate that improvement is releasing sustainable clinical capacity or financial benefit.

Current: Reported productivity remains above the 2% year-on-year national NHSE target and our True North goal. Sustained productivity growth is a core five-year ambition because it enables us to make better use of our workforce and resources, creating capacity to meet growing demand and ensuring more clinical time is directed towards patient care. Work is underway to strengthen assurance that our productivity measures accurately reflect clinical activity, with early analysis suggesting some preparation time and indirect clinical work may be under-recorded.

Looking ahead: Over the next 3 – 6 months our focus will be on strengthening the evidence behind our productivity position and demonstrating its impact. This includes establishing a reliable baseline and consistent approach to measuring productivity among consultants and psychologists, including clearer smarter-working standards and improved recording of psychological practice. This will provide stronger assurance on how clinical time is being used to inform future workforce planning and the April job-planning cycle.

Next assurance point: an agreed and clinically validated productivity measure and baseline.

2. Board Assurance Statement

Assurance level: Partial

The board can take partial assurance from this report that the Trust understands its principal strategic risks, has identified mitigating actions, although further evidence is required to ensure adequacy and impact.

There are several areas of improvement within the report both in terms of performance and strengthening controls. This can be seen in, elements of quality and safety and the delivery of the financial plan. However, assurance remains constrained by variation between services, the immaturity of the productivity measures, and continued challenges within patient flow. With limitations identified against the underlying data.

Direction of travel: Mixed, with improving assurance in some areas, but deterioration in others.

The principal assurance challenge remains on variation across the trust, whilst patient flow remains the most significant operational and strategic constraint. There is evidence of genuine improvement in some elements of access, quality and safety and in the delivery of the financial plan. However, across all area's improvement remains inconsistent, with a recurring theme across all metrics being pockets of good performance but also variation. This comes through as an area of focus where further development is required.

Additionally, the Trust's largest operational constraint remains within patient flow, which is impacting on wider metrics including finance. The trust's evidence base on productivity is not sufficiently mature to support stronger assurance.

Key Assurance Challenge: Demonstrable impact from actions

The overall challenge isn't the absence of activity but whether the current level of interventions can be demonstrated to have a sustained impact, reducing variation and delivering reliable improvement across all directorates. Across each of the metrics until the improvement can be demonstrated assurance should remain cautious.

Board Focus

The board's focus should be on

- Access performance, including improvements and variation
- Flow and delayed discharge
- Reducing unwarranted variation across all clinical services
- Evidence that productivity improvement is impacting upon capacity
- Outcome based assurance using DIALOG, further development required for maturity

3. Quality & Safety

Overview:

The quality and safety position is mixed and supports an overall assessment of **partial assurance**. There is evidence of improvement in several important areas: violence and aggression reduced to 333 incidents in July, achieving the monthly threshold for the first time this year, after a month on month decrease for four months. Risk and care plan compliance continue to improve; and participation in patient feedback has increased substantially. However, several measures remain materially below standard or are deteriorating with some areas providing particular concern, the top three of concern from a chief nurse perspective remains risk assessment quality and compliance, medication errors and physical health checks for people prescribed clozapine or depot medication. Although we are seeing some improvement in these areas, overall, these remain below expected standard.

Directorate review shows that aggregate performance masks significant variation between services, with issues concentrated in some teams. This enables targeted action but means improving Trust-level totals do not yet demonstrate that controls are consistently embedded. East Kent has improved risk-assessment compliance and quality and is now a positive outlier, with learning shared across community directorates. Medication errors, where (as would be expected) the acute directorate has higher than expected levels of incidents, we are supporting certain wards.

Measure Name	Target	V	A	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Ref.19: Clozapine and depot clinic physical health check screening in last 12 months (MHT+)	85.0%			79.6%	80.7%	80.0%	80.0%	80.2%	76.7%	75.7%	77.2%	77.1%	78.2%	77.0%	75.5%
Ref.24: Complaints - actuals	43			52	66	43	46	38	71	49	72	70	54	52	78
Ref.25: Compliments - actuals	177			118	139	153	150	178	124	135	117	147	141	138	172
Ref.27: Your experience matters: Response Count				424	456	507	353	434	405	501	478	427	621	744	938
Ref.28: Your experience matters: Response Volume				2.6%	3.1%	2.8%	2.0%	2.5%	2.2%	2.8%	2.7%	2.4%	3.6%	4.0%	5.1%
Ref.29: Your experience matters: Achieving Regularly, % good/very good	90.0%											81.0%	81.0%	80.1%	79.0%
Ref.30: Complaints acknowledged within 3 days (or agreed timeframe)	100%			95%	89%	84%	95%	96%	97%	94%	96%	97%	98%	90%	92%
Ref.31: Complaints responded to within 30 days (or agreed timeframe)	100%			80%	83%	88%	75%	81%	79%	72%	86%	78%	80%	93%	80%
Ref.32: Decrease violence and aggression	334			392	462	456	469	371	386	363	384	352	344	346	333
Ref.33: Medication errors	21			45	55	54	36	40	31	52	45	38	37	51	48
Ref.39: Risk Compliance	90.0%			12.3%	15.0%	17.3%	19.2%	19.5%	21.3%	26.4%	31.5%	35.6%	38.2%	42.7%	45.6%
Ref.40: Care Plan Compliance	90.0%			0.0%	0.0%	0.0%	0.8%	0.9%	2.1%	15.4%	25.6%	32.9%	39.9%	46.5%	51.7%
Ref.41: Patients receiving follow-up within 72 hours of discharge	90.0%			85.8%	88.5%	87.0%	88.7%	85.9%	90.8%	86.7%	88.2%	85.6%	86.8%	82.5%	85.3%
Ref.42: Occurrence Of Any Never Event	0			0	0	0	0	0	0	0	0	0	0	0	0
Ref.43: All Deaths Reported And Suspected Suicide				112	137	146	104	161	177	145	133	91	80	66	120
Ref.44: Restrictive Practice - All Restraints	85			87	111	163	170	141	99	140	131	104	88	89	101
Ref.45: Restrictive Practice - No. Of Prone Incidents	0			4	7	16	12	4	10	3	10	7	7	2	3
Ref.46: Care Plan in date for patients in treatment (CYP & AAED)	90.0%			75.4%	75.9%	77.3%	78.1%	77.7%	77.7%	77.8%	79.0%	79.6%	79.1%	73.0%	73.3%
Ref.47: Risk assessment in date for patients in treatment (CYP & AAED)	85.0%			85.1%	84.4%	84.3%	84.6%	84.7%	83.6%	83.9%	84.7%	85.2%	84.7%	79.2%	79.0%

The direction of travel is therefore positive in selected domains but not yet sufficiently consistent to provide reasonable assurance overall. Improvement programmes, audit, thematic review and directorate oversight are in place, but the available information does not yet demonstrate that these controls are delivering sustained improvement across all areas of concern. The next area of focus will therefore be on narrowing service-level variation, ensuring recovery milestones are achieved and audits demonstrate better quality of practice rather than completion alone. Executive attention will remain focused on the pace and impact of recovery actions, with escalation where trajectories are not achieved.

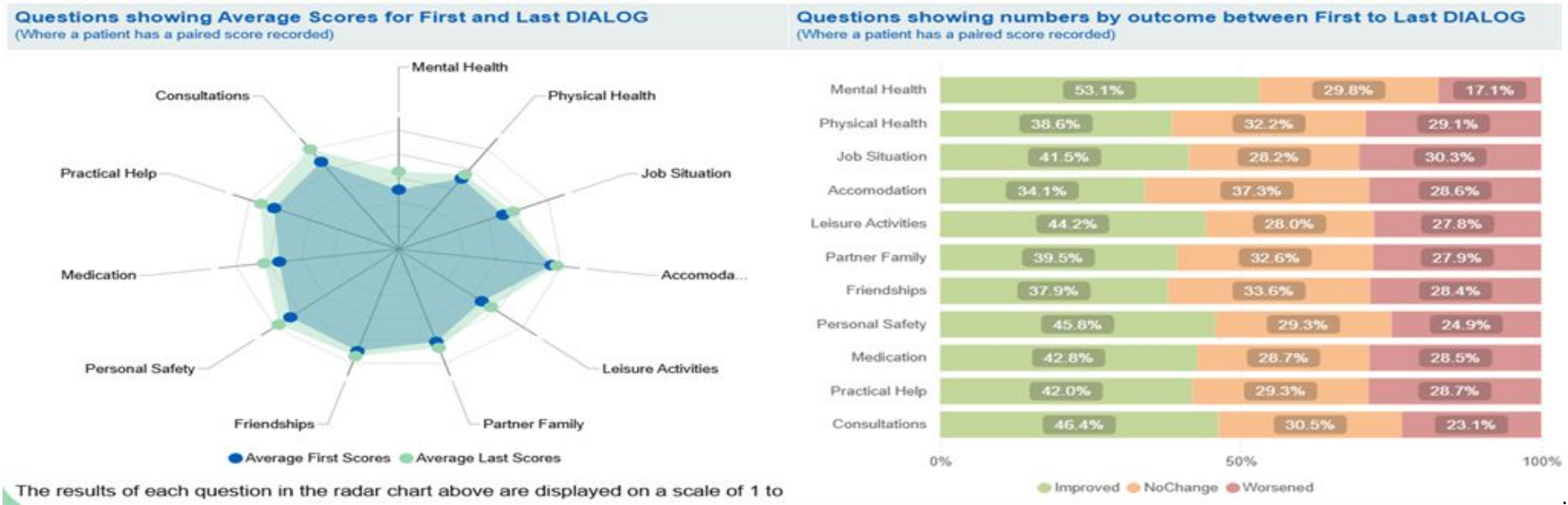
Area	Current assessment	Controls and required focus
Medication Errors	Medication performance varies: West Kent reported a reduction in medication incidents (3 in July, down from 5), while Acute services identified a localised increase at Priority House requiring focused review by ward managers and pharmacy support. This indicates variation in performance but supports the judgement that risk is concentrated in specific services rather than systemic.	Continuation of targeted reviews with assurance demonstrating that focused interventions are reducing recurrence and that improvement seen in other directorates, including West Kent, is being sustained. Continued encouragement of increased reporting culture, which is reported both within each directorate governance meetings and the trust wide Quality and Patient Safety Assurance Group, with exceptions reported into Quality Committee where required.
Clozapine/depot physical health checks.	Clozapine and depot physical health checks deteriorated to 75.3% against an 85% target. The improving Trust trend is supported by more developed recovery activity in across community directorates. However, variation remains significant and the approach is not yet reliably embedded across all services.	Maintain directorate oversight, monthly audit and recovery plans, with clear trajectories and escalation of services not improving at the expected pace. Focus on reducing unwarranted variation and demonstrating sustained improvement.
CYP care planning and risk assessment compliance.	CYP review indicates potential denominator and recording issues affecting reported compliance; however, local validation work suggests performance may be understated rather than fully reflective of clinical practice. Directorate reviews have identified discrepancies between manual audit findings and system-reported data, requiring further validation whilst maintaining focus on improving care planning and risk assessment compliance.	Complete validation of denominator and recording issues while maintaining focus on improving clinical compliance. Assurance should demonstrate that reported improvement reflects actual clinical practice and that recovery actions are consistently embedded across CYP services.
Complaints volume and response timeliness	Patient feedback participation increased to 938 responses and compliments rose to 164. In contrast, complaints increased to 80 in July, the highest level in the reporting period; only 80% were answered within 30 days. The increased response volume provides a stronger evidence base, but directorate analysis shows that experience of involvement varies materially and has declined in some services. Common themes concern communication, discharge planning, and timeliness of response, supporting the need for continued improvement in both experience and the reliability of the process.	Analyse themes and service-level variation, strengthen oversight of overdue responses and demonstrate how learning is translated into measurable improvement. Directorate actions include standardising feedback collection, seeking direct patient narrative, improving communication with carers, making ward-review arrangements clearer and ensuring care and discharge plans are shared consistently. The next assurance point should show whether these actions improve both experience scores and the timeliness of complaint responses.
72 hour follow up	72-hour follow-up performance was 85.7% against a 90% target and has not shown sustained achievement. Review of four West Kent breaches identified issues at different points in the pathway, including administrative allocation delay, incomplete ward discharge planning, and transfer-of-care arrangements. This suggests that improvement requires reliable controls across the discharge-to-community handover rather than action on a single cause.	Review discharge and community follow-up processes, with targeted action in areas contributing most to missed follow-up. Improvement should focus on timely allocation, documented discharge plans, clear ownership when care transfers between services and assurance that the required contact has occurred. Further work to understand breach themes and to improve reliability of the follow up.

4. Patient Outcomes

The Trust routinely uses a range of outcome measures, of which DIALOG is the most widely completed. Work to date has focused on embedding its use; the next phase is to use the information more consistently to understand whether care is improving outcomes for our patients. Initial analysis covers 3,037 discharges in the last 12 months where two or more DIALOG assessments were completed across ARMS, Community Rehabilitation, Early Intervention, Home Treatment, Inpatient Rehabilitation, Mental Health Together and Mental Health Together Plus, Older Adult Psychology, Open Dialogue, Personality Disorder and Psychological Therapies services.

This is a useful baseline, but incomplete coverage means it is not representative of all services or patients. Interpretation should consider completion rates, service variation, assessment intervals and clinical significance. Future reporting will show change, coverage, variation, learning and actions, enabling the Board to assess outcomes and evidence reliability.

DIALOG scores improved across all domains, with the greatest gains in Mental Health, Consultations and Personal Safety. Smaller improvements in Physical Health, Accommodation and Job Situation highlight the influence of wider determinants and the need for continued partnership working



Data extracted 04/09/2026

Next steps: improve completion of paired assessments; agree a consistent method for interpreting meaningful change; identify unwarranted variation and areas requiring clinical review; and incorporate outcome trends, learning and actions into future IQPR reporting.

3. Operational Performance

Access

Measure Name	Target	V	A	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Ref.03: Face to Face v's virtual (MHT+ & EIP)				71.4%	73.7%	72.1%	72.1%	68.2%	71.1%	73.6%	73.4%	74.3%	76.1%	76.2%	76.5%
Ref.04: Open Access Crisis Line: Calls received	3,274			3,047	2,976	3,227	2,794	2,968	3,174	3,070	3,159	2,848	3,068	3,112	3,366
Ref.05: Open Access Crisis Line: Abandonment Rate (%)	12.0%			38.9%	40.2%	28.3%	21.2%	25.0%	22.4%	25.7%	24.3%	20.2%	20.7%	25.1%	25.6%
Ref.06: Assess people in crisis within 4 hours	90.0%			91.4%	93.6%	91.0%	90.9%	84.9%	91.4%	85.1%	73.0%	88.1%	84.9%	83.8%	82.4%
Ref.07: People presenting to Liaison Services: triaged within 1 hour				89.4%	90.8%	90.9%	89.2%	93.9%	92.3%	89.6%	90.0%	92.6%	93.4%	91.5%	90.0%
Ref.08: Liaison Psychiatry referrals closed within 12 hours	95.0%			82.1%	81.8%	82.8%	81.5%	82.6%	82.8%	81.6%	85.8%	84.7%	85.3%	84.9%	86.3%
Ref.09: Liaison Psychiatry referrals closed identified as requiring a bed within 12 hours	95.0%			12.3%	10.4%	6.5%	16.2%	15.7%	8.3%	8.5%	16.3%	18.0%	13.9%	12.0%	18.9%
Ref.11: MAS diagnosis within 6 weeks	95.0%			25.3%	21.3%	22.5%	27.2%	23.2%	20.0%	17.7%	31.5%	29.1%	21.6%	22.0%	18.6%
Ref.12: People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral	60.0%			85.7%	92.3%	87.0%	76.5%	76.9%	50.0%	80.0%	68.2%	83.3%	52.9%	50.0%	59.3%
Ref.13: % MHL D referrals commencing treatment in 18 weeks	86.1%			84.8%	83.8%	83.7%	70.7%	95.8%	87.7%	87.5%	87.5%	75.5%	72.2%	85.1%	88.6%
Ref.14: Perinatal assessments (against annual target)	2,000			163	177	180	161	144	174	150	175	603	193	192	151
Ref.16: % of Active Referrals waiting less than 18 weeks to first contact (MHS CYP inc Neuro)				13.6%	14.9%	13.5%	16.3%	14.9%	15.7%	15.6%	16.9%	16.9%	15.3%	16.9%	16.2%
Ref.17: CYP Crisis Assessments within 4 hours (Referral to Contact)	95.0%			88.4%	77.6%	77.1%	76.0%	76.1%	79.3%	76.7%	67.8%	81.6%	90.7%	61.1%	79.2%
Ref.18: % Routine Eating Disorders Activity-Based Clock Stop Achieved Within 4 Weeks Aged 0–18				91.1%	92.0%	100.0%	97.1%	93.0%	98.2%	96.8%	93.1%	78.0%	89.3%	92.5%	90.2%
Ref.49: % of Referrals waiting greater than 104 weeks for ND assessment (ADHD & ASC)				37.7%	38.8%	40.2%	41.6%	43.8%	46.2%	48.7%	52.2%	54.8%	57.7%	60.0%	62.5%

Overview:

The July performance position remains mixed. MHL D 18-week access has improved to 88.6%, exceeding the national target, while Liaison Psychiatry 12-hour closure performance has also improved. Early Intervention in Psychosis (EIP) performance remains below the required standard and has declined over the last three months; however, performance in July improved compared with the previous two months. It should be noted that EIP performance is based on very small patient numbers, with breaches primarily attributable to individual patient circumstances rather than any inability of the service to offer timely appointments.

Significant operational pressure persists across urgent and crisis pathways, evidenced by record Open Access Crisis Line demand, an abandonment rate of 25.6%, declining adult and CYP four-hour response performance, and continued delays where Liaison patients require a bed. The sustained increase in

neurodevelopmental referrals waiting more than 104 weeks, now at 62.5%, represents a particularly concerning deterioration and requires focused recovery action, alongside continued work to improve crisis capacity, call responsiveness, patient flow and dementia diagnostic timeliness.

The aggregate position masks differences within individual services. In community mental health services, a proportion of longer waiters have received an assessment or commenced elements of care but remain on the reported waiting list because all actions required to trigger clock stops have not been completed. This means that both genuine clinical delay and pathway or recording reliability contribute to the position. East Kent has reduced the longest waits materially (208 to 63), but improvement is not yet consistent across directorates. CYP crisis review similarly identifies no single cause for four-hour breaches: family availability and patient choice, workforce capacity, recording accuracy and pathway interpretation all contribute. Business continuity arrangements in the most pressured CYP services include weekly review, daily safety huddles, cross-directorate support and recruitment, with planned recovery milestones extending to November and December 2026.

The Board can therefore take partial assurance that targeted controls are in place and addressing identified causes, but improvement is not yet embedded consistently and therefore further focus is required.

Flow

Measure Name	Target	V	A	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Ref.10: Place of Safety Length of Detention: % under 24 hours	75.1%			78.7%	86.9%	86.4%	89.8%	90.5%	85.2%	89.8%	93.3%	100.0%	100.0%	100.0%	100.0%
Ref.52: Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)	608			608	574	590	561	482	407	453	316	218	355	437	716
Ref.53: Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs) at period end	21			17	22	18	17	14	13	17	5	9	16	14	24
Ref.54: CRFD Bed Days Lost (Acute beds)				1,827	1,690	1,565	1,723	1,717	1,647	1,712	1,657	1,441	1,758	1,650	1,738
Ref.55: Clinically Ready for Discharge (CRfD) length of stay (LoS)	64.7			82.2	81.9	92.9	45.8	69.9	116.1	53.7	74.9	58.5	85.6	83.2	64.5
Ref.56: Clinically Ready for Discharge (CRfD) over 100 days at period end	0			17	16	15	17	19	20	22	14	14	15	16	15
Ref.57: Clinically Ready for Discharge (CRfD): YA Acute	7.0%			17.5%	17.9%	15.2%	20.3%	22.0%	19.9%	22.0%	17.1%	14.7%	18.4%	17.7%	18.7%
Ref.58: Clinically Ready for Discharge (CRfD): OA Acute	12.0%			36.2%	31.8%	30.6%	28.7%	23.6%	24.6%	29.6%	31.3%	27.9%	31.5%	31.7%	30.9%
Ref.59: Average Length Of Stay (Younger Adults Acute)	34.0			32.8	42.6	50.9	27.5	31.5	61.3	44.1	46.0	51.8	54.6	46.0	48.2
Ref.60: Average Length Of Stay (Older Adults - Acute)	77.0			69.1	104.3	79.7	76.0	81.6	71.1	120.4	115.3	92.1	104.6	117.0	100.2
Ref.61: Adult acute LoS over 60 days % of all discharges	16.0%			12.2%	14.4%	22.9%	12.9%	13.3%	20.4%	15.6%	19.7%	23.7%	20.2%	19.4%	23.6%
Ref.62: Older adult acute LoS over 90 days % of all discharges	37.7%			30.0%	43.3%	31.3%	24.0%	42.9%	25.9%	29.6%	50.0%	44.0%	32.1%	38.5%	41.2%
Ref.63: Readmissions within 30 days (YA & OP Acute)	8.8%			16.7%	12.6%	12.0%	10.3%	12.2%	12.3%	11.8%	9.9%	7.8%	11.8%	10.4%	12.8%
Ref.64: Average Length of Stay in C&YP Mental Health wards (Days)	60.0			91.0	46.0	63.0	41.0	80.0	98.0	0.0	111.3	59.7	79.0	61.2	37.0

Overview:

The July flow position remains challenged: while Place of Safety performance has been sustained at 100% and CYP average length of stay has reduced significantly to 37 days, inappropriate out-of-area placement bed days increased sharply to 716 and active placements rose to 24.

Delayed discharge continues to constrain flow, with 1,738 CRfD bed days lost, 15 patients waiting over 100 days and CRfD prevalence remaining substantially above target in both younger and older adult acute services. Although CRfD and older adult lengths of stay improved during July, extended stays and 30-day readmissions remain above target, reinforcing the need for continued focus on complex discharge pathways, ward rigour (timely discharge), community capacity and alternatives to admission.

Effective patient flow remains a significant challenge and continues to be a key area of focus. We have seen improvements in clinically ready for discharge (CRFD) performance following recent changes in practice; however, it is too early to determine whether these gains are sustainable. Strengthening ward-based operational rigour remains a priority, as length of stay performance has not improved in line with reductions in delayed discharges, suggesting that variation in practice is continuing to impact flow. The Acute Directorate leadership team has been tasked with driving greater consistency and improvement across services.

Admission avoidance also remains critical, with further work required to reduce avoidable admissions, particularly through strengthening gatekeeping arrangements and ensuring the least restrictive care pathways are consistently applied.

Productivity

Measure Name	Target	V	A	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Ref.15: DNA Rate – All Appointments	8.0%			10.1%	10.5%	10.4%	9.8%	10.0%	10.6%	10.5%	10.2%	10.1%	10.1%	10.1%	10.6%
Ref.66: Psychology & Medic contact time per FTE				0.36	0.38	0.40	0.39	0.34	0.39	0.36	0.35	0.37	0.40	0.24	0.23
Ref.77: Clinician Contact time per FTE				0.32	0.35	0.33	0.34	0.32	0.34	0.34	0.32	0.36	0.37	0.24	0.23

Overview:

DNA performance remains stable but above the Trust target, with 10.6% of appointments not attended in July 2026. The immediate priority is to maintain performance through effective appointment management, patient engagement, digital access and local recovery actions, reducing non-attendance and maximising available clinical time. The operational model reset planned for next year will identify further opportunities for sustainable improvement.

Workforce

Measure Name	Target	V	A	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Ref.34: Increase percentage of BAME staff in roles at band 7 and above	20.0%			30.6%	30.9%	30.9%	30.7%	30.5%	31.1%	31.0%	31.0%	31.1%	31.1%	32.6%	32.4%
Ref.35: The number of minority ethnic staff involved in conduct and capability cases: variation against the numbers of white staff affected.	0.50%			0.39%	0.23%	0.12%	0.11%	0.27%	0.35%	0.23%	0.23%	0.36%	0.35%	0.35%	0.26%
Ref.67: Staff Sickness - Overall	4.5%			5.2%	4.9%	4.9%	5.5%	5.9%	5.1%	5.2%	5.1%	5.1%	5.1%	5.5%	5.4%
Ref.68: Vacancy Gap - Overall	11.5%			10.3%	10.2%	10.2%	10.3%	10.2%	10.4%	10.4%	10.3%	10.4%	10.6%	10.5%	10.8%
Ref.69: Mandatory Training For Role	90.0%			95.6%	94.8%	95.4%	95.3%	95.6%	95.7%	95.5%	94.9%	94.6%	94.4%	94.3%	94.6%
Ref.70: Leaver Rate	12.3%			11.9%	11.4%	11.2%	11.7%	12.1%	12.3%	12.6%	12.3%	11.8%	11.9%	12.4%	11.8%
Ref.71: Leaver Rate (Voluntary)	13.0%			8.1%	7.8%	7.7%	7.4%	7.4%	7.5%	7.6%	7.3%	7.2%	7.5%	8.4%	7.4%
Ref.72: Safer staffing fill rates	80.0%			109.2%	110.3%	109.0%	108.6%	109.6%	109.4%	110.8%	109.0%	111.0%	110.3%	108.0%	109.3%

Overview:

The workforce position provides partial assurance. Mandatory training is strong at aggregate level, but directorate detail shows variation in safety-critical subjects, including life support, safeguarding, infection prevention and clinical record keeping.

Supervision is also inconsistent: the Acute Directorate has remained below target since December 2025, with marked ward-level variation, while specific crisis, liaison and community services continue to experience vacancy and sickness pressures that are affecting access, cancellations and resilience. Recovery actions include weekly exception reporting, additional training dates, targeted plans for non-compliant staff, recruitment and use of cross-directorate support.

These controls are appropriate, but the evidence does not yet demonstrate sustained recovery across the areas of highest operational risk. Future work is required to align workforce measures directly to service impact.

Finance

Measure Name	Target	V	A	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Ref.79: In Month Turnover					25,080	25,321	26,587	25,769	25,158	26,885	41,498	29,749	30,029	29,996	29,786
Ref.80: In Month Expenditure					(24,897)	(25,137)	(26,405)	(25,584)	(24,974)	(26,700)	(41,268)	(29,749)	(30,029)	(29,996)	(29,785)
Ref.81: In Month Variance					182	184	182	185	183	185	230	0	0	0	1
Ref.82: Agency spend as a % of the trust total pay bill	696				350	418	350	432	258	338	133	596	679	801	872
Ref.83: Bank spend as a % of the trust total pay bill	1,356				1,636	1,728	1,525	1,692	1,743	1,727	1,794	1,810	1,863	1,631	1,924

Overview:

The financial position provides partial assurance. The Trust reported break-even at Month 4 and delivery remains aligned to the £10.35m Cost Improvement Plan. However, agency expenditure has worsened slightly and requires further focus on workforce controls. The underlying position remains challenged due to the continued use of external bed use, and the higher than planned use of temporary staffing. The increase to 716 out-of-area placement bed days and the loss of 1,738 bed days through clinically ready for discharge delays demonstrate that operational flow is impacting financially.

Current productivity measures are not yet sufficiently mature to evidence that reported activity gains are releasing sustainable benefit.

The next assurance point should therefore triangulate financial delivery with agency use, external placement expenditure, vacancies, CRfD bed days and measurable capacity released through service redesign. This will enable the Board to distinguish delivery of the in-year plan from improvement in the underlying recurrent position.

6. Appendices

National oversight Framework (NOF) Rating Quarter 1

KMMH Position: Overall

Average score

2.69

Below Average
and/or Financial
Deficit
Likely range: 2.20 to
3.13

Financial deficit

No

Overall segment

3

Below Average and/or
Financial Deficit
Based on average metric
score

Capability rating

Amber/Green

Provider rank

53 out of 58 providers
Likely range: 25 to 58

Breakdown by domain:

Domain	Ave score	Quartile
Access	3	4
Patinet Safety	2.37	3
Finance, productivity and innovation	1.33	1
People	3.1	4
Experience of care	3.45	4
Effectiveness of care and population health	2.67	4

Data source: [Kent and Medway NHS and Social Care Partnership Trust – Mental health and community provider – NHS Oversight Framework - NHS England public data gateway](#)

Full national dashboards used in 25/26 not updated as at 11/09/26

Trust Board meeting

Meeting details	
Date of meeting:	24 September 2026
Title of paper:	Neighbourhood Health Collaborative Board Progress Report
Author:	Julia Hart, Deputy Director, Neighbourhood Collaborative
Executive Director:	Sheila Stenson, Chief Executive Officer

Purpose of paper	
Purpose:	Noting
Submission to Board:	Board requested

Overview of paper
This paper provides an update on work of the Neighbourhood Health Collaborative Board There are updates on the workstreams which previously fell under the Mental Health and Learning Disability Collaborative and wider updates from the new collaborative board, which covers, mental health, dementia and neighbourhood. This report includes: • A progress report on UEC services focused on East Kent • An update on Community Mental Health -Mental Health Together • An update on key performance metrics including UEC.

Areas to bring to the Board's attention
• Community Mental Health Framework - The programme is moving from detailed design into delivery, with good progress in agreeing the refreshed Model of Care and establishing the clinical, workforce, financial and partnership foundations for implementation. • Overall assurance is reasonable. Direction and core design are clear, but delivery confidence will depend on maintaining pace and strengthening implementation grip as the programme enters its most complex phase. • UEC mental health services: Operational improvements reported in January have been sustained.

- Eliminating Corridor Care: Measurable improvements are evident in diversion rates and 12-hour breach performance, particularly in Thanet. The Needs Assessment indicates that further left-shift will require targeted neighbourhood investment, rather than continued reliance on crisis and acute capacity alone.
- Significant slippage in some UEC delivery milestones.

Governance	
Implications/Impact:	KMMH Trust Strategy
Assurance:	Reasonable
Oversight:	Trust Board and Kent and Medway Joint Committee

1. Board reporting – programme update forward plan for 2026-27

Programme	2026-2027	
	November	January
Community Mental Health Framework		
Dementia Diagnosis Pathway		
Urgent and Emergency Care		
Enhanced Therapeutic Observation Care (ETOC)		
Joint Working Across Health and Social Care		
Neighbourhood Health (Frailty, Dementia, End of Life Care)		

2. Programme updates September 2026**2.1 Community Mental Health Framework****Introduction**

This paper, together with the programme assurance framework, provides a comprehensive overview of the Mental Health Together programme. Building on previous Board updates and subsequent assurance reviews, it summarises progress to date, the current delivery position, the next phase of implementation, and the principal risks requiring ongoing oversight.

The programme has reached a significant transition point. The majority of design, planning and mobilisation activity has been completed, and the focus has now shifted to implementation across localities. This represents substantial progress and provides evidence that the programme remains on track to deliver its intended model and benefits.

The Board can therefore take assurance that the programme is progressing positively and is entering delivery with the necessary foundations in place. However, implementation is now dependent on a number of critical enablers that require continued monitoring and active management. These include workforce capacity and recruitment, locality readiness, partner mobilisation, digital and data capability, and the need to maintain operational performance while transformation activity is delivered.

As the programme moves into this next phase, risk is increasingly associated with the pace, consistency and interdependency of delivery across multiple workstreams and localities, rather than programme design. Continued oversight of these dependencies will be essential to sustain momentum, realise benefits and ensure successful implementation at scale.

Context

Mental Health Together is an ambitious partnership model bringing together Kent and Medway Mental Health NHS Trust (KMMH), Kent and Medway Integrated Care Board (ICB), primary care and voluntary, community and social enterprise (VCSE) delivery partners to provide a more integrated community mental health offer. Its purpose remains to simplify access, clarify the interventions provided at different levels of need, strengthen care navigation and partnership working, and improve outcomes and experience for service users, carers and staff.

The programme has continued to learn from earlier implementation, the independent review, Care Quality Commission (CQC) feedback and wider improvement activity. The refreshed approach seeks to retain the ambition of the Community Mental Health Framework while ensuring that implementation is clinically safe, operationally deliverable and supported by effective engagement and enabling functions.

The programme is organised around the Model of Care, workforce, digital and data, finance and commissioning, communications and engagement, and delivery through localities. The approach is deliberately iterative, enabling local learning while maintaining a common clinical and assurance framework.

Current programme position

The overall position is positive but appropriately cautious. The programme has moved from conceptual redesign to practical preparation for delivery. The refreshed Model of Care and demand and capacity model provide a clear basis for implementation, and the associated workforce consultation and partner mobilisation are progressing. The next requirement is to convert these foundations into sequenced, locality-level implementation plans.

The critical path has been refreshed to align with agreed plans and timelines. It brings together the key activities needed for implementation and provides a stronger basis for programme control, oversight, and assurance.

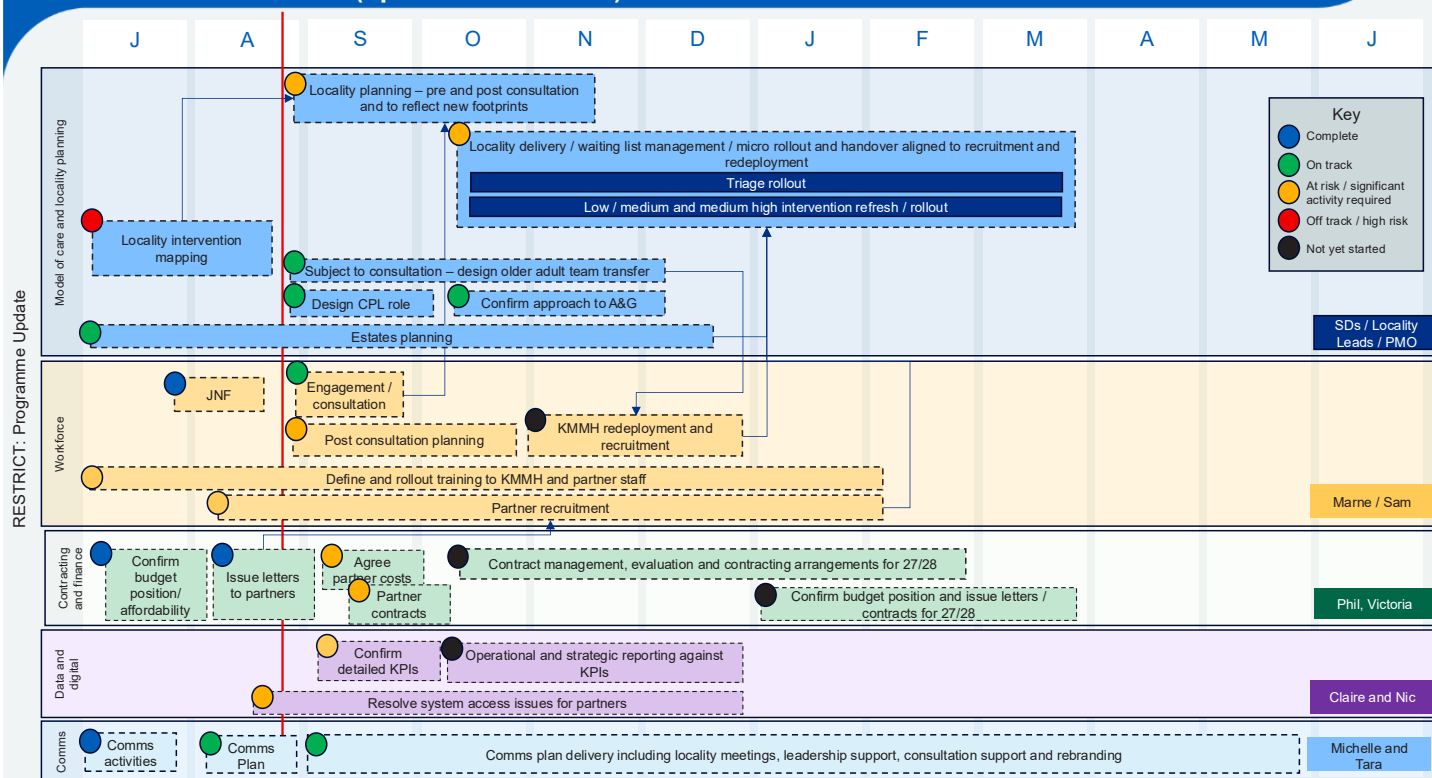
Key achievements in 2026

- Refreshed Model of Care agreed and signed off.
- Detailed clinical and operational design progressed through task and finish groups.
- Demand and capacity modelling completed and the scale and scope of the workforce requirement established.
- Consultation documentation, Joint Negotiating Forum (JNF) paper and manager briefings completed, enabling formal consultation to commence on 24 August 2026, closing on the 8th October 2026.
- Financial envelope agreed and 2026/27 partner arrangements progressed.
- Letters of intent issued to support partner recruitment ahead of contract completion.
- Locality intervention mapping and implementation planning commenced.
- Core digital and data requirements mapped, operational Key Performance Indicators (KPI) development progressed and RiO electronic patient record system changes prepared.
- Communications and engagement activity established to support consultation and wider programme delivery.
- Critical path refreshed to align the Model of Care, workforce, partners and localities.

Collectively, these milestones demonstrate the programme has established the principal foundations required for implementation. The core clinical model is no longer the primary area of uncertainty. The central challenge is now coordinated delivery: ensuring that workforce changes, partner mobilisation, training, estates, systems, communications and operational processes are ready in the right sequence in each locality. Engagement continues to be a golden thread during the next phase of readying mobilisation.

What next - programme delivery focus, governance and workplan

The programme is organised around the Model of Care, workforce, digital and data, finance and commissioning, communications and engagement, and delivery through localities. The approach is deliberately iterative, enabling local learning while maintaining a common clinical and assurance framework. A critical path is updated weekly to reflect priorities and progress.

CRITICAL PATH – 2026/27 (updated 14/08/2026)**Model of Care and Locality planning**

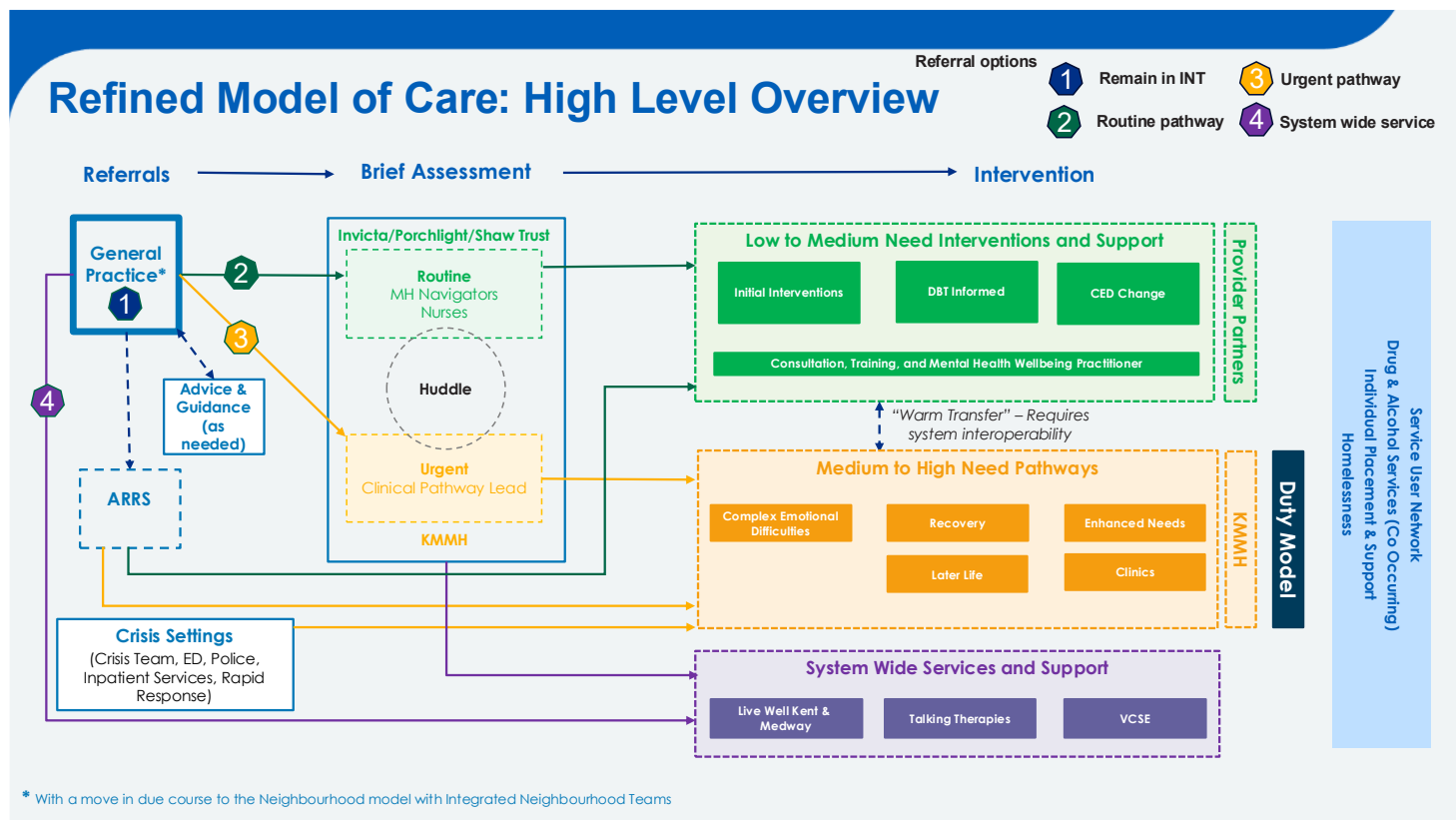
The refreshed Model of Care has been agreed and provides greater clarity on the interventions to be delivered for people with low-to-medium and medium-to-high levels of need. It reinforces the role of care navigation and partnership delivery while retaining appropriate clinical oversight and access to specialist input. A small number of outstanding activities remain, primarily to support operationalisation, including:

- Advice and Guidance has been approved in principle and joint standard operating procedure development has started
- Work is underway to define and operationalise the revised Clinical Pathway Lead role
- Planning for older adult team changes is being prepared, subject to the outcome of consultation
- Estates requirements are being connected into locality and Model of Care planning
- Training requirements are being clarified for both KMMH and partner staff, with the workforce workstream, including working in old age mental health.

Locality planning is now central to programme delivery. Each locality must translate the common Model of Care into a practical implementation plan reflecting its starting position, population need, current pathway maturity, workforce, partner readiness, estates and operational pressures. This is inherently complex and requires coordinated management of multiple dependencies.

Intervention mapping is underway to identify what has and has not been established in each locality, which interventions will transfer or change, and the practical requirements for rollout. A locality readiness assessment has been developed. It considers pathway design, workforce and training, process and governance, activity and outcomes, data and reporting, and stakeholder readiness. The approach will now be refined and applied across all localities to provide a

consistent view of implementation maturity, outstanding dependencies and action required before go-live.



Workforce

The workforce workstream has achieved a significant milestone in moving from demand and capacity modelling into formal consultation and implementation preparation. The consultation paper, supporting documentation and Joint negotiating forum paper have been completed and considered, and formal consultation commenced on 24 August 2026. The consultation is a genuine opportunity for colleagues to share their views and help shape what happens next. Most importantly, no decisions have been made. It is planned to run for 45 days.

Achievements of this group include:

- Demand and capacity modelling completed, including consideration of the Memory Assessment Service (MAS) and dementia position
- Workforce mapping completed and used to shape proposed arrangements
- Manager briefings and pre-engagement sessions delivered ahead of consultation
- Human Resources (HR) support and communication routes established to support staff and managers
- Care navigator recruitment commenced through partners
- Recruitment and backfill activity initiated to strengthen commissioning and programme capacity
- Robust plan for ongoing communication and engagement for the next phase

The consultation is an essential route to implementing the agreed model safely and fairly. However, consultation is not the end point. Detailed planning is required now so that decisions can be translated rapidly into locality workforce plans, recruitment and redeployment activity, training,

onboarding, estates and operational transition arrangements once the consultation outcome is known.

Priorities going forward include and are subject to staff feedback:

- Post-consultation planning for redeployment and recruitment, aligned with partner mobilisation and locality implementation plans
- Maintaining safe business-as-usual delivery during consultation and transition, including active management of waiting lists, vacancies, staff wellbeing and retention risks
- Confirming the future-state workforce by locality and sequencing KMMH redeployment and recruitment with partner recruitment and onboarding
- Developing and delivering an integrated training and competency plan for KMMH and partner staff, aligned to the timing of pathway rollout
- Ensuring managers and affected staff receive timely information and support throughout consultation and implementation
- Tracking recruitment, redeployment and workforce readiness through locality plans and the programme critical path, with early escalation where capacity or timing may affect safe implementation, including for partners

Finance and commissioning

The financial and commissioning foundations for Mental Health Together are now in place, with 2026/27 funding arrangements agreed and delivery partners operating within a clear planning framework. This has enabled mobilisation activities to proceed and provides a firm platform for implementation. The next phase will focus on completing the service specification, outcomes and assurance framework, alongside longer-term contractual and evaluation arrangements. Collectively, these actions will support delivery of a sustainable, outcomes-focused model that improves access to mental health support and addresses population need across Kent and Medway.

Digital and data

Digital and data activity has progressed from high-level requirements into operational preparation. The streamlined allocation of RiO interventions has been completed and system changes are prepared for implementation when care navigators are in post. KPI and reporting requirements are being developed alongside operational process design.

- Confirmation is required that all relevant measures are fully reflected in operational and strategic reporting
- Referral and process mapping must be finalised to determine how workflows will operate across KMMH and partners
- Partner access to systems and tools, including RiO, SharePoint and practical workspace systems, remains an implementation dependency
- Data and digital requirements must remain aligned to contracting and reporting obligations

Communication and engagement

Communications and engagement have been strengthened, particularly in support of consultation. Leadership briefings, pre-engagement sessions and staff communications have been developed, and engagement routes are being used to identify concerns and inform implementation.

The next step is to bring the full range of communication activity into one coordinated programme plan covering consultation, locality implementation, partner mobilisation, primary care and referrer engagement, and service user information. This will reduce the risk of inconsistent messages

where decisions are still being finalised. This will be informed by the outcome of consultation and the locality planning exercise underway.

Partnership working

The programme is continuing to mature and strengthen the provider partnerships and has a real opportunity to improve its strategic leadership as a lead provider. Since the Attain review, the engagement across the delivery partnership has developed and all partners are committed to improving the Mental Health Together offer based on learning to date. The commitment to shared planning at this critical stage of the programme is excellent. As part of the clinical model refinement our partners provided leadership in understanding the interventions that they will provide and are now supporting the delivery modelling.

Waiting Time Management

Mental Health Together continues to manage a high volume of referrals through KMMH's electronic patient record, including activity delivered by partner organisations. The centralised arrangements provide visibility of demand across the pathway, but also create a need for clear ownership, accurate recording and coordinated management of referrals, caseloads and waiting lists across the partnership.

The programme has built on the waiting-list management approach introduced in 2025, including more systematic use of data, regular operational oversight, huddles and clearer escalation. Localities continue to focus on reducing waits, improving management of non-attendance and increasing the use of group and partnership interventions where clinically appropriate. This work is aligned with wider KMMH improvement priorities, including the 0-38 week breakthrough objective, as part of the True North ambition to ensure that 85% of people referred to Mental Health Together start treatment within 18 weeks.

There is evidence of local progress. East Kent has reported reductions in elements of the Complex Trauma waiting list and increased use of group interventions, while West Kent teams continue to address waiting lists and reinforce the DNA policy. However, the position is not yet consistent across pathways or localities, and some services continue to experience demand, workforce and intervention-capacity pressures. To alleviate this, we are now prioritising the implementation of mental health care navigation across all teams.

The refreshed Model of Care, locality intervention mapping and partner mobilisation are intended to improve access and flow by clarifying which interventions are available, where they are delivered and how people move safely between services. The programme will need to maintain close oversight during consultation and transition so that implementation activity does not adversely affect business-as-usual performance.

Further assurance is required through a consistent set of programme and locality measures covering referral volumes, waiting times, caseloads, throughput, outcomes and partner-delivered activity. These measures should be incorporated into routine reporting and used to demonstrate whether implementation of the refreshed model is improving access and reducing unwarranted variation.

Currently, our waiting list position is:

- 47% reduction in the number of people waiting over 38 weeks since January 2026.
- 77% of people have started treatment within 18 weeks which is below the 85% target.
- North and East Kent continue to demonstrate an overall improved position, and we are now working with West Kent to ensure a sustainable trajectory.

Risks

Risks are being managed through the programme governance and to Executive Management Team (EMT) itself. A key risk to advise Board is:

- Delivery risks associated with the pace, coordination and momentum of delivery required across multiple localities, partners and corporate functions

A full risk log is maintained by the Programme Management Office (PMO).

As well as the programme risk community mental health is a strategic risk, which overseen through the Board Assurance Framework. Progress is being made with delivering Board Assurance Framework (BAF) actions and subject to Board approval the scoring of the strategic risk will reduce in October 2026 as a result of improvements with waiting times.

In summary - how the programme has evolved and what is different this time?

The Mental Health Together (MHT) programme has now reached a significant transition point. Over the past 18 months, the focus has been on reviewing and refining the model, understanding demand and capacity, working through the implications for services and pathways, and building a more sustainable delivery approach with partners. The programme now has a much clearer and more mature foundation for implementation. The refreshed Model of Care has been agreed, key design decisions have been made, the workforce and financial implications are understood, and detailed locality planning is underway to translate the model into operational delivery. The programme has therefore moved from a period of design and discovery into a period of implementation and delivery.

As previously reported to this Board, it is equally important to recognise the experience of staff during the earlier stages of implementation. The original rollout of Mental Health Together was widely experienced as being undertaken at pace, without a clear assessment of organisational readiness and insufficient opportunity for meaningful engagement, involvement and communication with those responsible for delivering services. This created confusion and uncertainty for many frontline teams, with some staff feeling that decisions had been made without sufficient understanding of the practical implications for services and patients. Following feedback from staff, partners, service users and the independent review by Attain, the Trust's leadership made a commitment to both staff and the Board that the next phase of implementation would be approached differently, with a much greater emphasis on engagement, co-design, communication and operational readiness.

The current programme has been intentionally designed to reflect those commitments. Considerable effort has been invested in workforce engagement, consultation, manager briefings, partnership working, locality planning and the development of clear implementation plan before changes are introduced. Alongside the formal consultation process, staff are being supported through dedicated HR support, leadership engagement sessions, regular programme communications and opportunities to shape local implementation. Whilst the programme is now entering a demanding delivery phase, there is significantly greater clarity about the future direction of travel and a stronger focus on bringing staff, partners and corporate teams with us through the change. The aim is not simply to deliver the refreshed model, but to do so in a way that is measured, transparent and supportive, maintaining confidence, service continuity and patient safety throughout the transition.

2.2 Kent and Medway Mental Health Urgent and Emergency Care (UEC) Update – Progress against January 2026 commitments

In January 2026 the Board received assurance on continued reductions in primary mental health Accident and Emergency (A&E) presentations, growing Safe Haven utilisation, falling police and ambulance conveyance, and strengthening East Kent interface working. The subsequent publication of the Kent and Medway Mental Health Healthcare Needs Assessment (May 2026) and the Neighbourhood Alliance Investment in Mental Health Proposal have provided a sharper population-health and investment framework against which these operational gains can now be assessed and accelerated.

Key developments since January

Population need confirmation

The May 2026 Needs Assessment confirms that overall A&E pressure is driven by a combination of rising demand and concentrated high-intensity cohorts. 6.4% of the mental health population account for nearly nine times more A&E attendances; approximately half of mental health crisis presentations to Emergency Departments (ED) are not known to secondary services. East Kent remains an outlier for both volume and acuity, consistent with the January audit findings that admissions reflect genuine clinical need rather than avoidable factors.

The Needs Assessment and resident insight (Healthwatch, December 2025) both underline that many people reach ED because they do not know, or cannot access, trusted community alternatives – reinforcing the case for scaled, no-referral neighbourhood crisis options.

Crisis alternatives and Safe Havens

Utilisation continues to grow, particularly at co-located sites. The Thanet ground-floor relocation has been completed, with the co-located Safe Haven now based on the ground floor of Thanet Mental Health Unit (TMHU), improving accessibility and suitability.

Ashford's planned move remains on track, although construction delays within the wider East Kent Hospitals capital programme have affected the timetable. In parallel, NHS England is introducing consultant-led Crisis Assessment Centres nationally, which differ from the existing Kent and Medway Safe Havens model.

The key issue the ICB is addressing is how these models should operate alongside each other to provide a coherent, sustainable crisis alternative offer across Kent and Medway. No final decisions have been taken, and work is continuing with system partners to ensure the future model reflects local need and avoids duplication.

A system workshop is planned for early October to consider the emerging clinical model and future crisis offer. This will provide an opportunity to test the approach with partners and inform recommendations on the next phase of crisis support.

East Kent interface working

Daily ED huddles, bi-monthly interface meetings, clearer escalation routes and joint work-with days between liaison and Safe Haven staff have now become embedded. Weekly performance huddles focused on 12-hour breaches and purposeful admission continue. Estate constraints at William Harvey remain unresolved and are escalated through the estates risk register and Executive Management Team discussions with East Kent Hospitals University NHS Foundation Trust (EKHUFT).

A Home Treatment Team (HTT) in-reach pilot into Liaison Psychiatry Services (LPS) has commenced. Initial data show positive results and the pilot has been extended for a further three months. Over the last three months there have been 38 referrals across both sites where patients were stepped down from admission (18 at William Harvey Hospital Ashford and 20 at Queen Elizabeth The Queen Mother Hospital Thanet). Of these, 19 referrals were stepped down from an informal admission and discharged to HTT, and 6 were stepped down from a Section 2 admission and discharged to HTT. Conversion rates have reduced, with both LPS teams admitting 5% of all referrals in July 2026, in line with the Kent and Medway average of 4.7%.

Eliminating Corridor Care Programme – East Kent progress

The Eliminating Corridor Care Programme is beginning to demonstrate measurable improvement:

- **East Kent overall:** Diversion to Safe Haven or Crisis House provision has increased from 19% to 24%. Twelve-hour breaches where a bed was not required have reduced significantly from an average of 12 during quarter 1 to 8 in the latest weekly position.
- **Thanet:** Ambulance conveyance for mental health patients has reduced from 63.32% at baseline to 58.54% in the latest week.
- **Ashford:** Total mental health ED attendances show a –6.0% variance to baseline. Twelve-hour breaches where no bed was required have reduced from an average of 6 during quarter 1 to 4 in the latest weekly position. Ambulance conveyance remains an area for continued focus.

The following improvements are now embedded:

- Daily oversight and escalation of mental health delays, liaison waits and admission pressures.
- Strengthened liaison psychiatry input and senior clinical review of 12-hour breaches.
- Improved interfaces between Liaison, Home Treatment Teams, Safe Havens, Crisis Houses and Recovery Houses to support alternatives to admission and discharge flow.
- Regular clinical and data huddles to review patient flow, No Criteria to Reside (NCTR) and operational pressures.
- Secured Business Intelligence support to improve reporting and establish a single version of the truth across East Kent and Medway.

Additional operational progress:

- Improving diverts to Safe Haven and Crisis Houses. Kent and Medway will have a third Recovery House, based in Thanet and opening late Autumn 2026. Mental Health Matters (MHM) have agreed to co-triage with ED staff where they have capacity and to link in with the MH leads to promote the service.
- A workshop is planned for 6 October with South East Coast Ambulance Service NHS Foundation Trust (SECAMB) and partners to support a reduction in mental health ED attendances via ambulance conveyance. A gap analysis is underway comparing the Kent and Sussex models (Sussex has seen a significant reduction in see-and-convey via their blue light line). KMMH is leading a review of existing resource and policies.
- Identified High Intensity User (HIU) cohort work continues with system partners to deliver joint safety community care plans. HIU ED attendances remain low (average 1–2 per week). Self-harm attendances are decreasing.
- Dedicated team focus on 12-hour breaches (bed required / not required) through weekly huddles. Increased and sustained performance for 12-hour breaches where a bed is not required: 83.8% (Ashford) and 88.3% (Thanet) in July 2026.
- Senior leadership across East Kent is supporting mental health acute discharges, strengthening community engagement and a greater understanding of mental health Clinically Ready for Discharge (CRFD) patients.

Link to system investment priorities

The Neighbourhood Alliance proposal (developed in response to the ICB's original Outline Business Case 4 (OBC4)) sets out three high-impact priorities that directly address the residual risks highlighted in January:

- I. **Short-term step-down capacity and crisis-prevention models** (Assist & Embrace extension plus StartAfresh Cognitive Behavioural Therapy (CBT)/ Acceptance and Commitment Therapy (ACT) clinic) to reduce avoidable ED presentations and improve flow for Clinically Ready for Discharge patients. Local Clarendon House data already demonstrate 1,306 additional bed days released and £642k cost avoidance over seven months.
- II. **Rebalancing of the dementia pathway** so that specialist KMMH capacity is protected for diagnosis, medication and complex cases while post-diagnostic support is delivered at scale by VCSE partners in neighbourhoods.
- III. **Sustainable, supervised Additional Roles Reimbursement Scheme (ARRS) mental health practitioner workforce** with formal clinical governance from KMMH, standardised role identity, and clearer links into Mental Health Together teams.

These priorities are designed to deliver the left-shift that the January paper identified as essential if East Kent's disproportionately high mental health demand within UEC is to be sustainably reduced.

Future focus (aligned to January commitments and new evidence)

- I. Transition Ashford Safe Haven to 24/7 once estates decisions are confirmed.
- II. Embed the three investment priorities within the ICB's Mental Health Commissioning Review (commencing October 2026) so that recurrent funding decisions for 2027/28 are informed by the population-health evidence now available.
- III. Complete the formal evaluation of step-down beds and Assist & Embrace impact (bed-day release, out-of-area reduction, ED avoidance) and report findings to the Board in the next cycle.
- IV. Progress the Safe Haven and Crisis House programme, including the additional Recovery House in Thanet (late Autumn 2026).
- V. Deliver the ambulance conveyance workshop (6 October) with SECamb and partners and complete the Kent-Sussex gap analysis.
- VI. Continue High Intensity User workstream and embed new interventions through Start Afresh and Assist & Embrace; maintain weekly senior clinical data huddles on 12-hour breaches and focused work to reduce CRFD delays.

Areas to bring to the Board's attention

The operational improvements reported in January are real and sustained. The Eliminating Corridor Care Programme, for which we are leading on the mental health improvements is now showing measurable gains in diversion rates and 12-hour breach performance, particularly in Thanet. However, the Needs Assessment makes clear that further left-shift requires targeted neighbourhood investment rather than continued reliance on crisis and acute capacity alone.

East Kent estate constraints (particularly at William Harvey) and the absence of permanent step-down capacity remain the principal risks to flow and purposeful admission.

The Neighbourhood Alliance proposal provides a coherent, evidence-based vehicle for the system to address these residual risks.

2.3 Health Inequalities Update

Reducing health inequalities remains a key priority across Kent and Medway, where mental health need, poorer wellbeing outcomes and service demand are disproportionately concentrated within more deprived communities. Wider determinants such as housing, employment, social isolation, transport, physical health and discrimination continue to influence both mental health outcomes and access to support.

During 2025/26, the Kent and Medway Provider Alliance and Kent County Council Public Health commissioned a health inequalities project within Thanet Mental Health Together. The project piloted a Mental Health Inequalities Checklist, complementing existing Equality Impact Assessments (EQIAs) by combining population health data with staff, VCSE and lived experience insights to identify inequalities and inform mitigating actions.

Although undertaken within a single locality, the project demonstrated the value of combining quantitative and qualitative evidence to identify barriers linked to deprivation, housing, transport, digital exclusion, caring responsibilities and access for underserved groups. These findings were subsequently reinforced by the Kent and Medway Mental Health Healthcare Needs Assessment (May 2026), which highlighted significant variation in need, access and outcomes associated with deprivation, ethnicity and social vulnerability, and emphasised the importance of prevention, earlier intervention and neighbourhood-based models of care.

These insights have informed a more systematic approach to addressing inequalities across mental health transformation programmes. Alongside EQIAs, programmes increasingly utilise population health management, equality data, engagement and lived experience evidence to understand variation in access, experience and outcomes and to identify mitigating actions at the earliest stages of design.

This approach is reflected within the Neighbourhood Alliance Mental Health Proposal, which recognises the concentration of mental health need within deprived communities and the presence of hidden and unmet need. The proposal sets out a direction of travel focused on neighbourhood-based support, strengthened VCSE partnerships, dementia pathway redesign, earlier intervention, and Mental Health Practitioners in primary care. These developments are intended to improve access, strengthen prevention, reduce unwarranted variation, and better support communities experiencing the greatest burden of mental ill health. The detailed business case, including associated financial requirements, is now being developed for final consideration and agreement.

3. Current performance data

Measure	Agreed trajectory	Current data												AVG	Line Graph
		Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26		
Methodology: Red, Amber, Green (RAG) is determined by two factors; - Agreed target, or - Averages. These are compiled based on performance data for the previous 6-month financial period covered and may therefore change for the report period being covered. The RAG rating reflects this same 6-month period.															
		Programme: Dementia Pathway Transformation													
Increase dementia diagnosis rate	66.7% by March 2026	62.1%	62.1%	62.3%	62.3%	62.1%	62.0%	62.4%	62.4%	62.7% (now quarterly)			-	N/A	
		Programme: Mental Health Urgent and Emergency Care													
Reduced MH A&E attendance and increase in attendance at safe havens	Reduce	% MH A&E presentations against total presentations												1.67%	
	Reduce	1.20%	1.00%	1.14%	1.17%	1.18%	1.19%	1.9%	1.9%	2.3%	2.3%	2.2%	2.5%		
	Increase	A&E attendances for adult patients with primary MH need													
	Increase	897	799	866	805	713	771	688	820	898	920	927	1069		
Crisis house bed occupancy	85%	Safe Haven attendance												848	
		1758	1751	1811	1753	1887	1778	1748	1681	1976	2210	2284	2232		
		Medway bed occupancy												N/A	
		64%	78%	85%	83%	80%	75%	74%	74%	94%	70%	89%	98%		
Reduced mental health in ambulance/ police conveyances to A&E	Reduce	Ashford bed occupancy												1906	
		85%	90%	80%	90%	80%	68%	80%	68%	95%	81%	73%	92%		
		Primary MH A&E presentation - Ambulance conveyance												411	
		373	333	410	381	346	110	375	424	527	533	500	621		
Reduction in incidence of Section 136	Reduce	Primary MH A&E presentation - Police conveyance												42	
		45	32	38	24	31	23	50	51	57	42	48	55		
														61	
		74	67	68	58	66	73	55	56	56	57	49	53		

Exception reporting on performance

- July saw increased mental-health presentations at EKHUFT, Medway and QEQM. The ICB report there is a seasonal increase in mental health presentations during the summer months with demand often increasing across urgent and emergency care pathways.
- Ambulance conveyance to emergency departments reached its highest level in the reporting period.
- In terms of wider mitigating actions, the system has continued to invest in and expand alternatives to ED attendance, including the new crisis recovery house and continue to promote mental health support services (especially around world mental health day).
- In addition, work is progressing on the development of Crisis Assessment Centres, which are intended to provide an alternative destination for people experiencing a mental health crisis and reduce reliance on both EDs and ambulance conveyance.
- Safe Haven attendances are approximately 20% higher year-on-year, led by Thanet and Medway.
- Association between increasing Safe Haven use and reduced ED reliance continues, although direct causation cannot be confirmed.
- Liaison to Safe Haven discharges have been reducing over the last 6 months and repeat attendance remains elevated and increasing.
- To remedy this KMMH are providing additional support to Clinicians to increase their confidence in VCSE provision and a workshop on the 22 September with system stakeholders will explore the value of strengthening clinical in-reach into Safe Havens.
- Crisis Houses maintain high occupancy, supporting patient flow and reducing inpatient demand. Across 2025/26, both houses accepted more referrals than they declined.

4. Programme Milestones for 2026-2027

Milestone Tracking Key

X complete X not complete but confident on future timescale X has/will slip

Community Mental Health Framework				
Milestone	26-27			
	Q1	Q2	Q3	Q4
Development of refined operating model to support delivery of agreed clinical model (to incorporate demand/capacity, workforce, digital, estates and contracting)		X		
Transition and sustainability of refined clinical and operating model to business as usual			X	
Implementation of new CHYPS AMS pathway into the CMHF		X		
Dementia Pathway Transformation				
Milestone	26-27			
	Q1	Q2	Q3	Q4
Level 1 – Continuation to roll out new care home diagnosis process and training across the county	X	X		
Level 1 – Additional funding for primary care supporting level 1 and 2 dementia diagnosis to be agreed	X	X		
Level 1 – Evaluate the care home pilots based on data and completed Diagnosing Advanced Dementia Mandate (DiADeM) tools. Expected evaluation period to be assessed in September	X	X		

Level 2 – Go live with community dementia diagnosis pilot in Folkestone & Hythe	X				
Level 2 – Conduct a clinical audit on Folkestone & Hythe to assess efficacy of model	X	X			
Level 2 – Scale up pilot across 2 additional PCN areas within the Folkestone & Hythe footprint		X			
Mental Health Urgent & Emergency Care					
Milestone	25-26	26-27			
	Q4	Q1	Q2	Q3	Q4
Bespoke Conveyance (to include sit and wait) go-live	X				
Publishing of revised Crisis 136 Standards				X	
Centralised health-based place of safety (HBPOS) Go Live				X	
William Harvey Safe Haven increase to 24-hour service				X	
Procurement of Thanet and Medway Crisis Houses					X

Exception reporting on milestones

Community Mental Health Framework (CMHF)

- Revised delivery timescales have been agreed and are reflected within the updated programme critical path. Further detail is provided within the CMHF programme update, including workforce consultation, locality readiness and partner mobilisation activities required to support implementation of the refreshed model of care.

Dementia

- Primary care funding arrangements remain subject to ongoing ICB and Local Medical Committee (LMC) discussions regarding the preferred contractual mechanism. A revised funding offer is anticipated in October 2026, which is expected to support wider primary care participation and increased DiADeM activity.
- Evaluation of the Level 1 care home model has been delayed pending increased DiADeM activity and confirmation of primary care funding arrangements, with evaluation now expected following implementation of the funding enabler.
- The Level 2 community diagnosis pilot has been delayed whilst completing workforce alignment, operational readiness, system access requirements and finalisation of clinical governance arrangements with the participating PCN. Prescribing arrangements have now been resolved and the programme anticipates mobilisation towards the end of September/October, with aligned staffing expected by the end of the month.
- Audit and wider rollout milestones are expected to move to Q4 to reflect the revised pilot mobilisation timeline and ensure learning from initial implementation informs future expansion.

MH UEC

- The MH Conveyancing will not be delivered until **Q3 27/28**. The ICB are working on getting a 12-month extension
- Procurement of Thanet and Medway Crisis Houses- Procurement of Medway Crisis house is going to be signed off in September. Urgent Award for Thanet Crisis house has happened, and it will open in November 2026
- The S136 standards and centralised place of safety remain on track on the revised timeline.

Trust Board meeting

Meeting details

Date of meeting:	24 th September 2026
Title of paper:	Kent and Medway ICB Draft Commissioning Intentions
Author:	Nick Brown, Chief Finance and Resources Officer
Executive Director:	Nick Brown, Chief Finance and Resources Officer

Purpose of paper

Purpose:	Discussion
Submission to Board:	Board Requested

Overview of paper

This paper summarises the Kent and Medway Draft Commissioning Intentions for 2027/28, the Trust's consultation response, the strategic opportunities for the Trust and the matters that need further clarification following the consultation.

The approach aligns strongly with the Trust's five-year strategy; with delivery dependent on joint working across the system.

Issues to bring to the Board's attention

Strategic alignment and opportunity

- The four-layer model and the emphasis on prevention, neighbourhood care, integration and outcomes align with the Trust's strategy and build on the work we have begun within community services through Mental Health Together.
- The intentions create the opportunity to improve how services come together to support the population, with a focus on underserved communities, and to redesign all-age pathways around need rather than organisational boundaries.
- The Trust supports the stronger focus on outcomes and patient benefit rather than activity alone.
- There is consistent alignment in approach across physical and mental health.

Next Steps

- Further work is needed to understand the current foundations and the steps required to develop mental health services across the system.
- Further work is needed to agree the future commissioning arrangements for a number of services.
- Investment and workforce assumptions require clarification, informed by the Mental Health Commissioning Review.

The full Kent and Medway Commissioning Intentions are available on the link below.

<https://www.kentandmedway.icb.nhs.uk/download/kent-and-medway-commissioning-intentions-202728.pdf?ver=7571&doc=docm93jjjm4n4442.pdf>

Governance	
Implications/Impact:	The intentions create opportunities to improve access, outcomes and integration. Delivery will require clarity on the clinical model, commissioning responsibilities, investment, workforce, digital and estates requirements, and safe management of transition risks.
Assurance:	Reasonable
Oversight:	Executive Management Team

Kent and Medway ICB Commissioning Intentions

Introduction

This paper provides the Board with an overview of the draft Kent and Medway Commissioning Intentions for 2027/28 and the Trust's initial assessment of their implications.

It summarises the formal response submitted on 24th August 2026 and highlights the strategic opportunities, key dependencies and areas where greater clarity is needed.

ICB Commissioning Intentions

The ICB's commissioning intentions signal a significant change in how services may be organised and commissioned across Kent and Medway. They describe four layers of care: primary care, single-neighbourhood care, multi-neighbourhood care and acute. This approach is being consistently applied across both physical and mental health bring a parity in approach to the system.

For mental health, learning disability, autism and ADHD, the proposed direction places greater emphasis on prevention, primary care, neighbourhood and community support, while retaining specialist provision for people with the highest levels of complexity, risk and clinical need.

At the heart of the intentions is a significant shift towards prevention, tackling health inequalities, neighbourhood and integrated care, with success judged increasingly through outcomes, quality and patient experience rather than activity alone.

These priorities are expected to inform provider requirements through the 2027/28 commissioning and contracting process.

The ICB is commissioning a system-wide Mental Health Commissioning Review. This should establish a clear understanding of current provision and system gaps, providing the evidence base for the future development of mental health services.

Overall, the direction is aligned with the Trust's five-year strategy and should provide the trust with an opportunity to build on the community transformation already under way through Mental Health Together.

The Trust is well placed to help shape the future model, although further work will be needed across the system to translate the intentions into a deliverable approach. As the main mental health provider in Kent and Medway, we have a key role in supporting this work with the ICB and our partners.

Strategic Opportunity

Area	Potential Opportunity
System Leadership	The commissioning intentions provide an opportunity to develop the models of care required to meet the needs of our population. Building on Mental Health Together and wider community transformation, the Trust can make a leading contribution to the future clinical model, commissioning framework and implementation approach, working with the ICB and system partners.

Prevention and Neighbourhood Care	The emphasis on prevention, early intervention and neighbourhood health creates an opportunity to support people earlier and reduce reliance on more specialist services over time. Building on the Trust's community model, KMMH are well positioned to work with primary care, community providers, local authorities and VCSE partners to define the mental health contribution at each layer and ensure clear access, escalation and clinical accountability.
Pathway Redesign and Outcome-Based Care	The intentions support pathways designed around need, recovery and outcomes rather than organisational boundaries or activity alone. This creates an opportunity to agree consistent all-age standards and transitions, while recognising where distinct age-appropriate services remain necessary. The Trust can build on its approach with commissioners, patients and partners to define measures that drive improvement, investment and reduced inequalities.

Overall Trust Assessment

The Trust supports the strategic direction and recognises the work undertaken to establish a clear and coherent set of principles across the Kent and Medway health system. The intentions provide a significant opportunity to develop mental health services and improve access, integration and outcomes across the system.

Reflecting their stage of development, the intentions represent the strategic direction, with further work required to turn these into a fully defined delivery model. The Trust will continue to work with the ICB and partners to ensure that the final approach is grounded in evidence, supported by realistic investment and workforce assumptions, and implemented through clear governance and accountability.

Next Steps

To take this forward, the Trust believes the next phase should focus on:

- **Learning from the current position** – To support delivery of the ambition, further work is needed to understand the existing foundations and identify the steps required to develop mental health services within the system.
- **Investment and commissioning clarity** – The Trust's response highlights the importance of recognising the historical underinvestment in mental health. The Mental Health Commissioning Review provides an opportunity to identify priorities and future investment requirements, alongside greater clarity on the commissioning arrangements for memory assessment services, learning disability, autism and ADHD.
- **Service model fidelity and all-age pathways** – Delivering the intended outcomes will require evidence-based service models, commissioned with sufficient fidelity. An all-age approach should provide a consistent offer and clear transitions, while retaining distinct age-appropriate provision where clinically necessary.

Board Ask

The Board is asked to:

- Note the strategic alignment between the commissioning intentions and the Trust's five-year strategy;
- Note the Trust's assessment of the opportunities, and next steps; and
- Endorse continued engagement with the ICB and system partners to shape the final model, commissioning arrangements and implementation approach.

Title of Meeting	Board of Directors (Public)
Meeting Date	24th September 2026
Title	Quality Committee Chair's Report
Author	Margaret Dalziel, Non-Executive Director
Presenter	Margaret Dalziel, Non-Executive Director
Executive Director Sponsor	Julie Kirby, Acting Chief Nursing Officer
Purpose	Discussion

Agenda Items

<u>People items</u>	<u>Patient items</u>	<u>Finance & Governance items</u>
Chief Nurse's Quality Report	- Quality Improvement Plan - National clinical audit participation and actions - Accreditation and Quality Network Membership - Annual Ligature Audit Report – 6-month update	- Director of Infection Prevention and Control (DIPC) Annual Report and Declaration - Terms of Reference

Agenda Items by exception	Assurance narrative by exception. Key items to be raised to the Committee.	None Limited Reasonable Substantial	Actions, mitigations and owners Refer to another committee.
Chief Nurse's Quality Report	The Committee noted the significant gap between newly qualified mental health nurses and available posts. Longer-term workforce planning is being developed, and a proposal will be taken to the People Committee for consideration. Patient flow and corridor care remain under close oversight, with some improvement noted, although delays in accessing beds continue. Propose: The Committee received limited assurance regarding the Trust's ability to convert its mental health nursing education pipeline into substantive employment. Of 79 recently qualified mental health nursing students, six had been appointed at the point reported, with a further 19 potential opportunities subject to service developments and consultation. The Committee was concerned that this is a recurring issue and could affect the future nursing workforce pipeline. A consolidated nursing workforce plan, covering newly qualified nurses, Band 5 to Band 6 progression, apprenticeships and advanced practice, will be presented to the People Committee. The Committee considered and agreed with the proposal that inquest reports and Prevention of Future Deaths reports (PFDs) that currently go to the private Board are reported through the Quality Committee,	Limited	Workforce plans will be developed further through the People Committee A proposal will be made for inquest and coroner assurance to come routinely to Quality Committee, with exception reporting to the private Board. Future reporting should identify recurring themes, actions, learning and evidence that changes have been sustained.

	enabling discussion and triangulation to be considered first. Additionally, the Trust has experienced several PFDs that have indicated a change in approach from the coroner's office. The Committee were assured that senior medical leaders from across the system have written jointly to coroners to address this.		
Quality Improvement Plan	The Committee noted the asserted continued progress, including improved risk formulation compliance and stronger environmental oversight, though no written evidence was provided at this meeting to draw from. Limited assurance remains appropriate because performance is still below target and current reporting does not yet show priorities, trends, patient impact and sustainability clearly enough. The Committee questioned whether the current volume of Key Performance Indicators (KPIs) obscures the principal priorities and whether all stated delivery dates remain credible.	Limited	A revised reporting format will be available at the next committee to set out evidence for assurance of to highlight risks. This will outline key priorities, priority outcomes, trends, residual risks and evidence of sustained improvement. Data-quality and reporting issues will continue to be addressed.
National clinical audit participation and actions	Full participation in mandatory national clinical audits was noted, alongside the benefits of accreditation and quality-network membership. The Committee requested clearer evidence that audit findings and external learning are aligned to Trust priorities, implemented consistently and resulting in sustained improvement.	Reasonable	Future reports will demonstrate the impact of audit and accreditation activity, completion of improvement actions and how learning is shared across services.
Annual Ligature Audit Report – 6-month update	The Committee received reasonable assurance that All 2026 ligature audits have been completed, and that oversight of resulting actions has been strengthened.	Reasonable	Good practice will be shared across inpatient services. Outstanding environmental works will

	The Committee welcomed evidence that environmental risks are being considered alongside individual patient risk and care planning. Some capital works remain unfunded and therefore require continued local mitigation and oversight.		remain visible through risk management and capital prioritisation arrangements.
Terms of Reference	The Committee supported in principle the transfer of Mental Health Act (MHA) and Mental Capacity Act (MCA) assurance and the move to bi-monthly meetings. Limited assurance remains because further clarity is required on Integrated Quality and Performance Report (IQPR) oversight, Board Assurance Framework (BAF) reporting, risk-register frequency and protection of MHA scrutiny.	Limited	The Terms of Reference will be revised following Committee feedback and the wider governance review. The proposed route for IQPR oversight will be considered further, taking feedback from Non-Executive Directors (NEDs) before Board approval. Mental Health Act shall be explicitly protected through agenda planning, with effectiveness reviewed after the new arrangements have operated for an agreed period.
The Committee asked the Board to note: • The unresolved governance route for overall IQPR assurance, which should be settled before the revised committee Terms of Reference are approved; • The significant gap between the number of newly qualified mental health nurses and available substantive posts, with a consolidated workforce response to be considered through the People Committee; • The need to establish routine Quality Committee oversight of coroners, inquests and Prevention of Future Deaths learning; and • That, while the Quality Improvement Plan speaks to progress, further development of reporting is required before the Committee can obtain clear assurance on priorities, risk profile, patient impact, delivery trajectories and sustainability.			

Title of Meeting	Public Board Meeting
Meeting Date	24th September 2026
Title	People Committee Chair's Report
Author	Pam Creaven, People Committee Chair, Non-Executive Director
Presenter	Pam Creaven, People Committee Chair, Non-Executive Director
Executive Director Sponsor	Ali Layne-Smith, Interim Chief People Officer
Purpose	Discussion

Agenda Items

<u>People items</u>	<u>Patient items</u>	<u>Finance & Governance items</u>
• Deep Dive - diversity & Inclusion and staff health inequalities • People Committee Main Report including the People Plan • People Risk Register • Staff Standards • Staff Survey Response Rate to 65% • Cultural Inclusion Ambassador recruitment • Future Workforce Solution		• HR Policies and Procedures • Committee Effectiveness Review

Agenda Items by Exception	Assurance narrative by exception. Key items to be raised to the Board.	None Limited Reasonable Substantial	Actions, mitigations and owners Refer to another Committee.
Deep Dive - diversity & Inclusion and staff health inequalities	The Committee received reasonable assurance on workforce ethnicity data completeness (99%), but limited assurance that this is yet reducing inequality. Patient ethnicity data was 87%, with significant service variation. The Committee requested clearer evidence of impact, including how inequalities are being addressed and services redesigned.	Limited	A further progress report will return in January 2027. It will address service-level variation, triangulate workforce and patient insight, demonstrate impact and include a summary of relevant patient and carer race equality work.
People Committee Main Report including the People Plan	The Committee welcomed the improved dashboard and alignment of the People Plan to the Trust strategy. Workforce metrics were reviewed, including increased long-term absence, agency expenditure, recruitment performance and local variation. The Committee considered that Trust-wide averages may mask directorate-level differences and requested clearer evidence that the People Plan is delivering measurable outcomes rather than reporting activity alone.	Reasonable	Future reporting will continue to show directorate-level variation and will strengthen the link between actions, outcomes and demonstrable impact. Targeted work is under way in areas of higher long-term absence.
People Risk Register	The Committee reviewed culture, agency expenditure and sponsorship risks during a period of transition to the revised Board Assurance Framework approach. Limited assurance was received on agency expenditure because the current position remains above plan and the effectiveness of controls is not yet sufficiently clear. The Committee also identified the newly qualified	Limited	People risks will be aligned to the revised cause-and-effect and control-focused risk framework. Agency information will be disaggregated to show CYP separately, with clearer narrative on controls and improvement. A summary of CYP medical recruitment and agency actions will return to the next meeting. The nursing workforce pipeline and

	nursing workforce pipeline and implementation of the People Portal as risks requiring continued visibility.		People Portal will be added to risk oversight until sufficiently mitigated.
Staff Standards	The Committee supported the proposed approach to establishing a baseline against the six NHS Staff Standards and integrating delivery with existing culture and workforce programmes. The line management standard was recognised as foundational. Assurance remains limited until the baseline, gaps, accountabilities and evidence of consistent staff experience are available.	Limited	An integrated improvement plan will return in January 2027, setting out the baseline, gaps, priorities, risks and accountable owners. It will also consider system working and the implications of future neighbourhood arrangements. The Board will be sighted through the Chair's report.
Staff Survey Response Rate to 65%	The Committee received reasonable assurance on the robustness of the process and leadership focus supporting the 65% response-rate ambition, including weekly executive oversight, targeted support, local action and peer learning. Limited assurance was received on delivery and impact because the outcome is not yet known and the Committee cannot yet determine which interventions are making a measurable difference.	Limited	Progress will be monitored through response-rate data and local narrative. Reporting should demonstrate leadership accountability, variation between teams, learning from high-performing areas and whether staff believe that feedback leads to meaningful action.
Cultural Inclusion Ambassador recruitment	The Committee reaffirmed support for mandatory Cultural Inclusion Ambassador involvement in Band 7 and above recruitment and did not support removing the requirement. The programme provides an independent inclusion perspective, but the Committee received limited assurance on its measurable impact and sustainability. Delays were linked principally to late engagement and release of	Limited	The mandatory requirement will remain. A report will return to the next meeting showing Band 7 and above recruitment data, ambassador feedback, evidence of challenge and impact, and practical improvements to contact, notice, release and recognition arrangements. Expansion should be considered only after the current model is demonstrably effective and sustainable.

	ambassadors rather than the overall number available.		
Future Workforce Solution	The Committee endorsed the strategic direction of the People Portal and supported adoption of all domains but agreed to note rather than approve the programme at this stage. Members sought clearer assurance on Trust-level governance, readiness, accountability and mitigation of risks while the solution remains under development. The Committee agreed that the Board should be fully sighted through the Chair's report.	Limited	The programme will clarify the respective roles of the Committee, Board and internal governance arrangements, and how Trust-level risks will be managed and escalated. The Committee will receive proportionate updates on readiness, digital maturity, implementation and risk mitigation.
The Committee asked the Board to note: * Limited assurance on whether improved diversity data is yet producing demonstrable reductions in inequality, with a fuller impact report due in January 2027. • The newly qualified nursing workforce pipeline and the People Portal were identified for continued risk oversight. • Limited assurance on agency expenditure and the need for clearer, disaggregated reporting on CYP, effective controls and improvement trajectories. • The Committee endorsed the strategic direction of the People Portal but noted, rather than approved, the programme pending clearer Trust governance, readiness and risk mitigation. • The Cultural Inclusion Ambassador requirement for Band 7 and above recruitment will remain, with impact and sustainability evidence to return to the Committee. • The NHS Staff Standards baseline, and integrated improvement plan will return in January 2027, with clear gaps, risks and accountable owners.			

Title of Meeting	Board of Directors (Public)
Meeting Date	24 th September 2026
Title	Audit and Risk Committee Chair's report
Author	Kevin Corrigan, Non-Executive Director
Presenter	Kevin Corrigan, Non-Executive Director
Executive Director Sponsor	N/A
Purpose	Discussion

Agenda Items

<u>Finance and Regulatory items</u>
• Board Assurance Framework • Trust Risk Register • Cyber Risk Deep-Dive • Internal Audit Report • Anti-Crime Report • Effectiveness and Value for Money (VFM) of Auditors Review • Director of Finance Items • Trust-wide Health, Safety and Risk Group Biannual Report • Fire Safety Report • Emergency Preparedness and BRP Reviews • Information Governance Assurance • Gifts and Hospitality Registers • Review of Terms of Reference

Agenda Items by exception	Assurance narrative by exception. Key items to be raised to the Board.	None Limited Reasonable Substantial	Actions, mitigations and owners Refer to another committee.
Board Assurance Framework	The Committee approved the current Board Assurance Framework as an interim position pending introduction of the revised, strategy-aligned framework. The Committee remained concerned that the current presentation did not provide a sufficiently clear basis for assessing the effectiveness of controls and assurance during the transition. The Committee highlighted that greater clarity was required on the distinction between risk appetite and tolerance, the relationship between qualitative appetite statements and quantitative scoring, and the treatment of emerging external and regulatory risks.	Limited	The Committee emphasised the need for a clear audit trail between the current and revised frameworks, identifying risks retained, reformulated, transferred or removed.
Trust Risk Register	Trust Risk Register was reviewed and Committee Members challenged the consistency and credibility of risk scoring where initial and current scores remained unchanged despite controls being recorded as operating, or mitigating actions being shown as completed.	Limited	The Committee acknowledged the work by the Risk Management Team to strengthen quality control and challenge over risk scores, control effectiveness and completed actions.
Cyber Security Deep-Dive	The Committee received a comprehensive deep dive, with substantial assurance that mandatory assessment arrangements were in place for new digital products. The Committee supported strengthening procurement controls to ensure that contracts cannot proceed without appropriate cyber review.	Reasonable	It was confirmed a six-monthly supplier assurance dashboard should be developed, to enable oversight of external risks. The Committee noted that any material constraint caused by insufficient specialist capacity should be escalated through the Executive and to the Committee

Internal Controls – 3 rd party	<u>Internal Audit Report</u> The delivery of the 2026/27 plan remained on track and the 2025/26 programme was substantially complete. The Committee suggested that changes to the Internal Audit Plan should be considered in response to emerging organisational risks throughout the year. <u>Anti-Crime Report</u> The Committee received an encouraging report, supported by benchmarking against comparable trusts. The Trust had undertaken the highest number of investigations within the comparator group and recovered the highest amount of identified fraud loss. <u>Effectiveness and VFM of Auditors Review</u> The Committee received a report setting out relevant sector developments and examples of good practice arising from external auditors' value-for-money work, including medium-term financial planning, benchmarking, procurement discipline and Board decision-making.	Reasonable	
Internal Controls - Trust	<u>Fire Safety</u> The Committee approved the Fire Safety Report and received assurance that fire risk assessments had been completed across the Trust estate. However, the Committee challenged the training compliance target and suggested that a 100% target should be introduced. <u>Emergency Preparedness and BRP Reviews</u> The Committee received a positive annual review and endorsed its submission to the Board, subject to resolution or transparent reporting of the remaining technical compliance point.	Reasonable	The Committee considered the material strategically relevant and requested that the Trust assess its arrangements against the good-practice examples. The Committee requested stronger alignment between the Fire Safety Report and the related Fire Safety risk on the Trust Risk Register.

	<u>Information Governance Assurance</u> The Committee noted increasing demand for subject access requests and requested trend information to support future assessment of capacity and performance. <u>SIRO Annual Report</u> Reviewed and discussed. Committee received assurance that information governance arrangements remain effective, with incidents largely attributable to human factors rather than systemic control failure.	Reasonable Reasonable	The Committee supported the need for continued monitoring of Information Commissioner's Office-reportable incidents, to identify any underlying issues.
Terms of Reference	The Committee approved the Terms of Reference, subject to implementation of the requested amendments, and subsequent circulation to members.	Reasonable	

Title of Meeting	Board of Directors (Public)
Meeting Date	24th September 2026
Title	Finance, Business and Investment Committee Chair's Report
Author	Kevin Corrigan, Non-Executive Director (Acting Committee Chair)
Presenter	Kevin Corrigan, Non-Executive Director (Acting Committee Chair)
Executive Director Sponsor	Nick Brown, Chief Finance and Resources Officer
Purpose	Discussion

Agenda Items

<u>People items</u>	<u>Patient items</u>	<u>Finance items</u>
Committee effectiveness review and Terms of Reference	- Research and Innovation Update - Estates Update and Estate Strategic Plan 2026-2031 - Mental Health Together next steps - Assertive Outreach Business Case	- Chief Finance and Resources Officer Report including BAF risks - Finance Report for Month 5 - Cost Improvement Programme and Medium-Term Plan - Service Line Reporting - Digital Plan Update - Perinatal Provider Collaborative contract extension - Multidisciplinary consultancy services contract award

Agenda Items by exception	Assurance narrative by exception. Key items to be raised to the Committee.	None Limited Reasonable Substantial	Actions, mitigations and owners Refer to another committee.
Research Investment Update	The Committee welcomed an update on the research programme and members recognised the potential benefits for patients, staff recruitment and retention, and the Trust's research profile. Assurance was sought on how the financial and wider value of research investment would be demonstrated and linked clearly to the <i>Doing Well Together</i> strategy.	Reasonable	Future reporting will provide a clearer assessment of financial and non-financial benefits, strategic alignment and partnership opportunities.
Chief Finance and Resources Officer Report including BAF risks	The Committee noted the national benchmarking opportunity in the corporate cost base and the ongoing work around this. The work on unblocking the block within Mental Health was noted. Members discussed whether cyber should remain within the wider digital strategic risk or be presented as a separate strategic risk.	Reasonable	Further updates on corporate costs and the developing contracting approach will return to the Committee. The treatment and oversight of cyber risk will be considered by the Board as part of BAF discussion.
Finance Report for Month 5 and Cost Improvement Programme	The Trust reported a break-even position at Month 5 and remained on plan. However, delivery continues to depend on reducing external bed use and managing inpatient staffing pressures.	Reasonable	Continued close monitoring is required of external bed use, clinically ready for discharge levels, length of stay, staffing pressures and cash.

	The Committee also noted the position was being support by non-recurrent mitigations and that delivery of the medium-term plan would require locally developed schemes while national guidance was awaited.		
Digital Plan Update	The Committee noted progress in delivering the Digital Plan, including work supporting the transfer of children's and all-age eating disorder services. Delivery remained under pressure because of dependencies, supplier-related delays and the need to reprioritise specialist resources. The Committee received assurance that the risks were being actively managed and subject to continued executive oversight. Members also welcomed approval to progress Dragon Copilot.	Limited	Delivery will remain under close review, with continued escalation of supplier dependencies and monitoring of the impact on the service-transfer timetable.
Estates Update and Estate Strategic Plan 2026-2031	The Committee received assurance that facilities and maintenance contracts were performing well and welcomed progress on major developments. Members asked for future reporting to show the key quality and patient-experience measures underpinning headline contract KPI performance. The draft strategy was welcomed and members requested stronger emphasis on neighbourhood health, partnership use of estate, geography and access, climate resilience, neuro-inclusive environments, digital alignment and future priorities.	Reasonable	The Estate Strategic Plan will be revised to reflect the Committee's feedback. Future estates reporting will provide clearer assurance on the quality and patient-experience measures supporting headline performance.

Business cases and contract approvals	<u>Contract extension – Kent and Medway Perinatal Provider Collaborative</u> The Committee approved the five-year extension of the perinatal provider collaborative arrangement. <u>Contract Award Recommendation: Multidisciplinary Consultancy Services for the Estates and Capital Programme</u> The Committee approved the contract award for multidisciplinary consultancy services supporting the estates and capital programme. <u>Mental health Together next steps – Contract update</u> The Committee endorsed the proposed contractual arrangements, subject to satisfactory financial and operational due diligence, delivery within the available financial envelope, and completion of procurement, legal and governance requirements.	Reasonable	Further work is required to finalise partner contracts, test performance and capacity, and close the financial gap through review of Trust budgets and commissioning arrangements. The new Partnership Committee will provide an important route for assurance and accountability.
Assertive Outreach Business Case	The Committee supported the proposed direction of travel and recognised the patient-safety case for a dedicated assertive outreach model for people who may disengage from services. However, members concluded that the paper required further development before final approval, particularly to strengthen the financial and workforce case.	Limited	A strengthened Assertive Outreach business case will return to the Committee.

Committee Effectiveness Review and Terms of Reference	The Committee noted the effectiveness review, recognising that the HFMA-based questionnaire differed from previous years and that four of five members had responded. Overall results were positive, with engagement identified as a relative strength. The revised Terms of Reference were supported, including the proposed change to Finance and Performance Committee, subject to resolution of membership and role-boundary points.	Reasonable	The final Terms of Reference will clarify membership, the relationship with the Quality Committee and oversight of the IQPR, and arrangements to manage potential conflicts arising from cross-committee membership.
The Committee asked the Board to note the assurance received, the limited assurance relating to delivery pressures within the Digital Plan and the further work required on the Assertive Outreach business case.			

Title of Meeting	Board of Directors (Public)
Meeting Date	24th September 2026
Title	Children and Young People's and All Age Eating Disorders (CYPMHS & All AED) Committee Chair's Report
Author	Stephen Waring, Committee Chair
Presenter	Stephen Waring, Committee Chair
Executive Director Sponsor	Donna Hayward-Sussex, Chief Operating Officer and Deputy Chief Executive
Purpose	Assurance

Agenda Items

<u>People items</u>	<u>Patient items</u>	<u>Finance items</u>
• Workforce & Capacity Report • Patient Story / Service Development - Mental Health Schools Team • Deep Dive: Medical Staffing	• Quality & Safety Dashboard • CYP and AAED Risk Register	• Digital and Estates

Agenda Items by exception	Assurance narrative by exception. Key items to be raised to the Committee.	None Limited Reasonable Substantial	Actions, mitigations and owners Refer to another committee.
Workforce & Capacity Report	Recruitment and training compliance improved, including progress in filling Band 5 vacancies and NHS Professionals arrangements. However, vacancies, sickness absence and wider capacity pressures remain, with continued reliance on temporary staffing. Further evidence is needed that improvements are sustained and support safe service delivery.	Limited	Provide an interim capacity update at the next meeting, followed by a full report covering staffing trends, mandatory training compliance, use of temporary staff and clarification of agency expenditure.
Quality and Safety Dashboard	Oversight arrangements, service-user feedback, training compliance and safeguarding performance have improved, supported by weekly monitoring and earlier learning from incidents. Reasonable assurance was provided, although future reports should show clearer trends, residual risks and evidence that actions are improving outcomes.	Reasonable	Future reports should include performance trends, the effectiveness of business continuity arrangements, regulatory assurance, evidence of learning impact and clearer articulation of current and emerging risks.
Patient Story / Service Development - Mental Health Support Teams	The school-based Mental Health Support Teams demonstrated effective early intervention, strong co-production and positive outcomes for children and young people, with plans for further expansion. Substantial assurance was provided, although future presentations should give greater prominence to direct service-user and family feedback.	Substantial	Consider wider sharing of the service model and include direct feedback from children, young people and families in future presentations to demonstrate impact.
CYP and All Age Eating	While appropriate controls exist to support patients placed out of area for eating disorder treatment, the current model retains responsibility within Kent following transfer. This	Limited	Escalation to ICB is being progressed.

Disorders Risk Register	creates a potential risk in relation to oversight, accountability and service management, and warrants a high-level discussion with the ICB to explore more sustainable arrangements. Waiting times have improved, although further evidence is needed that this performance is sustainable and supported by sufficient capacity.		Continue monitoring waiting-time sustainability, available capacity, out-of-area oversight and the impact on staff.
Digital and Estates	Progress on the digital transition was noted, but key dependencies remain unresolved across telephony, printing, data migration, reporting templates and intellectual property. A paper on estates will be presented at the next committee.	Limited	Provide a detailed delivery plan showing milestones, dependencies, risks and mitigations against the March 2027 deadline. Resolve intellectual property issues and submit an estates paper, including any outstanding decisions, to the next meeting.
Deep Dive: Medical Staffing	The medical workforce plan, recruitment activity, recent appointments, training posts and strengthened agency governance provide a sound framework. However, reliance on agency staff remains a risk, and further evidence is required that vacancies, capacity and job-planning milestones are improving as intended.	Reasonable	Provide six-monthly updates demonstrating progress against workforce milestones, including mitigations, vacancy levels, agency use and expenditure, service capacity, job planning and any emerging delivery risks.

Trust Board meeting

Meeting details

Date of meeting:	24 th September 2026
Title of paper:	Triangulated Culture, Performance and Quality Deep Dive
Author:	Kindra Hyttner, Director of Strategy & Engagement Sarah Atkinson, Deputy Director of Transformation & Partnerships
Executive Director:	Kindra Hyttner; Director of Strategy & Engagement

Purpose of paper

Purpose:	Discussion
Submission to Board:	Board requested

Overview of paper

This paper brings together for the first time: culture data from the 2025 staff survey, our freedom to speak up annual report for 2026, workforce data, and existing trust performance and quality data, to test whether cultural concerns are reflected in operational outcomes and where they diverge. At this stage, the data is illustrative and demonstrates correlation but does not reinforce much of our understanding of the organisation including that significant variation exists across the trust and that East Kent is the directorate where culture, performance and workforce pressures converge most clearly. Establishing causality and quantifying observed patterns would require further analysis.

It responds directly to the Board's request for better triangulation of data to inform understanding of risk and improved decision-making.

The paper recommends a combination of trust-wide action focused on three identified cultural outcomes, targeted local improvement and systematic learning from high-performing teams.

Issues to bring to the Board's attention

The analysis shows that culture, workforce, quality and performance need to be understood together, but do not move in a simple or predictable way. Some directorates show comparatively strong culture alongside weaker operational performance and vice versa. The value of triangulation is therefore not to demonstrate direct causality, but to identify where signals converge, where they diverge and where further enquiry is required. This gives the Board a richer understanding of organisational risk than any individual dataset provides in isolation.

Items of excellence:

-
- Leadership Behaviour Index remains the strongest cultural measure (76.2%), close to the Picker benchmark of 76.6%, and staff continue to report high confidence to speak up (87.8%).
 - Genuine pockets of excellence exist – including Places of Safety, the Acute PICU, in-patient rehabilitation in North Kent, Estates and low secure services – with culture, psychological safety and inclusion scores well above trust averages.
 - Local team culture consistently scores higher than perceptions of the wider organisation, showing staff feel connected to their immediate team even where trust-wide confidence is lower.
 - We propose undertaking structured learning from teams with consistently stronger results to understand what they do differently in relation to leadership and management, staff voice, clarity of expectations, inclusion and organisational follow-through, and to test how this learning can be spread elsewhere.

Improvements in matters that were previously an area of concern:

- This is the first paper to bring together culture, performance, quality and workforce equality data in one evidence base, rather than reporting each separately.
- A targeted improvement programme is under way in East Kent as part of our Positive Staff Experiences true north ambition. In parallel, East Kent has made the greatest progress out of all community directorates in its recent performance to reduce the number of people waiting more than 38 weeks as part of our Timely Access true north ambition; and is also slightly ahead of other community directorates in its risk formulation compliance which is a key improvement measure in the Quality Improvement Plan. This provides an important opportunity to test over time whether targeted changes in leadership, staff voice and accountability are associated with improvements in both staff experience and broader performance and quality measures.
- Staff are increasingly willing to be identified when raising concerns. Only 3.6% of Freedom to Speak up cases were anonymous, against a 10% national average, suggesting trust in the process. Very few concerns relate to patient safety or quality issues but corroborate identified challenges around leadership and management.

Items of concern and hotspots:

- East Kent is the only directorate where culture, performance and workforce risk converge, reinforcing the decision to prioritise it for the first phase of our Positive Staff Experiences true north ambition.
- West Kent is showing emerging signs of cultural and workforce pressure that require deeper investigation. And there is potential sustainability risk in West Kent that is not yet fully visible.
- Confidence that concerns raised will be addressed remains the lowest-scoring cultural measure (46.5%) and Freedom to Speak Up annual data shows the proportion of staff citing fear of reprisal rose last year from 5% to 15%.
- Global majority staff are 2.78 times more likely than white staff to enter the formal disciplinary process, with further disparities in recruitment shortlisting.
- There is no single, uniform staff experience at KMMH, with substantial variation between teams, professions, locations as well as demographic groups.
- Significant team level variation persists beneath strong-directorate averages - reinforcing that directorate-level reporting alone is not sufficient.

Overall assessment

The analysis moves us beyond describing culture to identifying three proposed outcomes that we believe would demonstrate meaningful cultural improvement:

- **Issues lead to action and learning** – staff can see that when concerns or problems are raised, they are heard, acted upon and feedback is provided and learning is shared
- **Managers and leaders are clear and empowered to act** – they understand what is expected of them and have the authority, support and organisational conditions to act consistently
- **Experience is equitable and consistent** – staff have an equitable and inclusive experience, while recognising that people's experiences and needs are not the same.

Taken together, the strategic story is that people need to see action when they raise issues, understand what is expected of them, and experience the organisation equitably and consistently. If we improve those conditions, over time we should expect staff confidence, pride and advocacy for the trust (both as a place to work and as a place to receive care) to strengthen, and to create the conditions for higher-quality care and more reliable performance.

Governance

Implications/Impact:	If the Trust does not maintain an effective, inclusive, and improvement-focused organisational culture this would limit our ability to deliver safe, high-quality care, retain and engage our workforce, and achieve the ambitions set out in the <i>Doing Well Together</i> strategy. It also impacts on our ability to demonstrate we are well-led.
Assurance:	Limited assurance: This is the first paper to triangulated culture, performance, quality, safer staffing and workforce quality data but data quality and completeness vary, so findings should be read as indicative and signalling rather than fully validated fact. Assurance will strengthen through a small standing set of cultural outcome measures, supported by qualitative staff insight and triangulated with workforce, quality and performance information.
Oversight:	Oversight by the People Committee and Board.

Introduction

The Board has identified culture as a key strategic transformation priority within the Doing Well Together strategy. Following the culture-only deep dive previously shared with the People Committee, this paper brings that work together with existing performance, quality and workforce data already held across the trust, to present a triangulated view - where culture sits alongside, and is tested against, existing performance and quality data.

Culture has developed unevenly over time, with staff experience influenced by local leadership and management, systems, expectations and operating conditions. This paper tests cultural strengths and concerns against workforce, quality and performance information and, importantly, uses that analysis to identify what meaningful cultural improvement should look like. The findings do not answer every question, but they give us a clearer set of hypotheses to test and a more tangible direction for the next phase of the culture programme.

A note on the data

A wide range of existing data has been brought together through two new dashboards - the Cultural Change dashboard, and the Culture vs Performance dashboard. These draw on systems that were not originally designed to be analysed together, and which refresh at different times. The findings should therefore be treated as signals of pattern and variation rather than a live casual assessment. It should be noted that the dashboards do not recognise trends in performance and so will not show if performance is increasing or decreasing.

Culture measures rely mainly on the 2025 NHS staff survey. While quality, access and workforce measures are more current. Directorate measures are also not always directly comparable, and team-level results with small response numbers require local validation. The dashboards are intended to support discussion and enquiry, not replace qualitative evidence, professional judgement or local understanding and insight.

The dashboards used do not yet incorporate the trust's more recent quarterly pulse surveys. These provide a smaller but more current source of staff insight and have been considered as additional triangulation in this paper, rather than as part of the dashboard scores.

In July, we also started including a small set of questions at the end of mandatory training, to get a broader pool of staff engagement. Early insight from this small pool of data demonstrates a more positive picture from those staff who have completed it, but cannot yet provide a robust comparison.

What the triangulated data tells us trust-wide

Across the data, three consistent cultural outcomes emerge. These provide a clearer articulation of what we believe needs to change and, importantly, what the Board could monitor over time to understand whether cultural transformation is having an impact.

1. Issues raised need to lead to action and learning

Staff are encouraged to report incidents: 87.8% responded positively that they feel confident to speak up and this has been a positive improvement in recent years. However, only 46.5% believe that when they do, concerns would be addressed. The gap suggests that the trust has established routes for raising issues, but has not yet built consistent confidence in response, action and feedback.

We were told in the 2025 Staff Survey that: *"Speaking up is a waste of time. Nothing ever gets done."*

The 2024/25 Freedom to Speak Up Annual Report, shared with Public Board in July 2026, provides further evidence. While only 3.6% of cases were anonymous, compared with a 10% national average, 44% of staff who approached the Guardian reported having already raised their concern internally without feeling heard. The proportion citing fear of reprisal also increased from 5% to 15% between the first and second halves of the year. This reinforces the distinction between having mechanisms to raise concerns and staff trusting what will happen afterwards.

West Kent raised the highest proportion of concerns of any directorate (5.17% of staff, 25 cases) and the highest share of both management issue and system/process themes cases – consistent with the workforce fragility identified in culture dashboards. Though a higher rate of concerns raised can also reflect a more open culture, rather than a worse one, and should be read alongside not instead of the workforce and access findings.

There are teams trust-wide that do feel their issues would be addressed if they raised concerns. This is felt most strongly in some of our in-patient wards such as Woodchurch and Jasmine where 78.3% and 76.2% of staff respectively, reported positively in the staff survey. Similarly, Heather and Foxglove wards reported that 68.4% and 64.3% (respectively) of their staff felt their concerns would be addressed. It is important that we not only recognise these teams for their approach to addressing concerns but learn from this and share widely where possible.

Engagement questions included at the end of mandatory training in July 2026 asked over 100 staff trust wide if they felt their views and ideas were listened to and taken seriously, with around 10% of staff replying positively that they did.

Taken together, the evidence suggests that the principal cultural weakness is not the absence of routes to speak up, but inconsistent manager and leadership follow-through when people do. Our ambition should therefore be a clear and visible learning loop: concern raised - accountable owner identified - action taken and tracked - learning shared – feedback provided. We should also understand what those teams with stronger results are doing differently and spread that learning where appropriate.

2. Managers and leaders need to be clear and empowered to act

Leadership behaviour is a relative strength. The leadership behaviour index is 76.2%, close to the Picker average of 76.6%, and many staff report positive relationships with their immediate managers. However, this is not consistently translating into stronger staff voice, operational performance of consistent ways of working. For example, the patient flow team has a strong overall culture score and challenging operational performance.

Our qualitative evidence provides an important explanation. Leaders and managers' report: uncertainty about what is expected of them; pressure from competing priorities; inconsistent communication; varying confidence in handling difficult conversations and performance; and systems and policies that do not make their day-to-day jobs easier. Some feel accountable for delivery without always feeling they have authority, management skills or organisational support to act. This suggests the challenge is not simply to improve leadership and management behaviour, but to create greater clarity and consistency around expectations, responsibilities and accountability; and for the organisation to create the right conditions for success.

Comments taken from the 2025 Staff Survey illustrate this: *“Managers are not trained to be managers...”* and *“KMMH has an abundance of managers but a serious lack of leadership throughout.”*

Safer staffing evidence – presented to the Board in May 2026 - adds a further, independent signal here. Zonal observations, a deliberate, less restrictive alternative to prolonged 1-2-1 observations, is applied inconsistently across the trust, which the establishment review attributes to varying local understanding of when and how to use it. This provides a practical example of how unclear or inconsistently applied expectations can translate into variation in practice, even where good practice exists elsewhere in the organisation.

Our leadership and management response should therefore preserve supportive and positive leadership behaviours, while strengthening clear expectations, accountability, constructive challenge, performance management and the confidence and capability of managers to act consistently.

3. Experience must feel equitable and consistent

Disabled colleagues reported 66% for respect for individual differences, against 72.6% for non-disabled colleagues, and 45.3% would recommend the trust as a place to work against 58.2%. This gap requires a more explicit focus on whether inclusion is experienced consistently in day-to-day work, leadership decisions and responses to concerns.

One comment taken from the 2025 Staff Survey reports:

- *“When I ask for help and adjustments due to disability, I am just told no...”*

The culture dashboard also looks at the culture composite scores through an ethnicity lens and whilst the trust-level Inclusion & Belonging score of 74% suggests generally positive experiences, ethnicity analysis demonstrates material variation between demographic groups. The largest experience gaps are evident in Culture Composite (40.1 percentage points), Psychological Safety (35.8 percentage points) and Staff Voice (31.7 percentage points). T

Equity of experience needs to be understood more broadly than protected characteristics alone. While the differences experienced by disabled colleagues, global majority colleagues and other protected groups remain important and require targeted action, the data also shows significant variation within and between demographic groups, professions, teams and services. There is no single, uniform staff experience at KMMH, including for white colleagues. Our ambition should therefore be an equitable, diverse and inclusive culture for all staff, recognising that achieving equity will require different response for different groups, professions, teams and areas, rather than a single trust-wide intervention.

This suggests that improvement efforts should focus not only on improving overall culture, but also on ensuring that culture is experienced consistently across ethnic groups, other demographics and professional groups.

This year's workforce race equality standard (WRES) and workforce disability equality standard (WDES) data gives this theme a harder evidence base than staff survey findings alone. Global majority staff are 2.78 times more likely than White staff to enter the formal disciplinary process – the most significant single WRES finding and one that should read alongside the ethnicity gaps. White applicants are 1.76 times more likely to be appointed from shortlisting than global majority applicants, and non-disabled applicants 2.32 times more likely than disabled applicants. Disabled staff are nearly twice as likely as non-disabled colleagues to report feeling

pressure from their manager to attend work when unwell (21.5% versus 11.2%) - a direct link between EDI and psychological safety.

From the Staff Survey 2025 comments, a member of staff tells us:

- *“I still face inequalities based on my colour and race...”*

Taken together, this evidence shows why an overall trust inclusion score is not sufficient assurance. A relatively positive average can mask materially different experiences between staff groups and between teams.

Our improvement aim should therefore be not only to improve average staff experience, but to reduce unwarranted variation in psychological safety, staff voice, inclusion and opportunity across demographic groups, professions and teams. EDI should remain a core element of the cultural transformation programme, but success should increasingly be judged by whether these experience gaps narrow.

What the triangulated data tells us at a directorate level

The analysis reinforces that culture is experienced locally and the trust-level and directorate averages can mask significant variation between individual teams. No two directorates show the same combination of culture, workforce, quality and access indicators, which means improvement responses will need to reflect local diagnosis rather than applying a single intervention everywhere.

The analysis also shows that culture consistently scores lower not just in East Kent community directorate but also among in-patient teams in our Acute directorate who are based in East Kent – suggesting there may be an underlying reason that differs from other areas.

Directorate	Culture	Access	Quality	Workforce	Board interpretation
North Kent	58.2%	45	86	71	Strongest overall community picture for quality and workforce. Recommendation: Understand what can be learned from local operating and leadership practice, while testing sustainability and team-level variation in staff experience.
West Kent	53.5%	21	92	48	Quality is holding, but access and workforce pressures suggest an emerging sustainability risk. Recommendation: Prioritise local enquiry and early intervention.
East Kent	47.2%	36	72	66	Culture and access pressures converge, with workforce signals also requiring attention. Recommendation: Continue targeted improvement as part of Staff Experience strategic priority and use as an early test of the proposed cultural approach.
Acute	63.7%	45	49	43	Comparatively strong aggregate culture alongside significant operational and quality pressure. Recommendation: Prioritise flow, capacity and productivity, while investigating team variation.
Forensics & Specialist	62.5%	70	88	84	Aggregate picture appears positive but does not align with current local intelligence and team-level variation to provide assurance. Recommendation: Further triangulation and the current quality review should inform conclusions and next steps.

East Kent

Culture score 47.2%, with access below target across all four community measures and the quality composite is 72 (amber). Sickness absence is 7.3% against a 4.5% target, and the leaver rate is 14.0% against 12.3%. Despite this picture, the directorate is performing well in

some quality measures. East Kent receives the highest number of compliments from patients as a percentage of the number of contacts, and risk formulation is the highest of all community directorates.

The static nature of the culture dashboards makes it difficult to see trends but many of East Kent's quality measures have positively improved since the start of the quality improvement plan (QIP). Early impact from the QIP shows that risk formulation has improved from 50% to 75%. 50% to 75% and are one of the most improved directorates and the number of patients waiting over 38 weeks in community mental health has reduced by over 70% in East Kent, as well as improvements to environments and an increase in patient experience responses. This demonstrates a positive trajectory but is not evident in the current dashboards.

However, some East Kent teams have some of the lowest culture scores of the trust, which combines with our organisational knowledge of the directorate. East Kent is the priority area of focus in our Positive Staff Experience true north ambition. Existing listening work provides a foundation for targeted tests of change. Directorate averages still mask variation, so action should be framed around team-level problem statements and root cause analysis rather than a single directorate-wide response.

A targeted programme of support is underway in East Kent, focused on strengthening leadership, staff voice, communication and local accountability. This has included four facilitated focus groups involving 208 colleagues, with the themes discussed with senior leaders and teams now developing local people engagement plans in response.

The directorate senior leadership team has completed an engagement reset and agreed a consistent set of leadership expectations. These include high-quality one-to-one conversations, greater everyday recognition of staff and new weekly virtual and monthly face-to-face East Kent huddles to improve communication and the cascade of information. Similar reset sessions are being extended to managers across the directorate, supported by Organisational Development, the HR Business Partner and the staff engagement and experience facilitator. Training to build capability and confidence in effective performance management is underway.

A Staff Voice forum has also been established across the directorate, alongside enhanced engagement and communication during forthcoming organisational change. Leaders are being supported to demonstrate how staff feedback results in action through a clear "You Said, We Did, We Are Doing" approach.

The July 2026 pulse survey provides a small, but more current indicative signal, with 37.7% of 61 respondents recommending KMMH as a place to work.

East Kent therefore provides a useful early test bed for the wider culture programme. We should use the three proposed cultural outcomes to evaluate whether these interventions are improving culture alongside delivery over time.

West Kent

West Kent has a culture score of 53.3%, with the weakest community access composite at 21 and a workforce composite of 48. Quality is currently holding, but vacancy gaps (12.9% against 11.5% target) and temporary staffing pressures (8.8% of the workforce are temporary staff) raise questions about the sustainability of that position. We need to understand whether this represents a resilient service managing pressure, or whether performance is being sustained in ways that could affect staff experience and delivery over time.

The July pulse survey shows 43.8% of 64 respondents would recommend KMMH as a place to work, broadly unchanged from previous pulse surveys but below the 52% target, suggesting staff advocacy remains an area for consideration.

Like other directorates, West Kent has improved its risk formulation compliance as part of the Quality Improvement Plan (69.2%). This compares to North Kent (70%), East Kent (75%) and Acute (100%).

It has also improved alongside other community directorates against our true north ambition to reduce the number of people waiting over 38 weeks. Variation does remain across directorates, and July performance shows that West Kent is now the directorate with the highest number of patients waiting over 38 weeks at 83, compared with 20 in North Kent and 58 in East Kent.

With regards to FTSU concerns raised within directorates, West Kent saw the highest number of staff raising concerns in 2025/26.

Unlike East Kent, where considerable listening and diagnostic work has taken place, the underlying cultural issues in West Kent are less well understood and not fully visible through quality measures. The next step should be targeted local enquiry, particularly within teams with weaker staff voice, psychological safety indicators, alongside action on capacity and workforce pressures.

North Kent

North Kent presents the strongest overall community picture for quality and workforce and should therefore be considered an important source of internal learning. Quality and workforce composites are 86 and 71, respectively. Its culture score of 58.2% is highest across the community directorates, but is lower than Acute and Forensics & Specialist. However, this should not overshadow comparatively strong performance measures.

We should understand which operating, leadership and team practices are contributing to this position and what could be adapted elsewhere. Especially as North Kent has been piloting the Medway and Swale model to test new ways of working, which has improved access performance. At the same time, local enquiry should test whether areas such as sickness, staff voice or other team-level variation indicate potential sustainability risks that are hidden within the aggregate position.

Acute

The strongest clinical-directorate culture score (63.7%) sits alongside the weakest quality composite of 49 and an access composite of 45. Average out-of-area bed days and Place of Safety length of stay are above target, however length of stay for both older and younger adults remain a challenge.

Safe staffing evidence adds detail here: female acute wards (Foxglove and Fern) show substantially higher incident volumes over six months (338 and 397 respectively) than comparable male wards (Boughton 142, Amberwood 11), driven largely by self-harm, and are managed through high reliance on temporary staffing. Foxglove's night-time HCA fill rate reached 165% of planned establishment. Upnor Ward's incidents rose from 18 in January to 45 in March, alongside a 193% HCA fill rate, illustrating staffing being increased reactively. This does not necessarily mean these wards are the same teams showing lowest culture scores in the dashboard. Although younger adult wards in East Kent and West Kent showed low culture scores (48.3% & 51%, respectively), it is not possible to determine specific wards due to low

staff survey response rate. This link needs to be tested directly but does reinforce that Acute's low-quality composite reflects real, specific pressure. That said, we should recognise efforts made as part of the Quality Improvement Plan which demonstrate a 100% compliance in risk formulation.

The first response should focus on flow, capacity and process reliability. Team results also show wide variation, including a 22.6% culture score in the Patient Flow Team, so the directorate average should not be treated as evidence that culture is uniformly strong. This triangulates with what we know from other data sources, that the Acute directorate experiences intense operational pressure and variation. These issues are being addressed through the Staying Well trust initiative. Further exploration is needed to understand if operational pressure is directly impacting culture in some teams.

External benchmarking of key acute indicators should be incorporated into the next phase of analysis so that the Board can understand performance relative to comparable mental health providers.

Forensics & Specialist

The aggregate quantitative picture is comparatively positive, with a culture score of 62.5%, an access composite of 70 and quality composite of 88. However, this does not align fully with current local intelligence, and there is significant variation between teams and within teams themselves. For example, neuropsychology has a culture score of 33.3% despite a Leadership Behaviour score of 82.7%.

The July pulse survey provides a further signal -18.2% of 33 respondents would recommend KMMH as a place to work, substantially down from the 66% target.

We therefore do not regard the aggregate position as sufficient assurance that culture is consistently strong across the directorate. The current improvement work underway in forensic services, and further triangulation of staff voice, speaking up information and team-level data should conclude before Forensics & Specialist is treated as a benchmark for the organisation.

Support Services

Support services has the highest directorate culture score at 68.3%, but team-level results vary substantially, and no comparable access or quality measures apply. Team scores range from 39.3% in contracting and information governance to 84.2% in estates. Team level staff experience, voice and local qualitative evidence should be used to identify strengths and areas requiring improvement. For example, in estates we know leaders have intentionally focused on recognition as well as creating a "you said, we did" feedback loop.

The July pulse survey shows weakening advocacy with 48.4% of 93 respondents recommending KMMH as a place to work, below a 65% target, reinforcing the importance of looking beneath its strong aggregate score.

We also know from cultural workshops held that some corporate teams feel disconnected from the wider organisation and valued less than clinical colleagues - a pattern recognised across the NHS more broadly, but an important cultural challenge in its own right. And one the trust should be mindful of in recognising the expertise and enabling role these teams play.

Children and young people and all age eating disorder services

These services transferred to the trust in April 2026 and are not yet represented consistently within the datasets used to construct dashboards. We do not have comparable 2025 Staff Survey data, and some performance information remains unavailable due to the first-year transition and digital migration.

However, CYP should not be absent from our cultural learning. The July pulse survey provides an early source of staff insight, with 58 CYP colleagues responding to their first KMMH pulse survey and 60.3% recommending KMMH as a place to work, meeting the 60% target.

We have also seen through our engagement during the transition, and since colleagues have joined KMMH, that leaders and managers demonstrate the positive behaviours and conditions described in this paper, particularly around clarity, empowerment, and supporting staff through significant change. We will capture this learning more systematically and consider what can be adapted elsewhere while building a stronger quantitative evidence base during the transition year.

Team level data triangulation

The dashboard already identifies hotspot teams by culture score. Extending triangulation to team level for performance, quality and workforce measures is a significant data-linking exercise requiring identification of comparable measures that are available at team level. This is especially challenging when looking at access or quality domains, however, it would enable meaningful comparison and evaluation.

It is recommended that this is owned and driven locally, recognising that in many cases this data is likely, locally owned. We will also support the use of improvement methodology and take an A3 problem solving approach for each directorate, owned by directorate leadership teams. Then the actions will be owned by each directorate and will support them to deliver against their trust strategic ambitions.

Over time, team-level analysis should also enable us to test whether the three proposed cultural outcomes are improving locally and whether variation between teams is narrowing.

Learning from good practice

The data shows genuine areas of excellence, as well as areas for improvement. Teams including Places of Safety in Acute, Acute PICU, North Kent in-patient rehab, estates and low secure services report comparatively strong culture scores above 60%, psychological safety above 70% and inclusion approaching 80%. Local team culture also tends to score more positively than perceptions of the wider organisation.

We should move beyond recognising these teams to systematically understanding what they do differently. A structured learning review will explore leadership practice, clarity of expectations, staff voice, inclusion, response to concerns and other local conditions. Where transferable practices are identified, these will be tested and adapted elsewhere through the culture transformation programme.

The positive-deviance approach will sit alongside targeted intervention in areas of concern, enabling the trust to build on what already works rather than relying solely on new interventions.

Proposed approach to measurement

This triangulated analysis has enabled us to move from describing culture to identifying three proposed outcomes that could provide a clearer definition of what meaningful cultural improvement looks like:

- **Issues lead to action and learning**

Staff can see that when concerns or problems are raised, they are heard, acted upon, learning is shared and feedback is provided.

- **People are clear and empowered to act**

Leaders and managers understand what is expected of them, have clarity about their responsibilities and accountability, and have the authority, support and organisational conditions they need to act consistently.

- **Experience is equitable and consistent**

Staff experience should not depend materially on their team, profession, ethnicity, disability or other characteristic, and unwarranted variation should reduce over time using targeted approaches where different groups or different areas require different responses.

Taken together, they describe the conditions we believe need to change. We propose that these become the basis of a small standing set of Board-level cultural measures. They would not be considered in isolation: each would be supported by qualitative staff insight and triangulated with relevant workforce, quality and performance information.

In addition, we will need to manage the interdependencies with existing programmes of work that will inevitably have an impact on culture. The culture programme governance already runs in parallel to the staff experience true north ambition to ensure alignment and oversight. Further work will need to align the programme with broader strategic plans - the Quality Improvement Plan, the Integrated Neighbourhoods strategic initiative, and the productivity breakthrough objective, especially.

Our overarching test of improvement should be whether staff increasingly feel proud to work for the trust and advocate for the organisation and care it provides. Over time, we would also expect stronger culture to contribute to the conditions for higher-quality care, more reliable performance and staff that would recommend the trust as a place to be cared for.

Further work is needed to identify the most meaningful measures, establish baselines and determine appropriate trajectories.

Recommendations and next steps

The cultural transformation programme would provide the delivery response through three trust-wide workstreams:

1. **Improving our learning culture** – strengthening follow-through and ensuring actions are owned, completed, learning is shared and feedback is visible.
2. **Leadership, management and organisational capability** – creating clearer expectations and accountability and building the confidence and capability of managers to lead consistently while also removing unnecessary barriers, systems and processes that make it harder for managers and leaders to do their job well.
3. **Equity, diversity and inclusion and consistency of experience** – building on our existing EDI plan, while broadening our approach to understand and reduce variation across demographic groups, professions, teams and locations.

In addition to these trust-wide workstreams, a directorate level approach will be taken to explore the findings of the culture dashboards and the triangulated data. Each directorate will use A3 methodology to understand local causes and test targeted countermeasures

through the Doing Well Together Improvement Management System (IMS). This will be complemented by structured learning from high-performing teams so that good practice is systematically understood and spread. Appendix 1 gives a high-level proposed delivery plan which shows a phased approach to the directorate approaches based on the prioritisation highlighted in the data. This will evolve as detailed approaches are agreed and defined.

The Board is asked to:

1. **NOTE** the findings from the first triangulated analysis of culture, workforce, quality and performance and the significant variation identified between teams and staff groups.
2. **ENDORSE** the three proposed cultural outcomes as the basis for how the trust defines and assesses cultural improvement.
3. **AGREE** that these outcomes should form the basis of a small standing set of Board-level culture measures, supported by qualitative staff insight and triangulated with relevant workforce, quality and performance information.
4. **SUPPORT** the proposed improvement approach of trust-wide workstreams, local diagnosis and systematic learning from teams demonstrating strong culture and outcomes.

We propose using the October Board seminar to discuss this further as a Board, ahead of finalising the Culture Transformation Plan to come back to the Public Board in November.

Appendix 1 – High-level delivery plan for the cultural change programme



Trust Board meeting

Meeting details

Date of meeting:	24 th September 2026
Title of paper:	Finance report for Month 5 (August 2026)
Author:	Nicola George, Deputy Director of Finance
Executive Director:	Nick Brown, Chief Finance and Resources Officer

Purpose of paper

Purpose:	Noting
Submission to Board:	Regulatory Requirement

Overview of paper

The attached report provides an overview of the financial position for Month 5 (August 2026).

Issues to bring to the Board's attention

On 31 August 2026, the Trust reported breakeven, in line with plan. Acute inpatient and external bed pressures are being offset by non-recurrent mitigations.

The principal pressures are:

External beds

- Acute bed use increased from 12.6 to 15.7 in August; PICU reduced from 11 to 9 beds and Step-Down from 11 to 7, with Step-Down use due to cease by the end of September.
- The year-to-date external bed pressure is £2.33m, including Step-Down beds.
- The forecast pressure is £3.47m, reflecting current demand, Step-Down closure and planned ICB bed purchases. Continued acute demand remains a material risk.

Acute Inpatient staffing

- Acute wards continue to use registered and unregistered nursing staff above establishment because of operational pressure and patient complexity.
- August usage was 41.8 WTE above establishment, eight WTE higher than July, creating a £0.79m year-to-date pressure.

Agency spend

- August agency spend was £0.54m: £0.43m in CYP/AAED and £0.11m for East Kent medical cover. The reported cost reduction reflects assumed VAT recovery, not lower usage.

- Agency spend is forecast at £7.87m, £1.41m above the £6.46m cap, driven mainly by essential medical cover for sickness and vacancies and delayed CYP/AAED invoices.

Mitigations

- Community and CYP/AAED budget slippage, alongside additional non-recurrent and technical mitigations, is offsetting pressures. These measures are not sustainable and cannot provide recurrent cover for bed and acute staffing costs.

Capital Programme

- Capital is £12.65m above the plan submitted to NHS England, mainly due to asset recognition following the CYP and AAED service transfer.
- Of this, £12.81m relates to intra-DH leases and does not score against CDEL.
- The resulting £0.16m underspend reflects delays in the Female PICU, Eureka House lease remeasurement and R&D Hyperfine projects, partly offset by £1.66m of IFRS 16 lease overspend from the NELFT service transfer.
- The Trust is discussing the effect on its capital allocation with the NHS England regional team.

Cash

- August cash closed at £7.72m, down £1.20m in month but £0.14m above plan.
- ICB receivables of £3.43m and £0.85m are over 120 and 90 days overdue respectively, creating a cash risk. This has been escalated through contract meetings.

Governance

Implications/Impact:	Failure to deliver the financial plan may result in NHS England regulatory action.
Assurance:	Reasonable
Oversight:	Finance, Business and Investment Committee

Finance Reporting Pack

August 2026

Contents

1. Executive Summary
2. KPIs
3. Primary Statements (I&E and Balance Sheet)

Appendices:

Cost Drivers (Inpatient WTE & External Beds)
Forecast Position
Cost Improvement
Capital

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1. Executive Summary

Board view: on plan year to date, but recurrent delivery depends on reducing bed, staffing and agency pressures.

YTD financial position

●

£0.00m surplus

Plan: breakeven

External beds

●

£2.33m pressure

Acute increase to average 15.7

Inpatient staffing

●

£0.79m pressure

41.8 WTE above establishment

Agency spend

●

£1.41m over cap

Forecast £7.87m vs £6.46m

What the Board needs to know

Forecast: AMBER

Reported position remains on plan but is not yet recurrently balanced.

Breakeven relies on non-recurrent mitigations and Community/CYP slippage.

Main run-rate risks: external beds, acute staffing and agency.

Forecast assumes delivery; confidence based on reduction in external beds and acute staffing through the next few months.

Priority risks and controls

External beds: PICU above funded levels and significant use of Acute beds. Reduction trajectory in place.

Acute staffing: Staffing WTE usage increased 41.8 WTE over establishment. Review to establish seasonal impact.

Agency: August £0.54m, mainly children’s services and medical vacancies. Forecast £1.41m above agency cap.

Area of focus for September

Assure

Confirm the external bed reduction trajectory and route to replacing temporary step-down with commissioned capacity.

Control

Track staffing controls, observation reductions and agency reductions.

Note

Capital is £12.65m above plan, mostly non-CDEL lease recognition; cash is £7.72m but will tighten as payments progress.

2. Finance KPIs



FINANCIAL POSITION

On plan overall
Pressures in Acute staffing and external beds
Supported by non-recurrent benefits

£0.00m
Breakeven YTD

Plan: Breakeven



CASH POSITION

On plan position
Impacted by delayed LVA receipts
Forecast to be lower in future months as capital programmes progress

£7.72m
Cash balance

8.3 days
of expenditure



CAPITAL PROGRAMME

Operational capital under plan
Major schemes (Female PICU and Section 136) completing in year.
CDEL pressures due to CYP transfer being worked through with NHSE

£18.91m
YTD Spend

Plan: £6.26m



TOTAL WORKFORCE

No change in month
Substantive and agency decreases offset by bank increases

4,560 WTE

Plan: 4,615



ACUTE WORKFORCE

In month increases due to higher agency & substantive recruitment
Driven by enhanced care, including prolonged observations

672 WTE

Plan: 630



COMMUNITY WORKFORCE

Vacancies driving underspends
Demand and capacity review being finalised

1,553 WTE

Plan: 1,752



AGENCY SPEND

Decrease in month due to estimated impact of VAT reclaim
Remain below plan YTD but exceeding NHSE Cap

£0.54m in month

Last month spend £0.87m
Below plan of £0.69m, above NHSE cap



BANK SPEND

Above planned spend
Main drivers of over spend being Acute inpatient staffing
Over NHSE cap for bank

£2.01m in month

Last month spend £1.85m
Above plan of £1.34m, above NHSE Cap



EXTERNAL BEDS

Increased Acute bed usage in month (13 to 15 in month)
Step down beds in addition; 7 beds used in month
Increasing cost pressure partly driven by CRFD

25 beds
(↑ from 23)



CYP RUN RATE

Below plan levels of spend
Costs still under review post transfer
High vacancies drive underspend

£3.60m

average run rate vs budget £3.70m



CORPORATE COSTS

Professional fees remain a pressure. Run rates are not reducing as per Plan
CYP posts being recruited to as per transition plan
Excludes Facilities and Estates costs

£4.19m

average run rate vs £3.78m plan



KEY MESSAGES

-  Breakeven achieved but reliant on non recurrent mitigations
-  Acute staffing and external beds driving cost pressures
-  Capital programme above plan driven by CYP leases and being managed with NHSE
-  CYP & AAED budgets continue to be reviewed and refined. Demand and Capacity review underway to inform sustainable position.
-  Cash reasonably strong but will be more pressured in year as capital programmes are finalised

3. Primary statements

Statement of Comprehensive Income	Annual	Current Month			Year to date		
	Budget £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000
Income	355,344	29,876	30,249	373	149,783	149,808	25
Employee Expenses	(282,838)	(23,845)	(23,908)	(63)	(119,818)	(117,890)	1,928
Operating Expenses	(65,799)	(5,519)	(5,830)	(311)	(26,986)	(28,997)	(2,012)
Operating (Surplus) / Deficit	6,707	512	511	(1)	2,980	2,921	(59)
Finance Costs	(6,264)	(481)	(478)	3	(2,915)	(2,951)	(36)
Surplus / (deficit) for the period	444	31	32	1	65	(31)	(96)
Excluded from System control (Surplus) / Deficit:							
Technical adjustments	(443)	(31)	(36)	(5)	(65)	31	96
System control Surplus / (Deficit)	0	(0)	(4)	(4)	0	0	0

Statement of Financial Position	31st March 2026	31st July 2026	31st August 2026
	£000	£000	£000
Non-current assets	183,623	198,006	197,924
Current assets	21,129	22,777	22,028
Current liabilities	(31,756)	(33,420)	(32,400)
Non current liabilities	(37,757)	(50,076)	(49,724)
Net Assets Employed	135,240	137,288	137,828
Total Taxpayers Equity	135,240	137,288	137,828

The Trust is reporting a breakeven position at the end of August, in line with Plan.

Income

In month, income has exceeded plan. The full inflationary uplift for the final agreed pay awards is now reflected in the position, along with assumed funding to support patients with prolonged observations.

Employee expenses

The Trust is reporting a year-to-date underspend on employee expenses of £1.93m. Substantive pay overspends in month include an estimated impact of the resident doctor pay award which will be resolved in September salaries and backdated to April.

Pay underspends were due to vacancy slippage across East, North and West Kent Community Directorates total £1.51m, including funds reserved for extending services under CMHF. An additional £1.75m is due to slippages in CYP recruitment (£1.13m of which is offset to income shortfalls). This slippage will reduce through the year as recruitment continues, as per the plan, to increase Community pay run rate by £2.5m across the year by filling vacancies. Current slippages are partially offset by pressures in additional temporary staffing on Acute wards.

Operating expenses

Non pay includes spend on external placements compared to budget, with additional Acute beds utilised resulting in an overall year to date pressure of £2.33m, including spend on stepdown beds.

In August, usage of external Acute beds increased, from average 12.6 beds to 15.7. PICU usage reduced from 11 beds to 9. Step Down usage decreased in preparation for ceasing use of these beds. 32 external beds were used in month against a commissioned base of 7 external female PICU beds.

Total assets

Total assets decreased by £0.83m in the month the contributing factor being LVA cash receipts being paid later than expected.

Total liabilities

Total liabilities have decreased by £1.38m in the month. Trade Payables being the contributing factor has decreased by £0.97m, the largest reductions being £0.77m Galliford Try and £0.37 with Softcat PLC. Borrowings, which are the IFRS16 lease liabilities has reduced by £0.39m this relates to a reduction due to updated terms being received for the transfer of the Dover Health Centre from NELFT.

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Appendices

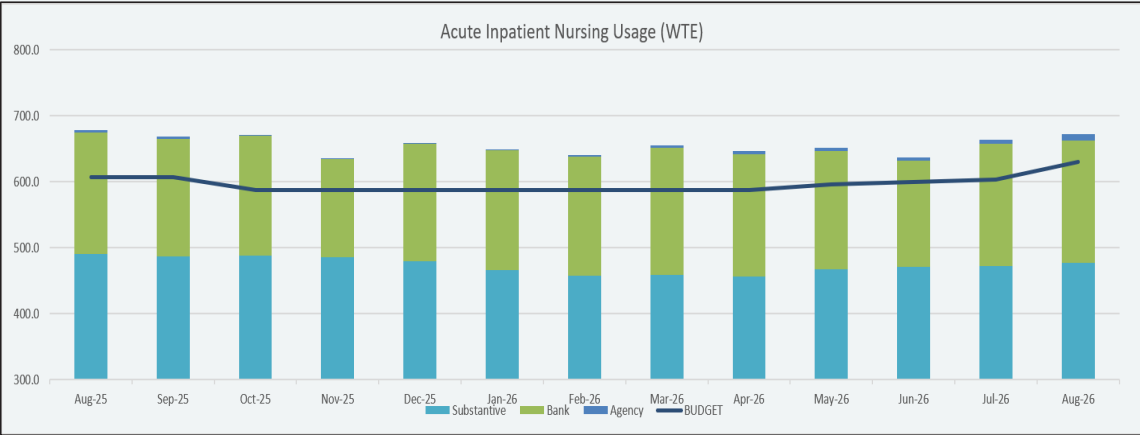
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Exception report – Expenditure Drivers

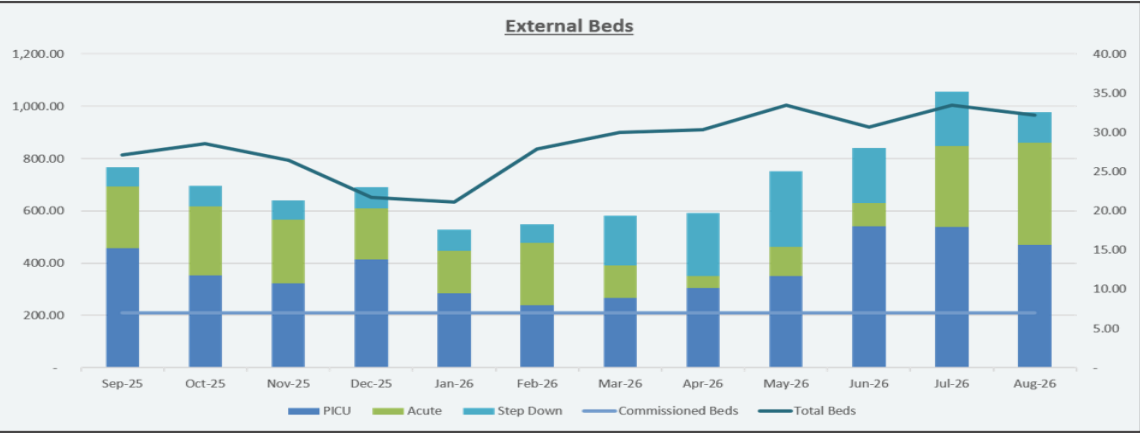


Commentary
Acute inpatient wards continue to use registered and unregistered nursing staff above funded establishment. Over the past 12 months, this has averaged **58.9 WTE** and **£0.24m** per month.

In August, staffing was **41.8 WTE above establishment**, eight WTE higher than July but below the 12-month average. The resulting year-to-date financial pressure is **£0.79m**.

The principal drivers are enhanced patient observations, complex care needs, annual leave and sickness cover, estate works, training, and backfill for staff unable to undertake their full duties for health and safety reasons. Commissioning discussions continue regarding funding for patients with exceptional care needs.

Work focused on increasing controls to reduce spend with Strengthen leave and rota management; rebalance staffing from older to younger adult services; introduce twilight bank shifts; and tighten enhanced-observation control.



Commentary
External bed use remains above commissioned levels, primarily because high numbers of patients clinically ready for discharge (CRFD) continue to restrict internal capacity.

In August, external acute bed use increased from an average of **12.6 to 15.7 beds**. PICU use reduced from **11 to nine beds**. Step down bed usage reduced from 11 to 7 beds.

The position is improving on older adult wards, with CRFD numbers falling to **44 by 9 September**.

Management actions focus on strengthening admission controls, accelerating discharge and resolving CRFD delays. These measures are intended to release internal capacity, support repatriation and reduce external-bed expenditure.

Cost Improvement 2026/27



Total CIP target
£10,352k



Total CIP identified
£10,367k



CIP delivered YTD
£3,264k



Recurrent CIP FOT
£7,285k

Performance to date:

At month 5, £3.26m of CIP has been delivered to date.

There are some schemes for which delivery is delayed namely Acute inpatient schemes which relates to utilisation of rotas and temporary staffing provision and the external beds utilisation which the Trust has experienced pressures on due to the increased demand on the Trust's bed base.

There are work programmes in place within the Trust and wider system which should enable these schemes to progress.

Corporate post reviews are underway, and the Trust has implemented a recruitment freeze on all corporate posts, covering both new appointments and the replacement of vacant roles.

Any exception will be limited to posts that are required to meet statutory obligations or are demonstrably safety-critical and will be subject to executive review and approval.

Pipeline schemes are being developed to address any slippage and provide the required mitigation, and these align to the 3-year CIP and Service Review programme that is already in place.

Area of spend	Recurrent?	Planned CIP Target	Forecast delivery	Variance
Acute inpatients	✓	1,600	1,050	(550)
Corporate review	✓	1,000	540	(460)
External beds	✓	2,620	1,383	(1,237)
Agency VAT	✓	1,000	1,000	0
CYP budgetary review	✓	1,100	958	(142)
Non pay review	✓	1,000	600	(400)
Agency Premium	✓	600	600	0
Community mitigations	✗	-	3,082	3,082
Forensic controls	✓	-	393	393
Community Service reviews	✓	-	589	589
Other	✗	1,432	172	(1,260)
Total		10,352	10,367	15

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Income and Expenditure Forecast

Commentary

The organisation has developed its forecast scenarios to reflect the principal risks and opportunities within the financial position. This work is on-going and a standing item of discussion within the Executive Team.

This assessment considers best, worst and likely positions, reflecting pressures such as external bed usage, patient acuity, complex care requirements and delivery of the Cost Improvement Programme. This work is supported by a developing set of actions and mitigations to strengthen the Trust's financial position and support delivery of the plan.

As reported in previous months of this financial year, the Trust continued to experience financial pressures during Month 5, principally from external bed use and operational pressures across acute inpatient wards.

These pressures have been mitigated predominantly by phasing elements of the planned community expansion (in-line with operational plans) and a number of non-recurrent measures to support delivery of the financial position.

At Month 5 the Trust is forecasting:

- A breakeven mid-range position,
- A best case of £0.9m surplus
- A worst case of £4.9m deficit.

The worst case reflects the impact if CIP is not achieved.

The forecast position is based on the following principal assumptions:

Area of spend	Rationale
External Acute bed	Bed usage reducing to planned levels with beds reducing upon the commencement of K&M ICB commissioned beds. Forecast includes 2 external Acute beds from October 2026.
External PICU bed pressures	Male PICU usage increased materially in June. This is currently assessed as a non-recurrent pressure and is expected to remain at 10 beds until the end of the calendar year.
External step-down bed provision	The Trust has maintained a contract for step-down beds to manage winter pressures and provide interim capacity pending ICB-commissioned provision. Step down bed usage is minimal with the remaining patients expected to have been discharged by 30 September.
Community expansion	Mobilisation in Care navigation services (front door), remaining community investment aligned to operational plans.
Other run rate changes	Seasonal impacts
Medical pay award pressure	Estimate ahead of the processing pay award in September
Other controls & mitigations	Acute inpatient pressures for prolonged observations and EPCs
Community framework roll out	Planned community expansion may be paused where necessary while bed-related pressures remain.
Delivery of the Cost Improvement Programme (CIP).	Focus on reducing inpatient staffing costs, supported by automated processes for temporary staffing, delivery of the bed trajectory and finalisation of the non-pay review

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Capital position

	Annual			In month			Year to Date		
	Plan £'000	Forecast £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
System Capital expenditure									
Capital Maintenance and Minor Schemes	2,866	1,681	1,185	32	(142)	174	143	250	(107)
Information Management and Technology	350	1,375	(1,025)	0	59	(59)	0	155	(155)
Section 136 development	2,250	2,250	0	598	(26)	624	2,140	1,941	199
Out of Area Placement (Female PICU)	2,539	2,539	0	700	588	112	2,539	1,679	860
Solar Installation	138	141	(3)	0	86	(86)	138	141	(3)
IFRS 16 Leases	585	585	0	0	20	(20)	575	65	510
IFRS 16 Leases - CAMHS	70	1,809	(1,739)	0	0	0	7	1,665	(1,658)
Contingency	381	538	(157)	0	0	0	0	0	0
Total system expenditure	9,179	10,918	(1,739)	1,330	585	745	5,542	5,896	(354)
External expenditure									
PFI 2025/26	236	236	0	20	20	0	100	98	2
R&D - Hyperfine Swoop Imaging System	578	578	0	0	4	(4)	578	5	573
Thanet Crisis Assessment Service	50	50	0	0	0	0	0	0	0
Estates Safety Fund	0	4,451	(4,451)	0	47	(47)	0	59	(59)
EV Charge Points	0	0	0	0	0	0	0	0	0
Total external expenditure	864	5,315	(4,451)	20	71	(51)	678	162	516
Total Capital Expenditure against CDEL	10,043	16,233	(6,190)	1,350	656	694	6,220	6,058	162
Intra DH expenditure									
Winthrop Hall	0	8,958	(8,958)	0	0	0	0	8,958	(8,958)
Dover Health Centre	0	331	(331)	0	(229)	229	0	102	(102)
Cherry Tree House	33	1,019	(986)	0	0	0	33	1,019	(986)
Georges Turtles Clinic	0	1,876	(1,876)	0	0	0	0	1,876	(1,876)
Unit 1, Gillingham Business Park	0	324	(324)	0	0	0	0	324	(324)
Maidstone Studios M2	2	229	(227)	0	0	0	2	229	(227)
Courtyard, Pudding Lane	0	340	(340)	0	0	0	0	340	(340)
Total Intra DH expenditure	35	13,077	(13,042)	0	(229)	229	35	12,848	(12,813)
Total Capital Expenditure	10,078	29,310	(19,232)	1,350	427	923	6,255	18,906	(12,651)

Commentary:

As of 31st August, the overall capital position is £12.65m over the planned position submitted to NHSE, driven primarily by the recognition of assets associated with the CYP and AAED service transfer.

The majority of this (£12.81m), however, does not score against the Trust's CDEL as intra DoH leases are excluded.

The remaining underperformance against plan of £0.16m relates to delays in the Female PICU programme, lease remeasurement of Eureka House and R&D Hyperfine projects; this is being offset by overspend on IFRS16 leases of £1.66m relating to the transfer of services from NELFT.

Discussions are on-going with the NHSE regional team regarding these and the impact it is having the trust's capital allocation.

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Glossary

Acronyms and abbreviations:

AAED — All Age Eating Disorders

BPPC — Better Payment Practice Code, the NHS measure of prompt supplier payment.

CDEL — Capital Departmental Expenditure Limit; the capital spending control used for NHS bodies.

CRFD — Clinically Ready for Discharge, where a patient no longer requires the current acute bed for a clinical reason.

CYP — Children and Young People services.

DoH — Department of Health

HCA — Healthcare Assistant.

I&E — Income and Expenditure statement or position.

IFRS 16 — Accounting standard for leases, relevant to capital recognition and remeasurement.

MAS — Memory Assessment Service.

MHT / MHT+ — Mental Health Team / enhanced Mental Health Team

NHS / NHSE — National Health Service / NHS England.

PICU — Psychiatric Intensive Care Unit.

PO — Purchase Order.

RAG — Red, Amber, Green status rating.

SBS — NHS Shared Business Services and provider of finance ledger services

WTE — Whole Time Equivalent, used to express staffing capacity or vacancies.

YTD — Year to Date, cumulative performance from the start of the financial year.

Finance terms:

Accrued income — Income recognised before the cash has been received or invoiced.

Agency spend — Cost of temporary staff supplied through an external agency.

Bank staff — Temporary staff engaged through the Trust's internal staff bank.

Breakeven plan — A financial plan where income and expenditure are expected to balance.

Capital allocation — The agreed capital funding or limit available to the Trust.

Cash headroom — Available cash above the planned or minimum level.

Employee expenses — Total pay costs, including substantive, bank and agency staffing.

Forecast — Projected financial position for a future period or year end.

In-month — Activity, cost or movement arising within the reporting month only.

Pay award — Nationally agreed change to staff pay, reflected in budgets and spend.

Prepayments — Costs paid in advance and recognised over the period they relate to.

Run-rate — The recurring level of spend or activity implied by recent performance.

Technical adjustments — Accounting entries that affect the reported position but are not operational spend.

Trade payables — Amounts owed to suppliers for goods or services already received.

Vacancy slippage — Temporary underspend caused by posts being vacant during recruitment.

Operational and capital terms:

Acute beds — Inpatient beds supporting patients requiring acute mental health care.

Block contract — A fixed arrangement for a specified capacity or service, rather than spot purchase.

Commissioned levels — The level of activity or capacity funded by commissioners.

Establishment — The planned staffing level for a ward or service.

External beds — Beds purchased from providers outside the Trust to meet patient need.

Funded levels — The activity or capacity assumed within the Trust's agreed funding.

Intra-DH leases — Leases within the Department of Health group, treated differently for CDEL purposes.

Lease remeasurement — Accounting reassessment of lease value, for example after a rent review.

PO hold — A purchase order or invoice issue that delays payment processing.

Repatriation — Returning patients from external placements into Trust-provided beds.

Step Down beds — Lower-acuity capacity used to support discharge flow and reduce acute external bed use.

Treasury management — Managing cash, payments and financial obligations.

Year-end position — The forecast or actual financial position at the end of the financial year.

YTD pressure — Cumulative overspend or adverse variance against plan to date.

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Trust Board meeting

Meeting details

Date of meeting:	24 th September 2026
Title of paper:	Medical Revalidation Report
Author:	Dr Mohan Bhat, Deputy Chief Medical Officer for Workforce
Executive Director:	Dr Afifa Qazi, Chief Medical Officer

Purpose of paper

Purpose:	Approval for Submission to NHS England
Submission to Board:	Regulatory (Responsible Officer Regs 2010 (as amended 2013))

Overview of paper

Annual Organisation Report and Statement of Compliance to Board for approval prior to submission to NHS England (2025/2026).

Report is submitted to Board to provide assurance on appraisal and revalidation of doctors employed by the organisation and following approval will be submitted to NHSE as a statutory requirement.

Issues to bring to the Board's attention

- 1) A total of 192 doctors have a prescribed connection to KMMH as their Designated body. There were 7 who had approved exemptions for the appraisal year (5 of them long term sick and 2 due to circumstances not under their control) but completed the appraisal outside the agreed timescale. 182/185 (98%) completed the appraisal in the timescale, 3 doctors had an unapproved miss. There is a plan in place to address these misses.
- 2) In line with GMC requirement and Responsible Officer Protocol, KMMH has a robust process in place to ensure recommendations to the GMC are timely and our doctors are revalidated in line with GMC requirements. All recommendations (100%) to GMC were made in time.
- 3) All actions raised from 2024/2025 Annual Board Report have been completed.

Governance

Implications/Impact:	KMMH meets the regulatory requirement for designated bodies (Responsible Officer Regs 2010 (as amended 2013)) to ensure all Doctors employed by the organisation are fit to practice. There are no Resource and Financial Implications.
Assurance:	The paper is to provide assurance on compliance with the Responsible Officer (RO) regulations submission of the Annual Organisation Audit Report to NHS England.
Oversight:	Chief Medical Officer



Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative

Section 2 – Metrics

Section 3 - Summary and conclusion

Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2025 – 31 March 2026

1A – General

The board/executive management team of:

Kent and Medway Mental Health NHS Trust

can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Yes
Action from last year:	None
Comments:	Chief Medical Officer is our Responsible officer.
Action for next year:	None

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes
Action from last year:	None
Comments:	We have an established Medical Revalidation team and the Deputy Chief Medical Officer also supports the responsible officer in this function.
Action for next year:	None

1A(iii) An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Yes
Action from last year:	None
Comments:	The Medical Revalidation team keeps an updated record of all the licensed medical practitioners with a prescribed connection to KMMH.
Action for next year:	None

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Yes
Action from last year:	None
Comments:	Revalidation and Medical Appraisal Policy has been ratified by Local Negotiating Committee and the Trust People's Committee.
Action for next year:	None

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	Yes
Action from last year:	None
Comments:	TIAA audited our appraisal and revalidation processes in January 2025 and all the recommendations previously made were completed with no further recommendations issued. The next TIAA external audit is due in 2026/27
Action for next year:	None

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Yes
Action from last year:	None
Comments:	
Action for next year:	None

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Yes
Action from last year:	Layout for the job plan domains to be completed by end of 2025 on SARD with it coming out with Version 7.

Comments:	Complete
Action for next year:	None

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	N/A
Action from last year:	None
Comments:	N/A
Action for next year:	None

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Yes
Action from last year:	None
Comments:	This has been approved by the Trust People's Committee
Action for next year:	None

1B(iv) Our organisation has the necessary number of trained appraisers¹ to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	Yes
Action from last year:	None
Comments:	Annual refresher training for appraisers is completed yearly.

¹ While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Action for next year:	None
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1B(v) Medical appraisers participate in ongoing performance review and training/development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements ([Quality Assurance of Medical Appraisers](#) or equivalent).

Y/N	Yes
Action from last year:	None
Comments:	All appraisers are required to attend annual appraisal refresher training and receive anonymised, collated feedback from their appraisees as part of the quality assurance and continuous improvement process.
Action for next year:	None

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Yes
Action from last year:	None
Comments:	
Action for next year:	None

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	None

Comments:	All recommendations are made within the expected time scales.
Action for next year:	None

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Yes
Action for next year:	None
Comments:	Reasons for deferral are discussed with the concerned doctor in advance to making that recommendation to the GMC
Action for next year:	None

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Yes
Action from last year:	None
Comments:	There is a robust line management and supervision structure for all doctors in KMMH
Action for next year:	None

1D(ii) Effective [systems](#) are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Yes
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Action from last year:	To continue processes
Comments:	This is via the rigorous monthly Decision-Making Unit (DMU) chaired by the Chief Medical Officer/Responsible Officer
Action for next year:	None

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Yes
Action from last year:	None
Comments:	
Action for next year:	None

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns [policy](#) that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Yes
Action from last year:	None
Comments:	This is via the rigorous monthly Decision-Making Unit (DMU) chaired by the Chief Medical Officer/Responsible Officer
Action for next year:	None

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Yes
Action from last year:	To report these figures annually from this year (2025-26) to the People Committee in the “Managing concerns around doctors”.
Comments:	The action to report information annually through a dedicated “Managing Concerns Around Doctors” report has not been fully implemented. Instead information relating to concerns involving doctors is reported through the wider Employee Relations reporting arrangements rather than a specific medical workforce report. At present, the Trust does not routinely report a detailed analysis of concerns relating to doctors, including associated demographic information such as protected characteristics and country of primary medical qualification.
Action for next year:	To review the process to record and monitor concerns relating to doctors in a consistent format, enabling annual reporting through the Employee Relations update to include: • Number of concerns raised. • Type of concern (e.g. conduct, capability, health, behaviour). • Outcome of the concern. • Analysis by protected characteristics where data is available. • Analysis by country of primary medical qualification where data is available. A manual data collection process is likely to be required initially, as current systems do not routinely capture or report all of these fields in a consolidated format. Following the first year of data collection, consideration will be given to whether system enhancements or alternative reporting mechanisms are required to improve efficiency and accuracy.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with [appropriate governance responsibility](#)) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Yes
Action from last year:	None
Comments:	This is supported by the Medical Revalidation Team
Action for next year:	None

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref [GMC governance handbook](#)).

Y/N	Yes
Action from last year:	This is will be monitored by the annual report on "Managing concerns around doctors" to the People Committee
Comments:	The action to report information annually through a dedicated "Managing Concerns Around Doctors" report has not been fully implemented. Instead information relating to concerns involving doctors is reported through the wider Employee Relations reporting arrangements rather than a specific medical workforce report.
Action for next year:	

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Yes
Action from last year:	To continue processes.

Comments:	This is supported by Medical Education and Clinical Effectiveness and Outcome Group (NICE guidance, research, clinical audit and clinical policies are monitored via this group)
Action for next year:	None

1D(ix) Systems are in place to review professional standards arrangements for [all healthcare professionals](#) with actions to make these as consistent as possible (Ref [Messenger review](#)).

Y/N	Yes
Action from last year:	To continue processes
Comments:	We have a digital appraisal system for all staff. Clinical Directors have oversight of the professional standards for all healthcare professionals within their respective directorates
Action for next year:	None

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Yes
Action from last year:	None
Comments:	This has been maintained by the medical staffing team for the reporting year. KMMH uses an applicant tracking system, Trac to manage the full recruitment process from advertising through to offer and pre-employment checks.

Action for next year:	Medical staffing team to support the general recruitment team with the transition of medical recruitment requirements following the People Team organisation changes. General recruitment team maintain from next reporting year.

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Yes
Action from last year:	None
Comments:	Job planning is used to ensure consistency and delivery of expectations for clinical activity, ensuring high professional standards with a culture of transparency and collaboration. The Trust has continued the monthly excellence awards called 'Values in Practice Awards' for this reporting year which supports recognising excellence in care. We have also implemented the Patient Safety Incident Response Framework meeting the four key aims the framework sets out to provide.
Action for next year:	None

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Yes
Action from last year:	None

Comments:	We are dedicated to creating services that allow everyone to reach their potential, and where people treat each other with dignity and respect. We actively engage with interest groups to identify and remove barriers for protected groups. We have a dedicated Equality, Diversity, and Inclusion (EDI) team to lead this work. We continue a focus on EDI and have substantive plans and actions across the trust to reduce violence, aggression and racism.
Action for next year:	None

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Yes
Action from last year:	None
Comments:	Our Freedom to Speak Up service is managed by The Guardian Service. They are independent and external to KMMH. They operate 24 hours a day, seven days a week for 365 days a year. Our CEO continues to provide regular 'Speak to Sheila' sessions for all staff who are able to raise and discuss any topics they feel of relevance, ask questions and discuss matters of importance to them.
Action for next year:	None

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Yes
Action from last year:	None
Comments:	We have a framework for management supervision for all doctors where these can be raised. The organisation provides access to a freedom to speak up guardian and there is a clear whistle blowing policy.
Action for next year:	None

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the [Equality Act](#).

Y/N	Yes
Action from last year:	This will be reported annually to the People Committee via the "managing concerns around doctors" report
Comments:	The action to report data annually through a dedicated "Managing Concerns Around Doctors" report has not been implemented as originally planned and data relating to concerns involving doctors is not routinely analysed or reported by country of primary medical qualification or by all protected characteristics under the Equality Act.
Action for next year:	Review current data collection and reporting arrangements to determine how parity monitoring can be strengthened for doctors involved in concerns and disciplinary processes. This will include: - Identifying what demographic information is currently available and can be reliably reported. - Exploring options for recording country of primary medical qualification and relevant protected characteristic data alongside concerns cases.

	• Developing a proportionate reporting mechanism through existing Employee Relations reporting processes. • Undertaking ethnicity-based analysis where data is available, while considering the feasibility of extending this to additional protected characteristics in future years.
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1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Yes
Action from last year:	None
Comments:	The RO and Deputy RO attends the network meetings and high-level RO meetings
Action for next year:	None

Section 2 – metrics

Year covered by this report and statement: 1 April 2025 – 31 March 2026.

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	192
Total number of appraisals completed	182
Total number of appraisals approved missed	7
Total number of unapproved missed	3
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	9
Total number of late recommendations	0
Total number of positive recommendations	8
Total number of deferrals made	1
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	14
Total number of trained case managers	3
Total number of concerns received by the Responsible Officer ²	10
Total number of concerns processes completed	9
Longest duration of concerns process of those open on 31 March (working days)	221
Median duration of concerns processes closed (working days) ³	58
Total number of doctors excluded/suspended during the period	0
Total number of doctors referred to GMC	0

² Designated bodies' own policies should define a concern. It may be helpful to observe <https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/>, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

³ Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	24
Total number of new employment checks completed before commencement of employment	24
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld ⁴	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
At KMMH in the last year we had a total of 182 doctors who had their appraisals. Seven doctors who did not have the appraisal had agreed exceptions. A total of 3 Doctors had missed their appraisal without an agreed exception. We support the doctors in process and also ensure appraisers are trained to continue to improve our appraisals, refresher training remains an annual event for all the appraisers in the Trust in support of standardising the quality of appraisals. Monitoring of performance, concerns and remediation are managed under the Trust's Decision-Making Units, meetings are held monthly with the Chief Medical Officer and Deputy/Responsible Officer and Chief People Officer and Deputy in attendance, the Responsible Officer and Deputy meet with the GMC Employer Liaison Advisor quarterly. A number of quality assurance mechanisms are in use in relation to medical appraisal. Each appraisal in a revalidation portfolio is checked for key items against the GMC's 5 domains and the Trust's local requirements. Discrepancies are notified to the doctor and, if necessary, an action plan prepared to rectify omissions to ensure a recommendation to revalidate can be made. The Medical Staffing Team in HR has been responsible for ensuring that all necessary pre and post-recruitment checks are completed in full for this reporting year and for taking any required action, including dealing with start dates or withdrawing offers of employment, where the responses to these checks are not satisfactory. This process is complaint. This process will be moving the core/general recruitment team for the next

⁴ Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

reporting period following the outcome of the People Team organisational change process.
Actions still outstanding
None
Current issues
None to report
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
To review the process to record and monitor concerns relating to doctors in a consistent format, enabling annual reporting through the Employee Relations update to include: • Number of concerns raised. • Type of concern (e.g. conduct, capability, health, behaviour). • Outcome of the concern. • Analysis by protected characteristics where data is available. • Analysis by country of primary medical qualification where data is available. A manual data collection process is likely to be required initially, as current systems do not routinely capture or report all of these fields in a consolidated format. Following the first year of data collection, consideration should be given to whether system enhancements or alternative reporting mechanisms are required to improve efficiency and accuracy. Review current data collection and reporting arrangements to determine how parity monitoring can be strengthened for doctors involved in concerns and disciplinary processes. This will include: • Identifying what demographic information is currently available and can be reliably reported. • Exploring options for recording country of primary medical qualification and relevant protected characteristic data alongside concerns cases. • Developing a proportionate reporting mechanism through existing Employee Relations reporting processes.

• Undertaking ethnicity-based analysis where data is available, while considering the feasibility of extending this to additional protected characteristics in future years.
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
We have had another successful year with regards to Doctors having their annual appraisals completed. We have also taken steps to support the doctors in this process and also ensured that the current appraisers are trained to improve the quality of appraisal experience of our doctors. We are committed to maintain and continually improve this overall process.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	Kent and Medway Mental Health Trust
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Name:	Sheila Stenson
Role:	Chief Executive Officer
Signed:	
Date:	

Name of the person completing this form:	Dr Mohan Bhat
Email address:	Mohan.bhat1@nhs.net

Trust Board meeting

Meeting details

Date of meeting:	24 September 2026
Title of paper:	Emergency Planning, Resilience and Response (EPRR) Annual Report, Compliance Self-Assessment Statement, EPRR Policy and 2026/27 Work Plan.
Author:	Emergency Preparedness and Resilience Lead
Executive Director:	Dr Adrian Richardson (Accountable Executive Officer, EPRR)

Purpose of paper

Purpose:	Noting, NHSE EPRR Core Standards Compliance.
Submission to Board:	Statutory compliance

Overview of paper

This report provides assurance that the Trust is meeting its statutory duties under the Civil Contingencies Act 2004 and is compliant with the NHS England EPRR Framework and 2025/26 Core Standards Assurance Programme.

Issues to bring to the Board's attention

The Board is asked to receive the Emergency Preparedness, Resilience and Response (EPRR) Annual Report, endorsed by the Audit and Risk Committee on 1 September 2026.

In doing so, the Board is asked to:

- Accept the EPRR Annual Report as assurance of the Trust's compliance with its statutory duties under the Civil Contingencies Act 2004.
- Reaffirm its understanding of, and commitment to, the Trust's responsibilities as a Category 1 Responder under the Civil Contingencies Act 2004.
- Note the completion and closure of the 2025/26 EPRR Work Plan.
- Note the 2025/26 EPRR Statement of Compliance (Appendix 1).
- Note the 2026/27 EPRR Improvement Plan (Appendix 2).
- Note the revised EPRR Policy, version 11.1 (Appendix 3 *uploaded to Reading Room*),
- Note the content of the 2026/27 EPRR Work Plan (Appendix 4 *uploaded to Reading Room*), commencing 1 September 2026.

Governance	
Implications/Impact:	In line with NHS England requirements, the Trust is required to share its NHS England-ratified EPRR audit outcomes annually with stakeholders and service users through the Trust Annual Report or another appropriate public reporting mechanism. The EPRR Policy is approved and owned by the Board. Executive accountability for EPRR rests with a designated Executive Director. In July 2026, responsibility transferred from the Chief Nurse to the Director of Partnerships and Transformation. To provide independent assurance of compliance with the Civil Contingencies Act 2004, the Trust completes an annual assessment against the NHS England EPRR Core Standards. This assessment is subject to review and validation through the Kent and Medway Integrated Care Board (ICB) assurance process before submission to NHS England. The Trust received confirmation from NHS England in Quarter 4 of 2025/26 that it was assessed as 'Fully Compliant' against the NHS EPRR Core Standards. The 2025/26 NHS EPRR Core Standards self-assessment was undertaken during July and August 2026. Following validation through the Kent and Medway ICB assurance process and ratification by NHS England, the outcome will be reported to the Audit and Risk Committee (ARC) in Quarter 4 of 2026/27. This provides independent assurance that the Trust continues to meet its statutory responsibilities for emergency preparedness, resilience and response arrangements.
Assurance:	The EPRR work programme operates on an annual cycle commencing on 1 September each year, following completion of the NHS England EPRR Core Standards self-assessment process during July and August. Delivery of the programme is overseen by the Trust-wide EPRR Working Group, chaired by the Accountable Emergency Officer, providing organisational oversight and supporting compliance with the Civil Contingencies Act 2004 and NHS England EPRR Core Standards. Progress against the EPRR Work Plan is monitored throughout the year via the Trust-wide EPRR working sub-group and reported through the Trust-wide Health, Safety and Risk Group to the Audit and Risk Committee. This governance framework ensures appropriate oversight of EPRR arrangements and provides assurance regarding the Trust's preparedness, resilience and compliance with statutory and national requirements.
Oversight:	This paper has been reviewed and supported by the Audit and Risk Committee on 1 September 2026 and is submitted to the Board for assurance.

Emergency Preparedness, Resilience and Response – Annual Report to Board (Period 01 September 2025 – 31 August 2026)

Background and context

1. The Civil Contingencies Act (2004)

Statutory duties

The Civil Contingencies Act 2004 places several statutory duties on the Trust, as a category 1 responder, which must be delivered in partnership with other local responders. These duties include:

- Undertaking risk assessment activities.
- Developing, maintaining and exercising emergency response plans.
- Developing, maintaining and exercising business continuity plans.
- Establishing arrangements for warning and informing the public.
- Sharing information with partner organisations, where appropriate.
- Co-operating with other category 1 and category 2 responders to support an effective multi-agency response to emergencies and major incidents.

Board assurance

This annual report provides assurance to the Board that the Trust has established and maintains effective Emergency Preparedness, Resilience and Response (EPRR) arrangements to meet its statutory duties under the Civil Contingencies Act 2004 and associated NHS England requirements. It demonstrates that appropriate governance, emergency planning, business continuity, training, exercising, and partnership arrangements are in place to enable the Trust to prepare for, respond to, and recover from a range of incidents and emergencies, ensuring the continuity of critical services and the safety and wellbeing of patients, staff, visitors, and the wider community.

The report further provides assurance that the Trust remains compliant with the NHS England EPRR Framework and Core Standards Assurance Programme. Through ongoing assessment, improvement, and collaboration with local, regional, and national partners, the Trust continues to strengthen organisational resilience and maintain preparedness for identified risks, threats, and hazards that may impact the delivery of healthcare services

2. Assessing and documenting compliance

NHS England EPRR Core Standards Assurance Programme

The NHS England Emergency Preparedness, Resilience and Response (EPRR) Core Standards Assurance Programme is the mandated framework through which NHS organisations assess compliance with statutory EPRR requirements and provide assurance regarding organisational preparedness and resilience.

Self-assessment process

All NHS providers are required to complete an annual self-assessment against the NHS England EPRR Core Standards. The assessment is based on a nationally prescribed framework and evidence requirements, which are designed to demonstrate compliance with the duties placed upon Category 1 Responders under the Civil Contingencies Act 2004 and associated NHS England guidance.

2025 Assessment outcome

Within the 2025 assurance process, the Trust was required to provide evidence against 58 lines of inquiry covering all aspects of emergency preparedness, resilience and response. The Trust achieved compliance against all 58 lines of inquiry, resulting in a self-assessment score of 100%, demonstrating full compliance with the NHS England EPRR Core Standards. No improvement plan was required.

Independent validation and ratification

The Trust's 2025 self-assessment submission was subject to independent review and validation through the Kent and Medway Integrated Care Board (ICB) assurance process. Regional results were subsequently collated and submitted to NHS England for ratification.

In March 2026, NHS England formally confirmed the Trust's assurance outcome, awarding a rating of fully compliant. The ratified assurance letter was presented to the Audit and Risk Committee, where the outcome was noted and accepted as independent assurance of the Trust's compliance with the Civil Contingencies Act 2004, the NHS England EPRR Framework and the EPRR Core Standards Assurance Programme.

2026 Assurance process

The current NHS England Core Standards are organised around 10 domains:

- Governance
- Duty to Risk Assess
- Duty to Maintain Plans
- Command and Control
- Training and Exercising
- Response
- Warning and Informing
- Co-operation
- Business Continuity
- CBRN (Chemical, Biological, Radiological and Nuclear) / HAZMAT (Hazardous Materials)

For mental health trusts, the applicable standards under these domains total 58 lines of inquiry, although other organisation types may have a different number (for example, some acute trusts assess against 62 standards and specialist trusts against 59 standards).

The 2026 EPRR Core Standards self-assessment was completed during July and August 2026. For the 2025/26 assurance cycle, the Trust submitted evidence against 58 NHS England EPRR Core Standard lines of inquiry. Based on the evidence provided, the Trust has self-assessed as substantially compliant achieving compliance against 57 of 58 applicable NHS England EPRR Core Standard lines of inquiry (98.3%), pending external validation and ratification by NHS England. The one element preventing the 100%

compliance was the change required to the job descriptions of the accountable emergency officer and deputy accountable emergency officer. This element was not completed by the date of submission of papers to the Audit and Risk Committee. It is hoped that this will be resolved prior to the evidence assessment by the ICB on the 18th September including the report to Board, therefore it is currently on the improvement plan for the 2025/26 submission.

Following review and validation by the Kent and Medway ICB the next anticipated milestone is in October 2026 when all evidence in Kent and Medway is discussed by the Local Health Resilience Partnership Executive Group and then sent for ratification by NHS England, the final assurance outcome, from NHSE will be reported to the Audit and Risk Committee and then Board, via a chairs report, in quarter four.

This process provides independent assurance that the Trust continues to maintain effective EPRR arrangements and improvement, as a learning organisation, and remains prepared to respond to, recover from, and learn from incidents and emergencies affecting patients, staff, services and the wider community. In 2025/26 examples of this were:

- The development of new business continuity plans for the Children and Young People/All Age Eating Disorder Directorate who joined the Trust in April 2026.
- Continued development of EPRR capability and expertise, through training, delivery of the exercise programme and lessons learned from exercises and incident response.
- Strengthened partnership leadership through training, co-chairing and membership on active workstreams of the Kent and Medway Resilience Forum as a standing member or in support of the ICB EPRR function.

Compliance Level	Evaluation and Testing Conclusion
Full	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed to an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed to an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation is compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed to an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

3. Risk assessment and risk management

Kent and Medway Resilience Forum (KMRF)

The Trust EPR Lead co-chairs the KMRF Risk Assessment Group. Through these arrangements, the Trust contributes to the assessment and review of local risks and threats and supports the maintenance of the Community Risk Register, ensuring alignment with the National Security Risk Assessment (NSRA) and national resilience priorities.

Trust Non-Clinical Risk Management Framework compliance

The Trust reviews its emergency preparedness, resilience and response risk profile at least annually and more frequently where new or emerging risks, hazards or threats are identified. Risks are assessed and managed through the Trust's risk management framework and recorded on the EPRR Risk Register.

The EPRR risk register is subject to regular review to ensure that risk controls, assurances and mitigating actions remain effective. Where risks exceed the Trust's risk appetite or may impact the achievement of strategic objectives, they are escalated through the Trust's governance processes to the Trust Corporate Risk Register and, where appropriate, the Board Assurance Framework (BAF).

This approach ensures that EPRR risks are appropriately identified, assessed, managed and monitored; while providing Executive and Board-level oversight of risks associated with the Trust's statutory duties under the Civil Contingencies Act 2004 and NHS England EPRR requirements. The key risks on the EPRR register typically focus on the ability to prepare for, respond to incidents and emergencies and link to the two main Trust command and control documents for major and significant (scale of incident minor up to and including critical) incidents:

Risk	Key EPRR Mitigations
Cyber attack	Cyber Resilience and Response Plan, IT Business Continuity arrangements; communication and escalation procedures through EPRR response structures and various mitigations held by Digital at an official sensitive level
Unplanned infrastructure failure (electrical)	Electrical Supply Disruption Plan; backup power arrangements; generator testing and maintenance; prioritisation of critical services; Business Continuity Plans; escalation through incident management arrangements
Hazardous Materials risk and response	Hazardous Materials Plan; staff training and awareness; incident control arrangements; liaison with emergency services and Business Continuity Plans
Impact from national planned rolling power disruptions to manage peak demand	Electricity Disruption Plan; identification of critical services; contingency power supplies; business continuity arrangements; communication and escalation procedures through EPRR response structures
Organisational risk (summer resilience) - severe weather	Summer Resilience Plan; monitoring UKHSA and Met Office alerts; heatwave action plans; staff and patient welfare measures; business continuity

	arrangements; escalation through EPRR command and control arrangements
Organisational risk – Emerging infectious disease and subsequent variants	Pandemic Plan and Infection prevention and control measures; outbreak management arrangements; business continuity plans; surveillance and horizon scanning; vaccination and workforce resilience programmes.
Organisational risk flooding	Flood escalation procedures; Estates monitoring and escalation; Environment Agency warnings/mapping; local site assessments; business continuity plans; remote working and alternative service delivery arrangements where required
Organisational risk – Industrial action	Industrial Action Standard Operational Procedure; workforce contingency planning; mutual aid and prioritisation of critical services; command and control arrangements; advance risk assessments and communications.
Organisational risk – Infrastructure failure (fuel)	Fuel Crisis Plan; fuel permit arrangements; prioritisation of essential travel and services; alternative working arrangements; coordination with local resilience partners
Organisational risk – infrastructure failure (water)	Water Resilience and Response Plan; business continuity arrangements; bottled water and alternative supply arrangements; Estates-led escalation and recovery processes
Organisational Risk - Transport Accident/Incident (including border flow disruptions at Port of Dover and Dartford Crossing)	Business continuity plans; monitoring of road and transport network disruptions; use of alternative routes and remote working; liaison with resilience partners; service prioritisation and escalation through EPRR arrangements
Organisational Risk (Winter Resilience) - Severe Weather excluding flooding	Winter Resilience Plan; severe weather monitoring and alerts; gritting and site safety measures; 4x4 and accommodation arrangements where appropriate; workforce resilience measures; Business continuity, incident management and recovery processes.

Local Health Resilience Partnership

As allocated by the Local Health Resilience Partnership the Trust EPR Lead and Officer additionally participate in multi-agency Safety Advisory Groups and wider resilience partnership arrangements to support the identification, assessment and management of risks that may impact public safety and healthcare services. These arrangements facilitate joint planning, information sharing and coordinated risk mitigation with partner agencies.

4. Develop emergency plans

In accordance with the Civil Contingencies Act 2004 and NHS England EPRR Core Standards, the Trust maintains a suite of emergency response plans designed to enable a timely, coordinated and effective response to a range of incidents and emergencies. These arrangements support the Trust's ability to protect patients, staff, visitors and services during periods of disruption.

The Trust's emergency planning framework includes the Major Incident Plan and a range of supporting response plans and procedures covering foreseeable risks and threats identified through local and national risk assessment processes. Plans are reviewed

regularly, or in response to organisational, legislative or operational changes, to ensure they remain current and effective.

Emergency plans are developed in collaboration with internal stakeholders and partner organisations across the health and resilience community, ensuring alignment with local, regional and national arrangements and supporting a coordinated multi-agency response to emergencies.

The effectiveness of emergency plans is supported through training, exercising, incident response and lessons-learned processes. Outcomes from exercises, incidents, debriefs and assurance activities are used to inform continuous improvement and ensure that emergency arrangements remain fit for purpose.

During 2025/26, the Trust maintained and reviewed its emergency planning arrangements in line with statutory requirements and NHS England guidance, providing assurance that robust plans are in place to respond to, recover from and learn from emergencies and incidents.

5. Develop business continuity plans (aligned to ISO 22301)

In 2025/26 the trust enacted business continuity arrangements for the following examples:

Portland Building Fire, Northfleet	Business continuity arrangements supported assessment of the impact of the fire and asbestos on clients, staff and service delivery, implementation of alternative working arrangements where required, communication with affected teams, and maintenance of critical clinical functions during the response and recovery phase
Water outages	Business continuity plans enabled services to identify critical dependencies on water, implement local contingency measures, maintain patient safety, prioritise essential activities, and coordinate with Estates and utility providers until normal supplies were restored.
Unplanned IT outages	IT System Business Continuity Plans supported the continuation of critical services through downtime procedures, alternative communication methods, manual workarounds, prioritisation of key systems, and recovery arrangements until digital services were restored.
Planned rail works Isle of Grain	Planning and risk assessment; staff communications; alternative travel and access arrangements; monitoring of operational impact; maintenance of critical service delivery during transport disruption to the island.

The Civil Contingencies Act 2004 requires category 1 responders to maintain arrangements to ensure that critical services can continue to be delivered during and following disruptive incidents. NHS England's EPRR Core Standards further require organisations to have effective business continuity management arrangements in place to support organisational resilience.

The Trust maintains a comprehensive Business Continuity Management (BCM) Framework, supported by a Management of Business Continuity Policy and Directorate-

level and information technology business continuity plans. These arrangements identify critical activities; risk assess potential disruptions and establish proportionate strategies to support the continued delivery of essential services.

Business continuity plans are reviewed and updated regularly to reflect changes in services, organisational structures, emerging risks and lessons identified from incidents, exercises and debriefs. Plans are required to identify key dependencies, recovery priorities and escalation arrangements to ensure an effective and coordinated response to disruption.

The Trust's business continuity management arrangements are supported through individual support in the writing and reviewing of plans via the EPR Lead who holds a certificate in business continuity from the Business Continuity Institute (BCI). Exercising and assurance activities are encouraged and supported. This enables services to test their response arrangements, identify opportunities for improvement and demonstrate compliance with statutory and NHS England requirements.

During 2025/26, the Trust continued to maintain and develop its business continuity arrangements in line with strategic priorities, such as the onboarding of Children and young person/All age eating disorder Directorate; where sixteen new plans were created to be validated, providing assurance that robust plans are in place to support the continuation and recovery of critical services during incidents affecting staff, premises, technology, suppliers or other essential resources.

Through these arrangements, NHSE assurance and the ARC agreed workplan for internal audit 2026 (Operational Resilience and Business Continuity Audit), the Board can be assured that the Trust is meeting its current statutory duty to maintain business continuity plans and is taking reasonable steps in the development of the EPRR Officer; to ensure the resilience of critical services is supported by a second BCI subject matter expert from the 2026/27 work plan.

6. Warning and informing

In the context of the Civil Contingencies Act (CCA) 2004, the duty to warn and inform requires Category 1 responders (including NHS organisations) to:

- Warn the public when an emergency is likely to occur or has occurred.
- Provide timely information and advice to help people protect themselves, their families, and their communities.
- Make information available in advance about local risks and emergency preparedness arrangements

Via the EPRR single point of contact (SPOC) function and with the Trust Communications team and StaffRoom application, arrangements are in place to make available information on resilience and response to the public and staff. Examples of this in the 2025/2026 work plan have been in relation to summer and winter preparedness, planned and unplanned Information Technology down time potentially requiring IT System Business Continuity Plan activation, unplanned motorway closures, Met office forecasts and Southeast Water outages inclusive of the utility company priority service arrangements for vulnerable persons.

7. Sharing information

The Civil Contingencies Act 2004 (CCA) places a legal duty on category 1 responders to share information with other responders where it is necessary to support emergency preparedness, response, and recovery activities. This duty helps ensure that

organisations have a common understanding of risks and can coordinate effectively during emergencies.

The Trust as part of the Kent and Medway Resilience Forum and Local Health Resilience Partnership has processes in place to share information with other local responder organisations to enhance co-ordination both ahead of and during an incident.

During 2025/2026 this has included Industrial action, Incident responses led by Medway Council and Dartford Borough Council in relation to declared Major Incidents. Additionally our trust and all NHS providers have shared information on incidents and complex capital projects with a potential impact on shared sites; where joint incident planning arrangements may and have been required.

8. Co-operation with other local responders.

The Trust as part of the Kent and Medway Resilience Forum, as a category one responding organisation the Trust has processes in place to co-operate with other local responder organisations to enhance co-ordination both ahead of and during an incident. To support this approach the Joint Emergency Services Interoperability Principles (JESIP) are embedded and form part of the training on the EPRR Policy, Business Continuity and all response plans.

9. Training programme

Training and exercising activity continued throughout 2025/26, supporting the development of incident response, business continuity and command-and-control capabilities across the Trust. Where measured, compliance and attendance data is reported alongside training activities to provide assurance that appropriate resilience competencies are being maintained.

Induction via eLearning	Number in 2025/26 12 months, 286
Loggist training	Number of current staff 39 trained and available
Staff entering onto the Director on call rota, Manager on call rota and Clinical Leads and has promoted refresher training sessions.	Number entering director on call rota in 2025/26 3, total trained and on rota 24 Number entering manager on call rota in 2025/26 51, total trained and on rota 79 Number entering Clinical Leads rota in 2025/26 2, total trained 15 inclusive of CCTV viewings (2 new listed for training in August 2026, total number now 17) Number of Facilities and Estates Senior Managers trained in 2025/26, 7. Number of Switchboard staff trained to answer dedicated incident line 8
Those requiring support with writing and reviewing Service and IT system business continuity plans.	All directorates 35 in 2025/26, total trained and plan authors 86, who return for ad hoc support when required based on quality review prior to publications.
Management of self-referrals with a hazardous material contamination, at reception areas across the Trust via eLearning	Total current staff 138 and 7 Estates Senior Managers

EPRR Officer

- Diploma in Health Emergency Planning (DipHep)

Externally EPRR Team members have provided training

- In conjunction with the ICB on Loggist Training
- In conjunction with the Kent and Medway Resilience Team on Risk Assessment for members of the county Risk Assessment Group.

The training delivered during the reporting period has supported the development of individual and organisational capabilities required to meet the Trust's duties under the Civil Contingencies Act 2004 and NHS England EPRR Framework. The programme has strengthened preparedness, response and business continuity arrangements both within the Trust and across the wider health and resilience partnership.

10. Exercise programme and Incidents

The duty placed on the Trust within the NHSE Core Standards is that it performs a communications cascade bi-annually and a tabletop exercise annually with a live exercise tri-annually. These elements have all been achieved in the 2025/26 work plan.

During 2025/26 the Trust completed all NHS England mandated exercising requirements, including communications exercises and multiple tabletop exercises covering cyber response, major incidents and business continuity. These activities provided assurance regarding organisational readiness and generated improvement actions which have been incorporated into the 2026/27 work plan.

Internally communication and multiple exercises were undertaken, to allow for learning in support of service business continuity plans and incident plans these included:

Communication

Exercise Activate1 Communications Exercise – 24th March 2026

Exercise Activate 2 Communications Exercise - 16th July 2026

Tabletop

- Exercise Arrow 4 (LSU) – 14th October 2025
- Exercise Oakwood (Major Incident joint exercise with Maidstone and Tonbridge Wells NHS Foundation Trust and external pharmacy contractor - 17 October 2025
- Exercise Globe 5 (TGU) – 20th March 2026
- Exercise Marvel 2 (Cyber Exercise) – 23rd April 2026
- Exercise Keystone (Waste management contractor) – 12th June 2026

Live Exercise

- NA – Last 11/07/2025

Externally the trust has attended regional and local exercises and received or attended specialist briefings which have allowed for the review, validation and adaptation of response plans:

- Counter Terrorism Local Profile (CTLP) open session briefing
- Martyn's Law (various)
- Flood warning service.
- Entry and Exit System.
- SS Montgomery
- Unexploded ordinance risk assessment

Within 2025/2026 the trust responded to the following business continuity/ regional incident declarations which have allowed for further validation of current plans and procedures where any recommendations are managed via a corrective action database:

- Portland Building Fire Northfleet (asbestos incident management)
- Canterbury Meningitis Outbreak
- Industrial action (various)
- Water outages (various)
- Sinkhole Canterbury
- Dartford crossing police led incidents
- Critical road infrastructure incidents (various)
- Miller Heights - Maidstone
- Red Heat Health Alert
- Darrent Valley Hospital - Oxygen tank leak

11. Lessons identified/Lessons learnt

Corrective actions from 2025/26, that are being addressed but moving to the current work plan into the 2026/27 work plan:

Theme	What we want to achieve
Relocation of post rooms	The Trust can demonstrate that the location of mailroom services will not adversely affect patient care, information governance, security, statutory compliance or business continuity.
Isolation of hazardous packages	Procedures are in place for the identification, isolation, and management of suspected hazardous packages to protect staff, patients, visitors, and Trust operations.
Review of Hazardous Materials Policy	The Hazardous Materials Policy and associated e-learning package will be reviewed and updated to reinvigorate staff awareness.
Quarterly inspections of HAZMAT grab boxes	Quarterly inspections of Hazardous Materials (HAZMAT) grab boxes are undertaken by staff on site via a new checklist to ensure equipment remains available, serviceable, appropriately stocked, and fit for purpose. Inspection records are maintained, deficiencies are addressed promptly, and consumables are replenished or replaced as required and reported centrally.
Joint control room principles when attending another organisation – added to training	Joint control room principles and interoperability arrangements when attending incidents at another organisation's premises will be incorporated into training programmes to improve multi-agency coordination, situational awareness, communication, and command and control during incident response.
On roll out of Duty Senior Nurses – Hi-vis tabards and duty incident decision logs	To support the rollout of the Duty Senior Nurse role, high-visibility tabards and Duty Incident Decision Logs will be introduced to improve role identification, provide greater visibility during incidents, and support the recording of key decisions, actions, and rationale throughout incident response and escalation processes.

Alternative access to Oakwood site if main entrance blocked	As part of any capital building works alternative access arrangements to the Oakwood site will be reviewed, commissioned and documented, and communicated to ensure continued access for emergency services, staff, patients, and suppliers should the main entrance become blocked or inaccessible
Airlock failure process and security system failures – targeted training	Provide targeted training on managing airlock failures and security system failures, including contingency arrangements, escalation pathways, and maintaining safety and security during outages.

During 2025/26, thirteen lessons were identified through exercises and incidents and recorded on the Trust-wide EPRR Working Group Corrective Action Database. Further lessons were linked directly to the Trust's Cyber Risk on InPhase. Of the EPRR corrective actions, eight items remain in progress on the corrective action database.

The outstanding actions will be monitored through the Trust-wide EPRR working group. To strengthen governance and provide greater assurance, from September 2026, any corrective actions that identify a gap in control or assurance, on a risk, will be reported through the Trust's risk management processes and recorded on the InPhase risk management system where appropriate. This will ensure that lessons identified are fully integrated into corporate risk management arrangements; preventing it being maintained in isolation outside of the Trust's formal risk framework.

12. Methodology on opening of the 2026/2027 EPRR work plan

Priorities moving into the 2026/27 Work Plan:

Statutory duties	Maintain continued compliance with the Civil Contingencies Act 2004 through Board ownership of the Trust EPRR Policy and EPRR Work Plan, ensuring robust governance, oversight, assurance and delivery of statutory emergency preparedness, resilience and response duties
Self – assessment improvement plan	Review and align the Accountable Emergency Officer (AEO) and Deputy Accountable Emergency Officer job descriptions to ensure responsibilities, delegated authority, statutory duties and assurance requirements are clearly defined and consistent with NHS England EPRR expectations.
Evidence captures for 2026/27	Further develop and strengthen the evidence capture process for the 2026/27 self-assessment, ensuring evidence is comprehensive, auditable, and aligned with any revised NHS England (NHSE) requirements, guidance, or assessment criteria.
Revalidation of risks highlighted via National Security Risk Assessment (NSRA) cycles	Monitor and track changes to the National Security Risk Assessment (NSRA) process, ensuring Trust arrangements adapt to the transition from an annual assessment model to a cyclical assessment process, with evidence collection, risk assessments, and mitigation plans reviewed and updated accordingly
Terrorism, Protection of Premises Act 2025 (Martyn's Law)	To ensure the Trust is prepared for implementation of Martyn's Law by 3 April 2027 through a structured programme of site categorisation, governance,

	policy development, training, protective security risk assessment, evidence capture, and assurance reporting
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Statutory duties under the Civil Contingencies Act 2004, NHS England EPRR Core Standards and relevant NHS contractual requirements have been reviewed and reflected within the refreshed Trust EPRR Policy to ensure continued compliance and alignment with national requirements.

The annual NHS England EPRR Core Standards self-assessment has been completed and used to inform the 2026/27 EPRR Improvement Plan. As the Trust has self-assessed as substantially compliant against all applicable standards, improvement actions focus on the uplift of two job descriptions for the accountable emergency officers and enhancement and maturing of existing arrangements rather than corrective actions.

Risk identification, assessment and management is a continuous process and transitions seamlessly between annual work programmes. Key EPRR risks identified for 2026/27 include:

- Increasing complexity of national security threats, including terrorism and the implementation of the Terrorism (Protection of Premises) Act 2025 (Martyn's Law).
- Cyber disruption affecting critical systems, communications and service delivery.
- Severe weather and climate-related events impacting Trust operations and patient care.

The review and development of policies, plans and standard operating procedures for 2026/27 have been aligned to the Trust's policy master index and governance arrangements to ensure documents remain current, compliant and fit for purpose.

The requirement for new plans and procedures has been determined through risk assessment, lessons identified from incidents and exercises, audit findings and assurance activities, providing additional controls where required.

The Business Continuity Management Programme has been prioritised according to organisational risk, critical service dependencies and alignment with the Trust's strategic objectives.

The exercise programme has been developed to ensure compliance with NHS England EPRR Core Standards and to provide assurance that emergency, incident response and business continuity arrangements remain effective.

The 2026/27 EPRR Training Programme and Training Needs Analysis will be aligned to the EPRR National Occupational Standards (2022), ensuring the Trust develops and maintains the knowledge, skills and competencies required to prepare for, respond to, recover from and learn from incidents and emergencies.

Collectively, these activities form the basis of the 2026/27 EPRR Work Plan and support the Trust's ongoing compliance with the Civil Contingencies Act 2004, NHS England EPRR Framework and national resilience expectations

13. Workforce Resource 2025/26

The Trust maintains access to both clinical and non-clinical EPRR subject matter expertise, supported by recognised professional qualifications in emergency planning and business continuity management.

The current resource available to EPRR in 2025/26 was

Role	Role in function
Chief Nurse	Accountable Emergency Officer until July 2026
Deputy Director of Quality and Safety	Deputy Accountable Emergency Officer until July 2026.
Director of Transformation and Partnerships	Accountable Emergency Officer from July 2026
Deputy Director of Transformation and Partnerships	Deputy Accountable Emergency Officer from July 2026
Emergency Preparedness and Resilience Lead	Subject Matter Expert (RGN, DipN, DipHEP, CBCI, BTEC Education and training)
Emergency Preparedness, Resilience and Response Officer	Non-Clinical Subject Matter Expert (DipHEPRR)
Resilience and Risk Administrator	Office functions

The available resource to open the new work plan in 2026/27 is

Role	Role in function
Director of Transformation and Partnerships	Accountable Emergency Officer
Deputy Director of Transformation and Partnerships	Deputy Accountable Emergency Officer
Emergency Preparedness and Resilience Lead	Subject Matter Expert (RGN, DipN, DipHEP, CBCI, BTEC Education and training)
Emergency Preparedness, Resilience and Response Officer	Non-Clinical Subject Matter Expert (DipHEP)
Resilience and Risk Administrator	Office functions

Appendix 1 Statement of compliance

Statement of Compliance

The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident. The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded care, to show that they can deal with such incidents while maintaining services.

NHS England has published NHS core standards for Emergency Preparedness, Resilience and Response arrangements. These are the minimum standards which NHS organisations and providers of NHS funded care must meet. The Accountable Emergency Officer in each organisation is responsible for making sure these standards are met.

As part of the national EPRR assurance process for **2025/26** Kent and Medway Mental Health NHS Trust has been required to assess itself against these core standards. The outcome of this self-assessment shows that against 58 of the core standards which are applicable to the organisation, Kent and Medway Mental Health NHS Trust:

- is compliant with 57 of these core standards;

The overall rating is: Substantial Compliant

Dr Adrian Richardson (AEO)

Kent and Medway Mental Health NHS Trust

09 September 2026

NHS England South East EPRR Assurance compliance ratings

To support a standardised approach to assessing an organisation's **overall preparedness rating** NHS England have set the following criteria:

Compliance Level	Evaluation and Testing Conclusion
Full	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

Appendix 2 Improvement Plan

Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description	The Trust has appointed the Director of Transformation and Partnerships as the Accountable Emergency Officer (AEO), with responsibility for ensuring compliance with the Civil Contingencies Act 2004 and NHS England EPRR Core Standards. The Deputy Director of Transformation and Partnerships acts as Deputy AEO. Following this recent appointment, the job description is currently being revised to formally incorporate AEO responsibilities and is awaiting publication. As the updated job description is not yet available, it cannot be submitted as evidence. The Chief Nurse job description has therefore been provided as interim supporting evidence, as it previously contained the AEO responsibilities. Consequently, this Core Standard has been assessed as Partially Compliant pending publication of the revised job description.	Partially compliant	Job descriptions to be uplifted for Director and Deputy Director of Transformation and Partnerships to include AEO and Deputy AEO role.	Director of Transformation and Partnerships	18-Sep-26	Awaiting REDCOM
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Trust Board meeting

Meeting details

Date of meeting:	Thursday 24 th September 2026
Title of paper:	Winter Plan Board 2026/27 Board Assurance
Author:	Neil Robertson (Interim Deputy Chief Operating Officer)
Executive Director:	Donna Hayward-Sussex (Chief Operating Officer and Deputy CEO)

Purpose of paper

Purpose:	Approval
Submission to Board:	NHSE Board Assurance and sign off.

Overview of paper

Winter Plan 2026/27

Purpose: To ensure the continued delivery of safe, effective mental health services throughout winter, support system resilience across Kent and Medway, and provide assurance to the Board that robust plans are in place to manage anticipated seasonal pressures.

Priorities

- Mental health flow and crisis alternatives (Red): Improve patient flow by reducing discharge delays, minimising avoidable admissions and strengthening community-based crisis pathways.
- Flu vaccination and infection control (Amber): Increase staff vaccination uptake from 46.4% to a minimum of 50% through targeted communications and accessible vaccination opportunities.
- High-intensity service users (Amber): Strengthen proactive support for individuals with high levels of service use to reduce repeat attendances and admissions.
- Adverse weather resilience (Green): Maintain service continuity through robust contingency arrangements for staffing, estates, transport and utilities.

Critical Targets

- Clinically Ready for Discharge (CRFD): no more than 27 patients.
- Out of Area Placements (OAPs): average no more than 5 patients.
- Emergency Department to psychiatric inpatient conversion rate: below 4%.
- Safe staffing and business continuity maintained across all services.

Principal Risks

Key risks include discharge delays, workforce vacancies in East Kent, low bank-fill rates, increased winter sickness absence, limited utilisation of admission avoidance pathways, Emergency Department pressures, lower than expected vaccination uptake, and severe weather events.

Leadership and Governance

Deputy Directors will lead delivery of the Winter Plan within their portfolios. Day-to-day coordination will be overseen by the Deputy Chief Operating Officer, with overall accountability retained by the Chief Operating Officer in their role as the Trust's nominated Winter Director.

Submission and Approval

The Winter Plan was submitted to the Integrated Care Board (ICB) on 7 September 2026 in line with local planning requirements. This differs from NHS England's published submission deadline of 30 September 2026. The ICB has been advised that the Trust Board will formally review and discuss the plan at its meeting on 24 September 2026.

Issues to bring to the Board's attention

The greatest risk to winter resilience remains patient flow. Mitigating this risk will depend on reducing delays in discharge, maintaining sufficient workforce capacity, and ensuring that admission avoidance and crisis alternatives are consistently and effectively utilised.

Governance

Implications/Impact:	The delivery of the Winter Plan is subject to a number of operational risks, including discharge delays, workforce vacancies and low bank fill rates, particularly in East Kent. In addition, increased staff sickness during winter months, underutilisation of admission avoidance pathways, Emergency Department pressure and lower than expected flu vaccination uptake. Failure to mitigate these risks may impact patient flow, service capacity, quality of care and overall system resilience.
Assurance:	Assurance is provided through oversight by the Executive Management Team, regular operational performance reviews, winter resilience reporting, workforce monitoring, system-wide escalation arrangements with Kent and Medway partners, and ongoing scrutiny through the Quality and Performance Committee and Trust Board.
Oversight:	Trust Board, supported by the Quality Committee, with operational oversight through the Executive Management Team.

Winter planning 2026/2027

August 2026 DRAFT 1

Winter Plan 2026/27 — summary

Purpose: Maintain safe mental-health services through winter pressures, support system partners and assure the Board of readiness.

Main priorities

- Mental-health flow and crisis alternatives — Red: Reduce discharge delays, avoid unnecessary admissions and improve crisis pathways.
- Flu vaccination and infection control — Amber: Increase staff vaccination from 46.4% to at least 50% through targeted campaigns and flexible clinics.
- High-intensity users — Amber: Proactively support frequent service users and reduce repeat admissions.
- Adverse-weather resilience — Green: Protect staffing, site access, utilities and continuity of care.

Critical targets

- Clinically ready for discharge: no more than 27 people.
- Out-of-area beds: average no more than 5 people.
- ED-to-mental-health admission conversion: below 4%.
- Maintain minimum staffing and business continuity across all services.

Key risks

- Persistent discharge blockages, East Kent vacancies and poor bank-staff fill rates, winter sickness, underuse of admission alternatives, ED delays, low vaccination uptake and severe weather.

In summary patient flow is the most urgent concern; success depends on reducing discharge delays, strengthening workforce capacity and making better use of community and crisis alternatives.

Regional Winter Planning Event – September 2026

The Trust attended the regional winter planning event to support on going reflections and action for winter planning.

Winter pressures and priorities:

- System-wide concerns remain focused on maintaining workforce resilience through periods of increased sickness absence and achieving timely transfers of care within the 12-hour standard. For mental health services, key priorities include reducing out of area acute admissions to an average of no more than five patients, achieving the 12-hour transfer of care standard, reducing the clinically ready for discharge (CRFD) cohort to 10% (a maximum of 27 patients), and addressing increased length of stay. During the 2025/26 winter period, the Trust operated at OPEL 4 for 68% of the defined winter period, with sustained pressure from prolonged Emergency Department waits contributing to increased reliance on out of area placements across mental health providers.
- The Trust's winter planning approach is dynamic and responsive, with plans subject to ongoing review as operational pressures and system risks emerge. Following the regional winter planning event, further work will focus on testing the resilience of staffing plans against a 20% sickness scenario, strengthening arrangements to manage a potential 40% increase in acute mental health demand presenting through Emergency Departments, embedding the GIRFT mental health Emergency Department standards, and delivering focused discharge improvement initiatives during October and November. Additional priorities include developing alternatives to reactive private sector admissions, evaluating the impact of NHS 111 crisis line diversion activity, exploring the North London known-presenter model within Emergency Departments, and promoting least restrictive approaches to post-discharge care to improve patient flow and reduce unnecessary admissions.

Winter Planning (1)



Kent and Medway
Mental Health
NHS Trust

Purpose

- The purpose of this plan is to ensure that we are proactive and responsive to the needs of the people we service over the winter period due to seasonal demand and potential adverse weather
- Play our part in support our system due the likely extraordinary demands placed on acute and community partners.
- Ensure that our board are assured about our preparation and response to the winter period.

Objectives for 2026/27

- Ensure that we have realistic and measurable plans in place to effectively manage the pathways for people using crisis services.
- Ensure that we increase our uptake of the influenza vaccine, specifically target our clinical workforce.
- Respond to adverse weather through effective mobilisation of resources in line with our winter resilience plan to ensure patient safety and business continuity.
- Provide appropriate support to system partners to mitigate demand in key hotspots of known service users.

Headlines on last years position

- The start of winter pressures **fluctuates from year to year** and is usually quantified by an increase in acute demand in the Autumn period.
- For the trust we do see variation when demand for our crisis and acute system occurs in winter. The data for 2025/2026 shows that **December 2025 to March 2026 saw a significant increase in demand across our acute and crisis system**. Out of area bed use also **significantly increased** in March 2026; however, this can be accounted by other variables, especially for the number of people clinically ready for discharge, which is a chronic issue. Analysis shows the KMMH bed system works effective with c. 27 (10%) people clinical ready for discharge. The average number of beds subject to clinically ready for discharge is c. 23%. However, since greater system support from the beginning of the financial year, there has been a small improvement in July 2026.
- The Trust were in OPEL 4 for 68% of the defined winter period.
- From a sickness and absence perspective, we **did not see any material episodes** in 2025/26.
- For **uptake of flu vaccination, 2025/26 saw only a 46.4% uptake by our staff**, though the national uptake was 45%.
- The UK experienced a mild winter in 2025/26 with **no material adverse weather issues impacting on our business continuity**.
- A key difference now for this winter is the KMMH vacancy rate across St Martins Hospital and liaison and home treatment in East Kent
- Since last year KMMH have now implemented a digital bed management tool to support monitoring and responsiveness of flow.
- Link: [Bed Management - Power BI](#)

Winter Planning (2)

Key Policies and resources

KMMH Winter Resilience Plan – update for 2025/26

- Trust Pandemic Plan
- Trust Infection Control Policy
- Kent Local Resilience Forum
- Kent and Medway corridor care huddles and system MDTs for Acute and mental health CRFD.
- GOV.UK resource website for winter pressures
- Cabinet Office Resilience Direct
- NHSE 10 High Impact Interventions
- NHS Tean Year Plan

Risk

The top six risks for KMMH this winter are:

- There is a risk of continued that we could have less bed capacity due to the chronic numbers of people clinically ready for discharge. **Currently mitigated by a dedicated trust wide leadership post and system discharge review.**
- Not optimising alternatives to acute care and failing to reduce clinical ready for discharge leading to high levels of 12-hour Emergency Department breaches and high use of out of area beds. **Currently mitigated by system corridor care process and plans. And our internal programmes for admissions and discharge.**
- Adverse weather impacting on business continuity in delivering core inpatient, community and crisis services. **Mitigated by our annual adverse weather plan.**
- Failing to achieve 50% uptake of influenza across our clinical workforce, which could impact on patient safety, clinical effectiveness and business continuity. **Mitigated by a clear agile vaccination uptake plan.**
- Seasonal illness impacting on our workforce sickness and absence. **Mitigated by wellbeing support, effective use of annual leave and the flu vaccination plan.**
- Vacancy factors across East Kent acute and crisis services, coupled with poor NHSP fill rate impacting on service responsiveness **Mitigated by roster management and intensive work with NHSP about fill rate..**

Assurance

This organisational plan for responding to winter will be subject to the completion of a Board Assurance Statement, which provide a checklist for readiness. This includes a QEIA. It is due to be signed off TBC

INDIVIDUAL PLAN 2026/2027

Winter Planning: Strengthening pandemic, seasonal flu and vaccination plan

Overall Status

Amber
**Kent and Medway
Mental Health**

Action	Key Activities			
• Increase the uptake of staff seasonal flu vaccination to 50% in 26/27. • Ensuring that all areas adhere to the Trust Infection Prevention and Control guidance.	• Mobilisation plan being overseen by a task and finish group in readiness for vaccine issue. This will be supported by vaccination campaign that includes myth busting. • Fixed, pop ups, and mobile vaccination clinics will be established, as well as attending clinical teams, such as, community and inpatient service. • Last year KMMH vaccinated 46.4% of the workforce, we are committed to achieving 45% as per national expectations and are currently finalising the trajectory for vaccine uptake. • From a mental health perspective, we will manage flu outbreak in inpatient services in line with our IPC policy and will cohort according to the numbers of people effected. • Physical health screening forms for hospital admission will be used to assess risks in relation to virus and infection to support admission management inline with our IPC policies. • The Trust pandemic plan is updated https://app.joinblink.com/#/hub/01910972-7078-7950-8766-0af1abb51464 • IPC Staff Room Link https://app.joinblink.com/#/hub/018fc4e0-023d-79cf-b547-52c6fcdc8b56 • Trust IPC Policies Link https://app.joinblink.com/#/hub/018fda1d-7dfe-71bd-869b-de365246ac3c			
Keys Issues / Risks		Impact	Likelihood	Status
Inadequate uptake of flu vaccination by our workforce could impact on high sick rates impacting on business continuity, inpatient flow and increases the risk of our inpatient being exposed to influenza.		5	2	10
Failing to adhere to Infection Prevention and Control guidance increases the risk of both service users contracting seasonal flu and other viruses, impacting on sickness and increased risk of serious illness to vulnerable patients.		5	1	5
Mitigations		Metrics		
• Targeted communication and engagement with the workforce, which includes myth busting and effectively reaching our ethnically diverse workforce. • We are working with pharmacy and procurement to ensure we have suitable storage for vaccines stored off our hospital sites. • Adhering to infection control policy. • Ensuring agility within our bed base to managed flow challenges because of influenza outbreak.		• By March 2027 the Trust will demonstrate: • ≥50% staff flu vaccination uptake. • Reduced variation between clinical areas. • Effective deployment of peer vaccinators. • Positive staff feedback regarding access.		

Winter Planning: Mental health flow and crisis alternatives (1)

Overall Status

Red


**Kent and Medway
Mental Health**
NHS Trust

Action	Key Activities
Rapid assessment through crisis pathways will continue to be provided by rapid response and with in 4 or 24 hours dependent on need.	• Critical to the plan is admission avoidance and using alternative to admission. The following service responses are to work in an integrated way to ensure people are provided with least restrictive care. This will ensure that acute admission flow is prioritised for the greatest need, reducing 12-hour breaches where we can. • Persistent high number of clinically ready for discharge since August/Sept 2025, means that we are at risk of going into the winter with on average 23% of bed blocked due to clinically ready for discharge. Critical to further reduction is the weekly system delayed discharge huddle supported by the system improvement director. • Improved system of monitoring and responding to mental health admission conversion rates in Emergency Departments. East Kent and Maidstone hospitals have a higher conversion rate, which is subject to an improvement plan. • Rapid Response Teams in each locality will respond with in 4hr, 24hr and 72hr based on needs and risk. The service is 24 hours. We continued to sustain over 80% compliance with target last year. • Established across Kent and Medway is daily corridor care huddles that bring all system partners together so monitor and respond to flow. In addition, KMMH participate in weekly systems MDTs to support Acute no criteria to reside cases. • In the event of an Emergency Department critical surge, the departments front door will be strengthened with additional staffing for triage. • Both Rapid Response and Liaison Teams work directly with KMMH Home Treatment Team to provide alternatives to admission. • The system have access to recovery house and safe havens to support alternatives to admission or ED presentations, the diversion to these facilities is reported and monitored by the system weekly. • The system have access to recovery house and safe havens to support alternatives to admission or ED presentations. We will work with providers and commissioners to continue to optimise this resource and be agile where we can, to support system pressures. • The Trust will adhere to the NHSE OPEL action card for 2024-2026 (see attached document). • From November 2025 – March 2026, KMMH averaged 5 people admitted to an out of area providers. There were peaks above the average in March and August 2026. • Currently scoping temporarily standing up a mixed gender younger adult acute ward to support timely admission at times when there are increases in specific genders. • Since 2025/26 KMMH have now implemented a digital bed management tool to support monitoring and management of patient flow. This also support OPEL management. Link: Bed Management - Power BI • GIRFT ED and Mental Health Standards New standards to improve urgent and emergency care for mental health patients in crisis - Getting It Right First Time - GIRFT

Winter Planning: Mental health flow and crisis alternatives (2)

Overall Status

Red

**Kent and Medway
Mental Health**

Keys Issues / Risks	Impact	Likelihood	Status
Sickness due to winter illness and acute and crisis service vacancy rate could impact on team responsiveness during the winter period	5	3	15
Not using alternatives to admission effectively due to risk aversion.	4	3	12
Increase in the use of out of area acute beds because of lack of system cohesion, which increases the risk of poor care and is not affordable.	4	4	16
Usage of corridor care in Acute ED's impact on the safety and experience of service users waiting for assessment and/or admission to a mental health bed.	4	3	12
Due to the number of people clinically ready for discharge remaining static at 23% occupied beds, this could impact on our winter bed capacity if we do not act now.	4	3	12
Delays in admission to a mental health bed, regardless of where the person is waiting from delays treatment which impact on experience and safety.	4	4	16

Mitigations	Metrics
- Sickness monitoring, deploying staff resource to challenged area and uptake of the flu vaccination. - East Kent recruitment plan and manage responsiveness of NHSP in relation to shift fill rate - Utilise the KMMH bed management tool to ensure data driven responses. - Continue to engage and communicate the workforce to "think alternatives" and provide check and challenge through our flow team. - Continue with progress made in reducing acute out of area and ensure existing structures are strengthened. - Leadership conversation taking place with KCC to explore devolvment. - Continue to reduce clinically ready for discharge to a target of 35 people . - Increase Emergency Department triage resourcing at the front if there is a surge in mental presentations. - Following scoping exercise, decision to be made about standing up a mixed sex	- Maintaining minimum staffing levels in ALL services. - Business continuity is maintained across the winter for all services. - An increase in the use of crisis alternative based on previous winters demand. - Crisis plans for people known are updated leading up to the winter period. - Responding with alternatives to emergency care in October 2025 and March 2026. - Out of Area bed usage to average no more than 5 people. - Ensure Emergency Department conversion rate to mental health admission does not exceed 4%. - Clinically ready for discharge numbers to be no more than 27 (10%) people across younger and older adult wards. - Emergency Department ED presentation surge of more than 40% - Reduction of time subject to in OPEL 4 to be reduced from 68 to 40%

Winter Planning: Supporting vulnerable high intensity users (HIU).

Overall Status

Amber
**Kent and Medway
Mental Health**

Action	Key Activities
Proactively identify high intensity users to reduce readmissions	- The HIU project is underway and the first data set shows reductions in contacts across KMMH and some patients improving to an extent to facilitate a discharge from the service (5 out of 28 HIU patients in the first quarter January-April 2025). - The system wide part of this project has great representation from our partnering agencies and is supporting better working relations across Kent and Medway. - As part of the Kent and Medway corridor care plans, a working group is exploring approaches to the prevalence of people presenting in ED's with self harm. (Ongoing BAU work). - This work has also identified another group of patient readmissions who don't meet the HIU definition criteria of 5 + contacts in 90 days but instead have 3 or 4 contacts. Work is then happening at pace to address this cohort who are hard to engage relationally but do need some intensive psychotherapeutic support. - We are exploring options currently within our existing psychotherapeutic offer, as part of the CMHF revisions to look at alternative interventions for this cohort. Learning from other areas assist and embrace clinical model is being implemented as a flexible and responsive therapeutic approach. - The lead psychologist for acute inpatient services is working on adopting the Cheshire model to support the prevention of long admissions for people with Complex Emotional Difficulties.

Keys Issues / Risks	Impact	Likelihood	Status
Demand and capacity issues for staff (time and resources), which is currently be reviewed and will be updated at a later date.	4	3	12
Over use of beds by people deemed a high intensity user impacting in the use of out of area beds	5	2	10
Mitigations	Metrics		
- Undertake a piece of work to engage and communicate the workforce to "think alternatives" and provide check and challenge through our flow team. - Continue with progress made in reducing acute out of area and ensure existing structures are strengthened. - Implementing assist and embrace clinical model.	- Reduction in the number of people in identified needing a regular requirement for admission over a year. - Out of area beds use to not exceed 8 people at anyone time.		

Winter Planning: Emergency planning, resilience and response to adverse weather

Overall Status

Green
**Kent and Medway
Mental Health**

Action	Key Activities
Effective interventions for the management of adverse weather to support business continuity.	Clinical services and relevant corporate services to implement the winter resilience plan and cold weather action card

Keys Issues / Risks	Impact	Likelihood	Status
Extreme cold weather can cause: transport disruption; increased cases of slips/trips; cardiovascular or respiratory illnesses and hypothermia; increased hospital admissions, especially among vulnerable individuals; and power and telecom outages.	5	2	10
Mitigations	Metrics		
The Truest Action Card for responding to adverse weather. Adverse Weather and Health Plan - GOV.UK https://www.gov.uk/government/publications/cold-weather-plan-action-cards-for-cold-weather-alert-service Adverse Weather Health Plan	- Maintaining minimum staffing levels in ALL services - All sites are accessible for staff, service users and the public. - All site that are operating have sufficient heat, electricity and a water supply. - Effective use of command structure as required. - All patients deemed physically vulnerable have a support plan. - All teams have access to a reviewed business continuity plan meaning no service fully closes		

Winter Planning 26/27

Board Assurance Statement (BAS)



1. Purpose

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

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

Section A: Board Assurance Statement

Please include the Trust / Provider name at the top of the tab.

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

Section B: 26/27 Winter Plan checklist

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

3. Submission process and contacts

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



Winter Planning 26/27

Section A: Board Assurance Statement (BAS)

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

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

Provider/Trust Name (drop down): OTHER - Please write below

If Other, write Provider/Trust Name:

Contact details (email, phone number): Neil Robertson 07920056151

Date: 01/07/2026

			Please complete these sections		
Assurance statement			Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Governance and executive leadership					
1	1.1	The Board has assured the Trust Winter Plan for 2026/27.	Yes		
	1.2	The Board is assured that a robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes		
	1.3	The Board is assured that the Trust's plan was developed with appropriate input from and engagement with all system partners, including primary care and social care.	Yes		
	1.4	The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.		This is not until the 14th September	
	1.5	The Board has identified a named Executive Winter Sponsor with accountability for winter preparedness (including vaccinations), escalation and operational delivery.	Yes	Donna Hatward-Sussex Deputy Chief Executive and Chief Operating Officer	
	1.6	The Board is assured that clear governance arrangements, escalation processes and operational leadership arrangements are in place throughout the winter period.	Yes		

Winter Planning 26/27**Section B: 26/27 Winter Plan checklist**

This section provides a checklist on what Boards should assure themselves is covered by 26/27 Winter plans.

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

Section B: 26/27 Winter Plan checklist			Please complete these sections		
			Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Prevention					
1	1.1	The Board is assured there are plans in place to deliver a frontline healthcare worker (FHCW) flu vaccination programme that achieves the trust level uptake ambitions and demonstrates: •the offer is accessible to all frontline staff between 1 October – 31 March with the majority of vaccinations completed by 30 November; •that both walk-in and bookable appointments are available; •that all FHCW vaccination activity will be recorded on Record a Vaccination Service (RAVS); and •the FHCW flag has been applied to the ESR records of all clinical and non-clinical staff who are in direct contact with patients to ensure accurate reporting on FDP.	Yes	A flu vaccination plan in situ and examined by the system. Plan provides an agile approach to support vaccination uptake.	
	1.2	The Board is assured that frontline staff vaccination, respiratory virus prevention, and staff health measures are supported by targeted operational plans.	Yes		
	1.3	The Board is assured that plans are in place to offer vaccinations (flu and COVID-19) to long stay inpatients (21 days and above) and inpatients who are being discharged into a care home.	Yes		
	1.4	The Board is assured that population health intelligence and risk stratification information are used in partnership with system colleagues to identify and support vulnerable patients and high-risk cohorts ahead of and during periods of winter pressure.	Yes		
Occupancy and discharge					
2	2.1	The Board is assured that a review of discharges across each pathway required to manage bed demand and occupancy has taken place ahead of winter with system partners. These have been developed jointly with local authority, Community Health Service Providers and system partners, including holiday-period arrangements.	Yes		
	2.2	The Board is assured that model discharge pathway requirements are in place to optimise discharge seven days a week across acute, community and social care services. This should include: •coordinated escalation, surge and extreme surge response arrangements, including bed escalation capacity, which have been tested and capable of safe activation to maintain patient flow, create additional capacity and support operational resilience during periods of increased demand. •executive-led governance arrangements to provide oversight of occupancy, the number of discharges required and delivered each day to support safe bed availability and flow, along with the number of patients who are NCTR by pathways 1 to 3 with monitoring of patients with long discharge delays. •targeted operational actions to reduce long discharge delays. •Discharge to Assess pathways that operate effectively with home first as the default and assessment taking place outside hospital wherever possible. These should be supported by integrated escalation arrangements with community and social care partners to maintain patient flow.	Yes	Please note on the context of mental health processes and system working in place to support flow and discharge. Integral to approach is the Kent and	
	2.3	The Board is assured that pre-Christmas and holiday-period occupancy reduction plans will be implemented.			
	2.4	The Board is assured that Same Day Emergency Care (SDEC) and ambulatory emergency care pathways have been optimised to support admission avoidance.	No	Mental health trust not applicable	
	2.5	The Board is assured that frailty pathways have been reviewed and are operating effectively to support avoidance of unnecessary admission.	Yes	Mental health trust we support the frailty pathway as required.	
Capacity					

Winter Planning 26/27**Section B: 26/27 Winter Plan checklist**

This section provides a checklist on what Boards should assure themselves is covered by 26/27 Winter plans.

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

Section B: 26/27 Winter Plan checklist			Please complete these sections		
			Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
3	3.1	The Board is assured that workforce resilience assumptions are evidenced and include safe staffing levels, appropriate skill mix, redeployment models and staff wellbeing support, with clear mitigations in place for sustained periods of increased demand.	Yes		
	3.2	The Board is assured that rotas have been reviewed to ensure consistent senior clinical decision-making capacity at times of peak pressure, including weekends, supported by clear escalation and supervision arrangements.	Yes		
	3.3	The Board is assured that elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	No	Mental health trust not applicable	
	3.4	The Board has reviewed its 4-hour and 12-hour, and RTT trajectories, and is assured that the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off for 2026/27.	Yes		
	3.5	The Board is assured that there are effective operational actions in place to ensure urgent community capacity is prioritised for the sickest patients.	Yes		
Flow					
4	4.1	The Board is assured that emergency department crowding mitigations have been reviewed and implemented to actively eliminate corridor care as a patient safety priority. This should include implementation of relevant GIRFT recommendations, and with defined safety thresholds, clear escalation triggers, and routine Board level oversight of associated risks, including dignity, privacy and clinical harm.	Yes	We work in partnership with acutes and community as a mental health trust through daily corridor care huddles.	
	4.2	The Board is assured that ambulance handover plans are deliverable and supported by appropriate operational arrangements and escalation processes.	No	Mental health trust not applicable, though we are work with the ambulance provider to ensure diversion of mental health patients where appropriate.	
	4.3	The Board is assured that escalation arrangements with system partners support timely transfer of care and patient flow.	Yes	Enhanced by daily corridor care huddles with all Kent and Medway Acutes	
	4.4	The Board is assured that plans are in place to implement the Model ED and Model Discharge requirements ahead of winter.	No	Mental health trust not applicable	
Infection Prevention and Control (IPC)					
5	5.1	The Board is assured that plans, infrastructure, estates arrangements, IPC governance and operational capability are in place to enable the safe rapid reconfiguration of physical space, creation of additional clinical capacity and implementation of patient cohorting arrangements during periods of increased demand or infectious disease transmission, supported by appropriate environmental risk assessments and compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections.	Yes		
	5.2	The Board is assured that IPC colleagues, including the Director of Infection Prevention and Control or nominated IPC Lead, have been engaged in the development of the winter plan, and are confident in the planned mitigations and actions.	Yes	This is the Chief Nurse at Kent and Medway	
	5.3	The Board is assured that fit testing arrangements are in place for relevant staff, are appropriately recorded and monitored, and can be rapidly expanded during periods of increased respiratory disease and gastrointestinal viral transmission. Appropriate PPE supply, stock management and escalation arrangements are in place to support periods of increased demand.	Yes		

Winter Planning 26/27
Section B: 26/27 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 26/27 Winter plans.

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

Section B: 26/27 Winter Plan checklist			Please complete these sections		
			Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
	5.4	The Board is assured, as encompassed by criterion 5 of the Health and Social Care Act 2008: code of practice on the prevention and control of infections, that a patient cohorting plan, including risk-based escalation, is in place that is understood by all staff and is ready to be activated by site management teams.	Yes		
Leadership and operational grip					
6	6.1	The Board is assured that on-call arrangements are in place and have been tested, and those on-call have access to medical and nursing leaders for urgent advice, and effective operational oversight to ensure urgent community capacity is prioritised for the sickest patients, where needed.	Yes		
	6.2	The Board is assured that plans are in place to monitor and report real-time pressures utilising the OPEL framework, with clear triggers for escalation and timely operational response.	Yes		
	6.3	The Board is assured that mutual aid arrangements have been reviewed and are capable of activation, if required.	Yes		
	6.4	The Board is assured that business continuity plans have been reviewed and tested where appropriate.	Yes		
	6.5	The Board is assured that severe weather and infrastructure disruption contingencies have been reviewed.	Yes		
	6.6	The Board is assured that industrial action contingencies have been reviewed where relevant.	Yes		
	6.7	The Board is assured that plans are in place to support staff welfare through periods of high demand.	Yes		
Specific actions for Mental Health Trusts					
7	7.1	The Board is assured that a plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via NHS 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	Yes		
	7.2	The Board is assured that any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	Yes		
	7.3	The Board is assured that liaison psychiatry pathways and Section 136 arrangements remain resilient during periods of peak demand.	Yes		

Executive Approval

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

Trust / Provider Name: Kent and Medway Mental Health NHS Trust

Provider CEO name: Sheila Stenson

Date reviewed: 02/09/2026

Provider Chair name: Colin Lynch

Date reviewed: 02/09/2026

Please update following completion of the BAS template

Please provide name and contact details of designated Senior Responsible Officer (Executive Level)

Donna Hayward-Sussex Chief Operating officer and Deputy Chief Executive

Please provide confirmation that the SRO has reviewed and approved the responses within this document, confirming they are correct and complete.

Yes

Please confirm date reviewed

02/09/2026

BAS Self-Assessment Dashboard		
Trust		
Overall Assessment Rating: 5 - Full assurance		
Section B	Prevention	5 - Full assurance
	Flow, occupancy and discharge	Awaiting assessment
	Capacity and community	4 - Substantial assurance
	UEC Flow	3 - Moderate assurance
	Infection Prevention and Control (IPC)	5 - Full assurance
	Leadership and operational grip	5 - Full assurance
	Specific actions for Mental Health Trusts	5 - Full assurance

Trust Board meeting

Meeting details

Date of meeting:	24 th September 2026
Title of paper:	Register of Board Members' Interests – September 2026
Author:	Lucia Barnes, Deputy Trust Secretary (Interim)
Executive Director:	Tony Saroy, Trust Secretary

Purpose of paper

Purpose:	Noting
Submission to Board:	Regulatory Requirement

Overview of paper

This paper presents the updated Register of Board Members' Interests for noting. The register will be published on the Trust website following the meeting.

Issues to bring to the Board's attention

The NHS Code of Accountability and NHS England guidance on managing conflicts of interest in the NHS require Board Directors to declare interests that are relevant and material to the Board. This includes any interest that could conflict with the impartial discharge of their duties or create a conflict between private interests and NHS responsibilities.

The Trust formally updates the Register of Interests twice each year. Board members must, however, declare interests as they arise, and an opportunity is provided at the start of each meeting to declare any new interests or interests relevant to the decisions or discussions at that meeting.

The updated register is attached. All Board members listed have made a declaration to the Trust Secretary, including where there is no interest to declare.

The Board is asked to note the updated Register of Board Members' Interests and that it will be published on the Trust website following the meeting.

Governance

Implications/Impact:	Compliance with regulatory requirements
Assurance:	Reasonable

Oversight:	Audit and Risk Committee/Remuneration and Terms of Service Committee
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Register of Board Members' Interests – September 2026

The NHS Code of Accountability and NHS England's guidance on managing conflicts of interest in the NHS requires Board Directors to declare any interests which are relevant and material to the Board. This includes any interest that could conflict with the impartial discharge of their duties and which could cause conflict between their private interests and their NHS duties.

Interests fall into the following categories:

- **Financial Interests** Where an individual may get direct financial benefit (or avoidance of a loss) from the consequences of a decision they are involved in making.
- **Non-Financial Professional Interests** Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.
- **Non-Financial Personal Interests** Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.
- **Indirect Interests** Where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

The Register of Interests is held by the Trust Secretary, in the Chief Executive's Office and Board Directors are asked twice a year to declare their interests

REGISTER OF BOARD MEMBERS INTERESTS AUGUST 2026

Director	Position	Interest declared
Colin Lynch	Trust Chair	Chair for Locala Community Partnership CIC.
Kim Lowe	Non-Executive Director	Non-Executive Director and Deputy Chair at Kent Community Health Foundation Trust. Independent Governor for London and South East University Group (LASE)
Stephen Waring	Non-Executive Director (Senior Independent Director)	Non-Executive Director at Kent Community Health Foundation Trust.

Director	Position	Interest declared
Kevin Corrigan	Non-Executive Director	Trustee of MIND (national charity) and non-executive director of MINDS Matter Ltd - neither entity commissions services from the NHS) Vice President of the University of Reading Trustee of Suicide & Co – (no relationship with NHS) Trustee of COIF/CCLA investment funds
Julius Christmas	Non-Executive Director (Deputy Chair)	Non-Executive Director at Dartford and Gravesham NHS Trust Technology Advisor, Lantern UK
Margaret Dalziel	Non-Executive Director	Trustee of Seaford Learning Trust (Education)
Pam Creaven	Non-Executive Director	Owner and Director of Creaven Consulting Ltd
Susan Baker	Non-Executive Director	Trustee of OASIS (Domestic Abuse) charity
Dr Julie Hammond	Associate Non-Executive Director	Health Governor for Kent Community Health NHS Foundation Trust GP for Dartford East Health Centre NED at Elles Bliss CEO and Founder of mamAR, Dr Hammond Aesthetics Ltd, DH-GP Locum Ltd Private GP at LycaHealth Orpington Hospital NHS Clinical Entrepreneur Health Columnist at The Voice Newspaper Steering Group Member for the London Inspire Programme
Sheila Stenson	Chief Executive Officer	Chair of the South East Finance Academy Partner Non-Executive Director to the Kent and Medway Integrated Care Board and one of their Board Sub-Committees
Donna Hayward-Sussex	Chief Operating Officer & Deputy CEO	None declared

Director	Position	Interest declared
Dr Afifa Qazi	Chief Medical Officer	None declared
Julie Kirby	Interim Chief Nursing Officer	None declared
Nick Brown	Chief Finance and Resources Officer	Spouse is an employee of Kent Community Health Foundation Trust.
Ali Layne-Smith	Chief People Officer	Non-Executive Director and Chair of the Remuneration Committee for Cambridge University Hospitals (Addenbrookes) NHS Foundation Trust Member of UK Advisory Board – Common Purpose UK Trustee and Deacon – High Street Baptist Church Freeman of the Company of HR Professionals
Dr Adrian Richardson	Director of Partnerships and Transformation	Spouse is an employee of Frimley ICS

Trust Board meeting

Meeting details

Date of meeting:	24 th September 2026
Title of paper:	Standing Orders Amendment (Partnership Committee)
Author:	Tony Saroy, Trust Secretary
Executive Director:	Sheila Stenson, Chief Executive

Purpose of paper

Purpose:	Approval
Submission to Board:	Statutory

Overview of paper

A paper setting out the proposed change to the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation to create the Partnership Committee.

Issues to bring to the Board's attention

The paper sets out the changes to the Trust's Standing Orders, which operationalises the Board's approval in July 2026 for the creation of a sub-board committee responsible for matters pertaining to partnerships, including commissioning.

Approval will come into effect once the Board has approved the Partnership Committee's Terms of Reference, which is currently being reviewed by the proposed chair of that sub-board committee.

Governance

Implications/Impact:	Well-Led: Governance
Assurance:	Significant
Oversight:	Oversight by Audit and Risk Committee

Key Changes Requested for Approval

Changes are highlighted in **bold** in the table below.

SO/SFI number	Current wording	New wording	Reason
8.12.9	N/A	Primary Role: To provide the Board with assurance regarding the effectiveness of the Trust's commissioning responsibilities, strategic partnerships and collaborative arrangements, ensuring that these support delivery of the Trust's strategic objectives and create value for patients, communities and the organisation. The Committee will assure the Board that appropriate governance structures, systems and processes are in place and operating effectively to oversee partnership, commissioning and collaborative activities, including the identification and management of associated benefits, risks, dependencies and performance outcomes. The Committee will provide assurance that partnership and commissioning arrangements remain aligned to the Trust's strategy, statutory responsibilities and agreed priorities, and that opportunities for collaboration, integration and service improvement are being appropriately evaluated and progressed. It will assure the Board that material risks, delivery challenges, governance concerns or emerging issues that may affect the achievement of strategic objectives, commissioning responsibilities or partnership commitments are identified, escalated and managed in a timely and controlled manner, with appropriate action taken or referred to the Board where required.	To formally create the sub-board committee within the Trust's governance structure