AGENDA

Kent and Medway Mental Health NHS Trust

Title of Meeting Trust Board Meeting (Public)
Date 27th November 2025
Time 09.30 to 12.00
Venue MS Teams

Agenda Item	DL	Description	FOR	Format	Lead	Time
TB/25-26/91	1.	Welcome, Introductions & Apologies		Verbal	Chair	09.30
TB/25-26/92	2.	Declaration of Interests		Verbal	Chair	
BOARD REFLECTION ITEMS						
TB/25-26/93	3.	Personal Experience – Patient Safety Partner	FN	Verbal	AC/SM	09.35
TB/25-26/94	4.	Continuous Improvement Story - Improving the provision of Physical Health Assessments within the Community Mental Health setting	FN	Paper	AR	09.45
STANDING ITEMS						
TB/25-26/95	5.	Minutes of the previous meeting	FA	Paper	Chair	09.55
TB/25-26/96	6.	Action Log & Matters Arising	FA	Paper	Chair	
TB/25-26/97	7.	Chair's Report	FN	Paper	JC	10.00
TB/25-26/98	8.	Chief Executive's Report	FN	Paper	SS	10.05
TB/25-26/99	9.	Board Assurance Framework	FA	Paper	AC	10.10
STRATEGY, DEVELOPMENT AND PARTNERSHIP						
TB/25-26/100	10.	MHLDA Provider Collaborative Progress Report	FN	Paper	SS	10.20
TB/25-26/101	11.	Trust Partnership Working	FD	Paper	AR	10.30
OPERATIONAL ASSURANCE						
TB/25-26/102	12.	Integrated Quality and Performance Review	FD	Paper	SS	10.45
TB/25-26/103	13.	Finance Report	FD	Paper	NB	11.00
TB/25-26/104	14.	Workforce Deep Dive – Sustainability Pillar	FD	Paper	NB	11.10
TB/25-26/105	15.	Doing Well Together Improvement Programme	FD	Paper	AR	11.25
TB/25-26/106	16.	Safer Staffing – Mid-Year Establishment Review	FD	Paper	AC	11.35
TB/25-26/107	17.	Resident doctor 10-point plan	FD	Verbal	AQ	11.45
CONSENT ITEMS						
TB/25-26/108	18.	Report from Quality Committee • Mortality Report – Executive Summary	FN	Paper	SW	
TB/25-26/109	19.	Report from People Committee	FN	Paper	KL	
TB/25-26/110	20.	Report from Mental Health Act Committee	FN	Paper	SBK	
TB/25-26/111	21.	Report from Finance, Business and Investment Committee	FN	Paper	MW	
TB/25-26/112	22.	Report from Charitable Funds Committee	FN	Paper	SBK	
TB/25-26/113	23.	Use of Trust Seal	FN	Paper	TS	
CLOSING ITEMS						
TB/25-26/114	24.	Any Other Business			Chair	11.55
TB/25-26/115	25.	Questions from the Public			Chair	

	Date of Next Meeting: Thursday, 29th January 2026

Members:		
Dr Jackie Craissati	JC	Trust Chair
Peter Conway	PC	Non-Executive Director (Deputy Chair)
Stephen Waring	SW	Non-Executive Director (Senior Independent Director)
Mickola Wilson	MW	Non-Executive Director
Kim Lowe	KL	Non-Executive Director
Julius Christmas	JCh	Non-Executive Director
Sean Bone-Knell	SBK	Non-Executive Director
Dr MaryAnn Ferreux	MAF	Non-Executive Director
Julie Hammond	JH	Associate Non-Executive Director
Pam Craven	PCr	Associate 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
Andy Cruickshank	AC	Chief Nurse
Nick Brown	NB	Chief Finance and Resources Officer
Sandra Goatley	SG	Chief People Officer
Dr Adrian Richardson	AR	Director of Partnerships and Transformation
In attendance:		
Kindra Hyttner	KH	Director of Communications and Engagement
Tony Saroy	TS	Trust Secretary
Hannah Stewart	HS	Deputy Trust Secretary
Steve Marshall	SM	Personal Story
Gillian Leighton	GL	Continuous Improvement Story
Apologies:		

Key: DL: Diligent Reference FA- For Approval, FD - For Discussion, FN – For Noting

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details	
Date of meeting:	27th November 2025
Title of paper:	Improvement Story: Improving the provision of Physical Health Assessments within the Community Mental health setting
Author:	Gillian Leighton, Community Matron – East Kent Ben Francis, Head of Improvement
Executive Director:	Adrian Richardson, Director of Transformation & Partnerships

Purpose of paper

Purpose:	Noting
Submission to Board:	Board requested

Overview of paper

The presentation set out in this paper, shows how improvement methodology has been used to improve physical health assessments in Ashford & Canterbury MHT+

Issues to bring to the Board's attention

Using the described improvement approach has seen a c15% increase in the number of patients with serious mental illness receiving a physical health assessment from 57.3% to over 70%. Against a projected target of 85% by March 2026.

Governance

Implications/Impact:	N/A
Assurance:	N/A
Oversight:	N/A

Version control 02 - **Public**

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Mental Health
NHS Trust

Improvement Story:

Improving the provision of Physical Health Assessments within the Community Mental Health setting

Gillian Leighton

Caring | Inclusive | Curious | Confident

1 Problem:

People living with Serious Mental Illness (SMI) face one of the greatest health equality gaps in England. Their life expectancy is 15-20 years shorter than that for the general population, and this disparity is largely due to preventable physical illness. As of December 2024, 57.3% of Ashford and Canterbury MHT+ patients with a SMI have had a completed physical health check. Our target is 85%. If we do not provide the physical health assessments to the patients with SMI we will not be able to provide the necessary interventions. This would contravene the organisations policy, recommendations from NHS England, Public Health England, NICE guidance (CG185, CG178 and NG181) and the Community Mental Health Transformation.

2 Approach:

Problem Statement

People living with SMI face one of the greatest health equality gaps in England. Their life expectancy is 15–20 years shorter than that for the general population, and this disparity is largely due to preventable physical illnesses.

As of December 2024, 57.3% of Ashford and Canterbury MHT+ patients with an serious mental illness have had a completed physical health check. Our target is 85%.

If we do not provide the physical health assessments to the patients with SMI we will not be able to provide the necessary interventions. This would contravene the organisations policy, recommendations from NHS England, Public Health England, NICE guidance (CG185, CG178 and NG181) and the Community Mental Health Transformation.

Goal & Targets

Goal

Ensure all community SMI patients open to KMPT have received the annual cardio metabolic physical health assessment.

Targets

- 60% of all community SMI patients who are open to KMPT, will have the cardio metabolic physical health assessment completed by September 2025.
- 70% of all community SMI patients who are open to KMPT, will have the cardio metabolic physical health assessment completed by October 2025.
- 85% of all community SMI patients who are open to KMPT, will have physical health checks completed by March 2026.

Progress

- Clinical lead Nurse in post
- Clinic Meeting taken place – Led be clinical Lead Nurse
- Increase team – Nursing associates to support provision of physical health clinics
- Regular Monday clinics to be arranged (Canterbury)
- Physical Health Portal Live – Jan 25
- Older adults and younger adult data now combined – Jan 25

Current State

- 2024
- December 57.3 %
- 2025
- January 53.6 %
- February 52.5 %
- March 52 .3 %

Patients identified via BI report – physical check completed either through clinic or a separate physical health appointment

Countermeasures

Next Steps

- Plan next clinic meeting – CLN
- Monitor Power BI – CLN/ Matron
- Discuss with service manager / OTMs to ensure clinic time is protected
- Explore Rota possibility
- Explore PH for later life pathway
- Devise action plan Lithium patients monitoring
- Patient survey
- Staff survey

- Digital blood labelling

Root Cause

Actions

Action	Who	When	Status
Regular clinic meetings to review current state	Kevin Friel	March-25	Complete
Develop PowerBI tool	BI team		Complete
Power BI monitoring started	Gillian Leighton, Kevin Friel, Shannon Petrie	March-25	Complete
Physical Health Portal	RAG team & corporate nursing/Pradnya	January-25	Complete
Texting / calling patients as a reminder ahead of appointments	Admin & clinic team	April-25	Complete
Invite Nursing associates to support clinics	Kevin Friel	March-25	Complete
Explore PH leaflet availability and distribute	Gillian Leighton	June-25	Complete
Competency training for staff	Gillian Leighton	July-25	Complete
Staff rota adjusted to include clinics – identify staff who are working in clinics	Kevin Friel, Rosie Coombes	May-25	Complete
Devise plan for lithium monitoring	Kevin Friel/Clinical team	Oct-25	Complete

Reflection

- Staff , time , rooms

- Positive engagement staff and clients

- Should've carried out a patient survey to capture Voice of the Customer to better understand current state of problem.

This improvement was achieved using the A3 thinking methodology, supported by learning and coaching delivered through Yellow Belt training.

3 Goal / Aim:

Goal:

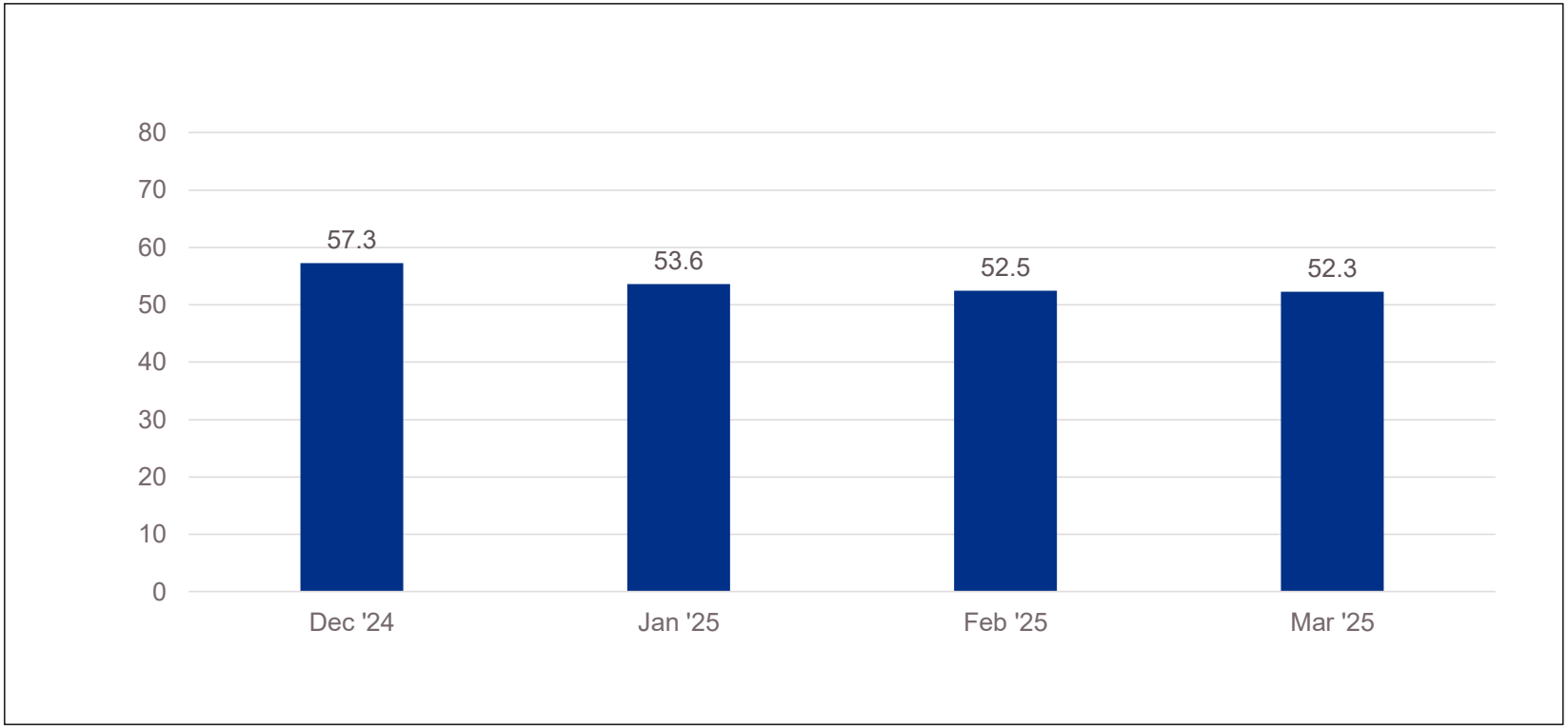
Ensure all community SMI patients open to Kent and Medway Mental Health NHS Trust have received the annual cardio metabolic physical health assessment.

Targets:

- To incrementally increase the percentage of these assessments from a starting point of 57.3% to 85%.
  - **September 2025:** Achieve 60%
  - **October 2025:** Achieve 70%
  - **March 2026:** Achieve the final target of 85%

4 Current State:

% of patients that have had a physical check completed, either through clinic or a separate physical health appointment (identified via BI report).



5 Implementation / Change:

The service successfully implemented and standardised Physical Health Clinics across the locations of Ashford and Canterbury by establishing a clinical lead and organising regular team meetings.

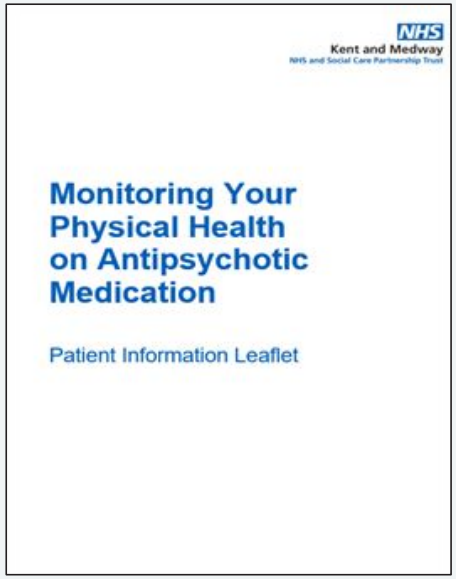
Key Actions & Achievements:

- Team & Capacity: Increased clinic team capacity by ensuring protected clinic time and identifying staff in the rota to provide clinics, while adding a nursing assistant for support

- Digital & Monitoring: Launched a physical health portal (January 2025) for better documentation and used regular Power BI monitoring for oversight

- Pathways & Protocols: Developed a plan for a dedicated later life physical health pathway (led by a nurse prescriber). A specific process was created for clients starting antipsychotics to ensure timely checks (MHT/MHT+), supported by a new intervention tab

- Staff Enablement: Ensured all staff received physical health training and gained access to the pathology lab for blood results. A patient texting service was introduced to aid communication.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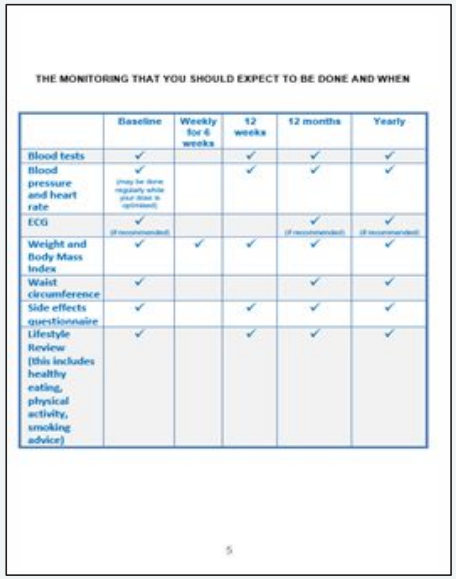
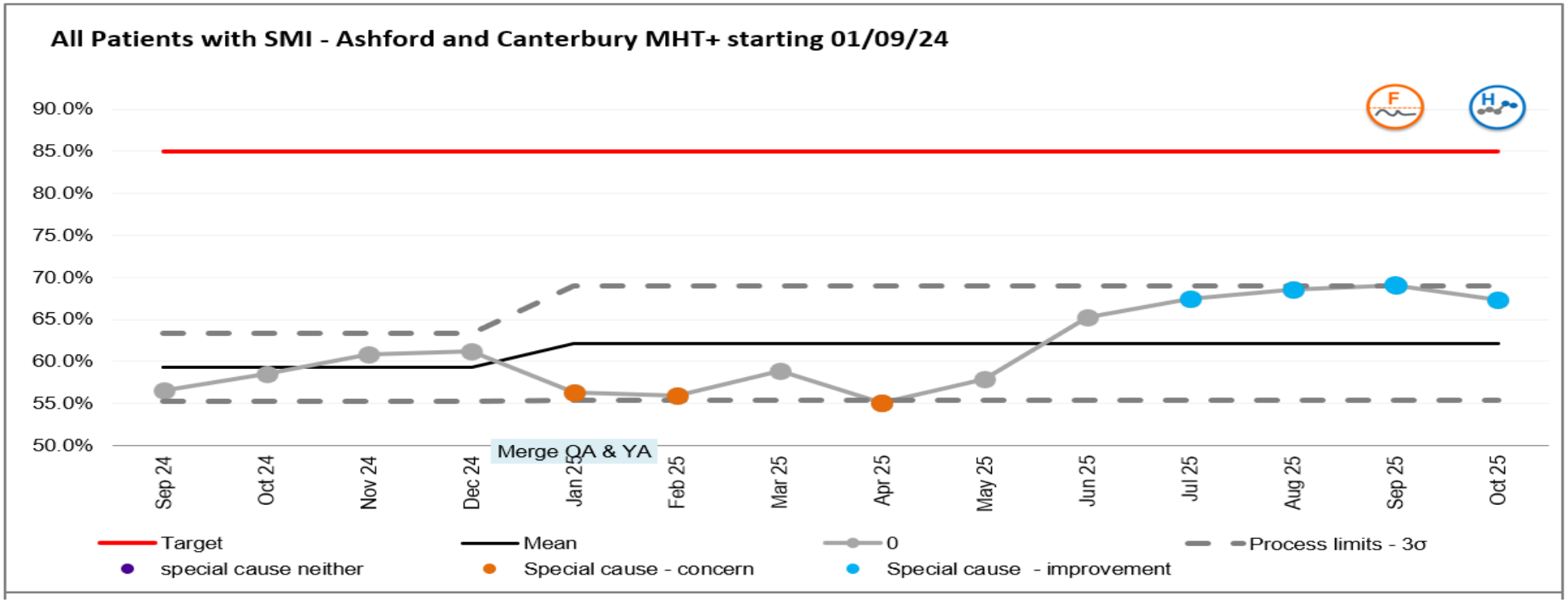
Monitoring Your Physical Health on Antipsychotic Medication

Patient Information Leaflet


THE MONITORING THAT YOU SHOULD EXPECT TO BE DONE AND WHEN

	Baseline	Weekly for 6 weeks	12 weeks	12 months	Yearly
Blood tests	✓		✓	✓	✓
Blood pressure and heart rate	✓		✓	✓	✓
ECG	✓			✓	✓
Weight and Body Mass Index	✓	✓	✓	✓	✓
Waist circumference	✓			✓	✓
Side effects questionnaire	✓		✓	✓	✓
Lifestyle Review (this includes healthy eating, physical activity, smoking advice)	✓		✓	✓	✓

6 Results / Benefits:



There has also been positive engagement from staff and clients – anecdotally. Patients have fed back that they now understand why we provide physical health assessments and health promotion. Staff have fed back that they enjoy learning about and providing physical health assessments.

7 Scalability:

The successful Ashford/Canterbury model is ready to be scaled organisation-wide to significantly boost physical health check completion rates.

Key Requirements for Success:

- Dedicated Staffing: Appoint a Physical Health Nurse for education and support, moving beyond reliance on goodwill
- Protected Capacity: Ensure staff time is formally protected and clearly identified on rotas to facilitate clinics
- Proactive Uptake: Implement staff in waiting areas to proactively invite patients for checks before appointments
- Structured Evaluation: Introduce mandatory pre- and post-implementation surveys (staff/patient) to identify barriers and ensure continuous improvement
- This scale-up will be conjoined under one umbrella with other A3 projects and linked to the work led by Shannon Paine for Trust-wide cohesion and consistency

Kent and Medway NHS and Social Care Partnership Trust Board of Directors (Public)
Minutes of the Public Board Meeting held at 09.30 to 11.45 on Thursday 25th September 2025
Meeting Room 2 and 3, Farm Villa

Members:			
	Dr Jackie Craissati	JC	Trust Chair
	Julius Christmas	JCh	Non-Executive Director
	Stephen Waring	SW	Non-Executive Director (Senior Independent Director)
	Peter Conway	PC	Non-Executive Director (Deputy Trust Chair)
	Sean Bone-Knell	SBK	Non-Executive Director
	Kim Lowe	KL	Non-Executive Director
	Dr MaryAnn Ferreux	MAF	Non-Executive Director
	Mickola Wilson	MW	Non-Executive Director
	Pam Creaven	PCr	Associate Non-Executive Director
	Dr Julie Hammond	JH	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
	Andy Cruickshank	AC	Chief Nurse
	Sandra Goatley	SG	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 Communications and Engagement
	Tony Saroy	TS	Trust Secretary
	Jane Hannon	JHa	Programme Director
	Daryl Judges	DJ	Deputy Trust Secretary
	Hannah Stewart	HS	Deputy Trust Secretary (Maternity Leave)
	Sharn Clare	SC	Trust Secretariat Assistant
	Kate Merlini-Moorcroft	KMM	Occupational Therapy Assistant - Continuous Improvement Story
	Dan	Dan	Personal Story
	Ben Francis	BF	Head of Improvement – Continuous Improvement Story
	The Board was joined by members of the public and members of staff.		
Apologies:			

Item	Subject	Action
TB/25-26/62	**Welcome, Introduction and Apologies** The Chair welcomed all to the meeting and apologies were noted as above. All written reports were taken as read.	
TB/25-26/63	**Declarations of Interest** No interests were declared.	

Item	Subject	Action
TB/25-26/64	**Personal Experience – Standing Tall** The Board received a personal account from Dan, who shared his journey through adversity and mental health challenges. Dan highlighted both positive and negative aspects of his care, including the impact of out-of-area placements, the importance of consistent care coordinators, and the challenges faced during section 136 admissions. The Board **noted** the Personal Experience – Standing Tall	
TB/25-26/65	**Continuous Improvement Story - Minimal Risk Activity Packs (MRAP)** The Board received a presentation from Kate Merlini-Moorcroft, assistant Occupational Therapist, on the MRAP quality improvement project, aimed at reducing self-harm among female inpatients. The project involved creating activity packs with minimal risk items, leading to significant reductions in self-harm incidents (64% on Chartwell Ward, 47% on Upnor Ward) and positive patient feedback. The Board praised the initiative and discussed opportunities for wider rollout, involvement of volunteers, and the importance of occupational therapy in patient recovery. The Board **noted** the Continuous Improvement Story - Minimal Risk Activity Packs (MRAP).	
TB/25-26/66	**Minutes of the previous meeting** The Board **approved** the minutes of the meetings held on the 31st July 2025.	
TB/25-26/67	**Action Log & Matters Arising** The Board **approved** the action log, noting that all actions were completed or in progress, subject to the following. TB/25-26/9 - Board Assurance Framework (BAF) – Discussed at FPC on Tuesday; risk update due with a revised date of November 2025. TB/25-26/50 - Memory Assessment Service System Delivery Plan - To be addressed within the dementia programme and health inequalities. Transition to new structure will clarify site responsibilities. MW and SW to complete handover. TB/25-26/56 - Report from People Committee - SS to liaise with Andy; new target date is November 2025. As a matter arising, KL noted absence of milestone records within the System Digital Plans. **Action: By November 2025, NB to report to the Board the milestones for the Kent and Medway Digital Plans.**	

Item	Subject	Action
TB/25-26/68	**Chair's Report** The Board received the Chair's Report and the following items were highlighted: • Completion of the Annual Fit and Proper Persons raised no issues and the Trust submitted its annual return to NHSE on 19.06.25. • Positive reflections on partnership working with the voluntary sector, particularly in Dover, but concerns about the sustainability of our increased referrals to the third sector. The Board **noted** the Chair's Report and **approved** the Board Effectiveness Review Action Plan.	
TB/25-26/69	**Chief Executive's Report** The Board received the Chief Executive's Report and the following items were highlighted: • The Trust's segment rating: 9th out of 61 nationally for NHS non-acute trusts. • Launch of the new Trust identity and name change on 13.10.25. • Long service awards for 161 staff, which was a great event. • Transition of children's and eating disorder services is still planned for April 2026. The Board **noted** the Chief Executive's Report.	
TB/25-26/70	**Board Assurance Framework (BAF)** The Board received the BAF, noting • This the first BAF to include comparison to risk appetite and tolerance, highlighting several risks outside of tolerance. • A new risk has been put on the BAF regarding self-harm on inpatient units, following recent incidents. • There have been updates on cyber risk and business continuity planning. • A board session on autism is scheduled for October. The Board **approved** the Board Assurance Framework.	
TB/25-26/71	**Strategy Delivery Plan Priorities – Mid-Year Review** The Board received a mid-year review of the Strategy Delivery Plan. The Board discussed the visibility and impact of digital projects, noting concerns around the lack of clarity in reporting arrangements. Members emphasised the need to assess how digital initiatives contribute to sustainability, with positive engagement from clinicians who find digital tools supportive of their work. Collaboration with KCHFT on ambient voice technology is progressing, offering potential for shared learning and innovation. The Digital Clinical Forum was highlighted as a space for close collaboration between clinical and digital teams. It was noted that the effectiveness of digital solutions varies across settings, underscoring the importance of tailoring approaches to local needs.	

Item	Subject	Action
	On staff engagement, the Board reviewed the latest pulse survey results. While the overall engagement score had dipped slightly, the global majority score showed improvement. The annual staff survey was underway, with results expected in the new year. It was agreed that staff recommendation remains a key indicator of organisational health. In terms of leadership and culture, it was recognised that while support functions are active, operational leadership plays a critical role in driving engagement. The Board stressed the importance of frontline leaders modelling positive behaviours and supporting staff effectively. Patient safety metrics were scrutinised, particularly the designation of our strategic aim to reduce self-harm indicator as green despite a recent increase in the BAF rating to 20. Furthermore, the aim to reduce violence and aggression was not yet fully embedded and required possible reclassification. Regarding clinical productivity, the Board explored the shift in focus for senior clinical contacts. The aim is to maximise contact time while balancing activity with cost. Consultant job planning has been refined, but members emphasised that productivity must not come at the expense of health outcomes. The Board confirmed that a deep dive into the sustainability pillar will be presented in November. Demand and capacity planning is underway across services, though concerns remain that increased contact volume does not always translate into improved outcomes. This will be a key focus in future strategic planning. The Board **noted** the Strategy Delivery Plan Priorities – Mid-Year Review.	
TB/25-26/72	**Mental Health, Learning Disability and Autism (MHDLA) Provider Collaborative Progress Report** The Board received the MHLDA Provider Collaborative Progress report, and was informed of: • Positive evaluation of out-of-area autism work and improvements in dementia diagnosis rates (now at 62%). • Challenges in capacity and resource within the ICB. • Progress in partnership working and monitoring of dementia patients. • Ongoing work to improve urgent and emergency care pathways and safe haven provision. **Action: By November 2025, SS to bring a report to Board showing all partnership working within the Trust.** The Board **noted** the Mental Health, Learning Disability and Autism (MHDLA) Provider Collaborative Progress Report.	
TB/25-26/73	**Risk Management Framework** The Board received and **noted** the Risk Management Framework, including updates to the risk appetite statement and the phased rollout of risk governance changes.	

Item	Subject	Action
TB/25-26/74	**Getting the Basic Right paper** The Board received the Getting the Basic Right paper, which outlined progress in standardising administrative and clinical processes, reducing inefficiencies, and improving data quality. Discussion included: • The importance of staff engagement in administrative changes. • Progress in reducing appointment cancellations and DNAs. • The need for further work on standard operating procedures and data capture. • Assurance that the timelines detailed in the paper were both necessary and would be achieved. The Board **noted** the Getting the Basic Right paper.	
TB/25-26/75	**Integrated Quality and Performance Review** The Board received the Integrated Quality and Performance Review (IQPR), and was informed of the key areas of success within the reporting period. The Chief Executive highlighted that the Trust had moved to segment one in the new NHS oversight framework, ranking 9th out of 61 non-acute trusts in England. This achievement reflects strong performance in patient experience, clinical outcomes, and financial sustainability. Key areas of improvement included: • A significant reduction in the number of patients waiting over 52 weeks for a dementia diagnosis (down 80.8% from 260 to 50). • Average waiting times for dementia diagnosis reduced by 47.9% over the past year (from 190 days to 99 days). • The MHT (Mental Health Together) waiting list reduced by 15% since March 2025, with 82% of those waiting under 18 weeks. • Bed occupancy remained high at 96.8% in August, with ongoing focus on patient flow and reducing the number of clinically ready for discharge (CRFD) patients. • Agency spend as a percentage of the pay bill was 2.0% in August, below the mean for the last 24 months. • Workforce metrics for vacancies, training, and turnover showed sustained improvements. The Board discussed several ongoing challenges facing the organisation. One of the primary concerns was the persistently high bed occupancy and the extended length of stay for patients who are CRFD. This situation places continued pressure on inpatient services and impacts the Trust's ability to admit new patients in a timely manner. Additionally, the Board noted significant variation in waiting times between different localities, with East Kent in particular experiencing longer waits compared to other areas. This disparity highlights the need for targeted interventions to ensure more equitable access to services across the region.	

Item	Subject	Action
	The Board also emphasised the importance of maintaining a strong focus on reducing call abandonment rates for the crisis line, recognising that timely and effective responses to those in crisis are critical for patient safety and experience. **Action: By November 2025, DHS to ensure that the IQPR includes further information on call abandonment** The Board **noted** the IQPR.	
TB/25-26/76	**Communality Mental Health Framework programme** The Board received the Communality Mental Health Framework programme and noted the following: • Progress in reducing waiting times and improving access. • Ongoing work to refine the clinical model and strengthen partnership working. • The importance of communication and engagement with staff and stakeholders. The Board **noted** the Communality Mental Health Framework programme.	
TB/25-26/77	**Finance Report for Month 5** The Board received the Finance Report for Month 5 (August 2025), noting: • The Trust reported a pre-technical adjustment surplus of £0.55m and a post-technical adjustment surplus of £0.92m, in line with the financial plan. • External bed usage remained a pressure, with 10 acute and 7 PICU beds used in month, resulting in a year-to-date budgetary pressure of £3.03m. Mitigations included non-recurrent slippage and the introduction of step-down bed capacity. • Agency spend to Month 5 was £2.22m, with a forecast of £4.98m for the year. This is above the agency cap of £4.27m, but actions are in place to reduce spend and deliver within the cap. • Acute inpatient wards continued to utilise additional nursing staff above establishment, mainly due to annual leave and vacancies, but overall staffing numbers were only slightly above plan. • The Trust's capital programme was £0.66m under plan due to project delays, but the forecast spend remains on track. • Cash position at the end of August was strong at £13.81m, higher than forecast due to timing of payments and receipts. The Board discussed the ongoing challenge of managing agency and bank staffing costs, noting that this issue was particularly pronounced in East Kent and West Kent. The Board highlighted the importance of maintaining a strong focus on rota management and recruitment in order to reduce the Trust's reliance on agency staff, which continues to be a significant cost pressure. The Board also reviewed progress on the Cost Improvement Plan (CIP), acknowledging that 67% of the target for 2025/26 was already in delivery, demonstrating positive momentum towards achieving financial objectives. In addition, the Board considered the risks associated with external bed usage, emphasising the importance of maintaining effective patient flow to avoid incurring	

Item	Subject	Action
	further financial pressures and to ensure that resources are used as efficiently as possible. The Board **noted** the Finance Report.	
TB/25-26/78	**Winter Plan 2025/26** The Board received the Winter Plan 2025/26, which included: • Objectives to manage crisis pathways, increase flu vaccination uptake, and ensure business continuity. • Identification of key risks and mitigations for winter pressures. The Board **approved** the Winter Plan 2025/26.	
TB/25-26/79	**Medical Revalidation** The Board received and **approved** the Medical Revalidation report, confirming compliance with statutory requirements and high appraisal completion rates.	
TB/25-26/80	**Business Continuity and Emergency Planning Report** The Board received and **noted** the Business Continuity and Emergency Planning Report, including the annual EPRR compliance statement and improvement plan.	
TB/25-26/81	**Social Value and Net Zero Annual Report** The Board received and **noted** the Social Value and Net Zero Annual Report, highlighting progress in procurement, supplier engagement, and sustainability initiatives.	
TB/25-26/82	**Revised Standing Orders and Standing Financial Instructions** The Board received and **approved** the revised Standing Orders and Standing Financial Instructions.	
TB/25-26/83	**Register of interests** The Board received and noted the Register of Interests, with updates as required. **Action: By November 2025, TS to amend the Register of Interests: remove the sentence regarding power of attorney; add KL's work with University of Kent; and ensure SG's interests are added**.	
TB/25-26/84	**Report from Quality Committee** The Board received and **noted** the Quality Committee Chair's report.	
TB/25-26/85	**Report from People Committee** The Board received and **noted** the People Committee Chair's report.	

Item	Subject	Action
TB/25-26/86	**Report from Audit and Risk Committee (Terms or Reference for approval)** The Board received and **noted** the Audit and Risk Committee Chair's report, and **approved** the revised Terms of Reference.	
TB/25-26/87	**Report from Finance and Performance Committee** The Board received and **noted** the Finance and Performance Committee Chair's report.	
TB/25-26/88	**Use of Trust Seal** The Board **noted** the use of Trust Seal report.	
TB/25-26/89	**Any Other Business** None.	
TB/25-26/90	**Questions from Public** Questions were invited from members of the public. One member expressed a desire to support the Trust in addressing self-harm, sharing personal experience and offering to help.	
	Date of Next Meeting The next meeting of the Board would be held on Thursday 27th November 2025, via Microsoft Teams.	

Signed …….. (Chair)

Date ……..

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 20.11.2025

NHS
Kent and Medway
Mental Health
NHS Trust

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
ACTIONS DUE IN NOVEMBER 2025								
27.03.2025	TB/24-25/137	Action Log & Matters Arising	Submit a report to the Quality Committee on the Trust's future clinical staffing model	DHS, AC and AQ	July 2025	November 2025	The report went to the Quality Committee in November. Recommended to close.	**In progress**
29.05.2025	TB/25-26/9	Board Assurance Framework (BAF)	Review, and amend, the risks within the "we use technology, data and knowledge to transform patient care and our productivity" section of the Board Assurance Framework	NB	July 2025	November 2025	On risk, a review is underway of the use and approach to date within the Trust, this will be used to inform an updated risk for January.	**In progress**
29.05.2025	TB/25-26/12	Integrated Quality and Performance Review	Schedule a Board Seminar on a one-year review of the Purposeful Admission Programme	TS	July 2025	September 2025	This has been added to the Board Seminar and Development Planner, for consideration with the Chair and Chief Executive. Recommended to close.	**In progress**
29.05.2025	TB/25-26/15	Continuous Improvement Impact Report	Schedule a Board Seminar on the Continuous improvement programme in terms of its underlying activity and proposed outcomes.	TS	July 2025	September 2025	On the agenda as the "Doing Well Together" item. Recommended to close.	**In progress**
31.07.2025	TB/25-26/39	Personal Experience – Julie's Story	Provide an update to the Quality Committee on the improving family engagement as part of care and the progress which had been made	AC	November 2025		Progress was discussed in our Quality Committee Workshop in October. Recommended to close.	**In progress**
31.07.2025	TB/25-26/50	Memory Assessment Service System Delivery Plan	Explore the demographics of appointment cancellations, to determine whether there were underlying health inequalities	AR	September 2025	November 2025	Appointment cancellations and underlying health inequalities is being addressed within the dementia programme board, further analysis and any associated actions is expected by the end of Q3. An update will be provided in January.	**In progress**
31.07.2025	TB/25-26/56	Report from People Committee	Discuss with JC and SS the scheduling of a report on the development and management of a female pathway, which included the specific FPICU risks	TS	September 2025	November 2025	Discussions were held and it was agreed that the development and management of a female pathway should be considered at the Quality Committee. Recommended to close.	**In progress**
25.09.2025	TB/25-26/67	Action Log & Matters Arising	Report to the Board the milestones for the Kent and Medway Digital Plans	NB	November 2025		Digital Reporting is being discussed through Finance, Business and Investment Committee with a draft report and reporting approach being proposed	**In progress**

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 20.11.2025

NHS
Kent and Medway
Mental Health
NHS Trust

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
							at the November Committee. It is proposed that the outcome of this is used to produce a position for January.	
25.09.2025	TB/25-26/72	Mental Health, Learning Disability and Autism (MHDLA) Provider Collaborative Progress Report	Bring a report to Board showing all partnership working within the Trust	SS	November 2025		The partnership approach will be considered at the November Board meeting, with details of the work to be considered in January 2026.	**In progress**
25.09.2025	TB/25-26/75	Integrated Quality and Performance Review	Ensure that the IQPR includes further information on call abandonment	DHS	November 2025		The IQPR paper in pack has been updated with this. Recommended to close.	**In progress**
25.09.2025	TB/25-26/83	Register of interests	Amend the Register of Interests: remove the sentence regarding power of attorney; add KL's work with University of Kent; and ensure SG's interests are added	TS	November 2025		The register of interests was amended to reflect the requested amendments. Recommended to close.	**In progress**
ACTIONS NOT DUE OR IN PROGRESS								
								Not Due
CLOSED AT LAST MEETING OR COMPLETED BETWEEN MEETINGS								
29.05.2025	TB/25-26/12	Integrated Quality and Performance Review	Provide additional detail, as part of the IQPR, in regard to progress in address unwarranted variation between the six Memory Assessment Services	AR	September 2025		Closed- dementia variation has been added to IQPR narrative	**Closed**
29.05.2025	TB/25-26/12	Integrated Quality and Performance Review	Produce a separate report on the Mental Health Together (MHT) programme	DHS	September 2025		On the agenda. To be closed.	**Closed**
31.07.2025	TB/25-26/46	Mental Health, Learning Disability and Autism (MHDLA) Provider	Ensure future MHDLA Provider Collaborative Progress Report highlighted progress against each of the programmes (e.g. via a RAG rating, or timeline illustrating intend progress and current position)	JHa	September 2025		Closed – this is covered in the agenda	**Closed**

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 20.11.2025

NHS
Kent and Medway
Mental Health
NHS Trust

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
		Collaborative Progress Report						
31.07.2025	TB/25-26/47	Trust's Digital Plan Refresh	Circulate the key milestones for the Trust's refreshed Digital Plan	NB	September 2025		Closed – information in the Diligent Reading Room	**Closed**
31.07.2025	TB/25-26/49	Integrated Quality and Performance Review	Circulate an update on the progress against each of the actions within the eight-week patient flow plan	AQ	September 2025		An update was circulated to all Board members on the 22nd August 2025. To be closed.	**Closed**
31.07.2025	TB/25-26/49	Integrated Quality and Performance Review	Refer to the Quality Committee consideration of how the Trust Board, and associate sub-Committees, can ensure effective triangulation of information	DJ	September 2025		The matter was duly referred to the September 2025 Quality Committee meeting for further consideration. To be closed.	**Closed**

Kent and Medway Mental Health NHS Trust

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**27th November 2025**
Title	**Chair's Report**
Author	**Dr Jackie Craissati, Trust Chair**
Presenter	**Dr Jackie Craissati, Trust Chair**
Purpose	**For Noting**

1. Kent & Medway system and national activity

During this period that has been a focus on collaborative working, with a productive Board to Board meeting held with North East London NHS Foundation Trust (NELFT), with discussions focused on maintaining quality, patient safety and patient experience during the transfer of Children's and Young People Services, as well as the All Age Eating Disorder Service. Furthermore, a recent 'Get Together' with Kent Community Health NHS Foundation Trust enabled leaders from both organisations to identify those areas for collaborative working that might have the greatest impact in terms of improving health inequalities.

There have been two Kent & Medway system Joint Committee meetings since our last Board meeting, with an agenda focused on the need for a system financial recovery plan, and a great deal of discussion about obstacles to delivering transformation across the six NHS Trusts in the county. There will be action taken to fully understand the drivers of the underlying deficit in the system, and each Trust will need to play their part in supporting the recovery plan.

I attended the NHS Providers conference in Manchester, including a session for chairs overseeing two trusts (or a group of trusts), and a further meeting with the Chair of NHS England. These meetings laid out the priorities for NHS England over the next year. The conference content itself was very notably focused on digital transformation and the role of neighbourhood health.

2. Trust Board Seminar

At the October Trust Board Seminar, the Board approved a £1.3m Business Case for the Centralised Health Based Place of Safety, which was supported by money allocated to the Trust through the achievement of segment 1 rating in the National Oversight Framework. We also received an update on cyber security.

We were delighted to welcome our NELFT clinical and operational leaders to the Board seminar, and we were impressed by their presentations. Their passion and the clarity of their service offer were impressive.

It was a salutary experience, hearing first hand, the experiences and successes of the chairs of the Trust staff networks; rightly, they challenged board members to support them in areas requiring improvement over the next six months.

3. Trust Chair and NED visits

Since the last Board meeting, the following visits having taken place.

Where	Who
August 2025	
Arndale House, and the older peoples Team at Littlebrook, Dartford	Pam Creaven
September 2025	
Britton House, Gillingham	Pam Creaven and Kim Lowe
Community Mental Health Service, Albion Place, Maidstone	MaryAnn Ferreux
Children & young people service (CYP) & Mental Health Together (Highlands House)	Jackie Craissati
October 2025	
Forensic Outreach Liaison Services, Maidstone	Sean Bone-Knell
Royal Clarendon Hotel Age UK residential service	Jackie Craissati

Chair visits

Visiting NELFT's Childrens & Young People (CYP) service was an excellent way to build my understanding of the service. Both the service manager and the team leader were very positive about joining our Trust and had had good experiences thus far. Their service was clearly well thought through, and they were open about some of the delivery problems they faced. I then visited the Mental Health Together team (MHT), who were gradually working through implementation problems with signs of improvement. I encountered enthusiastic and committed local leaders, both operational and clinical, with a good grip on data and a focus on problem solving. I continue to wonder whether there is enough resilience within the staffing model, and also encounter occasional references to clinical practices which are resistant to change.

Further to my visits, I also joined our latest leader's event, which was focused on strategic thinking, roles and risks. There was considerable enthusiasm in the room, a great foundation on which to build some greater strategic capabilities.

With our Chief Medical Officer, I met the chair of Age UK (North Kent) and the CEO of their facility in the converted Royal Clarendon Hotel in Gravesend. This is a mutually beneficial partnership in which our patients can be cared for as a stepping stone from a ward into independent community living. It is a delightful facility without any of the institutional features that might be associated with formal care, and the staff are gradually building confidence in working with our service users. I would like to see us develop these creative community solutions further, and have asked for a business case to come to the board after an evaluation of this pilot in the next few months.

Pam Creaven's visit to Arndale House and the older peoples Team at Littlebrook

During the visit staff morale seemed high, with teams motivated and dedicated, despite pressures in within the services. The Memory Assessment Service in the North is performing strongly, with a growing number of patients seen within 6 weeks. Expertise and knowledge amongst the team, specific to older people seems to be a part of their success and close collaboration with voluntary sector partners and the dementia coordinators are seen as invaluable by the team. It would be good to review on how learning can be shared across teams. There were concerns raised about young people falling from the Trust between children's and adult services, and it was felt this presented an opportunity for all-age provision with the NELF and CAMHS transfer.

Improvement areas highlighted included deeper engagement with staff and service users during redesign, and robust testing before new models launch. Staff felt the key challenges to the service were inpatient bed delays, and as a result, the challenges associated with keeping people safe in the community, and lack of social care support, which has led to safeguarding concerns being raised. Stronger strategic partnerships and consistent GP engagement are essential for integrated care and NHS 10-year plan delivery. Finally, staff reported that racism from patients toward staff often goes unreported and more work needs to be done in this space to support staff.

Pam Creaven and Kim Lowe's visit to Britton House, Gillingham

Whilst the exterior of Britton House left a lot to be desired, inside was a modern, welcoming environment. As with Arndale House, there was a general feeling of a strong and open team culture. We had an opportunity to discuss the work of the Early Intervention and the At-Risk Mental State teams. They provide support to people aged 14+. Hearing about their early intervention approach was enlightening and convincing in terms of offering more support at an early stage, particularly for younger people and their families. As was reflected at the Arndale House visit, there was a great deal of support for the transfer of the NELFT CAMHs.

Areas for improvement included offering a more flexible service, not strictly Monday to Friday, 9 to 5 - something that could improve patient and staff experience. In meeting our voluntary sector partners – although generally very positive in their feedback - it was identified that they could have been provided with more information about the Trust when they first joined; there were some IT problems which had not yet been resolved, and having access to Staffroom would facilitate a feeling of connection to the Trust.

MaryAnn Ferreux' visit to Community Mental Health Services, Albion House, Maidstone

I recently visited Albion House. The team were very positive and actively wanted to discuss their ideas for improving the service, particularly around digital. They were open and with their concerns and had identified some ways to enable changes and were seeking more support from the senior team. The building was well maintained and the clinical assessment spaces were well placed to meet clinical needs.

Sean Bone-knell's visit to the Forensic Outreach Liaison Services (FOLS), Maidstone

An enjoyable visit to a highly motivated and patient focused team. I met with three managers of the FOLS team who provide a community pathway service for patients stepping down from medium or low secure, in-patient services.

Staff had some concerns about the time and process to recruit new team members with waits of 8-10 months as the norm. This can cause issues with patient support as contacts vary rather than being kept stable.

At the time of my visit the Trevor Gibbens Unit site still has ongoing issues with reliability of the increased security measures and these have been raised with senior management. The new site security is now in place however after initially working effectively the barrier control has been out of operation for a number of weeks. Hence site security is not at the required level.

Staff were aware and supportive of the new Trust identity and spoke confidently about Freedom to Speak up issues, as we were meeting during the national speak up month. On the whole a very motivated and focused team providing a great service to our patients.

Chief Executive's Board Report

Date of Meeting: 27th November 2025

Introduction

Since we last met we have launched our new identity and become Kent and Medway Mental Health NHS Trust (KMMH). Feedback from our staff and stakeholders has been extremely positive regarding our new identity and name change. Our staff are proud to work for a mental health trust and patients visiting our new sites have told staff they think the reception areas feel welcoming and professional.

It is extremely busy in the NHS currently and also within our trust. Many staff continue to share their experiences with me and what they would like to see improve in the coming months. We have a very clear quality plan that we must implement and will be at the heart of all that we do in the next six months.

National and Regional Update

SE Leadership Event – 13th October, Brighton

On 13th October I attended the Kent Surrey and Sussex Learning Improvement Network. The networks in the last year have bought together organisations across the region to collaborate and drive improvement in various areas. The October meeting marked the first network specifically for Mental Health, where providers and partners explored opportunities to improve elements of inpatient flow. KMMH have been working with the network to design the format and have included content from our lived experience experts to drive the discussion and identify opportunities to improve. The CEO and Chairs also came together as part of this day to focus on the priorities for the South East region and what we can do together to improve and sustain the services we provide.

NHS Providers Conference

I attended the NHS Providers Conference in Manchester this month. It was a packed two days with key note speakers and examples of good practice being shared from across the country. It was great to hear from some regions regarding the work they are doing to progress integrated neighbourhood health and integrated neighbourhood teams. Sir Jim Mackey, CEO of NHSE England updated on the months ahead and some important milestones including medium term planning for the NHS. The Secretary of State, Wes Streeting also presented setting out what has been delivered in the last year and thanked all staff for their commitment to the NHS.

Provider Capability Self-Assessment for NHSE

In October 2025 the Trust completed and submitted the Provider Capability Self-Assessment, to NHS England, with a 'Confirmed' rating allocated to four of the six domains, and 'Partially Confirmed' ratings allocated to the quality of care, and access and delivery of

services domains. The Trust is currently awaiting the feedback of the review of the Self-Assessment by NHS England.

New Chief Executive – ICB

On 15th October 2025, Adam Doyle became the new CEO of the Kent and Medway ICB. Adam joins the system with extensive NHS leadership, having been one of the longest serving Chief Executives in the NHS, including his 9 years at NHS Sussex, where he drove integration across health and care systems. He also served as National Director for System Development at NHS England for two years, shaping national healthcare strategy.

Adam's early priorities for the system, which have been agreed with all CEOs include:

- Ensuring a smooth leadership transition
- Strengthening partnerships with local trusts, councils, and community organisations
- Accelerating progress on neighbourhood health initiatives within the 10-year plan
- Addressing system-wide challenges such as cost improvement targets and workforce engagement. Initial actions involve reviewing transformation programmes, and aligning operational plans with strategic objectives to deliver sustainable improvements

All-Party Parliamentary Group (APPG) for Mental health

Our Chief Medical Officer, Dr Afifa Qazi, recently addressed the All-Party Parliamentary Group (APPG) for Mental Health, calling on government to urgently tackle growing workforce challenges facing mental health professionals in order to deliver the 10-Year Plan for Health. We're proud to advocate for our sector and our people at this national forum.

Sustainable Community Provider Collaborative

We have held the first Sustainable Community Services Provider Collaborative. It was well attended by all partners. We agreed the following areas of focus for the provider collaborative moving forward: Community Mental Health Framework (CMHF), Better use of Beds (BUOB), Urgent & Emergency Care (UEC), Joint working with Kent County Council (KCC), Frailty/Dementia and End of Life Care, Children's & Young People and Learning, Disability and Autism (LDA). We meet again in December to review the frailty and dementia work and how this programme comes together moving forward.

Medium Term Planning

The NHS has launched a planning process covering the three years from 2026/27 to 2028/29. The intention of this work is to allow longer term decision making to support the delivery of improved care in the medium term (in line with the objectives of the 10-year plan). The trust has updated its planning processes and is working across operations, finance, workforce and performance to ensure delivery of a plan that supports the delivery of are. Draft plans are due in December, with a final submission expected in February 2026.

Trust Update

Care Quality Commission (CQC) Report publication

In March 2025, the CQC undertook an inspection of our community mental health and crisis care/Health Based Place of Safety services and re-rated us in six key areas.

Domain	Community Mental Health services rating	Crisis/Health Based Places of Safety rating
Overall	Requires improvement	Requires improvement
Safe	Inadequate	Requires improvement
Effective	Requires improvement	Requires improvement
Caring	Requires improvement	Good
Responsive	Requires improvement	Requires improvement
Well-led	Requires improvement	Requires improvement

Whilst the CQC reports are a challenging read, the areas of improvement CQC identified were already known to us following an independent review we had commissioned earlier in the year. We therefore either had plans already in place or are now in place to address as part of our ongoing community services transformation. It is also important to recognise that while the CQC identified areas for improvement, there were also areas of good practice and performance, notably:

- A strong learning culture;
- Delivery of evidence-based care;
- Effective partnership working;
- Kindness, compassion and dignity in care;
- Promotion of equality and supporting healthy lives;
- A culture of openness and speaking up;
- Support for patient wellbeing and independence.

Going forward, the trust priority remains to provide high quality care and support our people in the delivery of care. The quality plan we have developed underpins our journey of improvement, placing patients first and ensuring that process supports rather than hinders high quality care.

We have developed a whole-organisation approach using both the CQC findings, and our own observations to drive improvement. It aims to:

- Simplify our approach to quality;
- Link our strategic improvement programmes to daily management;
- Share transparently what the CQC found, what we have already done and what we will do next;
- Deliver the improvements necessary in a collaborative manner with staff, patients, families and our partners.

And, we have identified four thematic areas for improvement:

- Safety and risk management including physical health checks, care records, infection control and medicine optimisation;
- Assess and waiting times including demand and capacity and waiting list management

- Environmental, experience and equity including building standards, tailoring interventions and addressing health inequalities;
- Leadership, culture and governance including embedding new models and improving oversight.

We are already making real progress in delivering against our quality plan, which we will report to the Board, and patients and partners in due course.

New Trust Identity and our future ambitions

On 13th October, Kent and Medway NHS and Social Care Partnership Trust became Kent and Medway Mental Health NHS Trust and launched its new co-created identity.

Our new vision forms part of this identity - *creating communities where mental health care helps people not just live with mental illness, but live well* – and will drive forward our future ambitions as we develop our next organisational strategy. Engagement on this has already begun and I look forward to discussing this further with our stakeholders, and the Board.

Kent and Medway Mental Health NHS Trust and North East London Foundation Trust Board to Board

On 21st October, Boards from KMMH and NELFT met at the NELFT Headquarters in Essex to discuss the forthcoming transition of the Children and Young Peoples and All Aged Eating Disorder Services on 1st April 2026. The Boards were assured with the current progress on the transition.

Big Mental Health Conversation – 10th October

I was delighted to attend an event at the Detling Show Ground on Mental Health Day, which brought together people from all aspects of looking after people with mental health. Our team attended and supported the Children's and Young People team from NELFT, it was fantastic to be part of such an event and will support the trust in building relationships with a group of new stakeholders as the children services transition over to us.

Black History Month

This year's Black History Month, under the powerful theme "Standing Firm in Power and Pride," has been a resounding success for our trust and our system partners. Throughout October, we witnessed a profound demonstration of this strength as our Global Majority colleagues, allies and communities came together to celebrate the indelible legacy and achievements of Black individuals. The events, from deeply inspiring and compelling panel discussions on resilience especially against the backdrop on national unrests to celebrations of cultural heritage, were not just about reflection, but a vibrant affirmation of identity and a collective commitment to equity.

I am filled with immense pride for the unwavering power displayed by our staff and the courageous spaces they created. This month has fortified our resolve, providing a powerful foundation from which we will continue to actively build a more inclusive and representative Trust, one where every voice is heard, valued and empowered to lead.

Armed Forces Covenant

We have reinforced our commitment to inclusion by re-signing the NHS Armed Forces Covenant and launching an Armed Forces Community plan to ensure fair, timely access to specialist mental health support for serving personnel, veterans, reservists, and their families. Building on its longstanding support for the armed forces community since 2019, the trust continues to strengthen awareness, accessibility, and partnership working through services such as Op Courage and collaboration with voluntary and charitable organisations. Its recent Defence Employer Recognition Scheme (ERS) Gold Award further demonstrates the trust's dedication to inclusive employment practices and strong support for the armed forces community.

Webb's Garden

On 14th November, I was delighted to be able to attend the opening of our summerhouse in Webb's Garden in Canterbury. The building was sponsored by Redrow homes, who via our trust charity have built a summerhouse and donated fixture and fittings for the house and used their own resources to invest time in this excellent project. We are extremely grateful to Redrow for this kind donation, this summerhouse and space will make such a difference for our patients.

Staff Awards

Since my last update, the trust and our colleagues have continued to be recognised for the excellent work we have been doing.

- Nat Farley, our Involvement and Engagement Manager, won *Kent Public Sector Wellbeing Champion* at the Kent Mental Wellbeing Awards (East Kent Mind). The award recognises Nat's pioneering work to transform engagement with sex workers and develop our first trauma-informed engagement framework - a national first rooted in dignity and safety.

- Clare Taylor, STR worker, and Richard Buxton, Peer Support Worker, received the *Sir Maurice Hatter Outstanding Contribution to the Community Award* for their work bringing together the Early Intervention Service and Charlton Athletic Community Trust (CACT). The partnership has supported people for over 18 years, with Clare involved since the very start.

Well done to all our staff for the recognition of their hard work and dedication with these awards.

Value in Practice Awards

We continue to receive lots of nominations for our trust Value in Practice Awards. We have decided to change the awards from next year, and will be introducing an employee of the month for each directorate. Winners for September are included in the appendix of this report. Well done to everyone who was nominated and who won.

Summary and Conclusion

As we enter into the winter months, working with our acute trust colleagues will be more important than ever to ensure we support each other and care for our communities safely.

As I have said at the beginning of my report, I am extremely grateful to our staff for their continued openness and feedback. Over the next 6 months the quality plan will be our key

area of focus to ensure we embed the changes we have started and implement the recommendations from our recent CQC inspection.

And finally, we are starting the development of our new trust strategy which will be discussed at a Board development session in December and signed off at the Trust Board in March.

Sheila Stenson
Chief Executive
27 November 2025

Executive Team Visits

Sheila Stenson:
NELFT – Canterbury Hub
NELFT – Dartford Hub
NELFT – Maidstone Hub
Canterbury - Bluebell ward, Foxglove ward and EIP admin team
Dartford – Cherrywood, Amberwood, Pinewood wards and Rosewood Mother & Baby unit
Highlands House
Forensics & Specialist Community of Practice

Donna Hayward-Sussex
NELFT – Canterbury Hub

Highlands House

Littlebrook Forensic Inpatient Services and wards

St Martins Wards

Archery House

QEQM

Ashford Liaison & Wards

Priority House Wards

CYPMHS Sheerness

CYPMHS Medway

CYPMHS Ashford

Eureka Place, Ashford

Nick Brown
CYPMHS – Seashells Family Centre, Sheerness

Andy Cruickshank
NELFT Dartford Hub
ECAO/Canterbury Inpatients
Highlands House

Dr Afifa Qazi
NELFT – Maidstone Hub

Adrian Richardson
NELFT Mental Health Support Team
NELFT Single Point of Access
NELFT CYPMHS – Orchard House, Thanet
NELFT CYPMHS – Cherry Tree House, Folkestone

Sandra Goatley
Britton House

Kindra Hyttner
Priority House
TGU
Rosebud
Cherry Tree House NELFT
Willow Suite
RoseWood, Mother & Baby Unit

Value in Practice Awards – September

Directorate		September
North	Individual	Esther Ifonlaja, Lead Clinician, Medway/Swale MAS
East	Individual	Dr Mansi Mohammadkarimi
West	Individual	Natalie Groves, Nurse, MHT+
Forensic	Individual	Juley Shaji, Nurse
Support services	Individual	Mark Gower, Communications Manager
Acute	Individual	Naye Bugden, Deputy Ward Manager

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details	
Date of meeting:	27 November 2025
Title of paper:	Board Assurance Framework
Author:	Louisa Mace, Risk Manager
Executive Director:	Andy Cruickshank, Chief Nurse

Purpose of paper

Purpose:	Approval
Submission to Board:	Regulatory Requirement

Overview of paper

The Board are asked to receive and review the Board Assurance Framework (BAF) and to ensure that any risks which may impact on achieving the strategic objectives have been identified and actions put in place to mitigate them.

The Board are also requested to approve the risks recommended for removal.

Issues to bring to the Board's attention

The BAF was last presented to the Audit and Risk Committee and Board in September 2025.

New Risks:

No new risks have been added since the BAF was presented to Board in September

Risk Movement:

Two risks have changed their risk score since the Board Assurance Framework was presented to Board in September:

- Risk ID 02290 – CQC Regulatory Compliance
- Risk ID 08174 – Delivery of Financial Targets

Version control 02 - **Public**

Risks recommended for Removal:

No risks are currently recommended for removal

Risk Appetite:

The Risk Appetite statements continue to be applied to the BAF risks and are included in this report.

Governance

Implications/Impact:	Ability to deliver Trust Strategy
Assurance:	Reasonable Assurance
Oversight:	Oversight by the Audit and Risk Committee and Board level risk Owners (EMT)

The Board Assurance Framework

The BAF was last presented to ARC on 3rd September and Board on 25th September 2025. This report reflects further updates on risks since the beginning of September.

The Top Risks are

- Risk ID 00580 - Organisational inability to meet Memory Assessment Service Demand (Rating of 20 – Extreme)
- Risk ID 07960 – Self Harm incidents on Acute inpatient units (Rating of 20 – Extreme)
- Risk ID 02290 – CQC Regulatory Compliance (Rating of 16 - Extreme)
- Risk ID 08065 – Inpatient Flow (Rating of 16 – Extreme)
- Risk ID 04673 – Organisational Risk – Cyber Attack (Rating of 15 – Extreme)

Risk Movement

Two risks have changed their risk score since the Board Assurance Framework was presented to Board in September:

- **Risk ID 02290 – CQC Regulatory Compliance (Increased from 12 (High) to 16 (Extreme))**
  This risk has increased in risk score in light of recent inspections and the development of the Trust Quality plan.

- **Risk ID 08174 - Delivery of Financial Targets (Reduced to 12 (high) from 15 (Extreme))**
  This risk has reduced in risk score as the current forecast is showing that the planned financial position will be met this year, considering that we are past the halfway point of the year the likelihood of us not achieving that has reduced.

Risks Recommended for Removal

No risks are being recommended for removal at this time:

New Risks

No risks have been added since the BAF was presented to Board in September.

Emerging Risks

The Executive team continue to Horizon scan for emerging risks to delivery of services. Currently the following area is being evaluated for inclusion on the BAF:

- **Autistic and Neurodivergent Population**
  There are some emerging concerns that the current service provision is not serving the Autistic and Neurodivergent population well.

Other Notable Updates

- There have been no other notable updates to the BAF risks at this time. Risks continue to be reviewed and updated by the risk owners.

Risk Appetite:

Following the Board Session earlier in the year, the Risk Appetite Statements that were discussed and agreed have been incorporated in the Trust Risk Management Framework. These have been applied to the BAF risks for this report, according to the table below.

Risk Appetite Scale	Appetite (by current risk score)	Tolerance (by current risk score)	Outside of tolerance (by current risk score)
Averse	1 – 3	4 – 6	> 6
Minimal	1 – 5	6 – 10	> 10
Cautious	1 – 8	9 – 15	> 15
Open	1 – 10	12 – 20	> 20
Seek	1 – 15	16 - 25	
Mature	1 - 25		

The following table identified the risk appetite statement for each of the risks on the BAF:

Risk ID	Title	Current Risk Score	Appetite	Appetite Status
00580	Organisational Inability to meet Memory Assessment Demand	20	Cautious	Outside of Tolerance
02290	CQC Regulatory Compliance	16	Averse	Outside of Tolerance
04673	Organisational Risk – Cyber Attack	15	Averse	Outside of Tolerance

04682	Organisational Risk – Industrial Action	4	Cautious	In Appetite
07557	Trust Agency Usage	9	Seek	In Appetite
07891	Organisational Management of Violence and Aggression	12	Minimal	Outside of Tolerance
07960	Self Harm Incidents on Acute inpatient Units	20	Minimal	Outside of Tolerance
08065	Inpatient Flow	16	Cautious	Outside of Tolerance
08146	Maintenance of a Sustainable Estate	8	Cautious	In Appetite
08157	Community Mental Health Framework Achieving outcomes to evidence success	12	Minimal	Outside of Tolerance
08173	Delivery of a fit for purpose estate	9	Cautious	In Tolerance
08174	Delivery of Financial Targets	12	Minimal	Outside of Tolerance
08175	Delivery of Underlying Financial Sustainability	12	Minimal	Outside of Tolerance
08337	Organisational Culture impact on Change Programmes	9	Seek	In Appetite

Recommendations

The Board is asked to receive and review the BAF and to confirm that they are satisfied with the progress against these risks and that sufficient assurance has been received.

The Board are requested to note that work continues to ensure that all actions are identified and attention to detail within the recording of actions and their management is the primary focus of the named board level risk owners.

Updated: 10 November 2025

NHS
Kent and Medway
NHS and Social Care Partnership Trust

Board Assurance Framework

Risks which may impact on delivery of a Trust Strategic Objective.

Definitions:
Initial Rating = The risk rating at the time of identification

Current Rating = Risk remaining with current controls in place. This should decrease as actions take effect and is updated when the risk is reviewed

Target Rating = Risk rating Month end by which all actions should be completed

Action status key:

Actions completed	G
On track but not yet delivered	A
Original target date is unachievable	R

1 - We deliver outstanding, person centred care that is safe, high quality and easy to access

1.1 - Improving Access to Quality Care

12/01/2022 — BAF Risk Opened

The demand for memory assessment services has been reflected on the care group risk register since October 2020. This has been escalated to the BAF due to the need for a whole system response, from the Kent and Medway system partners as agreed at Board in November 2021.

31/10/2022

Since the introduction of the ICB, the clinical lead role for Dementia across K&M has been dissolved. This has created a gap in system leadership that casts doubt on the whether the Dementia workstreams in progress thorgh the SIG will be delivered on target.

15/05/2024

This risk has been reviewed and reframed. There remains an ongoing need for a system response to the demand for Memory Assessment services. Risk scores have increased due to the current position and anticipated growth in demand over the coming years.

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Action owner	Risk Appetite	Target rating L	Target rating C	Target rating Rating	Target Date (end)
ID 00580	Jan 2022	Director of Partnerships and Transformation	**Organisational inability to meet Memory Assessment Service Demand** If KMPT remain the sole provider of Memory Assessment Services, despite the internal work to redesign services, and the ongoing system programme of work to redefine the community model Then there is a risk that patients will not receive a diagnosis in a timely manner and access to treatment and services. Resulting in continued failure to achieve Dementia Diagnosis Rate across Kent and Medway, potential harm to patients and their families who are unable to access necessary treatment or services, increased regional or national scrutiny, financial and reputation impact to the organisation and system, given the expectation of increased demand from population over the coming years.	5	5	25	System wide response to achieve improved Memory Assessment services across Kent and Medway through the Mental Health Learning Disability and Autism (MHLDA) Provider Collaborative and Ageing Well Board. - BI Functionality to drive performance at team, directorate and organisational level - Stand alone assessment model formed, currently being optimised through Tiered Accountability work - Completing the Demand and Capacity for the multi-disciplinary model for memory assessment within KMPT (to be rolled out across the organisation) - Community Model Task Force formed comprising KMPT and wider NHS and VCSE partners.	Weekly reporting of performance and issues with the optimisation of Phase 1 to Executive Management Team Highlight reports to Trust Leadership Team, FPC and QC on 6 week performance Reporting to MHLDA and Ageing Well Board	4	5	20	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Phase 2: Launch of multi-disciplinary assessment model within KMPT — Director of Partnerships and Transformation — 22/12/2025 — A Optimisation of phase 1 stand-alone model — Director of Partnerships and Transformation — 31/12/2025 — A Phase 2 resourcing and implementation — Director of Partnerships and Transformation — 29/08/2025 — A Focussed activity on 52 week waits — Director of Partnerships and Transformation — 30/09/2025 — A Resourcing and roll-out of community model alongside ICB and community services — Director of Partnerships and Transformation — 29/05/2026 — A	Director of Partnerships and Transformation	Outside of Tolerance	3	4	12	31/03/2026

12/06/2024 — Risk Opened

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Action owner	Risk Appetite	Target rating L	Target rating C	Target rating Rating	Target Date (end)
ID 00065	Jun 2024	Chief Medical Officer	**Inpatient Flow** If the long waits in ED, Community and the Place of Safety remain in excess of 12 hours for an inpatient admission to an acute psychiatric ward Then treatment maybe delayed, Resulting in risk of harm, poor patient outcomes and potential longer length of stay. Reputational damage with partners organisations and the wider NHS system is a risk.	5	4	20	Patient flow team jointly working with Liaison Psychiatry, Home Treatment and community services on case by case basis to ensure each admission is purposeful, and inappropriate admissions are avoided. At the same time, we are ensuring that the clinically ready for Discharge patients get the right support in a timely manner so that they spend the least amount of time, beyond what is clinically relevant, in hospital. twice daily reports including the Place of Safety Breaches [1d] daily system calls [1d] business case approved through ICB to move to CORE 24 across all acute hospitals liaison teams [1a] CRFD programme of work underway to release capacity within the KMPT bed stock- Discharge to Assess (D2A) transition arrangements for CRFD patients; internal pathway review [1f] CRFD Programme is a system wide programme in conjunction with the ICB Local Authority and supported through the Provider collaborative.[1f] review of current metrics to understand and agree when agreement to admit patient commences and when 'clock' starts to be able to accurately measure patients wating in EDs for Beds.[1a] Use of VCSE partners to support CRFD onward transition. Currently 5 patients have gone through this pathway. Clarendon House commissioned 13 beds to support people who are Clinically fit for Discharge with onward pathway thus improving capacity in Acute Psychiatric bed stock.	Weekly CRFD report Daily Bed state including Place of Safety and A&E Breaches	4	4	16	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Countywide Safe Haven Provision — Deputy Chief Operating Officer — 02/06/2025 — A Implementation of CORE 24 across all Hospital Liaison Services — Deputy Chief Operating Officer — 13/10/2025 — A Recovery Houses across the County — Deputy Chief Operating Officer — BLOCKED — A Virtual ward Model for People with Dementia — Chief Medical Officer — 31/12/2025 — A	Chief Medical Officer	Outside of Tolerance	1	3	3	30/03/2026

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Action owner	Risk Appetite	Target rating L	Target rating C	Target rating Rating	Target Date (end)
12/06/2024 Risk Opened																			
ID 08157	Aug 2024	Chief Operating Officer	**Implementing the Community Mental Health Framework to deliver high quality care and support through Mental Health Together** IF we don't complete enough paired DIALOG+ as a partnership to understand people needs and improvement and are not able to deliver an responsive access to care and support THEN we will a) not be able to assess outcomes for our service users and will b) delay commencement of treatment, RESULTING IN poor patient experience.	5	5	25	Daily review of waiting lists at service level, weekly review of waiting list at operational level and fortnightly review of waiting lists at programme management level (1d) with measures for mitigation shared with all partners. Amendments to the front door are underway as part of the Community Mental Health Programme refresh, the interface with GP's is undergoing improvement and the voluntary sector are moving resources to entry points to enable improved triage. Team level daily management. Tactical groups in all localities monitoring waits and clinical risk to patients (1c). Monthly deep dive by programme management to each locality (1a) Dashboard in place (1d) BI Team reviewing weekly MHT report to align to waits and patient flow to enable patient level data at service level. (1d) DNA policy has been reviewed and updated to support effective and safe discharge from MHT for people who do not want the service (1f) Rio updated to include ability to record onward referral to alternative provision (such as Talking Therapies). (1f) Fortnightly partnership interface meeting to identify pathway challenges and response to this. Refresh of Community Mental Health Programme to refine	Robust team level management Dashboards Caseload management tool Partnership Forums	3	4	12	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Review of Mental Health Together Front Door Processes — Deputy Chief Operating Officer — 30/11/2025 — A Capacity Planning — Deputy Chief Operating Officer — 30/11/2025 — A	Chief Operating Officer	Outside of Tolerance	3	3	9	31/12/2026
1.2 - Creating safer and better experiences on our wards																			
04/12/2014 BAF Risk Opened; 20/07/2023 Risk returned to BAF																			
ID 07891	Jan 2024	Chief Nurse	**Organisational Management of violence and aggression** IF the Trust does not manage violence and aggression effectively THEN staff and patients will be exposed to physical injury and psychological harm RESULTING IN increased incidents of seclusion and restraint; longer recovery times for patients; lack of staff confidence to report and in managing incidents of Violence and Aggression; increased staff sickness, reduced staff capacity to manage incidents and provide quality care, reduced staff retention, reputational damage, difficulties recruiting, reluctance of agency staff to work on wards with high levels of violence and aggression, reduced staff engagement with violence reduction strategies.	5	3	15	Restrictive Practice policy and guidance the Continuous Improvement Approach Violence Reduction Strategy PSS Strategy Use of Force Act Operation Cavell Security strategy CCTV (where available) Trust Strategy identifies a reduction of V&A for inpatients and Racial incidents with associated workstreams to support this. How to manage challenging telephone calls Policy Therapeutic observations Policy Control of Ligatures Policy Safer Staffing	Incident reporting via InPhase Quality Improvement Data	4	3	12	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Quality Improvement project in place to implement and test evidence based interventions to reduce violence and aggression across all inpatient services. — Chief Nurse — 30/03/2026 — A New Violence and Aggression Policy 2025 — EPR Lead — 15/11/2025 — A	Chief Nurse	Outside of Tolerance	2	3	6	31/03/2026
01/04/2014 Risk Opened; 15/06/2025 Risk escalated to BAF																			
ID 02290	Apr 2014	Chief Nurse	**CQC Regulatory Compliance** IF we don't have effective means for assessing, measuring, monitoring and reviewing the regulations as set out in the Health and Social Care Act 2008 required to evidence compliance with fundamental standards and to uphold CQC registration THEN inspections may highlight areas of poor quality of care RESULTING IN avoidable harm, legal claims, regulatory breaches, enforcement action from our regulators and damage to the confidence in the Trusts reputation as a provider of choice.	4	4	16	QPRs held within the Directorates and audits that identify areas of concern for further action Learning Review Group (LRG) – learning is identified from patient safety incidents and lessons shared to prevent reoccurrence CQC MHA Reviews for inpatient areas – provider action statements generated, reports to Mental Health Legislation Operational Group (MHLOG) and Mental Health Act Committee (MHAC) Regulation, Compliance and Quality Group (RCQG) – meets monthly and reports to Quality Committee (QC) Quarterly engagement meetings with CQC whereby areas of concern are discussed and assurance provided against quality statements and the five key questions Support tools and evidence lists for staff based on CQC quality statements and five key questions. This is available on staffroom. Quality improvement plans following inspection activity - these are monitored via RCQG and QC Regulations set out in the Health and Social Care Act – Trust assessment against these identifying good compliance and gaps in assurance. (This is a new process starting this month).	QPR minutes and audit results within the Directorates identify areas of concern and actions are then generated to rectify these Learning Review Group minutes identify learning shared from patient safety incidents Quarterly engagement meeting with CQC minutes The provider action statements from MHA inpatient reviews and quality improvement plans from inspection activity are reviewed for oversight and assurance purposes at the Regulation, Compliance and Quality Group, with points of escalation/concern highlighted to Quality Committee and Mental Health Act Committee Workplan for Regulation, Compliance and Quality Group which has set items that are regularly reported to these meetings i.e. Rapid tranquilisation data, supervision/training data, complaints, serious incidents etc. Quality statement presentation slides have been shared within directorates so that staff are aware of what evidence would be required under each quality statement. Quality improvement plans – when actions are complete, these move to the assurance check phase and are monitored via the Regulation, Compliance and Quality Group. Regulations set out in the Health and Social Care Act – Trust assessment against these identifying good compliance and gaps in	4	4	16	↑	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Delivery of Place of Safety Quality Improvement Plan — Chief Nurse — 30/07/2025 — A Delivery of Community Teams Quality Improvement Plan — Chief Nurse — 30/10/2025 — A	Chief Nurse	Outside of Tolerance	2	3	6	31/03/2026

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Owner	Target Completion (end)	Status	Action owner	Risk Appetite	Target rating L	Target rating C	Target rating Rating	Target Date (end)
								assurance. (This is a new process starting this month). Quarterly Performance and Quality Meeting (PQM) with the ICB Minutes.														
02/04/2024 Risk Opened — 08/09/2025 Risk escalated to BAF																						
ID 07960	Apr 2024	Chief Nurse	**Self harm incidents on Acute inpatient units** IF the inpatient wards do not have adequate knowledge and safety structures in place to assess, prevent, review and respond to incidents of self harm, THEN incident frequency and severity will increase, RESULTING IN compromised patient safety and wellbeing and actual harm coming to patients, compromised staff wellbeing, increased oversight from regulatory bodies, negative impact on Trust reputation.	5	4	20	Trauma informed approach to Therapeutic Observations and clinical risk management Clinical risk assessment and management (1a, 2e) Person centred care plans (1d) Therapeutic observations (1d, 1e, 1f, 2e) Therapeutic interventions (1d, 2a, 2e) Staff support: reflective practice and debrief (1a, 1d, 1f, 2e, 2a) Safety huddle/bundle (1f) Search procedures (2e) Staff training in self harm and trauma informed care (1f) Environmental Ligature risk management (1d, 1f) Matrons skills workshops and emergency walk throughs (1f) learning bulletins (1f) matrons weekly environmental walk arounds (1f) Rescue kits (1d) Clinical Handover (1f) Red2Green (1f) Rapid review learning (1f) Designated Senior Responder (1f) Clinical risk forum Acute and trust wide (1d) Trust wide self harm steering group (1d) High intensity user pathway Purposeful admission protocol	Incident reporting- identifying trends and themes per area. New BI dashboard to support data analysis. Matrons daily huddle Governance Huddle Clinical risk forum minutes Trust wide self harm steering group meeting records Yearly environmental ligature audit	5	4	20	⇔	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**	Chief Nurse	Outside of Tolerance	3	2	6	12/09/2026
													Re establish the clinical risk forum for cases of frequent self harm and High intensity users	Clinical Director for Acute	30/09/2025	A						
													Self harm data analysis on wards	Head of Nursing and Quality, Acute	03/11/2025	A						
													Collaborative discharge planning with community teams	Clinical Director for Acute	01/12/2025	A						
													Social Media awareness	Lead for Psychological Practice, Acute	01/12/2025	A						
													New Style Person Centred Care Planning	Head of Allied Health Professionals, Acute	29/12/2025	A						
													Alternative to Self Harm Pilot Project	Head of Allied Health Professionals, Acute	19/01/2026	A						
													Minimal Risk Activity Pack Pilot Project	Head of Allied Health Professionals, Acute	19/01/2026	A						
													Enhanced Therapeutic Observations and Care (ETOC)	Head of Nursing and Quality, Acute	02/03/2026	A						
													Clinical Handover Process Review	Corporate Head of Nursing & Quality	18/03/2026	A						
													CAPLET training for all inpatient staff	Head of Nursing and Quality, Acute	01/04/2026	A						
1.3 - Actively involving service users, carers and loved ones in shaping the services we provide.																						
			No Risks Identified against this Strategic Objective																			
2 - We are a great place to work and have engaged and capable staff living our values																						
2.1 - Creating a culture where our people feel safe, equal and can thrive																						
30/01/2025 BAF Risk Opened																						
ID 08337	Jan 2025	Chief People Officer	**Organisational Culture impact on Change Programmes** If the Trust's current interventions do not successfully build its capability and capacity to deliver its strategy , Then change efforts are unlikely to succeed and engagement will deteriorate, Resulting in poor organisational culture, impact on our people, patients and population, reduced ability to deliver key strategic ambitions	4	3	12	Work to introduce and embed new and coherent organisational values Delivery of leadership development programme Delivery of equality, diversity and inclusion interventions Delivery of 'Doing Well Together' and improvement capability building	Staff Survey results Pulse Survey results	3	3	9	⇔	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**	Chief People Officer	In Appetite	2	3	6	31/03/2026
													Delivery of Leading Well Together programme	Deputy Chief People Officer	31/12/2025	A						
													Delivery of Management Development Programme	Deputy Chief People Officer	31/12/2025	A						
													Roll out and embedding of New Organisational Values	Deputy Chief People Officer	31/03/2026	A						
													Embedding of staff voice initiatives	Deputy Chief People Officer	31/03/2026	A						
2.2 - Building a sustainable workforce for the future																						
			No Risks Identified against this Strategic Objective																			
2.3 - Creating an empowered, capable and inclusive leadership team																						
			No Risks Identified against this Strategic Objective																			
3 - We lead in partnership to deliver the right care and to reduce health inequalities in our communities																						
3.1 - Bringing together partners to deliver location-based care through the community mental health framework transformation																						
			No Risks Identified against this Strategic Objective																			

				Initial rating					Current rating						Target rating			
ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	L	C	Rating	Controls Description	Top Five Assurances	L	C	Rating	Trend	Planned Actions and Milestones	Action owner	Risk Appetite	L	C	Rating	Target Date (end)
3.2 - Working together to deliver the right care in the right place at the right time																			
			No Risks Identified against this Strategic Objective																
3.3 - Playing our role to address key issues impacting our communities																			
			No Risks Identified against this Strategic Objective																
4 - We use technology, data and knowledge to transform patient care and our productivity																			
4.1 - Have consistent, accurate and available data to inform decision making and manage issues																			
22/07/2015 Risk Opened → 15/06/2025 Risk escalated to RAF																			
ID 04673	Jul 2015	Chief Finance and Resources Officer	**Organisational Risk - Cyber Attack** IF the Trust is the victim of a successful cyber attack THEN this is likely to impact on the availability or accessibility of key business systems including patient records and other sensitive data held by the organisation RESULTING IN clinical risks due to a loss of access to patient records (including pharmacy information), breaches of IG, financial cost, penalty or fine from the ICO and damage to trust reputation.	4	5	20	Omitted for security reasons	Omitted for security reasons	3	5	15	⇔	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Omitted for security reasons	Chief Finance and Resources Officer	Outside of Tolerance	2	3	6	29/03/2026
4.2 - Enhance our use of IT and digital systems to free up staff time																			
			No Risks Identified against this Strategic Objective																
4.3 - Effective digital tools are in place to support joined-up, personalised care																			
			No Risks Identified against this Strategic Objective																
5 - We are efficient, sustainable, transformational and make the most of every resource																			
5.1 Achieve financial sustainability																			
22/08/2023 Risk Opened																			
ID 07557	Aug 2023	Chief Medical Officer	**Trust agency usage** IF the Trust fails to recruit to its establishment and relies on Agency staff THEN this could impact on the quality and safety of services RESULTING IN an increased risk and impact on the Trust ability to deliver safe care and long term financial sustainability and a risk to the ICS system financial performance. There maybe further sanctions from NHSE which have not yet been confirmed.	4	5	20	Sign off of Medical Agency spend at exec level. [3a] Sign off for above cap rate posts at CEO level [3a] Reporting to Trust Board [3a] Reporting the NHSE [3b] QPR Meetings [2a] Monthly Exec led Directorate Management Meetings to review Agency Usage [2a] Finance and Performance Committee monitoring [2b] Standing financial instructions [2e] Agency recruitment restriction [1a] Budget holder authorisation and authorised signatories Weekly monitoring of agency spend Medical lead for recruitment appointed to support areas which are challenging to recruit to. All non medical vacant posts are reviewed at the weekly vacancy control panel. No retrospective approval of Agency shifts Increase in recruitment and retention premium for consultant posts in the East. Virtual consultant post is being tested for the East Vacancies.	Monthly IQPR (reported to each public board) Monthly statements to budget holders [1a] Monthly Finance Report [1h] Internal audit [3d]	3	3	9	⇔	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Reduce Nursing Agency Spend by 50% to meet the National ask — Chief Medical Officer — 30/10/2025	Chief Medical Officer	In Appetite	3	3	9	28/03/2026

				Initial rating				Current rating					Target rating				
ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	L	C	Rating	Controls Description	Top Five Assurances	L	C	Rating	Trend	Planned Actions and Milestones	Action owner	Risk Appetite	L	C	Rating	Target Date (end)
	25/06/2024 Risk Opened																		
ID 08174	Jun 2024	Chief Finance and Resources Officer	**Delivery of Financial Targets** IF the Trust is unable to deliver its financial targets THEN additional scrutiny will be attached to its financial position RESULTING IN sanctions from NHS England	3	5	15	Standing Financial Instructions [2e] Delegated budgets [1a] Agency recruitment restriction [2e] CIP Process [2e] Monthly statements to budget holders [1a, 1h] Budget holder authorisation [2a] Authorised signatories [2a] Trust Capital Group oversight [2b] Business Case review group [2b]	Trust Board Reporting to NHSE Monthly Finance Reporting Finance position and CIP Update Internal Audit	3	4	12	↓	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Forecast of the Trust Agency spend (signed off by Service Directors) — Associate Director of Finance — Completed — G Forecast of the Trust Bank spend (signed off by Service Directors) — Associate Director of Finance — Completed — G Review of the use of temporary staffing and identify appropriate mitigations and controls — Associate Director of Finance — 31/03/2026 — A Review of Trust Reporting Pack — Associate Director of Finance — 31/03/2026 — A	Chief Finance and Resources Officer	Outside of Tolerance	2	4	8	31/03/2026
	25/06/2024 Risk Opened																		
ID 08175	Jun 2024	Chief Finance and Resources Officer	**Delivery of Underlying Financial Sustainability** IF the Trust fails to maintain financial sustainability THEN this could lead to an inability to deliver core services and health outcomes, and financial deficit, RESULTING IN intervention by NHS England and insufficient cash to fund future capital programmes.	3	4	12	Long term sustainability programme [1g] Cost Improvement Programme [1d]	Monthly external reporting to ICB and NHS England	3	4	12	↔	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Separate workstream for Corporate Savings to monitor delivery to include system stretch requirement — Associate Director of Finance — 31/03/2026 — A Agreed Cost Improvement Plan programme of work with agreed timeframes — Associate Director of Finance — 31/03/2026 — A Review of Trust controls on Non Pay — Associate Director of Finance — 31/03/2026 — A Out of Area Placements - detailed reporting of external beds utilisation and financial risk arising — Associate Director of Finance — 31/03/2026 — A Refresh and review underlying position at service and commissioner level. — Associate Director of Finance — 31/03/2026 — A	Chief Finance and Resources Officer	Outside of Tolerance	3	2	6	31/03/2026
5.2 Exceed the ambitions of the NHS Greener programme																			
			No Risks Identified against this Strategic Objective																
5.3 Transform the way we work																			
			No Risks Identified against this Strategic Objective																
6 - We create environments that benefit our service users and people																			
6.1 - Maximise our use of office spaces and clinical estate																			
			No Risks Identified against this Strategic Objective																
6.2 - Invest in a fit for purpose, safe clinical estate																			
	29/03/2024 Risk Opened																		
ID 08173	Mar 2024	Chief Finance and Resources Officer	**Delivery of a fit for purpose estate** If the Trust is unable to invest in its estate Then the clinical and workplace environments may not be fully fit for purpose Resulting in the loss of services	4	4	16	Identifications of needs of Estates Regular updates to FPC regarding present options Robust design of estates requirements with operational leadership Capital Working Group in place and assesses the requested capital schemes with input from clinical colleagues, giving priority against a range of criteria for consistency. Regular Reviews of clinical environments with Estates and Clinical Teams (Inc. PLACE inspections) Seven facet building surveys (EstateCode - Building Condition assessment)	Trust Capital Group - Estates annual capital works programme Trust Strategy - Estates Strategy Delivery annual report Estates Capital Delivery Resource structure (sub-EFM Org Structure) Annual ERIC backlog data (building functional condition)	3	3	9	↔	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** To complete the Annual ERIC Return — Deputy Director for Estates — Completed — G Tender for 6 Facet Survey — Deputy Director for Estates — 30/03/2026 — A	Chief Finance and Resources Officer	In Tolerance	2	3	6	31/03/2026
	01/04/2020 Risk Opened																		
ID 08146	Aug 2024	Chief Finance and Resources Officer	**Maintenance of a Sustainable Estate** If the Trust is unable to support the maintenance of its estate Then clinical and workplace environments may not be fully fit for purpose Resulting In the loss of operational capacity	3	4	12	Robust contract specification for the delivery of safe, compliant and effective maintenance and upkeep of buildings. Proactive management of Hard FM contract. Robust governance of Hard FM through regular contract meetings and KPI's monitoring. Asset Planned Preventative Maintenance programmes (PPMs) Room availability performance monitored monthly Quality and performance monitoring monthly WSMT, quarterly support services QPR Investment in backlog maintenance prioritised in Operational Capital planning (2e) Services Business Continuity Plans	Reporting to FPC TIAA Audit Contract Monitoring Minutes	3	3	9	↔	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Review of the present hybrid working arrangements — Director of Estates and Facilaities — 31/03/2026 — A	Chief Finance and Resources Officer	In Appetite	2	3	6	31/03/2026

Trust Board meeting

NHS
Kent and Medway
Mental Health
NHS Trust

Meeting details	
Date of meeting:	27th November 2025
Title of paper:	Mental Health Learning Disability and Autism Provider Collaborative (MHLDA) Update
Author:	Julia Hart, Deputy Director Provider 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 Sustainable Community Care Collaborative.

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, learning disability, autism, community and primary care services.

This report includes:

- An update on progress to design and implement Dementia Diagnosis Pathways
- An update on progress to develop joint mental health pathways with social care colleagues
- Feedback from the October 2025 Sustainable Community Care Provider Collaborative Meeting

Issues to bring to the Board's attention

- Training in care homes for dementia diagnosis is progressing well, with 42 staff in 3 care homes trained to date for the Level 1 system model roll out.
- The Sustainable Community Care meeting has held its first formal meeting – well attended and good engagement. Visions for each workstream drafted, clear outcomes now being finalised.

Version control 02 - **Public**

- One of the three priorities agreed with Kent County Council regarding social workers and a future model has commenced. The Lead social workers on wards are demonstrating improvements for patients

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 2025-26

Programme	2025	2026	
	27 Nov	29 Jan	26 Mar
Community Mental Health Framework			
Dementia Diagnosis Pathway			
Urgent and Emergency Care			
Joint working across health and social care			
Frailty, Dementia, EOLC			
Integrated Neighbourhood Health			

2. Programme updates September 2025

2.1 Dementia Diagnosis Pathway

There has been good progress on implementing the Dementia Diagnosis pathway work within care homes for the Level 1 system model. There is now a clinical nurse lead supporting the team with training and clinical expertise. Training has taken place in 3 care homes reaching 42 care home staff. This training is to up-skill care home staff in undertaking pre-assessment work with a standardised approach for referring people for assessment and diagnosis in order to get a speedier diagnosis.

The training includes experiential awareness raising exercises to help colleagues better understand the challenges faced by people with dementia and how this might be impacting on communication and the evaluation feedback shows a significant increase in confidence of recognising dementia from 40% to 95%. This training will be rolled out further and a further 5 sessions are already provisionally booked across 3 care homes. GP training is being put in place to support colleagues aligned to the pilot care homes.

The team has been working with local authorities to link up with care homes. On 9 October 2025, team members attended a Medway Council event to share information about the training and the new pathway. Care home staff were interested and enthusiastic about getting involved and have been linked in with the programme.

The team are now preparing the data analysis required for Phase 2 of the care home roll out. They are ensuring that efforts are targeted at care homes located within primary care networks with the greatest need based on prevalence and the dementia register itself.

We have developed operating protocols for level 1 and will continue to develop level 2 of the Kent & Medway Dementia model.

A baseline review of health inequalities in relation to dementia diagnosis has been undertaken. We are building this understanding into how we implement the programme. We know that dementia disproportionately affects certain groups including Black and Asian Communities, Women, Lower Socio-economic Groups and people with Learning Disabilities. We are working to ensure we can measure the impact for different groups. Examples of what we are doing include:

- ensuring training materials reference health inequalities,
- capturing case studies and voices from disadvantaged groups,
- working with a range of providers and
- incorporating a specific workstream in the level 3 work to ensure the needs of people with learning disabilities and autism are met.

2.2 Joint Working Across Health & Social Care

Joint Pathways

The Trust is working with local authorities and the ICB to improve mental health pathways.

The aim of this work is to support independent living, ensure inpatient beds are available when needed, to use resources more effectively and promote prevention.

The work includes:

Workstream 1 - Overall work to improve pathways
Workstream 2 - A specific initiative to embed social work in early discharge planning and discharges via lead social work posts
Workstream 3 – programme to improve use of resources for prevention by joining up voluntary sector commissioning across organisations

Workstream 1 – Mental Health Pathways

This group ensures programmes stay on track, resolve issues, and measure impact. Members include both councils, the ICB, and the Trust.

Current priorities include agreeing on a trusted assessor framework across partners to improve the effectiveness of lead social workers on wards. Partners in Kent County Council are actively developing this. The group has also reviewed interface meetings to streamline processes and agreed on the following metrics:

- Eliminate patient stays beyond 100 days once clinically ready for discharge (Trust Target)
- Reduce readmissions within 30 days (National Target)
- Increase 'Red to Green' days — i.e. days that add value to an inpatient stay

Workstream 2 - Lead social workers

Two internal social workers were seconded in July 2025 to:

- Embed a holistic approach using social work skills
- Support complex cases to free up local authority teams
- Improve ward engagement in discharge planning
- Reduce the number of patients deemed Clinically Ready for Discharge (CRFD) and the length of time they have to wait for discharge

Their focus is on:

- Starting care needs assessments earlier
- Preventing unnecessary admissions through better social care input
- Reducing readmissions

This work aims to strengthen partnership working, including closer collaboration with local councils on safeguarding

Metrics for lead social workers

Case studies and feedback are being used to improve **qualitative understanding** of the impact of this work.

Quantitative process and outcome metrics are being captured by the lead social workers are below, we expect to see refined data in quarter 3.

Process metrics

- number of patient related meetings attended by the lead social workers
- number of safeguarding champion meeting attended

Outcome metrics

- number of cases where lead social workers have contributed directly to reduction in delayed discharges
- number of patients moved on from the provision at Clarendon (temporary provision to support discharge for people who are ready) directly through lead social worker input

Work stream 3 focuses on mapping mental health prevention spending to work system wide on agreeing on where total resource is best spent (sustainability). A meeting to agree mapping of data and activity was held in October between the ICB, Public Health and the Provider Collaborative to begin this process.

Case study feedback from lead social workers

While IQPR data, since July 2025, is yet to show improvements in CRFD numbers, readmissions and length of stay, completed case studies show patient level impact on care and partnership working.

Below are some examples of lead social work interventions (up to October 2025).

The case studies highlight key patient benefits from lead social worker interventions and the promotion of dignity, independence, and holistic support, bridging clinical and social needs.

Area	Examples
Supporting safe and Timely Discharges	Patient 1 to Clarendon resolving housing delays; Patient 2 with reinstated package of care; Patients 2 and 3 were discharged pending community assessments, rather than waiting in hospital.
Upheld Rights to protect autonomy and prevent unlawful actions.	Patient 4 supported under Deprivation of Liberty Safeguards (DoLS) to manage vulnerability; Patient 5 through a mental capacity assessment (MCA) for rehabilitation; Patient 6 with proper use of holding powers and advocacy for funeral attendance; Patient 7 advancing best interest decisions post-MCA.

Reduced Distress and Improved Emotional Well-Being	Patient 8 empowered with housing steps and family support, avoiding suicidal plans; Patient 9 resolving a mother-son conflict over Clarendon placement, making patient "very happy".
Enhanced Support Networks and Access to Services	Patient 10 with sister housing and Home Treatment Team (HTT) referral; Patient 11 Breathing space referral completed led to maintaining tenancy independence and avoidance of being made homeless and improved knowledge and access to housing and social care network.
Empowerment and Person-Centered Recovery	Patient 12 moving forward with home-based recovery; Patient 13 with assessed capabilities for independent management.
Prevention of Further Harm or Readmission, by addressing root issues, interventions reduce relapse risks	Patient 14 risk of being made homeless and suicide threats, intervention included working with housing and family to provide new temporary accommodation and avoid re admission on to ward. Safe discharge, improved support network, access to correct services, avoided distress. Patient empowered to find solutions to housing issue, and avoid further mental health crisis.

Next steps

- The evidence being collected will help determine whether to extend the lead social worker secondment roles beyond the currently agreed six-month period and support a wider understanding of discharge barriers
- Kent County Council Colleagues are scoping trusted assessor frameworks which will enable faster discharges as long as a place of stay is identified
- Working with both KCC and Medway Council to identify the strategic social worker model required for the system to move forward.

2.3 Update from Sustainable Community Care meeting 20 October 2025

The Sustainable Community Care Collaborative met for the first time as a board on 20 October 2025.

Partners reviewed the vision and objectives for the board and discussed key areas for the board including: -

Progress on the dementia diagnosis pathway work with the implementation of the care home pilot at Level 1. Capturing the voices of those with a dementia diagnosis and their families to enable co-production of the pilot has been integral to success and shaped approach. Membership for the test and learn groups has been refreshed to enable greater stakeholder participation across the system. December Board will focus on stronger alignment between the dementia work and frailty outcomes.

An update on the Better Use of Beds and Short -Term Services programme confirmation that the programme is unlikely to be cash releasing in this financial year but the quality of care to patients is evident. Board members recommended HomeFirst to be commissioned and funded across Kent & Medway, which will support the system as we enter the critical winter period. This will be taken through the Kent & Medway Joint Committee for a decision.

The placements repatriation work carried out for people with autism has evidenced a number of successes, including the repatriation of a patient into the community after 23 years within a mental health facility. The number of autistic patients being placed out of area has reduced. The Integrated Care Board has been asked to look into the support required for long-term patients in the acute setting to be discharged.

Progress on improving care for people with mental health problems in acute sector settings partners shared progress in tracking interventions and spend for this area. While presently there is not a consistent way to collect data across the system, the team are working on standardising methods to address this. MTW have developed a dashboard to capture and analyse enhanced care costs (including mental health). This is supporting improved resource planning and cultural changes. Better data recording has enabled MTW to track Registered Mental Health Nurse usage, reducing costs from £100k to £5k per month The Provider Collaborative team is supporting the Enhanced Care Therapeutic Observations Care Steering Committee to continue to share good practice across trusts. The collaborative board is expecting to receive a further update in June 2026 in order to capture the full year's data.

3. Current performance data

Measure	Agreed trajectory	Current data						Trend
		Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	
Programme: Dementia Pathway Transformation								
Increase dementia diagnosis rate	66.7% by March 2026	60.8%	61.1%	61.4%	62%	62.1%	N/A	↑
Programme: Mental Health Urgent and Emergency Care								
Reduced MH A&E attendance and increase in attendance at safe havens	Reduction	*% MH A&E presentations against total presentations*						↓
		1.64%	1.11%	1.25%	1.29%	1.20%	1.00%	
	Reduction	*A&E attendances for adult patients with primary MH need*						↓
		772	810	901	976	897	799	
	Increase	*Safe Haven attendance*						→
		1525	1623	1572	1526	1758	1751	
Crisis house bed occupancy	85%	*Medway bed occupancy*						↑
		71%	70%	26%	92%	64%	78%	
		Ashford bed occupancy						↑
		64%	74%	81%	89%	85%	95%	
Reduced mental health in ambulance/ police	Reduction	*Primary MH A&E presentation - Ambulance conveyance*						↓
		336	329	380	428	373	N/A	
		Primary MH A&E presentation - Police conveyance						↑
		33	34	51	37	45	N/A	

conveyances to A&E							
Reduction in incidence of Section 136	Reduction	55	57	75	58	74	67

Exception reporting on performance

The number of people with a primary mental health presentation conveyed to A&E by ambulance reduced to 1% of all A&E presentation in September 2025, despite a continuing overall increase in A&E attendance over the last two quarters. September saw 799 primary mental health presentation compared to 976 in July 2025.

- Police conveyance remains low but did see an increase in August.

4. Programme Milestones for 2025-2026

Milestone Tracking Key

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

Community Mental Health Framework			
Milestones	**Q2**	**Q3**	**Q4**
Milestones for CMHF being refreshed as per separate Board report			
Dementia Pathway Transformation			
Milestone	**Q2**	**Q3**	**Q4**
Go live with level 1 pilots (care homes)	X		
Finalise GPwER and GP capacity increase (level 1)	X		
Design MDT model for levels 2 and 3	X		
Review MDT model to inform continuation and scaling opportunities			X
Expand pilot and scale up			X
Continue expansion of pilots and scale across system			X
Finalise reflections on pilots and new model and communicate			X
Mental Health Urgent & Emergency Care			
Milestone	**Q2**	**Q3**	**Q4**
Publication of MH Housing Strategy		X	
Publishing of revised Crisis 136 Standards		X	
Centralised HBPOS Go Live		X	
William Harvey Safe Haven increase to 24-hour service			X
Bespoke Conveyance (to include sit and wait) go-live			X
Procurement of Thanet and Medway Crisis Houses			X
Joint Working Across Health & Social Care			
Milestone	**Q2**	**Q3**	**Q4**
Working group established to deliver on mental health pathways development	X		
Mapping of existing programmes of work and meetings to ensure alignment across KMMH and Local Authorities	X		
KMMH Social Workers commence internal secondment	X		

Obtain and assess contracting data for current services across health and social care, identifying overlaps/gaps	X		
Proposed workshop surrounding prevention across health and social care takes place		X	
Embedding joint working practices and culture of inter-organisational collaboration			X
Evaluation of KMMH Social Worker secondment work takes place			X

We are here

Exception reporting on milestones

Dementia

- Due to complexity of implementing a new dementia diagnosis model, the delivery timeframe for the level 2 element is now expected to take place through Q3 and Q4 instead of full delivery in Q3.

Joint Working Across Health & Social Care

- A mapping exercise is taking place to understand services and commissioning across the system to illustrate gaps and opportunities, this will be completed in quarter 3.

Urgent and Emergency Care

- Recommendations from the consultancy HACT's report and priorities identified by the ICB, Kent and Medway Mental Health Trust and the Provider Collaborative are being taken forward with a number of goals set for early December. Completion of mapping exercise, outline proposal on how to build trust with supported housing providers to take MH discharges, scoping commissioning of Porchlight to provide discharge and community housing support and confirmation on plan for joint Associate Director post for housing.
- Centralised Health Based Place of Safety (HBPOS) will now be delivered in Q1 2026. This has slipped from Q3 2025 due to delays in the build. KMMH Board fully sighted.
- Revision of S136 standards will now be implemented in Q4 2025-26, in line with the changed HBPOS go live date.
- The Ashford co-located Safe Haven will be mobilising during Q4 25/26.
- Margate crisis house opening delayed from Q4 2025 to Q1 2026. The capital investment is from the Pears Foundation. The delay is due to difficulties procuring a suitable building.

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details	
Date of meeting:	27th November 2025
Title of paper:	Trust Partnership Working
Author:	Hannah Roberts, GMTS Trainee & Improvement Practitioner
Executive Director:	Adrian Richardson; Director of Transformation & Partnerships

Purpose of paper

Purpose:	Discussion
Submission to Board:	Board requested

Paper overview

Kent and Medway Mental Health NHS Trust currently lacks a formal partnership framework, creating inconsistency in governance and oversight. This paper proposes a tiered, risk-based model to classify partnerships at System, Place, and Neighbourhood levels, ensuring proportionate governance and alignment with statutory requirements. The approach draws on national guidance and benchmarking with NHS peers to provide a clear, consistent structure for accountability and assurance.

Issues to bring to the Board's attention

- The absence of a structured partnership framework poses a strategic risk, with inconsistent governance and unclear accountability across collaborations.
- National guidance and CQC Well-Led standards make partnership governance a statutory expectation, meaning the Trust must demonstrate compliance.
- The proposed framework introduces a tiered, risk-based model with practical tools (bull's-eye diagram and governance pathway) to ensure proportionate oversight.

Governance	
Implications/Impact:	Implementing the Partnership Framework will strengthen governance, meet statutory requirements, and provide assurance on partnership risks and benefits. It supports integrated care delivery and positions the Trust as a well-led organisation. Failure to adopt the framework could result in continued variation, missed opportunities for collaboration, and potential regulatory scrutiny.
Assurance:	Reasonable
Oversight:	Trust Board/ Future oversight from Partnerships Committee

Background

To date, Kent and Medway Mental Health NHS Trust has not had a structured partnership framework. The development of our Community Mental Health Framework model has highlighted the impact of this gap, with variation and some disconnect in how partnerships are currently managed and governed. This reinforces the need for a formalised framework to bring consistency and clarity to partnership working.

The development of Kent and Medway Mental Health NHS Trust's proposed Partnership Framework has been shaped by national guidance, regional policy, and practical learning from NHS peers across England. The aim is to provide a proportionate, risk-based approach to defining, categorising, and governing partnerships, ensuring consistency, accountability, and measurable impact across the system. The framework is designed to align partnership working with statutory expectations, while providing the Trust with a mechanism for oversight and assurance.

National and Strategic Context

The Health and Care Act (Health and Care Act, 2022) and accompanying NHS England guidance repositioned partnership working as a statutory requirement across the health and care system. Providers are now expected to collaborate across Systems, Places, and Neighbourhoods to improve population health outcomes, reduce inequalities, and support sustainable services. In this context, NHS England's Guidance on Good Governance and Collaboration (NHS England, 2022) and Working Together at Scale: Guidance on Provider Collaboratives (NHS England, 2021) call for NHS organisations to establish clear frameworks that define partnership types, assign accountability, and provide proportionate assurance and evaluation.

Complementary guidance from the CQC Well-Led Framework (CQC, 2023) highlights that effective partnership governance is a hallmark of a well-led organisation, requiring Boards to demonstrate clear oversight of partnership risks, benefits, and impact. The King's Fund (2022–2023) publications - Place-Based Partnerships Explained (Naylor and Charles, 2022), Actions to Support Partnership (Gilburt and Ross, 2023) and Place-based Partnerships Challenges and Opportunities (Ross et al., 2025) - further advocate for tiered governance models that distinguish between strategic, operational, and local collaborations to enable joined-up decision-making across population footprints.

Adopting a 'System, Place, Neighbourhood' model allows the Trust to differentiate between partnerships that influence system-wide strategy, those focused on local coordination and delivery, and those operating at service or community level. It provides a scalable and flexible framework where oversight and accountability increase in proportion to strategic impact and risk, ensuring that governance effort is targeted where it adds most value.

Evidence and Benchmarking

To ensure that the Kent and Medway Mental Health NHS Trust approach aligns with best practice benchmarking and engagement were undertaken with peer organisations. Key learning was drawn from the Nottingham University Hospitals

(NUH) Partnership Strategy (Nottingham University Hospitals NHS Trust, 2023), the Royal Wolverhampton and Walsall Framework (Royal Wolverhampton NHS Trust, 2023), and partnership policies from organisations including Yorkshire Ambulance Service, The Christie NHS Foundation Trust, Mersey and West Lancashire Teaching Hospitals, University Hospitals of Northamptonshire, and Kent and Medway ICB.

From NUH, a three-tier model emerged as the most effective way to bring consistency, proportionality, and clarity to partnership oversight. This approach recognises that partnerships operate at different levels of strategic influence, scale, and complexity, and that governance must therefore be calibrated accordingly. The Royal Wolverhampton model reinforced the use of risk-weighted matrices - including financial and strategic impact assessments - to determine governance tiering and assurance requirements.

Together, these insights show that an effective framework should do more than define what partnerships are about - it should also set out clear governance arrangements, making sure operational delivery, strategic goals, and corporate accountability stay aligned.

Framework Structure and Governance

Overview

The proposed Partnership Framework offers a clear and proportionate approach to classifying and governing partnerships. It would ensure that oversight, accountability, and assurance are applied consistently and scaled according to strategic influence, financial exposure, and risk.

At the centre of the Partnership Framework is the bull’s-eye diagram, which shows how the Trust’s partnerships would be organised and prioritised. The model uses a tiered structure, placing System, Place, and Neighbourhood partnerships in rings., with the innermost tier representing ‘system’ partnerships with the greatest strategic importance. The middle and outer layers cover ‘place’ and ‘neighbourhood’ partnerships focused on local delivery and community collaboration.

This bull’s-eye diagram makes demonstrates how all partnerships would form part of one connected system, with governance and assurance increasing in line with risk, influence, and strategic impact. It also reinforces the principle that decisions and accountability sit at the lowest effective level, while providing a clear route for escalation when partnerships carry significant strategic or financial implications.

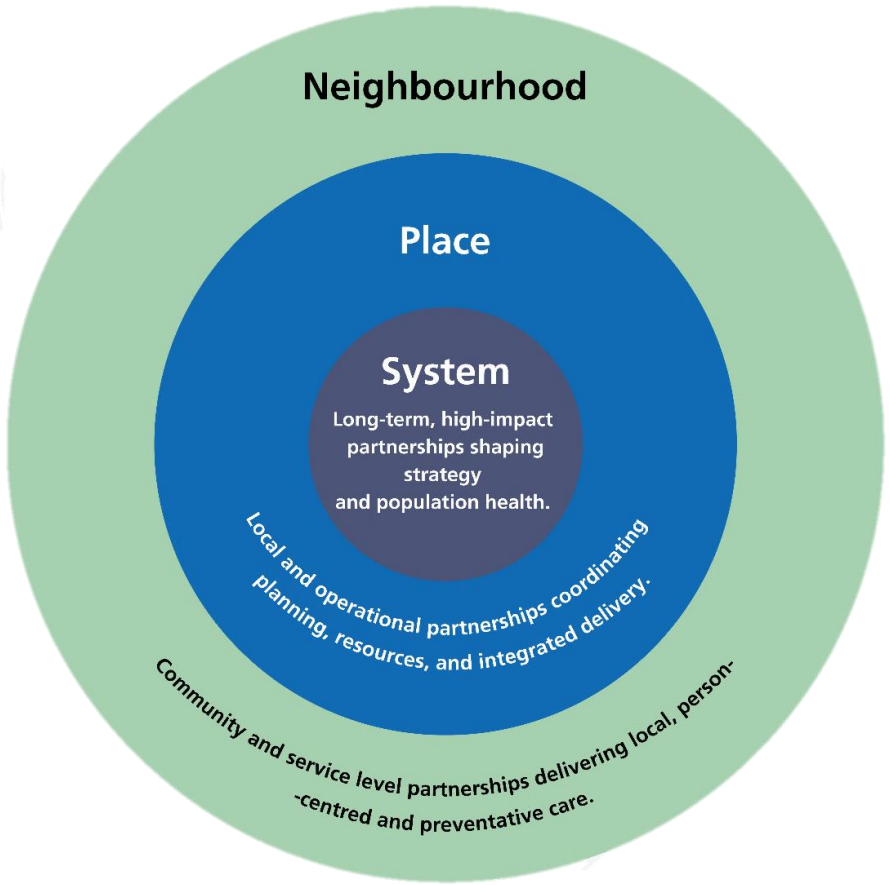


Figure 1. Core partnership bull's-eye diagram

The Partnership Governance Pathway Flowchart (Appendix 1) supports this process by determining whether a partnership requires high, medium, or low levels of governance within the System, Place, and Neighbourhood tiers. This assessment is being developed based on weighted criteria, including strategic alignment, level of exposure, and financial risk.

Governance Framework

The accompanying System, Place, and Neighbourhood tables set out how each tier would be governed, who holds accountability, how risks would be managed, and how outcomes are evaluated. They provide a consistent structure for oversight and would ensure that partnerships of varying scale and complexity receive governance that is proportionate to their strategic or operational significance.

The following pages outline the proposed governance for each level of partnership.

System-Level Governance

System partnerships represent the highest tier of collaboration.

Tier & Level	Governance Lead	Accountable Lead	Reporting Structure	Risk Management	Financial Assurance	Evaluation
System – High	EMT	Executive Lead	Impact report and updates to EMT, including escalations from Partnerships Committee. Board kept sighted when relevant to BAF.	Board Assurance Framework	Open-book finance and EMT level reporting	Assurance reviews, impact reports, feedback and learning to EMT.
System – Medium	Partnerships Committee	Project / Partnership Lead in Partnerships Committee	Highlight reports to Partnerships Committee including escalations from directorate Management	Partnerships Risk Register	Monitored via finance meetings and reported to Partnerships Committee	Evaluation Framework to Partnerships Committee
System – Low	Directorate Management	Service / Project Lead & Partnerships Manager	Progress updates to directorate management	Partnerships Risk Register	Monitored via finance meetings and reported to Partnerships Committee	Self-evaluation with feedback to partnerships committee.

Figure 2. System-level governance assurance table

High-level partnerships are suggested to be overseen directly by the Executive Management Team to ensure alignment with strategic objectives and maintain visibility of any shared financial or reputational risk. Medium and low-level partnerships proposed to be managed through the Partnerships Committee or directorate-level structures, allowing proportional oversight without duplicating reporting. Even low-risk system partnerships would retain a degree of financial monitoring to maintain transparency and compliance with NHS England's guidance on good governance and collaboration (NHS England, 2022).

Place-Level Governance

Place partnerships sit between system-wide strategy and local delivery, bringing together organisations within a defined geography to plan and coordinate integrated care across that area.

Tier & Level	Governance Lead	Accountable Lead	Reporting Structure	Risk Management	Financial Assurance	Evaluation
Place – High	EMT	Executive Lead	Impact report and updates to EMT, including escalations from Partnerships Committee. Board kept sighted when relevant to BAF.	Trust Risk Register	Open-book finance and EMT level reporting	Assurance reviews, impact reports, feedback and learning to EMT.
Place – Medium	Partnerships Committee	Project / Partnership Lead in Partnerships Committee	Highlight reports to Partnerships Committee including escalations from directorate Management	Partnerships Risk Register	Monitored via finance meetings and reported to Partnerships Committee	Evaluation Framework to Partnerships Committee
Place – Low	Directorate Management	Service / Project Lead	Progress updates to directorate management	Local Risk Register	Budget tracking, reported to directorate management.	Self-evaluation with feedback to partnerships manager

Figure 3. Place-level governance assurance table

While the suggested governance approach at this tier is similar to that for system-level partnerships, it is not predisposed to the highest levels of oversight. This is because place-based partnerships cover a specific area (albeit large) rather than the whole system. As a result, governance is scaled to reflect their more localised scope and risk profile, ensuring proportional oversight without unnecessary escalation.

Neighbourhood-Level Governance

Neighbourhood partnerships represent the most local tier of collaboration, focusing on smaller, community-based areas where care is delivered closest to people's everyday lives.

Tier & Level	Governance Lead	Accountable Lead	Reporting Structure	Risk Management	Financial Assurance	Evaluation
Neighbourhood – High	EMT	Executive Lead	Impact report and updates to EMT, including escalations from Partnerships Committee. Board kept sighted when relevant to BAF.	Partnerships Risk Register	Open-book finance and EMT level reporting	Assurance reviews, impact reports, feedback and learning to EMT.
Neighbourhood – Medium	Partnerships Committee	Project / Partnership Lead in Partnerships Committee	Highlight reports to Partnerships Committee including escalations from directorate management	Local Risk Register	Monitored via finance meetings and reported to Partnerships Committee	Evaluation Framework to Partnerships Committee
Neighbourhood – Low	Directorate Management	Service / Project Lead	Progress updates to directorate management	Local Risk Register	Budget tracking, reported to directorate management.	Self-evaluation with feedback to partnerships manager

Figure 4. Neighbourhood-level governance assurance table

Neighbourhood partnerships focus on the most localised areas, smaller and more community-based than Place partnerships. Because they operate at this scale, governance is proposed to be deliberately lighter and more flexible, while still connected to the wider assurance framework. This ensures that local initiatives can remain agile and responsive without unnecessary bureaucracy, while any partnership that grows in scope or risk can be escalated for stronger oversight when needed.

Application and Current Partnerships

The following examples illustrate how partnerships would be assessed using the Partnership Governance Pathway flowchart and risk-weighted matrices, showing the level of governance each would receive based on strategic significance, financial exposure, and risk profile. Please note that the table is for illustrative purposes only and does not represent actual partnerships; it is intended solely to demonstrate the format and structure of partnership data.

Partnership	Tier	Importance Matrix Score	Risk Matrix Score	Governance assurance level
Example 1	System (+15)	25	20	System High
Example 2	System (+15)	25	15	System High
Example 3	Place (+10)	20	15	Place High

Integrated Assurance and Escalation

Together, the flowchart and governance tables create a single, proportionate framework that would enable the Trust to classify partnerships consistently, apply appropriate levels of oversight, and maintain transparency from local neighbourhood initiatives through to system-level strategy. Partnerships could move between governance levels as their scope, financial exposure, or risk profile evolves, ensuring the model remains dynamic and responsive. This proposed framework ensures partnership governance remains consistent, proportionate, and adaptable, supporting collaboration and innovation across all levels of the system.

Proposed next steps

The following actions are suggested as the next steps in the development of the proposed Partnership Framework:

Action	Due
Paper presented to board on current partnerships, mapped to proposed format.	Jan 2026
Confirm alignment and agreement on the weighting matrices by engaging with the relevant committees	Feb 2026
Confirm alignment and agreement on the proposed levels of governance and assurance through discussion at relevant committees.	Feb 2026
Partnerships Committee to be established.	Feb 2026

The proposed Partnership Framework offers a structured, risk-based approach to governing collaborations across System, Place, and Neighbourhood levels, ensuring consistency, accountability, and alignment with statutory requirements. By adopting a tiered governance model informed by national guidance and best practice benchmarking, it can help the Trust further strengthen oversight, mitigate risks, and enable proportionate assurance while supporting innovation and integrated care. This framework would provide a clear mechanism for escalation and adaptability, positioning the Trust to deliver coordinated, sustainable services and improved population health outcomes.

This work is also critical to delivering the ambitions of the NHS 10 Year Plan and supporting new ways of working across NHS organisations. Establishing a clear, risk-based partnership framework will enable the Trust to collaborate effectively, drive innovation, and meet expectations for joined-up care over the next decade.

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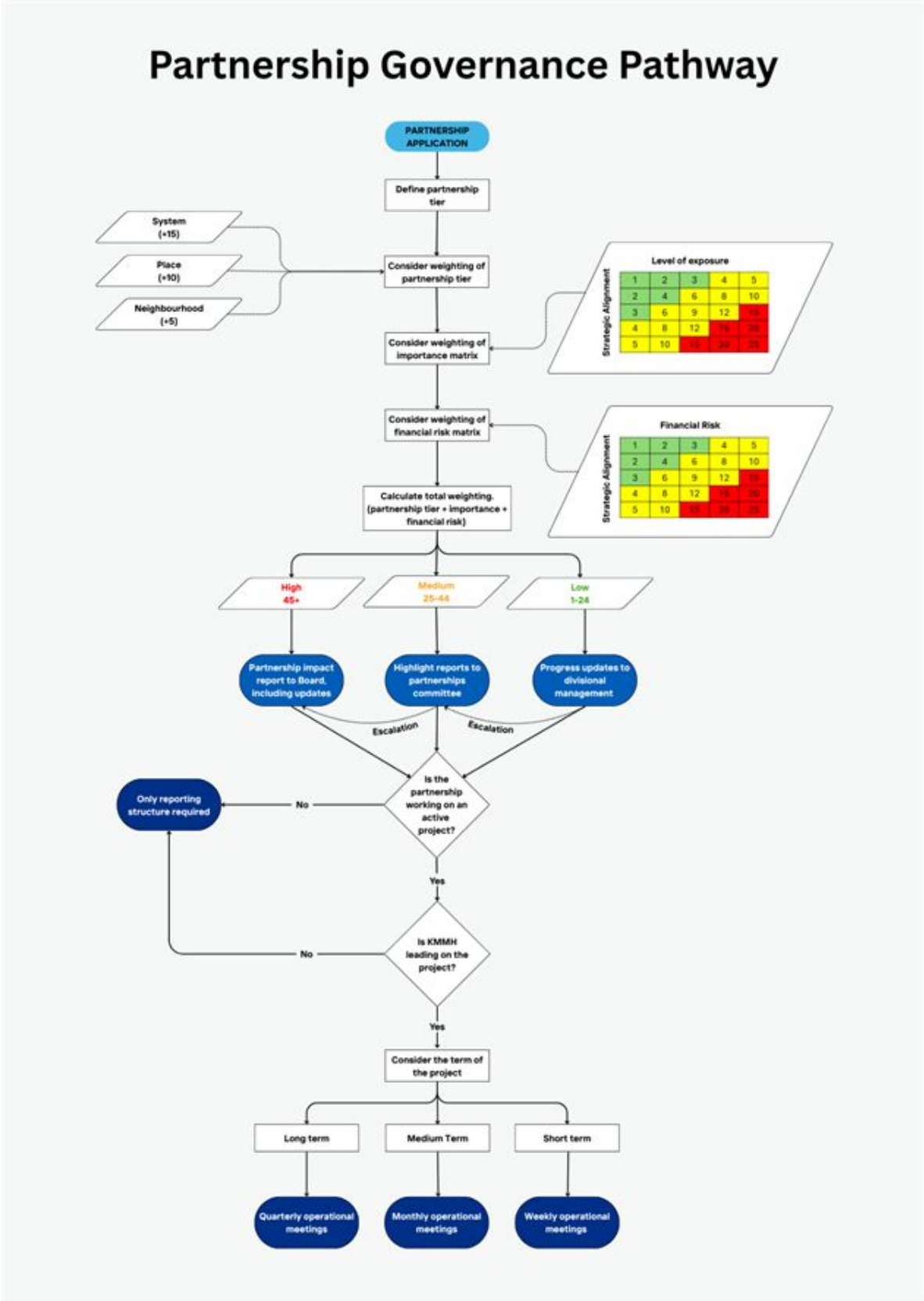
Appendix 1 – Partnership Governance Pathway Flowchart



Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details	
Date of meeting:	27th November 2025
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

A paper setting out the Trust's performance aligned the targets and metrics from the trusts Doing Well Together Programme.

The report focuses on the True North and Breakthrough Objectives in order to deliver the key strategic aims.

Issues to bring to the Board's attention

The Trust has moved to segment one in the new NHS oversight framework which reviews trusts performance looking at a wide set of measures, including patient experience, clinical outcomes and financial sustainability. We are in the highest segment (segment 1), and are ranked 9th out of 61, across all the non-acute trusts in England

The IQPR provides an overview of trust services across numerous indicators, this represents one element of the trusts Performance Management Framework and is supported by monthly Executive led Directorate Quality Performance Review meetings.

Version control 02 - **Public**

The Chief Executives Overview at the start of the report highlights the key areas of focus: patient flow and bed state along with dementia services and mental health together waiting times. Key areas of improvement in recent months are also noted.

The reporting against each domain additionally includes a focus on the relevant Breakthrough Objective.

Governance

Implications/Impact:	Regulatory oversight by CQC and NHSE/I
Assurance:	Reasonable
Oversight:	Oversight by Trust Board and all Committees

NHS
Kent and Medway
Mental Health
NHS Trust

Integrated Quality & Performance Report

(IQPR)

November 2025

Contents

1. Chief Executive Overview

This report highlights the trust performance for October, focussing on where performance is improving, areas of concern and what actions we are taking to address these. This month I continue to focus my overview on our inpatient beds, the work we are undertaking in our community mental health teams (MHT), dementia, Urgent Crisis Line (111) and a number of areas we are making positive progress.

Patient flow / Bed state

Management of our beds remains a key priority for us. Bed occupancy across our acute beds was the highest since February at 97.7% for October. Our Length of Stay (LOS) for Clinically Ready for Discharge (CRFD) patients was 92.9 days in October, a position that is significantly higher than this time 12 months ago and since 2023 we have seen an increase in weekly CRFD by 46%.

There are currently a number of workstreams being implemented across the organisation and these are monitored through a programme oversight group which this month is being refreshed to allow for even more senior oversight.

Key actions and improvements:

- Despite the high levels of CRFD we have seen a reduction in CRFD (all beds) since the beginning of 2025/26.
- We have provided Step Down Bed provision in Clarendon House that for 18 patients allowing for 6 out of area patients to be repatriated from when the initiative began in the summer. This has resulted in the use of over 1,000 bed days to date. The average length of stay for those patients is 48 days.
- Reduced our CRFD cohort of patients to 60 in acute beds as at November 11th, lower than a high of 70 in January.
- The role out of standardised work on the wards is underway, led by the Clinical Director. This included establishing standard working practice across all wards to eliminate variation in practice, setting of clinically informed estimated discharge dates within 72 hours of admission and ensuring the Red to Green process is rigorously followed. This will allow us to have a consistent offer of care across our in-patient wards and will identify likely delays to discharge earlier.
- Our purposeful admission process is establishing an updated gatekeeping process.
- We are in the process of creating our patient expectation policy setting out expectations for our patients on their discharge process.
- Our work on the Urgent Emergency Care Coordination Centre continues with an approved model and we are now working on the workforce processes needed to establish the centre.

- We are collaborating closely with KCC and the ICB to address delays in discharging clinically ready patients, focusing on joint thematic reviews, developing step-down bed models, and implementing a trusted assessor framework. Working together on discharge planning standards, data sharing, and commissioning responsibilities, with regular joint meetings and shared project support to ensure alignment and avoid duplication

We recognise the need to continue to achieve a reduction in those people waiting over 12 hours in an emergency department for admission to an acute bed. In October 1.6% of those identified as needing a bed where discharged from liaison teams within 12 hours. Work continues to understand the causes behind the variation across the Liaison Services with East Kent having the most impact on the overall percentage, largely driven by the volume of admissions for this area. A clinical audit is being undertaken to understand the nature of presentations for patients open to our services. Once the audit has been completed and findings understood we will agree the impact any actions needed have on our flow priority.

Community Mental Health, Mental Health Together (MHT)

Progress is being made within the Community Mental Health Programme. The refinement of the model is near completion with good engagement from staff, our patients and partners. The key next step will be communicating this to the organisation and partners in a clear way, involving and taking stakeholders with us on this next crucial stage of our journey.

I am pleased to report that for Mental Health Together we have seen a reduction in wait times. The MHT waiting list has reduced from 6,949 at the end of March to 6,249 (November 11th), which is a 10.1% reduction. This has been achieved through:

- An increase in the lower level clinical interventions offered, such as group interventions for people with a low intensity level of need
- A weekly sustainability meeting is in place to monitor progress and ensure activity is maximised and job plans are followed
- Ensuring appointments are correctly outcomed

Of the 6,249 waiting (as at 11th November) 80.5% are waiting under 18 weeks and 32.3% are within 4 weeks. The waiting list reflects all those open to MHT awaiting the commencement of an intervention. A significant proportion (65.4%) of those waiting have been seen at least once, the majority of these patients have been assessed, have had an outcome score recorded and are now awaiting the commencement of an intervention. The 34.6% yet to be seen are new referrals with over 70% of these patients waiting under 4 weeks to date. Referral rates to MHT remain high with 44,000 received by MHT in the last 12 months

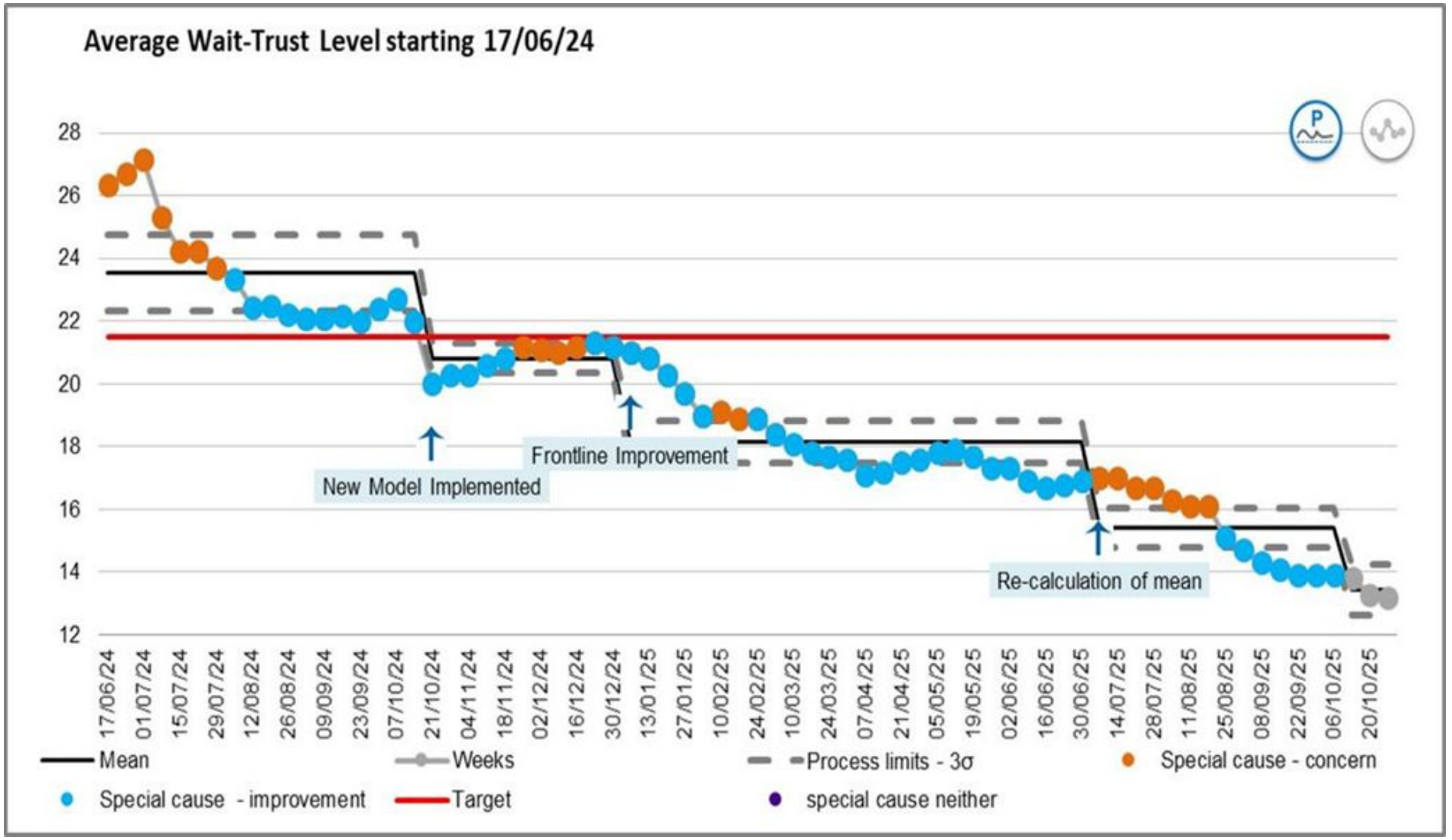
(3.7k/month). Despite this volume of referrals approximately 600-700 patients each month receive their first intervention. The refinement of the clinical model, adjusts processes within the pathways and reduces duplication with the overall aim of increasing capacity and improving the experience for our patients.

Our focus in the next month is to eliminate those waiting over 52 weeks which is reported as 78 patients (1.2% of total list) as at 11th November. However, all of these patients have been seen in MHT and are awaiting the recording of an intervention and/or commencement of an intervention. All patients reported as waiting over 52 weeks are reviewed weekly to ensure plans are in place.

Dementia

We continue to make significant progress in the last 6 months. This is set out below:

- We have seen an improvement from 8.8% in May 2024 to consistent performance of over 20% since November 2024. This is above both the national performance (16.6% for May 2025) and south-east England performance of 3.4%.
- Increased the dementia diagnosis rate to the highest it has been in Kent & Medway to 62.1% (Sept 25), moving towards the national ambition of 66.7%
- An average of 384 diagnosis have been recorded each month in 2025/26 to date, an increase from 352 on average for the second half of 24/25.
- We have focussed on reducing long waits, with patients waiting over 52 weeks for a diagnosis reducing by 80.8% from 260 in February to 38 as at November 11th (1.6% of the total waiting list). Work is continuing to eliminate non-clinically necessary waits over 52 weeks in the coming weeks by utilising team's capacity to ensure this is complete in the coming weeks.
- Average time waited for diagnosis to be completed was 121 days in October, below the national average wait reported in the national dementia audit (2023) of 151 days.
- The average time waiting to date of those remaining on the waiting list has reduced significantly (-53%) in the last 16 months, from 190 days in July 2024 to 90 days as at November 2025.


Average Wait-Trust Level starting 17/06/24
28
26
24
22
20
18
16
14
12
New Model Implemented
Frontline Improvement
Re-calculation of mean
17/06/24
01/07/24
15/07/24
29/07/24
12/08/24
26/08/24
09/09/24
23/09/24
07/10/24
21/10/24
04/11/24
18/11/24
02/12/24
16/12/24
30/12/24
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24/03/25
07/04/25
21/04/25
05/05/25
19/05/25
02/06/25
16/06/25
30/06/25
14/07/25
28/07/25
11/08/25
25/08/25
08/09/25
22/09/25
06/10/25
20/10/25
Mean
Weeks
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target
special cause neither

6

Open Access Crisis Line: Abandonment Rate (%)

A review of abandoned calls has been undertaken in the Crisis Line. Key findings include, frequent callers taking an average of 15-20 minutes per call with over 70% of callers being open to community services. This needs to be an area of focus for us moving forward to understand why such a high volume of patients already known to our services are feeling the need to use our urgent crisis line.

Further areas I'd like to note;

- 87% of those with a suspected first episode of psychosis began treatment with a NICE recommended care package within two weeks of referral, the sixth successive month exceeding the 60% target.
- Workforce metrics for vacancies, training and turnover continue to show sustained improvements and attainment of the targets set.
- We identified a disproportionate involvement of Global Majority colleagues in formal conduct cases and implemented an early resolution approach. This has significantly reduced the likelihood of Global Majority colleagues entering a formal process—from 2.57% previously to 0.08% last month, with a year-to-date average of 0.34%.
- There is further work for us to do regarding our patients awaiting a bed who are in an emergency department – this links to our current bed state and we need to develop a sustainable response to managing demand

2. Trust Wide Integrated Quality and Performance Dashboard

Patients we care for: *We provide equitable, timely access for all*

Executive Sponsor: Adrian Richardson, Director of Transformation & Partnership

True North

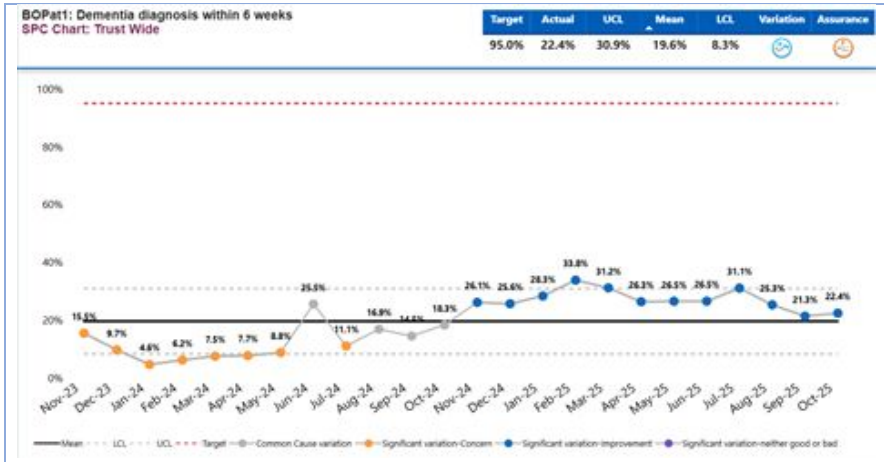
Measure Name	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
TNPat1: Timely access: Community (CMHF/MAS) patients needs are met within timeframes	85.0%	18.7%	19.9%	15.5%	16.2%	17.5%	13.9%	12.7%	15.5%	16.5%	17.3%	13.3%	16.3%
TNPat2: Equitable access: <1% variance in waiting time (MHT/MAS) between most deprived and least deprived.	1.0%								(3.5%)			(9.2%)	

**TNPat2: Variation shown in brackets reflects waiting times being less compliant in the least deprived, variation not shown in brackets demonstrates waiting times being less compliant in the most deprived. Measure compares performance between indices of deprivation 1 (most deprived) to level 5 (least deprived), wider variation may exist between other categories of deprivation.*

Breakthrough Objectives

Measure Name	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
BOPat1: Dementia diagnosis within 6 weeks	95.0%	26.1%	25.6%	28.3%	33.8%	31.2%	26.3%	26.5%	26.5%	31.1%	25.3%	21.3%	22.4%
BOPat2: Community (CMHF/MAS) referrals have ethnicity recorded	90.0%	84.8%	84.5%	84.2%	84.1%	84.0%	83.8%	83.9%	84.0%	83.9%	84.0%	83.6%	83.6%

Focus on Breakthrough Objectives



Data Source	RiO	Data Quality Confidence	

A confirmed diagnosis is not always recorded correctly on Rio, even though the diagnosis may have been confirmed with the patient and the GP via a letter.

What is being measured?

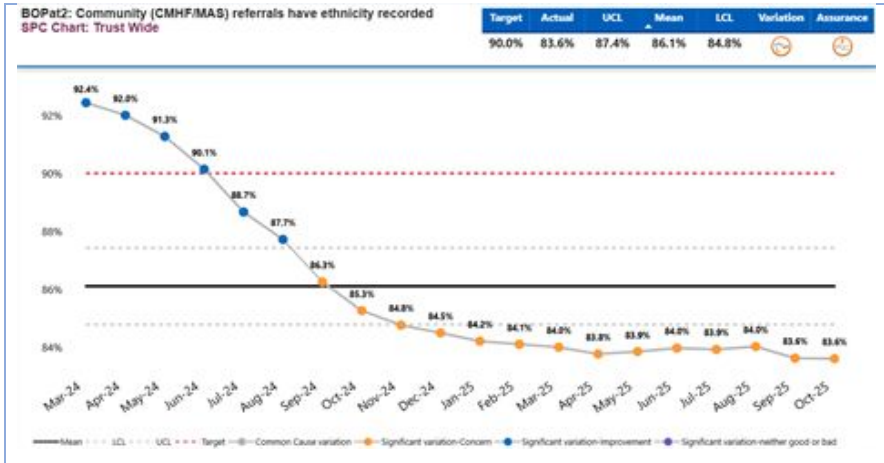
Time between a referral into the Memory Assessment Service and a confirmed diagnosis.

What is the data telling us and key actions in place

The SPC chart shows that the Trust is consistently failing the 95% target for compliance with the mean for compliance since July 2023 being 19.6%. However, the last thirteen months' compliance has been above the mean triggering an SPC rule that signifies special cause variation of improved performance.

Since February there has been a focus on eliminating non-clinically necessary waits of over 52 weeks. This has seen a reduction in patients waiting over 52 weeks from 260 to 38 (11th November). Work continues to eliminate these non-clinically necessary waits

The improvement noted here is also reflected in the Kent and Medway system dementia diagnosis rate (DDR) which has increased from 59.1% in January 2024 to 61.1% in May 2025.



Data Source	RiO	Data Quality Confidence	

What is being measured?

Referrals for MHT, MHT+ and MAS that were open at month end or ended during the month, of which there is a valid recording of ethnicity on RiO. Excluded invalid codes: *Not stated, Information not yet obtained / Not requested, Not known & Client refused*

What is the data telling us and key actions in place

The SPC chart shows the Trust is consistently failing the 90% target for completeness and there is been special cause variation of a concerning nature with the last 11 months' performance falling below the mean of 87.8%.

A reduction is observed since MHT go live, likely due to increased referral numbers and instances of patients discharged following assessment not resulting in ethnicity being recorded.

Watch Metrics

Measure Name	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
1.1.01: Open Access Crisis Line: Calls received		3,195	3,287	3,373	2,920	3,362	3,229	3,110	3,266	3,383	3,047	2,976	3,227
1.1.02: Open Access Crisis Line: Abandonment Rate (%)		20.4%	22.1%	26.8%	30.9%	33.6%	31.5%	34.3%	36.9%	37.1%	38.9%	40.2%	28.3%
1.1.03: Assess people in crisis within 4 hours		92.5%	90.7%	90.9%	89.5%	86.9%	94.9%	94.7%	86.9%	93.7%	91.4%	93.6%	91.0%
1.1.04: People presenting to Liaison Services: triaged within 1 hour		88.3%	87.6%	90.6%	83.4%	88.0%	88.6%	90.7%	92.3%	92.1%	89.4%	90.8%	90.8%
1.1.05a: Liaison Psychiatry referrals closed within 12 hours	95.0%	27.7%	39.2%	53.0%	61.9%	78.1%	80.4%	80.0%	81.6%	84.6%	82.1%	81.8%	83.0%
1.1.05b: Liaison Psychiatry referrals closed identified as requiring a bed within 12 hours	95.0%	0.0%	6.3%	6.1%	3.3%	5.4%	6.8%	6.7%	2.0%	5.7%	8.8%	6.1%	1.6%
1.1.06: Place of Safety Length of Detention: % under 24 hours		60.0%	77.1%	76.2%	76.6%	77.6%	75.0%	75.0%	79.0%	80.0%	78.7%	86.9%	84.7%
1.1.07: People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral	60.0%	85.0%	66.7%	58.3%	75.0%	61.5%	52.6%	69.6%	72.2%	70.0%	85.7%	92.3%	87.0%
1.1.09: % MHLD referrals commencing treatment in 18 weeks		83.3%	87.1%	85.4%	94.1%	92.1%	88.6%	100.0%	81.3%	92.9%	84.8%	83.8%	83.7%
1.1.10: Perinatal assessments (against annual target)	2,000	166	146	193	136	158	514	216	182	183	163	177	178
1.2.09: Dialog assessment completed in Community Service (MHT/MHT+/EIS/Com.Rehab/Inpt.Rehab)		1,543	1,389	1,563	1,371	1,819	2,035	2,205	2,053	2,281	1,861	2,231	2,294
1.3.01: Mental Health Scores From Friends And Family Test – % Positive	86.0%	87.3%	89.4%	88.1%	88.7%	87.9%	87.7%	88.7%	91.2%	90.8%	88.4%	88.8%	87.4%
1.3.02: Complaints - actuals		37	32	51	44	60	45	61	58	51	53	66	44
1.3.03: Compliments - actuals		130	151	147	122	122	131	122	159	174	118	139	152
1.3.04: Compliments - per 10,000 contacts		37.2	48.9	40.7	37.5	34.5	35.5	32.8	41.0	40.8	31.8	34.5	35.9
1.3.05: Patient Reported Experience Measures (PREM): Response count		510	594	540	529	563	513	626	605	577	424	456	507
1.3.06: Patient Reported Experience Measure (PREM): Response rate		3.3	4.1	3.7	3.6	3.6	3.2	3.7	3.5	3.2	2.6	3.1	2.8
1.3.07: Patient Reported Experience Measure (PREM): Achieving Regularly %		8.2	8.3	8.5	8.6	8.5	8.5	8.5	8.4	8.4	8.5	8.4	8.1
1.3.08: Complaints acknowledged within 3 days (or agreed timeframe)	100%	97%	95%	100%	98%	97%	96%	94%	93%	93%	95%	89%	84%
1.3.09: Complaints responded to within 30 days (or agreed timeframe)	100%	66%	87%	92%	82%	81%	89%	76%	81%	86%	80%	83%	89%
1.4.05: Decrease violence and aggression on our wards	(7.5%)	9.0%	(1.3%)	14.8%	28.3%	12.2%	34.1%	23.8%	23.8%	21.9%	0.6%	30.3%	50.2%
1.4.06: Medication errors		54	46	50	39	54	46	62	50	54	45	55	52
2.1.01: Referrals to MHT commence treatment within 4 weeks		11.0%	10.7%	4.0%	4.6%	9.0%	5.5%	4.2%	8.2%	7.6%	11.5%	8.5%	12.4%
2.1.02: MHT waiting list size		5,704	6,007	5,995	6,243	6,573	6,186	5,687	5,472	5,590	5,468	5,772	5,992
2.1.03: MHT 2+ contacts		17,246	17,866	18,507	19,137	18,987	19,797	20,600	21,641	22,623	23,316	24,150	24,913

Note: 1.1.10 Perinatal Access – Target is for annual position, national methodology results in a significantly larger figure reported in April compared to other months.

People who work for us: *We support & empower our staff*

Executive Sponsor: Sandra Goatley, Chief People Officer

True North

Measure Name	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
TNPeo1: Staff Engagement score from 6.8 to 7.3 by 2030	7.1					6.8							

**Data reported annually in line with national staff survey*

Breakthrough Objectives

Measure Name	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
BOPeo1: Staff feel able to make improvements in their workplace	60.3%					58.5%	54.8%			58.7%			

**March data reflects annual staff survey results. All other results are taken from the pulse survey which is administered during Quarters 1,2 and 4 each year. There may be variation in the results between the two sources due to differences in survey format and response rate.)*

Focus on Breakthrough Objectives

BOPeo1: Staff feel able to make improvements in their workplace

Insufficient data points to analyse by SPC

Data Source National staff survey & Pulse survey **Data Quality Confidence**

March data reflects annual staff survey results. All other results are taken from the pulse survey which is administered during Quarters 1,2 and 4 each year. There may be variation in the results between the two sources due to differences in survey format and response rate.)

What is being measured?

% positive response to the question: I am able to make improvements happen in my area of work

What is the data telling us and key actions in place

Variation exists across directorates with targets set accordingly as shown below:

Directorate	Target	Mar-25	Apr-25	Jul-25
Acute	58.8%	61.6%	57.1%	64.7%
East Kent	44.6%	36.4%	43.3%	29.3%
Forensic and Specialist	68.7%	65.1%	66.7%	64.8%
North Kent	51.5%	55.4%	50.0%	60.0%
West Kent	54.9%	50.2%	53.3%	69.4%
Support Services	79.0%	70.5%	77.2%	71.9%

July 2025 data reflects the latest pulse survey for which the sample size was 478.

We are currently coming to the end of the annual employee engagement survey, currently the Trust has a response rate of 45.42% with 3 weeks to go until the Survey closes, weekly engagement is being sent to all managers including completion rates by directorate and top and bottom performing areas.

The two programmes of work expected to drive improvements in these results relate to the roll out of the Staff Council, and the delivery of the Doing Well Together programme.

The Staff Council has been piloted in Forensic and Specialist services and is anticipated to be rolled out across the organisation early 2026, with new councils being in place in all directorates by spring 2026.
Leadership Behaviours – improvement leadership behaviours have been incorporated in the trust leadership programme – Leading Well Together. Behaviours were assessed to gain a personal benchmark through the creation of a new 360 tool, this will be repeated in Spring 2026. The programme commenced in April 2025 and will end in April 2026. There are 4 modules Leads Self, Leads Team, Leads Organisation and Leads System. Leads Self Module is completed and Leads Team will be completed by mid November 2025. Leads Organisation starts in December 2025.
The second Innovation Den has also just closed for bid submission, and capability building is taking place with directorates and local teams.
Health and Wellbeing - Clinical psychology in-house mental health 1:1 and group support offer available for staff to access to support mental health and wellbeing and reduce sickness absence.

Engagement underway to consult staff on health and wellbeing strategic plans as current strategy nears the end of it's 3-year period.

Watch Metrics

Measure Name	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
3.1.01: Staff Sickness - Overall	3.5%	4.6%	5.1%	5.2%	5.0%	4.6%	4.3%	4.3%	4.1%	5.0%	5.2%	4.9%	4.9%
3.1.02: Vacancy Gap - Overall	14.0%	11.0%	11.1%	10.8%	10.7%	9.8%	10.0%	10.1%	10.3%	10.2%	10.3%	10.2%	10.2%
3.1.03: Mandatory Training For Role	90.0%	94.7%	95.1%	95.0%	95.2%	95.5%	95.4%	95.4%	94.8%	95.4%	95.6%	94.8%	95.4%
3.1.04: Leaver Rate	15.0%	13.4%	13.3%	13.4%	13.4%	12.5%	12.8%	12.6%	12.6%	11.9%	11.9%	11.4%	11.2%
3.1.05: Leaver Rate (Voluntary)	14.0%	9.3%	9.3%	9.3%	9.3%	9.1%	9.2%	8.9%	9.0%	8.2%	8.1%	7.8%	7.7%
3.1.06: Safer staffing fill rates	80.0%	116.1%	108.7%	109.6%	110.1%	108.8%	110.7%	112.1%	109.6%	110.2%	109.2%	110.3%	109.0%
3.1.07: Increase percentage of BAME staff in roles at band 7 and above	20.0%	27.0%	27.1%	28.1%	28.4%	28.5%	28.5%	27.0%	27.5%	29.8%	30.6%	30.9%	30.9%
3.1.08: The number of minority ethnic staff involved in conduct and capability cases: variation against the numbers of white staff affected.	0.50%	0.27%	0.18%	0.35%	0.21%	0.21%	0.05%	0.17%	0.32%	0.44%	0.39%	0.23%	0.12%

Sickness absence is still above target. Our policy is currently under review and progressing through internal governance. Additionally, we are piloting initiatives to support colleagues who are on long term sick, returning to work after stress, anxiety, or depression, providing proactive assistance during change programmes, and offering individual support following workplace incidents such as violence or aggression.

Safer Staffing fill rates: Lower fill rates typically occur in services where there is high acuity – so less appealing for temporary staff to work within or where there is sickness in a more isolated unit such as the Inpatient Rehabilitation services or Thanet Mental Health Unit. This is considered to be caused by their geographical position meaning filling shifts at short notice is harder.

In October, we saw Cherrywood struggle to cover all their RN day shifts – circa 66%. This happened at a time of higher levels of patient dependency and associated violence and aggression. The other wards that struggled with day shift cover were Woodchurch and Sevenscore at TMHU, circa 77% and the Grove rehab unit at 65%. All shifts were covered by moving resource from other services.

Partners we work with: *We create healthier communities, together*

Executive Sponsor: Dr Afifa Qazi, Chief Medical Officer

True North

Measure Name	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
TNPar1: Reduce clinically ready for discharge (CRfD) length of stay (LoS) by 25% by 2030	68.3	44.9	62.6	60.0	111.8	67.2	94.5	86.9	69.6	46.3	82.2	81.9	92.9

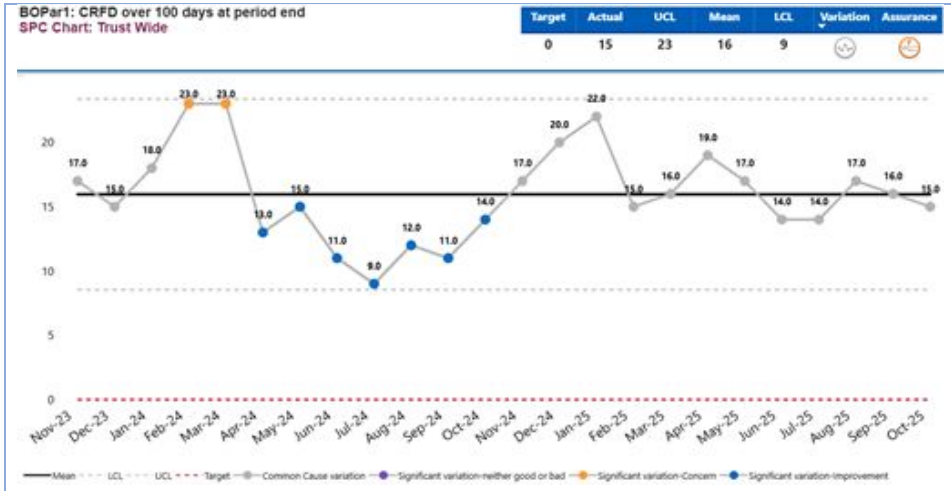
**target reflects year one target of a 5% reduction compared to 2024/25 baseline*

Breakthrough Objectives

Measure Name	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
BOPar1: CRFD over 100 days at period end	0	17	20	22	15	16	19	17	14	14	17	16	15

**methodology changed and applied retrospectively to report the number of CRFD with a length of delay of 100 days or more to date on the last day of the month. Previously reported those discharged in month who had experienced at delay of 100 days or more.*

Focus on Breakthrough Objectives



Data Source	RiO	Data Quality Confidence	

As a result of significant focus on the recording of CRFD in the last year no significant concerns remain on the data quality of this measure

What is being measured?

Total number of patients with a CRfD on the last day of the month with a CRfD Length to date of over 100 days

What is the data telling us and key actions in place

The data shows normal variation over the last 2 years with no periods of significant change, resulting in an average of six per months. There is consistent failing of the target of 0, although numbers are small.

Social care interface work is progressing at pace under three strands of work 1) KMMH social workers on secondment to KCC 2) KMMH reviewing high cost community placements 3) Joint pathways for mental health needs, identifying these early and supporting both early discharge and prevention of admissions.
The HIU project was evaluated in September and a detailed analysis of impact on admission will be available in November.
Purposeful admission protocol continues to be refined across all CRHT, Liaison, Older adults and other teams for all patients who are referred for an admission. This also includes maximising the use of the Crisis houses in Medway and Ashford to support patients who present with needs that can be better met in these settings

Watch Metrics

Measure Name	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
1.2.01: Average Length Of Stay (Younger Adults Acute)	34.0	34.6	40.3	35.0	51.5	49.4	36.9	38.9	35.1	36.2	32.8	42.6	50.9
1.2.02: Average Length Of Stay (Older Adults - Acute)	77.0	95.2	103.2	63.3	124.4	125.8	87.7	102.4	88.8	71.4	69.1	104.3	79.7
1.2.03: Adult acute LoS over 60 days % of all discharges		13.9%	16.5%	19.1%	17.3%	22.6%	18.4%	17.0%	14.9%	14.5%	12.2%	14.4%	22.9%
1.2.04: Older adult acute LoS over 90 days % of all discharges		41.4%	31.3%	28.0%	57.1%	48.0%	35.1%	40.0%	33.3%	30.3%	30.0%	43.3%	31.3%
1.2.06: Readmissions within 30 days (YA & OP Acute)	8.8%	11.7%	13.1%	12.2%	8.8%	11.9%	11.5%	6.3%	11.4%	10.4%	16.7%	12.6%	12.0%
1.2.07: Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)		303	264	467	596	926	1,026	875	775	625	608	574	590
1.2.08: Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs) at period end	0	9	9	27	24	36	31	28	28	19	17	22	18
2.1.04: Clinically Ready for Discharge: YA Acute	7.0%	21.3%	20.6%	19.6%	24.3%	21.7%	22.0%	18.9%	15.2%	14.4%	17.5%	17.9%	15.2%
2.1.05: Clinically Ready for Discharge: OP Acute	12.0%	32.2%	29.9%	37.6%	36.1%	32.9%	29.3%	21.3%	25.4%	31.9%	36.2%	31.8%	30.6%
4.1.01: Bed Occupancy (Net)	92.0%	96.8%	92.6%	97.4%	97.7%	97.4%	94.2%	94.0%	95.8%	95.3%	96.8%	97.7%	96.4%

1.2.07 & 1.2.08 Out of Area Placements – these figures include beds used for Females PICU under contracted beds due to the absence of female PICU beds in Kent and Medway. 6590 bed days were used in October 2025, 152 were female PICU patients within contracted beds resulting in 438 out of area placement days as an accurate reflection of trust performance.

Safety: *We work with our community to provide safe, harm free care*

Executive Sponsor: Andy Cruickshank, Chief Nurse

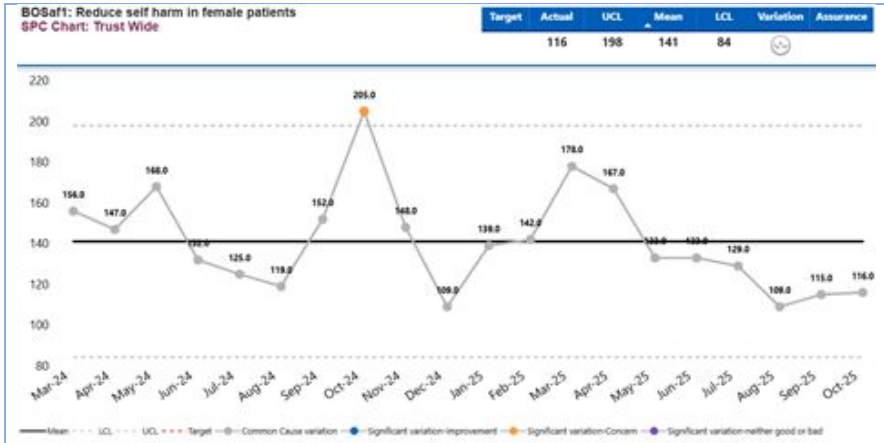
True North

Measure Name	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
TNSaf1: Reduce the number of patient harms		200	147	177	172	232	207	165	175	178	149	146	152

Breakthrough Objectives

Measure Name	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
BOSaf1: Reduce self harm in female patients		148	109	139	142	178	167	133	133	129	109	115	116

Focus on Breakthrough Objectives



Data Source	InPhase	Data Quality Confidence	
Some potential data completeness issues being investigated within community services			

What is being measured?

Count of incidents across all wards and teams within following incident sub categories where patient gender is Female: Actual self-harm, Other self-harming behaviour, Self-harm attempt / gesture, Suicide attempt / gesture (not overdose), Suicide attempt / gesture (overdose)

What is the data telling us and key actions in place

SPC is showing normal variation but there is a lot of variation in the number of female self-harms from month to month. The mean since March 2024 is 141.

The acute directorate accounted for 82 incidents in November 2025 and have adopted a target of 60 by March 2026. It should be noted that Chartwell's recent switch from female to male patient care provision is likely to impact the data in terms of the overall number of incidents of self-harm by a female patient.

The majority of self-harm incidents reported within the organisation are linked to female patients. The services with the highest number of self-harm incidents over the past 12 months are: Chartwell, Fern, Foxglove, Upnor and Walmer wards. Ligature is the most prevalent form of self-harm reported, with the majority of incidents being of a non-fixed ligature type, followed by cutting.

Direct A3 engagement work with the staff on the female wards, beginning in East Kent is due to take place at the beginning of December. This is later than initially anticipated due to sickness within the improvement team. The "lived experience of self-harm" survey is now live and has been shared via the communications team, engagement team and through both operational and clinical leads within each directorate. A set of principles for working with individuals who self-harm has been drafted and are currently with the membership of the self-harm steering group for comment. In addition, multi-disciplinary clinical case note reviews for individuals with the greatest number of reported self-harm incidents have begun to take place to identify any learning, themes or areas for improvement.

Watch Metrics

Measure Name	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
1.2.05: Patients receiving follow-up within 72 hours of discharge		85.5%	78.2%	84.3%	85.0%	84.5%	82.8%	83.9%	89.9%	91.3%	85.8%	88.5%	87.6%
1.2.10: %Patients with a CPA Care Plan	95.0%	82.4%	80.0%	87.1%	90.1%	89.3%	89.5%	90.7%	89.7%	84.7%	81.8%	82.2%	81.4%
1.2.11: % Patients with a CPA Care Plan which is Distributed to Client	75.0%	72.2%	72.1%	72.4%	71.4%	70.7%	71.6%	71.9%	70.4%	74.1%	74.7%	76.1%	76.2%
1.2.12: %Patients with Non CPA Care Plans or Personal Support Plans	80.0%	60.1%	55.8%	58.6%	62.4%	61.1%	56.4%	54.7%	57.1%	53.1%	48.7%	46.8%	45.5%
1.4.01: Occurrence Of Any Never Event	0	0	0	0	0	0	0	0	0	0	0	0	0
1.4.02: All Deaths Reported And Suspected Suicide		137	113	198	174	159	121	150	152	135	112	135	132
1.4.03: Restrictive Practice - All Restraints		87	67	63	77	109	103	95	57	100	87	111	163
1.4.04: Restrictive Practice - No. Of Prone Incidents	0	6	7	3	7	8	5	2	12	8	4	7	16
4.1.02: DNAs - 1st Appointments		10.7%	11.6%	10.2%	10.3%	10.7%	10.9%	10.7%	10.7%	10.5%	10.4%	10.9%	10.8%
4.1.03: DNAs - Follow Up Appointments		10.1%	10.9%	10.7%	9.9%	10.0%	10.5%	10.4%	10.5%	10.5%	9.8%	10.2%	10.1%

Sustainable Care: *We invest wisely in our resources to improve our services*

Executive Sponsor: Nick Brown, Chief Finance and Resources Officer

True North

Measure Name	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
TNSus1: Clinician Contact time per FTE							0.31	0.33	0.33	0.32	0.32	0.35	0.33

**see further details on methodology for breakthrough objective on the next page, methodology consistent for this measure and applied to all staff groups*

Breakthrough Objectives

Measure Name	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
BOSus1: Psychology & Medic contact time per FTE							0.35	0.40	0.40	0.38	0.36	0.38	0.40

Focus on Breakthrough Objectives

BOSus1: Psychology & Medic contact time per FTE *Insufficient data points to analyse by SPC*	**Data Source**	ESR & RiO	**Data Quality Confidence**	
	Significant data validation and increased data integration required to acquire a higher degree of confidence in the outputs of this new measure			
	What is being measured?			
	This breakthrough objective aims to improve the efficiency and effectiveness of clinical time by increasing the proportion of available working time spent in direct clinical contact. The measure reflects the total duration of all appointments recorded in RiO—including attended, DNA, and cancelled sessions—against the available working minutes derived from ESR data. **Numerator:** Duration (mins) of all appointments in period divided. Includes unoutcommed appointments, DNAs and all Cancellations. Includes any staff who record 1 or more contacts in period on RiO **Denominator:** total working mins available in period (using 21 working days) based on FTE. Does not account for individual Annual Leave or Sickness; an uplift is generically applied to all staff for average absence per annum. Includes staff on ESR with a role that is under the ESR staff group for consultants and psychologists as per agreed definition with trust leads. The results are a ratio of total staff time, of which expected clinical facing time is a subset which will vary by professional and role. Work is underway to identify expected levels against which the reported numbers should be viewed.			
	What is the data telling us and key actions in place			
	Currently the data reflects approximately 140 medics and 240 psychologists. While variation exists across staff groups, the baseline provides a valuable starting point for understanding clinical productivity and identifying opportunities for improvement. As the method is refined we can expect some variation in outputs, for example: The calculation at the moment over counts contact duration for any group contacts e.g. one clinic session of 60 minutes that is attended by 10 patients will be including 600mins in the model. Work is underway to adjust for this which will result in lower reported clinical contact time. To explore concerns over the activity recording data quality in-depth reviews have commenced on an initial subset of consultant and psychology activity. This will also provide an opportunity to identify opportunities to improve both performance and methodology. Ongoing Actions and Next Steps: • Strengthen data integration between ESR and RiO to improve confidence in the measure. • Refine the denominator to better account for individual leave and sickness, moving beyond generic uplift assumptions. • Engage clinical leads to validate contact recording practices and ensure consistency across services. • Use this metric to inform workforce planning, service redesign, and targeted support for teams with lower contact ratios.			

Watch Metrics

Measure Name	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
4.1.04: In Month Budget (£000)	0	(14,814)	(15,042)	(14,756)	(14,708)	(14,742)	(15,122)	(15,315)	(15,413)	(15,303)	(17,957)	(15,725)	(15,710)
4.1.05: In Month Actual (£000)		(14,756)	(14,960)	(15,863)	(15,637)	(15,488)	(16,169)	(16,064)	(15,684)	(15,469)	(17,979)	(16,362)	(16,352)
4.1.06: In Month Variance (£000)		58	82	(1,107)	(930)	(746)	(1,047)	(749)	(271)	(166)	(23)	(637)	(642)
4.1.07: Agency spend as a % of the trust total pay bill	3.2%	3.2%	2.8%	2.6%	2.5%	1.9%	2.7%	2.5%	2.6%	1.9%	2.0%	1.8%	2.2%

5. Appendices

NHS Oversight Framework

NHS England » NHS Oversight Framework 2025/26

Each provider will receive an individual organisational delivery score derived from its performance against the metrics within the framework applicable. Each metric has an individual set of scoring rules and based on these, a provider will receive a score between 1 and 4 for each domain and metric.

As of Q1 2025/26 KMPT is in segment one, the highest segment available: *The organisation is consistently high-performing across all domains, delivering against plans*.

Headlines	Data period	Provider value	Peer average		National value	National value method	Chart
Adjusted segment			Q1 2025/26	1	NOF Score	Provider value	
Average metric score			Q1 2025/26	1.91	NOF Score	Provider value	
Unadjusted segment			Q1 2025/26	1	NOF Score	Provider value	
Financial override	Q1 2025/26	No	Yes		Yes	Provider median	
Is the organisation in the Recovery Support Programme?	Q1 2025/26	No	No		No	Provider median	

The following summarises segmentation by domain, highlighting a range of scores with the greatest challenge being shown in the People and workforce domain. Individual metrics which underpin the domain scores are routinely monitored to ensure ongoing compliance and actively address areas requiring improvement.

Domain Scores	Data period	Provider value		Chart
Access to services domain segment	Q1 2025/26	1	NOF Score	
Effectiveness and experience of care domain segment	Q1 2025/26	1	NOF Score	
Patient safety domain segment	Q1 2025/26	2	NOF Score	
People and workforce domain segment	Q1 2025/26	3	NOF Score	
Finance and productivity domain segment	Q1 2025/26	1	NOF Score	

Extract as at 09/09/2025

Report Guide

True North

The guiding direction of the organisation

Timeframe: 3-5 years

- **Measurable outcome**
- **Achieved through the delivery of breakthrough objectives, trusts initiatives & key projects**

Breakthrough Objectives

The improvement focus of the organisation

Timeframe: 0-12 months

- **Measurable outcome**
- **Top contributors to our True Norths**
- **Improvements delivered through frontline teams**

Watch Metrics

Important metrics to understand department performance

- **Performance on these metrics is monitored monthly**
- **We will "watch" for adverse trends in performance, at which time the metric may become something we actively work to improve if it is decided that action needs to be taken**

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details	
Date of meeting:	27th November 2025
Title of paper:	Finance Report for Month 7 (October 2025)
Author:	Nicola George, Deputy Director of Finance
Executive Director:	Nick Brown, Chief Finance and Resources Officer

Purpose of paper

Purpose:	Discussion
Submission to Board:	Regulatory Requirement

Overview of paper

The attached report provides an overview of the financial position for Month 7 (October 2025).

Issues to bring to the Board's attention

For the period ending 31st October 2025, the Trust has reported a pre-technical adjustments surplus of £0.86m and a surplus of £1.28m post technical adjustments, this is in line with the financial plan.

The key financial challenges for the Trust are:

- Use of external beds remains a pressure, with 12 Acute and 5 PICU beds used in month and a year to date budgetary pressure of £3.83m.
- Year to date agency spend is £2.92m. The current agency forecast pre-mitigations is £4.98m and with measures in place to deliver spend in line with capped levels of £4.27m.
- The Trust's Acute Inpatient wards pay pressures have continued to utilise additional Nursing staff (both registered and unregistered) over and above established levels causing an average financial pressure of £0.35m per month.

Governance

Implications/Impact:	If the Trust fails to deliver on its 2025/26 financial plan then this could impact on the long-term financial sustainability agenda.

Version control 02 - **Public**

Assurance:	Reasonable
Oversight:	Finance, Business and Investment Committee

NHS
Kent and Medway
Mental Health
NHS Trust

Finance Reporting Pack

Trust Board
October 2025

Contents

1. Executive Summary

Key Messages

For the period ending 31st October 2025, the Trust has reported a pre technical adjustments surplus of £0.86m and a surplus of £1.28m post technical adjustments, this is in line with the financial plan.

Key pressures for the Trust are:

External beds

- External bed expenditure continues to be a financial pressure. While overall utilisation of external beds has remained broadly stable since July, there has been some variation in the mix between PICU and Acute placements.
- An average of 12 Acute beds were utilised in month costing £0.24m. The Trust doesn't hold a budget for external acute beds.
- External PICU bed usage decreased in month with an average of 5 external Female PICU beds (6 in September) and an average of 2 external Male PICU beds (3 in September) being utilised at a cost of £0.34m. The Trust holds a budget for 7 PICU beds.
- The Trust has put in place stepdown capacity, which will facilitate the repatriation of patients from external Acute beds to KMPT beds. 2,448 block bed days have been purchased at a cost of £0.40m, with usage estimated at 933 bed days since June; at this level the trust has seen cost avoidance of £0.59m.

Acute Inpatient staffing

- The Trust's Acute Inpatient wards have consistently utilised additional Nursing staff (both registered and unregistered) over and above established levels.
- In October, 84.4 additional WTE above establishment were utilised, increasing from 81.4 WTE in September. The year-to-date pressure this presents now totals £2.58m.

Agency spend

- In month spend increased to £0.42m, £0.07m higher than September. Year to date agency spend is £2.99m, with East Kent medical agency and West Kent nursing agency being key areas of pressure.
- In month spend levels were highest in East Kent, with 49.3% of overall agency spend, due to medical vacancies, but also West Kent (30.1%) due to pressures within Liaison services, CMHTs and Crisis teams.
- For 2025/26 an agency spend limit has been set for the Trust of £4.27m. Based on current forecasts, the Trust would spend £4.64m, £0.37 over the cap. This is under review with a potential increase in forecast to address community backlog.

At a Glance - Year to Date

Income and Expenditure	●
Efficiency Programme	●
Agency Spend	●
Capital Programme	●
Cash	●

Key

On or above target	●
Below target, between 0 and 10%	●
More than 10% below target	●

Capital Programme

As at 31st October the overall capital position is £1.27m under plan. This is primarily due to delayed lease remeasurements (£2.32m) and the trust's decision not to secure additional administrative office space. This is offset by the planned overspend in relation to the Section 136 Development.

The forecast spend position has risen by £0.12m from £17.88m to £18.00m. This is due to the a PDC award for Cyber Risk Reduction of £0.12m

Cash

The closing cash position for October was £10.22m which was an increase in month of £0.51m and is £0.32m lower than the forecast of £10.53m. This is the result of higher than expected creditor payments partially offset by training receipts from NHS England.

2. Finance KPIs

I&E YTD position

M7 YTD actual	**£1.28m surplus**
Forecast outturn	£2.20m surplus

Year to date position on plan with a reported £1.28m surplus. Key pressures include Acute Inpatient staffing and External beds and are mitigated with non-recurrent benefits and pay slippage.
The Trust is forecasting an outturn position of a £2.20m surplus as per plan.

Efficiency delivery

M7 YTD actual	**£7.35m**
Full year identifed	£13.62m

The CIP programme is currently on plan. Work is underway on the CIP programme for 2025/26 to ensure delivery and any slippages in planned delivery mitigated.
In month progress has been made on the Community Services and Forensic Inpatient schemes.

Capital spend

M7 YTD actual	**£3.88m**
Forecast outturn	£17.14m

As at 31st October the overall capital position is £0.82m under plan. This is primarily due to underspends on IFRS 16 lease costs due to both IFRS 16 lease expendure remeasurements which have not yet taken place and planned expendure on a new corporate office not taking place.

Bank spend

M7 actual	**£1.73m**
Planned Run Rate	£1.67m

Bank spend increased in month by 5.3%. Usage increased across Forensic and Inpatient wards in response to higher observations, estate works that required additional escorting, cover for training and away days.

Agency spend

M7 actual	**£0.42m**
Planned Run Rate	£0.36m

Agency spend increased in month. The current forecast for agency is £4.64m, which against a cap of £4.27m results in the annual cap being exceeded by £0.37m.This is under review with a potential increase in forecast to address community backlog.

WTEs utilised

M7 actual	**4,068**
Planned Staffing	4,039

WTEs utilised are monitored by NHS England against the Trust's workforce plan. Actual staffing figures include contracted substantive staff as well as any bank and agency usage within the reporting month. The in month increase is predominantly due to increase in bank usage in month.

External beds spend

Year to date overspend	**£3.83m**
Average Beds in Month	19

External beds reduced to an average of 19 beds, with PICU reducing from 9 to 7 beds and Acute increasing from 11 to 12 beds. This remains a key area of financial pressure for the Trust.

Cash position

M7 cash balance	**£10.22m**
Operating Expenditure Days	13.2

The closing cash position for October was £10.22m which was an increase in month of £0.51m and is £0.32m lower than the September forecast of £10.53m.

Principles

The KPIs included reflect the key metrics for which the Trust's performance is monitored by NHSE.

Indicate a favourable or adverse movement against the previous month, or a static position.

Indicates the performance against plan - on or above target, below target between 0 and 10% or more than 10% below target.

Caring | Inclusive | Curious | Confident

3. Primary statements

Statement of Comprehensive Income

	Annual	Current Month			Year to date		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance
	£000	£'000	£'000	£'000	£'000	£'000	£'000
Income	295,294	24,608	25,321	713	172,255	176,079	3,825
Employee Expenses	(229,166)	(19,097)	(19,403)	(305)	(133,680)	(132,906)	774
Operating Expenses	(59,038)	(4,920)	(5,439)	(519)	(34,438)	(39,728)	(5,290)
Operating (Surplus) / Deficit	**7,090**	**590**	**479**	**(112)**	**4,137**	**3,446**	**(691)**
Finance Costs	(4,892)	(408)	(295)	112	(2,854)	(2,162)	692
System control Surplus / (Deficit)	**2,199**	**183**	**183**	**0**	**1,283**	**1,283**	**0**
Excluded from System control (Surplus) / Deficit:							
Technical adjustments	**(194)**	**(10)**	**(10)**	**(0)**	**(537)**	**(428)**	**109**
Surplus / (deficit) for the period	**2,004**	**173**	**173**	**0**	**746**	**855**	**109**

The Trust is reporting a surplus of £1.28m at the end of October. This is in line with plan.

Employee expenses

The Trust is reporting a year-to-date underspend on employee expenses of £0.77m.
This consists of an underspend on substantive pay of £1.08m with an additional underspend of £0.20m on bank (where bank is planned to support rotas), offset by overspends on agency of £0.50m.
The Trust spent £0.42m on agency in month, representing 2.2% of pay spend. In staff group terms, spend within the Medical and Nursing staff groups accounted for the majority of the spend equating to 54.4% and 41.5% of overall agency spend, respectively.

Operating expenses

In month operating expenses are over plan by £0.52m which is heavily driven by external bed spend. The Trust utilised 7 external PICU beds (7 PICU beds funded) and 12 external Acute beds, all of which are unfunded, and this presents a financial pressure to the end of October of £3.83m.

Statement of Financial Position

	30th April 2025	30th September 2025	31st October 2025
	Actual	*Actual*	*Actual*
	£000	£000	£000
Non-current assets	174,192	171,396	172,280
Current assets	20,105	19,529	21,107
Current liabilities	(30,182)	(26,886)	(29,217)
Non current liabilities	(39,058)	(37,997)	(37,955)
Net Assets Employed	**125,057**	**126,042**	**126,215**
Total Taxpayers Equity	**125,057**	**126,042**	**126,215**

Total assets

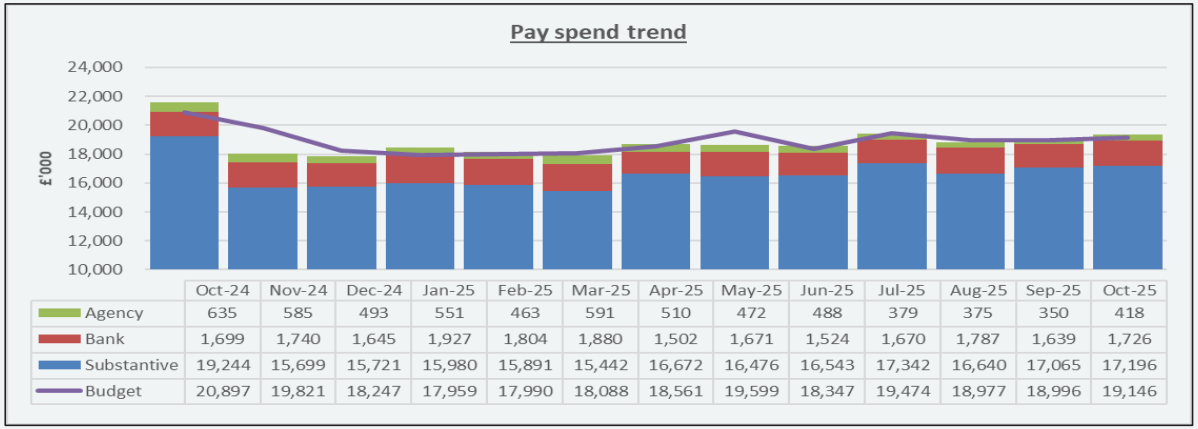
Total assets for the month saw an increase of £2.46m.
This is driven by an increase in non-current assets of £0.88m which is the capital programme for the month offset by depreciation, an increase in cash held of £0.51m and an increase in trade receivables of £1.07m

Total liabilities

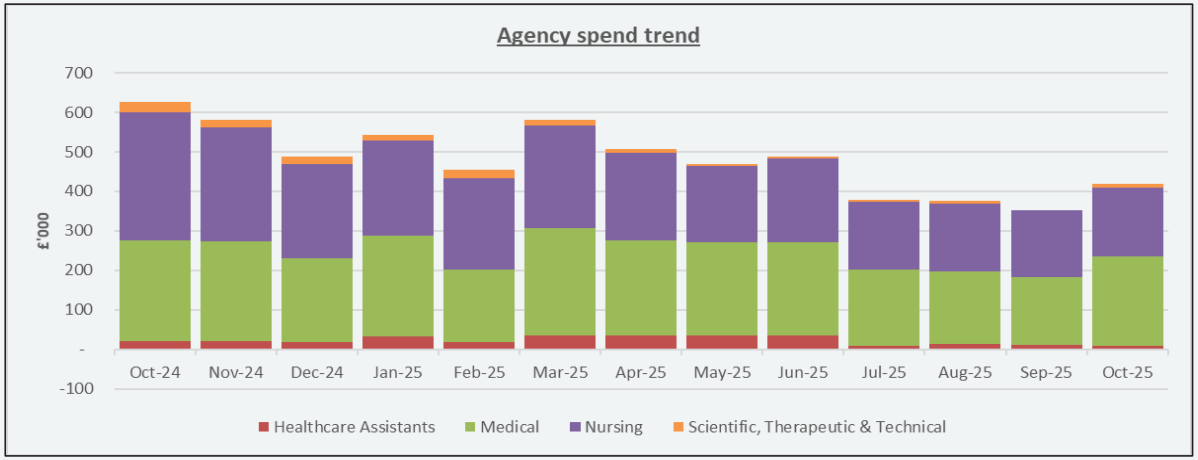
Overall total liabilities increased by £2.29m in month.
This is directly related to a receipt from NHS England of £3.12m in October for training which covers October 25 to January 26, a large proportion of which has been deferred into future periods.

Appendices

4. Exception report – Pay trend



	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Agency	635	585	493	551	463	591	510	472	488	379	375	350	418
Bank	1,699	1,740	1,645	1,927	1,804	1,880	1,502	1,671	1,524	1,670	1,787	1,639	1,726
Substantive	19,244	15,699	15,721	15,980	15,891	15,442	16,672	16,476	16,543	17,342	16,640	17,065	17,196
Budget	20,897	19,821	18,247	17,959	17,990	18,088	18,561	19,599	18,347	19,474	18,977	18,996	19,146



As at the end of October the Trust reported a year-to-date underspend on pay of £0.77m, including the impact of the pay award for the year to date for all substantive and bank staff.

In month, recognition payments of £0.10m were made to Band 3 staff working on wards as part of the Band 2 to 3 changes for Healthcare Assistants.

There is a high level of focus from the system and NHS England to ensure pay run rates and WTEs are not increasing in year. The Trust is presently 29 WTE above plan, and 24 WTE above April 2025 levels.

Bank spend increased in month by 5.3%. Usage increased on Acute and Forensic wards as observations increased on Cherrywood ward, estate works in Low Secure required additional escorting and training and away days were covered on Medium Secure wards.

Agency spend in October totalled £0.42m, which represents a 34.1% reduction on spend seen for the same period in 2024/25, and a 19.5% increase on spend in September due to an increase in PAs from agency consultants in Ashford MAS.

- Medical agency WTE was 7.8 WTE in October, 5.3 WTE of which were in East Kent. Whilst we continue to focus on medical recruitment this position is anticipated to continue for the majority of the year.

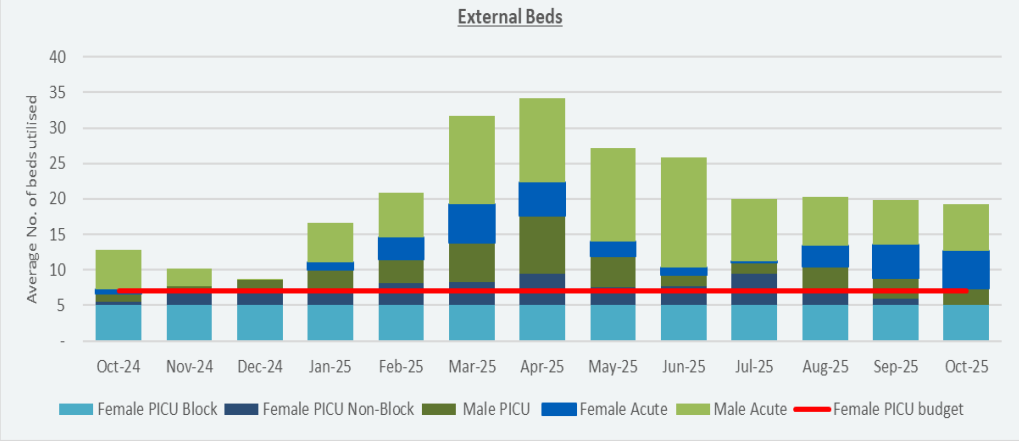
- Of the Nursing agency utilised, 71.2% is supporting community teams covered by CMHF and most of the remainder is supporting Liaison and Homecare teams. Recruitment continues to these teams and agency is forecast to reduce in coming months.

- HCA agency decreased by 0.8 WTE to 2.8 WTE, the biggest user being West Kent Crisis & Homecare team (1.2 WTE). Implementation of Golden Key controls has significantly reduced the use of HCA agency with the aim of stopping it entirely.

- The unadjusted current forecast for agency spend is £4.64m, £0.37m above a cap of £4.27m; with further work planned to bring spend back in line with CAP.

Caring Inclusive Curious Confident

5. Exception report – External beds



Commentary

The Trust is funded for the equivalent of 7 Female PICU beds, which is predominantly used to fund a block contract for 5 Female beds. The Trust doesn't hold funding for external acute beds.

From October 2024, there has been an increase in the run rate for External beds being utilised, predominantly due to the number of Clinically Ready for Discharge (CRFD) patients held on Acute Inpatient wards. As a result this has led to both external Acute and PICU beds being utilised above funded levels.

In October, usage of external Acute beds increased, from average 11 beds to 12. Female PICU usage has reduced from 6 to 5 beds and male PICU usage has reduced from 3 to 2 beds.

To help alleviate this pressure; the Trust has introduced step-down beds to support improved patient flow. Since June, block contracts have secured 13 beds with the primary provider of step-down beds of which 9 are currently filled and approximately 933 bed days have been utilised. The contracted rate for these beds is £171 per bed day which on a like for like basis would have cost approximately £800 per day and there resulted in avoiding £0.59m of cost. Purchase of step down beds has cost £0.40m.

Exception report – Inpatient staffing

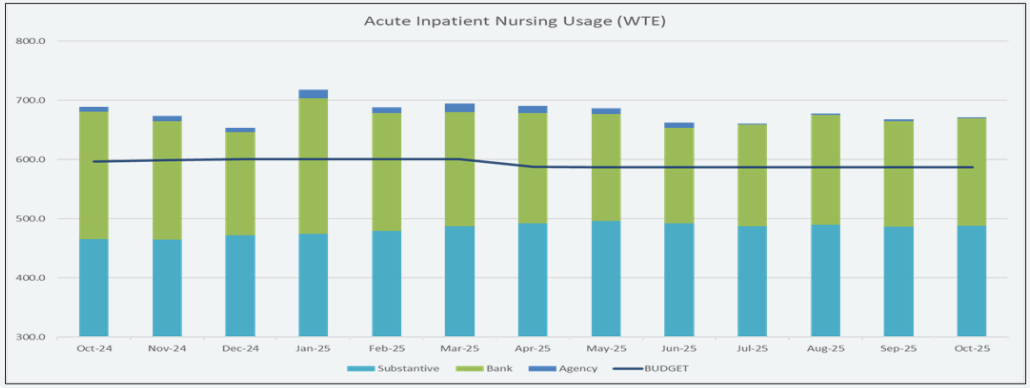
Commentary

The Trust's Acute Inpatient wards have consistently utilised additional Nursing staff (both registered and unregistered) over and above established levels. On average usage over and above establishment over the last 12 months equates to 86.3 additional WTEs and £0.35m per month.

The following steps have been identified to mitigate the pressure:

- Recharge of additional costs for patients requiring specialist care.
- Review of supernumerary staffing to identify the reasons why.
- Senior management approval for all bank staff
- Implementation of greater scrutiny on rotas

Cover for sickness and management days reduced in month but increased observations on Cherrywood ward saw an increase in temporary staffing usage.



6. Income and Expenditure Forecast

Forecasting assumptions and Principles

For 2025/26 the Trust has submitted a plan to deliver a surplus position of £2.20m, post-technical adjustments. The current forecast is based on present run rate and includes known actions such as the use of step-down beds to alleviate bed pressures and more detail is included below.

Pay

Substantive pay is forecast considering known changes such as starter and leaver information and assumes a level of successful recruitment for specific areas such as A&E Liaison following the Core 24 investment and within Community Rehabilitation following the mobilisation of the county wide service. The forecast also includes £0.40m of mobilisation costs for the new Female PICU.

Redundancy costs are included in the forecast for areas where staff consultations have completed and either the impact is known or an estimate included to reflect anticipated workforce impacts.

Agency - Based on current forecasts, the Trust is anticipating to spend £4.64m on agency in year which represents £0.37 over the cap.

This forecast takes into consideration the following:

- The successful recruitment particularly in community Nursing teams within North and West Kent which will enable key areas of agency to reduce significantly by the end of the financial year.
- It assumes that the current medical agency position is held with no further medical agency placements approved.
- No further agency usage for HCAs following the implementation of the golden key initiative.

The agency plans are currently under review with a potential increase in forecast to address community backlog.

Bank – whilst there have been some reductions in key areas of spend such as Acute Inpatients, run rates remain high. Further system wide workforce controls have been introduced which may result in a reduction in the Bank forecast for future months – these include blanket ban on non clinical and support services roles and senior staff authorisation for headroom related shifts.

Non-Pay

External beds - The introduction of the step-down beds has eased some of the pressures seen in external beds particularly within Acute beds. Spend for an average of 6 Acute beds and 5 PICU beds has been included in the forecast for the remainder of the financial year and therefore any usage above this will bring further financial pressures. This position is being monitored regularly by the patient flow team and operational teams.

- The current provision has been assumed to continue until the end of the financial year which provides 13 step down beds.
- Therefore, overall external bed provision allowed for in the forecast is 19 external Acute / step down beds and 5 PICU beds.

System savings

For 2025/26, a surplus plan was submitted that included an additional £2.20m stretch target. This was expected to be achieved through significant efficiency savings by streamlining processes, reducing administrative costs, and fostering system-wide collaboration between providers and commissioners.

While work is underway to implement new ways of working, progress has been slower than anticipated; therefore, the current forecast does not include any assumptions in this regard.

In order to mitigate the gap and deliver the required surplus, additional non recurrent benefits have been identified to deliver the required position for 2025/26 - these include standardising system accounting treatments for laptops and the recognition of prior year capital scheme VAT rebates.

This will mitigate the known pressures as included in this forecast anything in additional will being further financial pressures for which mitigations will need to be identified.

7. Cost Improvement plans 2025/26

Savings plans

Scheme	Planned CIP	Identified to date	% identified	Expected completion date
	£'000	£'000		
Support Services	3,700	2,205	59.6%	30th September 2025
Estates	1,600	1,348	84.2%	30th June 2025
Forensic Inpatient	1,000	500	50.0%	31st July 2025
Provider Collaborative Risk Share	1,000	800	80.0%	On-going
Provider Collaborative contract prices	-	1,344	100.0%	31st August 2025
Perinatal	500	493	98.5%	30th September 2025
Community Review	2,400	4,240	176.7%	31st July 2025
Rota Management	1,700	-	0.0%	On-going
Budget Management	1,800	1,795	99.7%	On-going
Non-Pay Review	1,000	200	20.0%	On-going
Other	700	700	100.0%	31st October 2025
Trust schemes total	**15,400**	**13,624**	**88.5%**	
System Stretch target	2,200	-		Work on-going
Total	**17,600**	**13,624**	**77.4%**	

Commentary

The Trust submitted a surplus plan of £2.20m for 2025/26 and this is predicated on delivery of a 5% efficiency target (£15.4m) plus an additional £2.20m stretch target to achieve the required surplus.

Schemes underway:

- Support Services – a 10% reduction in costs, reflecting NHS England benchmarking and growth analysis . Further plans continue to be developed with system partners. Fully developed plans are now progressing with consultations being launched from June 2025 to ensure savings are realised.
- Provider Collaborative Risk Share – Working with KSS PC to reduce out of area placements with funding secured through risk share arrangements, as per prior financial years. Discussions are progressing with the Provider Collaborative to confirm in year arrangements.
- Perinatal service review – underspends delivered, service review required to identify opportunities for recurrent reductions. Review of benchmarked costs and productivity metrics is underway.
- Community review – Service review for Early Intervention & At Risk Mental State services underway with Consultation paper taken to Joint Negotiating Forum at the end of July and savings recognised from September. This work is anticipated to bring cost in line with contractual envelopes. Proposed establishments for MHT+ were shared with Directorate teams June with final amendments to be agreed.
- Budget management – 1% non-recurrent savings identified from slippages.
- Estates – a 10% reduction in costs. Following the decision to permanently remove administration estate, the whole estate is being reviewed for consolidation opportunities.

Plans under development:

- Forensic Inpatient – review of all costs, building on benchmarking work, has commenced with the Directorate team and discussions continue with the Provider Collaborative to review the contracted bed day price.
- Non-Pay Review – working with system partners supported by NHS England productivity packs. Areas of focus include taxi spend, policy and process, discretionary spend and interpreting costs.

8. Balance Sheet and Treasury Management

Statement of Financial Position

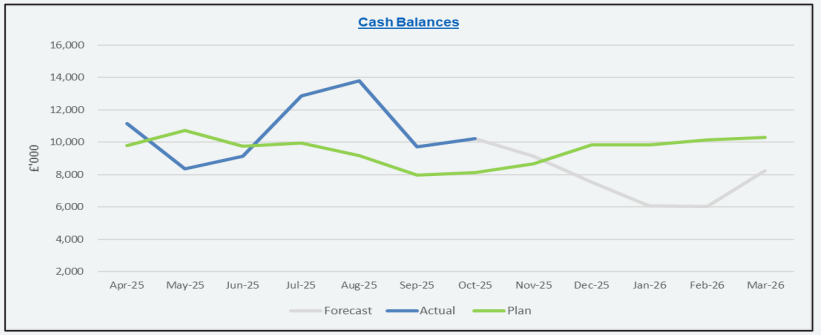
	30th April 2025 Actual £000	30th September 2025 Actual £000	31st October 2025 Actual £000
Non-current assets	174,192	171,396	172,280
Current assets	20,105	19,529	21,107
Current liabilities	(30,182)	(26,886)	(29,217)
Non current liabilities	(39,058)	(37,997)	(37,955)
Net Assets Employed	**125,057**	**126,042**	**126,215**
Total Taxpayers Equity	**125,057**	**126,042**	**126,215**

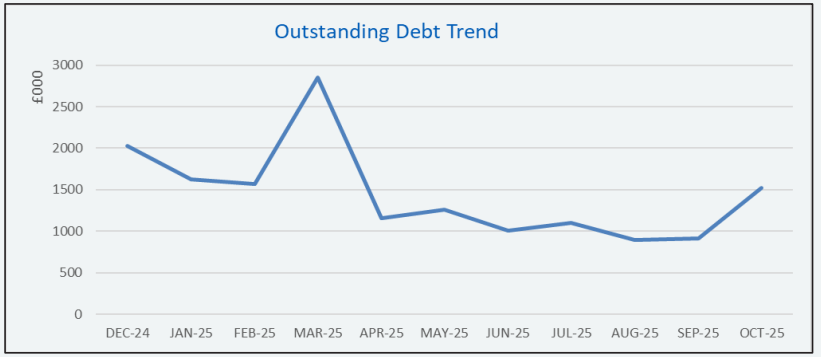
Total assets
Total assets for the month saw an increase of £2.46m.
This is driven by an increase in non-current assets of £0.88m which is the capital programme for the month offset by depreciation, an increase in cash held of £0.51m and an increase in trade receivables of £1.07m.

Total liabilities
Overall total liabilities increased by £2.29m in month.
This is directly related to a receipt from NHSE of £3.12m in October for training which covers October 25 to January 26, a large proportion of which has been deferred into future periods.

Outstanding debt
51% of the total debtors figures is less than a month old. Debtors over 60 days stand at £0.3m. £0.1m of this is for debts owed by individuals, including staff (for issues such as salary overpayments & lease cars) for all of these collection activity is in progress and for many there is a payment plan.

BPPC
The performance for Non-NHS payments to date remains on target by value at 97.0% and are in line with target of 95.0% by number. NHS payments are above target at 99% by value and by number. BPPC is measured upon payment of invoices so the lack of access to the finance system experienced last month has led to fewer invoices being processed and paid.





Non NHS	YTD Number	YTD £000
Total bills paid in the year	6,273	53,774
Total bills paid within target	5,957	52,165
Percentage of bills paid within target	95.0%	97.0%

NHS	YTD Number	YTD £000
Total bills paid in the year	792	8,923
Total bills paid within target	783	8,380
Percentage of bills paid within target	98.9%	93.9%

Caring | Inclusive | Curious | Confident

9. Capital position

	Annual			In month			Year to Date		
	Plan	Forecast	Variance	Plan	Actual	Variance	Plan	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
System Capital expenditure									
Capital Maintenance and Minor Schemes	4,164	4,356	192	220	190	(30)	1,947	1,633	(314)
Information Management and Technology	1,299	1,699	400	0	(39)	(39)	0	(41)	(41)
Section 136 development	3,462	4,958	1,496	0	516	516	0	1,237	1,237
Public Decarbonisation	200	0	(200)	0	0	0	0	0	0
IFRS 16 Leases	3,375	1,487	(1,888)	21	231	210	2,557	242	(2,315)
Total system expenditure	**12,500**	**12,500**	**0**	**241**	**898**	**657**	**4,504**	**3,071**	**(1,433)**
External expenditure									
Out of Area Placement (Female PICU)	3,940	3,940	0	40	4	(36)	40	58	18
PFI 2025/26	461	461	0	38	39	1	266	274	8
Public Decarbonisation	629	0	(629)	0	0	0	0	0	0
Estates Safety Fund	0	400	400	0	0	0	0	25	25
R&D - Hyperfine Swoop Imaging System	0	578	578	0	(23)	(23)	0	0	0
Section 136 development	2,250	0	(2,250)	83	0	(83)	83	0	(83)
VAT Reclaim	(2,250)	0	2,250	(100)	721	821	(200)	0	200
Cyber Risk Reduction	0	119	119	0	0	0	0	0	0
Total external expenditure	**5,030**	**5,498**	**468**	**61**	**741**	**680**	**189**	**357**	**168**
Total Capital Expenditure	**17,530**	**17,998**	**468**	**302**	**1,639**	**1,337**	**4,693**	**3,428**	**(1,265)**

Commentary:
As at 31st October the overall capital position is £1.27m under plan. This is primarily due to underspends on IFRS 16 lease costs totalling £2.32m due to both lease expenditure remeasurements which have not yet taken place and planned expenditure on a new corporate office not taking place.

This is partially offset by overspends YTD in relation to the Section 136 Development of £1.35m and represents the movement of the VAT reclaim monies to support the revenue position.

The forecast spend position has risen by £0.12m from £17.88m to £18.00m. This is due to the a PDC award for Cyber Risk Reduction of £0.12m.

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details	
Date of meeting:	27th November 2025
Title of paper:	Workforce Deep Dive – Sustainability Pillar
Author:	Nicola George, Deputy Director of Finance
Executive Director:	Nick Brown, Chief Finance and Resources Officer

Purpose of paper

Purpose:	Discussion
Submission to Board:	Board Requested

Overview of paper

This paper provides an update on the Trust's progress towards its sustainable care True North.

Issues to bring to the Board's attention

The paper provides a summary of the key developments undertaken to date, looking at the key developments in demand and capacity management, benchmarking of clinical activity, and productivity improvements.

In year, the Trust has seen 3.2% productivity growth based on nationally reported metrics.

Governance

Implications/Impact:	If the Trust fails to deliver sustainable care this will impact upon its ability to ensure
Assurance:	Reasonable
Oversight:	Trust Board

Version control 02 - **Public**

1. Executive Summary

The Trust is experiencing increased demand for services, driven by changing population demographics and greater complexity of need. These pressures are especially pronounced in Kent and Medway, where financial constraints across the health system restrict available resources. In response, NHS England's emphasis on maximising value and efficiency requires us to achieve optimal outcomes within these limitations.

To address these challenges and support long-term financial sustainability, the Trust has incorporated a True North metric into its reporting framework. This metric provides a clear organisational focus, enabling targeted discussion and informed decision-making. It ensures that our efforts remain aligned with strategic priorities, guiding how we monitor, evaluate, and respond to evolving demands.

By integrating the True North metric into our approach, it ensures that oversight and resource management remain focused on our strategic priorities and are responsive to emerging challenges.

2. Background

The Trust operates within a health economy experiencing significant demand growth and increased acuity. These challenges are intensified by system-wide financial constraints, which limit our capacity to meet evolving needs. NHS England requires all NHS organisations to maximise value, eliminate unnecessary waste, and deliver the highest possible activity within available resources.

In Kent and Medway, these pressures are especially acute, further restricting our ability to respond to the growing needs of our population. The Trust recognises that sustainable improvement cannot be achieved through short-term measures or by placing additional burdens on staff. Instead, our strategy is focused on long-term enhancements to care delivery, supported by robust productivity measures that enable us to monitor progress and benchmark performance.

To reinforce this commitment, the Trust has embedded the True North metric within its reporting framework. This metric provides a clear organisational focus, aligning our work with strategic priorities and breakthrough objectives. Regular review of performance against the True North metric ensures that oversight and resource management are directed towards achieving transformative outcomes and responding effectively to emerging challenges.

The Trust's workforce remains a critical limiting factor, and national challenges persist even if additional funding becomes available. To address rising demand, it is essential to develop a sustainable care model that empowers staff to work as efficiently as possible in supporting patients.

For 2025/26, the True North metric of sustainability has been introduced to measure the proportion of time clinical roles are released to provide direct patient care. This includes identifying and eliminating barriers—whether related to staffing, processes, or other factors—to optimise service delivery**.**

3. Progress to Date

The Trust has made significant progress in strengthening its approach to demand and capacity management, recognising this as a critical enabler for sustainable service delivery and financial resilience. Recent work has focused on several key areas

- ***Comprehensive Modelling and Analysis:***
  The finance team has undertaken in partnership with operational teams, detailed demand and capacity modelling across multiple services, including Mental Health Together and Mental Health Together Plus, Memory Assessment Service. These models are being refined through ongoing engagement with service directors and clinical leads, ensuring they reflect current and anticipated needs.

- ***Collaborative Workshops and Stakeholder Engagement:***
  A series of workshops and oversight group meetings have brought together operational, clinical, and finance colleagues to review modelling outputs, identify gaps, and agree next steps. This collaborative approach is helping to clarify the causes of any mismatch between demand and capacity, and to develop targeted solutions—such as changes to job plans, skill mix, and resource allocation.

- ***Integration with Financial and Workforce Planning:***
  Demand and capacity modelling is directly informing financial reviews, workforce planning, and service transformation initiatives. For example, modelling outputs are being used to inform staffing models and pay budgets. The Trust's position to date reflects a coordinated, data-driven, and collaborative approach to demand and capacity management. Ongoing modelling, stakeholder engagement, and alignment with national frameworks are enabling the Trust to respond proactively to rising demand, optimise resource use, and support sustainable service delivery. These efforts are integral to achieving our strategic priorities and underpin the Trust's commitment to continuous improvement.

- ***Understanding Expected Clinical Contacts, Methodology and Principles:***
  To ensure the Trust delivers sustainable, high-quality care, a robust methodology has been developed to benchmark expected clinical practice across multiple staff groups. This process, validated in collaboration with Professional Leads, enables the Trust to compare actual recorded clinical activities against established expectations, providing a clear basis for assessing current performance and identifying areas for improvement.

- ***Collaborative Approach to Benchmarking:***
  Expected levels of clinical activity were determined through joint working with Professional Leads, who contributed their expertise to define the allocation of time within an average job plan devoted to clinical duties. This collaborative approach ensures that benchmarks are both realistic and representative of the diverse roles within the Trust. Consideration was also

given to the proportion of clinical time that is recorded and reportable, supporting transparency and accountability in performance monitoring.

- ***Examples Across Staff Groups***:

Medical Staff: For Consultants, a typical job plan comprises ten programmed activities (PAs), with 7.5 PAs assigned to clinical work. Of these, 4.0 PAs represent clinical contacts that are recorded and reportable, while 3.5 PAs relate to clinical activities not currently captured on Rio. Non-Consultant grades generally allocate 8.0–8.5 out of 10 PAs to clinical activities, with 4.5–5 PAs corresponding to recorded clinical contacts.

Psychology: Expected levels of clinical practice have been confirmed for each psychology role, reflecting the varied scope of responsibilities. Some roles focus more on clinical supervision, resulting in less direct clinical contact time.

Nursing: Community nursing resources have been reviewed as part of the Mental Health Together and Together Plus demand and capacity work. Band 5 and Band 6 nurses are expected to complete four clinical contacts daily. Job planning for other nursing roles, including non-registered staff and clinical leads, will be developed to clarify expectations and align with the approach used for psychology.

- ***Continuous Improvement and Alignment***

This benchmarking exercise provides the Trust with a validated framework for monitoring clinical activity, supporting the identification of opportunities to optimise service delivery. By aligning job planning and performance monitoring with these principles, the Trust is better positioned to ensure that clinical resources are used efficiently and that staff are empowered to deliver the highest standards of care.

4. Breakthrough Objective

A key breakthrough objective for the Trust is to maximise the proportion of clinical time dedicated to direct patient care. Achieving this requires a clear understanding of both the expected and actual clinical contacts delivered by each staff group. Through rigorous benchmarking, validated in collaboration with Professional Leads, the Trust has established evidence-based expectations for clinical activity across medical, psychology, and nursing roles. This enables a direct comparison with recorded activity, highlighting where staffing levels and deployment may need to be adjusted to meet service demand and strategic goals.

By aligning staffing models with these benchmarks, the Trust can ensure that workforce planning is both responsive and sustainable. For example, if actual clinical contacts consistently fall short of expected levels, this may indicate a need for additional staff, changes in role allocation, or process improvements to release more time for patient-facing duties.

5. Enablers for Breakthrough Objectives

Achieving the Trust's breakthrough objectives for sustainable care can be supported by a combination of digital innovation and robust job planning performance management processes.

Digital solutions, such as such as Ambient Voice technology can free up clinical staff to dedicate more time to direct patient care. These technologies can also facilitate real-time

monitoring and reporting, supporting evidence-based decision-making and resource optimisation.

Alongside digital advancements, effective job planning and performance management frameworks ensure that staff roles and responsibilities are clearly defined, expectations are aligned with service needs, and progress is regularly reviewed. Together, these enablers create a responsive and efficient environment, empowering staff to deliver high-quality care and supporting the Trust's strategic priorities.

6. Current Reporting

The table below details what is being reported currently within the IQPR and demonstrates the proportion of each staff group's time attributed to recorded clinical activities.

Average clinical time

Staff group	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Medical	0.20	0.19	0.20	0.20	0.18	0.22	0.21
Psychology	0.45	0.54	0.53	0.50	0.48	0.51	0.56

Initiatives are underway to rigorously review the data underpinning the True North metric, ensuring it effectively supports the Trust's breakthrough objectives for sustainable care. Several factors may contribute to anomalies in reported data, including:

- The methodologies used to record and attribute group contacts to staff, which can impact the accuracy of individual-level reporting.
- The need for RiO data to reliably reflect actual clinical activities, such as appointment durations.

To address these issues, the metric and its detailed outputs are being shared with clinical leads for assessment and validation. This collaborative process enables clinical leads to refine the data, ensuring it accurately represents current clinical activity levels.

Once this review is complete, team-level performance will be evaluated locally to identify obstacles and areas for improvement. Targeted actions will then be implemented to optimise clinical time and reallocate resources.

National Productivity reporting

To assist Trusts in their Sustainability and Productivity initiatives, NHS England is now providing Trusts with Implied Productivity data. Implied productivity serves as an indicative metric that compares outputs (measured as cost-weighted activity) to inputs (including spend and workforce).

The data for Month 3 (June 2025), as detailed below, shows a net increase of 3.2% compared to the same period in 2024/25. This suggests that, after accounting for inputs such as expenditure and staffing, outputs have risen by 3.2%.

	M3 25/26 vs M3 19/20			M3 25/26 vs M3 24/25		
Org name	YTD Cost weighted activity growth	YTD real terms resource growth	YTD productivity growth estimate	YTD Cost weighted activity growth	YTD real terms resource growth	YTD productivity growth estimate
Kent & Medway Mental Health Trust	Not reported			5.50%	2.30%	3.20%

7. Next Steps

The Trust's methodology for benchmarking and monitoring clinical contacts, job planning, and performance management is fully aligned with the national strategic direction.

1) Empower Teams to Identify and Address Barriers - Facilitate team-level reviews to identify obstacles to maximising clinical time, encouraging staff to propose and implement practical solutions that improve patient-facing care.

2) Medical Job Planning – Work with medical teams to ensure alignment to the job planning work, ensuring that benchmarks for clinical activity align and support the trust's breakthrough initiatives.

3) Embed Local Improvement Initiatives - Support local teams to develop, implement, and monitor targeted improvement actions, sharing best practice and learning across the Trust to drive continuous improvement.

4) Align Workforce Planning with Strategic Priorities - use validated benchmarking data to inform workforce planning and resource allocation, ensuring staffing models are responsive to service demand and enable staff to work efficiently together

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details	
Date of meeting:	27th November 2025
Title of paper:	Doing Well Together (DWT) Improvement Programme
Author:	Sarah Atkinson, Deputy Director of Transformation & Partnerships Ilias Elsdon- Rentoulis, Head of Improvement – Strategy Deployment Ben Francis, Head of Improvement – Capability & IMS
Executive Director:	Adrian Richardson; Director of Transformation & Partnerships

Purpose of paper

Purpose:	Discussion
Submission to Board:	Board requested

Paper overview

This paper gives an overview of progress so far of the Doing Well Together Improvement Programme, the early success as well as some of the challenges we face in rolling out the programme.

Issues to bring to the Board's attention

Progress to Date

- Strategy Deployment Reviews (SDRs) have replaced Quality and Performance Reviews, ensuring proactive monitoring of strategic priorities.
- IMS Rollout: Wave 1 completed successfully in Dartford wards; Wave 2 underway in Canterbury. Leadership engagement has been strong.
- Capability Building: Over 100 staff trained at Yellow Belt level, delivering measurable benefits, including several high-impact projects.
- Leadership Development: Coaching and gemba visits are reinforcing cultural change and frontline empowerment.

Impact

- Improved alignment of local improvements with strategic objectives.
- Increased staff engagement and ownership of problem-solving.
- Early evidence of measurable benefits from certified projects

Governance

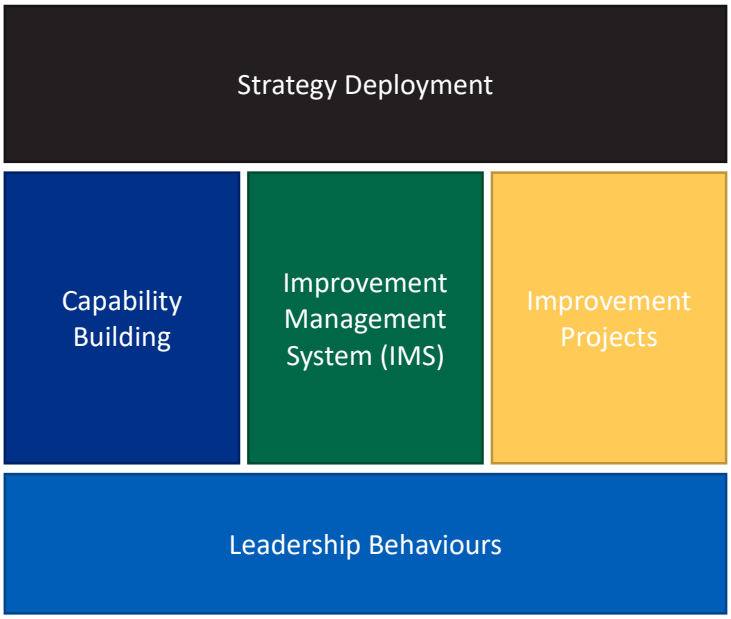
Implications/Impact:	Key Risks and Mitigation • Risk: Insufficient leadership engagement *Mitigation:* Ongoing coaching, structured SDRs, and visible leadership presence through gemba walks. • Risk: Cultural resistance to new ways of working *Mitigation:* Embedding leadership behaviours, continuous communication, and celebrating early successes to build momentum.
Assurance:	Reasonable
Oversight:	Oversight by the Finance and Performance Committee

Version Control: 01

Introduction

The Doing well Together (DWT) Improvement Programme is a continuous improvement programme which aims to embed improvement into the way we run the business and to give our people the skills to deliver sustainable and meaningful improvements.

Doing Well Together launched in March 2025. The programme consists of 5 pillars, aiming to deliver a cultural shift in the trust in how we approach improvement; making it everyone's business to deliver change.



Strategy Deployment – aligns directorate improvement activity to the wider trust strategy. Ensuring that all improvement, supports the delivery of the trust's strategic ambitions. Strategy deployment also incorporates the governance of the strategy through strategy deployment reviews and also, manages the maturity of DWT itself.

Improvement Management System – empowering frontlines teams to make improvement in their areas through an extensive training programme and on-going coaching. Teaching tools such as improvement huddles, A3 Thinking, visual management, data for improvement and process confirmation.

Capability Building – building improvement capability across the organisation, enabling individuals to undertake strategically aligned improvement projects rather than reliance on a central improvement function to lead change.

Improvement Projects – larger strategic transformation programmes require improvement subject matter experts and/ or traditional project management. The improvement team has capabilities in both methods of project delivery and provides support to drive complex change such as the trust breakthrough objectives, strategic initiatives and key projects. We also work with clinical audit and research in the Improvement Collaborative to co-ordinate ad-hoc requests for improvement support.

Leadership Behaviours – embedding daily continuous improvement requires a different leadership style; one that encourages problem solving, is less reactive and using coaching to

Version Control: 01

support staff to be empowered to make improvement. Embedding these leaderships behaviours, will enable Doing Well Together to be sustainable for the future.

The below sets out in more detail the approach of each of the 5 pillars and the progress to rollout DWT so far.

Strategy Deployment

Strategy Deployment is the structured process of translating the Trust's vision and strategic priorities into actionable objectives across all levels of the organisation. It ensures a clear 'golden thread' from Board to ward, so that every team and individual understands how their work contributes to the Trust's overarching goals. This approach fosters alignment, accountability, and focus on what truly matters for delivering high-quality care and operational excellence

As part of the Doing Well Together programme, Strategy Deployment is responsible for delivering four key domains:

1. Directorate DWT – our DWT leadership training, equipping directorate senior leadership teams and management teams with practical tools and behaviours to lead improvement effectively.
2. Yearly Catchball conversations - the catchball process is a structured approach that ensures each Directorate actively contributes to the Trust's overarching strategy. By combining objective data with expert insight, this process establishes annual scorecard metrics for every Directorate.
3. Monthly Strategy Deployment Reviews (SDR) at Directorate and Trust levels - replacing Quality and Performance Reviews (QPR) as the primary mechanism for monitoring performance and providing assurance on strategic priorities.
4. Programme maturity - Strategy deployment is also the mechanism for sustaining DWT.

Progress

To date, Acute and Forensics and Specialist directorates have completed their Directorate DWT training and coaching. East & West Kent Directorates have completed their training and are currently in their coaching period. North Kent will start their training in February. The table below shows high-level feedback from the training/ coaching.

Directorate	Training	Feedback	Coaching	Feedback
Acute	Completed	**70%** found the training a **useful** and **valuable** use of their time	Completed	**100%** found the coaching a **very useful** and **valuable** use of their time
F&S	Completed		Completed	
East Kent	Completed	**71%** found the training was **very useful** and a **valuable** use of their time	Started 4/11/25	-
West Kent	Started 30/10/25	-	-	-

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North Kent	Start Feb 2026	-	-	-

All directorates have had a catchball to identify their driver and watch metrics. These metrics are now being monitored through the new Directorate SDR's which started in September. Directorate SDR's are continuing to evolve. We have implemented business rules ensuring that reporting is data driven and standardised and are working with BI colleagues to develop a mechanism for the reporting of business as usual metrics using a similar data driven approach. From December Trust level SDR will commence, reviewing the strategic ambitions Trust wide.

Improvement Management System (IMS)

The Improvement Management System (IMS) is a cornerstone of the DWT programme. It is a structured management system, which seeks to empower teams and individuals at all levels to solve problems within their services, using data and evidence to inform decisions. This differs to the other capability building programmes as it seeks to make daily continuous improvement part of the way we manage the business as opposed to a standalone improvement project

For Kent and Medway Mental Health NHS Trust, IMS means:

- **Embedding a culture of continuous improvement** where every team feels ownership of their problems and have the capability to solve them locally.
- **Creating consistency** across teams by standardising improvement practices through structured improvement huddles, visual performance boards, root cause analysis, and proven tools that sustain change, ensuring a common language and approach throughout the organisation.
- **Aligning local improvements with strategic goals**, so frontline actions directly contribute to our strategy and the directorate breakthrough objectives and driver metrics.
- **Building capability at scale**, so improvement becomes part of everyday work, not an add-on.

IMS is based on proven systems but has been adapted for mental health care to drive better outcomes for patients and staff.

Progress

Our IMS training is delivered in 'waves'; each wave is currently 4 teams. Teams are selected by several key factors: strategic priorities, data insights, top contributors, CQC requirements, the wider Trust landscape, and input from executive and leadership teams. An overview of the rollout plan and the content of the training is in Appendix A

Wave 1 (Model Cell/ pilot approach) included four wards in Dartford across the acute and forensics & specialist directorates; Amberwood, Pinewood, Tarentfort & Allington. All wards have successfully completed their training and are now in their final month of coaching before transitioning the four teams to their Strategy Deployment Business Partners for embedding the IMS into business-as-usual.

Version Control: 01

The Model Cell pilot concluded its training phase on schedule, with strong leadership engagement demonstrated by attendance from six Executive members and one Non-Executive Director. Planning for Wave 2 is underway, with several leadership visits already scheduled.

Leadership visits (gemba walks) have been completed across all four areas, reinforcing visibility and alignment with organisational priorities.

Wave 2 includes 4 acute wards at the Canterbury sites; Fern, Bluebell, Heather & Foxglove. Training started in early November and will continue to February 2026.

Wave 3 is yet to be scoped, however, plans are in place to look at how the training may need to be adjusted for community teams or corporate functions.

Capability Building

Building capability within the Doing Well Together programme ensures staff have the skills and confidence to embed continuous improvement into everyday practice. This approach underpins sustainable transformation across the Trust and aligns directly with our strategic priorities and True North objectives.

We are creating a culture where improvement is part of daily practice through three key areas:

1. **Equipping Staff with Practical Tools and Methods**

A structured training suite enables staff to solve problems locally and deliver improvements at scale:

- **White Belt** – Internal Lean and improvement awareness.
- **Yellow Belt** – A3 methodology training, leading to an internationally recognised qualification (Lean Competency System/Cardiff University). Supports medium to large-scale strategic improvements.
- **Green Belt** – DMAIC (define, measure, analyse, implement, control) training for complex improvements across the Trust (design phase underway for 2026 delivery).
- **Black Belt** – External qualification for Trust and system-level improvements.

Capability Offering:	**Frequency**	**Goal:**	**Delivery Status**
Trust Induction	Fortnightly	100% of new starters	
White Belt	Monthly	100% (4,000 staff)	
Yellow Belt	Quarterly	10% (400 staff)	
Green Belt	To be defined	1% (40 staff)	
Black Belt	As required	0.1% (4 staff)	

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In addition to these core training programmes we are also delivering training at trust induction to provide awareness of DWT to new starters and within the medical education programme to support our medical colleagues to deliver the Quality Improvement Projects but also to engage the workforce in the wider improvement programme.

2. Developing Leadership Capability

We are investing in leadership development to ensure leaders can effectively sponsor and support improvement initiatives at all levels. Our Directorate DWT training closely integrates with frontline team training through the Improvement Management System and individual development via our Belt training pathways

3. Aligning Capability with Strategic Priorities

All capability-building efforts are linked to strategic objectives, ensuring measurable benefits for patients and staff while maintaining focus on our True North. Training is priorities for those who are responsible for strategic programmes/ workstreams.

Progress

So far, 329 staff members (8.2%) have been trained in white belt. This is slightly off our planned trajectory but plans are in place to reschedule sessions to recover the pace. Improvement awareness training is included in trust induction and is being delivered to 100% of new starters.

Currently, 102 staff members have been trained in Yellow belt and 52 of them have been fully certified, a further 22 are currently being coached to completed their improvement projects before certification. 26 of those trained have failed to complete the Yellow belt accreditation. There are a variety of reasons for this, some have since left the trust but there has also been some learning to ensure that an appropriate improvement project is identified before a delegate attends training to ensure they can be successful.

We are working to develop our green belt accreditation in 2026/27, this is not currently being delivered in-house. However, we have a number of individuals within the improvement team who already have the accreditation.

Similarly, we have 2 accredited Blackbelts within the Improvement team and another 2 currently being trained by an external provider.

The Improvement team monitor a variety of KPI’s related to the delivery of our training programmes which can be seen in Appendix B.

However, we are keen that our capability building results in key measurable benefit for the trust. For example, each yellow belt delegate must undertake an improvement project in order to become accredited. We monitor the benefits realisation for these projects closely and categorise their impact to the organisation

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CATEGORY	LABEL	DESCRIPTION
Cat. 1	No Benefits	No measurable or observable benefits have been realised.
Cat. 2	Potential Benefits Identified	Benefits are anticipated but not yet realised or evidenced.
Cat. 3	Benefits Realised (Not Evidenced)	Benefits have been observed or reported but lack formal evidence or metrics.
Cat. 4	Benefits Realised and Evidenced	Benefits are realised and supported by clear evidence (data, feedback, etc)
Cat. 5	Benefits Sustained and Embedded	Benefits are sustained over time and embedded into practice as supported by clear evidence (data, feedback, etc)

The 52 certified yellow belts have delivered as follows:

Category	**Yellow Belt Benefits**
Category 1 – No benefits	17
Category 2 – Potential benefits Identified	21
Category 3 – Benefits realised (not evidenced)	2
Category 4 – Benefits realised and evidenced	7
Category 5 – Benefits sustained and embedded	1
Uncategorised (pending assessment)	4

This distribution demonstrates a strong contribution to organisational improvement, with several high-impact initiatives already realised.

Improvement Projects

Whilst empowering staff to make improvements in their workplace is imperative for cultural change. The Doing Well Together model recognises the need for central oversight for complex strategic improvements.

Strategic Project support

Strategic improvements that require a problem-solving approach are supported using the A3/ DMAIC methodologies. This includes our breakthrough objectives and most of our strategic initiatives. Transformation programmes with clear deliverables are supported using traditional project management. The improvement team has capability in both approaches and so can support all of the strategic outcomes.

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Governance

Project managers have been working with SRO's to ensure that each strategic programme has a clear and consistent governance structure and that standardised reporting and documentation is used across all programmes.

Prioritisation

A strategic filter has been developed and is being tested in different levels of the organisation to ensure that any new improvement commitments are aligned to the trust strategy and where necessary to de-prioritise existing work to enable capacity

Rapid Improvement events

Going forward the improvement team is working on a proposal to support rapid Improvement events (RIE's). This would include building capability whilst making process improvements in live time over a 5-day workshop. RIEs have been used successfully across other trusts and can give pace to some improvement programmes, particularly those that centre around improving processes and which are localised to a particular pathway or department.

Leadership Behaviours

Improvement leadership behaviours have been included in the Leading Well Together programme which is being delivered to our senior leaders across the organisation. Specifically focusing on skills such as coaching which empower staff to make improvement.

Leadership behaviours are also included in our Directorate DWT training and IMS. For Directorate DWT, there is a focus on going to gemba – 'where the value is added'; to understand the challenges faced by teams and to encourage the use of the DWT tools/ methods to make change. A number of directorate leaders and EMT have attended improvement huddles if the wave 1 IMS cohort to understand some of the challenges in implementing the huddles and the barriers to making improvement.

An example of this was during a visit to Tarentfort. The staff described challenges around patients looking through office window and the privacy issues with them being able to see computer screen but also the need for staff to have sight of the ward when in the office. The leader conducting the gemba visit, listened to the challenge and coached staff to consider using their improvement huddle to discuss the issue but also to think laterally about all the possible solutions. The staff then started to discuss how they might be able to use reflective film to solve the problem and decided to take their suggestion to the next huddle. Whilst a simple example, it shows how demonstrating humility and coaching staff can empower them to overcome local improvements themselves.

Conclusion

The Doing Well Together (DWT) Improvement Programme has begun to embed a culture of continuous improvement across Kent and Medway Mental Health NHS Trust and is delivering in accordance with rollout plans (see Appendix C). Through its five pillars the programme is delivering a tangible shift in how improvement is approached and sustained throughout the organisation.

DWT contributes to the breakthrough objective to increase the number of staff who feel able to make improvement in their areas. Whilst it is too soon to demonstrate any meaningful impact of DWT through data. There are early signs of the positive impact to the breakthrough objective. In

the July pulse survey; the acute directorate; saw a 7.5% increase in staff feeling able to make improvement from April and 3% increase from last year's annual staff survey. Whilst this is not conclusive, it is a positive indicator. The 2025 staff survey will provide the opportunity to better understand the impact of DWT on staff.

Other key achievements include the successful rollout of IMS training, the establishment of structured Strategy Deployment Reviews, and the development of robust capability-building pathways for staff at all levels. The programme's emphasis on leadership behaviours and coaching is empowering teams to identify and solve problems locally, fostering ownership and accountability.

Early outcomes demonstrate measurable benefits, with certified improvement projects already delivering high-impact results. The ongoing focus on governance, prioritisation, and alignment with strategic objectives ensures that improvement efforts remain targeted and effective.

Despite, the clear advantages of DWT, it is not without its challenges. The positive enthusiasm for the programme has resulted in a lot interest from staff to be part of the training. However, the limited capacity and capability of the improvement team, make it difficult to meet the demand and there is a risk that enthusiasm will wane if people can't engage in the programme.

The Improvement team is the result of a merge of the transformation team and the QI team, however, we are implementing a different improvement methodology through DWT and so there is a learning curve for the team. It will take time for individuals to be capable and confident enough to deliver training without the close support of the few with operational excellence experience - this is a significant pressure on those individuals.

Looking ahead, the DWT programme will continue to evolve, with further waves of IMS training, the introduction of rapid improvement events, and ongoing support for both frontline and strategic initiatives. By maintaining momentum and embedding these practices into everyday operations, the Trust is well positioned to deliver sustainable improvements for the benefit of patients, staff, and the wider community.

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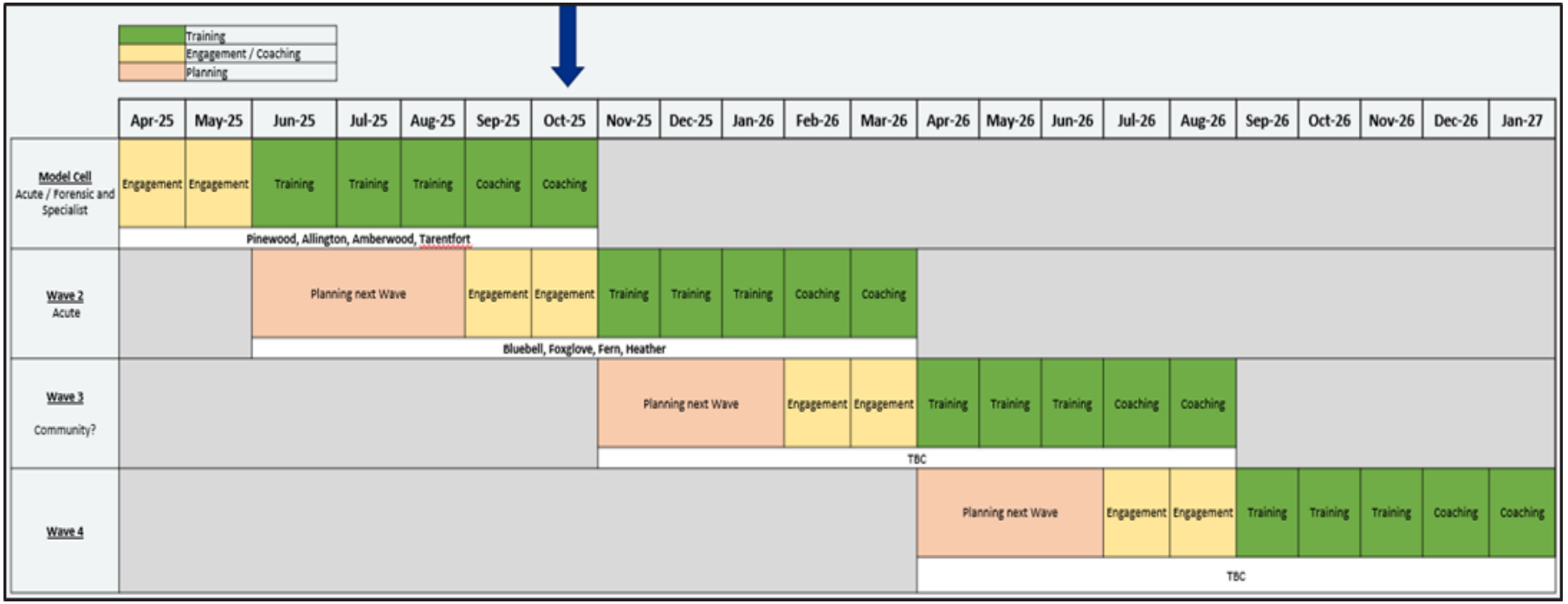
Appendices

Appendix A – IMS Rollout Plan & Training content

IMS Rollout Plan



IMS training content

Session 1 Trust Strategy & Vision

- Strategy Deployment
- Overview of Model Cell

Session 2

- Introduction to PowerBI & Data
- Catchball conversation

Session 3

- Visual Management
- Improvement Huddle Board
- Performance Board

Session 4

- Process Observation
- A3 thinking
- Identifying Waste

Session 5

- Voice of the Performance
- Systems Thinking

Session 6)

- Root Causes Analysis
- Voice of the Customer

Session 7

- 5S
- Identifying Countermeasures

Session 8

- Plan, Do, Study, Act (PDSA)
- Process Standard Work
- Action Planning

Session 9

- Measuring for Improvement

Session 10

- Status Sheets

Session 11

- Maturity Assessment
- People Standard Work

Session 12

- Practising Improvement Huddles
- Sustaining DWT

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Appendix B – Capability Building Dashboard

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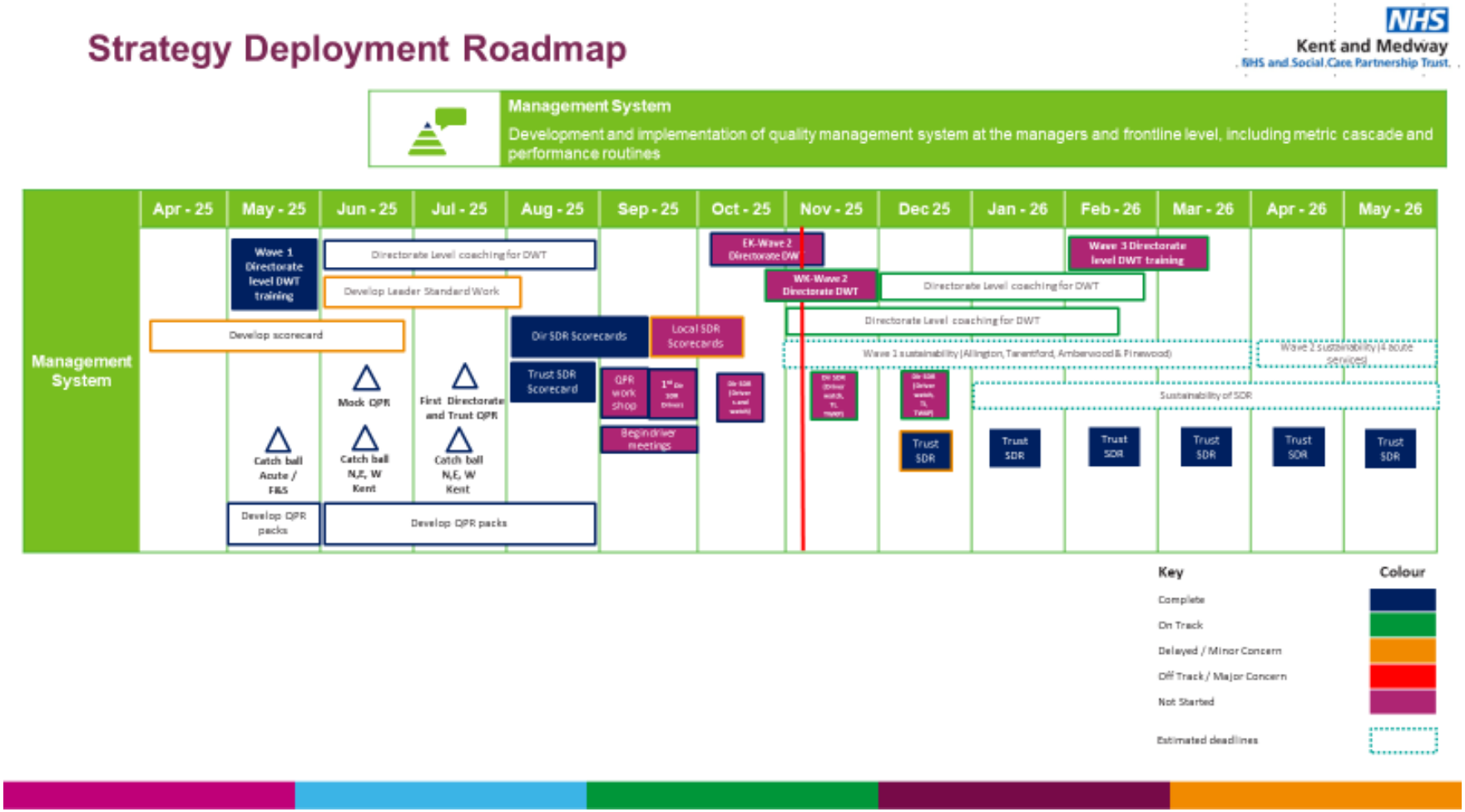
Appendix C – DWT Delivery Plans



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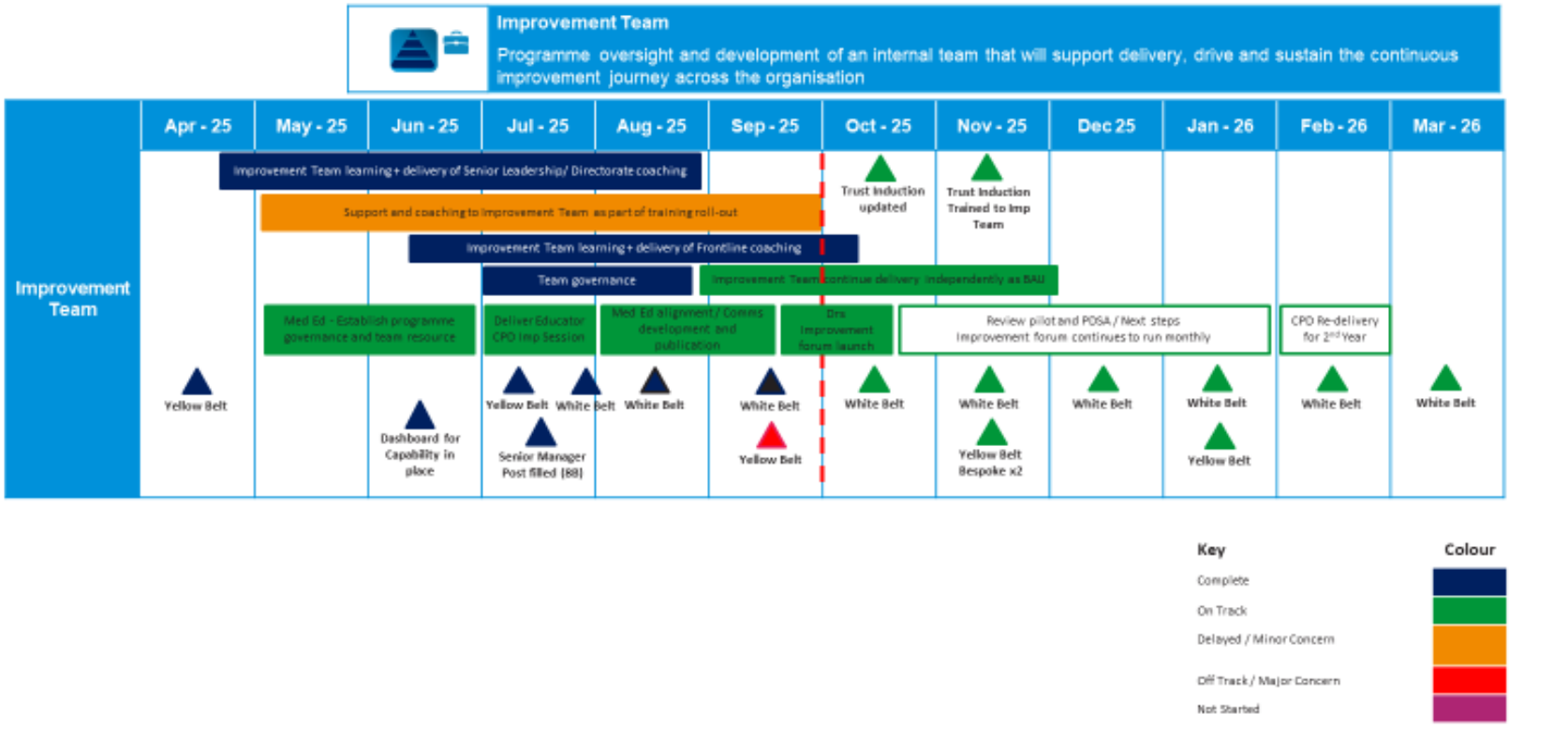
Capability Roadmap



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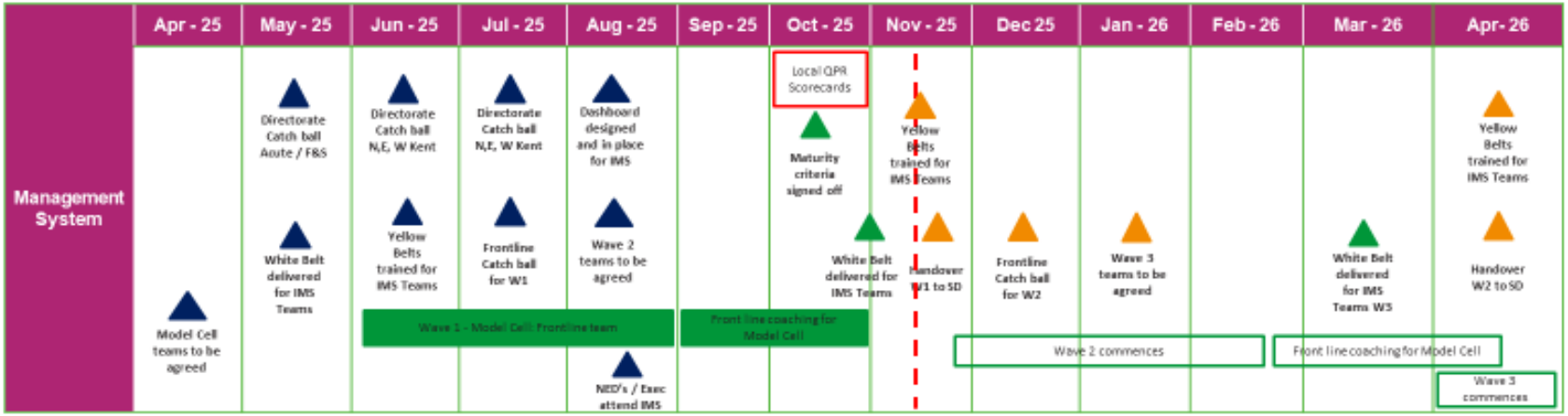
Improvement Management System Roadmap

NHS Kent and Medway NHS and Social Care Partnership Trust

Management System

Development and implementation of quality management system at the managers and frontline level, including metric cascade and performance routines



Key	Colour
Complete	
On Track	
Delayed / Minor Concern	
Off Track / Major Concern	
Not Started	

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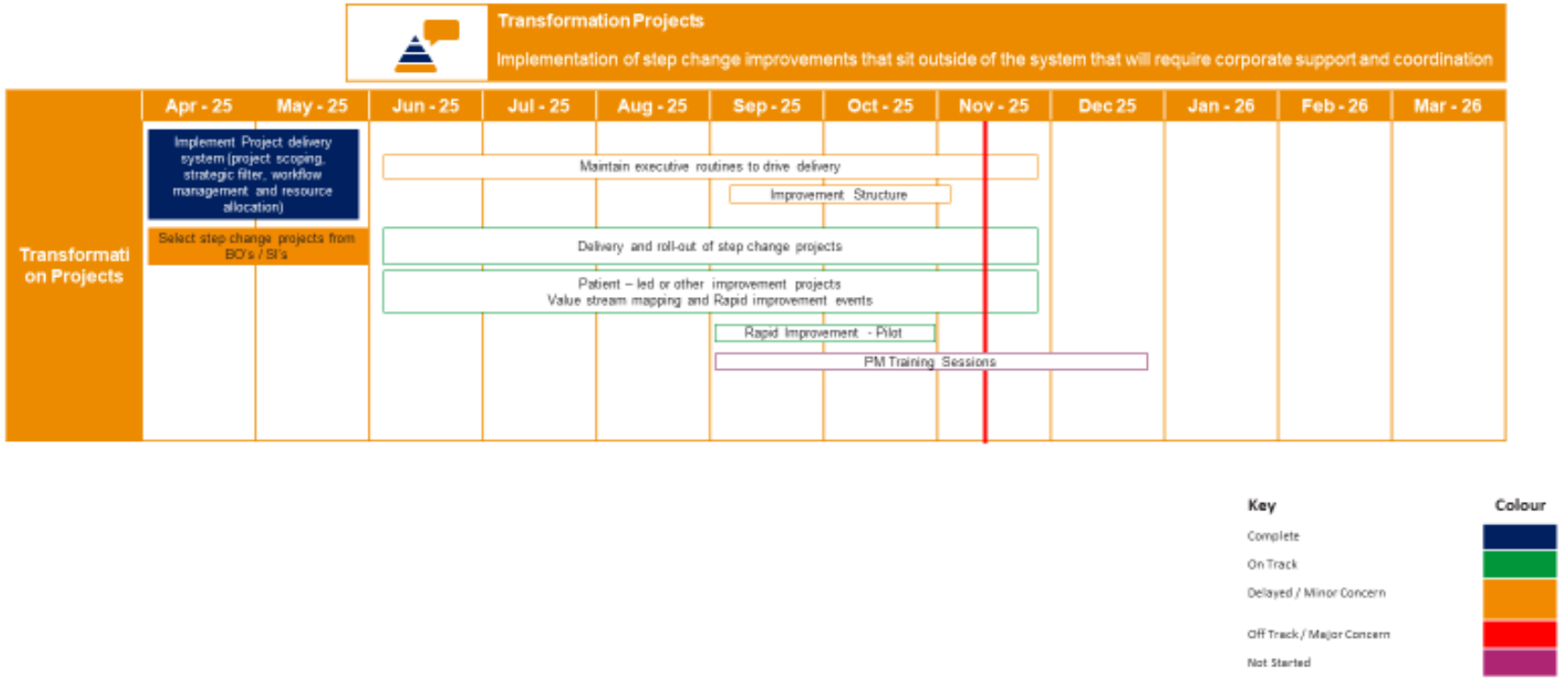
Improvement Projects Roadmap



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Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details

Date of meeting:	27th November 2025
Title of paper:	Safer Staffing – Mid-Year Establishment Review
Author:	Julie Kirby, Deputy Chief Nurse
Executive Director:	Andy Cruickshank, Chief Nurse

Purpose of paper

Purpose:	Discussion
Submission to Board:	Regulatory Requirement

Overview of paper

This paper provides a mid-year establishment review. A 21-day cycle of MHOST data was collected alongside CHPPD and fill rate data. This was triangulated with a professional narrative to summarise and conclude on the overall position of our safer staffing.

Issues to bring to the Board's attention

- In conclusion the review evidences that the establishments are appropriate and the wards are safely staffed however noting there continues to be a need for a review of the wider MDT in our female younger adult wards.
- Teams continue to require further support with acuity/ dependency scoring to establish an accurate data picture. This is being provided via NHSE CNO office using the train the trainer approach and is booked for January 2026.
- The trust is part of the national review of the MHOST which has just commenced and will include two wards (one younger adult and one older adult).

Governance

Implications/Impact:	Patient Safety
Assurance:	Reasonable
Oversight:	People Committee

1. Background and context:

The safer staffing and establishment reviews are a statutory responsibility of the Chief Nurse. The review must comply with set requirements detailed in the following:

- National Quality Board report, 2016
- Developing Workforce Standards – NHS Improvement, 2018
- Health & Social Care Act 2008 – Regulation 18

It is also imperative that staff understand safer staffing levels, including understanding the relationship between skill mix, safety and quality of care. The NMC provides clear expectations in their nursing proficiency standards for registered nurses under platform 6.2:

'Understand the relationship between safe staffing levels, appropriate skills mix, safety, and quality of care, recognising risks to public protection and quality of care, escalating concerns appropriately.'

2. Methodology

This paper provides a mid-year update of the annual safer staffing review.

The trust has previously undertaken cycles of reviewing staffing using the Mental Health Optimal Staffing Tool (MHOST). This tool is a 'multi-disciplinary tool, evidence-based system that enables ward-based clinicians to assess patient acuity and dependency, incorporating a staffing multiplier to ensure that ward establishments reflect patient needs in acuity and dependency terms.'

It is advised that the tool is used in conjunction with quality metrics. The information collated for this mid-year review included:

- MHOST data for 21 days between 6th – 26th October 2025
- Comparison of both CHPPD and FTE recommendations
- Fill rates per ward for the month of September
- Professional discussion

The purpose of Care Hours Per Patient Day (CHPPD) and Fill Rate data is to monitor and record the extent of which rota hours on a roster are filled and care hours provided. The below table shows a breakdown.

Key Differences from Actual CHPPD

- **Actual CHPPD** = worked hours ÷ patient days (retrospective measure).
- **MHOST CHPPD** = modelled care hours based on acuity and dependency (predictive measure).
- Recommended CHPPD is used for **establishment reviews**, not daily staffing decisions.

Ward	Actual CHPPD	MHOST CHPPD Recommended	Actual FTE	MHOST FTE Recommended
Allington Centre	213.97	209.47	43.72	19.24
Amberwood	140.81	152.38	30.25	14.10
Bluebell	127.33	195.96	32.00	18.30
Boughton	123.57	197.12	31.00	18.40
Bridge House	78.17	87.82	13.95	8.20
Brookfield Centre	131.79	148.90	30.29	13.65
Chartwell	118.42	236.12	28.25	22.00
Cherrywood	206.57	283.19	28.25	25.56
Emmetts	156.69	195.42	35.62	18.24
Ethelbert Road	63.57	99.16	13.80	9.26
Fern	129.50	208.53	28.00	19.38
Foxglove	138.60	228.31	29.00	20.91
Groombridge	151.59	235.72	22.99	21.59
Heather	140.19	120.11	27.00	11.21
Jasmine	137.45	141.29	28.25	13.17
Newhaven Lodge	73.25	73.66	13.20	6.88
Penshurst	223.64	264.61	43.82	24.07
Pinewood	123.76	186.17	28.25	17.30
Rivendell	70.82	154.77	14.00	14.45
Rosebud	75.24	99.84	14.50	9.33
MBU	147.22	136.03	26.43	12.69
Ruby	136.89	138.88	29.00	12.80
Sevenscore	136.17	185.46	31.00	16.99
Tarentfort Centre	232.89	197.99	42.64	18.48
The Grove	66.02	86.84	12.70	8.11
The Orchards	143.16	109.42	32.00	10.20
Tonbridge Road	79.95	76.97	14.60	7.19

Upnor	174.27	168.00	24.00	15.65
Walmer	175.03	251.32	39.29	23.24
Willow Suite	257.69	295.04	31.00	26.10
Woodchurch	133.87	199.68	20.85	18.20

Fill Rate Data:

At the time of writing this report the fill rate data for October was not available therefore September's data has been included to provide an indication. Individual fill rates showing a concern will be discussed in the relevant sections of this report below.

Care Group	Ward	Day		Night		Overall
		RN	HCA	RN	HCA	
Acute	Amberwood	104.8%	104.3%	103.3%	81.1%	98.8%
Acute	Bluebell	103.0%	86.5%	100.3%	118.7%	99.2%
Acute	Boughton Ward	110.5%	114.3%	104.9%	138.7%	116.5%
Acute	Chartwell Ward	96.6%	96.9%	100.1%	112.1%	100.6%
Acute	Cherrywood Ward	65.7%	145.2%	99.7%	224.6%	128.0%
Acute	Fern	96.0%	107.7%	101.0%	112.4%	104.9%
Acute	Foxglove	95.0%	124.7%	97.0%	160.5%	120.4%
Acute	Heather	89.2%	105.8%	99.9%	100.9%	99.7%
Acute	Jasmine	117.8%	76.7%	103.7%	74.2%	87.1%
Acute	Pinewood Ward	128.0%	145.3%	115.0%	206.9%	148.1%
Acute	Ruby Ward	84.8%	93.1%	98.3%	101.1%	94.2%

Acute	Sevenscore	77.0%	105.8 %	103.3 %	104.4 %	98.5%
Acute	The Orchards	98.1%	81.9%	100.5 %	102.1 %	93.0%
Acute	Upnor Ward	86.1%	111.6 %	100.1 %	127.2 %	105.5 %
Acute	Willow Suite	95.6%	278.0 %	123.6 %	339.5 %	218.9 %
Acute	Woodchurch	78.7%	87.0%	99.9%	103.2 %	91.0%
East Kent	Ethelbert Road	131.0 %	59.0%	100.0 %	100.0 %	87.1%
East Kent	Rivendell	83.5%	70.6%	99.9%	80.0%	80.1%
East Kent	The Grove	65.7%	64.1%	100.7 %	66.7%	69.8%
Forensic & Specialist	Allington Centre	99.9%	126.4 %	98.6%	144.1 %	122.2 %
Forensic & Specialist	Bridge House	147.4 %	99.7%	100.0 %	109.9 %	111.1 %
Forensic & Specialist	Brookfield Centre	100.6 %	97.9%	100.0 %	105.5 %	100.2 %
Forensic & Specialist	Emmetts	113.2 %	103.9 %	98.4%	75.0%	96.4%
Forensic & Specialist	Groombridge	103.5 %	108.1 %	96.7%	109.9 %	106.1 %
Forensic & Specialist	Penshurst	108.0 %	145.1 %	99.4%	162.3 %	134.1 %
Forensic & Specialist	South Central EDMBU	78.5%	81.1%	100.0 %	94.4%	75.7%
Forensic & Specialist	Tarentfort Centre	114.3 %	129.1 %	100.1 %	148.3 %	127.9 %
Forensic & Specialist	Walmer	113.3 %	98.3%	96.8%	102.2 %	101.8 %
North Kent	Newhaven Lodge	99.7%	112.0 %	99.8%	103.2 %	118.0 %
West Kent	111 Tonbridge Road	129.5 %	151.0 %	99.8%	112.4 %	137.0 %

West Kent	Rosewood Lodge	121.8 %	200.5 %	100.0 %	99.7%	147.7 %
Grand Total	**Grand Total**	**98.44 %**	**112.32 %**	**101.47 %**	**125.89 %**	**110.31 %**

Following an analysis of the MHOST data in the full year review earlier this year it was evident of a training need with regards to the acuity descriptors and how these relate to individual services. One of the recommendations was for the Deputy Chief Nurse and Corporate Head of Nursing and Quality to provide some training for the teams. Since the review and some discussion with the national CNO safer staffing team, training is booked to be provided by the national team in January 2026.

3. Medium Secure Units (MSU)

Within the trust we have three male MSU's and one female MSU based on one site. Penhurst report a higher fill rate and higher establishment which is to be expected for an admission ward. As with LSU the increase is in support workers which indicate enhanced observations and/or relational security needs.

The team also fed back that the current agreed % of headroom does not reflect the needs required for the workforce. It is difficult to ascertain this from a data perspective due to the data inputting.

It was noted that nursing recruitment and retention is positive and well managed.

4. Low Secure Units (LSU)

Within the trust we have three LSU's based on one site.

It is noted that both Allington and Tarentfort have higher fill rates for support workers and that both of their MHOST data showed an increase, however the MHOST completion remains inaccurate.

Nursing recruitment and retention is notably positive.

5. Mother & Baby Unit (MBU), Bridge House (Detox) & Willow Suite (PICU)

Bridge House has a small but sufficient staffing team. There are risks however due to such low numbers on shift in the event of sickness but this is mitigated by a reliable and effective use of known bank staff, skilled to work in this area. They are a positive outlier for reporting compliments and this was acknowledged in the professional discussion.

Willow suite continues to show as a significant outlier with a considerable fill rate as seen below. Compared to March this year there is an increase. The reason for the increased staffing is reportedly due to acuity and enhanced observations.

This ward is currently being monitored by the directorate leadership team and support in place including relational security training to support the team reducing restrictive practices affecting fill rates.

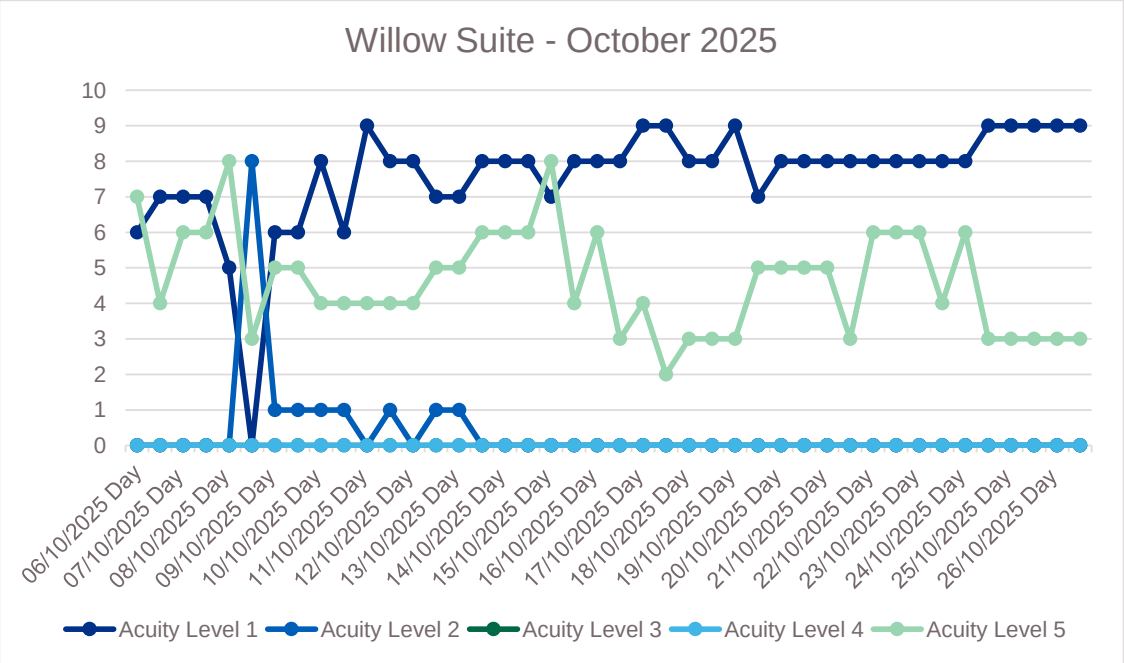
March 2025-

Willow Suite	99.8%	204.9%	149.9%	240.3%	176.3%

September 2025 –

Acute	Willow Suite	95.6%	278.0%	123.6%	339.5%	218.9%

We can also see that with regards to the MHOST data we would expect to see acuity levels of 3 and above for a PICU however the team reported lower levels on a daily basis, which doesn't align to the sustained heightened fill rate. This can be attributed to a training need for the team relating to MHOST, which is planned for January 2026.

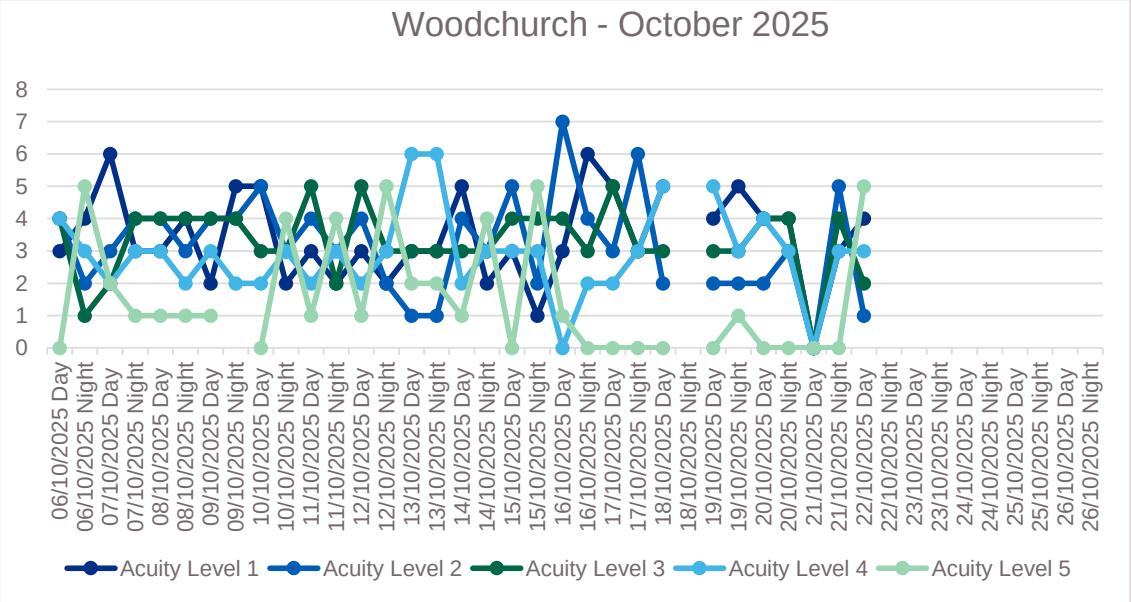


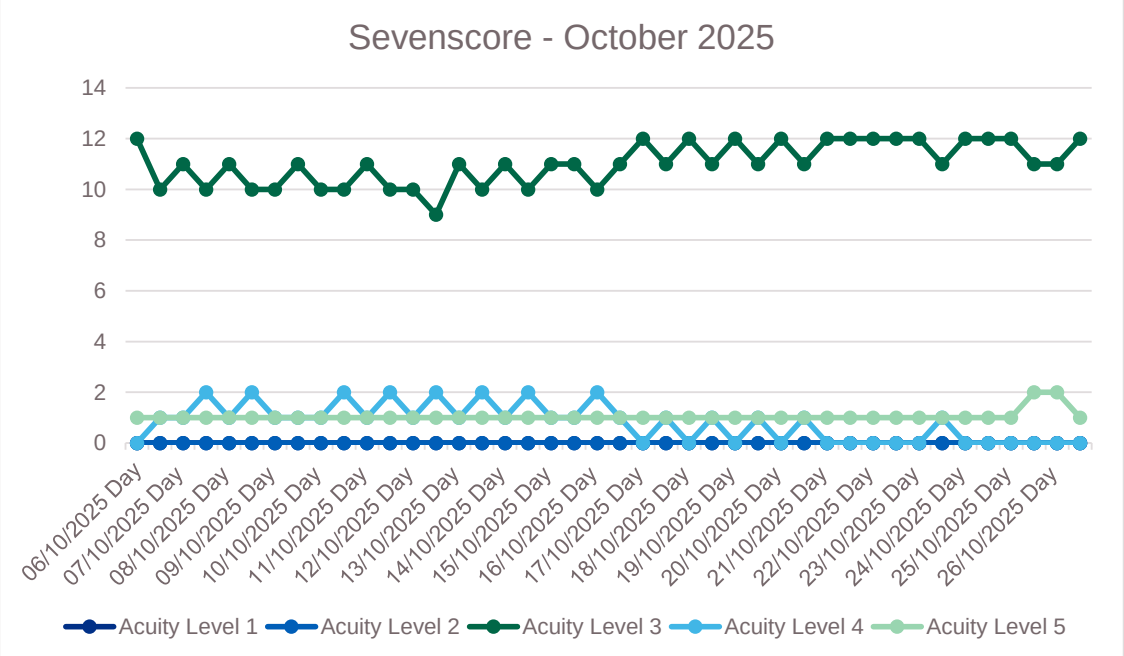
MBU show a low fill rate and are not aligned with MHOST and actual FTE recommendations however it should be noted that this ward do flex their staffing due to capacity and will have less staff on shift if there are fewer admissions. This is felt to be well considered and managed by the team and does not raise concerns regarding safer staffing.

6. Acute - Older Adult Wards

There are six older adult wards within the trust, three of each gender and these are located across the county.

Both Sevenscore and Woodchurch show low levels of fill rates for registered nursing staff however the team feel this is inaccurate due to establishment data errors and plan to rectify. Their MHOST data shows a variance across the wards in data reporting. We can see Woodchurch acuity is particularly variable and this would be unexpected and more likely related to data entry, identifying a training need. Sevenscore however show a more predicted consistent picture. Woodchurch also has missing periods of data from non-completion.





7. Acute - Younger Adult Wards

There are four male younger adult wards, and five female younger adult wards spread across Maidstone, Dartford and Canterbury sites.

Pinewood fill rates remain high, in March this was attributed to four new starters however this remains high in October. We have identified a need in our male wards for staff to have support with regards to relational security and restrictive practices, notably enhanced observations.

Fern ward was a notable outlier in March with higher levels of observation required, zonal observations inconsistently used, and the team reporting a high admission and discharge rate. Over the past few months there has been significant improvement with regards to observations and flow and we can see this reflected in the fill rate.

It was identified in March that for acute wards the MHOST only returned two wards recommended for higher levels of staffing, and these were both female younger adult wards, Chartwell and Upnor. It was however noted with caution as we were aware of the need for further support with a full understanding of MHOST acuity levels. The recent review in October evidenced further the training need as the MHOST data shows a reduction in acuity, which is not supported with other quality metrics.

8. Community Inpatient Rehabilitation Services

There are six community inpatient rehab wards across the county. Across these services it was clear that MHOST requires further support and understanding to how the tool can be applied for rehab services.

We can see variances in fill rates, with the Grove showing particularly low rates, and both 111 and Rosewood showing higher rates. This is attributed to the need for an e roster review due to inaccuracies with the reported establishment.

9. Health Based Place of Safety (HBPoS)

There are currently three HBPoS’s across the county. These were not included in the MHOST collection as the tool is not adequate for this setting.

10. Trust Wide Analysis

Fill rates on several wards appear to show a concern that staffing may be low at times however on every occasion the teams reported this wasn’t reflecting accurately. The wards indicated have been advised to meet with the e roster lead for further exploration and advice.

Notably staff reported feel less supported at night, which further supports the case for 24/7 Duty Senior Nurse onsite cover. There is a proposal for this to be consulted upon within the next month.

During the period of time between reviews the clinical model across all wards has changed and HCSW’s have been supported into band 3 positions. The only band 2 HCSW positions across wards are now apprenticeship roles.

At the current time the acuity descriptors for MHOST are completed on a daily basis and often completed by admin staff. The evidence for MHOST suggests this is more effective when only completed over two 21-day periods and purely for the use of establishment reviews. These should also be completed by a senior clinician and should reflect the clinical presentations of acuity on the ward.

From both the initial review and this mid review we can see that the MHOST data recording is both inconsistent and unreliable. Therefore, to improve the data quality it is proposed that this is discontinued and adapted to the national guidance of twice a year for 21 days and completed by a band 6 or above trained member of clinical staff.

11. Summary and Conclusion

In summary this review concludes the current establishments do meet the safer staffing requirements for the wards as they are defined, and that wards are safely staffed. There is an identified need for further work on relational security and reducing restrictive practices across our male wards, and women's health on our female wards. Both these areas have work underway.

Overall the MHOST and CHPPD data generally indicates that most wards are over staffed however when considering the data inputting and professional narrative this appears inaccurate. The MHOST acuity descriptors are widely mis interpreted by teams with most teams under rating their acuity levels significantly.

The new process commenced this year has been welcomed by teams and has encouraged discussion regarding safer staffing. There is however an identified need for further training. This was to be provided by the Deputy Chief Nurse and Corporate Head of Nursing and Quality however since this was agreed links have been developed with the CNO Safer staffing team who have offered train the trainer sessions. These were felt to be more thorough and detailed and are booked for January. Every ward manager across acute and F&S, alongside a matron from each site are all planned to attend.

The trust also responded to an invite to participate in the MHOST tool review and this has commenced recently, with two wards being a part of the review. Alongside a financial incentive for each ward, benchmarking data and activity will be shared within the review group and there is an increased opportunity for networking and sharing.

12. Recommendations

1- Safer staffing training to be delivered by NHS CNO team in January 2026
2- Daily acuity completion for MHOST to discontinue and be completed for two 21-day periods over 12 months by a band 6 (or above) trained clinician
3- Full establishment reviews to be undertaken post training in March/ April 2026

Kent and Medway Mental Health NHS Trust

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**27th November 2025**
Title	**Quality Committee Chair's Report**
Author	**Stephen Waring, Non-Executive Director**
Presenter	**Stephen Waring, Non-Executive Director**
Executive Director Sponsor	**Andy Cruickshank, Chief Nurse**
Purpose	**Noting**

Agenda Items

People items	**Patient items**	**Finance & Governance items**
	• Quality Digest • Violence and Aggression/Restrictive Practice Report • Section 29 Warning Notice Report • Suicide thematic review • Speech and Language Therapy • Liaison Psychiatry Performance • Research and Innovation Strategy Update (incl. Proposed research KPIs) • Quality Impact Assessments • Mortality Report	• Chief Nurse's Report • Quality Risk Register • CQC Report • Female PICU model

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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.
Chief Nurse Report	The Committee received a detailed report from the Chief Nurse on a recent cluster of community deaths. Assurance was received that no immediate common thread had been identified and that the Trust had commissioned an independent review, with outcomes expected to be reported by early 2026.	**Reasonable Assurance**	Next Steps: • An independent review has been commissioned, alongside the Trust's Patient Safety Incident Response Framework, to ensure objectivity and early learning.
Quality Digest	Discussion focused on the use of prone restraint and the need to monitor demographic data to address potential disproportionality. The Committee was assured that work is underway to improve training and reporting, and that future reports will enable a more nuanced understanding of restrictive practices through a health inequalities lens.	**Reasonable Assurance**	Next Steps: • The under-reporting of racially motivated incidents was noted as an area requiring further attention
Risk Register	The Committee welcomed the improved presentation of the risk register, particularly the mapping against the Board's risk appetite. While the prevalence of risks outside tolerance remains a concern, the Committee was assured that directorates are actively working to address these areas.	**Reasonable assurance**	Next steps: • The Committee referred risk ID 08458 "Inadequate Office Facilities/space for Ashford Liaison staff at William Harvey Hospital…" to the Audit and Risk Committee, for further consideration

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Suicide Thematic Review	The thematic suicide review was praised for its depth of analysis and clarity, particularly its focus on intersectionality and the need for professional curiosity.	**Reasonable assurance**	The Committee noted the need to strengthen diagnostic recording and to better understand the prevalence of neurodiversity among those affected.
Research and Innovation Update (incl. proposed research Key Performance Indicators (KPIs))	The Committee welcomed the progress on research and reviewed and approved the proposed KPIs for the Research and Innovation Strategy, recognising the need for greater ambition in staff engagement and the importance of support from the executive to enable clinical participation in research.	**Reasonable assurance**	The Committee had been asked by the Board to work with the Director of Research, and is content to recommend the approved KPIs to the Board.
Free Text – The Committee was delighted to welcome several observers to the meeting, including clinical and other colleagues who were shadowing attendees. The committee also welcomed an external Quality Committee Chair, as part of an exchange of learning between NHS organisations.			

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details	
Date of meeting:	27th November 2025
Title of paper:	Mortality Report – Executive Summary
Author:	Andy Cruickshank, Chief Nurse
Executive Director:	Andy Cruickshank, Chief Nurse

Purpose of paper

Purpose:	Noting
Submission to Board:	Regulatory Requirement

Overview of paper

This quarterly report fulfils regulatory requirements for monitoring and oversight of patient mortality incidents within Kent and Medway NHS Trust. It covers all reported deaths in Q2 2025/26, including natural causes, unexpected deaths, and suspected suicides, and compares them to previous quarters. The report also outlines learning from Structured Judgement Reviews (SJRs) and ongoing improvement initiatives.

Issues to bring to the Board's attention

- Structured Judgement Reviews (SJRs) have shown an increase in cases flagged as learning opportunities or potential patient safety events this quarter. Common themes include physical health and risk assessment, which will be addressed through existing strategic groups and improvement workstreams. Notably, some SJRs identified learning already actioned by governance teams or covered in Rapid Reviews, prompting a review of processes to reduce duplication and move towards a leaner, more efficient model.

- Mortality rates have shown common cause variation across the 21-month reporting period. Rates in Q2 were lower than the previous two quarters but remain broadly consistent with Q2 of 2024/25.

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Protected characteristics training is scheduled to go live at the end of October 2025. Work to improve data quality continues, including the recent implementation of interoperability between RiO and InPhase. However, ethnicity fields remain misaligned across systems, limiting progress. Once resolved, an improvement in ethnicity recording within InPhase is expected.

- Latest suicide data published by the Office for National Statistics (ONS), shows that suicide rate per 100,000 has reduced in Kent and Medway, with Medway falling just below the England average. Suicide rates in the trust have continued to fall in Q2.

Governance

Implications/Impact:	Patient Safety
Assurance:	Reasonable
Oversight:	Mortality Review Group, Trust Wide Patient Safety & Mortality Review Group, Quality Committee

Key Findings

Mortality Trends

- Total reported deaths in Q2 2025/26 were 376, lower than the previous two quarters but similar to Q2 2024/25.
- 70% of deaths were patients over 70, mostly due to natural or expected causes.
- Unexpected deaths outnumbered expected deaths, often due to unknown causes where no care or service delivery issues were identified.
- There was one homicide reported, but the patient was not under Trust care at the time.

Demographics

- Mortality rates are higher in males than females, consistent with national data.
- 73% of deaths were among White-British patients, mirroring national census data. Only 4% were from ethnic minority backgrounds, with no significant trends identified.
- There are ongoing gaps in ethnicity recording, with 20% of cases listed as unknown or not stated. Efforts to improve data quality are underway, including system integration and staff training.

Suspected Suicides

- The latest Office for National Statistics (ONS) data, shows that the rate of suspected suicides in Kent and Medway has declined, with Medway now below the England average.
- Most suicides occurred in middle-aged cohorts with males more affected overall, though female suicides were higher in September 2025.
- The Trust is auditing risk assessments and participating in national studies to better understand and address suicide risk.

Structured Judgement Reviews (SJRs)

- 24 SJRs were completed in Q2. 37% of cases were rated as good or exemplary care, down from 65% in the previous quarter.
- There was an increase in SJRs identifying learning opportunities or potential patient safety events.
- Key areas for improvement include physical health care (documentation, checks, response to abnormal findings) and risk assessment (documentation, professional curiosity, response to deterioration).
- Additional staff have been trained in SJR methodology to strengthen the review process.

Governance and Improvement

- Protected characteristics training for staff is launching, and a Power BI dashboard is available to monitor compliance.
- The Trust has improved data interoperability between RiO and InPhase systems, though ethnicity field alignment remains a challenge.
- The Medical Examiner referral process is established, but no referrals have been required since the national rollout.

Recommendations and Next Steps

- Continue to address gaps in data quality, especially ethnicity recording.
- Ensure learning from SJRs is embedded into strategic improvement workstreams, particularly around physical health and risk assessment. To review and refine parts of the SJR process, to avoid duplication.
- Monitor the impact of new training and system changes on data quality and patient safety outcomes.
- Maintain vigilance in suicide surveillance and risk assessment, with ongoing audits and staff engagement in national studies.
- Progress information sharing agreements with Medical Examiners to enhance oversight.

In summary: The Trust has seen a reduction in overall mortality and suicide rates in Q2 2025/26, with ongoing efforts to improve data quality, learning from incidents, and staff training. Key areas for improvement remain in physical health care and risk assessment, with actions underway to address these and ensure patient safety remains a top priority.

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Title of Meeting	**Public Board Meeting**
Meeting Date	**27th November 2025**
Title	**People Committee Chair's Report**
Author	**Kim Lowe, People Committee Chair, Non-Executive Director**
Presenter	**Kim Lowe, People Committee Chair, Non-Executive Director**
Executive Director Sponsor	**Sandra Goatley, Chief People Officer**
Purpose	**Noting**

Agenda Items

People items	**Patient items**	**Finance & Governance items**
• Staff Story – Consultation experience • People Committee Main Report • People Risk Register • 10-year plan • Deep Dive: Recruitment- Pipeline Modelling • Learning from recent consultations • Job Evaluation -Nursing and Midwifery Job Profiles		• HR Policies and Procedures

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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.
Main Report	The Committee reviewed the current workforce position and gained assurance that vacancy and turnover levels remain stable and within target, with continued progress across recruitment, leadership development and the People Plan priorities. However, sickness absence continues to exceed the target, with particular pressures in North Kent linked to long-term cases and seasonal illness. Mitigating actions are in place and will be monitored closely. System-wide changes present notable risks and dependencies. The introduction of Kent and Medway pay controls, the delay to the national Workforce Plan. All require coordinated action. The likelihood of missing the Oliver McGowan training target is high. The Committee is assured that early planning is underway, but oversight will be needed as the system approaches the withdrawal of funding in	**Reasonable Assurance**	Next steps: • Implement system pay controls and strengthen vacancy control processes. • Finalise and communicate the People operating model and roadmap. • Maintain close oversight of sickness absence, with targeted support in high-risk directorates. • Progress the Oliver McGowan training plan. • Complete development of the underrepresented talent programme and roll out the Talent & Succession Toolkit. • Revisit the EDI action plan.

	February 2026. KMMH will exceed that training target by March 2026. The People Plan programmes continue to mature, with positive progress on leadership development, succession planning, EDI, violence reduction and values implementation. The Committee took reasonable assurance overall but highlighted the ongoing need for cultural stability and a refocus on our EDI action plan during a period of significant operational and financial change.		• Continue rollout of leadership, management and culture programmes, ensuring alignment with transformation priorities.
Deep Dive: Recruitment-Pipeline Modelling	The Committee undertook a deep dive into recruitment pipeline modelling and concluded that only limited assurance can be provided at this stage. With no additional funding anticipated, recruitment efforts remain focused on Female Psychiatric Intensive Care Unit and newly qualified nurses; however, the Committee remains concerned about the ongoing barriers to progressing Band 5 nurses into Band 6 community roles, particularly the financial disincentives that continue to impact workforce supply and retention. While work has started to refresh the Band 5–6 development pathway, the Committee agreed that further action is required to ensure a sustainable community pipeline.	**Limited Assurance**	Next steps: • The Chief People Officer and Deputy Chief Nurse will undertake a full review of the Band 5–6 development programme and evaluate financial incentive options to support progression into community roles, bringing clear recommendations and an implementation proposal back to the Committee by the next reporting cycle.

Learning from recent consultations	The Committee reviewed learning from recent organisational consultations, noting that more than 800 staff have been affected in the past year, with further change expected. The Committee took limited to reasonable assurance from the current arrangements: while there is evidence of positive staff experience where managers are accountable and communicative, the approach remains inconsistent across the organisation. To strengthen assurance going forward, the Committee endorsed work to streamline consultation processes, reduce unnecessary bureaucracy, and provide clearer, more practical guidance for managers. Embedding early, open communication with staff was highlighted as essential.	**Reasonable Assurance**	Next Steps: • Updated management guidance, incorporating staff story insight and a revised set of consultation principles. • Operational leads will be invited to a future Committee meeting to support development of stronger and more consistent management accountability during change processes.

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Title of Meeting	**Board of Directors (Public)**
Meeting Date	**27th November 2025**
Title	**Mental Health Act Committee Chair's Report**
Author	**Sean Bone-Knell, Committee Chair**
Presenter	**Sean Bone-Knell, Committee Chair**
Executive Director Sponsor	**Dr Afifa Qazi, Chief Medical Officer**
Purpose	**Noting**

Agenda Items

People items	**Patient items**	**Finance items**
	• Chief Medical Officer's Report • Report from MHLOG • Serious incidents with a Mental Health Act Element • Mental Health Act Activity Data Quarterly Report • CQC MHA Reviews • AHM Governance Report • 136 Breaches • Legislation Updated	

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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.
Chief Medical Officer's Report	The Committee received the following highlights: • Successful ward staff training delivered on Community Treatment Orders (CTOs), particularly in the North. • Recruitment progress has strengthened the MHA team, with only one post remaining vacant. • Continued improvement in KPI performance and section paperwork scrutiny. • Section 17 Leave Form amendments piloted; implementation delayed until November due to digital rebranding priorities. • Associate Hospital Managers (AHMs) raised concerns regarding fee alignment with other Trusts following benchmarking.	**Reasonable**	Next Steps: • Digital team to prioritise implementation of Section 17 Leave Form updates once rebranding work concludes. • Ongoing review of CTO Policy in partnership with Kent County Council.
Report from MHLOG	The group reported improved attendance and engagement, with productive discussion across directorates. Positive progress was noted in Community Treatment Order (CTO) training, Trust rebranding preparations, and improved communication with the IMPULSE service.	**Limited**	

	A key concern remains the shortage of Approved Mental Health Professionals (AMPs), which continues to impact assessment timeliness and patient care.		Next Steps: A formal letter will be sent to the local authority highlighting these concerns, and the issue will be recorded as a Trust-level risk for ongoing monitoring.
Mental Health Act Activity Data Quarterly Report	The Committee noted improvement in scrutiny activity this quarter, with seven reviews completed and expectations to meet the standard of twelve per quarter now that the team is fully staffed. Recurring issues were identified around Section 62 processes, particularly delays in Second Opinion Appointed Doctor referrals. Refresher guidance has been cascaded to medical staff to ensure immediate referral upon completion. A gap in training for newly qualified nurses regarding Mental Health Act section papers was highlighted. Additional training is being rolled out trust-wide to strengthen compliance and understanding.	**Reasonable**	Next steps: • Continue delivering Mental Health Act training across all sites. • Strengthen ward-level oversight and accountability through deputy heads of nursing. • Ensure Section 62 and Second Opinion Appointed Doctor processes are embedded in staff practice. • Report progress on training impact and reduction in recurring scrutiny issues at the next meeting.
CQC MHA Reviews	The Committee received assurance of continued improvement in patient care, staff compassion, and the reduction of blanket restrictions. Remaining areas for focus include consistent application of Section 132 rights, Independent Mental Health Advocate (IMHA) access to ward reviews, and care plan documentation.	**Reasonable**	Next Steps: • Ensure IMHA access to ward reviews and sharing of ward schedules. • Continue oversight of consent and care plan recording practices.

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Title of Meeting	**Board of Directors (Public)**
Meeting Date	**27th November 2025**
Title	**Finance, Business and Investment Committee Chair's Report**
Author	**Mickola Wilson, Non-Executive Director**
Presenter	**Mickola Wilson, Non-Executive Director**
Executive Director Sponsor	**Nick Brown, Chief Finance and Resources Officer**
Purpose	**Noting**

Agenda Items

People items	**Patient items**	**Finance items**
	• IQPR • Dementia • Perinatal provider Collaborative – one-year extension • Water Aggregation	• Chief Finance Officers Report • Planning Paper • Financial Plan • Finance Report and Forecast • Service Line Report and Costing Update • BAF Risk Updates - Finance Risks • Digital and IT • CYP finance paper

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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.
Chief Finance Officers' Report	The Committee reviewed the Trust's current financial position, noting continued pressure from agency spend, which is now forecast to exceed the cap. Planning for 2026/27 is progressing within the new three-year rolling framework, with a minimum 4% cost improvement requirement identified. The Committee also considered the productivity opportunities highlighted in national benchmarking.	**Reasonable Assurance**	The Committee has requested a single, consolidated update at the next meeting from the Chief Finance Officer, covering the draft 2026/27 plan (including agency), and a mapped analysis of productivity opportunities.
IQPR	The Committee reviewed the IQPR and noted ongoing pressures across patient flow, driven by significant bed constraints affecting performance and the 12-hour ED mental health target. Mental Health Together continues to show improvement, with a 10% reduction in waits, and the refined model is due for implementation in January. The dementia diagnosis wait has reduced from 190 to 90 days. The Committee remains concerned about the 111-crisis line, with a 30% abandonment rate. The Chief Operating Officer explained the present work being undertaken. • Did not attend (DNA) rates remain at 10%, influenced by current referral routes. Mental	**Reasonable Assurance**	Next Steps include continuing work on the crisis line to deliver longer-term improvements. Implement Mental Health Together and clarify access with primary care. Continue sustainability work, with improved reporting anticipated for March 2026.

	Health Together is expected to reduce inappropriate referrals and improve engagement • Clinical contact time remains low at around 40%. Work continues to refine demand and capacity, standardise activity recording and increase patient-facing time, with improved reporting expected by March.		
Digital	The Committee received assurance on continued progress across the Digital portfolio, with the Windows 11 rollout completed and preparations underway for the Cyber Essentials Plus assessment. Key initiatives—including electronic referrals, patient portal pilots, and the bed management dashboard—are advancing well, supported by strong staff engagement through the Digital Hub and Digital Champions Network.	**Reasonable Assurance**	The Committee highlighted the need to strengthen clinical involvement in digital transformation and agreed that clinical digital leads will attend a future meeting. The Committee also requested clearer reporting on organisational benefits and impact to ensure digital investment aligns with strategic objectives. Cyber risk oversight will remain in the Audit and Risk Committee, strengthening assurance

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Title of Meeting	**Board of Directors (Public)**
Meeting Date	**27th November 2025**
Title	**Charitable Funds Committee Chair's Report**
Author	**Sean Bone-Knell, Committee Chair**
Presenter	**Sean Bone-Knell, Committee Chair**
Executive Director Sponsor	**Adrian Richardson, Director of Partnerships and Transformation**
Purpose	**Noting**

Agenda Items

People items	**Patient items**	**Finance & Governance items**
• Charity Name Change – Options Appraisal	• Quarterly Impact Report	• Charity Operational Plan • Charity Risk Register • Finance Report • Annual Report & Accounts • Approval for Requests over £5000

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.
Quarterly Impact Report	The Committee reviewed the Q2 Impact Report and was assured by the positive progress made. Corporate volunteering remains a clear strength, delivering financial and reputational benefits, while fundraising continues to perform well. The Committee welcomed the proactive approach to learning from grant applications and the planned improvements to beneficiary impact reporting.	**Reasonable Assurance**	The Committee is assured that the charity continues to deliver meaningful outcomes and is strengthening its evidence base for impact and future funding opportunities.
Charity Operational Plan	The Committee reviewed the Operational Plan, with a focus on ongoing delivery and preparation for the winter period. Key initiatives include: • Winter Campaign: Launch of a targeted campaign supporting the Rough Sleepers Service, incorporating a sponsored sleepout, coat drive, and hot water bottle tree. • Webb's Garden: Continued development as a key fundraising and community engagement asset. • Engagement Expansion: Plans to introduce a charity podcast and increase opportunities for corporate volunteering.	**Reasonable Assurance**	Next Steps: • Committee members to provide input and advice on the proposed telephone befriending service bid. • Ensure clear and consistent communication to staff, supporters, and the public regarding donation initiatives. • Progress updates on campaign outcomes and strategy refresh to be presented at the next meeting.

	• Strategic Alignment: Recognition of the need to refresh the charity strategy in line with wider Trust developments and the acquisition of CAMHS services.		
Charity Risk Register	The Committee reviewed the rationalised Charity Risk Register and was assured that risk management continues to strengthen. Members welcomed the streamlined approach and the focus on aligning with the Trust's framework. The Committee noted that the self-funding risk will be reviewed to ensure proportionality and that clear target dates are being introduced for all actions.	**Reasonable Assurance**	The Committee was assured that appropriate measures are in place to enhance oversight and maintain effective risk control within the charity.
Charity Name Change – Options Appraisal	The Committee considered options for renaming the charity in light of the Trust's recent name change. Three options were discussed: retaining the current name, Health, Heart, Hope; adopting Kent and Medway Mental Health NHS Charity; or undertaking a stakeholder engagement process to develop a new name and brand.	**Reasonable Assurance**	The Committee agreed that a full stakeholder engagement and rebranding process is the preferred approach, recognising the importance of allowing sufficient time and resource for this work. The discussion also highlighted the need for a clear, compelling tagline and for alignment with the Trust's evolving strategy and identity. This will be discussed further at the Trustees' meeting.

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details	
Date of meeting:	27th November 2025
Title of paper:	Use of Trust Seal
Author:	Nicola Legge, Legal Services Manager
Executive Director:	Sheila Stenson, Chief Executive Officer

Purpose of paper

Purpose:	Noting
Submission to Board:	Standing Order

Overview of paper

The report is to give reassurance to the Board that all documents endorsed with the Trust Seal have been done in accordance with the Trust Standing Orders, Standing Financial Instructions and Reservation of Powers to the Board – Scheme of Delegation.

Issues to bring to the Board's attention

Two documents have been signed and sealed as a deed during from Q2 25/26 This process has been undertaken by Legal Services as per the Trust Standing Orders.

Governance

Implications/Impact:	N/A
Assurance:	Substantial Assurance
Oversight:	Board

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Trust Board meeting

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Number	Date of Sealing	Description	Signatures	Comments
166	05.08.25	Underlease of Barrier Road Crisis House	Sheila Stenson Jackie Craissati	
167	05.08.25	Lease Renewal of Arndale House	Sheila Stenson Jackie Craissati	

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