AGENDA

Kent and Medway Mental Health NHS Trust

Title of Meeting	Trust Board Meeting (Public)
Date	29th January 2026
Time	09.30 to 12.00
Venue	MS Teams

Agenda Item	DL	Description	FOR	Format	Lead	Time
TB/25-26/116	1.	Welcome, Introductions & Apologies		Verbal	Chair	09.30
TB/25-26/117	2.	Declaration of Interests		Verbal	Chair	
BOARD REFLECTION ITEMS						
TB/25-26/118	3.	Personal Experience – My Occupational Therapy Journey	FN	Verbal	DHS	09.35
TB/25-26/119	4.	Continuous Improvement Story - Standardising Medication Storage in Allington Centre	FN	Paper	AR	09.45
STANDING ITEMS						
TB/25-26/120	5.	Minutes of the previous meeting	FA	Paper	Chair	09.55
TB/25-26/121	6.	Action Log & Matters Arising	FA	Paper	Chair	
TB/25-26/122	7.	Chair's Report	FN	Paper	JC	10.00
TB/25-26/123	8.	Chief Executive's Report	FN	Paper	SS	10.05
TB/25-26/124	9.	Board Assurance Framework	FA	Paper	JK	10.10
STRATEGY, DEVELOPMENT AND PARTNERSHIP						
TB/25-26/125	10.	Sustainable Communities Provider Collaborative Progress Report	FD	Paper	SS	10.20
TB/25-26/126	11.	Digital Progress Against Plan	FD	Paper	NB	10.30
TB/25-26/127	12.	Trust Quality and Safety Agenda	FA	Paper	SS	10.35
OPERATIONAL ASSURANCE						
TB/25-26/128	13.	Integrated Quality and Performance Review	FD	Paper	SS	10.45
TB/25-26/129	14.	Finance Report – Month 9	FN	Paper	NB	10.50
TB/25-26/130	15.	Planning Paper	FD	Paper	NB	10.55
TB/25-26/131	16.	Workforce Deep Dive – Talent and Succession Planning	FD	Paper	SG	11.00
TB/25-26/132	17.	Freedom to Speak Up 6 Month Report	FD	Paper	SS	11.10
TB/25-26/133	18.	CQC Community Mental Health Survey	FD	Paper	JK	11.25
TB/25-26/134	19.	Standing Financial Instructions	FA	Paper	NB/TS	11.35
CONSENT ITEMS						
TB/25-26/135	20.	Report from Quality Committee • Mortality Report – Executive Summary • Terms of Reference	FA	Paper	SW	11.40
TB/25-26/136	21.	Report from People Committee • Equality & Diversity Report (WRES and WDES)	FN	Paper	KL	
TB/25-26/137	22.	Report from Audit and Risk Committee	FN	Paper	PC	
TB/25-26/138	23.	Report from Mental Health Act Committee	FN	Paper	SBK	
TB/25-26/139	24.	Report from Finance, Business and Investment Committee • Terms of Reference	FA	Paper	MW	

TB/25-26/140	25.	Report from Charitable Funds Committee	FN	Paper	SBK	
CLOSING ITEMS						
TB/25-26/141	26.	Any Other Business			Chair	11.50
TB/25-26/142	27.	Questions from the Public			Chair	
	Date of Next Meeting: Thursday, 26th March 2026					

Members:		
Dr Jackie Craissati	JC	Trust Chair
Peter Conway	PC	Non-Executive Director (Deputy Chair)
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
Julie Kirby	JK	Chief Nursing Officer (Interim)
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
Caterina Powell	CP	Service User - Personal Story
Robin Smith	RS	Occupational Therapist - Personal Story
Adeyinka Lawal	AL	Allington Centre Team Leader - Continuous Improvement Story
Tammy Parkinson	TP	Registered Nursing Associate -Continuous Improvement Story
Rebecca Crosbie	RC	Freedom to Speak Up Guardian
Zara Church	ZC	CQC Representative
Natalie Edwards	NE	CQC Representative
Sam Hunt	SH	CQC Representative
Apologies:		
Stephen Waring	SW	Non-Executive Director (Senior Independent Director)

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:	29th January 2026
Title of paper:	Improvement Story: Standardising Medication Storage in Allington Centre
Author:	Adeyinka Lawal; Allington Centre Team Leader Hannah Roberts; B6 Graduate Management Training Scheme (GMTS)
Executive Director:	Adrian Richardson, Director of Transformation & Partnerships

Purpose of paper

Purpose:	Noting
Submission to Board:	Board requested

Overview of paper

This improvement initiative at the Allington Centre addressed inefficiencies and safety risks in medication administration by standardising the storage of patient medication baskets. By engaging staff in solution design and applying the 5S methodology, the team implemented a system where each patient's medication is stored in a clearly labelled, consistent location, with a photograph for visual verification.

Issues to bring to the Board's attention

The results demonstrate significant improvements, including faster medication rounds (reduced from 18 to 14 minutes), enhanced stock visibility, cost reductions, and positive feedback from Pharmacy. Importantly, the initiative has saved approximately eight hours per month in time. Initially deployed in Allington, this approach is now being piloted successfully in Tarentfort Centre and continues to roll out, with testing underway in Brookfield. It is considered highly scalable, with strong potential to further improve safety, efficiency, and resource utilisation across the organisation.

Governance

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

Version 2 - **Public**

NHS
Kent and Medway
Mental Health
NHS Trust

Improvement Story:

Standardising Medication Storage in the Allington Centre

Adeyinka Lawal & Tammy Parkinson

Caring | Inclusive | Curious | Confident

1. Problem:

The medication administration process at Allington Centre lacked a standardised approach to organising patient medication baskets within the medication cupboard. Medication baskets were stored without a consistent order, meaning their position frequently changed between medication rounds.

This resulted in inefficiencies during medication rounds, with staff spending additional time locating medication. Staff also reported frustration when medication cupboards had been organised during one round and then rearranged by others before the next, removing any consistency. The lack of standardisation increased the risk of medication errors, particularly for agency staff or staff unfamiliar with the ward, and reduced confidence in the process.

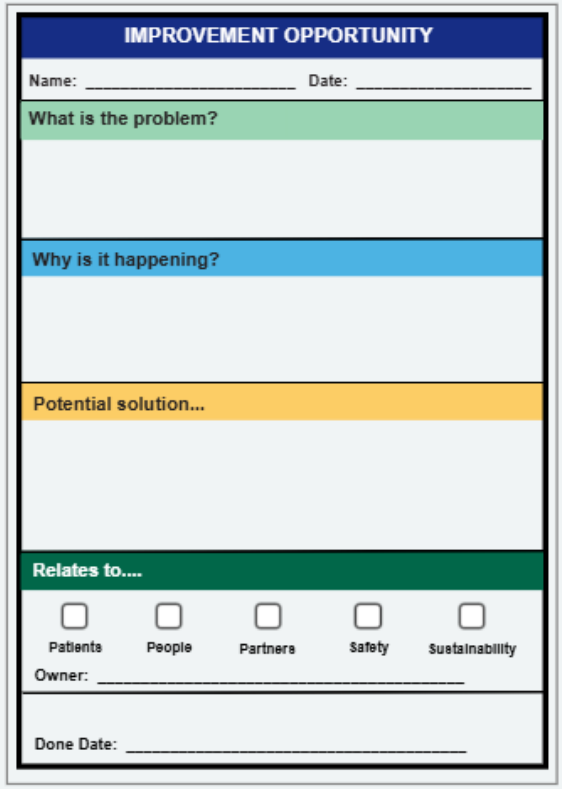
Limited visibility of medication stock levels further contributed to over-ordering, excess medication being held on the ward, unnecessary cost, and the risk of delays or missed doses.

2. Approach:

This improvement was raised as an Improvement Ticket during IMS training, following the identification of the issue through frontline staff experience. The issue was recognised as a quick win, suitable for testing and implementing at the ward level.

Potential solutions were discussed during the training session and then taken back to Allington Centre for wider team engagement. Staff who had not attended the training were actively involved in discussions, and feedback was sought to ensure the approach worked in practice. The team remained open to adapting the solution if it did not meet operational needs.

The 5S methodology (Sort, Set in Order, Shine, Standardise, Sustain) was applied to structure the improvement, supporting a simple, practical and sustainable solution.



3. Goal / Aim:

The main goals and aims for this improvement were:

- To streamline the medication administration process
- To reduce the time taken to complete medication rounds
- To reduce the risk of medication errors
- To improve visibility of medication stock to reduce over-ordering

4. Current State:

Medication baskets were stored with no set order, requiring staff to spend extra time locating the right basket.

Prior to implementation, medication rounds at Allington Ward took approximately 18 minutes per round, four times per day.

5. Implementation / Change:

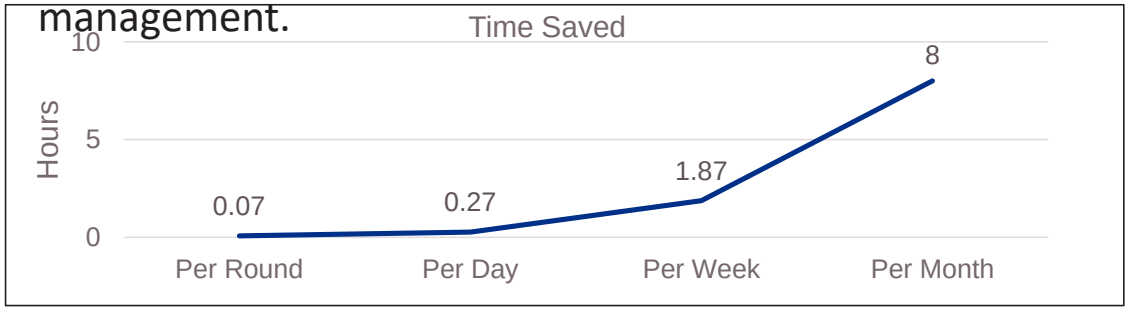
A standardised medication storage and preparation process was developed and implemented at Allington Centre. Each patient's medication was placed in an individual box, which was:

- Labelled with the patient's room or bed number
- Labelled with a patient photograph to support visual verification and accurate identification
- Stored in a consistent and agreed position within the medication cupboard

Patient photographs are updated in line with system requirements or when a patient's appearance changes.

6. Results / Benefits:

- Medication rounds are now reported to be faster, reduced from approximately 18 minutes to approximately 14 minutes per round, four times daily. Approx 8 hours per month saved.
- Clear identification and visual verification are believed to have reduced the risk of medication errors.
- Improved visibility of medication stock enables more timely reordering, reducing over-ordering, excess stock, and associated costs.
- Positive feedback from Pharmacy confirms that the new system is clear, effective, and safer for medication management.



7. Scalability:

This improvement would be easy to implement across other wards within the organisation, and has already been successfully implemented in both medication rooms at our Tarentfort Centre.

The approach works particularly well in wards with long-stay patients, as photos provide an extra level of assurance. On acute wards, where patient turnover is higher, there is potential to implement this approach without photos, as they are not essential, and use only room numbers.

If other wards adopt this process, it would lead to greater reductions in medication costs by preventing over-ordering and minimising excess stock, and further reductions in the risk of medication errors.

NHS
Kent and Medway
Mental Health
NHS Trust

Kent and Medway Mental Health NHS Trust Board of Directors (Public)
Minutes of the Public Board Meeting held at 09.30 to 12.00 on Thursday 27th November 2025
Via Videoconferencing

Members:			
	Dr Jackie Craissati	JC	Trust Chair
	Peter Conway	PC	Non-Executive Director (Deputy Trust Chair)
	Stephen Waring	SW	Non-Executive Director (Senior Independent 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
	Mickola Wilson	MW	Non-Executive Director – partial attendance
	Dr Julie Hammond	JH	Associate Non-Executive Director
	Pam Creaven	PCr	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 – Partial attendance
	Steve Marshall	SM	Patient Safety Partner - Personal Story only
	Christine Hemmings	CH	Interim Director of Quality and Safety - Personal Story only
	Ben Francis	BF	Head of Improvement – Continuous Improvement Story only
	Gillian Leighton	GS	Community Matron – Continuous Improvement Story only
	Julia Hart	JHa	Acting Programme Director for the Provider Collaborative - MHLDA item only
	Daryl Judges	DJ	Deputy Trust Secretary
	Hannah Stewart	HS	Deputy Trust Secretary (Minutes)
	The Board was joined by members of the public and members of staff.		
Apologies:			
	N/A	N/A	N/A

Item	Subject	Action
TB/25-26/91	**Welcome, Introduction and Apologies** The Chair welcomed all to the meeting and noted no apologies had been received. All written reports were taken as read.	
TB/25-26/92	**Declarations of Interest** No interests were declared.	

NHS
Kent and Medway
Mental Health
NHS Trust

Item	Subject	Action
TB/25-26/93	**Personal Experience – Patient Safety Partner** The Board heard from Steve Marshall, who shared his personal journey following the loss of his daughter to suicide in 2017 and his subsequent involvement with the Trust as a Patient Safety Partner. SM gave examples of his work, including suicide risk management, training, and participation in the Patient Safety Investigation Panel. SM discussed the importance of cultural change in risk management across the Trust, with more of a focus on learning and the need for collaborative, discussion-based risk formulation. The Board also heard about the challenges of embedding the new risk assessment practices, due to the RiO system. The Board thanked SM for his openness and for sharing his story. It was agreed that SM should provide a further update on progress regarding risk management to the Quality Committee in 12 months' time, alongside the Director of Psychological Therapies. **Action:** By January 2026, AC to invite SM and the Director of Psychological Therapies to the Quality Committee in 12 months' time, to provide a further update on his role as Patient Safety Partner and the cultural change in risk management across the Trust The Board **noted** the Personal Experience Story.	
TB/25-26/94	**Continuous Improvement Story – Improving the provision of Physical Health Assessments within the Community Mental Health setting** The Board welcomed Gillian Leighton, Community Matron, East Kent, who presented an improvement story on increasing the rate of physical health assessments for patients with serious mental illness in Ashford and Canterbury. The project used the Trust's 'Yellow Belt' training and included establishing dedicated clinics, improved digital monitoring and staff training to improve physical health assessments. Since the launch of the project, assessment rates have increased from 57% to over 70%, with a target of 85% by March 2026. The Board discussed the use of the Kent and Medway Care Record, to obtain some information required for the physical health checks, as well as the importance of tailoring the checks for certain groups of patients, such as those from a black and ethnic minority background. The Board **noted** the Continuous Improvement Story.	
TB/25-26/95	**Minutes of the previous meeting** The Board **approved** the minutes of the meeting held on the 25th September 2025.	
TB/25-26/96	**Action Log & Matters Arising** The Board **approved** the action log, noting that all actions were completed or in progress, subject to the following:	

NHS
Kent and Medway
Mental Health
NHS Trust

Item	Subject	Action
	The Board agreed to close actions, as indicated on the action log, apart from action TB/24-25/137, where it was agreed a revised date of January 2026 was required. Actions TB/25-26/9, TB/25-26/67 and TB/25-26/72 were given a revised due date of January 2026.	
TB/25-26/97	**Chair's Report** The Board received the Chair's Report and formally recognised that, at the October Trust Board Seminar, the Board approved a £1.3m business case for the Centralised Health-Based Place of Safety. The Board **noted** the Chair's Report.	
TB/25-26/98	**Chief Executive's Report** The Board received the Chief Executive's Report and the following items were highlighted: • 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. • Adam Doyle, has been appointed as Chief Executive of the Kent and Medway Integrated Care Board. • The recent CQC inspection resulted in the Trust being re-rated as 'Requires Improvement' in several domains, but also highlighted some areas of good practice. It was confirmed that the Trust has a plan in place in terms of quality, and is also carrying out an independent review on quality. The Board **noted** the Chief Executive's Report	
TB/25-26/99	**Board Assurance Framework (BAF)** The Board received the BAF, noting: • No new risks have been added since September and there were no risks recommended for removal. • The risk score for CQC regulatory compliance has increased, while the risk score for delivery of financial targets has decreased. • The Board noted the suicide risk is currently being reviewed and this may come back on to the BAF. In addition, the Board discussed the self-harm risk and how this could link in with the suicide risk. It was agreed that an update would come back to Board in due course, noting that this would also be discussed at the Audit and Risk Committee. **ACTION:** By March 2026, AC to bring back an update back to Board on both the suicide and self-harm risks to the Trust, and how these may link. The Board **approved** the Board Assurance Framework.	

Item	Subject	Action
TB/25-26/100	**Mental Health, Learning Disability and Autism (MHDLA) Provider Collaborative Progress Report** The Board received the MHLDA Provider Collaborative Progress report, and discussed: • The regional improvement in dementia diagnosis, with training in care homes and the use of two lead social workers to help support timely discharge. It was requested that the next report provides a timeline for the stated ambition. • The first meeting of the Sustainable Community Care Collaborative took place, with a focus on aligning mental and physical health • The ambition to work jointly with Kent County Council around social workers, and support for patients clinically ready for discharge. It was requested that 'number of meetings attended' should not be a key performance indicator, as this did not measure impact. **Action:** By the next meeting, JHa and SS to provide a timeline and ambition for care home training for memory assessment diagnosis. The Board **noted** the Mental Health, Learning Disability and Autism (MHDLA) Provider Collaborative Progress Report.	
TB/25-26/101	**Trust Partnership Working** The Board discussed the new proposed 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. The discussion included a number of challenges from the non-executives, with a request for a partnership register, a maturity matrix, and principles for working with the voluntary sector. It was agreed a further update should come to the March 2026 Board, and that the risk-based model to classify partnerships should be an appendix to an updated paper. **Action:** AR to revise the Trust Partnership Working report to include a partnership register, a maturity matrix, principles for working with the voluntary sector and a governance model. This should come back to the Board in March 2026. The Board **noted** the Trust Partnership Working report.	
TB/25-26/102	**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 following key areas were highlighted: • Good progress has been made against the Trust's breakthrough objective to reduce the number of patients clinically ready for discharge, who have been with the Trust over 100 days. The next breakthrough objective is being discussed by the Executive Management Team.	

Item	Subject	Action
	• The focus for the next month is to eliminate those waiting over 52 weeks which is reported as 78 patients. All of these patients have been seen in Mental Health Together. • Significant progress continues to be made for dementia diagnosis over the last six months, increasing to the highest rate it has been in Kent and Medway to 62.1%. • Call abandonment rates, variation in those attending emergency departments and aggression on the wards, were all raised as concerns by the Trust Board, and assurances were given that these are all being worked on and remain a priority for the Trust. The Board discussed the use of the Royal Clarendon Hotel Age UK residential service and the recent visit carried out there by the Trust Chair. The Board praised how the facility is used to re-integrate patients into the community, including temporarily registering with the local GP, noting that patients average a length of stay of around 4 weeks. It was noted that the Trust would be looking at what would be needed to further pursue this model across the county, with a report coming back to the Board in March 2026. **Action:** AQ to provide a report to the Trust Board on the use of the Royal Clarendon Hotel Age UK residential service, and what would be needed to further pursue this model across the county, at the March 2026 Board meeting. The Board **noted** the Integrated Quality and Performance Review.	
TB/25-26/103	**Finance Report for Month 7** The Board received the Finance Report. For the period ending 31st October 2025, the Trust 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 Psychiatric Intensive Care Unit (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. The Board **noted** the Finance Report for Month 7.	
TB/25-26/104	**Workforce Deep Dive – Sustainability Pillar** In year, the Trust has seen 3.2% productivity growth based on nationally reported metrics. The Board noted that significant progress has been made in strengthening its approach to demand and capacity management, recognising this as a critical enabler for sustainable service delivery and financial resilience. The Board discussed the low level of recorded clinical contact time for medical consultants, and the need for better measurement and job planning. It was noted	

Item	Subject	Action
	that much clinical work is not currently captured in the data, and that a target of 20 clinical contacts per week per consultant has been agreed. The need for a digital solution was discussed, noting that Kent Community Health NHS Foundation Trust is currently piloting this with RiO, and learning would be shared once the pilot has finished. The Board **noted** the Workforce Deep Dive – Sustainability Pillar.	
TB/25-26/105	**Doing Well Together Improvement Programme** The Board received an overview of progress so far of the Doing Well Together Improvement Programme to date, noting the following: • Strategy Deployment Reviews (SDRs) have been introduced, replacing Quality and Performance Reviews. • The Improvement Management System Rollout is underway, with wave 1 completed successfully in Dartford. • Over 100 staff trained at Yellow Belt level, delivering measurable benefits, including several high-impact projects. The Board **noted** the Doing Well Together Improvement Programme.	
TB/25-26/106	**Safer Staffing – Mid-Year Establishment Review** The Board received the mid-year establishment review for Safer Staffing and noted that the scoring shows dependency and acuity on the wards has changed. However, it has been determined that there is too much variation in how staff are reporting on the Mental Health Optimal Staffing Tool (MHOST). Training on the MHOST tool is scheduled for January 2026, with a full establishment review to follow in March/April 2026. The Board **noted** the Safer Staffing – Mid-Year Establishment Review.	
TB/25-26/107	**Resident Doctor 10-Point Plan** The Board received a verbal update on the Trust's compliance with the Resident Doctor 10-Point Plan, with assurances given that minor outstanding actions are being addressed. It was confirmed that the Trust has appointed the Chief Medical Officer, Dr Afifa Qazi, as the Senior Leader, and the Medical Education Wellbeing Fellow, Dr Carolina Pressanto, as the resident doctor peer representative. The Board agreed to delegate ongoing monitoring of the 10-point plan to the People Committee. **Action:** TS to adjust the People Committee workplan, to include the 10-point plan by the January meeting. The Board **noted** the Resident Doctor 10-Point Plan.	

NHS
Kent and Medway
Mental Health
NHS Trust

Item	Subject	Action
TB/25-26/108	**Report from Quality Committee (including Mortality Report – Executive Summary)** The Board received and **noted** the Quality Committee Chair's report, including the mortality report.	
TB/25-26/109	**Report from People Committee** The Board received and **noted** the People Committee Chair's report.	
TB/25-26/110	**Report from Mental Health Act Committee** The Board received and **noted** the Mental Health Act Committee Chair's report.	
TB/25-26/111	**Report from Finance, Business and Investment Committee** The Board received and **noted** the Finance, Business and Investment Committee Chair's report.	
TB/25-26/112	**Report from Charitable Funds Committee** The Board received and **noted** the Charitable Funds Committee Chair's report.	
TB/25-26/113	**Use of Trust Seal** The Board **noted** the use of Trust Seal report.	
TB/25-26/114	**Any Other Business** The Board formally recognised that this was Andy Cruickshank's last meeting as Chief Nurse and thanked him for his contribution to the Trust, particularly in reducing violence and aggression on the wards. The Board wished Andy well in his secondment.	
TB/25-26/115	**Questions from Public** Questions were invited from members of the public. The need for digital support and time to attend training for frontline staff was highlighted. In addition, the issue of administrative staff feeling undervalued was discussed. The Board acknowledged these points and committed to ongoing engagement and support for both clinical and administrative staff	
	Date of Next Meeting The next meeting of the Board will be held on Thursday 29th January 2026, via Microsoft Teams.	

Signed …….. (Chair)

Date ……..

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 22/01/2026

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 JANUARY 2026								
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, JK and AQ	July 2025	March 2026	The paper is due to the QC meeting taking place in March.	**Over due**
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	January 2026	An update has been included within the digital paper on the agenda and the BAF will be updated ahead of the March 2026 Board meeting	**Over due**
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	January 2026	Appointment cancellations and underlying health inequalities are being addressed within the dementia programme board; further analysis and any associated actions are expected by the end of Q3. A verbal update is to be given.	**Over due**
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	January 2026	To be closed - on the agenda to discuss.	**Over due**
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	March 2026	The partnership approach will be discussed at the March 2026 Board meeting.	**In progress**
27.11.2025	TB/25-26/93	Personal Experience – Patient Safety Partner	Invite SM and the Director of Psychological Therapies to the Quality Committee in 12 months' time, to provide a further update on his role as Patient Safety Partner and the cultural change in risk management across the Trust	JK	January 2026		This item has been added to the QC agenda for early autumn, and Sara Casado and Christine Hemmings are aware. Action recommended to be closed.	**In progress**
27.11.2025	TB/25-26/100	Mental Health, Learning Disability and Autism (MHDLA) Provider	Provide a timeline and ambition for care home training for memory assessment diagnosis.	JHa and SS	January 2026		A verbal update will be given at the meeting.	**In progress**

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 22/01/2026

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						
27.11.2025	TB/25-26/107	Resident Doctor 10-Point Plan	The People Committee workplan to be adjusted to include the 10-point plan, by the January meeting.	TS	January 2026		The workplan has been amended. Action recommended to be closed.	**In progress**
ACTIONS NOT DUE OR IN PROGRESS								
27.11.2025	TB/25-26/99	Board Assurance Framework (BAF)	Bring back an update to Board on both the suicide and self-harm risks to the Trust, and how these may link	JK	March 2026			**Not Due**
27.11.2025	TB/25-26/101	Trust Partnership Working	Revise the Trust Partnership Working report to include a partnership register, a maturity matrix, principles for working with the voluntary sector and a governance model. This should come back to the Board in March 2026	AR	March 2026			**Not Due**
27.11.2025	TB/25-26/102	Integrated Quality and Performance Review	The Board to receive a report on the use of the Royal Clarendon Hotel Age UK residential service, and what would be needed to further pursue this model across the county, at the March 2026 Board meeting.	AQ	March 2026			**Not Due**
CLOSED AT LAST MEETING OR COMPLETED BETWEEN MEETINGS								
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.	**Closed**
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.	**Closed**
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.	**Closed**

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 22/01/2026

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
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.	Closed
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.	Closed
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.	Closed

Kent and Medway Mental Health NHS Trust

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**29th January 2026**
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

NHS Confederation and NHS Providers have joined forces – in anticipation of their impending merger – to develop a network for chairs who are involved in developing shared leadership roles, and I have attended two of these meetings. Themes are emerging, although at present there is no standard formula for how group models are best set up.

There have been two meetings of the Kent & Medway Joint Committee, with constructive discussions between the Integrated Care Board and the NHS providers in the county. As our Board papers report, there are serious concerns regarding Kent & Medway's financial position, including challenging conversations regarding financial planning going forwards. A key component of the roadmap to improvement includes a clear understanding of what is driving the financial deficit for the NHS in the county.

In January, the CEO and I attended the Medway Council Health and Adult Social Care Overview and Scrutiny Committee (HASC) to respond to their concerns regarding the 2025 Care Quality Commission report on our community services and Place of Safety. We take their concerns very seriously and shared with them our analysis of the issues and our quality improvement plans. We look forward to engaging with the HASC more proactively going forwards and will invite them to see some of our services.

2. Trust Board meetings

At the December Trust Board Development Day, the Board received and discussed the Trust's Strategy for 2026-31, reviewed the draft financial plan for 2026-27, and carried out a Board Assurance Framework validation exercise; there ensued a lively and helpful discussion regarding Board members' prioritised risk concerns.

The Trust held an extraordinary Board meeting on 14th January 2026 in order to confirm readiness for the transfer of Children and Young People Mental Health (CYPMHS) and All Age Eating Disorder Service (AAED) from North East London Foundation Trust to our Trust on 1st April 2026. The Board approved the transfer, and this decision enabled the transfer of undertakings (protection of employment – TUPE) to commence, with the consultation with staff beginning the following day.

3. Board Member Updates

I would like to welcome Julie Kirby, as our Interim Chief Nursing Officer as a voting member to the Trust Board. In addition, I can confirm that our advert of the Audit and Risk Committee Non-Executive Director has closed, and interviews will be taking place shortly.

Kent and Medway Mental Health NHS Trust

4. Trust Chair and NED visits

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

Where	Who
December 2025	
Allington Ward (Low Secure Mental Health)	Jackie Craissati
Rosewood Ward (mother & baby unit)	Jackie Craissati
January 2026	
Mental Health Act (MHA) 2026: Webinar	Stephen Waring & Sean Bone-Knell
Day 6, IMS training (Doing Well Together)	Jackie Craissati & Mickola Wilson

Chair visits

I spent a morning visiting Allington ward and then Rosewood, both very positive visits. I was particularly struck by the Allington staff's commitment to the improvement huddles, and the number of 'tickets' they were working on. Brief conversations with patients were also positive. I was slightly disappointed to note that one of the two courtyards remains an unadorned concrete space with little to entice patients, although I recognise any transformation will require funds. The ward also struggles with some delayed discharges for patients who have complex needs. On Rosewood, I was particularly touched to hear the journey that one of our staff nurses had been on – from Rosewood inpatient, to volunteer, to peer support worker, to apprentice nurse. Her passion and commitment were very clear, and it was uplifting to see her flourish in the role.

I wanted to see the training for 'Doing Well Together' in action, and was delighted to be part of the Heather Ward team, working on engagement with stakeholders, and using data. There were some great conversations; my only concern is that we must provide sufficient ongoing coaching to our teams so as not to lose the momentum that the training instils.

Stephen Waring and Sean Bone-Knell attendance at Mental Health Act (MHA) 2026: Webinar

On 12 January, we attended an NHS Confederation webinar about the Mental Health Act 2025, which received Royal Assent on 18 December 2025. Implementation will be phased over approximately a decade, subject to government Spending Review decisions, with the first major reforms beginning in 2028. The Board will closely monitor implementation to ensure our service users benefit fully over time from these changes.

Kent and Medway Mental Health NHS Trust

Chief Executive's Board Report

Date of Meeting: 29th January 2026

Introduction

This is my first Board report of 2026 and I would like to start by thanking all of our colleagues who were working over the Christmas and New Year period to care for our patients. I spent some time with our community teams over Christmas and the new year period and I spent a morning on Jasmine ward. I was really proud to see the caring and compassionate care our staff were providing at a time that can be even more challenging for people. The patients on Jasmine ward were very complimentary about the staff and the care they were receiving. The community teams were also encouraged regarding the new refined clinical model, and I was heartened to hear how they were building working relationships across teams and focussed on patient safety and reducing waiting times for our services.

As we start the new calendar year and prepare to launch our new strategy in April, I am reflecting on what my commitment for the months ahead are: providing absolute clarity for us as an organisation. I want to support staff in understanding more clearly where we want to be, how we will get there, and everyone's individual and critical role in achieving our vision.

In December, I set out what we will be focused on for the remaining three months of our current strategy to ensure we are focused on what matters most for our patients. With my executive team we have deliberately narrowed our focus, recognising we cannot do everything at once, and trying to do so would not serve our patients or staff well. Our priorities are:

- delivering the Quality Plan and addressing immediate CQC recommendations
- preparing for children and young people, and all age eating disorder services joining us in April
- delivering the refined clinical model in our community services and continuing to reduce waiting times for patients
- managing our bed flow so that people who are well enough to leave can do so, and those who urgently need our acute help get it sooner
- accelerating our Doing Well Together improvement programme
- shaping our next trust strategy, with a strong focus on access, safety, experience, effectiveness and sustainability

Narrowing our focus will create the space, capacity and clarity needed to deliver safely and well on our most important priorities. We will of course continue to work as an active partner in the system and with our partners who are a vital part in providing care to our communities.

National and Regional Update

Financial Planning 2026/27

The trust submitted its first draft of its financial plan to NHS England as part of the planning round on the 17th December 2025. This committed the trust to a balanced financial position for both 2026/27 and 2027/28, with a cost improvement expectation of 4.5% across both years. In developing the submission, we highlighted two areas requiring further work: delivery of a 40% reduction in agency spend next year, which is particularly affected by the transfer of children's and young people services from NELFT, and the ongoing pressures on out-of-area placements given current inpatient bed demand and the challenges in the system regarding social care. National planning assumptions require systems to eliminate inappropriate OOA placements by 2028/29, and we are working closely with commissioners to determine how this can be achieved within our financial plan, ahead of the final submission next month.

NHS Joint Committee

We had a whole day workshop this month with system CEOs and Chairs to agree the strategic direction for the system, including how we tackle the financial challenge together. As a committee and the senior leaders of the system we are committed to financial recovery and ensuring we have a robust plan for 2026/27 that is deliverable by all partners.

Neighbourhood Health Programme Board

I have joined the recently established Integrated Neighbourhood Health (INH) Board. This Board will be responsible for overseeing the agreement of neighbourhood footprints, establishing natural communities and local patterns of care. In addition to this, the Board will have oversight of ensuring better outcomes for patients. This is an exciting programme of work for us to be involved in. We are in an excellent place as a trust, as we have a huge amount of learning to share with the system from our work to transform community mental health services in an innovative way, side by side with our voluntary, community and social care partners.

Trust Update

Changes to the Executive Team

Our trust has strong and stable leadership and I have made a number of changes to the executive team to strengthen the role mental health has in developing our new neighbourhood models. The Board will already be aware that from October 2025, Dr Afifa Qazi, our Chief Medical Officer, was appointed as Interim Chief Medical Officer for Kent Community Health Foundation Trust, alongside her role with us.

From the 1 January, our Chief Nurse Andy Cruickshank begun a secondment as the Chief Nurse for Integrated Neighbourhood Health in the Kent and Medway system. This is an exciting and excellent opportunity for us to have a mental health nurse shaping the future of community and neighbourhood care across Kent and Medway. To ensure continuity and stable clinical leadership, Julie Kirby is acting Chief Nursing Officer while we backfill her role as Deputy Chief Nursing Officer.

Sandra Goatley, our Chief People Officer, is retiring in the spring and I have decided to recruit an interim Chief People Officer for 12 months to give us stability while national

changes to NHS people services take shape. It also allows us to plan our long-term appointment thoughtfully. Sandra has played an instrumental role in shaping who we are today against significant change. From championing wellbeing and support for staff, to driving leadership and management development, leading our work on equality, diversity and inclusion, supporting our international recruitment and significantly reducing our vacancies and turnover numbers. Her impact has been felt right across the organisation.

Changes in the leadership team are aligned to where we are heading as a trust and a unified Kent and Medway NHS. Together, they strengthen the trusts influence, our partnerships and our ability to help people not just live with mental health challenges, but to live well.

Children's & Young People (CYP) and All Aged Eating Disorder (AAED) Services Update

We continue to work closely with North East London Foundation Trust (NELFT) to plan the smooth transition of services to the trust. We meet regularly with the Executive and Board members of NELFT and are holding webinars with the staff who will be joining us. I am pleased to share that last week our Board held an extraordinary board meeting and made the decision that we are ready to take the services over from the 1 April 2026. We are really looking forward to welcoming staff and caring for patients.

CQC Well-Led Inspection

The Care Quality Commission (CQC) has confirmed it will carry out a planned Well-Led inspection in March 2026. Our last inspection was in 2021. Since then we have been on a huge journey. From setting a clearer shared purpose and defining what excellence looks like to developing our leaders; building stronger collaborative relationships with our stakeholders; maturing our improvement approach and focusing on spreading what works; and strengthening our ability to use data and insight to better understand risks and priorities. We have a stronger grip and are tackling this head on. We welcome the opportunity to share this openly with the CQC and the continued improvement we are leading.

ICB visit to mental health services in Albion Place

On 6 January, Adam Doyle, CEO of the Kent & Medway Integrated Care Board (ICB) joined me in visiting our teams at Albion Place. It was a fantastic opportunity for our staff to share with Adam the significant transformation our community teams have undertaken in the last year. They shared learning for the future work the system will working on together for Integrated Neighbourhood Health. They also shared feedback on services that need to be further developed and the role the ICB as a lead commissioner has to play in this. The staff were positive and enthusiastic following Adam's visit and I was immensely proud of them.

Care Quality Commission (CQC)

As part of CQCs follow up to inspecting core services, we had a re-inspection of some of our community services (Ashford, Thanet, Canterbury and South Kent Coast) and a few of our Health Based Places of Safety (in the East and West Kent) before Christmas. Initial feedback was positive and could see the improvement journey the trust is on. Feedback included notable improvement in record keeping processes, care records being completed to a good standard, improved staff morale in some areas and positive patient feedback. While we have received recognition for the progress made, we are not complacent about the

further improvements we need to make and take this seriously. The CQC also revisited our crisis services unannounced earlier this month and we await further feedback from them.

In today's papers I share a more detailed report setting out the trust's position and my concerns about safety and quality and the action I have taken to seek independent external reviews to further strengthen our quality plan. assurance.

Medway Council Health and Adult Social Care Overview and Scrutiny Committee (HASC)

On 15 January, myself, the Chair, Adrian Richardson, director of transformation and partnerships, and Donna Hayward-Sussex, chief operating officer and deputy CEO, attended HASC alongside our ICB colleagues. The committee rightly scrutinised our recently published CQC report and the response we're taking as well as our preparedness to take on children's and young people's and all age eating disorder services in April. We have made positive strides to build open and transparent relationships with all of our stakeholders over the last few years, including HASC, and I welcome the committee's commitment to continue to do this and understand more about what we do.

Sharing good news

We are actively working to share more news stories about the innovative and transformative work we are undertaking as a trust which benefit our patients, our partners and our staff.

Since November, we have issued 24 positive news stories – compared to 8 in the same period last year (a 200% increase), and secured coverage in trade and local media including work to support veterans, our innovative pharmacy scheme and support for homeless people in the Healthcare Leader and a reduction in waiting times for local people waiting for a dementia diagnosis.

Older Adults Community of Practice first Clinical Summit

I had the pleasure of opening the first ever older adults' clinical summit. The event was attending by 98 people who had gathered to hear 25 speakers demonstrate their support to older people. The enthusiasm in the room for our older adult services was clear for all to see. The event received very positive feedback and covered the following topics and more, living with dementia, supporting patients, challenging discrimination, family therapy and people with dementia, an update from the Royal College of Psychiatry and art, drama and music therapies with older adults in ward and community settings I want to thank all those involved in the preparation for this event as I know considerable time and effort went into organising this successful event.

Value in Practice Awards

We continue to receive lots of nominations for our trust Value in Practice Awards. Please see the appendix for the latest winners – well done all!

Summary and Conclusion

I want to conclude by saying thank you again to all of our staff for their continued commitment to each other, the trust and most importantly our patients. While 2026 will present its own challenges, I am determined our staff, patients and partners will see a real difference – as we work towards creating communities where mental health care helps people not just live with mental illness, but live well.

There is a busy few months ahead for all of us in the NHS, locally and in our trust. Our three-year strategy draws to a close and we are excitingly developing our new five-year strategy with stakeholders building on all the data, insight and engagement we've done over the last few years. We will be finalising our trust financial plan and welcoming the CQC in March for our well-led inspection. Finally, we will play a critical role in establishing the new integrated system architecture to ensure the NHS in Kent and Medway is financially sustainable and working together as one NHS and I welcome the opportunity all of this brings to improve care for our communities.

I look forward to the year ahead with optimism and pride

Sheila Stenson
Chief Executive
29th January 2026

Executive Team Visits

Sheila Stenson:
Arndale House
Jasmine Ward
Maidstone Community teams (Albion Place)
Canterbury Wards : Bluebell, Fern, Foxglove and Heather

Donna Hayward-Sussex
Maidstone Liaison
Pembury Liaison
Ashford Community Teams
Mental Health of Learning Disability Team

Dr Afifa Qazi
CAMHS/AAED, Maidstone
Dartford Wards : Amberwood, Cherrywood, Pinewood
North Place of Safety

Value in Practice Awards

Directorate	October	November : Team and Employee
North	Amy-Louise Payne, Operational Team Manager	Jaspreet Nyote, Assistant Psychologist Team: Recovery College
East	Gill Fletcher, CPN	Sophie Corrigan Team: SKC MHT+ and HTT
West	Molly Stevens, Senior Occupational Therapist	Noel O'Shaughnessy Healthcare Assistant Team: West & North Kent Mental Health Homelessness
Forensic	Kayleigh Woodward, Quality & Performance Assistant	Olanrewaju Ibitoye, Social Worker Team: TGU Security and Reception Team
Support services	Olivia Pike, Information Governance	Cassie Hooper, Project Manager Team Highlands House, Housekeeping team
Acute		Muhammad Hossain, Senior HCA Team: Littlebrook Hospital Occupational therapy team

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details	
Date of meeting:	29 January 2026
Title of paper:	Board Assurance Framework
Author:	Louisa Mace, Risk Manager
Executive Director:	Julie Kirby, Acting Chief Nurse

Purpose of paper

Purpose:	Approval
Submission to Board:	Regulatory Requirement

Overview of paper

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

Issues to bring to the Board's attention

The BAF was last presented to the Board in November 2025 and to the Audit and Risk Committee (ARC) in December 2025.

In December, the Board held an away day which focused on the Trust's principal strategic risks and to reflect on whether the BAF continues to provide clear oversight of the main risks to delivery of our strategic objectives. The discussion confirmed that the current risk areas remain appropriate and highlighted opportunities to refine the articulation of a small number of risks to ensure greater clarity and consistency of risk language.

Updates this month also reflect learning and recommendations from a number of commissioned independent reviews (noted in the CEO's paper on patient safety and quality and her CEO report), ensuring the BAF continues to provide clear oversight of principal risks, controls and assurance.

The Board also identified several areas for continued focus over the coming period, including digitally enabled transformation (linked to the digital paper on today's agenda), Board leadership and succession planning, and ensuring appropriate support for operational and clinical leaders.

Version control 02 - **Public**

New Risks:

1 new risk has been added to the BAF since it was presented to Board in November

- Risk ID 08480 – Corporate Risk: Reputational Risk

Risk Movement:

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

- Risk ID 00580 – Organisational inability to meet Memory Assessment Service Demand
- Risk ID 07960 – Reduce Self harm in our female patients on Acute Wards
- Risk ID 08157 - Delivering the Community Mental Health Framework to provide high quality care and support through Mental Health Together to the right people, at the right time and in the right place.

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 Board on 27th November and ARC on 2nd December 2025. This report reflects further updates on risks since November.

The Top Risks are

- Risk ID 00580 - Organisational inability to meet Memory Assessment Service Demand (Rating of 16 – Extreme)
- Risk ID 02290 – CQC Regulatory Compliance (Rating of 16 - Extreme)
- Risk ID 07960 – Self Harm incidents on Acute inpatient units (Rating of 16 – Extreme)
- Risk ID 08065 – Inpatient Flow (Rating of 16 – Extreme)
- Risk ID 8473 - Digital operating dependency risk (CYPMHS/AAED transfer) (Risk rating of 16 - Extreme)
- Risk ID 04673 – Organisational Risk – Cyber Attack (Rating of 15 – Extreme)

Risk Movement

Three risks have changed their risk score since the Board Assurance Framework was presented to Board and ARC:

- **Risk ID 00580 – Organisational inability to meet Memory Assessment Service Demand (Reduced from 20 (Extreme) to 16 (Extreme))**
  This risk has reduced in risk score as IQPR data for November 2025 shows a 6 week performance at 27.2%. Whilst this compares favourably to the regional and national data (regional performance for September 2025 is reported as 3.2%, with the National performance in the same period as 17.4%) work continues to drive improvement across the service. The number of long waiters over 52 weeks has reduced by 90% and the average waiting time has continued to fall to 88.9 days (5th December). The improvement is reflected in the dementia diagnosis rate at system level which is currently 62.3%, which is the highest it has been in the system. Going forward the internal and system models will transition reflective of the Integrated Neighbourhood team models for which both programmes are actively contributing to.

- **Risk ID 07960 – Reduce Self harm in our female patients on Acute Wards (Reduced from 20 (Extreme) to 16 (Extreme))**
  This risk has reduced in risk score as there has been early data to show there has been a reduction in incidents of Self harm, but it is too early to determine if this is sustained. This would suggest the programme of work is having an effect.
  The actions remain under review.

- **Risk ID 08157 - Delivering the Community Mental Health Framework to provide high quality care and support through Mental Health Together to the right people, at the right time and in the right place. (Increased from 12 (High) to 16 (Extreme))**
  This risk has undergone a detailed review and refresh in January. This has led to an increase in risk score to 16.

  A single front door and the increase in demand experienced here has led to people with a very low level of need seeking support from Mental Health Together. The front door is

averaging 3741 referrals a month across the county. The approach to triaging and assessing each referral impacts on peoples waiting.

Waiting times for some people are long with c. 1200 people waiting over 18 weeks for their assessed intervention. However, nearly all of these people have had at least one contact. Of these people waiting, the majority are waiting for a lower level intervention, with people with more complex needs waiting less. At the time of this risk review all people are getting their first contact within four weeks and the average wait for an intervention is 12 weeks.

The effective use of data to effectively manage referrals and waits has previously been challenging, though there are marked improvements at the time of updating this risk, being competently data driven remains an area of need for some areas. Some of the waiting mechanisms previously put in place on the electronic patient record complicate the management of waits and is subject to review to stream line recording.

Risks Recommended for Removal

No risks are being recommended for removal at this time.

New Risks

1 new risk has been added to the BAF since it was presented to Board in November.

- **Risk ID 08480 – Corporate Risk: Reputational Risk (Risk rating of 16 (Extreme))**

  This risk has been added following discussions at the Board Away day in December and current heightened scrutiny.

Emerging Risks

The Executive team continues to horizon scan for emerging risks to delivery of services. Currently the following areas are being evaluated: digitally enabled transformation, Board leadership and succession planning; and ensuring appropriate support for operational and clinical leaders. This will be explored further and the BAF, as a live document, will be updated as appropriate.

As part of its due diligence regarding the Children and Young People Mental Health Services & All Age Eating Disorder Service (CYPMHS/AAED) transfer, the Trust has identified a number of emerging risks as detailed below. These emerging risks are being developed and will be monitored and mitigated in line with the Trust's Risk Management Framework. Regular updates on the emerging risks will be provided to the appropriate Board Sub Committees and escalated to Trust Board if and when appropriate.

- Risk ID 08473 - Digital operating dependency risk for Children and Young People's Mental Health Service and All Age Eating Disorder service transfer (CYPMHS/AAED)
- Risk ID 08474 – Kent and Medway Adolescent Hospital (KMAH) asset transfer/lease route (estate enablement)
- Risk ID 08475 - CYPMHS/AAED contracting continuity risk
- Risk ID 08476 - CYPMHS/AAED medical staffing sustainability
- Risk ID 08477 – Children and Young people Neurodiversity (CY ND) waiting list oversight and outcomes

Other Notable Updates

- **Risk ID 08065 – Inpatient Flow**
  This risk remains under regular review. Patient flow requires a whole system approach to resolve and the trust is working with our partners across the wider healthcare system to address this.

  Strong internal controls are in place: Daily bed-flow structures, twice-daily reporting, purposeful admission checks, and OPEL-aligned escalation show a mature operational grip. Controls are being actively used and adapted.

  System-wide dependencies remain the main constraint: Flow cannot be fully optimised by the trust alone. Social care pressures and limited step-down capacity are the principal contributors to CRFD numbers and slower discharge processes.

  Clarendon House (13 beds) has improved acute inpatient capacity. As at 16th January 10 beds are occupied. CORE 24 has strengthened acute hospital liaison responsiveness. Out of Area Placements have significantly reduced—an important indicator of improved internal capacity and system collaboration.

  CRFD remains a challenge but is trending positively. Current CRFD is at 52 in Acute beds as at 9 January 2026, down from 70 in Jan 2025, and a reduction from 58 in December 2025 suggesting stabilisation despite social care pressures.

  As of the 29th December 2025, Out of Area Placements has reduced from 30 in April 2025 to 3 females in acute. There are 4 males in a local independent provider for step-down. This excludes PICU.

  A number of immediate, medium and long-term actions have been added to the risk on review in January. These are shown on the attached spreadsheet report, but include:

  Immediate actions (identified to complete in 3 months):
  1- Expand Step-Down and Community Capacity for those patients with a higher risk profile currently as CRFD on the wards.
  2- Maximising Crisis and Home treatment team support to wards for early discharge.
  3- Improving proactive early discharge processes on the wards with support from the Acute Directorate.
  4- Trusted assessment model with social workers released from KMMS to support CRFD discharge

  Medium term (identified to complete in 6 months):
  1- Increased use of VCSE providers for ongoing support, housing, and social inclusion
  2- Enhanced social care presence on the wards

  Long term (identified to complete in 1 year)
  1- Directorate based beds
  2- Shared discharge pathways

- **Risk ID 07891 – Organisational Management of Violence and Aggression**
  This risk was reviewed and updated in December. General progress is good, but there remain concerns about inpatients responding to changes in the inpatient group and need to test the ideas around reducing verbal abuse and racism in community services.

- **Risk ID 02290 – CQC Regulatory Compliance**
  This risk was reviewed in December. Several reports are due from the CQC for re inspections in relation to the S29a warning notices. Once these updates are received this risk and its associated actions will be updated accordingly.

  The update from December highlighted that the Quality plan is now owned within the organisation, has good engagement and is on track for scheduled dates. The main area for focussed activity is around risk assessment and care planning.

- **Risk ID 08337- Organisational Culture impact on Delivery of Strategic Ambitions**
  This risk has been reviewed, and the risk description, controls and actions have been updated. It is recognised that culture change takes time, and there are a number of positive controls in place. Over the last 2 years, there has been significant change within the organisation.
  The Trust is waiting for the publication of the latest staff survey results, expected in March 2026, at which point this risk will be further reviewed and updated to take into account the findings.

- **Risk ID 04673 – Organisational Risk – Cyber Attack**
  This risk remains regularly reviewed and updated, as do the controls in place to ensure they remain robust. BCPs have undergone a recent uplift, and actions continue to be updated. It is recognised that the short-term actions from the Cyber exercise has passed its target date, but this is sitting at 94% complete and is waiting on confirmation of some final information before it can be updated. A further Cyber Exercise is planned for the Spring to test preparedness.

  This risk is due for review again at the end of January.

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	16	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	16	Minimal	Outside of Tolerance
08065	Inpatient Flow	16	Cautious	Outside of Tolerance
08146	Maintenance of a Sustainable Estate	9	Cautious	In Tolerance
08157	Delivering the Community Mental Health Framework to provide high quality care and support through Mental Health Together to the right people, at the right time and in the right place.	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 Delivery of Strategic Ambitions	9	Seek	In Appetite
08484	Corporate Risk: Reputational Risk	16	Averse	Outside of Tolerance

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: 21 January 2026

Board Assurance Framework

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

Kent and Medway Mental Health NHS Trust

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
ID 00580	Jan 2022	Director of Partnerships and Transformation	**Organisational inability to meet Memory Assessment Service Demand** If KMH 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 KMMH (to be rolled out across the organisation) - Community Model Task Force formed comprising KMMH 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, FBI and QC on 6 week performance Reporting to MHLDA and Ageing Well Board	4	4	16	↓

Actions to reduce risk	Owner	Target Completion (end)	Status
Phase 2: Launch of multi-disciplinary assessment model within KMMH	Director of Partnerships and Transformation	21/12/2026	A
Optimisation of phase 1 stand-alone model	Director of Partnerships and Transformation	27/02/2026	A
Phase 2 resourcing and implementation	Director of Partnerships and Transformation	Parked (To review in 6 months)	A
Focussed activity on 52 week waits	Director of Partnerships and Transformation	COMPLETED	G
Resourcing and roll-out of community model alongside ICB and community services	Director of Partnerships and Transformation	29/05/2026	A

Action owner	Risk Appetite	Target rating L	Target rating C	Target rating Rating	Target Date (end)
Director of Partnerships and Transformation	Outside of Tolerance	3	4	12	30/06/2026

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
ID 08065	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 Daily system calls Daily bed flow call chair by the Deputy Chief Operating Officer to examine demand, capacity, escalations, 7-day discharge trajectory and complex case review. This can increase twice a day if OPEL 4 is triggered. Daily bed flow meeting is clarifying reasons for admission and alternative to admission to support purposeful admission. Winter plan underpinned by NHSE Mental Health OPEL Framework. Local and system escalation of delayed discharge as required. CORE 24 rolled out across all acute hospital's liaison teams CRFD programme of work underway to release capacity within the KMMH bed stock- Discharge to Assess (D2A) transition arrangements for CRFD patients; internal pathway review CRFD Programme is a system wide programme in conjunction with the ICB, Local Authority and supported through the Provider collaborative. 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 waiting in EDs for Beds. Use of VCSE partners to support CRFD onward transition. As at January 2026, 25 patients have used 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. This has saved 13140 bed days so far (January 2026). Working with the ICB to explore additional step-down capacity. Red to Green and purposeful admission methodology in operation on all wards to support discharge.	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	COMPLETED	G
Implementation of CORE 24 across all Hospital Liaison Services	Deputy Chief Operating Officer	COMPLETED	G
Recovery Houses across the County	Deputy Chief Operating Officer	BLOCKED	
Virtual ward Model for People with Dementia	Chief Medical Officer	CANCELLED	
Expand Step Down and Community Capacity for those patients with a higher risk profile currently as CRFD on the wards.	Chief Medical Officer	30/04/2026	A
Maximising Crisis and Home treatment team support to wards for early discharge	Chief Medical Officer	30/04/2026	A
Trusted assessment model with social workers released from KMMS to support CRFD discharge	Chief Medical Officer	30/04/2026	A
Improving proactive early discharge processes on the ward with support from the Acute Directorate.	Chief Medical Officer	30/06/2026	A
Increased use of VCSE providers for ongoing support, housing, and social inclusion	Chief Medical Officer	31/07/2026	A

Action owner	Risk Appetite	Target rating L	Target rating C	Target rating Rating	Target Date (end)
Chief Medical Officer	Outside of Tolerance	1	3	3	30/03/2026

				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)
							Temporary employment of 2 social workers to support discharge and high levels of CRFD at Littlebrook Hospital and Priority House.						Enhanced social care presence on the wards	Chief Medical Officer	31/07/2026	A					
													Directorate based beds	Chief Medical Officer	31/01/2027	A					
													Shared discharge pathways	Chief Medical Officer	31/01/2027	A					
12/06/2024 Risk Opened																						
ID 08157	Aug 2024	Chief Operating Officer	**Delivering the Community Mental Health Framework to provide high quality care and support through Mental Health Together to the right people, at the right time and in the right place.** If we do not provide the right intervention to the right people due to extraordinary demand that matches the right capacity to provide accessible and responsive treatment and/or support THEN we will a) not be able to understand and meet peoples need in a timely manner b) delay commencement of treatment and/or support RESULTING IN poor service user experience, a potential risk to safety and a delay in meeting the outcome that are important to them.	5	5	25	Community Mental Health Programme milestone plan to implement change to service, which will support access, waiting times and case load management. - Daily review of waiting lists at service level, weekly review of waiting list at operational level (led by service directors) and fortnightly review of waiting lists at programme management level (1d) with measures for mitigation shared with all partners. - Actions in place to reduce the overall caseload for MHT and MHT plus, which will support transition to a new approach, which will be completed by April 2026. - Review of the front door are underway as part of the Community Mental Health Programme refresh, and it is agreed that we will launch the Medway Approach. - The COO agendas referrals, waiting times and caseload at their operational report meeting, to understand exception reporting. This is also scheduled regularly at the Quality Improvement Plan CQC Huddles on at least a monthly basis. - Review underway to simplify the mechanism for managing contacts and waits, this includes the DIALOG plus being launched as the initial assessment, care plan and baseline outcome at the point of triage in Q4 2025/26. - Community waits are reported weekly at the Trust wide safety huddle, which is chaired by the Chief Nurse. - A new approach to managing people waiting over 15 weeks is being developed with the service directors to ensure there is a consistent approach to waiting well system. - Referrals, waiting lists and caseload are subject to review and action at the directorate and trust wide SDR process. - Community waits are reported weekly at the Trust wide safety huddle, which is chaired by the Chief Nurse.	Robust team level management Dashboards Caseload management tool Partnership Forums	4	4	16	↑	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**	Chief Operating Officer	Outside of Tolerance	3	3	9	31/12/2026
													Review of Mental Health Together Front Door Processes	Deputy Chief Operating Officer	COMPLETED	G						
													Capacity Planning	Deputy Chief Operating Officer	31/01/2026	A						
													Effective waiting time management of people waiting over 18 weeks	Deputy Chief Operating Officer	31/03/2026	A						
													Risk Assessment compliance *All teams to deliver the Trust Quality Improvement Plan for Risk Assessment compliance*	Deputy Chief Operating Officer	15/06/2026	A						
													Compliance with DIALOG plus at initial contact	Deputy Chief Operating C	31/12/2026	A						
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**	Chief Nurse	Outside of Tolerance	2	3	6	31/03/2027
													Improvement project is in place to implement and test evidence based interventions to reduce violence and aggression across all inpatient services. Now testing directorate level assurance phrase.	Chief Nurse	30/04/2026	A						
													New Violence and Aggression Policy 2025	EPR Lead	COMPLETED	G						
													Violence and Aggression Listening Sessions to be held with Community Teams	Diversity and Inclusion Manager	17/04/2026	A						
													Allyship Training for Community and Children and Young People Teams	Diversity and Inclusion Manager	12/04/2028	A						

				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)
01/04/2014 — Risk Opened — 01/06/2025 — 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	Trust Quality Plan - reviewed 3x weekly to establish progress and improvement across the SDRs 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).	SDR minutes and audit results within the Directorates identify areas of concern and actions are then generated to rectify these Quality Plan progress review 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 assurance. (This is a new process starting this month). Quarterly Performance and Quality Meeting (PQM) with the ICB Minutes.	4	4	16	↔	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Place of Safety Quality Improvement Plan - aims to embed key areas for improvement including a flowchart detailing staff actions regarding consent to treatment, clarity regarding the process of patients remaining longer than 24 hours and standards of care expected. Addresses contents of the S29a warning notice. — Chief Nurse — 30/07/2026 — A Community Teams & Crisis services Quality Improvement Plan - aims to deliver and embed key areas addressed from the community inspections, including the S29a warning notice. These include actions across four key themes - Safety & Risk/ Access & waiting times/ Environment, experience & equity/ Leadership, culture & governance. — Chief Nurse — 31/07/2026 — A Notable areas for improvement and included in the above quality plan is Care Planning and Risk Assessment improvement work. Risk assessment trajectory is 50% in each team by end of Feb 26 and 90% by end of May. Care planning policy agreed. — Chief Nurse — 31/05/2026 — A	Chief Nurse	Outside of Tolerance	2	3	6	31/03/2027
02/04/2024 — Risk Opened — 08/09/2025 — Risk escalated to BAF																			
ID 07960	Apr 2024	Chief Nurse	**Reduce Self harm in our female patients on Acute Wards** IF we do not take an evidence based approached to self harm across admission, discharge and inpatient care. THEN we have increased frequency and severity of self harm. RESULTING IN risk of serious injury and/or death, escalation in self harm, increased observations and restrictive practice, financial impact, poor patient experience, increased regulatory oversight.	5	4	20	Evidence based approach across the three pillars of i) decisions to admit, ii) inpatient care and, iii) timely decisions around discharge Admissions: 1) Apply urgent senior clinical shared decision making to requests for admission by drawing upon NICE Guidelines (CG78) discerning between Acute and Chronic Risk. Includes 'Patient flow', 'Acute Directorate', 'Liaison Psychiatry Services'; CRHT, and MHT+. 2) Keen focus on 'Purposeful Admission Policy' and specifically the 'Gate Keeping Form' During Admission: 3) Patient specific bespoke Self Harm Care Planning including: Co created Psychological formulation & Simple PBS plans 4) Embedding/ and reinforcing across MDT / morning handovers 5) Focus on patient responsibility and ownership 6) Acute Clinical Risk Forum – supports positive risk taking, and discharge planning (1d) Discharge: 7) Acute SLT focus and follow-up on discharge planning to address any barriers to discharge Trustwide: - Trust wide self harm steering group (1d) - High intensity user pathway	Acute SDR - Driver Metrics 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	4	4	16	↓	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Clinical risk forums have been reimplemented. These can be requested by teams and chaired by the Chief Medical Officer. TOR to be agreed and approved. — Clinical Director for Acute — 28/02/2026 — A Self harm data analysis on wards — Head of Nursing and Quality, Acute — 28/02/2026 — A Social Media awareness — Lead for Psychological Practice, Acute — CANCELLED New Style Person Centred Care Planning roll out — Head of Allied Health Professionals, Acute — 01/02/2026 — A Alternative to Self Harm Pilot Project review — Head of Allied Health Professionals, Acute — 19/02/2026 — A Minimal Risk Activity Pack Pilot Project review — Head of Allied Health Professionals, Acute — 19/02/2026 — A Enhanced Therapeutic Observations and Care (ETOC) - national pilot underway, safer staffing training in January 2026 and policy refresh. — Head of Nursing and Quality, Acute — 02/03/2026 — A Clinical Handover Process Review — Corporate Head of Nursing & Quality — COMPLETED — G CAPLET training for all inpatient staff working in female acute wards — Head of Nursing and Quality, Acute — 01/04/2026 — A	Chief Nurse	Outside of Tolerance	3	2	6	12/09/2026
1.3 - Actively involving service users, carers and loved ones in shaping the services we provide.																			
			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)
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 Delivery of Strategic Ambitions** If there is an inconsistent culture across the trust, with pockets of excellence alongside areas of closed and poor culture, then phycological safety, openness and willingness to learn and improve are not consistently embedded. Resulting in the potential for reduced staff engagement and retention, weakened speaking up, further inconsistent practice, increase incidents and complaints, and increase regulatory scrutiny impacting the delivery of safe, effective and equitable care and the Trust strategic ambitions.	4	3	12	Leadership and Management development programmes 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 Prioritisations and regular review of Strategic Priorities and capacity	Staff Survey results Pulse Survey results	3	3	9	⇔	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Delivery of Leading Well Together programme — Deputy Chief People Officer — 29/05/2026 — A Delivery of Management Development Programme — Deputy Chief People Officer — COMPLETED — G Roll out and embedding of New Organisational Values — Deputy Chief People Officer — COMPLETED — G Embedding of staff voice initiatives — Deputy Chief People Officer — 30/06/2026 — A	Chief People Officer	In Appetite	2	3	6	31/03/2027
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																
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 BAF																			
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	29/03/2027
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																

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)
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**	Chief Medical Officer	In Appetite	3	3	9	31/03/2026
													Reduce Nursing Agency Spend by 50% to meet the National ask	Chief Medical Officer	COMPLETED	G						
													Review all medical agency and rationale as part of planning for 2026/27, identifying strategies to reduce usage	Deputy Chief Medical Officer	31/03/2026	A						
													Review agency controls on all staffing groups to ensure appropriate controls to maintain balance between financial discipline and clinical need	Associate Director of Finance (Financial Management)	31/03/2026	A						
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**	Chief Finance and Resources Officer	Outside of Tolerance	2	4	8	31/03/2026
													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 Trust Reporting Pack	Associate Director of Finance	COMPLETED	G						
													Accurate and timely forecasting to identify any financial pressures to enable mitigations and further controls to be identified and implemented	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						
													Scenario Planning & Risk Modelling	Associate Director of Finance	31/03/2026	A						
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**	Chief Finance and Resources Officer	Outside of Tolerance	3	2	6	31/03/2026
													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	Completed	G						
													Review of Trust controls on Non Pay	Associate Director of Finance	Completed	G						
													Out of Area Placements - detailed reporting of external beds utilisation and financial risk arising	Associate Director of Finance	Completed	G						
													Refresh and review underlying position at service and commissioner level.	Associate Director of Finance	31/03/2026	A						
													Delivery of Cost Improvement Plan programme of work with agreed timeframes. Slippage in delivery to be mitigated by alternative plans	Associate Director of Finance	31/03/2026	A						
													Implement 3 year planning model	Associate Director of Finance	31/03/2026	A						
5.2 Exceed the ambitions of the NHS Greener programme																						
			No Risks Identified against this Strategic Objective																			

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)
5.3 Transform the way we work																						
19/01/2026 Risk Opened																						
ID 08480	Jan 2026	Director of Communications and Engagemen	**Corporate risk: reputational risk** If heightened scrutiny following CQC activity and political / regulatory engagement leads to renewed attention on Trust performance and historic themes, Then media and stakeholder challenge may increase and escalate rapidly, particularly where complex issues are misunderstood or reported without context, Resulting in loss of confidence among patients, carers, staff and partners, increased regulatory and political scrutiny, workforce impacts, and reduced capacity to focus on and deliver improvement.	4	4	16	Executive-led issues management, escalation process and stakeholder management for sensitive matters Routine media monitoring and issues horizon scanning Coordinated handling of enquiries and reputational issues across communications, quality/safety, safeguarding, HR and legal Established governance for incidents, complaints and duty of candour Reactive briefing materials maintained for high-risk themes and external milestones A structured comms approach ahead of known scrutiny milestones. Proactive strategic storytelling to evidence improvement and learning, supported by updated briefings for senior leaders and services. Crisis Communications Plan Business Continuity Management Policy	Board oversight through formal committee and assurance reporting routes	4	3	12	NEW	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**	Director of Communications and Engagemen	Outside of Tolerance	3	3	9	31/03/2027
													Finalise and Implement a new corporate stakeholder engagement plan	Deputy Director of Communications and Engagement	31/01/2026	A						
													Development of a Media Training Plan	Deputy Director of Communications and Engagement	31/03/2026	A						
													Development of a media and communications dashboard to enable thematic reviews	Head of Communications and Marketing	01/04/2026	A						
													Development of a new process for responding to Out of Hours Media contacts	Head of Communications and Marketing	30/09/2026	A						
													Improved process for the triangulation of data to include consideration of an ICB approach, potentially through the purchase of a media monitoring system	Deputy Director of Communications and Engagement	30/09/2026	A						
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 Office	**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 FBI 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**	Chief Finance and Resources Office	In Tolerance	2	3	6	31/03/2027
													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						
													CAMHs Estate due diligence to understand and identify risk level within current estate and inform future investment needs	Deputy Director for Estates	31/03/2027	A						
01/04/2020 Risk Opened																						
ID 08146	Aug 2024	Chief Finance and Resources Office	**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 FBI TIAA Audit Contract Monitoring Minutes	3	3	9	⟺	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**	Chief Finance and Resources Office	In Appetite	2	3	6	31/03/2026
													Review of the present hybrid working arrangements	Director of Estates and Facilaities	31/03/2026	A						

Trust Board meeting

NHS
Kent and Medway
Mental Health
NHS Trust

Meeting details	
Date of meeting:	29th January 2026
Title of paper:	Sustainable Communities Provider Collaborative Progress Report
Author:	Julia Hart, Acting Director Provider Collaborative
Executive Director:	Sheila Stenson, Chief Executive Officer

Purpose of paper

Purpose:	Discussion
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, dementia and neighbourhood teams.

This report includes:

- An update on progress in East Kent mental health UEC services and collaborative working between KMMH psychiatry liaison teams and Acute staff
- An update on the neighbourhood care model
- Feedback from the December 2025 Sustainable Community Care Provider Collaborative Meeting

Areas to bring to the Board's attention

- Continued reductions in primary mental health A&E presentations evidenced through usage of alternative community care provisions.
- Improvements illustrated through collaborative working and interface between East Kent Acute and KMMH mental health support teams in UEC.
- ICB Neighbourhood Programme Board progressing the strategic commissioning approach to Neighbourhood Health

Version control 02 - **Public**

Governance

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

Kent and Medway Mental Health NHS Trust

1. Board reporting – programme update forward plan for 2025-26

Programme	2025	2026	
	26 March	28 May	30 July
Community Mental Health Framework			
Dementia Diagnosis Pathway			
Urgent and Emergency Care			
Enhanced Therapeutic Observation Care (ETOC)			
Joint Working Across Health and Social Care			
Neighbourhood Health (Frailty, Dementia, End of Life Care)			

2. Programme updates January 2026

2.1 Kent and Medway Mental Health Urgent and Emergency Care (UEC) Update

The Urgent and Emergency Care (UEC) Transformation Programme, led by the ICB, aims to deliver a seamless 24/7 care pathway for adult's in mental health crisis. The focus is on timely, evidence-based support in the least restrictive setting, close to home, and leveraging alternative crisis services to reduce reliance on Emergency Departments, inpatient units, and ambulance services.

Key Successes

Reduced A&E mental health presentations, despite rising demand:

- The 12 months up to November 2024 there were 793,074 A&E presentations with 11,062 being primary MH presentations. Comparing December 2023 – November 2024 with December 2024 – November 2025 - overall A&E presentations have increased 65,963 but MH presentations have reduced by 709. Total MH presentations as a percentage of all A&E presentations were 1.14% for October 2025 and 1.17% for November 2025, placing Kent and Medway among stronger national performers.
- Growing Safe Haven utilisation: Safe Haven 10-month attendance average has been 1705 (compared with around 1,625 per month over the previous year). Growth is strongest at co-located sites, with consistent month-on-month increases. An ICB-produced signposting video has been launched to support appropriate diversion from emergency services for clinicians and patients/carers.
- Reduced police and ambulance conveyance: Police conveyance for primary mental health A&E presentations remains low, falling to 23 in November 2025. Ambulance conveyance for non-Section 136 mental health presentations has reduced over the past 19 months. Section 136 detentions have been on a downward trajectory for the period August to November 2025; with improving conversion rates to acute treatment or admission (62.1% as of November 2025) demonstrating more effective and proportionate use of detention supported by the hear-and-treat model. The hear and treat' model with KMMH MH professionals advising police when to use detention and when not to supports the decrease in incidence of Section 136, and an increase in S136 conversion to acute treatment.

- Improved discharge pathways and clinical confidence: Discharges and referrals from psychiatric liaison services into Safe Havens have been gradually increasing over the last 20 months and maintained at around 60 per month since December 2024, reflecting sustained clinician confidence in community crisis alternatives.

Key Challenges and Risks

- Overall A&E attendances continue to rise, placing sustained pressure on the system and reinforcing need to maintain and expand diversion to alternative pathways.
- Some local variation persists, particularly in East Kent, requiring continued place-based oversight and targeted support.

Future Focus

The programmes will focus on:

- Transitioning Ashford co-located Safe Haven to a 24/7 model.
- Further embedding referral pathways into Safe Havens and Crisis Recovery Houses across all partners.
- Continued development of shared UEC metrics and dashboards to support system oversight.

East Kent UEC Mental Health - Progress Update Since September 2025 Report

Purpose

To provide the Board with an update on progress since the September East Kent UEC mental health report 2025 report presented to the Board against the risks, improvement actions and system commitments set out then and to offer assurance on current performance, admission appropriateness and system working.

1. Current Position

East Kent continues to experience disproportionately high mental health demand within Urgent and Emergency Care, with mental health presentations accounting for approximately 5.55% of all A&E attendances during Q2 25/26, remaining significantly higher than elsewhere in Kent (Medway Foundation Trust in comparison saw 0.72% mental health presentations during same period).

2. Liaison Psychiatry Services audit

From July to September 2025 a clinical audit to examine patient admissions via the Emergency Department was undertaken. This was due to East Kent being identified as an outlier for admissions.

The published audit confirms admissions are not driven by personality disorder diagnoses or high-intensity service use, instead it is driven by acuity factors. Most patients had significant prior contact with mental health services, often alongside high levels of clinical complexity, co-morbid

physical health needs and emerging risk, reinforcing that admission decisions reflect genuine acuity.
The findings highlight opportunities to strengthen earlier risk escalation, engagement and treatment concordance, rather than suggesting avoidable inpatient admissions.

A number of business cases are awaiting discussion and agreement at the Systems Improvement Group (SIG) in January 2026. SIG is a group formed by all Chief Executive Officers to agree investment and decisions across Kent and Medway. This includes a case for investment in Mental Health Community Capacity (including out of area placements) alongside; Investment in Neighbourhood-Anchored Community and Primary Care and Digital Health Models; Investment in Referral Management Including Digital Systems to Reduce the Number of Referrals into Secondary Care; Discharge Management (Flow, Length of Stay and No Criteria to Reside). Once agreed, the business cases will be funded through 2026/2027.

3. Crisis Alternatives and Safe Haven Utilisation

Progress has been made against September actions to strengthen crisis alternatives and build staff and patient confidence.

- The Thanet co-located Safe Haven has relocated to the ground floor, improving safety, accessibility and suitability, with further estates works ongoing.
- The Ashford Safe Haven continues to operate limited evening hours but is now supported by more consistent liaison team engagement, including routine opening and closing check-ins.
- Relationships between liaison psychiatry services and Safe Haven providers in Thanet and Ashford continue to strengthen, supported by stable leadership, clinical oversight and regular attendance at ICB bi-monthly Safe Haven/Liaison Psychiatry meetings.
- Joint working is also developing, with Safe Haven staff beginning work-with days alongside liaison teams in Ashford. A review of learning and impact of this will be developed in collaboration with East Kent KMMH colleagues and reported to the Board in the future.

These developments support the September ambition to increase safe and appropriate diversion, while recognising that a significant cohort of patients will continue to require in-patient care.

4. Service Configuration and Interface Working

The September report recognised that permanent co-location of all crisis functions is not feasible in East Kent and committed instead to strengthening interfaces between services. Since then, interface working has become more structured and embedded, including:

- Bi-monthly interface meetings with acute hospital partners
- Daily ED huddles attended by liaison operational leads in Ashford, with plans to extend model to QEQM.
- Regular meetings with Safe Havens, Recovery Houses, ICB partners, VCSE providers, ambulance and police.
- Liaison representation within wider system forums (e.g. Approved Mental Health Professionals (AMP) meetings, high-intensity user work, communities of practice).

- Clearer escalation routes are now in place, enabling ED staff to escalate concerns directly to liaison operational managers, who link into Trust-wide flow and bed management processes.

5. Purposeful Admission

Progress has been made in improving consistency and confidence in admission decision-making:

- Weekly performance huddles have been introduced, focusing on:
  - Patients requiring a bed within 12 hours.
  - Patients who should be discharged from ED within 12 hours.
  - Understanding and learning from breaches.
- Recruitment to Band 7 clinical leadership roles has increased senior decision-making capacity.
- Rota redesign has improved equitable senior cover across seven days, reducing reliance on informal admissions.
- Having a dedicated matron has also strengthened clinical leadership in the teams

Early evidence suggests reduction in inappropriate informal admission requests, with admissions more clearly aligned to clinical need. Documentation quality and timeliness have been identified as an area for continued improvement. These are being addressed at locality weekly performance meetings and monthly Strategic Development Review meetings.

6. Strengthening Understanding of Community Alternatives

In line with September commitments, practical steps are underway to improve liaison staff understanding of community pathways:

- Band 6 liaison staff are undertaking shadowing with patient flow teams, improving shared understanding of system pressures.
- Further shadowing with Rapid Response and Home Treatment Teams is planned to strengthen confidence in community-based alternatives.
- Recruitment of clinicians with recent community and crisis experience into liaison roles is already positively influencing decision-making.

7. Progress Against September Actions

Action Description	Status
Thanet Safe Haven ground-floor relocation	Completed
Clinical leadership and positive risk-taking: strengthened through senior recruitment, targeted development sessions and performance oversight.	On track
PLAN accreditation: application planned for end of March, with clinical leadership assigned.	On track
VCSE and pathway engagement: now embedded through routine system interfaces.	Completed

Kent and Medway Mental Health NHS Trust

8. Ongoing Challenges

- Estate and office space constraints at William Harvey (WH, Ashford) remain unresolved and present an ongoing estates risk as staffing numbers expand. With the redesign of the Same Day Emergency Care (SDEC) at William Harvey, there is a potential for one dedicated triage booth, an additional assessment room and one clinical office in phase 2 of the redevelopment of the Paula Carr Centre. The KMMH Executive Management Team are sighted on the challenges and are liaising with EKHUFT counterparts to reach a solution and agreed timeline. KMMH staff have mitigation plans in place including reviewing and monitoring of risk on the estates risk register; Ashford Liaison Psychiatry Service will continue to work within the space allocated to them and the Directorate will continue to seek support from executives as part of strategy deployment reviews.

- Some improvements (e.g. full 24/7 Safe Haven provision in Ashford) remain dependent on future estates and system decisions.

As part of the Kent and Medway Business Case for Investment in Mental Health Capacity, the proposal is committed to optimising community based mental health services to deliver, timely person-centred support with the aim of increasing capacity in primary care and areas of secondary community care. This will reduce unnecessary presentations at acute emergency departments, reduced inpatient admissions, accelerating discharge, shortening lengths of stay and reducing reliance on spot purchased beds and out of area placements.

2.2 Neighbourhood Health

The ICB Neighbourhood Programme Board was established in September and is attended by leadership across the Kent & Medway partners. The Board was established to progress the ICB strategic commissioning approach to Neighbourhood Health and the development of support enablers. At the December 2025 Board meeting it was agreed that the 45 Primary Care Networks would be the initial footprints for Single Neighbourhood footprints but with recognition that further work would need to be developed overtime to support natural community aligned footprints.

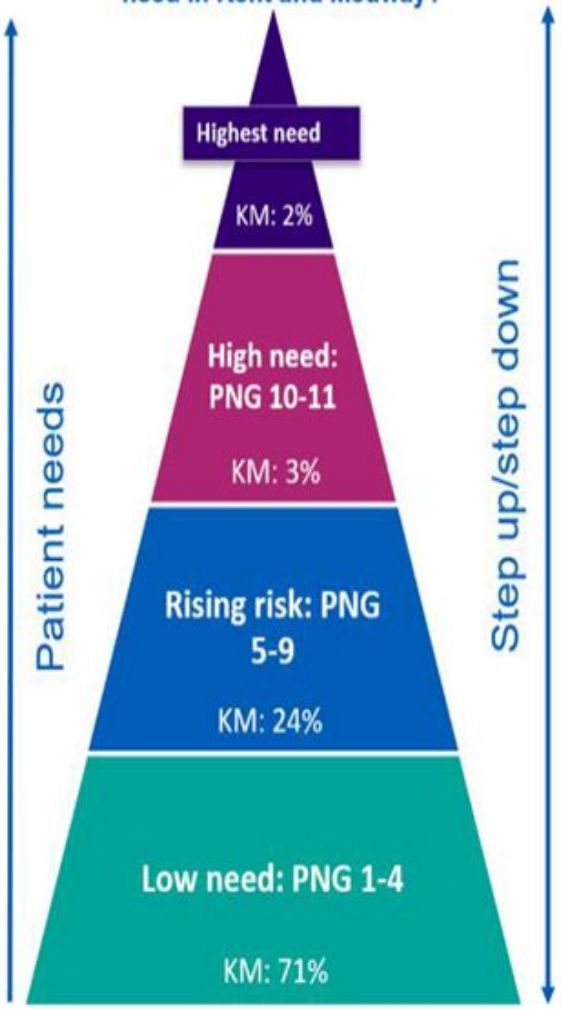
In addition, through a survey, a series of workshops and feedback from clinical leadership across the system, the Board approved the Kent & Medway Neighbourhood Clinical Model of Care, shown below.

Neighbourhood health and care model

Population Need Group (PNG)

	End of life
	Highest complexity care home
11	Frailty
10	Multi morbidity high complexity
9	Dominant major chronic condition
8	Dominant psychiatric behavioural condition
7	Pregnancy – high complexity
6	Pregnancy – low complexity
5	Multi-morbidity medium complexity
4	Multi-morbidity Low complexity
3	Low need adult
2	Low need child
1	Non-user

What are the levels of need in Kent and Medway?



Together, we can

Care will be:

- proactive identification and prevention
- accessible and reliable ongoing care
- rapid reactive care when needs arise
- the Integrated Neighbourhood Team working with one team ethos
- care matched to complexity, delivering the right intervention at the right time
- improved outcomes, experience and continuity for all patient groups.

Where and by which teams

Where: Predominantly out of hospital-general practice, neighbourhood, and people's homes/care homes.

Teams: GP teams, community health, mental health, social care, pharmacy, hospice, acute and VCSE partners working together.

Multi-neighbourhood teams provide higher-acuity, hospital-level care at home.

An **integrated neighbourhood workforce** wraps around patients across predominantly Out of hospital setting.

Key enablers

- Modern General Practice Access Model
- Population segmentation and risk stratification
- Digital transformation and interoperability
- Shared records
- Provider collaboratives
- Clinical governance/risk management

- Contracting mechanism/risk sharing
- Workforce
- Finance
- Clinically led
- Estates
- Communication and engagement

Kent and Medway Mental Health NHS Trust

2.3 Update from Sustainable Community Care meeting 01 December 2025

The Sustainable Community Care Collaborative met in December to discuss the below areas:

Ageing Well, Frailty, Dementia & End of Life

5.4 A system-wide approach is required to manage rising demand across the older adult population. Risk stratification has identified 92,000 high-need patients, with the top 10% prioritised. Key interventions include Comprehensive Geriatric Assessment, Structured Medication Reviews, Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) planning and digital surveillance, aligned to neighbourhood health models. Next steps focus on improving PCN-level data sharing, scaling remote monitoring and aligning frailty and neighbourhood workstreams. By March 2026, each neighbourhood will be covered by risk stratification which will inform each neighbourhood agreed delivery model, supported by shared data infrastructure and measurable improvement plans including, for example a quantified improvement in hospital mortality for frail older people and dying in place of residence.

West Kent Mental Health Multi-Disciplinary Team (MDT)

The integrated MDT aims to reduce A&E and GP demand through stronger VCSE and peer support partnerships and improved integration with secondary mental health services, including inclusive provision for autism and learning disability cohorts. Key risks relate to workforce fragility and gaps in autism/LD data.

We are working alongside colleagues in Kent County Council, Public Health Team, to analyse the effectiveness and if delivered, a reduction in mental health referrals. If this is proven, we will review and look to scale this across county, as part of the neighbourhood health programme. The analysis will be completed in quarter 4.

Learning Disability & Autism Strategy

The co-produced strategy is built around five lived-experience themes, with a focus on reducing inequalities, improving access and preventing premature mortality, including suicide prevention. Risks include inconsistent system engagement and misalignment with neighbourhood health models. A draft strategy will be circulated in January for feedback, The Provider Collaborative will review and make suggested changes before the strategy is approved by the Integrated Care Board.

3. Current performance data

Measure	Agreed trajectory	Current data						AVG	RAG
		Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25		
Methodology: Average is compiled based on performance data for the 25-26 financial period (the year to date). The RAG is the latest month's data measured against the target/agreed trajectory or where this is not available, the average.									

Programme: Dementia Pathway Transformation									
Increase dementia diagnosis rate	66.7% by March 2026	61.4%	62%	62.1%	62.1%	62.3%	62.3%	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*						1.23%	↓
		1.25%	1.29%	1.20%	1.00%	1.14%	1.17%		
	Reduction	*A&E attendances for adult patients with primary MH need*						853	↓
		901	976	897	799	866	805		
	Increase	*Safe Haven attendance*						1665	↑
		1572	1526	1758	1751	1811	1753		
Crisis house bed occupancy	85%	*Medway bed occupancy*						N/A	→
		26%	92%	64%	78%	85%	83%		
		Ashford bed occupancy							↑
		81%	89%	85%	95%	80%	90%		
Reduced mental health in ambulance/ police conveyances to A&E	Reduction	*Primary MH A&E presentation - Ambulance conveyance*						371	→
		380	428	373	333	410	381		
		Primary MH A&E presentation - Police conveyance						37	↓
		51	37	45	32	41	23		
Reduction in incidence of Section 136	Reduction	75	58	74	67	68	58	64	↓

Exception reporting on performance

- The number of people with a primary mental health presentation conveyed to A&E by ambulance continues to reduce. October's small rise was followed by a drop in November despite increased A&E attendances overall.
- While overall numbers of people presenting to A&E has increased, the percentage of these presentations, that are primarily driven by mental health, remains low including into the winter period. East Kent presentations make up a high proportion and the section above outlines drivers for this and actions being put in place.
- Police conveyance remains low.
- The Medway Crisis Recovery House shows a small dip in occupancy rate in November (83%) from October (85%). Work is underway to procure a long-term service for Medway and to increase MH Clinician's confidence in referring individuals to the Crisis House (where appropriate) as opposed to admitting to a psychiatric inpatient hospital bed. Ashford Crisis House is frequently meeting the 85% occupancy rate target.

4. Programme Milestones for 2025-2026 & 2026/2027

Milestone Tracking Key

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

Kent and Medway Mental Health NHS Trust

Community Mental Health Framework				
Milestone	**Q2**	**Q3**	**Q4**	**Q1**
Evaluation of Medway pilot – revised front door model will be reflected in the model of care refinement	X			
Demand and capacity for MHT+ workforce productivity	X	X		
Proposal/recommendations for refinement of MHT/+ clinical model – underway, workstream and T&F groups established	X	X		
Development of refined operating model to support delivery of agreed clinical model (to incorporate demand/capacity, workforce, digital, estates and contracting)			X	
Transition and sustainability of refined clinical and operating model to BAU			X	
Implementation of new CHYPS AMS pathway into the CMHF				X

Dementia Pathway Transformation				
Milestone	**Q2**	**Q3**	**Q4**	**Q1**
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**		**Q1**
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**	**Q1**
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	

Kent and Medway Mental Health NHS Trust

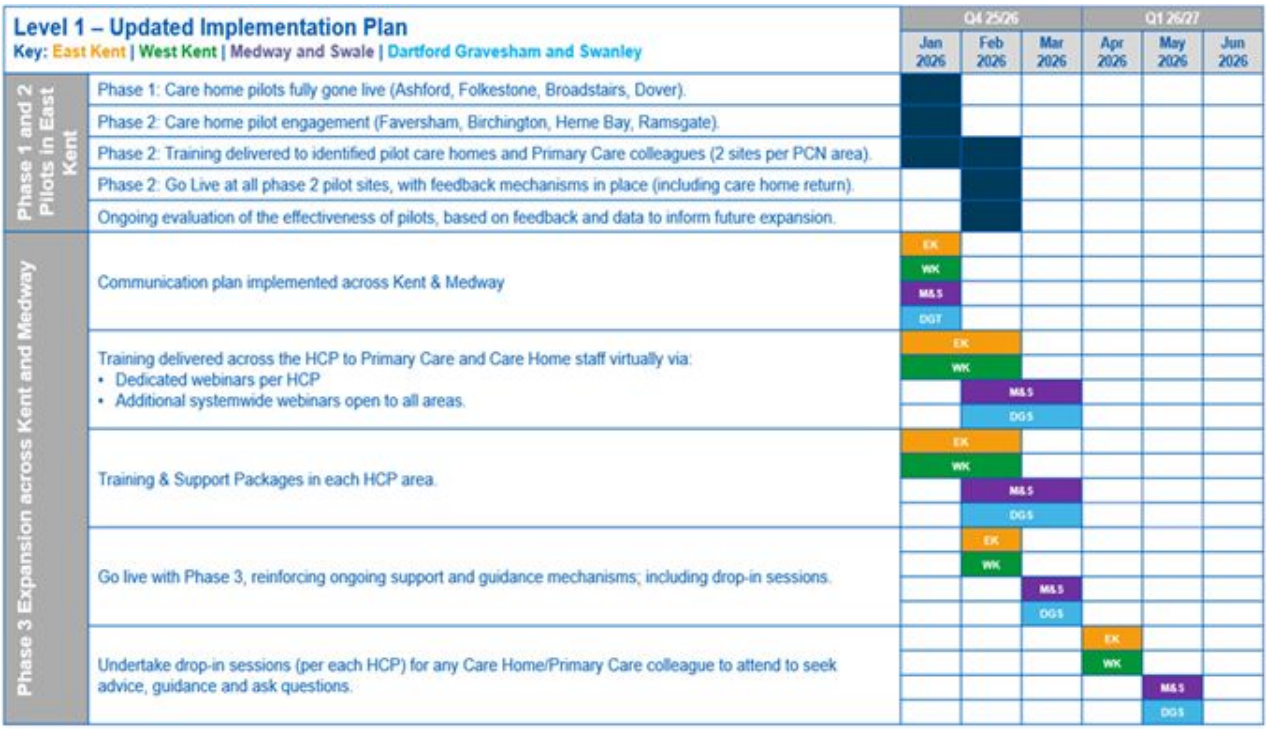
Exception reporting on milestones

Community Mental Health Framework

- Implementation of the new CHYPS AMS pathway into the CMHF will be established in line with the transfer of the children's service from NELFT in Q1 2026.

Dementia

- Due to complexities of the Kent & Medway Level 2 pathway, there has been slippage in the delivery dates. The intention is to align with the timings of the East Kent Neighbourhood Health and embed advanced dementia diagnosis within the pilot. The go live date for this is Q1 2026.
- As per the action established at the 27 November 2026 Board, to provide a timeline and ambition for care home training for memory assessment diagnosis, please find an implementation timeline for expansion of Level 1, phase 3 (diagnosis within care homes) below:



Joint Working Across Health & Social Care

- Work has begun to map all mental health services across the Kent & Medway system. The purpose is to help support a more strategic, insight-driven commissioning approach, aligning resources with population health needs. Delivery date will be agreed in January 2026 for this piece of work.

Urgent and Emergency Care

- 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.
- Margate crisis house opening delayed from Q4 2025 to Q1 2026. The capital investment is from the Pears Foundation. A building was identified but the Foundation had to withdraw due to buyer challenges and are now searching for an alternative premise.

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details	
Date of meeting:	29th January 2026
Title of paper:	Digital Progress Against Plan
Author:	Claire Hursell, Director of Digital and Performance
Executive Director:	Nick Brown, Chief Finance & Resources Officer

Purpose of paper

Purpose:	Discussion
Submission to Board:	Board Requested

Overview of paper

This paper provides a draft approach to the 2026/27 digital plan and provides an update on the digital programme for 2025/26.

Issues to bring to the Board's attention

The board are asked to note four main areas,

1) The use of clinical co-production in shaping priorities.
2) The proposed focus on four core outcomes within the 2027/28 digital programme in relation to clinical capacity, operational efficiency, improved patient care and safer more reliable care
3) The proposed developments around ambient voice, electronic prescribing, electronic referrals and enhanced workflow bed/tools.
4) The update on the projects undertaken in 2025/26.

Governance

Implications/Impact:	KMMH is reliant upon technology to deliver safe services to patients. Investment in digital can ultimately deliver savings and increase patient facing time.
Assurance:	Reasonable
Oversight:	Finance, Business and Investment Committee

Version 2 - **Public**

1. Executive Summary

This report provides an update on the Trust's digital programme. Whilst the Trust has taken significant steps over the last few years, our starting point was behind our peers. The progress described in this paper reflects the foundational gains that have been made, however the trust remains at an early stage of its digital maturity journey. Large elements of our digital estate and workflows remain manual, with the Trust reliant on manual workarounds in some areas.

The proposed plan for 2026-29 is focused on closing these gaps at pace, with a clinically led prioritisation model and a clear emphasis on time-release and safety.

2. Clinical Led Approach

The Trust recognises that strong clinical engagement is essential for successful adoption and effective product design, and significant progress has been made in embedding this approach.

A major enabler has been the appointment of a full time Chief Nursing/AHP Information Officer (CNIO), who leads the Digital Champion Network and drives digital literacy across the organisation. Alongside the CNIO, two further clinicians work within Digital: a Liaison Consultant who provides 0.5 days per week as Chief Clinical Information Officer, ensuring medical needs are represented; and a Clinical Safety Officer who works two days per week to ensure all digital changes comply with the mandatory DCB0129 and DCB0160 clinical safety standards. Together, these roles ensure that digital priorities are clinically led, safety assured, and firmly grounded in frontline practice.

We now have almost 160 Digital Champions across the Trust who actively feed ideas and feedback into Digital. They receive enhanced training, support colleagues locally, and play a central role in testing new products before Trust wide rollout. The network spans Operations, Nursing and Medical staff, ensuring broad representation. Their input has directly shaped recent developments, including the deployment of Windows 11, ongoing improvements to Rio, new BI dashboards and the workflow management solution. This reflects the wider shift within Digital and Performance toward genuine end user involvement and designing products around staff needs.

We have also further strengthened clinical engagement through the establishment of a Clinical Digital Forum, chaired by the Chief Medical Officer. Early priorities include Ambient Voice Technology and the examination of a patient self-monitoring app for serious mental illness, for which a business case is being progressed.

While we now have the structures for engagement in place, consistent clinical engagement and benefit quantification are still developing. Over the coming months we would seek to embed the Clinical Digital Forum to strengthen the flow into the existing governance forums. This present remains as the Digital and Data Strategy Group who hold responsibly for prioritising and approving digital projects. But this approach could be further strengthened by appropriately incorporating the digital forum. For assurance, the digital forum presently incorporates colleagues from operations, nursing, medical, quality and safety, transformation and communication, ensuring decisions reflect clinical, operational and strategic needs.

3. Deliverables

As the Trust moves into a new digital plan, it is essential we are clear on what we are targeting and how we will measure the success. Over the past year we have begun to evidence the time savings and workflow improvement emerging from our digital plan. The next phase will look to formalise this into a structured benefits framework that underpins all digital investment and delivery.

It is proposed that the digital programme is used as an enabler for four core outcomes.

1. **Clinical Capacity:** This will focus on measurable time released back to staff, reducing the administrative burdened and improving the ability for our clinicians to focus on direct care.
2. **Operational Efficiency**: This work will focus on automation of high-volume manual processes, ensuring greater interoperability between systems and supporting flow through better visibility of demand and capacity.
3. **Improved Patient Care**: This will seek to ensure better communication and transparency of information, with easier and more consistent digital access across services.
4. **Safer more reliable care**: With a focus on progressing the consistency of use of our patient records, looking to reduce duplications and errors.

In adopting this approach, it is important to ensure delivery is measurable, so the next phase of work will,

- Establish baseline time release metrics (e.g. minutes saved per referral)
- Build time release projections for each major project (developed with clinicians and validated in pre-deployment testing).
- Use these measures to prioritise investment and track benefit delivery.

This approach will support the trust at a time of limited resources, with decision making moved away from broad efficiency assumptions, to clinically defined benefits. It should be recognised that some of these will not be realised until wider work around data quality are addressed.

4. Forward View

While the Trust's overarching strategy for 2026 is being finalised, the digital plan will remain subject to final alignment, the digital team are progressing key programmes that are likely to be progressed.

The table sets out the proposed portfolio by year and reflects the national direction of travel towards a digitally first, community focused NHS set out in the 10-year plan. Acknowledging the developments in this area year 3 onwards are more indicative and remain flexible to national policy, as funding and technology paths evolve.

Year 1 (2026/27)	**Year 2(2027/28)**	**Year 3 (2028/29) - Indicative**
Ambient Voice Pilots High volume workflow and automation improvements Migration and full implementation of CAMHS/AAEDS MHT maturity and model refinement Foundations for Electronic Prescribing and Electronic Referrals SMI Self-Monitoring Tool	Full adoption of ambient voice Broader automation across corporate and clinical processes Full deployment of Electronic Prescribing and Electronic Referrals	Transition to digital first pathways Embedding AI supported clinical pathways Self-service and self-monitoring

4.1 Ambient Voice Technology

Ambient Voice Technology (AVT) is increasingly being used across the NHS, with successful deployments in primary care and emergency settings. The market is expanding rapidly, with a growing number of mature and emerging products now available.

NHS England has run a series of Ambient Voice Technology (AVT) pilots over the past year and, in April, published guidance to support safe deployment. The guidance confirms that AVT products are classed as medical devices and must be registered with the MHRA and hold a UKCA certificate before they can be used. It also strongly recommends full integration with Electronic Patient Records so that notes are stored automatically.

As Rio does not permit integration with third party AVT products, KMMH will likely be required to adopt The Access Group's Smart Notes solution. Although still in its early stages, Smart Notes is currently being tested within KCHFT, with outputs stored as progress notes. If Smart Notes proves unsuitable, alternative products will be considered; Digital has already evaluated several options with clinicians, giving us a clear understanding of the features and safeguards needed for successful implementation.

NHS England funding for AI enabled ambient scribing tools is anticipated in 2026/27, although this has not yet been confirmed. To ensure we are ready to move at pace should funding be released, KMMH will begin preparatory work in March 2026 so that the Trust is in a strong position to implement this technology.

4.2 Robotic Process Automation/Bots

The Trust has already proven the value of automation within Rio, with existing bots reliably handling account deletions and other system administrator tasks. With this capability now embedded, there is a clear opportunity to extend robotic processes to routine clinical and operational activities. Bots can safely and consistently manage tasks such as cancelling appointments for admitted patients or removing interventions when patients are discharged—functions that currently absorb valuable administrative and clinical time. More broadly, automation in Rio, including integrated workflows, auto populated forms, intelligent triggers and system to system data exchange, provides a scalable and clinically led route to reducing duplication, cutting administrative burden, and improving data quality. This approach enables staff to focus more of their time on direct care while supporting the Trust's wider digital maturity ambitions. Automation directly addresses the frustrations identified by clinicians, reduce variation, eliminate duplication, and improve data quality while enabling the organisation to meet digital maturity requirements.

4.3 Electronic Referrals

The Digital Team has specified a solution that will automatically create referrals in Rio, removing the need for staff to manually re key information from emails. This design has been clinically led from the outset, ensuring the specification reflects frontline needs. We are now ready to take these requirements to market and procure a product that delivers this automation. Given the high volume of referrals received into MHT, the potential time savings are significant, with each referral currently taking around 10 minutes to enter manually. Once a supplier is secured, we will work with them to finalise implementation plans and confirm an expected go live date.

4.4 Electronic Prescribing

We already have an Electronic Prescribing and Medicines Administration system in place across all inpatient services. However, we cannot yet extend electronic prescribing into community settings, as the product requires NHS England certification before it can be deployed beyond inpatient wards. Civica and NHS England anticipate that certification will be achieved next summer, subject to successful testing. In preparation, we are working closely with Civica to ensure we can adopt community prescribing functionality as soon as it becomes viable, recognising that

prescribing remains entirely paper based and creates a significant administrative and clinical burden. Enabling electronic prescribing in the community will therefore be a key priority for the coming year once national approval is confirmed.

4.5 CAMHS/AAEDS

We are preparing for the transition of Children's Services and All Age Eating Disorder Services (AAEDS) to KMMH on 1 April 2025. While staff will transfer to KMMH corporate services on this date, the clinical digital transition is significantly more complex. NELFT must first work with NHS England to migrate their email and Microsoft services to the central tenant before any safe transfer of clinical systems can occur. As a result, most clinical systems will remain with NELFT for up to 12 months under a new service level agreement currently being finalised.

The full migration of CAMHS and AAEDS digital services will be a major undertaking for the directorate, with this creating a significant demand on Digital resources in 2026/27. No digital staff will transfer from NELFT, and several key steps will require support from our partners in NELFT and from the Access Group (to support the RiO transition). This work is presently being planned but will have an impact on the phasing of other digital initiatives.

5. 2025/26 Ongoing Projects

The following projects are currently in flight and are due to complete by March 2026, as they fall within the scope of the existing corporate strategy, which concludes at the end of March 2026.

5.1 Bed Management Solution

A Rio-integrated bed management solution, replacing manual spreadsheets and enabling real-time visibility of bed status. The system provides consistent data for operational coordination and strategic planning, with enhanced Power BI reporting currently in development.
Impact: Improved patient flow, clearer operational control, and more reliable data to support decision-making across the Trust.

5.2 Caseload Management

A BI-driven complexity tool, co-designed with clinicians, that identifies key clinical and operational risk factors such as suicide trends, high-intensity service use, CTOs and patterns of non-engagement.
Impact: Enhanced risk oversight and earlier identification of individuals requiring proactive intervention.

6. 2025/26 Completed Projects

The Trust has already delivered major improvements that demonstrate clinical coproduction, digital first design, and measurable impact.

6.1 Clinical Engagement and Digital Skills

The NHS 10 Year Plan highlights the critical importance of digital capability, particularly in data management and AI, and the Trust has been proactively strengthening digital skills for some time. Last year we developed a Digital Skills Framework, enabling clinicians to self-assess their digital confidence, identify gaps, and access targeted training. The framework covers all Trust wide digital tools and is now being converted into an interactive resource to improve ease of use. A baseline digital skills survey carried out at launch identified priority development areas, and a follow up survey in February–March will assess progress and inform next year's training focus. This work has received national recognition, with both the CNIO and Director of Digital invited to present at conferences, and several Trusts adopting our framework as a model for their own programmes.

6.2 Rio Improvements

Through the development of new models of care in Community and Memory Assessment Services, Digital has worked closely with clinicians to redesign Rio so that it better reflects clinical practice and strengthens patient safety. As part of Mental Health Together (MHT), the Trust has moved to the referral-based methodology, enabled a clear understanding of patient pathways and supporting outcome-based monitoring. This shift now gives clinicians far greater visibility of what a patient is waiting for—initial meeting, assessment or intervention—and provides richer data for decision making. While the shift has improved clarity, consistent adoption across teams is still developing and remains a dependency for further work in this area such as automation.

Alongside these changes, a comprehensive suite of BI dashboards has been developed to give clinicians near real time information, supporting safer, more informed care. To address CQC concerns about care planning and risk, Digital is also working with clinical colleagues to consolidate these into a single combined form within Rio, reducing duplication and improving consistency. A new 'About Me' form will further streamline key patient information into one place. This work is ongoing as we continue to enhance Rio in collaboration with clinical teams.

6.3 Patient Portal – Patient Knows Best

The Patient Portal, Patient Knows Best (PKB), went live on 2 December for Perinatal and Early Intervention Psychosis services. As most acute Trusts across the system already use PKB, many patients were familiar with the platform, which integrates with the NHS App to bring together mental health, acute and primary care information. The configuration was co designed with people with lived experience to ensure it met the needs of service users.

Engagement is promising (with 64% of eligible patients are registered, with over 400 patients accessing content during the second week of January), but wider rollout will require substantial communication and ongoing support to ensure sustained use. Since go live, nearly 7,500 appointments have been shared through PKB, with 80% of documents read, demonstrating strong early engagement. Registered patients now receive correspondence electronically, reducing postage and administrative workload while ensuring faster communication. Trust wide rollout of PKB is expected by the end of this financial year.

6.4 Key Rio Integrations

InPhase/Rio Integration

One of the key successes recently has been the integration between InPhase and Rio. Clinicians no longer need to re-enter patient information into InPhase; instead, Rio now acts as the single patient repository, allowing staff to search for a patient and have all demographic details automatically pulled through. This not only saves time but also significantly improves data quality, as both systems now hold identical patient records, supporting safer care and better reporting. The integration is expected to release around 2 minutes per incident, with 30–40 incidents recorded daily, most of which are patient related, representing a meaningful and reliable time saving for frontline teams.

EMIS/Rio Integration

It is now possible for clinicians to access GP records directly from within Rio through the GP Connect integration. This functionality is available to all Rio users and provides immediate access to key GP information, including medication details, without needing to contact GP practices. This improves the quality and speed of referrals and supports safer, more informed clinical decision making.

6.5 Workflow Management

Managers currently have to submit the same information to multiple corporate teams when processing routine tasks, such as staff starters, changes and leavers, because the previous

corporate helpdesk systems did not allow information to flow between teams. To address this duplication, we have implemented a new workflow management system, Halo. Going forward, managers will submit a single request, and Halo will automatically route the information to all relevant corporate teams. The system also includes a chatbot to streamline interactions and improve efficiency, enabling staff to manage routine queries more easily while continuing with other work.

7. Risk

This paper sets out the programme of work required within the area of digital transformation. In doing this there is acknowledgement that if the trust is unable to meet the opportunity within digital, this will have an adverse impact on clinical capacity, trust efficiency and potentially impact on quality and safety.

With this in mind the trust is adding a risk to the BAF which highlights the risk of the Trust being unable to deliver key digital transformation initiatives at the required pace due to resource constraints, technical dependencies, and inconsistent clinical adoption, with the subsequent impact this would have in terms of variation and limitations on clinical resource.

8. Summary

The Trust is now entering a critical phase in its digital maturity journey. Over the last few years we have focus on building the foundations with the development of strong clinical leadership, co-production design, improved data quality and early evidence of measurable time release. We now have the conditions in place to develop a multi-year clinically led digital transformation programme. We are presently developing plans to ensure the trust is well place to implement the technologies that deliver automation, and save clinical time. In 2026/27 the Trust is targeting its investment on ambient voice, automation and electronic prescribing which are seen as the biggest opportunities to release clinical time.

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details	
Date of meeting:	29 January 2026
Title of paper:	Trust Quality and Safety Agenda
Author:	Sheila Stenson, Chief Executive
Executive Director:	Sheila Stenson, Chief Executive

Purpose of paper

Purpose:	Approval
Submission to Board:	CEO update

Overview of paper

This paper provides the Board with an integrated update on quality and safety, drawing together the risks, findings from independent reviews commissioned by the Chief Executive, and the Care Quality Commission's inspections of community services, health-based places of safety and inpatient wards. It sets out the actions underway to strengthen governance, assurance and improvement.

Issues to bring to the Board's attention

As Chief Executive, I have commissioned two independent external reviews in response to clear risk signals and as part of my responsibility to strengthen organisational assurance in regard to quality and safety. These signals include:

- sustained, systemic issues relating to culture, governance and risk management
- scale and complexity of community service transformation and the impact of that coupled with increased demand
- a cluster of patient safety incidents within community services, requiring independent scrutiny
- the Care Quality Commission's inspection of community services and crisis care and health-based places of safety services and inpatient wards

Version control 02 09.01.2026 - **Public**

The Board is requested to:

- Acknowledge the systemic and anticipated nature of the challenges identified and the potential risks this carries
- Support the Chief Executive's and Executive Management Team's continued prioritisation of the Quality Plan, the embedding of the Doing Well Together improvement approach, and the narrowing of organisational focus for the remainder of 2025/26 (included in my CEO report at Board today)
- Take assurance from the robust actions underway to strengthen safety and quality governance, learning and public transparency
- Note the approach to ongoing Board oversight and assurance

Governance	
Implications/Impact:	• **Quality and patient safety:** Direct - aimed at reducing incidents, improving safety and experience, and strengthening learning from incidents. • **Legal / regulatory:** Supports compliance with national patient safety and learning-from-deaths expectations; strengthens evidence for external scrutiny • **Reputational:** Transparent public reporting improves confidence in leadership and governance.
Assurance:	Limited assurance. Controls are strengthened and operating with increasing effect, but consistent impact across all services is not yet evidenced and further assurance activity is underway.
Oversight:	Executive weekly reviews; Trust Strategy Deployment Reviews (SDR), Quality Committee monthly deep-dives; IQPR and Quality Committee, Trust Board

Trust Quality and Safety Agenda

Chief Executive foreword

As the CEO of Kent and Medway Mental Health NHS Trust, I want to speak openly to our patients, families, staff and communities. Over the past year, while the trust has always been focused on quality and patient safety, we have not consistently evidenced the assurance needed to our communities.

To strengthen confidence, I commissioned two independent reviews: a rapid review of patient safety incidents and a review of our quality and safety governance processes. This paper brings together the findings from those independent reviews alongside the CQC's inspection findings in community, crisis and inpatient services, and the learning from the Attain peer review of community transformation and our own engagement and improvement work.

When I took up my post, I was clear that I was stepping into leading an organisation facing a complex set of challenges, alongside a significant programme of transformation within community mental health services which exposed increased unmet demand and complexity of need for our communities across Kent and Medway. The executive team and I made a deliberate decision to deepen our understanding of these challenges and to strengthen our grip on quality, safety, governance and culture.

What we now understand

My decision over the past year to commission independent, external reviews was deliberate. It reflects the scale of the challenges identified, the seriousness of recent incidents, and my commitment to openness with the Board, our staff and our stakeholders about where we are, what is working and where further improvement is required.

Taken together, external scrutiny, independent reviews and our internal learning now provide a clear and consistent picture of the issues we need to address. Five themes have emerged:

1. **Variation in culture and practice across teams and places** – influenced by our dispersed geography and long-standing teams, with uneven experience of psychological safety, leadership behaviours and accountability.
2. **Governance, risk and assurance fundamentals are not yet consistently embedded** – with variation in escalation, documentation and the translation of learning into sustained improvement
3. **Quality and safety intelligence needs strengthening** – including how we access, triangulate and use data and insight to provide timely assurance and learning.
4. **Transformation required a reset around clinical quality safety and consistency** – balancing delivery pace with a clearer clinical model and consistent standard of care.
5. **Stronger leadership grip and closed-loop oversight is required** – variable maturity across services and the need for more consistent approach to managing services.

   All of the above is against a backdrop of rising demand for our community services that has become more apparent and identified unmet need and demand for the population in Kent and Medway, as we transformed our services.

These insights mean we are no longer piecing together fragments. We have one clear picture of the issues, one set of priorities and one plan to embed change.

What we are doing

The trust's quality plan provides the primary vehicle for responding to the Attain review and the CQC's March inspection findings. The plan is structured around four areas for improvement and ultimately ensures that learning translates into sustained improvement across all teams.

1. **Safety and risk management**
2. **Access and waiting times**
3. **Environment, experience and equity**
4. **Leadership, culture and governance**

At the end of this report there is a clear conclusion to provide assurance of our approach for delivering sustained change to our services, quality and safety governance processes and ensuing we have robust ward to board oversight and assurance.

Our Strategic Approach

We have placed a renewed emphasis on listening – engaging extensively with staff, patients, carers and communities to understand lived experience of care, risk and reliability. We have increased visibility of performance and risk through more timely and accessible data, improving how insight is used to inform decision-making at both executive and Board level and we are beginning to strengthen the maturity of our quality and safety intelligence.
In addition, where required, I have commissioned independent reviews to inform my thinking and our approach to improving the services we provide.

This approach has been reflected in the most significant programme of engagement the trust has ever undertaken as part of the development of our new identity. This work was not simply about how the trust presents itself or what we are called, but about shaping and reinforcing the culture we want our staff and patients to feel: openness, learning, compassion and accountability. The insights gained through this engagement and co-creation of our new values - caring, inclusive, curious and confident - have informed our understanding of where care is working well, where it is inconsistent and where further improvement is required. It has also given us a shared vision for the future where we can be clear with our stakeholders and ourselves around what we're aiming for and the journey we are on.

For the remainder of 2025/26, mine and the executive team's relentless focus is on delivering the trust's quality plan and embedding improvement and our cultural values into everyday practice. I will continue to report openly to the Board and our stakeholders on progress, risks and assurance via our integrated quality and performance report (IQPR) and the Acting Chief Nurse will report to Quality Committee.

External peer review into the transformation of community services

In late 2024, I commissioned a review, led by Attain, into the delivery of the Mental Health Together transformation programme, regarding concerns about delivery, impact and safety. The review – which the Board considered earlier in 2025– identified that the organisation had become overly focused on the mechanics of operational transformation and delivery, at the expense of clarity of clinical vision, quality and safety and consistent experience for staff and patients.

The review enabled us to take a number of actions, which were already underway when the CQC inspected us in March, including: refinement of the community clinical model with our staff and partners; the incorporation of Mental Health Together (MHT) into the trust's Doing Well Together improvement approach; strengthened partnership working; additional programme leadership and capacity; and greater engagement and involvement with staff. These actions were intended to reset focus on the purpose of

the transformation, strengthen leadership oversight and ensure that improvement is delivered in a way that supports staff and improves outcomes for our patients.

The subsequent reviews referenced in this paper build on the learning from the Attain review, providing further independent assurance on quality, safety and governance.

Sustained, systemic issues around culture, governance and risk

External scrutiny, independent reviews and engagement insight highlight long-standing cultural challenges and variation in how consistently expectations are experienced across teams and places. These are experienced unevenly across the organisation and are more pronounced in specific teams and localities, influenced by our dispersed geography and the stability of long-standing teams. Addressing this requires sustained leadership focus and consistent expectations, support and oversight across all sites and services

The CQC, independent quality governance review and rapid review of patient safety incidents all highlight challenges in the consistent embedding of robust quality and safety governance fundamentals, including clarity of accountability, reliability of risk assessment and documentation, and the translation of learning into sustained improvement. While risk management is often occurring in practice, assurance has not always been sufficiently consistent, visible or timely to support effective oversight.

Independent engagement undertaken as part of the trust's identity and culture work reinforces this picture, identifying variation culture and practice across geographies and teams. This results in a gap between a strong ethos of care and the consistency of organisational culture experienced by staff across all teams and locations.

These insights have directly informed the trust's response, including a deliberate approach to culture change. The co-design of a new trust identity and cultural values in 2025 with staff, patients, carers and partners represented the first phase of this work, establishing a shared vision, common language and clear expectations about behaviours. This foundation is now being built upon through leadership development, embedding values-led behaviours, strengthened governance and assurance processes, improved use of data and intelligence and the embedding of improvement through the quality plan and Doing Well Together improvement approach.

Addressing these persistent cultural and governance challenges – and reducing variation between teams and places - remains a core priority for the trust. This requires a relentless and sustained focus, as we know changing organisational culture takes years and we are 18 months into this journey.

Sustained rising demand for community mental health services, increasing the importance of robust risk management and governance

The trust continues to operate within an environment of sustained and rising demand for community mental health services, alongside increasing complexity of need and workforce pressure. This context is central to understanding the risks and priorities set out in this paper.

Referral volumes, caseloads and acuity remain high across all localities. While progress has been made in improving access and reducing waiting times through refinement of the community mental health model, this has been achieved against continued pressure on capacity, patient flow and staff experience.

Rising demand and the pace of transformation do not excuse poor care experiences, but do increase the importance of robust risk management, clear prioritisation and strong governance oversight. This sustained pressure reinforces the need for the trust's current approach: narrowing organisational focus, embedding improvement through the quality plan, strengthening partnership working, and ensuring that transformation is delivered safely and with clear assurance to the Board.

CQC Inspection March 2025 inspection findings

The CQC's report, published in October 2025, confirmed that the trust was re-rated as *Requires Improvement* for community mental health services and Crisis/Health Based Place of Safety services. Ratings were previously shared at the November public board and are summarised below.

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

While these findings highlight areas of improvement, the CQC also identified important strengths, including:

- a stronger 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

Following the March 2025 inspection, the CQC recently undertook a focused re-inspection to teams in Thanet, Ashford, Canterbury and South Kent Coast in December 2025. High-level feedback provided in writing on 18 December 2025 recognised progress, while reinforcing the need to embed improvement consistently across teams.

The CQC reported improvements in record keeping and navigation of the electronic patient record, with progress notes generally completed to a good standard and accessible to staff. Inspectors also found that risk management activity was taking place in practice, supported by the use of progress notes to capture clinical information. Patient feedback gathered during the visit was positive, and staff morale was reported as good in Thanet, Ashford and Canterbury, with supportive local management. The CQC also noted that staff were able to articulate the direction of travel for service transformation.

However, the re-inspection also identified continued inconsistency in the use of formal risk assessment and care planning tools, and variation in how risk events were recorded and escalated. In some teams, inspectors noted reliance on staff knowledge of patients rather than consistently recorded risk information. In the South Kent Coast, challenges associated with the pace and impact of service transformation, and the local environment, were reflected in lower staff morale.

CQC inspection of inpatient services

In addition, the CQC inspected a number of acute inpatient wards and the psychiatric intensive care unit in September 2025 and provided written confirmation of its verbal preliminary feedback. This highlighted concerns about consistency in care planning, patient involvement and physical health support, alongside aspects of medicine management and monitoring arrangements. The CQC also raised issues relating to the ward environment and clinic room standards in some areas. Improvement actions were initiated immediately following the visits, and the trust is awaiting the draft inspection report for factual accuracy checks once the CQC process is complete.

The CQC has confirmed that no enforcement action would be taken.

Independent rapid review of patient safety incidents

I commissioned Hilary McCallion CBE, Peter Hasler and Patrick Scott (Independent Healthcare Consultants) to provide a rapid review of nine patient safety incidents that happened in close succession within community services in November 2025, alongside a thematic review of self-harm incidents reported between November 2023 and November 2025.

Given the rapid review and constraints on the availability and completeness of some information at the point it was undertaken, the reviewers were clear that this did not constitute a comprehensive assessment of all incidents. Within these constraints, the review did not identity evidence of immediate systemic failure. However, the findings highlighted limitations in the consistency and reliability of documentation, risk assessment, processes and organisational learning, and reinforced concerns already identified by the trust about variation in practice across community services.

Importantly, the limitations of the rapid review were themselves informative. They underlined the need to strengthen the trust's ability to access, triangulate and provide timely quality and safety information for assurance and learning, particularly during periods of heightened risk. As a result, further action will be taken to undertake a detailed review of our patient safety team and processes, alongside learning from the independent quality and safety governance review.

Learning and recommendations from the rapid review are being taken forward through the trust's quality plan. In addition, two follow up external reviews will be carried out to determine if further learning is needed. The first is to review historical data relating to deaths for incidences of substance misuse and previous self-harm, and the second of our liaison services. The reviewers felt that there may not be a consistent model in liaison psychiatry across the six sites in Kent and this should be explored and understood further, along with inconsistency in reporting.

Independent quality and safety governance review – early themes

The independent quality and safety governance review, being carried out by Moorhouse, benchmarked against national guidance, regulatory expectations and exemplar NHS mental health trusts, will be finalised in January. Preliminary draft findings show that the trust has strengthened strategic ambition and improvement intent, with areas of developing practice in patient safety, workforce and continuous improvement. However, it identified significant gaps in governance, assurance, risk management, data quality and culture, with variation in maturity between directorates and services, and limited evidence of consistent, closed-loop oversight. The findings align with themes from CQC, the independent rapid review and internal insight, and will inform prioritised action through the Quality Plan and Doing Well Together, our improvement approach.

Overall assessment

Taken together, the findings from external scrutiny, independent reviews and internal insight provide a consistent picture of both progress and the work still required to reduce variation and strengthen reliability and consistency across the trust. While progress is evident in a number of areas, sustained improvement is not yet consistent across the organisation and requires relentless focus.

The CQC's re-inspections in December have recognised progress we have made since March. External reviewers have recognised our growing improvement capability, a strengthening learning culture and areas where focused leadership has delivered tangible results. For example, in our Memory Assessment Services, sustained clinical and operational focus has resulted in significant reductions in waiting times and the elimination of very long waits, moving us to one of the best performing mental health trusts in the South East for diagnosing dementia within six weeks. This demonstrates what we can achieve when priorities are clear, attention is sustained and improvement is underpinned by our Doing Well Together approach.

However, these reviews and the findings from the CQC also make clear that improvement is not yet embedded consistently across the organisation. Further work is required to strengthen the reliability of key aspects of practice, including risk assessment, care planning, documentation and organisational and incident learning, and to ensure improvement is sustained over time through stronger governance grip, better quality and safety intelligence and consistent leadership oversight.

How assurance will be seen publicly

Progress against the quality plan and the actions arising from the independent reviews will continue to be monitored through established governance routes, which include the Trust Strategy Deployment Review approach, the Quality Committee and Trust Board. Quality Committee will receive regular updates on progress, risk and assurance, ensuring continued oversight, challenge and support as improvement is embedded.

The IQPR will also continue to provide regular updates to the board sub-committees and trust board, showing trend movement, stating what further actions are being taken where improvement is slower than planned. This should be reviewed alongside the Board Assurance Framework (BAF) where risks will remain visible with controls and milestones tracked openly.

Decisions requested:

1. **Approve** the continued prioritisation of the quality plan and associated public reporting through the Integrated Quality and Performance Report (IQPR), Board Assurance Framework (BAF) and the Quality Committee Chair's report.
2. **Endorse** a fundamental review and refresh of quality and safety metrics for learning and assurance at directorate, committee and Board level.
3. **Endorse** publication of a short **"**what we learned / what we changed**"** public update in May2026.

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details	
Date of meeting:	29th January 2026
Title of paper:	Integrated Quality and Performance Report (IQPR)
Author:	All Executive Directors
Executive Director:	Sheila Stenson, Chief Executive

Purpose of paper

Purpose:	Discussion
Submission to Board:	Standing Order

Overview of paper

A paper setting out the Trust's performance aligned to 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 remained in segment one in the 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 11th 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.

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.

This month an additional appendix is included to provide data insights into the MHT services in 2025 and details on future plans for the model of care.

Version control 02 - **Public**

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)

January 2026

Contents

1. Chief Executive Overview

This report highlights the trust performance for December, focussing on where performance is improving, areas of concern and what actions we are taking to address these. This month I have included a quality and safety lens in my overview to which I am keen we do more of as we move forward this year, strengthening our assurance regarding quality and safety and further develop the IQPR. The areas of focus I wish to bring to the boards attention this month are; patient flow, Mental Health Together and dementia performance. Please also note liaison and place of safety performance improvements.

Quality and Safety Overview

I procured an external independent review into our quality and safety assurance we take as a Board in November, this review will conclude at the end of this month. Alongside this we have commenced a review of the reporting of quality and safety data within the IQPR. This initial work has identified several opportunities for us to strengthen our reporting, and therefore the assurance we provide to board and our sub-board committees in particular quality committee. This work is on-going but will focus on clearer triangulation of harm-related metrics, a broader inclusion of quality and safety metrics and will be based on learning from our peers within the sector. We are working on this now and will reflect changes in future iterations of this report.

Reflecting on December, I would highlight the on-going work for reducing self-harm, which has seen an improvement in since May 2024. Work is ongoing in this area and following a focused piece of work looking at our female wards in East Kent, we expect to implement a trust-wide approach to self-harm in the coming months. In addition to this,

- Violence and aggression incidence totalled 203 in month, below the 13-month average of 234 but in line with normal variation.
- We saw AWOLs reduce to 46 (from 62 in November), and below a March peak of 71. Overall, AWOLs remain within expected levels.
- The use of restrictive practices remained in line with the range seen in year, with 141 incidents recorded in December, however this was down from 170 in November.

Patient flow / Bed state

Management of our beds remains a key priority for us. Bed occupancy across our acute beds has remained high throughout quarter 4, in excess of 97%. Our Length of Stay (LOS) for Clinically Ready for Discharge (CRFD) patients was 69.9 days in December against a target of 68.3 days, despite this CRFD continues to be a significant pressure accounting for over 20% of bed days. We have been in Operational Pressures Escalation Level (OPEL) 4 for most of the month of December and into January.

A revised programme for the FLOW True North is currently being collated and will be ready for week ending the 30th January as one of our priorities until the end of March, preparing for our busiest time of year during Spring. This will include a rigorous focus on our discharge processes and will be managed as business as usual.

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. Our CRFD cohort of patients reduced to 52 in acute beds as of January 9th, lower than a high of 70 in January 2025 and reduction from 58 in December.
- We continue to provide Step Down Beds in Clarendon House for 24 patients to date (9th January). This has resulted in the use of over 1,374 bed days to date. The average length of stay for those patients is 35 days.
- The role out of standardised work on the wards continues. This is led by the Clinical Director who is focusing on establishing standard working practice across all wards to eliminate variation in practice. In addition, ensuring that Red to Green is used appropriately and estimated discharge dates are recorded within 72 hours of admission.
- A dedicated piece of work with Crisis teams has been started to identify factors impacting on consistently implementing our purposeful admission protocol and gatekeeping processes.
- We are in the process of creating our patient expectation policy setting out expectations for our patients on their discharge process.
- Our work on establishing the Urgent Emergency Care Coordination Centre continues with staff engagement taking place.
- 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. There is considerable pressure in the social care system currently.

Community Mental Health, Mental Health Together (MHT)

Progress is being made within the Community Mental Health Programme. The refinement of the model is completed with good engagement from staff, our patients and partners in relation to next steps, which will include a phased implementation building upon the success of the Medway pilot. The critical path is built around the operational model to underpin the clinical model, which will be delivered in Q4 2025/26. 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 (MHT) we have seen a reduction in waiting times. The MHT waiting list has reduced from 6,949 at the end of March 2025 to 6,099 (January 9th), which is a 12.3% 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

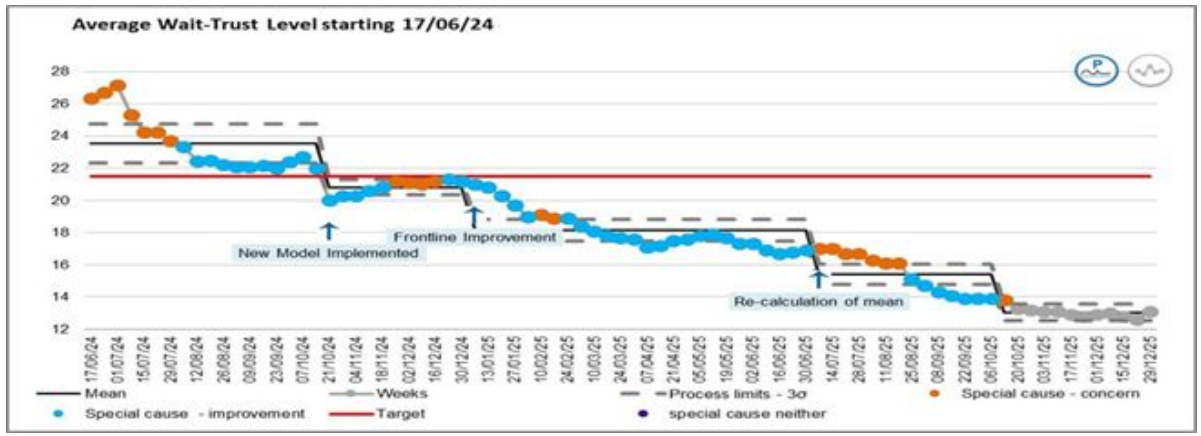
Of the 6,099 waiting (as of 9th January) 77% are waiting under 18 weeks and 23.4% are within 4 weeks. The waiting list reflects all those open to MHT awaiting the commencement of an intervention. A significant proportion (66.5%) of those waiting have been seen at least once, with most of these patients having been assessed, or have had an outcome score recorded and are now awaiting the commencement of an intervention. The 33.5% 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 97 patients (1.6% of total list) as at 9th January. 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 safety plans are in place.

Dementia

We continue to make significant progress. 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.
- Increased the dementia diagnosis rate to the highest it has been in Kent & Medway to 62.3% (Nov 25), moving towards the national ambition of 66.7%.
- We have focussed on reducing long waits, with patients waiting over 52 weeks for a diagnosis reducing by 92% from 260 in February to 23 as at January 19th (1 0.9% 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 118 days in December and 120 days for the last 12 months, 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 17 months, from 190 days in July 2024 to 90 days as at 9th January 2025.



I would like to say a massive thank you to our staff for achieving a huge reduction in our waiting times, against rising demand for our services in MHT and the significant progress we have made in our MAS for waiting times and the impact this has had positively on the DDR for the Kent and Medway system.

Further areas I'd like to note include:

- Liaison psychiatry referrals closed within 12 hours has improved to 82.6% in December 2025 from 53% in January 2025.
- Place of safety (POS) detention % under 24 hours has improved to 88.9% in December 2025 from 76.2% in January 2025.
- Following the November board, the open-line performance has improved, further work is underway to ensure this is sustained improvement and performance.
- Sickness rates have risen in line with seasonal pressures, including flu-related absence. HR are actively monitoring the position and have been encouraging staff to have their flu jabs. As at 15th January our uptake for frontline clinical staff was 45.8%, this was 8% higher than the local peer medium.
- Older adult length of stay has been adversely impacted by the discharge of a few long stay patients. This has seen a positive movement in the OA CRFD position.

  As per the Boards request in November we have included 3 pages in the appendix to this report focussed on the refined CMHF model and the percentage of referrals at each stage of the model.

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

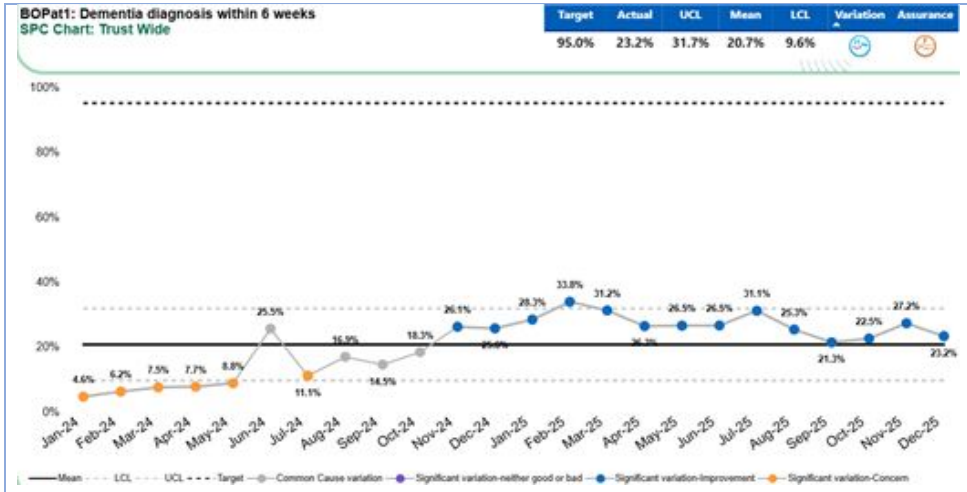
Measure Name	Target	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
TNPat1: Timely access: Community (CMHF/MAS) patients needs are met within timeframes	85.0%	15.5%	16.2%	17.5%	13.9%	12.7%	15.5%	16.5%	17.3%	13.3%	16.5%	16.1%	16.3%
TNPat2: Equitable access: <1% variance in waiting time (MHT/MAS) between most deprived and least deprived.	1.0%						(3.5%)			(9.2%)			(1.6%)

**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	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
BOPat1: Dementia diagnosis within 6 weeks	95.0%	28.3%	33.8%	31.2%	26.3%	26.5%	26.5%	31.1%	25.3%	21.3%	22.5%	27.2%	23.2%
BOPat2: Community (CMHF/MAS) referrals have ethnicity recorded	90.0%	84.2%	84.1%	84.0%	83.8%	83.9%	84.0%	83.9%	84.0%	83.6%	83.6%	84.1%	85.4%

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

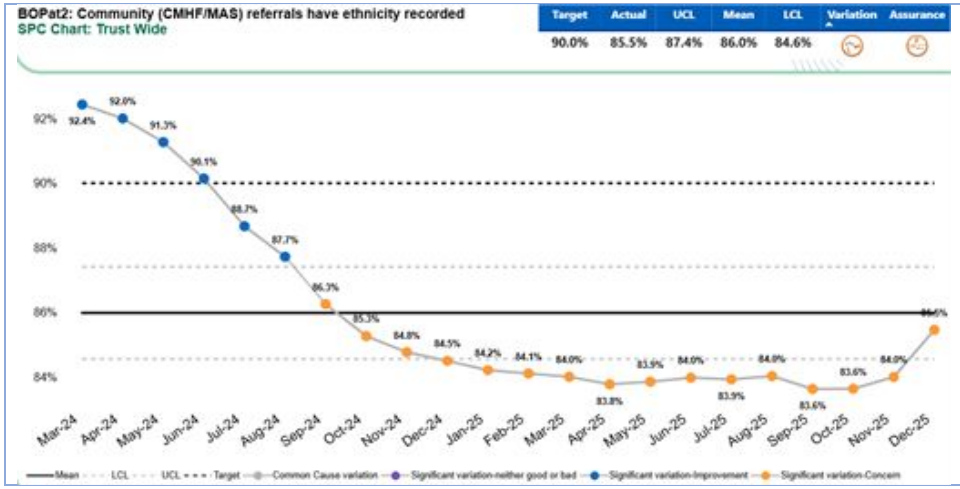
The SPC chart shows that the Trust is consistently failing the 95% target (not a national target, locally agreed) for compliance with the mean for compliance since January 2024 being 20.7%. However, the last thirteen months' compliance has been above the mean triggering an SPC rule that signifies special cause variation of improved performance. KMMH performance remains above national and regional data reporting on 6-week performance from the NHS England MAS dashboard.

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 23(19th January). 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 62.3% in November 2025.

The review of the ethnicity of MAS patients who experience a Trust-led cancellation has highlighted that a) ethnicity is under-recorded (ethnicity was not recorded for 31.1% of MAS patients seen) and b) where ethnicity is recorded, trust led cancellations are proportionately more likely for Asian or Asian British patients.

To address under-recording, the Trust implemented the 'about me' page on RIO in January 2026 which brings information together in one place and launched Health Inequalities training in December 2025. The impact of these initiatives, subsequent learning, and next steps will be considered in April 2026. In the interim, focused work through the Getting the Basics Right programme is seeking to address the reasons for trust-led cancellations including a focus on those of Asian and Asian British ethnicity.



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 has been special cause variation of a concerning nature with the last 15 months' performance falling below the mean of 86%.

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	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
1.1.01: Open Access Crisis Line: Calls received	3,274	3,373	2,920	3,362	3,229	3,110	3,266	3,383	3,047	2,976	3,227	2,794	2,968
1.1.02: Open Access Crisis Line: Abandonment Rate (%)	38.9%	26.8%	30.9%	33.6%	31.5%	34.3%	36.9%	37.1%	38.9%	40.2%	28.3%	21.2%	25.0%
1.1.03: Assess people in crisis within 4 hours		90.9%	89.5%	86.9%	94.9%	94.7%	86.9%	93.7%	91.4%	93.6%	91.0%	90.9%	84.9%
1.1.04: People presenting to Liaison Services: triaged within 1 hour		90.6%	83.4%	88.0%	88.6%	90.7%	92.3%	92.1%	89.4%	90.8%	90.9%	89.2%	93.7%
1.1.05a: Liaison Psychiatry referrals closed within 12 hours	95.0%	53.0%	61.9%	78.1%	80.4%	80.0%	81.6%	84.6%	82.1%	81.8%	82.8%	81.5%	82.6%
1.1.05b: Liaison Psychiatry referrals closed identified as requiring a bed within 12 hours	95.0%	6.1%	3.3%	5.4%	6.8%	6.7%	2.0%	5.7%	8.8%	6.1%	1.6%	8.1%	5.9%
1.1.06: Place of Safety Length of Detention: % under 24 hours	75.1%	76.2%	76.6%	77.6%	75.0%	75.0%	79.0%	80.0%	78.7%	86.9%	86.4%	89.8%	88.9%
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%	58.3%	75.0%	61.5%	52.6%	69.6%	72.2%	70.0%	85.7%	92.3%	87.0%	76.5%	75.0%
1.1.09: % MHLD referrals commencing treatment in 18 weeks	86.1%	85.4%	94.1%	92.1%	88.6%	100.0%	81.3%	92.9%	84.8%	83.8%	83.7%	70.7%	95.8%
1.1.10: Perinatal assessments (against annual target)	2,000	193	136	158	514	216	182	183	163	177	180	161	142
1.2.09: Dialog assessment completed in Community Service (MHT/MHT+/EIS/Com.Rehab/Inpt.Rehab)		1,563	1,371	1,819	2,035	2,205	2,053	2,281	1,861	2,231	2,321	2,067	2,125
1.3.01: Mental Health Scores From Friends And Family Test – % Positive	86.0%	88.1%	88.7%	87.9%	87.7%	88.7%	91.2%	90.8%	88.4%	88.8%	87.4%	83.6%	86.9%
1.3.02: Complaints - actuals		51	44	60	45	61	58	51	53	66	44	47	38
1.3.03: Compliments - actuals		147	122	122	131	122	159	174	118	139	153	147	157
1.3.04: Compliments - per 10,000 contacts		40.7	37.5	34.5	35.5	32.8	41.0	40.8	31.8	34.5	35.8	36.2	41.6
1.3.05: Patient Reported Experience Measures (PREM): Response count		540	529	563	513	626	605	577	424	456	507	353	434
1.3.06: Patient Reported Experience Measure (PREM): Response rate		3.7	3.6	3.6	3.2	3.7	3.5	3.2	2.6	3.1	2.8	2.0	2.5
1.3.07: Patient Reported Experience Measure (PREM): Achieving Regularly %		8.5	8.6	8.5	8.5	8.5	8.4	8.4	8.5	8.4	8.1	8.1	8.4
1.3.08: Complaints acknowledged within 3 days (or agreed timeframe)	100%	100%	98%	97%	96%	94%	93%	93%	95%	89%	84%	86%	98%
1.3.09: Complaints responded to within 30 days (or agreed timeframe)	100%	92%	82%	81%	89%	76%	81%	86%	80%	83%	89%	75%	82%
1.4.05: Decrease violence and aggression		220	231	210	246	226	237	276	224	277	256	242	200
1.4.06: Medication errors		50	39	54	46	62	50	54	45	55	54	36	38
2.1.01: Referrals to MHT commence treatment within 4 weeks		4.0%	4.6%	9.0%	5.5%	4.2%	8.2%	7.6%	11.5%	8.5%	12.7%	10.9%	13.2%
2.1.02: MHT waiting list size		5,995	6,243	6,573	6,186	5,687	5,472	5,590	5,468	5,772	4,592	4,625	5,842
2.1.03: MHT 2+ contacts		18,507	19,137	18,987	19,797	20,600	21,641	22,623	23,316	24,150	24,931	25,568	26,099
4.1.02: DNA Rate – All Appointments		10.9%	10.3%	10.4%	10.8%	10.7%	11.0%	10.7%	10.1%	10.5%	10.4%	9.8%	9.9%

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	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-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	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-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. The next Pulse survey has gone live in January 2026 following to completion of the national staff survey. East Kent is undertaking a focused piece of work in relation to the clinical and operational leadership within MHT and MHT+, specifically in relation to Operational Team Managers, Lead Nurses and Lead Clinicians. Line management structures and job plans have been revised with the intention this will result in clarity of job role and clear lines of responsibility and accountability for post-holders and the wider teams. This took place in Thanet last Autumn and has seen positive results. The change was implemented in Ashford and Canterbury in December and is being worked through in South Kent coast now. We are working with the Improvement Team as to how we can measure the impact and correlate it to more positive staff experience.

The annual employee engagement survey has now closed; the indicative Trust response rate is 50.6% which is a decline of approx. 4.62% on last year.

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 will be rolled out across the organisation early 2026, with new councils being in place in all directorates by spring 2026. This is being agreed at TLT on the 21st January.
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 and Leads Team modules have been completed. Leads Organisation started in December 2025.
The second Innovation Den has also just closed for bid submission, 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	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
3.1.01: Staff Sickness - Overall	3.5%	5.2%	5.0%	4.6%	4.3%	4.3%	4.1%	5.0%	5.2%	4.9%	4.9%	5.5%	5.9%
3.1.02: Vacancy Gap - Overall	14.0%	10.8%	10.7%	9.8%	10.0%	10.1%	10.3%	10.2%	10.3%	10.2%	10.2%	10.3%	10.2%
3.1.03: Mandatory Training For Role	90.0%	95.0%	95.2%	95.5%	95.4%	95.4%	94.8%	95.4%	95.6%	94.8%	95.4%	95.3%	95.6%
3.1.04: Leaver Rate	15.0%	13.4%	13.4%	12.5%	12.8%	12.6%	12.6%	11.9%	11.9%	11.4%	11.2%	11.7%	12.1%
3.1.05: Leaver Rate (Voluntary)	14.0%	9.3%	9.3%	9.1%	9.2%	8.9%	9.0%	8.2%	8.1%	7.8%	7.7%	7.4%	7.4%
3.1.06: Safer staffing fill rates	80.0%	109.6%	110.1%	108.8%	110.7%	112.1%	109.6%	110.2%	109.2%	110.3%	109.0%	108.6%	109.6%
3.1.07: Increase percentage of BAME staff in roles at band 7 and above	20.0%	28.1%	28.4%	28.5%	28.5%	27.0%	27.5%	29.8%	30.6%	30.9%	30.9%	30.7%	29.0%
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%	0.35%	0.21%	0.21%	0.05%	0.17%	0.32%	0.44%	0.39%	0.23%	0.12%	0.11%	0.27%

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

Executive Sponsor: Dr Afifa Qazi, Chief Medical Officer

True North

Measure Name	Target	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
TNPar1: Reduce Clinically Ready for Discharge (CRfD) length of stay (LoS) by 25% by 2030	68.3	60.0	111.8	67.2	94.5	86.9	69.6	46.3	82.2	81.9	92.9	45.8	69.9

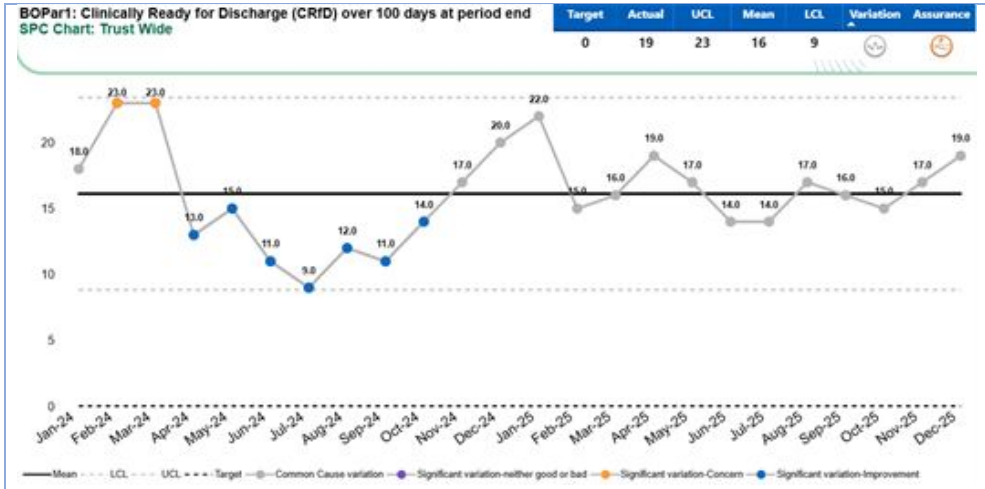
**target reflects year one target of a 5% reduction compared to 2024/25 baseline*

Breakthrough Objectives

Measure Name	Target	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
BOPar1: Clinically Ready for Discharge (CRfD) over 100 days at period end	0	22	15	16	19	17	14	14	17	16	15	17	19

**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 16 patients CRFD at month end over this period. There is consistent failing of the target of 0.

Joint system work is progressing under three main projects:
1) Care Act trusted assessment agreement (to enable KMMH staff to complete Care Act assessments)
2) KMMH and KCC Deep dive of patients CRFD >100 completed and identified three clear themes of required work: support to housing providers with mental health knowledge and confidence; community teams identifying potential risk of placement breakdown and proactively supporting supported accommodation discharge and housing in reach to the wards. Multiagency action plans to be completed for these in January
3) Joint working for a system funded business case for stepdown bed provision for males awaiting supported accommodation (our highest driver for CRFD>100days)

Additional specific projects will be being moved to business as usual: optimising inpatient operational processes to reduce time of CRFD and expedite discharge; purposeful admission protocol to be owned and reviewed by the urgent care and liaison community of practice; HIU work to be owned and reviewed by community directorates. This will free up the focus of the CRFD oversight group to the main projects highlighted above.

Watch Metrics

Measure Name	Target	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
1.2.01: Average Length Of Stay (Younger Adults Acute)	34.0	35.0	51.5	49.4	36.9	38.9	35.1	36.2	32.8	42.6	50.9	27.5	31.5
1.2.02: Average Length Of Stay (Older Adults - Acute)	77.0	63.3	124.4	125.8	87.7	102.4	88.8	71.4	69.1	104.3	79.7	76.0	81.6
1.2.03: Adult acute LoS over 60 days % of all discharges	16.0%	19.1%	17.3%	22.6%	18.4%	17.0%	14.9%	14.5%	12.2%	14.4%	22.9%	12.9%	13.3%
1.2.04: Older adult acute LoS over 90 days % of all discharges	37.7%	28.0%	57.1%	48.0%	35.1%	40.0%	33.3%	30.3%	30.0%	43.3%	31.3%	24.0%	42.9%
1.2.06: Readmissions within 30 days (YA & OP Acute)	8.8%	12.2%	8.8%	11.9%	11.5%	6.3%	11.4%	10.4%	16.7%	12.6%	12.0%	10.3%	12.2%
1.2.07: Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)	608	467	596	926	1,026	875	775	625	608	574	590	561	513
1.2.08: Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs) at period end	21	27	24	36	31	28	28	19	17	22	18	17	15
2.1.04: Clinically Ready for Discharge (CRfD): YA Acute	7.0%	19.6%	24.3%	21.7%	22.0%	18.9%	15.2%	14.4%	17.5%	17.9%	15.2%	20.3%	22.0%
2.1.05: Clinically Ready for Discharge (CRfD): OA Acute	12.0%	37.6%	36.1%	32.9%	29.3%	21.3%	25.4%	31.9%	36.2%	31.8%	30.6%	28.7%	23.6%
4.1.01: Bed Occupancy (Net)	92.0%	97.4%	97.7%	97.4%	94.2%	94.0%	95.8%	95.3%	96.8%	97.7%	96.4%	97.9%	97.0%

1.2.07 & 1.2.08 Out of Area Placements – these figures include beds used for Female PICU under contracted beds due to the absence of female PICU beds in Kent and Medway. 513 bed days were used in December 2025, 171 were female PICU patients within contracted beds resulting in 342 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: Julie Kirby, Chief Nurse

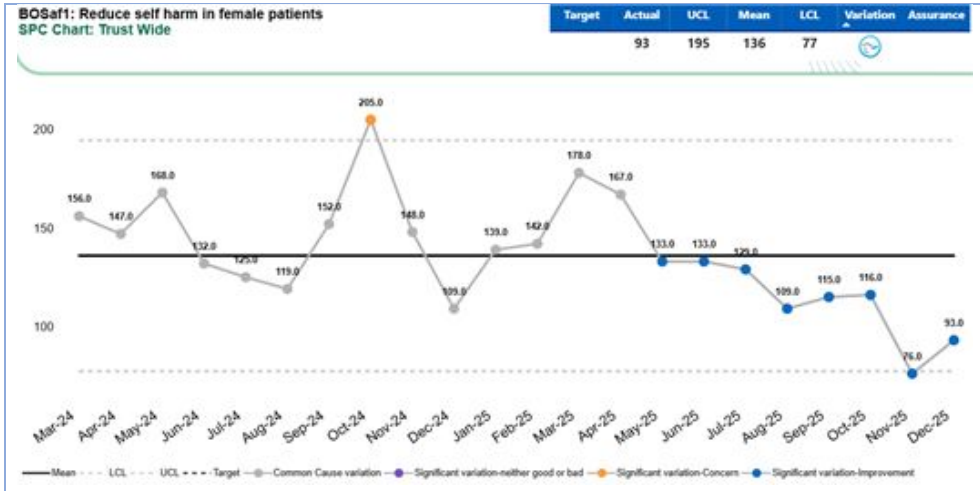
True North

Measure Name	Target	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
TNSaf1: Reduce the number of patient harms		177	172	232	207	165	175	178	149	146	152	105	121

Breakthrough Objectives

Measure Name	Target	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
BOSaf1: Reduce self harm in female patients		139	142	178	167	133	133	129	109	115	116	76	93

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 special cause variation of an improving nature due to 8 months below the mean. The mean since March 2024 is 136.

The Acute directorate accounted for 42 incidents in November 2025 and have adopted a target of 60 by March 2026. It should be noted that Chartwell's switch from female to male patient care provision in July 2025 will have had an impact on 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.

The A3 workshops on the East Kent female wards have been undertaken and the information gained from these aligned with the feedback gathered via the staff survey at the beginning of the year. The "lived experience of self-harm" survey has now closed and the results are being reviewed. A set of principles for supporting individuals who self-harm have been created based on patient and staff feedback and best practice guidance, and we are awaiting a confirmation of a trust launch date of these from the communications team. A staff room page has also been developed and is with the communications team to action. Both the ASH and MRAP pilots have concluded and work is underway to plan how these pilots can be operationalised and rolled out across the acute inpatient estate.

Watch Metrics

Measure Name	Target	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
1.2.05: Patients receiving follow-up within 72 hours of discharge		84.3%	85.0%	84.5%	82.8%	83.9%	89.9%	91.3%	85.8%	88.5%	87.0%	88.7%	85.9%
1.2.10: %Patients with a CPA Care Plan	95.0%	87.1%	90.1%	89.3%	89.5%	90.7%	89.7%	84.7%	81.8%	82.2%	81.5%	78.0%	75.7%
1.2.11: % Patients with a CPA Care Plan which is Distributed to Client	75.0%	72.4%	71.4%	70.7%	71.6%	71.9%	70.4%	74.1%	74.7%	76.1%	75.9%	74.5%	74.0%
1.2.12: %Patients with Non CPA Care Plans or Personal Support Plans	80.0%	58.6%	62.4%	61.1%	56.4%	54.7%	57.1%	53.1%	48.7%	46.8%	45.9%	44.0%	38.8%
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		199	174	159	121	151	152	135	112	137	145	104	149
1.4.03: Restrictive Practice - All Restraints		63	77	109	103	95	57	100	87	111	163	170	141
1.4.04: Restrictive Practice - No. Of Prone Incidents	0	3	7	8	5	2	12	8	4	7	16	12	4

1.2.10-12: As part of the quality plan and community mental health model refinement we are transitioning to DIALOG Plus serving as the Mental Health Together care and support plan for service users. As we transition there will be a period of data discrepancy in the CPA and non-CPA care planning. During the embedding we will see an increase in DIALOG Plus completion. DIALOG plus will also support assessment processes and remain an outcome measure. The implementation of this new approach will run alongside the work we are undertaking with risk assessment

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	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
TNSus1: Clinician Contact time per FTE					0.31	0.33	0.33	0.32	0.32	0.35	0.33	0.34	0.32

**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	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
BOSus1: Psychology & Medic contact time per FTE					0.35	0.40	0.40	0.38	0.36	0.38	0.40	0.39	0.34

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

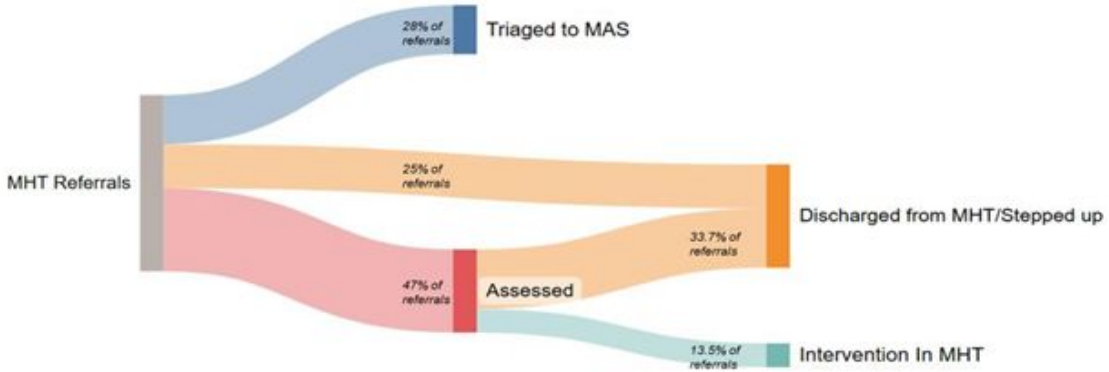
Measure Name	Target	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
4.1.04: In Month Budget (£000)	0	(14,756)	(14,708)	(14,742)	(15,122)	(15,315)	(15,413)	(15,303)	(17,957)	(15,725)	(15,710)	(15,553)	(15,537)
4.1.05: In Month Actual (£000)		(15,863)	(15,637)	(15,488)	(16,169)	(16,064)	(15,684)	(15,469)	(17,979)	(16,362)	(16,355)	(16,094)	(16,332)
4.1.06: In Month Variance (£000)		(1,107)	(930)	(746)	(1,047)	(749)	(271)	(166)	(23)	(637)	(645)	(541)	(795)
4.1.07: Agency spend as a % of the trust total pay bill	3.2%	2.6%	2.5%	1.9%	2.7%	2.5%	2.6%	1.9%	2.0%	1.8%	2.2%	1.7%	2.2%

5. Appendices

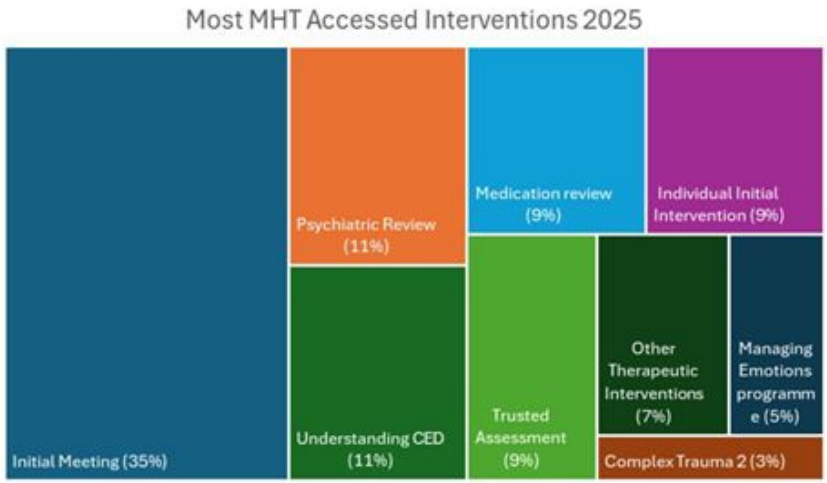
CMHF Model Clarification

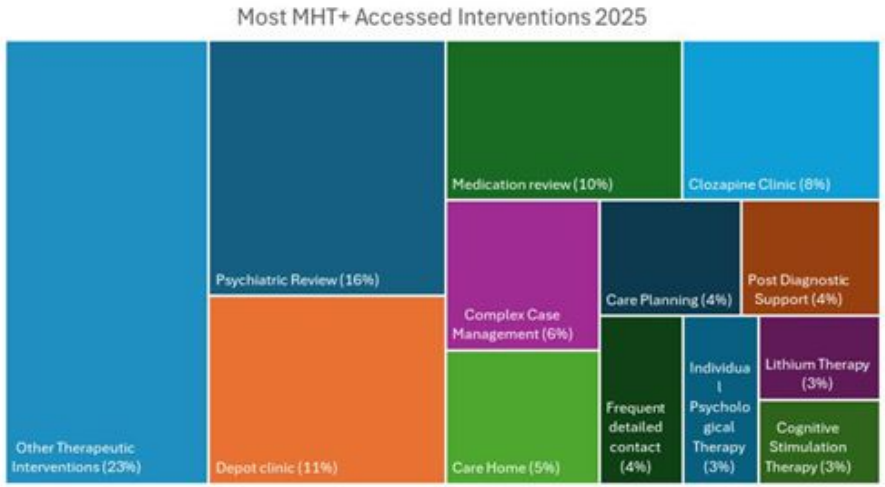
Referral Flow in Mental Health Together

The diagram represents the flow of referrals through MHT, assessment and interventions are defined as per the national waiting time definitions.
The 47% assessed will receive a Dialog+ alongside a brief intervention and care navigation.
Referrals discharged out will have been supported to access an alternative service based on need or will have been stepped up to receive a more intensive service such as MHT+ (approx. 11% of all MHT referrals).

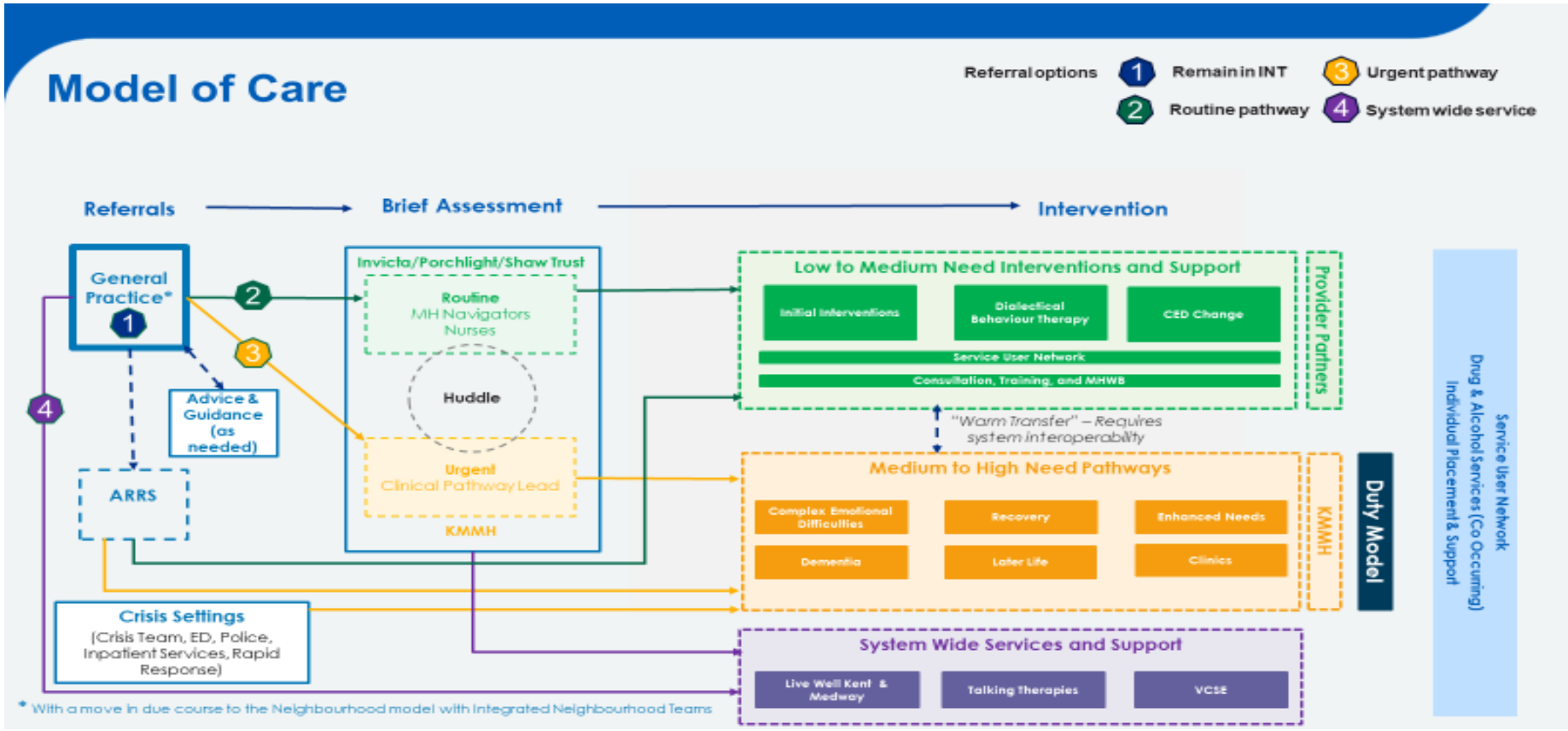


The following charts show the most accessed interventions in MHT & MHT+ in 2025. A large number of interventions exist within 'Other Therapeutic Interventions' reflecting the sum of 87 individual interventions in MHT+. There is ongoing rationalisation of the interventions available to enhance data quality and the insights from the data generated.





Our revised model of care



The revised model proposes further development of our Partnership Delivery Model which enables a more clearly defined role of provider partners across the service to enable delivery of services as close to local communities as possible. Under this proposed way of working, people with lower/medium needs would access services through local access points, managed and delivered by provider partner(s). While people with higher needs would step-up and/or be directly referred to Kent and Medway Mental Health Trust. The model was approved by the partnership oversight group in November 2025.

Ensuring the right support is provided in the right place at the right time

The proposed revised model supports improved clinical outcomes and experience by increasing the accessibility and responsiveness of services locally and maximising the skills and expertise available across system providers. The programme is addressing safety and risk priorities through alignment with feedback from last year's Care Quality Commission inspection to ensure that relevant learning and recommendations are embedded as part of the revised approach.

Primary Care Mental Health

Successful working with partners and primary care is an integral part of the proposed Partnership Delivery Model and we need to further strengthen our partnerships to effectively deliver our ambition for community mental health care. As part of the technical work planned for Quarter 4, we will be finalising the approach for integration of primary care practitioners and continue to work with the ICB about future primary care mental health. Also, we have formed a provider forum to work effectively with Kent and Medway Talking Therapies now and in the future.

In summary:

- The ambition of the Trust and its partners in further developing the delivery partnership and structures that underpin Mental Health Together, recognising that this is pioneering work.
- There is commitment across the delivery partnership to build and further improve.
- There have been many improvements that have been made since the initial implementation.
- Mental Health Together will be on a continuous journey of improvement as we ensure we have services that meet our patient's needs, and this is the latest iteration.
- The programme of improvement has been designed and structured to ensure that the lessons about communications and engagement and developing the enablers to support the change have been learnt.

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 Q2 2025/26 KMMH 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			Q2 2025/26	1	NOF Score	Provider value	
Average metric score			Q2 2025/26	1.94	NOF Score	Provider value	
Unadjusted segment			Q2 2025/26	1	NOF Score	Provider value	
Financial override	Q2 2025/26	No	Yes		Yes	Provider median	
Is the organisation in the Recovery Support Programme?	Q2 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	Q2 2025/26	1	NOF Score	
Effectiveness and experience of care domain segment	Q2 2025/26	1	NOF Score	
Patient safety domain segment	Q2 2025/26	3	NOF Score	
People and workforce domain segment	Q2 2025/26	3	NOF Score	
Finance and productivity domain segment	Q2 2025/26	1	NOF Score	

Extract as at 03/12/2025

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:	29th January 2026
Title of paper:	Finance Report Month 9 (December 2025)
Author:	Nicola George, Deputy Director of Finance
Executive Director:	Nick Brown, Chief Finance and Resources Officer

Purpose of paper

Purpose:	Noting
Submission to Board:	Regulatory Requirement

Overview of paper

The attached report provides an overview of the financial position for month 9 (December 2025).

Issues to bring to the Board's attention

For the period ending 31st December 2025, the Trust has reported a pre-technical adjustments surplus of £1.22m and a surplus of £1.65m 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 9 Acute and 8 PICU beds used in month and a year to date budgetary pressure of £4.55m.
- Year to date agency spend is £3.77m. The current agency forecast is £4.72m, this is £0.45m above the agency cap and reflects increases in recent months due to clinical need.
- 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.

The board are asked to note the cash position of £3.98m reflects a delay in process around the provider collaborative income, payment was made 2nd January and restored the cash balance to £7.50m.

Governance

Implications/Impact:	Risk of Delivery of Finance targets may result in sanctions from NHS England.
Assurance:	Reasonable Assurance
Oversight:	Finance, Business and Investment Committee

NHS
Kent and Medway
Mental Health
NHS Trust

Finance Reporting Pack

Trust Board
December 2025

Contents

1. Executive Summary

Key Messages

For the period ending 31st December 2025, the Trust has reported surplus of £1.65m (post technical adjustments) this is in line with the financial plan. The pre technical adjustments surplus totalled £1.22m.

Key pressures for the Trust are:

External beds

- External bed expenditure continues to be a financial pressure. In month, usage of external Acute beds decreased, from an average 11 beds to 9. External PICU usage increased by 1 bed, to 6 female beds and 2 male beds (8 in total). Year to date this represents a £4.55m overspend against budget.

- To help alleviate this pressure, the Trust has put in place stepdown capacity, which has facilitated the repatriation of patients from external Acute beds to KMMH beds. 2,782 block bed days have been purchased at a cost of £0.52m, with usage estimated at 1,306 bed days since June; at this level the trust has seen cost avoidance of £0.79m.

Acute Inpatient staffing

- The Trust's Acute Inpatient wards have consistently utilised additional Nursing staff (both registered and unregistered) over and above established levels.

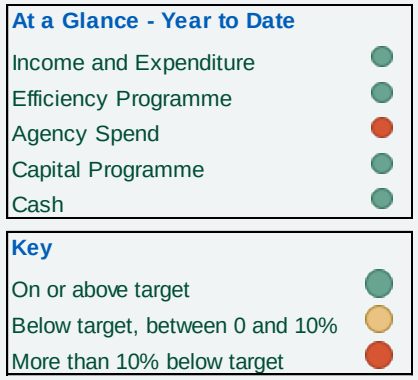
- In December, 72.2 additional WTE above establishment were utilised, increasing from 49.3 WTE in November. The year-to-date pressure now totals £2.60m.

Agency spend

- In month spend increased to £0.43m, £0.08m higher than November. Year to date agency spend totals £3.77m, 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 44.8% of overall agency spend, due to medical vacancies, but also West Kent (21.9%) 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 £4.72m, £0.45m over the cap.



Capital Programme

As at 31st December the overall capital position is £0.19m under plan. This is primarily due to underspends in Estates schemes (£0.08m) and the Female PICU project (£0.08m).

The overall forecast for capital spend remains at £18.59m, with a significant portion of spend scheduled for quarter 4, reflecting the extensive work required for two major capital projects.

Mitigation strategies are being developed to ensure swift action should any risks emerge during this demanding programme.

Cash

At the end of December, the Trust's closing cash balance was £3.96m. Payment for outstanding contractual; invoices from the Provider Collaborative were delayed in December but payment was made on 2nd January.

The Trust took a decision to maintain supplier payments as planned so not to destabilise their cash positions. The payment from the Provider Collaborative was received as planned which restored the cash balance to £7.50m.

The Trust's is forecasting its cash balance to be around this level for the remainder of the year reflecting its financial position and capital programme.

2. Finance KPIs

I&E YTD position

M9 YTD actual	**£1.65m surplus**
Forecast outturn	£2.20m surplus

Year to date position on plan with a reported £1.65m 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

M9 YTD actual	**£10.22m**
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

M9 YTD actual	**£7.44m**
Forecast outturn	£18.47m

As at 31st December the overall capital position is £0.19m under plan. This is primarily due to underspends in Estates schemes (£0.08m) and the Female PICU project (£0.08m).

Bank spend

M9 actual	**£1.67m**
Planned Run Rate	£1.67m

Bank spend increased in month by 10.9%. Usage increased across Forensic and Inpatient wards as cover for annual leave, sickness and observations increased.

Agency spend

M9 actual	**£0.43m**
Planned Run Rate	£0.36m

Agency spend increased in month. The current forecast for agency is £4.72m, which against a cap of £4.27m results in the annual cap being exceeded by £0.45m.This is under review with a potential increase in forecast to address community backlog.

WTEs utilised

M9 actual	**3,994**
Planned Staffing	4,024

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 decrease is due to decreases in substantive staff in month.

External beds spend

Year to date overspend	**£4.55m**
Average Beds in Month	17

External beds reduced to an average of 17 beds, with Acute decreasing from 11 to 9 beds but male PICU beds increasing from 1 to 2. This remains a key area of financial pressure for the Trust.

Cash position

M9 cash balance	**£3.96m**
Operating Expenditure Days	8.8

The closing cash position for December was £3.96m which was a decrease in month of £5.73m.

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.

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	296,077	24,526	25,769	1,243	222,532	228,436	5,904
Employee Expenses	(230,307)	(19,102)	(19,369)	(267)	(173,038)	(172,653)	385
Operating Expenses	(58,679)	(4,834)	(5,952)	(1,118)	(44,177)	(51,402)	(7,225)
Operating (Surplus) / Deficit	**7,090**	**591**	**449**	**(142)**	**5,318**	**4,381**	**(937)**
Finance Costs	(4,890)	(408)	(265)	142	(3,667)	(2,730)	937
System control Surplus / (Deficit)	**2,200**	**183**	**184**	**0**	**1,651**	**1,651**	**0**
Excluded from System control (Surplus) / Deficit:							
Technical adjustments	**(194)**	**(10)**	**(6)**	**4**	**(557)**	**(433)**	**124**
Surplus / (deficit) for the period	**2,006**	**173**	**177**	**4**	**1,094**	**1,217**	**124**

The Trust is reporting a surplus of £1.65m at the end of December. This is in line with plan.

Income

Year to date there is a favourable position against plan due to increased income for Forensic Provider Collaborative following a review of unit costs, Perinatal Provider Collaborative income is planned as Contractual clinical income but recorded in actuals as other income due to Costing guidance and this has created a mismatch in variances between categories.

Employee expenses

The Trust is reporting a year-to-date underspend on employee expenses of £0.39m.

This consists of an underspend on substantive pay of £0.63m with an additional underspend of £0.33m on bank (where bank is planned to support rotas), offset by overspends on agency of £0.57m.

Agency spend in month was £0.43m, up £0.08m from November; Medical (68.2%) and Nursing (31.3%) being the key drivers for agency costs.

Operating expenses

In month operating expenses are over plan by £1.12m which is heavily driven by external bed spend. The Trust utilised 8 external PICU beds (7 PICU beds funded) and 9 external Acute beds, all of which are unfunded, and this presents a financial pressure to the end of December of £4.55m.

The cost in relation to the Trust name change is included here and forecast at £0.09m which is lower than the initial planned spend of £0.25m.

Statement of Financial Position

	30th April 2025	30th November 2025	31st December 2025
	Actual	*Actual*	*Actual*
	£000	£000	£000
Non-current assets	174,192	174,269	174,210
Current assets	20,105	22,536	20,032
Current liabilities	(30,182)	(31,924)	(29,006)
Non current liabilities	(39,058)	(38,480)	(38,658)
Net Assets Employed	**125,057**	**126,401**	**126,578**
Total Taxpayers Equity	**125,057**	**126,401**	**126,578**

Total assets

Total assets decreased by £2.56m in the month, primarily driven by a £2.50m reduction in current assets.

This reflects a £5.75m fall in cash, partially offset by a £3.25m increase in Trade and Other Receivables.

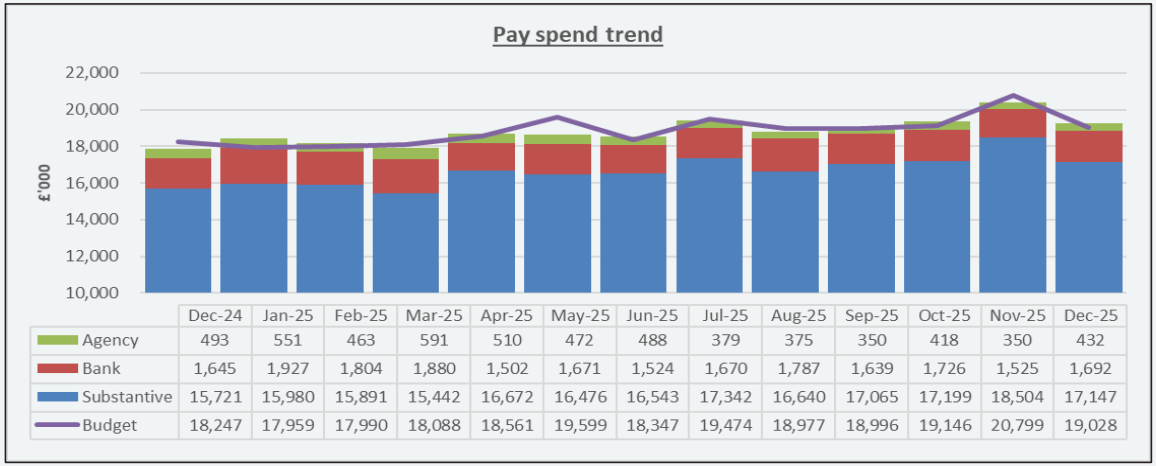
The cash reduction is largely due to the delayed receipt of December's Provider Collaborative invoice (£3.5m), which was received on 2 January.

Total liabilities

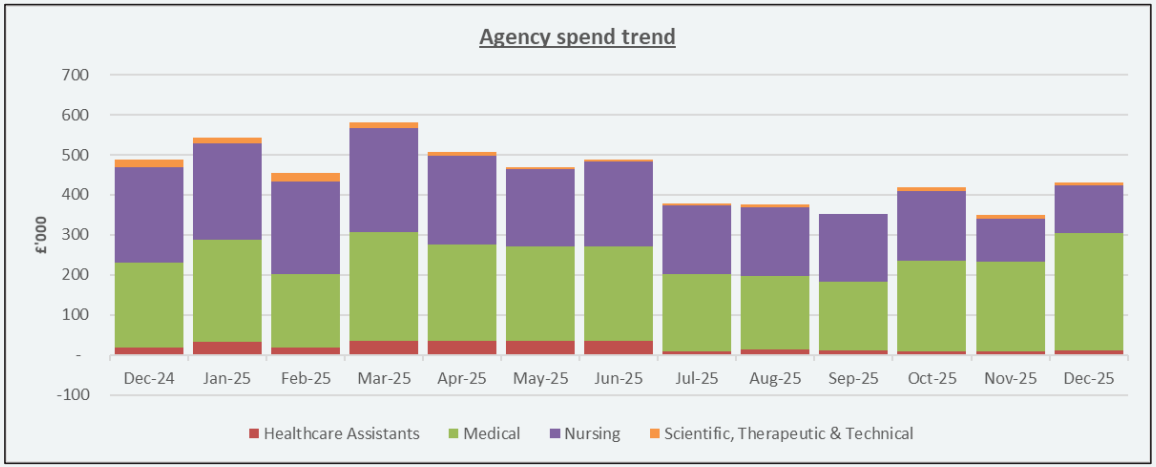
Total liabilities decreased by £2.74m in the month, driven by a £1.90m reduction in Trade and Capital invoices (including £1.0m catch-up payments for a prior period), the release of £1.00m of Deferred Income, and the recognition of £0.24m in provisions.

Appendices

4. Exception report – Pay trend



	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Agency	493	551	463	591	510	472	488	379	375	350	418	350	432
Bank	1,645	1,927	1,804	1,880	1,502	1,671	1,524	1,670	1,787	1,639	1,726	1,525	1,692
Substantive	15,721	15,980	15,891	15,442	16,672	16,476	16,543	17,342	16,640	17,065	17,199	18,504	17,147
Budget	18,247	17,959	17,990	18,088	18,561	19,599	18,347	19,474	18,977	18,996	19,146	20,799	19,028

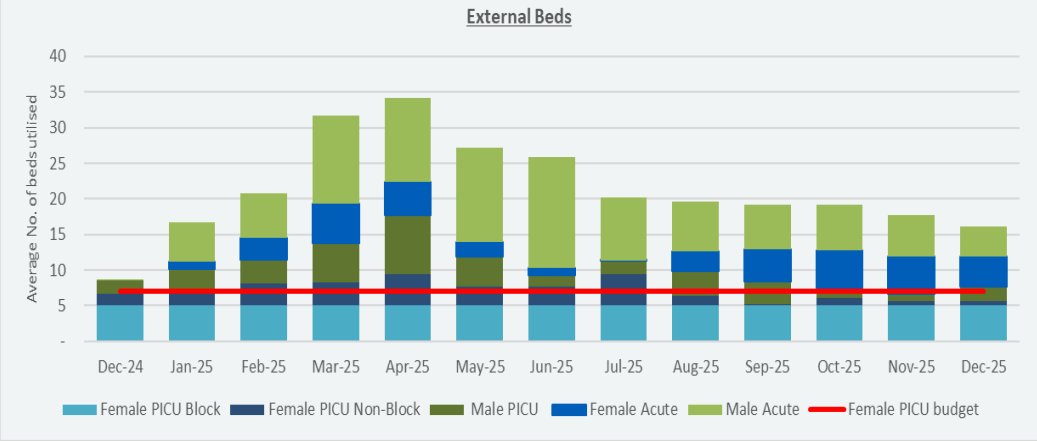


As at the end of December the Trust reported a year-to-date underspend on pay of £0.39m.

- 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 28.6 WTE below plan, and 47.6 WTE below April 2025 levels.
- Bank spend increased in month by 10.9%. Usage increased on Acute and Forensic wards to cover increased levels of annual leave, sickness and therapeutic observations. Bank usage also increased in North Kent to cover rotas in Crisis and Liaison teams.
- Agency spend in December totalled £0.43m, which represents a 12.4% reduction on spend seen for the same period in 2024/25, and a 23.4% increase on spend in November. Additional agency Consultants have been required to provide cover for long term sickness on 3 wards and additional nursing agency was used in East Kent to provide cover for Crisis and Liaison rotas.
- Medical agency WTE was 10.1 WTE in November, 5.4 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. 2.3 WTE were utilised to cover sickness on wards, this is forecast to all cease by the end of February.
- Of the Nursing agency utilised, 41.0% is supporting community teams covered by Mental Health Together and Mental Health Together plus. A further 49.3% of the total supports Liaison and Homecare teams. Recruitment continues to these teams and agency is forecast to reduce in coming months.
- HCA agency usage was 2.9 WTE, the biggest users being West Kent Crisis & Homecare team & Foxglove Ward (both 0.8 WTE).
- The unadjusted current forecast for agency spend is £4.72m, £0.45m above a cap of £4.27m; with further work planned to improve but due to medical pressures will be difficult.

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 December, usage of external Acute beds decreased, from average 11 beds to 9. PICU usage remained 6 female beds, male beds increased from 1 to 2.

To help alleviate this pressure, the Trust has put in place stepdown capacity, which will facilitate the repatriation of patients from external Acute beds to KMPT beds. 2,782 block bed days have been purchased at a cost of £0.52m, with usage estimated at 1,306 bed days since June; at this level the trust has seen cost avoidance of £0.79m.

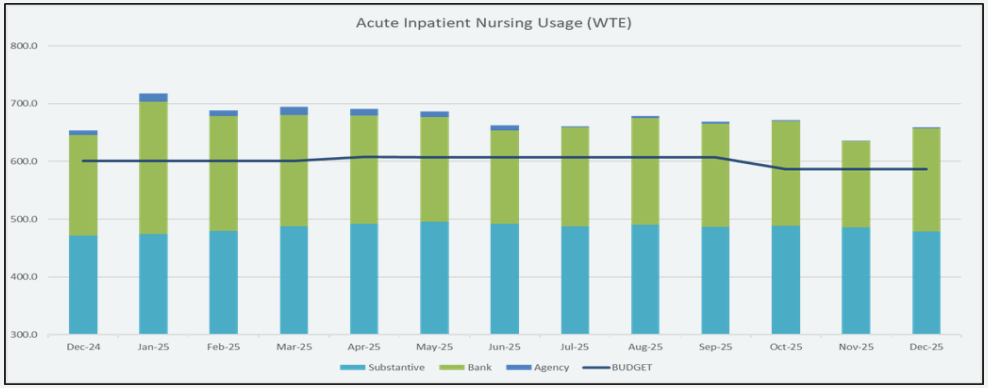
Exception report – Inpatient staffing

Commentary

In December, bank spend increased by £0.13m (28.9WTE) due to increased cover for annual leave, sickness and observations.

In month changes

- Levels of additional observations increased in month, costing approximately £0.16m in additional staffing to support; £0.04m more than last month.
- Following management review of rotas, the cost of cover for activities including away days, management days and maternity leave reduced from £0.11m in November to £0.06m in December.
- Annual leave cover increased from £0.22m to £0.27m
- Sickness cover increased from £0.13m to £0.15m



Caring | Inclusive | Curious | Confident

6. Income and Expenditure Forecast (1/2)

Commentary

The below represents the expected forecast outturn for the financial year which results in the Trust reporting a post technical adjustment surplus of £2.2m.

		Actual (£'000)									Forecast (£'000)				
	Plan	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total	Variance
Income															
Income from Activities	276,412	22,376	22,365	23,068	23,076	22,688	22,699	22,746	22,676	22,488	23,726	22,546	22,556	273,010	(3,402)
Other operating Income	19,665	2,485	2,295	2,445	2,721	2,303	2,381	2,575	3,911	3,281	2,345	2,342	2,765	31,850	12,185
Total Income	**296,077**	**24,862**	**24,661**	**25,513**	**25,797**	**24,992**	**25,080**	**25,321**	**26,587**	**25,769**	**26,072**	**24,887**	**25,321**	**304,860**	**8,783**
Expenditure															
Substantive	(205,952)	(16,672)	(16,476)	(16,543)	(17,344)	(16,641)	(17,065)	(17,195)	(18,461)	(17,147)	(17,217)	(17,341)	(17,499)	(205,600)	352
Bank	(20,086)	(1,502)	(1,671)	(1,524)	(1,670)	(1,787)	(1,639)	(1,726)	(1,525)	(1,692)	(1,485)	(1,452)	(1,392)	(19,064)	1,022
Agency	(4,270)	(510)	(472)	(488)	(379)	(375)	(350)	(418)	(350)	(432)	(362)	(299)	(286)	(4,721)	(451)
Locum		(58)	(76)	(53)	(41)	(86)	(82)	(63)	(43)	(99)	(100)	(55)	(55)	(813)	(813)
Total Employee Expenses	**(230,308)**	**(18,743)**	**(18,696)**	**(18,608)**	**(19,435)**	**(18,888)**	**(19,137)**	**(19,402)**	**(20,379)**	**(19,369)**	**(19,163)**	**(19,148)**	**(19,233)**	**(230,198)**	**110**
Clinical Supplies	(11,048)	(294)	(333)	(286)	(428)	(765)	(482)	(1,106)	(919)	(467)	(1,085)	(206)	(206)	(6,576)	4,472
Drugs	(3,825)	(286)	(290)	(288)	(299)	(294)	(311)	(297)	(289)	(316)	(296)	(297)	(297)	(3,560)	265
Other Non Pay	(34,087)	(4,125)	(3,882)	(4,761)	(4,225)	(3,722)	(3,762)	(3,302)	(3,537)	(4,642)	(4,070)	(3,902)	(4,183)	(48,112)	(14,025)
Non Exec Director	(183)	(15)	(15)	(15)	(15)	(15)	(15)	(15)	(15)	(15)	(15)	(15)	(15)	(184)	(1)
Redundancy Costs	-	(10)	(39)	-	(30)	(61)	0	-	-	(25)	(118)	-	-	(283)	(283)
Depreciation	(9,536)	(1,323)	(856)	(855)	(842)	(767)	(899)	(720)	(968)	(486)	(645)	(645)	(682)	(9,687)	(151)
Total Non Pay	**(58,679)**	**(6,052)**	**(5,414)**	**(6,206)**	**(5,839)**	**(5,624)**	**(5,469)**	**(5,439)**	**(5,728)**	**(5,952)**	**(6,229)**	**(5,066)**	**(5,384)**	**(68,402)**	**(9,723)**
Other (Post EBITDA & technical)	**(4,890)**	117	(367)	(516)	(340)	(297)	(290)	(295)	(297)	(265)	(497)	(489)	(521)	(4,059)	831
Total expenditure	**(293,877)**	**(24,678)**	**(24,477)**	**(25,329)**	**(25,614)**	**(24,809)**	**(24,896)**	**(25,137)**	**(26,404)**	**(25,586)**	**(25,889)**	**(24,703)**	**(25,137)**	**(302,660)**	**(8,783)**
System control Surplus /(Deficit)	**2,200**	**184**	**183**	**183**	**183**	**182**	**183**	**184**	**183**	**184**	**183**	**184**	**184**	**2,200**	**0**

Caring | Inclusive | Curious | Confident

7. Income and Expenditure Forecast (2/2)

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 £0.44m 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 £4.72m on agency in year which represents £0.45m 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 and that Acute agency medics will not be extended,
- 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.

Mitigations

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 addition will bring further financial pressures for which mitigations will need to be identified.

8. Cost Improvement plans 2025/26

Savings plans

Scheme	Planned CIP £'000	Forecast Delivery	Delivery %	Notes
Support Services	3,700	2,205	59.6%	Implementation Delays
Estates	1,600	1,348	84.3%	
Forensic Inpatient	1,000	1,844	184.4%	£1.3m additional income secured, further review of ward prices on-going
Provider Collaborative Risk Share	1,000	800	80.0%	On-going
Perinatal	500	493	98.6%	On-going (non-recurrent delivery whilst service model agreed)
Community Review	2,400	4,240	176.7%	Non Recurrent Delivery, final plans being signed off
Rota Management	1,700	-	0.0%	Further work Required
Non-Pay Review	1,000	640	64.0%	On-going
Budget Management	1,800	2,502	139.0%	Non Recurrent Budget management in line with plan
Other	700	1,000	142.9%	Delivered
Trust schemes total	**15,400**	**15,072**	**97.9%**	-
System Stretch target	2,200	2,528	114.9%	Non Recurrent Benefit
Total	17,600	17,600	100.0%	-

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.
- Estates – a 10% reduction in costs. Following the decision to permanently remove administration estate, the whole estate is being reviewed for consolidation opportunities.
- 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.
- 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 continues to identify opportunities for recurrent reductions. Review of benchmarked costs and productivity metrics is underway in conjunction with the Service specification to ensure ethe envelope is sufficient for the service commissioned.
- Community review – Service review for Early Intervention & At Risk Mental State services underway with Consultation now complete and new structure live/ This work has brought cost in line with contractual envelopes. Proposed establishments for MHT+ were shared with Directorate teams with final plans expected to be finalised by the end of January 2026.
- Rota Management – This savings is targeting the management of the rota pressures within the inpatient directorate.
- Budget management – 1% non-recurrent savings identified from slippages.
- 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.

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	456	89	(367)	2,878	2,800	(78)
Information Management and Technology	1,299	1,699	400	279	674	395	279	672	393
Section 136 development	3,462	4,958	1,496	385	355	(30)	535	1,896	1,361
Public Decarbonisation	200	0	(200)	0	0	0	0	0	0
IFRS 16 Leases	3,375	1,487	(1,888)	40	(193)	(233)	3,355	1,309	(2,046)
Total system expenditure	**12,500**	**12,500**	**0**	**1,160**	**925**	**(235)**	**7,047**	**6,677**	**(370)**
External expenditure									
Out of Area Placement (Female PICU)	3,940	3,940	0	300	18	(282)	440	359	(81)
PFI 2025/26	461	461	0	39	39	0	344	346	2
Public Decarbonisation	629	0	(629)	0	0	0	0	0	0
Estates Safety Fund	0	400	400	0	20	20	0	44	44
R&D - Hyperfine Swoop Imaging System	0	578	578	0	12	12	0	14	14
Section 136 development	2,250	0	(2,250)	115	0	(115)	298	0	(298)
VAT Reclaim	(2,250)	0	2,250	(200)	0	200	(500)	0	500
Cyber Risk Reduction	0	297	297	0	0	0	0	0	0
Solar Installation	0	417	417	0	0	0	0	0	0
Total external expenditure	**5,030**	**6,094**	**1,064**	**254**	**89**	**(165)**	**582**	**763**	**181**
Total Capital Expenditure	**17,530**	**18,594**	**1,064**	**1,414**	**1,014**	**(400)**	**7,629**	**7,440**	**(189)**

Commentary:

As at 31st December the overall capital position is £0.19m under plan. This is primarily due to underspends in Estates schemes (£0.08m) and the Female PICU project (£0.08m).

The forecast spend is higher than plan and reflects the additional funding the Trust has received in year for schemes such as the Estates Safety fund and remains unchanged at £18.59m.
This is being closely monitored by the Finance and Estates teams and mitigations are being identified so that they can be implemented quickly in case any risks arise from this challenging programme of works.

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details	
Committee:	Trust Board
Date of meeting:	29th January 2026
Title of paper:	Finance Planning 2026 to 2029
Author:	Nicola George, Deputy Director of Finance
Executive Director:	Nick Brown, Chief Finance & Resources Officer

Purpose of paper

Purpose:	Discussion
Submission to Board:	Regulatory Requirement

Overview of paper

This paper provides an update on the Trust's financial and operational planning for 2026/27 to 2028/29, highlighting progress, challenges, and key focus areas to meet regulatory requirements and ensure financial stability. An updated planning submission is due 10th February 2026.

Issues to bring to the Board's attention

The Trust continues to make progress on its planning response but challenges remain around Length of Stay, Clinically Ready for Discharge and Capital planning and funding constraints.

The committee is asked to acknowledge not only the work being undertaken in these areas but also the wider system dependencies that will have a direct bearing on the Trust's ability to meet its financial, operational, and workforce objectives. Collaborative efforts across the health system will be crucial to overcoming these challenges and ensuring the successful delivery of the Trust's strategic plans for 2026/27 to 2028/29.

Governance

Implications/Impact:	Ability to deliver Trust Strategy
Assurance:	Reasonable Assurance
Oversight:	Finance, Business and Investment Committee

Version 2 - **Public**

1. Executive Summary

This report provides an update on the Trust's planning position for 2026/27, focusing on the key areas required for financial stability and operational delivery. It seeks to summarise the progress and remaining challenges across the areas identified as part of the Board away day in December. These were,

- Challenges across temporary staffing
- Digital Transformation
- Length of Stay
- Out of Area Bed Usage
- Capital

The Trust continues to plan for a balanced financial position in 2026/27, supported by a 4.5% cost improvement requirement, and the expectation of a significant reduction in temporary staffing, improved patient flow; which in turn will led to significant reduction in out of area placements. Digital transformation will play a critical role in releasing clinical and administrative time through the planning period, with the focus of this work on improving workforce productivity.

Pressures persist in several areas, notably in agency medical spend, and inpatient nursing temporary staffing. Work is on-going to strengthen our capital programme with a focus on enabling some of the work required to support this approach.

2. December Submission

The Trust submitted its draft medium-term financial plan on the 17th December 2025. This set out a balanced position for 2026/27 and 2027/28, and was consistent with national expectations around productivity and temporary staffing.

For clarity, NHS England has set out clear requirements for improvement for four areas covering a reduction in temporary staff; productivity improvements of 2% per annum; a reduction in out of area usage and a focus on digital technologies to act as a core enabler for productivity, flow and patient access.

In submitting its plan, the Trust agreed to

- Balanced Plan Delivery for 2026/27 and 2027/28.
- CIP requirement: 4.5% each year (£16.7m in 2026/27).
- A reduction in temporary staffing (offsetting the impact of our efficiencies) with bank staffing anticipated to reduce from 393 wte to 352 wte, and agency staff from 90 wte to 80 wte in Year 1.
- A reduction in out of area placements from 19 to 12 beds initially, reflecting the delivery of the new Female PICU ward in July. Further work is required to reduce placements to 0 by the end of the planning period.

This report consolidates the further work on-going to strength out plan and deliver on the key areas identified by the board.

3. Analysis of Key Areas

3.1.1. Agency Reductions

The Trust's main challenge is around the reduction in temporary staffing, with agency reductions of 36% required against the Trust's present forecast. The Trust's agency challenge can be seen in three areas,

- The first one relates to **nursing usage**. Over the last few years the Trust has used temporary staffing to support its clinical model whilst reviews were undertaken around its community pathway (including CMHF, Early Intervention and Crisis & Home Treatment Services.

  This work is almost complete, and the Trust has seen reductions of 40% over the last 2 months, compared to the rest of this year (45% in the last quarter compared to 2024/25 figures). This work will need to continue with agency nursing usage needing to reduce by a further 50% next year.

  With the agreement of staffing models, this is anticipated to be delivered by tightening agency control. This work is being agreed with the services at present to ensure that services remain sustainable. If agreed, nursing agency would be expected not to exceed £0.60m in year (compared to £1.88m in 2025/26).

- The second area relates to **medical staff usage**. This is a challenging area with the Trust spending £0.25m per month over the last quarter. The Trust is likely to see a reduction in spend of £0.4m following a first-tier tribunal ruling on medical agency VAT which will mean the Trust can now recover this cost. However, to deliver a sustainable position medical agency will need to see a reduction of 40% by the end of the first year.

  Conversations in this area are being led by the Chief Medical Officer and her team, with a particular focus on improving the recruitment of substantive staff within East Kent (which remains the largest challenge).

  Presently agency usage is set out below, if the position can be agreed total medical agency spend for next year should be below £2.40m.

Agency spend	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Medical									
Acute Directorate	0	0	0	0	0	0	0	0	2
East Kent Directorate	4	5	8	2	7	6	5	6	5
Forensic and Specialist Services Directorate	1	1	1	0	0	0	0	1	1
North Kent Directorate	2	1	1	1	1	1	1	1	1
West Kent Directorate	2	1	2	2	2	1	1	1	2
Total Medical	*9*	*9*	*12*	*5*	*10*	*8*	*8*	*9*	*10*

- The final area of challenge is the **medical agency usage** within the transferring **CYP services**. This is a challenging area, with the medical vacancy rate at 48% and the medical directorate are working with colleagues within NELFT and CYP services to see

what can be done to secure substantive staff within these services. The Trust is also in discussion with NELFT to agree the level of agency cap that will transfer across.

3.1.2. Digital Programme and Efficiency Planning

Whilst the Trust has taken significant steps over the last few years, our starting point was behind our peers. The progress described in this paper reflects the foundational gains that have been made, however the Trust remains at an early stage of its digital maturity journey. Large elements of our digital estate and workflows remain manual, with the Trust reliant on manual workarounds in some areas.

The Trust is developing a programme is co-produced building on the pillars that have been developed over recent years through the use of the existing clinical leadership, the Trust's Digital Champion network and the clinical digital forum.

For 2026/27 plans are presently being developed and will be tested against an agreed framework that considers both clinical capacity and operational efficiency. The planned benefits will contribute to productivity improvements and enable reduction of temporary staffing as digital time-release strengthens the capacity of substantive teams.

3.1.3. Length of Stay and Out of Area Bed Usage

Length of stay continues to represent a challenge to the Trust. With delays exacerbated by the challenges within the wider health economy, causing increased delays in Clinically Ready for Discharge. Due to the CRFD position we have implemented the use of beds non-recurrently with a third sector partner. Whilst this hasn't seen the activity anticipated it has provided learning for further opportunities and has delivered £0.79m of cost avoidance.

Looking forward the Trust is refreshing is flow programme, with this intended to focus on

- Rigorous daily oversight of discharge planning, including strengthened Estimated Discharge Date (EDD) recording within 72 hours
- Standardised ward processes, supported by the Clinical Director, to remove unwarranted variation and ensure Red-to-Green is consistently applied
- Improved gatekeeping and purposeful admission processes through joint work with Crisis and Home Treatment teams
- Earlier multidisciplinary reviews, supported by digital tools to improve real-time visibility of delays and risks

In addition to this work, Kent & Medway ICB are developing a system proposal for mental health investment, part of which will consider the use of step-down bed capacity to support safe and timely discharge.

Taken together these actions allow the Trust to plan for the length of stay reductions required in the plan and for the elimination of out of area beds for by the end of the planning period.

3.1.4. Capital Investment

The Trust's capital position next year is challenged by the competing demands of an increased need for digital investment to support clinical efficiency and the wider demands

of delivering the Trust's estate. In addition, the Trust is managing two critical capital builds, the centralised place of safety at Maidstone and the Female PICU unit at Dartford, from 2025/26 into 2026/27.

This means that capital resources at the planning period are limited with the Trust undertaking a prioritisation process to agree the clinical priorities for investment. At a headline level, consideration is being made to the capital need based on

- Estates safety and backlog maintenance
- Digital Developments (automation, interoperability and AVT readiness)
- Flow-enabling infrastructure
- Medical equipment alignment with service transformation

Capital constraints present a material delivery risk to both the digital programme and the flow improvement initiatives. Several priority digital enablers cannot proceed without capital support, and therefore national funding or system prioritisation will be required.

4. Financial Implications (Cost Improvement Programme)

To deliver its financial plan, the Trust has a savings programme of 4.5% per annum to deliver.

This equates to £16.7m, £2.6m of this would be applicable to CYP and further work will be required in Quarter 1 to determine the exact requirement. For all other services the efficiency asks totals £14.1m.

In line with the approach over recent years the Trust's programme is focused on a 3-year rolling programme, with opportunities identified based on the Trust's benchmarking opportunities from internal and external measures.

The headlines areas for 2026/27 include a continued focus on corporate costs, and in improving flow to avoid expenditure in private sector providers. Development of plans is underway, with impact assessment to be undertaken prior to implementation. The focus on corporate and inpatient areas (with the focus on flow) is in line with the productivity opportunities identified by the NHS England productivity packs.

5. Risks

In developing its three-year plan, the Trust is faced with a number of challenges,

- The agency position is built of the Trust's ability to recruit and retain the necessary workforce to deliver its operational requirements. If this isn't in place we risk spending above the agency cap.
- The digital programme and the constraints in the capital programme will require national support for digital developments. We are wo
- The Trust's plans will be based on the approval and delivery of the system business case in Mental Health.
- Capital is a constraint.
- The transfer of CYP and Eating Disorder services represent a challenge to the Trust.

6. Recommendations

The Board are asked

- to note the position in regards to the Trust's planning.
- Endorse the approach on the key areas identified
- Support the direction of travel ahead of the February submission.

Trust Board meeting

NHS
Kent and Medway
Mental Health
NHS Trust

Meeting details

Date of meeting:	29th January 2026
Title of paper:	Talent and Succession Planning
Author:	Xanthe Whittaker, Head of Organisational Development
Executive Director:	Sandra Goatley, Chief People Officer

Purpose of paper

Purpose:	For Discussion
Submission to Board:	Board requested

Paper overview

This paper outlines the approach we will be taking in 2026 to roll out our talent and succession planning process and the areas to be explored as we embed the approach we have used with the executive management team consistently across the Trust and into our workforce processes.

Issues to bring to the Board's attention

To date we have focussed our succession planning at senior level. We need a consistent and sustainable approach to mapping performance and measuring talent potential across the Trust. It is a key objective of our People Plan to implement a succession planning process across the organisation with the purpose of retaining talent, developing talent and minimising vacancies in critical roles.

There is a considerable amount of work and education needed to ensure that our approach considers:

- How we engage managers and leaders at every level of the organisation to be committed to developing and retaining talent.
- How our talent strategies are aligned to the business strategy and objectives.
- How we encourage and enable a culture in which the workforce is valued for their contribution and where individuals take responsibility for managing their personal growth.
- How we can continuously develop the talent we have identified to be responsive to change, agile and future-focused.
- How we develop the talent of all staff – not just those identified as 'high potential'.
- How we align and embed talent and succession planning holistically across the organisation and into standard workforce practices.

Governance

Implications/Impact:	Retention and succession, engagement, performance management, career development
Assurance:	Reasonable Assurance
Oversight:	People Committee

1. Introduction and context

The implementation of a succession planning process is a key objective of the People Plan and one of the initiatives to support building a sustainable workforce for the future.

The goal of overall talent management is to create a high performing, sustainable organisation so we can meet our strategic and operational goals and objectives.

We have recognised that staff do not always feel supported to develop their career and potential within the organisation. We have seen a trending decline in positive responses from our annual staff survey in these two areas. Analysis of survey comments indicates career development and recognising ambition and talent as an area of dissatisfaction from a variety of professional groups.

Our staff are our most valuable asset; managing, nurturing and keeping staff engaged and motivated is key to our ability to provide high-quality care. This requires us to develop a talent management approach related to our vision, values and strategic objectives – one that is implemented in daily processes throughout the organisation as a whole.

In short, successful talent management needs to become an ethos – part of 'how we do things around here' – and core to developing a safe, compassionate culture.

Following the launch of our new identity – mission, vision values and name change – 2026 will be the optimal time to introduce a new approach and build on the culture change we aspire to achieve.

2. Outline of the approach we will take

From January 2026 we plan to introduce new succession planning tools. The tools have been designed to support in the following way:

Succession Planning: Identifies future leaders for senior roles by highlighting high-potential individuals.

Talent Development: Pinpoints specific development Organisational Development (OD) needs for individuals and teams, creating targeted coaching and training plans.

Performance Management: Offers a structured way to discuss performance beyond just reviews, connecting current results with future growth.

Strategic Workforce Planning: Provides an overview of the talent pipeline, helping us make informed decisions about recruiting, retention, and internal mobility.

They include:

Talent and succession Planning Tool

Using the 9-box grid approach the tool requires managers to assess 2 key areas; current performance (taken from the appraisal rating) and a measure of the employees' future potential.

To support with the measuring of 'potential' we have created a series of 'potential' indicators' – measuring potential is usually subjective and generally measured through behaviour. The indicators have been framed around our Trust values and we have used a range of resources to help us identify a series of behaviours that

support the requirement of leadership – improvement focused, compassionate, agile, determined and accountable.

As the 9-box approach is not a perfect model we have taken care to ensure guidance supports it being approached and used with integrity.

We have provided guidance on how to support each category, evaluate and move on.

The output of completing the model will be to plot all team members on the 9-box grid template, giving the manager and HR a full view of the whole team. This will enable transparency on who is the top talent, who is under performing, who are our vital middle. And more importantly, facilitate an effective and measurable performance management plan.

Talent Booklet – Building your Career

This focusses on the quality of the conversation between manager and employee. It guides on how to complete the talent form and signpost the development requirement and resources.

Talent Form

This form documents the output from the talent conversation and helps summarise the essential details needed for each individual, such as; mobility, next role, readiness, skill gaps.

We plan to start the process with our Trust Leadership Team and for each member of that team in turn to complete within their own Senior Leadership Team. This will enable us to test the process, gain clarity on what the talent pool looks like for our most senior managers.

The talent form also captures an individual's skills and strengths. Through our Doing Well Together Programme, this information enables us to identify colleagues who can be aligned to specific projects and organisational challenges, ensuring we draw on the right expertise to develop the strongest possible solutions. This approach supports a more agile and responsive way of working across the organisation.

3. Areas for further exploration and development

Use of the model will gradually be incorporated and joined to specific people processes throughout 2026/2027, namely;

- Career planning/mapping
- Development and talent programme selection
- Appraisal, 1-1's
- Performance management
- Succession planning

4. Expected outcomes

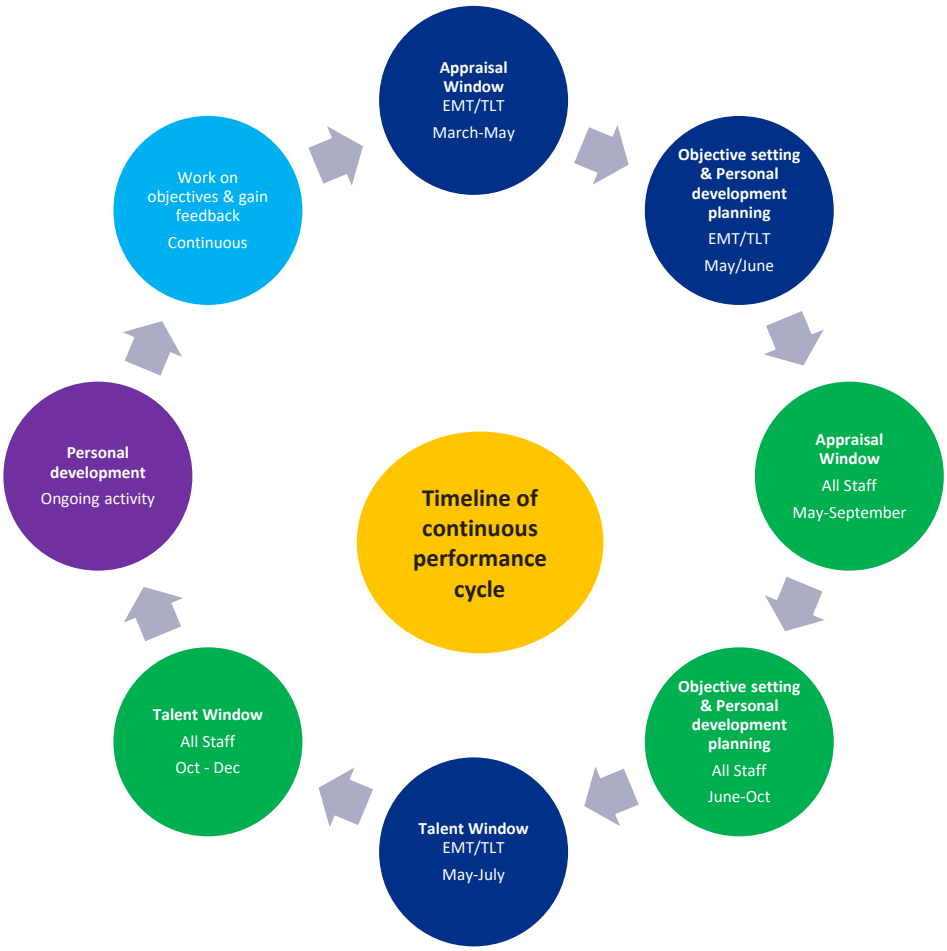
The successful implementation of the talent management plan is designed to

increase the levels of effective identification and support of talent, at every level of the organisation, and to improve staff ability to access appropriate and timely development (and thereby aid recruitment and retention).

Among the expected outcomes are:

- Talent development and succession planning are recognised as being an essential part of effective day to day people management.
- Talent discussions are included within the appraisal process and available at any time within the employee lifecycle.
- A clear path for career progression and personal development for existing and future leaders is established and understood;
- An increase in staff motivation with improved multi-disciplinary team working.
- Lower staff turnover rates (i.e. better staff retention).
- Continued improvement in performance against the range of staff engagement measures associated with the annual Staff Survey.
- Better quality candidates (both internal and external) applying for key roles within the organisation.
- The essential principles of coaching and mentoring are understood by leaders and applied to routine interactions with team members.
- Successful implementation will also support the organisation in demonstrating to external bodies that services are well led.

Cycle of activities



Overview of activities

Check-ins (1-1's, career discussions, performance & development discussions)
1-1 meetings throughout the year between manager and employee where they will discuss:

- Progress against goals
- Personal development
- Feedback

Any new objectives are added and action points agreed.

Objective Setting
An annual all Trust exercise where we set and agree objectives. Measures of success are set and actions agreed. These are reviewed at 1-1's, appraisal and within conversations on development and career planning.

Personal Development
An ongoing activity for all employees. Owned by the individual and supported by the manager.

Gaining feedback
Frequent, two-way feedback to see how employees are progressing against expectations and objectives. They also let managers know if they could be doing something differently to better support the employee. 360 tools and feedback mechanisms can be used.

Talent Grid
A tool we use for:

- Succession/workforce planning
- Development activities
- Identifying mentors/coaches

Using a set of 'potential indicators' to help identify behaviours and qualities which support our Trust objectives.

Recommendation

The Board is asked to note the contents of this paper

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details

Date of meeting:	29th January 2026
Title of paper:	Freedom to Speak Up 6th Month Report
Author:	Rebecca Crosbie, The Guardian Service
Executive Director:	Sheila Stenson, Chief Executive

Purpose of paper

Purpose:	Discussion
Submission to Board:	Regulatory Requirement

Overview of paper

This paper provides an update for the Board on the six-monthly performance (1 April to 30th September) of the Freedom to Speak Up (FTSU) Guardian Service.

Issues to bring to the Board's attention

During this 6-month period, 74 cases were raised to the Guardian Service 3 were rated as Red, 13 were rated as Amber and 58 rated as Green. 78% of cases reported were RAG rated as Green. 48% of cases have been resolved and closed. With regards to the prevalent themes we are seeing, 75% of cases were due to a management issue and 43% reported management issue as the primary theme. 54% of cases were due to system and process, with 25% reporting system and process as the primary theme.

Quarter 2 saw the highest number of concerns raised in any quarter since the service went live with our external provider in June 2022, with 44 cases reported. 65% of cases were escalated to the Trust to support with a resolution.

We have sadly seen an increase in staff using The Guardian Service due to fear of reprisal with 26% of staff sharing this as their reason for contacting the service.

The Administrative and Clerical staff group were the most prominent staffing group to raise concerns; this equated to 43% of cases.

No cases of detriment were reported during this period. 65% of cases were escalated to the Trust.

The Trust has a robust local improvement plan in place for our continuous learning from FTSU cases. This is monitored at the trust People Committee.

Our FTSU Guardian will be attending our TLT on 18th February to give a brief explanation of changes and resources available to support those who may be on the pathway. Once this is complete resources will be sent out in the managers mailout and means that everything will be live and out by end of February. It will also be utilised as part of the managers induction going forward.

There are four recommendations included in this report, the trust has the following in place to implement the recommendations:

1. Administrative and clerical staff group and the culture in these teams – The work we have done as part of the Getting the Basics Right programme to drive positive change and improved ways of working within our administrative and clerical teams gives us an opportunity to engage this staff group and introduce targeted interventions aimed at enhancing efficiency and fostering a positive team culture. This work will now continue as part of the Operational Plan (model reset).
2. Consultation processes and learning lessons - We have enhanced our consultation approach to ensure greater engagement and involvement in proposed changes before final proposals are developed. This process will continue to evolve where improvements are identified. Additionally, we are strengthening support for staff affected by change, offering resources such as interview coaching, outplacement assistance, and psychological support to ensure they feel personally supported.
3. Prominent theme of management issues when raising concerns – an extensive leadership development programme has been undertaken this year with the senior leaders in the trust. The plan is to roll this programme out to the next management and clinical led tier from April 26.
4. Follow up in action – The guardian has agreed with the CEO a short presentation and drop-in sessions to be rolled out to all managers that sets out how to respond to concerns, what the escalation pathway is and how to follow up and best practice for handling concerns. This will start imminently. The Guardian is also actively involved in the Trust Induction for managers and colleagues.

Governance

Implications/Impact:	Trust Strategy: Growing our capability to deliver
Assurance:	Reasonable
Oversight:	Oversight by People Committee/Trust Board

Kent and Medway Mental Health NHS Trust

The Guardian Service
Here to listen

Half Year Report (2025/26)
1st April to 30th September 2025

Circulation: **Public Board**

Main point of contact:
Sheila Stenson
CEO and Exec Lead for FTSU

Prepared by:
Rebecca Crosbie
FTSU Guardian
The Guardian Service Ltd.

Date: November 2025

The Guardian Service
Here to listen

Contents

1. Executive summary

Throughout the first half of the 2025/26 reporting period for Freedom to Speak Up there were **74 FTSU cases** reported via The Guardian Service.

78% of cases reported were RAG rated as **Green**.

48% of cases have been resolved and **closed**.

75% of cases had an element of **Management Issue** and 43% reported Management Issue as the primary theme.

54% of cases had an element of **System and Process** and 25% reported System and Process as the primary theme.

Quarter 2 of the 2025/26 period saw the highest number of concerns raised in any quarter since the service live date in June 2022 with **44** cases reported.

No cases of detriment were reported during this period.

65% of cases were **escalated** to the Trust.

There has been an increase is staff using The Guardian Service due to **fear of reprisal** with **26%** of staff sharing this as their reason for contacting the service.

Administrative and Clerical were the most prominent staffing group to raise concerns with **43%** of cases being raised by this group of staff.

There are **four recommendations** at the end of the report requesting considerations around a staffing group, consultation process, management issues and 'follow up' best practices.

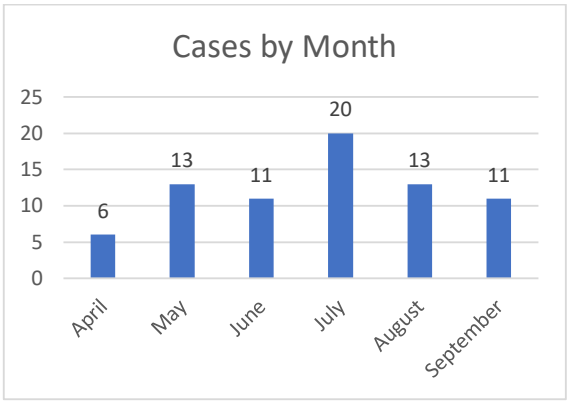
2. Purpose of the paper

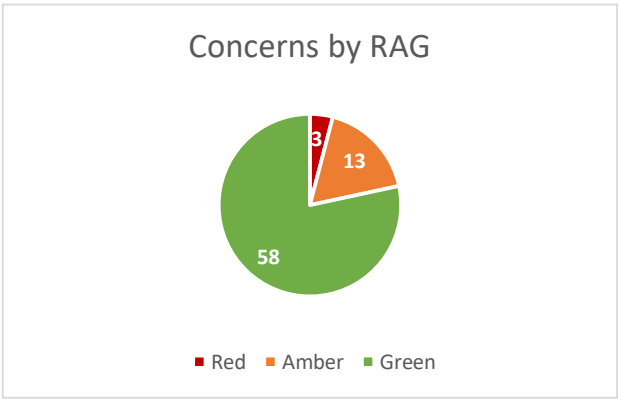
The purpose of this paper is to give an overview of the cases raised at Kent and Medway Mental Health Trust (KMMH) to the Freedom to Speak Up Guardian employed by The Guardian Service Limited (GSL) during the first half of the reporting year of 2025/26. This reporting period begins on 1st April 2025 and ends on 30th September 2025.

This paper does not include any data relating to cases raised internally and only those raised with the Guardian. This paper will not contain any identifiable information to ensure that confidentiality of those raising concerns is respected in line with national guidelines.

3. Number of concerns raised

For the first half of the 2025/26 period there have been 74 FTSU concerns raised through The Guardian Service. This figure does not include any concerns raised via internal routes. Of these 74 concerns: 3 were rated as Red, 13 were rated as Amber and 58 rated as Green. Quarter 2 for this period saw the highest concerns raised in any quarter since service live date (44).





4. Confidentiality

Confidentiality	No. of concerns	Percentage
Keep it confidential within Guardian Service remit	26	35%
Permission to escalate with names	29	39%
Permission to escalate anonymously	0	0%
Permission to escalate without name	19	26%
Total	**74**	

65% of cases were escalated to the trust in some capacity. The remaining 35% used the service for impartial support, often building confidence to go away and raise concerns internally.

5. Themes

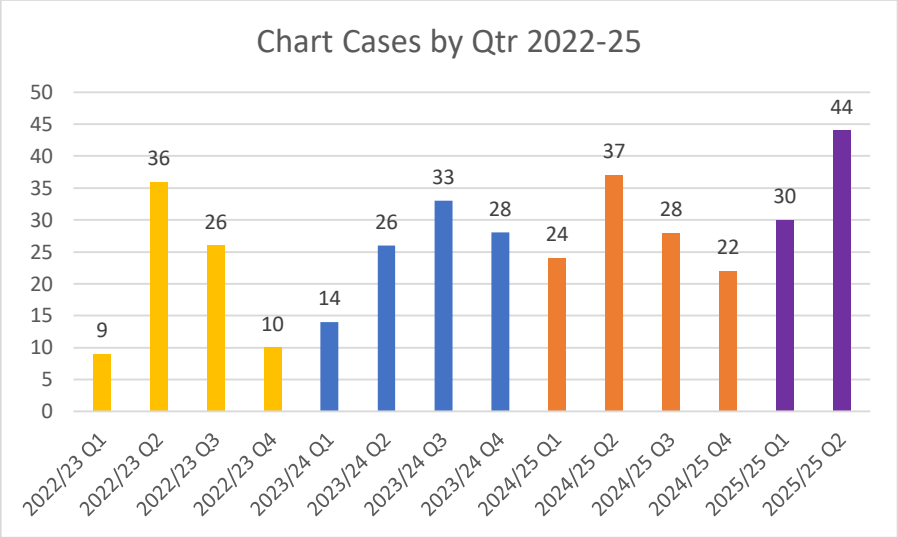
When recording concerns, we record primary themes and then multi theme occurrences where a case may have elements of other themes within it. Concerns raised are broken down into the following categories.

Primary Theme	Total
A Patient and Service User Safety / Quality	3
B Management Issue	32
C System Process	19
D Bullying and Harassment	7
E Discrimination / Inequality	2
F Behavioural / Relationship	7
G Other (Describe)	0
H Worker Safety	4
Grand Total	**74**

Multi Theme Occurrence	Total
A Patient and Service User Safety / Quality	4
B Management Issue	56
C System Process	40
D Bullying and Harassment	15
E Discrimination / Inequality	14

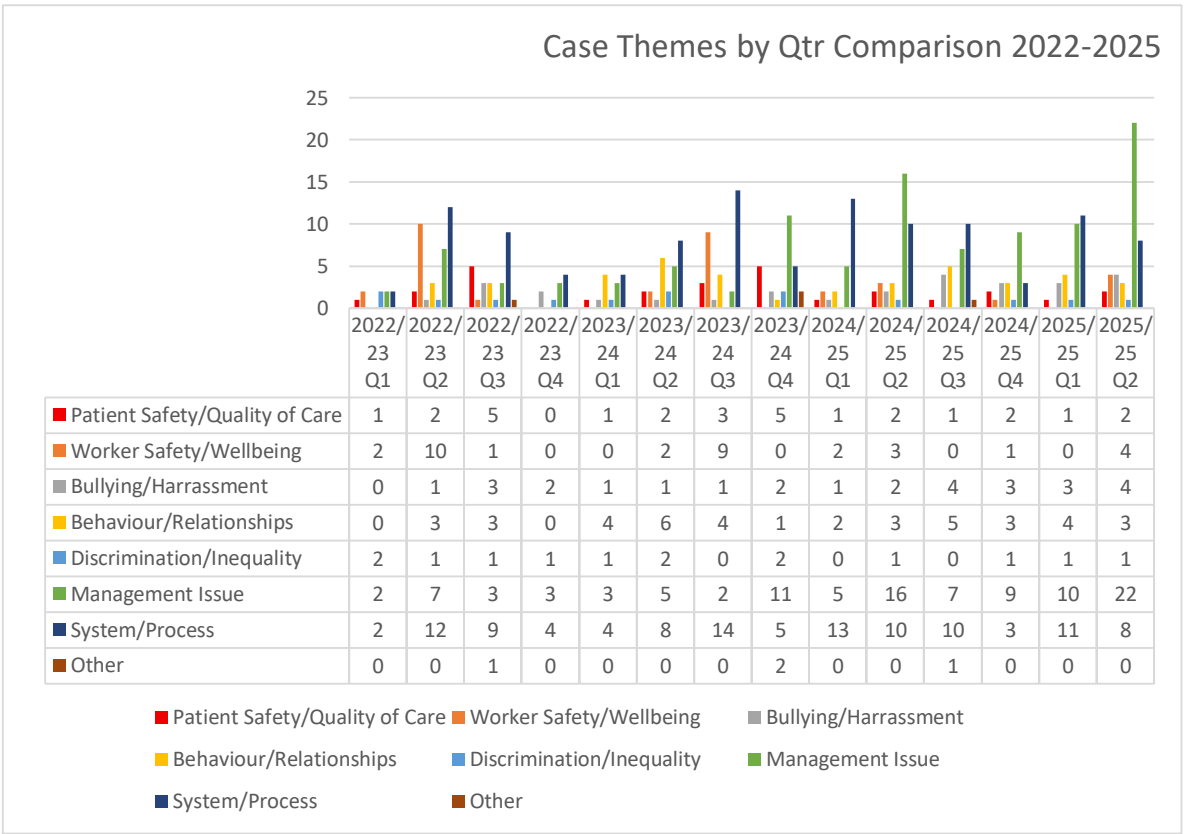
F Behavioural / Relationship	26
G Other (Describe)	0
H Worker Safety	19

6. Trends in Cases

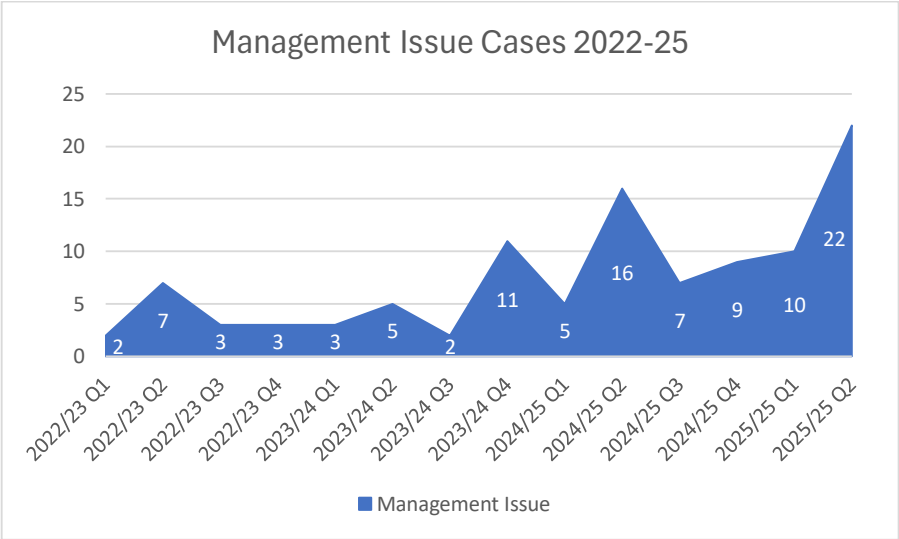


The Freedom to Speak Up reporting year runs from April to March.

Please note that Q1 2022 commenced at service live date of June 2022.



	2022/23 Q1	2022/23 Q2	2022/23 Q3	2022/23 Q4	2023/24 Q1	2023/24 Q2	2023/24 Q3	2023/24 Q4	2024/25 Q1	2024/25 Q2	2024/25 Q3	2024/25 Q4	2025/25 Q1	2025/25 Q2
Patient Safety/Quality of Care	1	2	5	0	1	2	3	5	1	2	1	2	1	2
Worker Safety/Wellbeing	2	10	1	0	0	2	9	0	2	3	0	1	0	4
Bullying/Harrassment	0	1	3	2	1	1	1	2	1	2	4	3	3	4
Behaviour/Relationships	0	3	3	0	4	6	4	1	2	3	5	3	4	3
Discrimination/Inequality	2	1	1	1	1	2	0	2	0	1	0	1	1	1
Management Issue	2	7	3	3	3	5	2	11	5	16	7	9	10	22
System/Process	2	12	9	4	4	8	14	5	13	10	10	3	11	8
Other	0	0	1	0	0	0	0	2	0	0	1	0	0	0



7. Assessment of Cases

We continue to see Management Issue and System/Process as the two top primary and multi-choice themes. 75% of cases had an element of Management Issue and 54% of cases had an element of System/Process.

11a. Management Issue

When looking cases relating to Management Issue, we see the following themes within concerns raised:

- Lack of support from management
- Lack of compassionate or empathic leadership
- Poor leadership style and communication
- Perceived misuse of or lack of understanding around internal processes including performance reviews, probation, early resolution, change forms.
- Inexperienced management
- Poor responses to staff raising concerns reported including a lack of action, follow up and/or minimising of concerns.
- A perception that management word is always taken over staff experience or perspective creating a feeling of hierarchy and a lack of objectivity when hearing staff concerns.
- Poor professional boundaries and breaches of confidentiality

It is important to recognise that that KMMH has invested significantly in training and development within the area of Leadership and Management and that these new programmes have commenced during this period. It may take some time to see the positive impacts of this. It is also important to consider how impact can be measured to ensure successful outcomes in this area.

11b. System/Process

When looking at cases relating to System/Process we see the following themes within concerns raised:

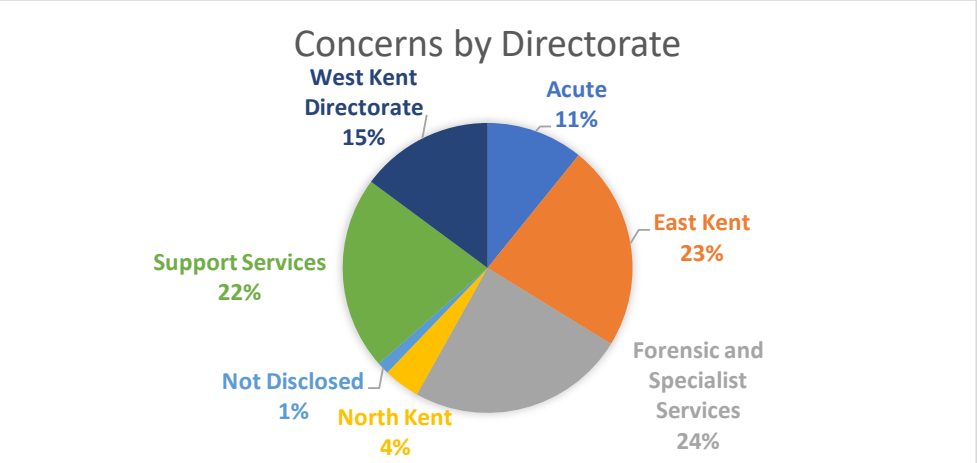
- Staff experience of consultation processes including engagement in the process, consideration of staff well being and transparency of the process.
- New starters report a lack of shadowing opportunities, not feeling welcomed into teams and a perception that induction processes are not robust enough for someone to thrive in their new post.

- Staff reported changes to roles or services whilst off sick or on maternity leave lacking transparency.
- Management of flexible working processes – staff feeling that managers use seniority to make decisions based on personal relationship with staff rather than objectively and fairly considering needs of services/personal circumstance.
- Displacement of staff due to building closure – considerations around impact to staff and service, communication and follow up.
- Payroll errors – staff reporting communication and handling of these to be lacking clear information causing psychological impact due to financial stress.
- Professional development opportunities lacking or a perception of these not being fairly allocated.

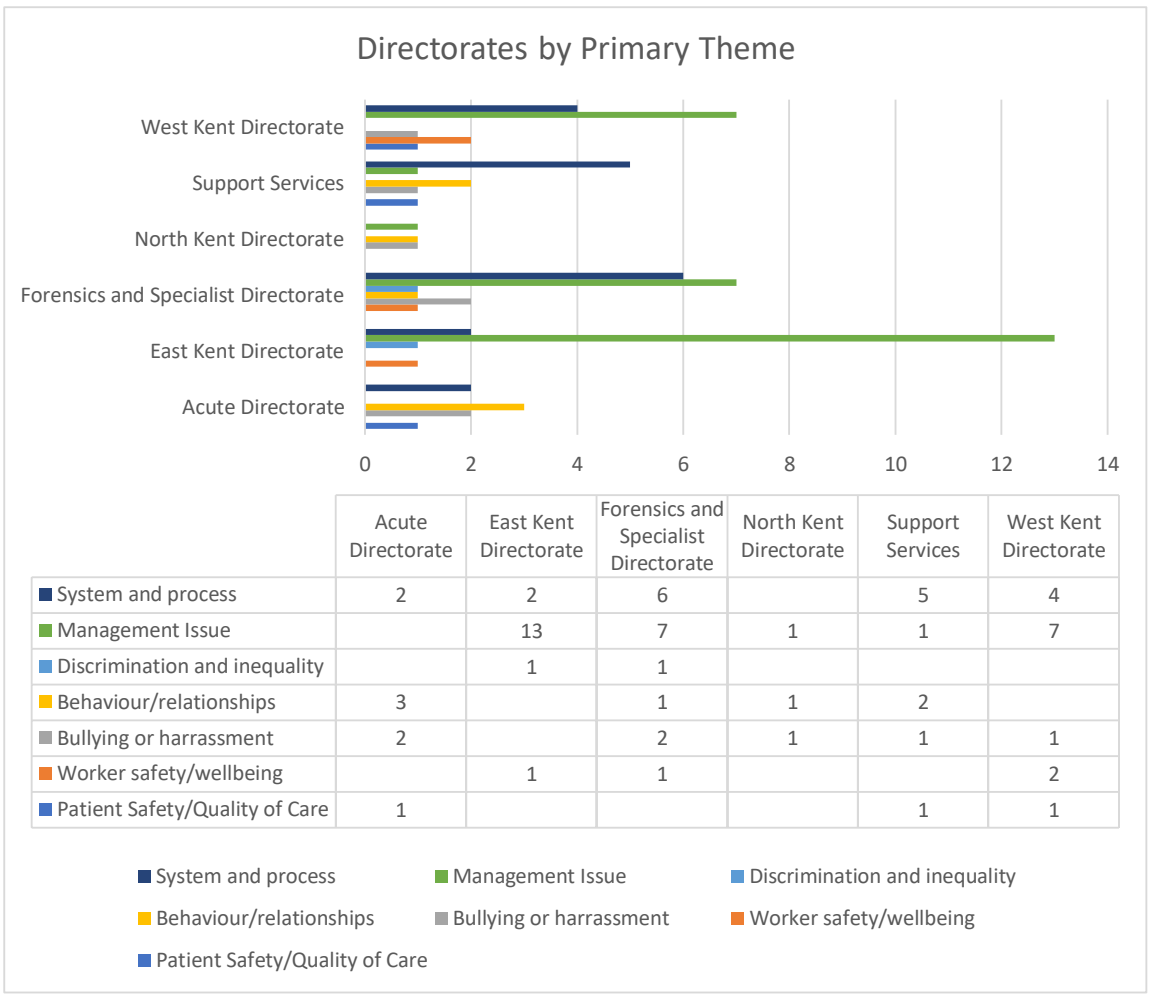
Staff experience of consultation processes has been a recurrent and ongoing theme. Further consultations are due to take place, and staff are requesting more transparency and engagement with them during these. Staff also feel these processes are inconsistent across teams and that management managing these processes often lack compassionate or empathic leadership.

8. Statistical Graphs

Concerns raised by Directorate

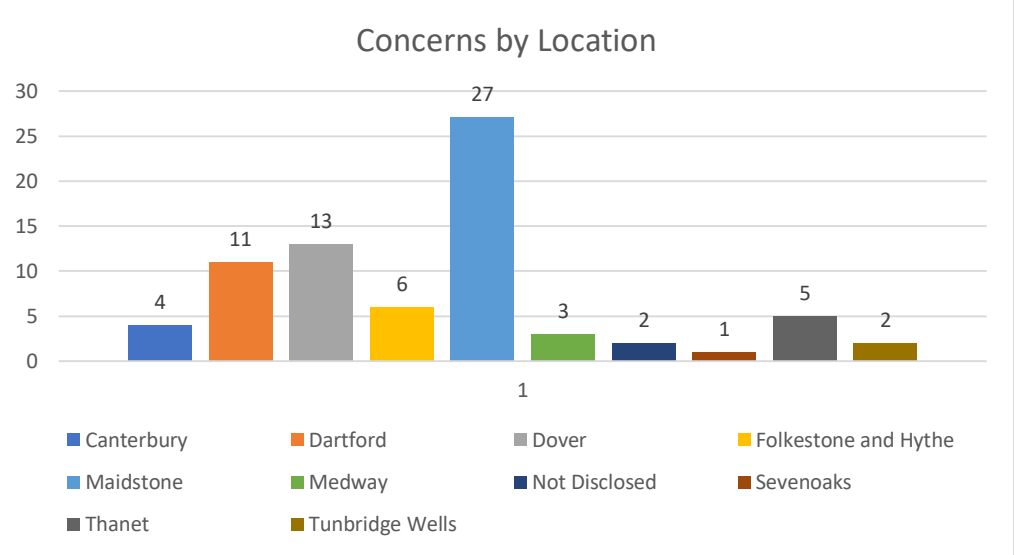


Directorate	Head Count	Concerns
Acute Directorate	706	8
East Kent Directorate	679	17
Forensics and Specialist Directorate	748	18
North Kent Directorate	507	3
Support Services	900	16
West Kent Directorate	483	11



	Acute Directorate	East Kent Directorate	Forensics and Specialist Directorate	North Kent Directorate	Support Services	West Kent Directorate
System and process	2	2	6		5	4
Management Issue		13	7	1	1	7
Discrimination and inequality		1	1			
Behaviour/relationships	3		1	1	2	
Bullying or harrassment	2		2	1	1	1
Worker safety/wellbeing		1	1			2
Patient Safety/Quality of Care	1				1	1

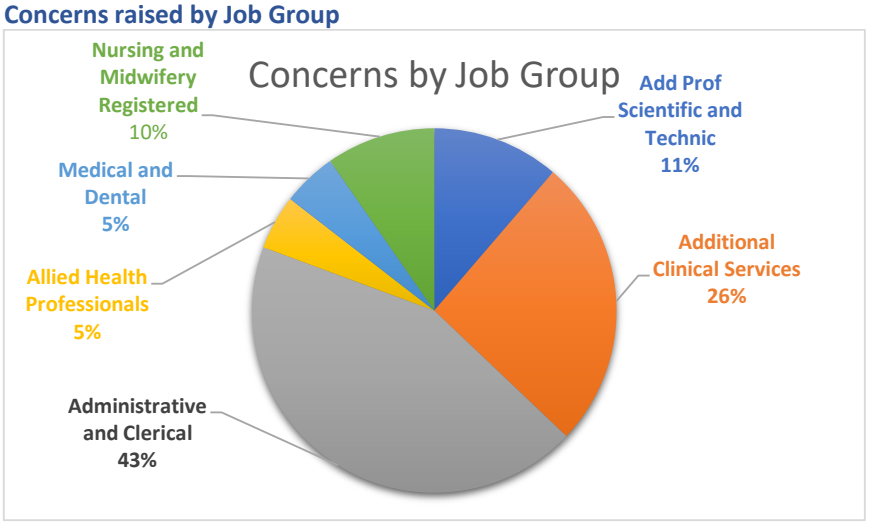
Concerns raised by Location



Location	Head Count	Concerns	% of staff raising concerns
Dartford & Gravesham	777	11	1.40%
Sevenoaks	23	1	4.30%
Tonbridge and Malling	27	0	0.00%
Maidstone	1201	27	2.24%
Tunbridge Wells	128	2	1.50%
Swale	124	0	0.00%
Ashford	115	0	0.00%
Canterbury	770	4	0.50%
Folkstone and Hythe	97	6	6.25%
Dover	93	13	14.00%
Thanet	292	5	5.30%
Medway	336	3	0.90%
Unspecified	42		
Not disclosed		2	
Grand Total	4025	74	

Figures remain high in Dover due to a recent cluster of concerns from a group of staff. These have subsequently been resolved and there is proactive communication between senior management and the guardian to ensure concerns are dealt with swiftly. It is positive staff feel able to speak up in this area without fear and management remain engaged in supporting concerns. There is some reflection around timeframes for follow up with one group concern and this has been discussed with leadership for learning.

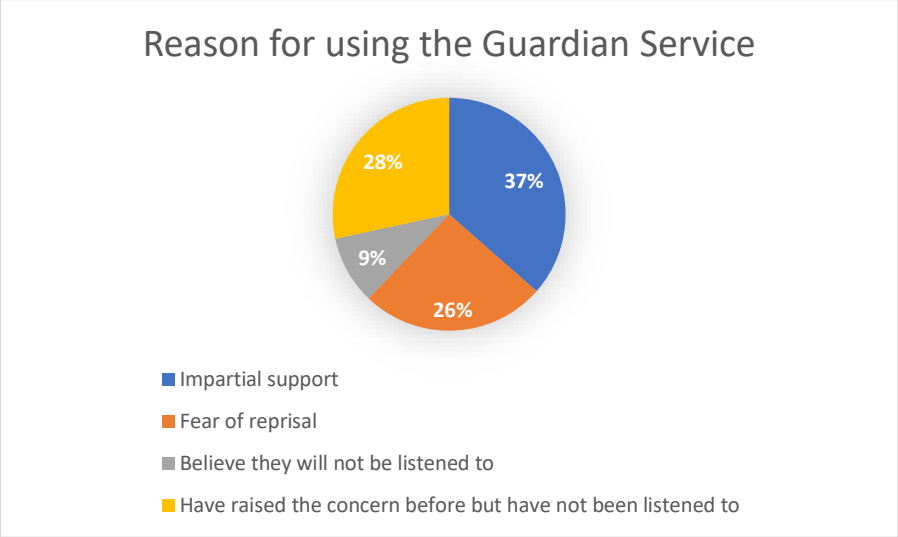
Concerns raised by Job Group



Job group	Head Count	Concerns	% of staff group
Add Prof Scientific and Technic	383	7	1.80%
Additional Clinical Services	975	16	1.60%
Administrative and Clerical	948	27	2.80%
Allied Health Professionals	247	3	1.20%
Estates and Ancillary	167	0	0.00%
Medical and Dental	242	3	1.20%

Nursing and Midwifery Registered	1062	6	0.60%
Students	unknown	0	
Not disclosed		12	
Misc	1		
Total	4025	74	

9. Why do staff use The Guardian Service?



10. Detriment

There have been no cases of detriment recorded for this period.

11. Action taken to improve the Freedom to Speak Up Culture

The trust is engaging well with the FTSU Guardian to ensure feedback and learning is in place using the themes, data and recommendations provided by the Guardian. There is a live action plan in place which is being reviewed and updated based on the comments and recommendations within the FTSU six monthly and annual report.

The escalation pathway will be reviewed to involve a wider range of leadership roles. FTSU will also be incorporated into HR drop in sessions for managers so questions can be asked around best practice responding to staff concerns. These updates are due to take place in early 2026.

12. Learning and Improvements

Leadership and Management development programmes are now live with new and developing managers being referred. In addition to this there will be dedicated HR drop-in sessions to support managers with challenges and questions they may have relating to HR and ER processes.

Speak Up Week saw the theme of 'follow up in action'. As part of this a poll was launched via Staff Room. The question put to staff was **'When speaking up to a colleague or manager did you receive any of the following?'**

Although it is positive that 72% of staff who took part in the poll reported receiving thanks for speaking up figures remained low for the other areas. Building best practice in these other areas is essential in supporting open and successful cultures within the organisation. See recommendation 4.

13. Comments & Recommendations

1. **Administrative and clerical staff** make up a large portion of concerns raised. The culture within these teams and how they are managed is a regular occurrence within cases. How can the trust ensure that positive cultures are maintained within these teams and that these teams feel part of their wider service. This staffing group often reports that it does not feel part of wider service discussion and engagement.
2. **Consultation processes** continue to be raised within concerns. Although there has been ongoing learning shared from previous consultations, how can the trust ensure that these are handled with compassion, fairness, consistency and transparency across the organisation?
3. **Management Issue** related concerns continue to rise. Considerations on the how the Trust can measure and monitor outcomes from new leadership and management development initiatives are welcomed.
4. **Follow up in action –** How can the organisation respond to the poll from speak up week and establish appropriate expectations to ensure best practice when following up on staff concerns. (The guardian has planned to engage with the communications team in January and is seeking input from the organisation to ensure a meaningful response)

Comments

The guardian is working with the organisation to update the FTSU escalation pathway. The aim of doing this is to empower and upskill wider levels of management to resolve concerns. Support will be put in place to ensure clear expectations and best practices around handling concerns through communications and HR drop-in clinics.

The trust hopes that developments to the escalation pathway and communications around this may help to contribute to better practice and continunity in relation to following up on concerns raised thus increasing confidence in speaking up.

14. Staff Feedback

- Rebecca was incredibly supportive and raised my concerns to relevant people. The trust did not respond to concerns in an appropriate time scale
- The FTSUG was quite diligent and very helpful but the Trust did not attend to issues as should be expected given relevant obligations.
- I would raise concerns regarding client safety only
- Although the main concern seemed to be getting stuck in limbo with the managers, I was kept informed and the anxiety of feeling powerless was lessened.

- The FTSUG was objective in advancing the issues raised with her.
- Rebecca was very professional yet also kind and compassionate. I felt that she was doing everything she could to get a resolution for myself.
- Rebecca was amazing. She was kind and supportive, always professional and measured in her responses. I felt very safe and that my concerns were important.
- The guardian service is highly valuable service
- Through using the guardian process, I've become more aware of limitations in the communication between the higher-ups in my trust, which I now feel empathy for.
- The interventions as provided by the FTSUG are very much appreciated.
- I did actually recommend the Guardian service to several of my colleagues, who did go on to use the service. Very satisfied.

15. Appendix

Background to Freedom to Speak Up

Following the Francis Inquiry[1] 2013 and 2015, the NHS launched 'Freedom to Speak Up' (FTSU). The aim of this initiative was to foster an open and responsive environment and culture throughout the NHS enabling staff to feel confident to speak up when things go or may go wrong; a key element to ensure a safe and effective working environment.

The Guardian Service

The Guardian Service Limited (GSL) is an independent and confidential staff liaison service. It was established in 2013 by the National NHS Patient Champion in response to The Francis Report. The Guardian Service provides staff with an independent, confidential 24/7 service to raise concerns, worries or risks in their workplace. It covers patient care and safety, whistleblowing, bullying, harassment, and work grievances. We work closely with the National Guardian Office (NGO) and attend the FTSU workshops, regional network meetings and FTSU conferences. The Guardian Service is advertised throughout the Trust as an independent organisation. This encourages staff to speak up freely and without fear of reprisal. Freedom to Speak Up is part of the well led agenda of the CQC inspection regime. The Guardian Service supports the Trust's Board to promote and comply with the NGO national reporting requirements.

The Guardian Service Ltd (GSL) was implemented in Kent and Medway Mental Health Trust (KMMH) in June 2022.

Communication and marketing have been achieved by meeting with senior staff members, joining team meetings, site visits, the Intranet and the distribution of flyers and posters across the organisation. All new staff will become aware of the Guardian Service when undertaking the organisational induction programme.

Access and Independence

Being available and responsive to staff are key factors in the operation of the service. Many staff members, when speaking to a Guardian, have emphasised that a deciding factor in their decision to speak up and contacting GSL was that the Guardians are not NHS employees and are external to the Trust.

[1] https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry

Categorisation of Calls and Agreed Escalation Timescales

The following timescales have been agreed and form part of the Service Level Agreement.

Call Type	Description	Agreed Escalation Timescales
Red	Includes patient and staff safety, safeguarding, danger to an individual including self-harm.	Response required within 12 hours
Amber	Includes bullying, harassment, and staff safety.	Response required within 48 hours
Green	General grievances e.g. a change in work conditions.	Response required within 72 hours
White	No discernible risk to organisation.	No organisational response required

Open cases are continually monitored, and regular contact is maintained by the Guardian with members of staff who have raised a concern to establish where ongoing support continues to be required. This can be via follow up phone calls and/or face to face meetings with staff who are in a situation where they feel they cannot escalate an issue for fear of reprisal. Guardians will also maintain contact until the situation is resolved, or the staff member is satisfied that no further action is required. Where there is a particular complex case, setbacks or avoidable delays in the progress of cases that have been escalated, these would be raised with the organisational lead for the Guardian Service at regular monthly meetings.

Escalated cases are cases which are referred to an appropriate manager, at the request of the employee, to ensure that appropriate action can be taken. As not all employees want their manager to know they have contacted the GSL, they either progress the matter themselves or take no further action. There are circumstances where cases are escalated at a later date by the Guardian. A staff member may take time to consider options and decide a course of action that is right for them. A Guardian will keep a case open and continue to support staff in such cases. In a few situations contact with the Guardian is not maintained by the staff member.

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details	
Date of meeting:	29th January 2026
Title of paper:	CQC Community Mental Health Survey
Author:	Rachael Sanderson, Strategic Lead for Allied Health Professions
Executive Director:	Julie Kirby, Acting Chief Nurse

Purpose of paper

Purpose:	Noting
Submission to Board:	Board requested

Overview of paper

This paper relates to the Care Quality Commission (CQC) Community Mental Health Survey 2024. The annual national survey reflects the views on the quality of care from a random sample of 1250 service users and was conducted during August to December 2024.

The CQC published the national benchmark reports on 03/04/2025. A presentation of the results from the survey was given to the trust by IQVIA on the 30/07/2025. Each question has a final score out of ten in addition to a system of benchmarking where, for each question, the trust is ranked better, the same or worse than average, compared to all mental health trusts across the country. The content of this report provides a snapshot of the results.

Issues to bring to the Board's attention

Highlights

The overall experience of patients of community services has improved since the last survey in 2023. The score for overall experience has improved from 5.9 to 6.3 (out of ten) and the trust is now performing the same as the other mental health trusts nationally for overall experience.

2 of the 3 action areas from 2023 have seen good improvement:

- Did the NHS mental health team give your family or carer support whilst you were in crisis?
- Thinking about the last time you contacted this person or team (your named contact), did you get the help you needed?

It is positive to see that whereas in 2023 there were 10 questions that were benchmarked as worse than other trusts, in 2024 two questions are benchmarked as worse than other trusts.

Version 2 - **Public**

22.6% of those invited to engage with the survey responded, which is both 1% higher than last year and above the national average for mental health trusts (20%).

Items of concern:

The questions that are benchmarked as worse than other mental health trusts, were as follows:

- Q29 - Thinking about the last time you contacted this person or team; did you get the help you needed?
- Q32_4 - In the last 12 months, did your NHS mental health team give you any help or advice with finding support for cost of living?

Governance

Implications/Impact:	Engagement and consultation
Assurance:	Reasonable
Oversight:	Trust wide patient experience meeting and CQC Quality Plan

Community Mental Health Survey 2024

Summary of results

The annual Community Mental Health Survey, commissioned by the CQC, looks at the experiences of those individuals who have accessed community mental health services. The 2024 survey was completed by 14,619 people across the country who had received treatment from a community mental health service provided by one of 53 mental health trusts and community interest companies across England between August and December 2024.

Kent and Medway Mental Health Trust's response rate for the 2024 Community Mental Health Survey was greater than in 2023, and continued to be above the average response rate.

When comparing the 2023 and 2024 survey results, there have been clear improvements in scores across a number of domains. Patient experience ratings have improved in relation to:

- Service users feeling that the side effects of medication were discussed with them
- Service users feeling the implications of stopping medication were discussed with them
- Service users feeling that the last time they had had contact with the team they felt that they had received the help they needed
- Service users feeling that their families, friends and carers were supported while the person was in crisis
- Service users being asked whether they needed support to access their care and treatment

Ratings on the Community Mental Health Survey are scored on a 0 – 10 scale, with 10 being the highest rating available for each domain. The five highest scoring areas on the 2024 survey were:

- Thinking about the last time you received therapy, did you have enough privacy to talk comfortably? (8.2)
- Would you know who to contact out of office hours within the NHS if you had a crisis? (8)
- Did your NHS mental health team treat you with care and compassion? (7.8)
- Overall, in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services? (7.7)
- In the last 12 months, has your NHS mental health team asked how you are getting on with your medication? (7.7)

Where service user experience has improved since 2023

Top 5 most improved scores

Have any of the following been discussed with you about your medication? Side effects of medication
- (your treatment) - this score has improved significantly from 4.8 to 5.6
- **Did the NHS mental health team give your family or carer support whilst you were in crisis?**
  (crisis care) - this score has improved significantly from 3.3 to 4.1*
- **Has your NHS mental health team asked if you need support to access your care and treatment?**
  (support and well being) - this score has improved from 3.6 to 4.2
- **Thinking about the last time you contacted this person or team (your named contact), did you get the help you needed?**
  (crisis care) - In 2023 too many felt that when they have made crisis contact, they did not receive the help that they needed when they were in crisis but this score has improved from 5.0 to 5.5*
- **Have any of the following been discussed with you about your medication? What will happen if I stop taking my medication**
  (your treatment) - this score has improved from 4.9 to 5.4

* Action area in 2023

In 2023, ten of the survey domains were benchmarked as scoring lower than other comparator trusts, however the 2024 survey results show that there are now only two questions which score in the worse, or somewhat worse, than other trusts range. These are:

(1) Did your mental health team give you help or advice with finding support for cost of living

(2) Thinking about the last time you contacted this person or team; did you get the help you needed?

There continue to be areas highlighted through the survey which provide the opportunity for the organisation to reflect on its current offer and to look for opportunities to further improve the experience of those individuals who are accessing our community mental health services.

Where service user experience could improve the most (5 lowest scores)

- In the last 12 months, did your NHS mental health team give you any help or advice with finding support for...Cost of living (support and well being) - 1.1
- In the last 12 months, did your NHS mental health team give you any help or advice with finding support for...Finding or keeping work (support and well being) - 1.8
- In the last 12 months, did your NHS mental health team give you any help or advice with finding support for...Financial advice or benefits (support and well being) - 2.1
- Aside from this questionnaire, in the last 12 months, have you been asked by NHS mental health services to give your views on the quality of your care? (overall) - 2.8
- Did the NHS mental health team give your family or carer support whilst you were in crisis? (crisis care) - 4.1

The community version of the trust Patient Reported Experience Measure currently asks service users whether they have been provided with support in relation to financial advice or benefits due the fact that it scored poorly in previous Community Mental Health Surveys. This is monitored by the directorate senior management teams, but does not appear to have improved in the 2024 survey results.

The last question on the CQC Community Mental Health Survey is “aside from in this questionnaire, in the last 12 months, have you been asked by NHS mental health services to give your views on the quality of your care?”. This scored 2.8 out of 10, which is in the 5 lowest scores, but for context it should be noted that this was ranked the same as the other mental health trusts who engaged with the survey.

While it has not been a statistically significant improvement, it should be noted that the trust’s score on this question has increased from 2.54 in 2023 to 2.8 in 2024.

It is also of note that the organisation scored lower than average in relation to the following questions:

- Thinking about the last time you contracted this person or team; how do you feel about the length of time it took you to get through to them?
- Have any of the following been discussed with you about your medication – benefits of medication?
- In the last 12 months, have you had a care review meeting with your NHS mental health team to discuss how your care is working?
- Were you given enough time to discuss your needs and treatment?
- Did you feel your NHS mental health team listened to what you had to say?
- Did you get the help you needed?

Patient Experience Data Overview

The results of the Community Mental Health Survey provide an opportunity for the organisation to reflect on how those using our community services experience the care and treatment that we offer. It should be noted that the results are from a relatively small sample and provides a point in time snapshot.

Due to the timescales between data being collected and the results becoming available, the 2025 survey has already been undertaken. This means that the actions taken to improve the lower scoring areas in the 2024 survey may not be evident until the 2026 survey is undertaken.

It is also important to acknowledge that this survey reflects only one of the means of gathering patient experience data for the organisation. We continue to report monthly on a team, directorate and trust wide level via the trust's Patient Reported Experience Measure, the Family, Friends and Carer Survey, the Friends and Family Test scoring, service accreditation patient and carer experience surveys (such as MSNAP), and via community meetings, patient councils and local patient experience meetings.

Sharing the Results

The results of this survey have been shared by the patient experience leads (Heads of Allied Health Professions) with the directorate senior management teams and these have been disseminated to local team level. A trust wide communications piece has been shared and the results have also been added to the patient and carer experience page on staffroom so that they are easily accessible to staff.

Actions

1) Individual teams have been asked to look at the data and put forward their thoughts or suggestions for how we might address the lower scoring areas, utilising a staff led approach to service improvement.

2) The Engagement and Involvement Team have undertaken a piece of work gathering first hand data from those who use our services to provide some additional context to the results that we have been given. Specifically, this sought to understand what service users understood each of the questions to mean and whether their understanding is the same as the trust's. For example:

- What do service users understand the term care review meeting to mean and does this match with what services identify as a care review meeting?

- What are service users expecting in terms of support in relation to finances, cost of living and housing and how does this align with the support that we are commissioned to provide?

Via the Engagement and Involvement Team, service users have also been asked to provide their views on how we might improve their experience in the lower scoring areas. This feedback will go to the Trust Wide Patient Experience Meeting for discussion and identification of actions.

3) Feedback from the scoping undertaken by the engagement and involvement team has highlighted that the understanding of what constitutes a care review meeting, who should attend, what should be discussed and how patients can contribute to these meetings varies significantly between individuals. This will be taken to the next Trust Wide Patient Experience Meeting for clinical and communications colleagues to agree a definition of a care review meeting and to agree a clear plan to then embed that definition and understanding into services and patient information.

4) Our communications team is currently reviewing the language and accessibility of our patient literature and the ways in which we can provide information easily to those using our services, for example, through the trust website. This will include a focus on information about finances, cost of living and accommodation. This is being monitored via the trust's CQC Quality Plan.

5) While the score relating to asking patients about their experiences on the quality of the care provided was low, the trust has continued to promote the organisation wide Patient Reported Experience Measure. Following on from feedback from clinical colleagues, and after consultation with service users via the engagement and involvement team, this measure has been updated and it is anticipated that this will be launched in March 2026.

   Communications colleagues will be involved in the launch and will be able to work with the Trust Wide Patient Experience Group membership to look at mechanisms for raising awareness of the measure with those individuals who use our services.

6) Work is underway to improve triangulation between complaints, lower scoring patient experience areas and the trust's improvement portfolio. Establishing this will ensure that patient experience data drives service improvement and increases the focus on these lower scoring areas. This has included work with digital colleagues to look at how we can make the data more accessible and usable.

7) Working With Families was identified as a Quality Account Priority in February 2025 and has continued to be monitored via the trust's Quality Committee. Regular Working With Families forums, attended by operational and clinical staff from across the organisation and facilitated by the Chief Nurse, have been held to open discussion around where the challenges and opportunities for development are in this area.

   Digital communications from the Chief Nurse and Trust Chair about the importance of working in collaboration with families have also been shared during this period. We have also continued to gather, and act on, feedback from carers about their experience of our services through our family, friends and carer survey.

8) Since November 2025, monthly reports being collated and shared with the service directors and operational leadership focusing

specifically on patient experience in relation to waiting for, or access to, community mental health services. This incorporates both qualitative and quantitative feedback gathered through the trust's patient reported experience measure.

9) The Community Mental Health Survey will be a standing agenda item in the Trust Wide Patient Experience Meeting. The feedback gained via the staff and service user engagement work will be used to form an action plan which will be monitored via this forum and will then feed into the Quality Committee.

Appendix 1 - CQC Community mental health survey results data

Data sources:

- CQC Early release data summary - 23/03/2025
- CQC NHS Community Mental Health Survey Assessment Service Groups (ASG)Benchmark Report 2024 - 03/04/2025
- IQVIA Management Report - 04/04/2025
- IQVIA Presentation of Results – 30/07/2025

Overall experience

Overall, in the last 12 months, how was your experience of using the NHS mental health service?

2019	2020	2021	2022	2023	2024
6.4	6.7	6.6	6.4	5.9	6.3

Banding

It should be noted that the data only shows performance relative to other trusts; CQC have not set out absolute thresholds for 'good' or 'bad' performance. Thus, a trust may have a low score for a specific question, while still performing very well on the whole. This is particularly true on questions where the majority of trusts exhibit a high score.

Expected ranges:

- Much better than expected
- Better than expected
- Somewhat better than expected
- About the same as expected
- Somewhat worse than expected
- Worse than expected
- Much worse than expected

Better
Your trust's results were much better than most trusts for 0 questions.
Your trust's results were better than most trusts for 0 questions.
Your trust's results were somewhat better than most trusts for 0 questions.

Worse
Your trust's results were somewhat worse than most trusts for **1** question
Your trust's results were worse than most trusts for **1** question
Your trust's results were much worse than most trusts for **0** questions.

Same
Your trust's results were about the same as other trusts for **34** questions

Questions where banding is worse than expected

Somewhat worse than expected

Crisis care:

- Q29. Thinking about the last time you contacted this person or team, did you get the help you needed?

Worse than expected

Support and Well being:

'The following question asks if your NHS mental health team helped you find support in these areas. This could be through providing posters, flyers, and leaflets.'

- Q32_4. In the last 12 months, did your NHS mental health team give you any help or advice with finding support for cost of living? Worse

Response Rate

The 2024 Community Mental Health Survey involved 53 providers of NHS mental health services in England. People aged 16 and over were eligible for the survey if they (1) had received specialist care or treatment for a mental health condition, (2) had at least one contact between 1 April and

31 May 2024, as well as at least one other contact either before, during or after the sampling period, and (3) were not a current inpatient.

CQC Early release response rate

• The response rate for Kent and Medway Mental Health NHS Trust was 22.6%

• The average response rate was 20%

277 out of 1270 people responded to the survey

IQVIA Management Report

The final response rate for the Trust was 23.1% (282 responses from a usable sample of 1,221).

CQC Benchmark Report

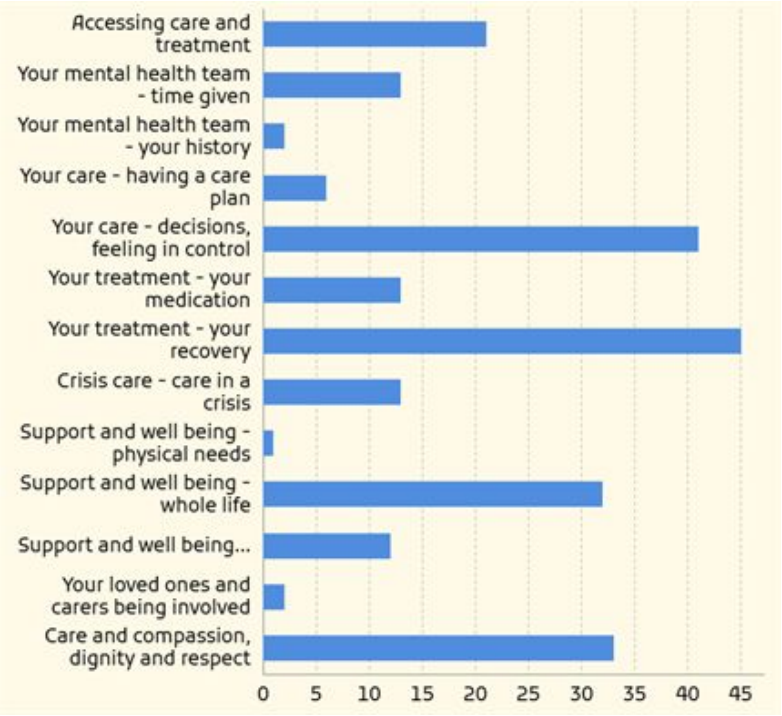
A total of 14,619 responses were received, an adjusted response rate of 20%.

2023 Response rate

CQC - KMMH 21% / Average 20%

CQC - 257 out of 1270 people responded to the survey

Qualitative data – Emerging Themes



Appendix 2: CQC Community mental health survey

Questions / result benchmark

KEY

- About the same as other trusts
- Somewhat worse than other trust
- Worse than other trusts

Accessing care and treatment	Q1 When was the last time you saw someone from NHS mental health services**? Not scored** Q2. Overall, how long have you been in contact with NHS mental health services? **Not scored** Q3. How long did you wait between your assessment with the NHS mental health team and your first appointment for treatment?	Q4. How did you feel about the length of time you waited between your assessment with the NHS mental health team and your first appointment for treatment? Q5. While waiting, between your assessment and your 1st appointment, did you experience any changes in your mental health?	Q6. While waiting, between your assessment and your first appointment for treatment, were you offered support with your mental health? Q7. Was the support offered appropriate for your mental health needs?		
Your mental health team	Q8. Were you given enough time to discuss your needs and treatment?	Q9. Did you feel your NHS mental health team listened to what you had to say?? Q10. Did you get the help you needed?	Q11. Did your NHS mental health team consider how areas of your life impact your mental health?	Q12. Did you have to repeat your mental health history to your NHS mental health team?	Q13. Did your NHS mental health team treat you with care and compassion?
Your care	Q14. Do you have a care plan? Q15. To what extent did your NHS mental health team involve you in agreeing your care plan?	Q16. Were you given a choice on how your care and treatment would be delivered?	Q17. In the last 12 months, have you had a care review meeting with your NHS mental health team to discuss how your care is working?	Q18. Has your NHS mental health team supported you to make decisions about your care and treatment?	Q19. Do you feel in control of your care?
Your treatment	Q20. In the last 12 months, have you been receiving any medication? **Not scored** Q21. Who prescribed medication for your mental health needs? **Not scored**	Q22. Have any of the following been discussed with you about your medication? 1- Purpose of medication 2-Benefits 3-Side effects 4-What will happen if I stop taking my medication	Q23. In the last 12 months, has your NHS mental health team asked you how you are getting on with your medication?	Q24. In the last 12 months, have you received any NHS talking therapies? **Not scored** Q25. How do you feel about the length of time between assessment and 1st talking therapies appointment?	Q26. Thinking about the last time you received NHS talking therapies, did you have enough privacy to talk comfortably?
Crisis care	Q27. Would you know who to contact out of office hours within the NHS if you had a crisis?	Q28. In the last 12 months, have you contacted this person or team?	Q29. Thinking about the last time you contacted this person or team, did you get the help you needed?	Q30. Thinking about the last time you contacted this person or team, how do you feel about the length of time it took you to get through to them?	Q31. Did the NHS mental health team give your family or carer support whilst you were in crisis?
Support and wellbeing	Q32. In the last 12 months, has your mental health team supported you with your physical health needs (this might be an injury, a disability, or a condition such as diabetes, epilepsy, etc)?	Q33. Did your mental health team give you help or advice with finding support for… 1- Joining a group or taking part in an activity 2-Finding or keeping work 3-Financial advice or benefits	Q33 cont'd 4- Cost of living Q34. Have mental health services involved a member of your family or someone else close to you as much as you would like?	Q35. Has your mental health team asked if you need support to access your care and treatment? Q36. Do you need support to access your care and treatment?	Q37. What support do you need to access your care and treatment? Q38. Do you feel the support provided meets your needs?
Overall	Q39. Overall, in the last 12 months, how was your experience of using the NHS mental health services?	Q40. Overall, in the last 12 months, did you feel that you were treated with respect and dignity?	Q41. Aside from this questionnaire, in the last 12 months, have you been asked by NHS mental health services to give your views on the quality of your care?		

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details	
Date of meeting:	29th January 2026
Title of paper:	Changes to Standing Orders and Standing Financial Instructions
Author:	Jo Newton-Smith, Associate Director of Procurement
Executive Director:	Nick Brown, Chief Finance and Resources Officer

Purpose of paper

Purpose:	Approval
Submission to Board:	Standing Order

Overview of paper

The government has introduced some legislative changes to the Procurement rules which apply to all public sector bodies including the NHS. This requires changes to be made to the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation in order to ensure compliance with the law.

Issues to bring to the Committee's attention

These are minor changes relating to procurement thresholds by which certain legislative provisions apply.

Governance

Implications/Impact:	The SFIs are a statutory requirement for all NHS organisations and it is important that this document is up to date and reflects changes in legislation.
Assurance:	Reasonable
Oversight:	Finance, Business and Investment Committee

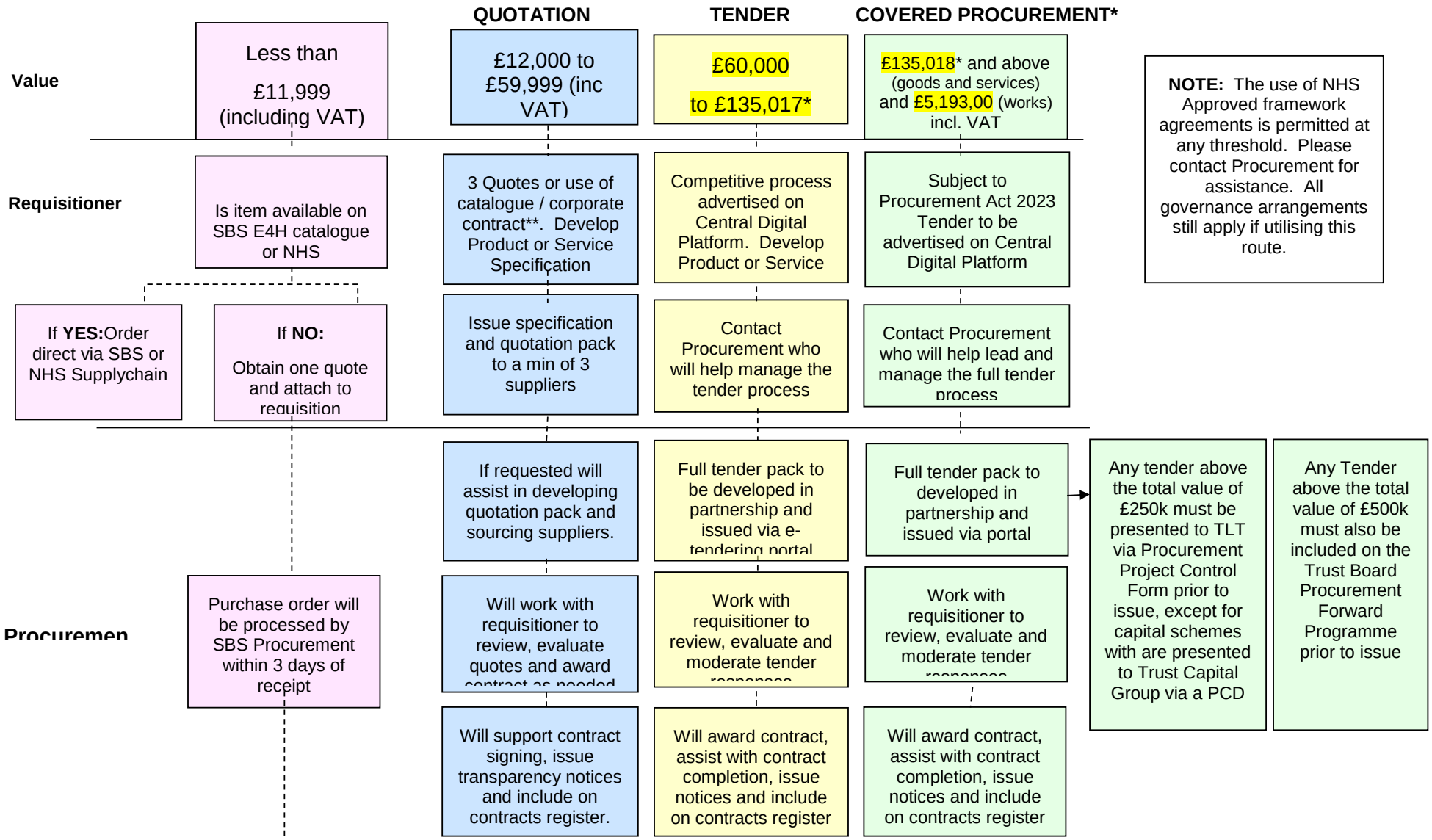
Version 2 - **Public**

Key Changes Requested for Approval

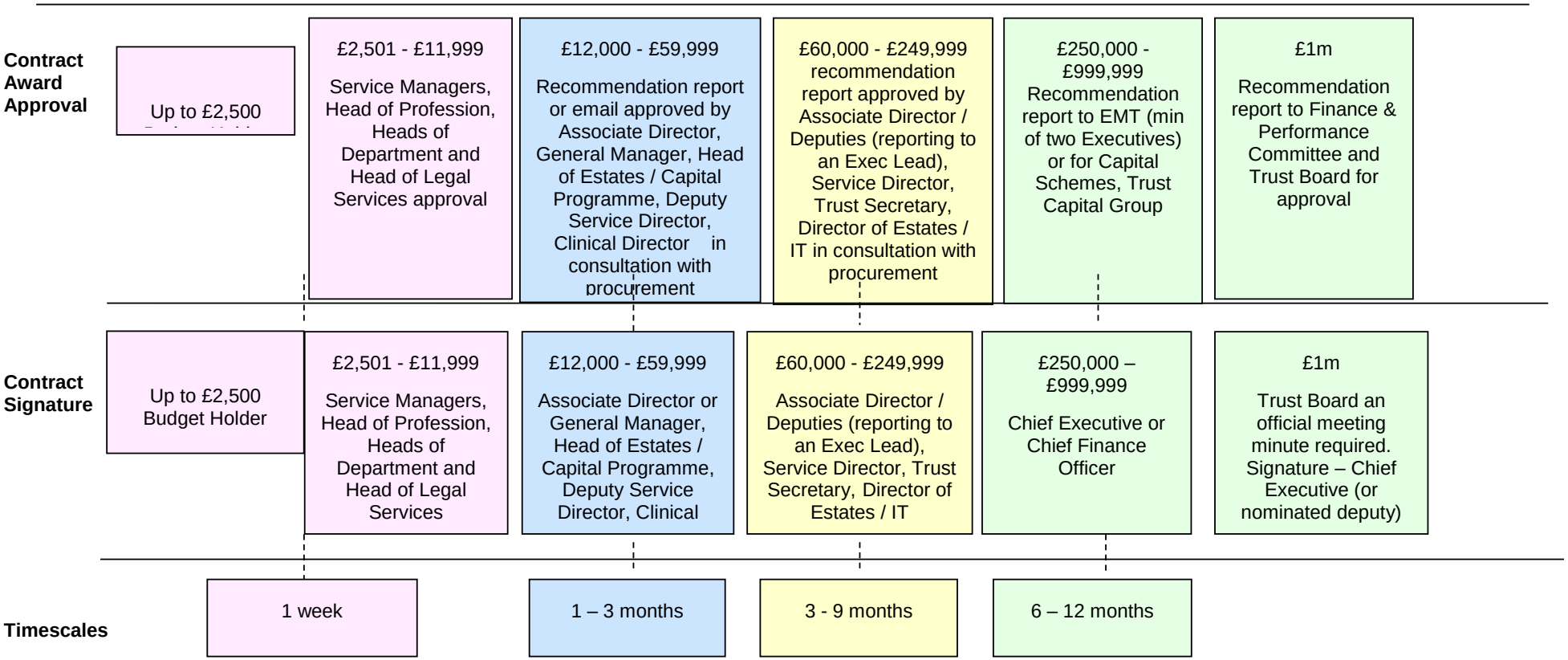
Changes are highlighted in **yellow** in the table below.

SO/SFI number	Current wording	New wording	Reason
Appendix D		Please see Appendix D attached with changes highlighted.	Amended to reflect the change in Thresholds published within PPN 023/2026.

APPENDIX D - TENDER THRESHOLDS. GOVERNANCE AND TIMESCALES



Version 2 - **Public**



Notes:

* Figures As of 1st January 2026. The Government Thresholds for **Covered Procurements** change bi-annually. The next change is due on 1st January 2028, the figures are inclusive of VAT. The Light Touch contract threshold is £663,540. The light touch concession contract threshold is £5,372,609

For any value procurement a Framework Agreement can be utilised as an alternative to the route to market as set out above, if the framework provider has been accredited by NHS England. The Framework Agreement must be accessed following the Framework Provider terms and conditions and in a compliant manner.

Please allow sufficient time for the above processes to be executed.

NHS
Kent and Medway
Mental Health
NHS Trust

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**29th January 2026**
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**
	• Risk Assessment • Person Centred Care Plans	• Chief Nurse's Report • CQC Report • Quality Plan

NHS
Kent and Medway
Mental Health
NHS Trust

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 noted the commissioning of an external rapid review in response to the recent increase in community deaths, with concerns highlighted around reliance on telephone assessments, continuity of care, and variable compliance with the formulation-based risk assessment approach. The importance of strengthening risk assessment processes and embedding learning from safeguarding reviews was emphasised. The Committee welcomed progress against the Self-Harm Breakthrough Objective in women's wards and noted positive improvements in the identification and care of autistic inpatients through digital flagging.	**Reasonable Assurance**	Next steps include reviewing community assessment processes, continued monitoring of risk assessment compliance and quality, spreading learning from self-harm reduction initiatives, and monitoring the impact of digital flagging to ensure consistent implementation.
Risk Assessment	The Committee were disappointed to read the Risk Assessment findings, which demonstrated low compliance, with only 22.8% of patient records containing a documented formulation, indicating limited assurance in this area. While some examples of good co-produced practice were identified, significant gaps remain, and the Committee expressed concern regarding ownership, accountability, and the need for a high ambition to achieve 100% compliance.	**Limited Assurance**	Next Steps • Finalising a clear improvement trajectory with milestones for 50% and 100% compliance and providing monthly progress updates to the Committee. • Embedding Digital Team representation within Committee

NHS
Kent and Medway
Mental Health
NHS Trust

			meetings to support delivery of planned system improvements.
Quality Plan	Following its review of the Quality Plan, the Committee can offer reasonable assurance to the Board. Good progress has been made, including the establishment of clear process and outcome KPIs, the adoption of a Plan–Do–Study–Act approach to monitoring, completion of the majority of Health-Based Place of Safety actions, and improvement in physical health monitoring within community services. However, the Committee noted areas requiring further strengthening, particularly communication with GPs, the estates strategy, health and safety inspections, safeguarding training, and reflective learning.	**Reasonable Assurance**	The Committee emphasised the importance of embedding and sustaining improvements, with ongoing assurance to be provided through monthly updates on improvement plans and further refinement of KPIs and timeframes by action owners.

NHS
Kent and Medway
Mental Health
NHS Trust

Title of Meeting	**Quality Committee**
Meeting Date	**29th January 2026**
Title	**Quality Committee Chair's Report**
Author	**Stephen Waring, Non-Executive Director**
Presenter	**Stephen Waring, Non-Executive Director**
Executive Director Sponsor	**Julie Kirby, Chief Nursing Officer (Interim)**
Purpose	**Noting**

Agenda Items

People items	**Patient items**	**Finance & Governance items**
•	• IQPR • Quality Digest • Mortality Report • CQC Community Mental Health Survey 2024	• Chief Nurse's Report • Trust Quality Plan • Independent External Review of 9 Incidents • Terms of Reference

Agenda Items by exception	**Assurance narrative by exception. Key items to be raised to the Committee.**	**None Limited Reasonable Substantial**	**Actions, mitigations and owners Refer to another committee.**
Chief Nurse Report	The Committee recognised that the Quality Plan continues to gain momentum however, care plans and risk assessments although improving, the pace of the improvements remains a concern.	**Reasonable**	A discrepancy was queried in the self-harm data and additional clarification requested.

	The review of out of date clinical policies has progressed and there has been a lot of meaningful engagement amongst staff. Self-harm incidents on the female wards continues to reduce however, it has been noticed violence and aggression is beginning to increase, and therefore an additional analysis will take place her and a further update given at the Quality Priorities workshop. The Trust received three Prevention of Future Deaths notices, and the Committee will be updated on these in due course.		The Committee want to monitor carefully the metrics on self-harm (which is a quality priority this year) and violence and aggression over a longer period.
IQPR	The Crisis Line abandonment rate has improved however, the target within the IQPR seems to be incorrect, noting that in the private sector the target would be more like 2.5% than our 5% target The Committee recognised the work done to date to improve the 'did not attend' (DNA) rate, however noted this remained high at 10%. Assurance were given that this is being reviewed as part of the 'Getting the Basics Right' programme. The Committee recognised the hard work done to achieve a 50% reduction in the number of out-of- area placements.	**Reasonable**	The Committee to receive confirmation regarding the target abandonment rate for the crisis line.
Quality Digest	The Committee discussed Duty of Candour compliance below 100%, noting that a process review is underway. In addition, it was requested that ligature and restraint data has a clearer narrative, and received assurance around	**Reasonable**	The Committee raised concern over the increase in antisocial behaviour and queried if there was a racial element too this. A separate report into this item was requested.

	implementation of changes following fixed ligature incidents		
Trust Quality Plan	It was noted that the risk assessment compliance trajectory targets are 50% by February and 90% by May.	**Reasonable**	
Mortality Report	The Committee noted that unexpected deaths remain higher than expected, with no care gaps identified. In addition, ethnicity recording compliance is at 79%.	**Reasonable**	
Independent External Review of 9 Incidents	The Committee were made aware of the outcomes and recommendations made following the independent external review of the 9 incidents. Recommendations included a second-phase review, which the Committee strongly endorsed.	**Reasonable**	
CQC Community Mental Health Survey 2024	The Committee noted that overall experience improved from 5.9 to 6.3; response rate above national average. Areas for improvement include cost-of-living support and timely help when contacting teams.	**Reasonable**	The Committee encouraged feedback to the CQC about some survey questions where there was some evidence of potential misinterpretation by our service users.
Terms of Reference	Endorsed for approval subject to minor amendments and requested changes to the workplan	**Reasonable**	
Free Text -			

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details

Date of meeting:	29th January 2026
Title of paper:	Quarter 3 Mortality Report
Author:	Frances Lowrey, Mortality Review Manager
Executive Director:	Julie Kirby, Acting Chief Nurse

Purpose of paper

Purpose:	Noting
Submission to Board:	Regulatory Requirement

Overview of paper

The Mortality Review report includes patient mortality incidents reported in Q3 2025/26, and compares to previous data reports. The data includes natural causes and unexpected deaths, including suspected suicides.

Mortality data is reviewed monthly and presented at the Mortality Review Group for discussion. Actions are assigned to members when required.

Note to the reader: *Overall mortality data has been pulled by reported date, and therefore will include deaths that may have occurred prior to Q3. Suspected suicides however, have been reviewed by the date of death occurring in Q3. This is to provide a near to real time suicide surveillance overview.*

Issues to bring to the Board's attention

- The number of unexpected deaths remains higher than expected deaths, and consistent with previous trends. This is to be expected as deaths are recorded as unexpected if cause is unknown at the time of reporting. Further work is required to address this to enable more accurate reporting. In Q3, 205 of the 214 unexpected deaths did not require further review or investigation under PSIRF, indicating no identified gaps in care.

- A recent *unexpected death in community services harm review*, found no immediate concerns or themes relating to the number or circumstances of deaths, but did make some recommendations, which included:

    - Refining the unexpected death sub-categories in InPhase
    - Adding cause of death and inquest conclusion fields to the InPhase incident form (this is complete)
    - Create a process for existing and future findings to be fed into improvement work (CMHF refinement, CQC improvement plan, CRAM review, substance use/co-occurring conditions work)

- Mortality rates reported in Q2 and Q3 of 2025/26 are comparable to those recorded in the same quarters of the 2024/25 financial year.
- Nationally, barriers to recording ethnicity have been recognised. Work on addressing health inequalities, can be further supported by the NHS England Ethnicity Recording Improvement Plan.
- There was a period of 3 months (Aug to October) where the suspected suicide rate remained the same. November and December however, have seen a variation (both below the mean line).
- Themes identified from Structured Judgement Reviews highlight recurring areas of good practice and areas for improvement, particularly around physical health and risk assessment. These areas have also been emphasised in previous SJR reports. Areas of learning have been shared with Directorates and leads of physical health and risk, of which are being addressed through quality improvement work. Further exploration is underway to drill down in more detail areas of good care and learning around physical health.

Governance

Implications/Impact:	Patient Safety
Assurance:	Mortality Review Group and Trust Wide Patient Safety and Mortality Review Group
Oversight:	Oversight by Quality Committee

NHS
Kent and Medway
Mental Health
NHS Trust

Terms of Reference

Name of Committee	**Quality Committee (QC)**	
Date	**19th January 2026**	
Version	**V.17**	
Approval	**QC**	**Date: 19th January 2026**
	Trust Board	**Date: 29th January 2026**
Next review due	**July 2026**	

Review - Document Control

Version	Status	Date	Author	Summary of Changes
V10	Draft	16.04.19	Quality Committee	Reviewed by Quality Committee
V11	Draft	17.04.20	Quality Committee	Reviewed by Quality Committee
V11	Final	xx.xx.20	Trust Board	Approved by Trust Board
V12	Draft	16.03.21	Quality Committee	Review in line with Governance Refresh
V13	Draft	15.03.22	Quality Committee	Change in the Non-Executive Director membership
V14	Draft	21.03.23	Quality Committee	Change in membership
V14	Final	30.11.23	Trust Board	Approved
V15	Final	25.07.24	Trust Board	Approved at Trust Board (approved by Committee members outside of the meeting, ahead of the Trust Board meeting)
V16	Draft	21.07.25	Quality Committee	Reviewed by Quality Committee
V16	Final	31.07.25	Trust Board	Approved at Trust Board
V17	Draft	19.01.26	Quality Committee	Transition of performance from Finance, Business and Investment Committee to Quality Committee
V17	Final	29.01.26	Trust Board	Approved at Trust Board

1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as Quality Committee. The Committee has no executive powers, other than those specifically delegated in these Terms of Reference.

The Terms of Reference can only be amended with the approval of the Trust Board.

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to cooperate with any request made by the Committee.

NHS
Kent and Medway
Mental Health
NHS Trust

2. Purpose

The purpose of the Quality Committee is to provide the Board with assurance concerning all aspects of operational performance, quality and safety relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients.

3. Aims

To assure the Board that the structures, systems and processes are in place and functioning to support an environment for the provision and delivery of excellent quality health care services.

To assure the Board that where there are risks and issues that may jeopardise the Trust's ability to deliver excellent quality health care that these are being managed in a controlled and timely way.

To seek assurance regarding the Trust's performance for the clinical services provided via the Integrated Quality and Performance Report (IQPR). This will cover performance against set Key Performance Indicators (KPIs) and the management of waiting lists.

4. Objectives

To seek assurance through formal reporting that

- The content and effectiveness of the structures, policies, systems and processes for quality assurance, continuous quality improvement and associated clinical governance, information governance and quality governance are in place.
- Effective processes are in place to achieve all areas of regulatory compliance including, but not limited to, CQC registration and implementing, where appropriate, recommendations of the CQC as issued from time-to-time.
- Current and future risks to quality and safety as recorded by the Trust are recognised, managed or mitigated in a timely manner.
- The Trust implements and monitors quality indicators and metrics that aid continual improvement in the quality of services and patient experience
- The meaning, significance and learning from trends in complaints, incidents and patient safety events is recognised and acted upon.
- The learning from internal reports, local or national reviews and enquiries and other data and information that may be relevant for understanding quality and safety with the Trust is acted upon.

5. Membership

The Committee will be appointed by the Board and its membership shall consist of the following:

- Two Non-Executive Board members (one of whom will Chair the Committee);
- Chief Medical Officer;
- Chief Nurse; and
- Chief Operating Officer.

The Committee will be supported by the following regular attendees

- Director of Psychological Therapies
- Strategic Lead - Allied Health Professionals
- Chief Pharmacist
- Deputy Chief Nurse
- Emergency Preparedness and Resilience Lead
- Senior Improvement Manager
- Director of Digital and Performance

In Attendance and on request:

Any Executive Director, senior manager, or employee may be invited to attend as appropriate by decision of the Committee or the Committee Chair. This includes representative members of the directorate leadership teams.

Meetings shall generally be monthly, with the exception of August, with additional meetings as necessary to fulfil the Committee Workplan.

6. Quorum

A quorum shall be four members, which must include one non-executive member and one executive member. The Executive member must include either the Chief Medical Officer or Chief Nurse.

7. Methodology (Duties, Reporting, Annual Workplan,)

The Committee will seek assurance on all aspects of operational performance, via:

- The Trust Integrated Quality and Performance Report, identifying progress against key targets and plans and provide regular reports to the Board.

- Analysis of significant variation from plan, with due explanation, and assure remedial actions are taken as necessary.

The Committee will seek assurance on all aspects of quality via:

Exception reports from:

- The Executive Directors which will highlight items to escalate to the Committee from the Quality Digest (QD) and key escalations from sub-groups

Scheduled reports from the various programmes including:

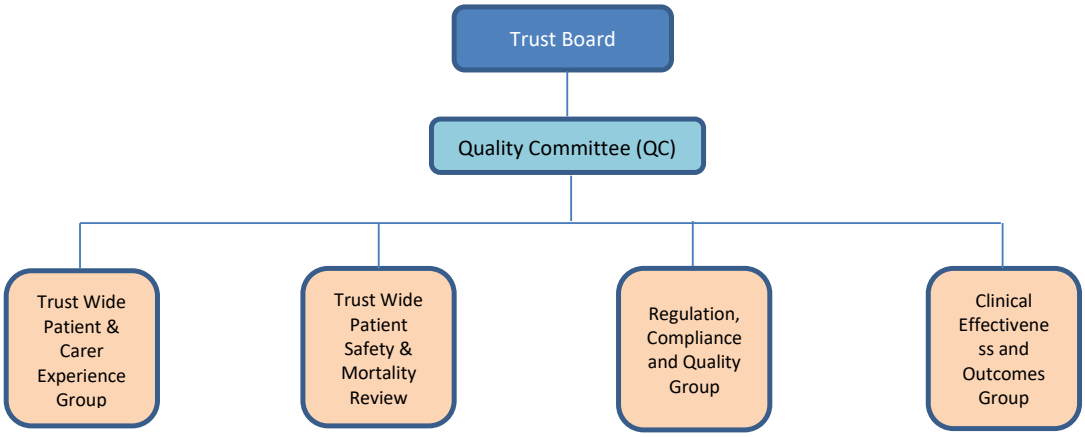
- Quarterly updates regarding Strategic Delivery Plan Priorities for matters that touch upon Quality and Safety,
- Regulatory Compliance and CQC oversight
- Annual Infection Prevention and Control
- Annual Privacy and Dignity –Delivering Same Sex Accommodation standards
- Quarterly Mortality Reviews
- Patient Experience of Care, including community engagement and complaints and national patient surveys

- Bi-Annual Research & Innovation including Clinical Audit & Effectiveness and Quality Improvement
- Learning from Deaths, Serious Incidents, and Incidents
- Annual Safeguarding
- Annual Clinical Outcomes
- Annual Ligature audit
- Annual Medicines Management
- Bi-Annual Quality Account Priorities
- Bi-Annual Safer Staffing Update
- The Trust's quality risk register will be scrutinised at alternate meetings.
- Heads of Service will present their progress in achieving quality priorities to the Committee at twice yearly Quality Workshops.

The Committee may also receive, exception reports from:

- Trust Wide Patient Safety and Mortality Review Group
- Trust Wide Patient and Carer Experience Group
- Clinical Outcomes Group

8. Accountability and Reporting – Group Structure



Full Governance Structure can be found on the Trust intranet

9. Committee rules and administration arrangements

The Committee will be supported administratively by a Secretary, whose duties in this respect will include:

- Agreement of agenda with Chair and attendees, and collation of papers
- Taking the minutes and keeping a record of matters arising and issues to be carried forward
- Advising the Committee on matters that assist in the Committee's discharge of its duties to the Board
- Ensuring the agenda, papers, and corresponding minutes reflect confidential items

The Secretary may delegate some or all of these duties as required.

The minutes of Committee meetings shall be formally recorded and stored by the Secretary.

10. Accountability and Reporting Arrangements (Annual Effectiveness Report)

The Chair of the Committee shall report to the Board after each meeting and draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action including details of any matters in respect of which actions or improvements are needed.

The Committee will report to the Board annually on its work in support of the Annual Governance Statement and after each meeting highlighting areas of success in quality improvement and risks to the improvement of quality in any area of the Trust's services.

The Chair of the Quality Committee has the Board's authority to report to other organisations working in partnership any matter the Committee considers impacts on clinical quality.

11. Review and Monitoring

The Committee will undertake and evidence a review of its performance against its purpose in order to evaluate its effectiveness, the fulfilment of its functions in connection with these terms of reference and achievement of its duties at the conclusion of the time line, at least annually.

The Committee will undertake an annual review of its Terms of reference, or sooner if required. Any proposed material amendments must be reviewed approved by the Board.

NHS
Kent and Medway
NHS and Social Care Partnership Trust

Title of Meeting	**Public Board Meeting**
Meeting Date	**29th January 2026**
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**
• People Committee Main Report incl: Strategic Delivery Plan Update with risks identified • People Risk Register • Deep Dive: Sickness Absence • Workforce Planning Assumption for 2026/27 • Equality, Diversity and Inclusion, Workforce Race Equality and Workforce Disability Standards update • Freedom to Speak Up 6 Month Report • Compliance with Mandatory Training		• HR Policies and Procedures

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.
People Committee Main Report incl: Strategic Delivery Plan, update with risks identified	The Committee received an update on system workforce arrangements and emerging shared service approaches across the Integrated Care Board (ICB). It was noted that workforce controls continue to operate on a comply or explain basis, with appropriate justification provided where full compliance would be unsafe. The Committee was advised that several ICB programmes are being wound down as part of wider system restructuring, with new shared workstreams emerging; however, these remain at an early stage and detailed specifications, objectives, and implications for the Trust are not yet fully defined. Members also noted risks associated with future funding arrangements and the need for clearer system-wide planning to support sustainable delivery.	**Limited Assurance**	Next steps: Further clarity will be brought to the Committee on the objectives, governance, and implications of emerging ICB shared workstreams. Workforce reporting will be strengthened to provide clearer analytical insight and trajectory measures, and alignment with the new Trust strategy will be reviewed once finalised. Updates on these areas will be presented to the Committee at the next meeting in March.
Deep Dive: Sickness Absence	The Committee received a deep dive on sickness absence and took reasonable assurance. The current sickness absence rate of 5.5% remains above the Trust's stretch target but is below the national mental health average. While a rise in long-term absence was noted, particularly among older staff, the Committee was assured that contributory factors are well understood and reflect national trends. A range of targeted support measures are already in place, including enhanced occupational	**Reasonable Assurance**	Next steps will focus on improving insight into flu vaccination uptake across staff groups and ensuring system-level musculoskeletal and physiotherapy discussions are informed by appropriate professional representation, with further updates to be provided to the Committee.

	health provision, psychologist-led wellbeing support, physiotherapy interventions, and focused support for the medical workforce.		
Workforce Planning Assumption for 2026/27	The Committee reviewed the initial workforce planning assumptions for 2026/27 and noted that these remain provisional pending confirmation of the financial envelope and completion of demand modelling. While key assumptions were outlined, the Committee took limited assurance due to the absence of a detailed demand-growth analysis and clearer alignment with transformation ambitions.	**Limited Assurance**	A revised and more developed paper will be returned to the Committee in March 2026 following submission of the final operational plan.
Freedom to Speak Up 6 Month Report	The Committee received the Freedom to Speak Up report for the first half of 2025/26, noting an increase in concerns raised via The Guardian Service, with the majority rated Green and no detriment reported. Themes continue to focus on management behaviours and system/process issues, particularly around consultation, induction and flexible working.	**Reasonable Assurance**	The Committee was assured that clear next steps are in place, including implementation and monitoring of leadership and management development programmes, strengthened consultation and follow-up practices, and ongoing oversight of themes and actions through routine reporting.

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details

Date of meeting:	29th January 2026
Title of paper:	Equality, Diversity and Inclusion, Workforce Race Equality and Workforce Disability Standards update
Author:	Yasmin Damree-Ralph – Equality, Diversity and Inclusion Manager
Executive Director:	Sandra Goatley – Chief People Officer

Purpose of paper

Purpose:	Noting
Submission to Board:	Board requested

Overview of paper

This paper has been prepared at the request of the People Committee to provide a detailed update on the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and the Equality, Diversity and Inclusion (EDI) plan. As agreed, a progress report is being presented at the six-month mark to review the status of actions, highlight any advancements made, and identify areas requiring further attention. This update serves to ensure transparency and track improvements.

Issues to bring to the Board's attention

The combined WRES and WDES action plan is a component of the EDI Plan, and also aligns with the EDI Plan's six focus areas to drive meaningful and sustainable improvements. The WRES and WDES objectives and the EDI Plan initiatives have been carefully designed to address key areas, ensuring that the improvements achieved are sustainable long term.

While there are minor delays in some of the actions, these are being actively managed to minimise any potential negative impact on overall progress. The interconnected nature of the WRES, WDES and the EDI Plan actions with broader Trust strategy ensures a cohesive approach, reinforcing long-term cultural and systemic change. This alignment supports not only immediate outcomes but also the integration of these improvements into KMMH's ongoing EDI efforts.

Governance

Implications/Impact:	Impact on KMMH Culture, reputation, recruitment and retention
Assurance:	Reasonable
Oversight:	People Committee

Version 2 - **Public**

Equality, Diversity and Inclusion (EDI) Action Plan 2025–2027 Update

1. Purpose of the Paper

This paper provides the People Committee with an update on progress against the Equality, Diversity and Inclusion (EDI) Action Plan 2025–2027. It offers assurance on delivery to date, alignment with the Equality Diversity and Inclusion (EDI) Plan, Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES), and highlights key areas of progress, dependencies, and emerging risks.

The People Committee is asked to note the progress outlined and the RAG-rated delivery position.

2. Background and Context

The EDI Action Plan 2025–2027 sets out a structured programme of activity to advance equality, diversity, and inclusion across the Trust's, People Strategy, and NHS England priorities.

The plan brings together statutory WRES and WDES requirements with broader workforce, culture, and leadership ambitions, ensuring that improvements are embedded, measurable, and sustainable over the medium to long term.

3. Overall Position

Delivery of the EDI Action Plan is on track. Early implementation has focused on establishing strong foundations around workforce data quality, inclusive recruitment, training, staff experience, and leadership accountability.

A small number of actions are at an early stage or dependent on forthcoming staff survey and workforce data. These are reflected as Amber within the RAG-rated summary but do not indicate material slippage. No Red risks have been identified at this stage.

4. Progress Update by Theme

4.1 EDI Plan – six focus areas

Focus Area One: Reducing Racial Violence and Aggression

Progress/Update:

A coordinated programme of work is underway to reduce racism, violence, and aggression experienced by staff and patients. This includes:

- A clinically led approach, overseen by the Chief Nurse Officer, strengthening early risk identification, de-escalation and consistent clinical responses.

- Delivery of Allyship and Active Bystander training through a Train-the-Trainer model; 84% wards have completed the training (both Acute and Forensic ward teams), with 30 staff trained to facilitate the training.
- A live pilot of the EDI End-to-End (E2E) pathway within the Acute Team to improve staff and patient experience.
- Implementation of the Respect and Safety Behavioural Accountability Process (RSBAP), providing a structured response to offensive or aggressive behaviour from patients, supported by clear escalation and governance arrangements.
- Implementation of empowerment cards distributed to staff – refresh of cards with new identity completed, and reprint of cards (smaller size to fit in the back of ID badges) to be costed and ordered.
- Approval given to mobilise a high level multi-disciplinary panel to case review high risk or repeat offenders of violence and aggression.
- Funding has been requested to proceed with the delivery of Restorative Practice training to train up to 20 facilitators across the trust (community, acute, support services). These facilitators will be in addition to the already established and trained restorative justice facilitators in our Forensic directorate.

Focus Area Two: Improving Leadership Accountability Through Cultural Competence

Progress/Update:

An EDI thread is embedded across leadership and management development programmes, including senior leadership and system-level courses. All facilitated programmes are designed to encourage leaders to apply a culturally competent and inclusive lens in practice.

All leadership roles (band 7 and above) include a cultural inclusion ambassador (CIA) on interview panels to eliminate bias in interviews and ensure the interview s are fair and equitable, list of CIA's held and updated regularly and available via staff room.

Focus Area Three: Enhancing the EDI Strategy Through Workforce Engagement and Data

Progress/Update:

- Staff Networks will operate using standardised agendas aligned to Trust priorities, learning and emerging themes, with refreshed standardised agenda's, Terms of Reference reflecting the Trust's Culture, Identity and Staff Experience vision. Monthly network chairs meetings have been established to discuss themes from network meetings and next steps.
- A workforce EDI dashboard is in final development following a data-cleansing exercise, with plans for annual refreshes and targeted campaigns to improve data completeness. Access to BI reports will be available to Human Resources Business Partners, managers and staff.

Focus Area Four: Reviewing and Enhancing People Policies

Progress/Update:

A workforce policy review working group has been established. In addition, an Equality Impact Assessment Consultation Group is now in place to support authors of policies, strategies and projects to identify potential positive or negative impacts on staff groups.
Psychological support is also being piloted for staff affected by violence and aggression in the workplace.

Focus Area Five: Workforce Communication and Engagement

Progress/Update:
Trust-wide communications are supporting the rollout of the Trust's new identity, using Staff Room, videos, bi-monthly EDI listening events led by Exec members and the EDI podcast. Messaging reinforces expectations around respect and anti-discrimination, with further engagement materials currently being developed.

Focus Area Six: Improving Incident Logging and Reporting (InPhase)

Progress/Update:

A range of improvements have been implemented to strengthen incident reporting and monitoring, underpinned by the principle of "if in doubt, report it." This includes bespoke dashboards (e.g. violence and aggression by ethnicity), regular staff training, clearer guidance within reporting forms, and ongoing communications via the InPhase Bulletin. Local improvements have focused on simplifying the reporting experience within the constraints of NHS England's LFPSE framework. The data below shows the number of reported incidents of violence and aggression broken down by ethnicity and incident category comparing data in 2024 to 2025.

Discussions have taken place with the InPhase Steering Group with a request submitted to enhance the managers section of the incident report to provide evidence of actions taken including updating the member of staff (victim) reporting the incident.

Violence and Aggression Data by Ethnicity reported via InPhase

V&A incidents to staff by Incident sub-category and Ethnicity (2024 and 25)	Arabic		Bangladeshi		Black African		Black Caribbean		Chinese		Indian		Mixed White and Asian		Mixed white and Black African		Mixed white and Black Caribbean		Not stated		Other Asian		Other Black		Other ethnic category		Other mixed category		Pakistani		White - British		White - Irish		White - other white		Unknown		TOTAL	
	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025
Physical contact (actual assault)	0	0	3	2	265	349	3	8	0	2	42	74	6	8	22	22	4	4	269	288	20	19	10	12	16	11	2	12	4	4	337	335	4	4	23	39	12	7	**1042**	**1200**
Physical contact (actual assault) with protected characteristics content / hate speech	0	0	0	0	2	4	0	0	0	0	1	4	0	0	0	0	0	0	3	9	1	0	0	0	0	0	0	0	0	0	4	8	0	0	0	0	1	1	**12**	**26**
Physical contact (actual assault) with racial intent	0	0	0	0	58	34	2	0	0	0	4	6	2	0	0	0	0	0	27	21	2	0	1	0	1	0	0	0	0	0	11	7	0	0	0	1	0	1	**108**	**70**
Physical threat (no contact)	0	0	1	1	87	94	2	0	1	0	4	13	0	3	4	7	1	0	120	112	4	2	0	0	1	1	2	2	0	0	90	85	0	0	7	7	7	5	**331**	**332**
Psychological abuse (bullying and harassment)	1	0	0	0	4	3	0	0	0	0	0	0	0	0	0	1	0	0	10	19	0	1	0	0	0	0	0	0	0	0	16	6	0	0	4	0	0	1	**35**	**31**
Sexual (including harassment and indecent exposure)	0	0	0	0	14	10	0	0	0	0	0	4	0	1	3	0	0	0	19	28	0	0	0	0	0	0	0	1	0	1	30	22	0	0	2	0	2	2	**70**	**69**
Verbal Abuse	0	0	0	0	50	61	1	0	0	0	1	5	0	0	2	1	1	1	224	220	5	3	3	1	2	2	1	1	0	0	87	57	1	3	4	3	11	19	**393**	**377**
Verbal abuse with protected characteristics content / hate speech	0	0	0	0	2	1	0	0	0	1	1	1	0	0	0	0	0	0	15	4	0	1	0	0	0	1	0	0	0	0	5	6	0	0	0	1	1	1	**24**	**17**
Verbal abuse with racial content	0	0	1	3	109	104	5	2	0	0	10	6	3	1	7	5	0	1	127	107	4	5	3	2	2	5	0	1	0	4	12	13	0	0	2	2	3	5	**288**	**266**
Total	**1**	**0**	**5**	**6**	**591**	**660**	**13**	**10**	**1**	**3**	**63**	**113**	**11**	**13**	**38**	**36**	**6**	**6**	**814**	**808**	**36**	**31**	**17**	**15**	**22**	**20**	**5**	**17**	**4**	**9**	**592**	**539**	**5**	**7**	**42**	**53**	**37**	**42**	**2303**	**2388**

Overall volume: 2,303 incidents recorded across 2024–25, with incident levels broadly consistent across both years.
Most common incident types:

- Physical contact (actual assault): 402
- Verbal abuse: 393
- Physical contact (no contact): 331
- Verbal abuse with racist content: 288

These four categories account for around 60% of all incidents.

Racist and hate-related incidents:

- Incidents involving racist or protected-characteristic content remain significant, particularly verbal abuse.
- Physical incidents with racist intent, while lower in volume, represent higher-severity risk.

Ethnicity recording:
Unknown ethnicity and not stated ethnicity limit robust equality analysis. Where recorded, incidents are most frequently associated (by raw count) with White British, Black African, and Mixed ethnic groups.

Key implication:
Staff safety risks are driven primarily by verbal abuse and physical contact, alongside a persistent issue of racist and hate-related behaviour. Improving data completeness, particularly ethnicity capture, is critical for effective monitoring and targeted intervention.

4.2 Representation and Workforce Data

WRES workforce data

Early indicators show that the proportion of our Global Majority workforce has increased to 31.5% since 1 April 2025, representing a 1.5 percentage point increase. This increase in representation may be partially attributed to the refreshed recruitment process and the introduction of Culture Inclusion Ambassadors.

Year-on-year growth has been sustained:

2021/22: 23.5%
2022/23: 25%
2023/24: 28%
2024/25: 30

The data shows that unknown ethnicity status has decreased to 6.8% from 7.13% (2024/2025).

WDES workforce data

Representation of disabled staff has increased to 9.36%, a 1.56 percentage point increase from 7.8% in 2024/25. This exceeds the NHS England WDES national average of 4.9%.

Year-on-year trends are as follows:

2022/23: 7.33%
2023/24: 7.69%
2024/25: 7.8%

However, the proportion of staff with an unknown disability status has increased to 19%, up from 16.25% in 2024/25. This may be attributable in part to neurodivergent staff not identifying as disabled, as there is currently no separate reporting category for neurodiversity

Declaration campaigns are ongoing to reduce “unknown” and “prefer not to say” rates across protected characteristics, supported by regular communications encouraging staff to update their ESR records.

Work to align ESR data with staff survey results will commence following publication of survey outcomes, enabling improved analysis of representation and experience gaps. Improving diversity at senior levels (Bands 8a–9 and Board) remains a longer-term priority and will be embedded within the People Plan for 2026–2027 as part of the talent and succession work.

4.3 Recruitment and Progression

Inclusive recruitment practice continues to strengthen. Culture Inclusion Ambassadors are now embedded within interview panels, and recruiting managers are required to include an

ambassador as part of the recruitment process. The ambassador pool continues to grow and is actively maintained.

The recruitment team have launched updated recruitment training which includes EDI for all recruiting managers to complete, all culture inclusion ambassadors are required to complete this training as part of their induction into becoming a culture inclusion ambassador.

Quarterly monitoring of recruitment outcomes by protected characteristic has been identified as a priority action and will be implemented once baseline recruitment data is established, with reporting aligned to WRES and WDES indicators from 2026. Mentoring and leadership pathways will be progressed through the wider talent and succession planning framework.

4.4 Training and Development

There has been strong progress in the rollout of Allyship training. To date, 84% of inpatient and forensic ward teams have completed the training. Additional sessions are available via iLearn, and 30 facilitators have been trained to support ongoing delivery and sustainability.

Further work on equitable access to CPD and leadership development will be informed by monitoring data and staff survey outcomes.

4.4 Workplace Culture, Harassment, Bullying and Abuse

Significant progress has been made in strengthening the Trust's response to racialised and discriminatory violence and aggression. Consequence letters have been approved and will be triggered through RIO, with additional system changes planned to improve feedback loops to affected staff.

Communications materials, including posters and external messaging, are in development or awaiting final approval, such as auto message on external telephone lines and posters which are currently being consulted with via the community and engagement team. Approval has also been secured to establish a High-Level Multi-Disciplinary Panel, alongside funding to train 20 facilitators in restorative practice by March 2026.

Staff network development continues, including the formalisation and forthcoming launch of the New Parents Network.

4.5 Health, Wellbeing and Reasonable Adjustments

Actions relating to wellbeing, presenteeism, and satisfaction with reasonable adjustments are at an early stage we have approx. helped 84 members of staff in the last 12 months. Progress in this area is dependent on forthcoming staff survey data, which will inform baseline measures and priority interventions. This work will align with the Trust's wider wellbeing and people policies.

4.6 Engagement and Staff Voice

Staff networks continue to play a central role in engagement and listening activity. Networks are delivering regular drop-in and listening sessions, including intersectionality-focused discussions, with further sessions planned into 2026.

Network chairs and members are actively involved in key organisational working groups, including people policy development and equality impact assessment consultation, ensuring that lived experience informs decision-making.

Network chairs have also been guests on the EDI podcast, talking about specific events such as Black History Month, National Coming Out Day and Pronouns Day, the podcast episode are available on Staff Room.

4.7 Leadership and Accountability

Leaders have been encouraged to complete ESR equality declarations, supported by regular prompts from Workforce Information.

Work to embed EDI indicators into leadership objectives is ongoing. The introduction of a Shadow Board has been deferred to 2026–2027, while mentoring and reverse mentoring will be incorporated into the Trust's talent management and succession planning framework to support development of a diverse senior leadership pipeline.

5. RAG-Rated Delivery Summary

Theme	RAG	Summary
Representation & Workforce Data	Green	Declaration campaigns underway; data alignment planned following staff survey.
Recruitment & Progression	Amber	Inclusive recruitment strengthened; outcome monitoring not yet commenced.
Training & Development	Green	Strong delivery of Allyship training with sustainable facilitator model.
Workplace Culture (Harassment, Bullying Abuse)	Green	Significant progress on violence and aggression actions and with next steps i.e. restorative practice.
Health, Wellbeing & Adjustments	Amber	Early stage; dependent on staff survey data for baselines.
Engagement & Staff Voice	Green	Active staff networks and listening mechanisms embedded.
Leadership & Accountability	Amber	ESR declarations encouraged; succession and mentoring work in progress.

Overall RAG Status: Green (On Track)

6. People Committee Assurance Statement

This update provides assurance to the People Committee that delivery of the Equality, Diversity and Inclusion (EDI) Action Plan 2025–2027 is progressing, with the majority of actions rated Green and those rated Amber reflecting early-stage delivery or dependencies on forthcoming staff survey and workforce data rather than material slippage. Governance, executive sponsorship, and reporting arrangements are in place to maintain oversight and manage risks, with no Red-rated issues identified at this stage. The integration of EDI actions within the People Plan, EDI Plan, WRES and WDES delivery, and wider cultural transformation programmes provides confidence that progress will be sustained and that identified workforce inequalities will continue to be addressed in a systematic and measurable way.

7. Recommendation

The People Committee is asked to note the progress outlined in this update and the current RAG-rated delivery position.

NHS
Kent and Medway
Mental Health
NHS Trust

Title of Meeting	**Board of Directors (Public)**
Meeting Date	2nd December 2025
Title	Audit and Risk Committee Chair's report
Author	Peter Conway, Non-Executive Director
Presenter	Peter Conway, Non-Executive Director
Executive Director Sponsor	N/A
Purpose	Noting

Agenda Items

Finance and Regulatory items
• Board Assurance Framework • Trust Risk Register • Trust's third line of defence in relation to cyber risks • NELFT Risk Register for CAMHS and the KMMH Risk Register for the CAMHS on-board project • External Audit Progress Report • Internal Audit Report • Anti-Crime Report • Director of Finance Items • Single Tender Waivers Update • Losses, Special Payments and Write-offs • Adequacy and effectiveness of the Conflicts of Interest Policy and Procedures • Adequacy and effectiveness of the Fit and Proper Persons Policy and Procedures • ICS Governance Issues (by exception) • Adequacy of the Policy Process in meeting Legal and Regulatory requirements

NHS
Kent and Medway
Mental Health
NHS Trust

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.
Risk Management	<u>Board Assurance Framework (BAF)</u> Discussions focused on the need for clear, up-to-date action tracking and risk ownership, noting several actions with lapsed dates. The Committee requested that the Chief Executive should hold the BAF discussions at the Trust Leadership Team meeting.	Reasonable	The Committee requested that the BAF is reviewed ahead of the January 2026 Board meeting to ensure there are clear, up-to-date action tracking and risk ownership.
	<u>Trust Risk Register</u> The Committee also discussed the need to distinguish between strategic and operational risks. Further work was required to review several risks to determine whether these are outside of the Board's tolerance and should instead be on the BAF.	Reasonable	
	<u>Trust's Third Line of Defence in Relation to Cyber Risks</u> The Committee welcomed the comprehensive controls and assurance mechanisms in place, including internal/external audits, penetration testing, and ongoing monitoring. Discussions included recognising the challenge of reducing the risk score given the high-impact, low-probability nature of cyber threats, and the need for realistic target ratings.	Reasonable	
	<u>NELFT Risk Register for CAMHS and the KMMH Risk Register for the CAMHS On-Board Project</u> The Committee did not receive the requested Risk Registers for this item, and therefore agreed that this agenda item should come back to the March 2026 meeting, and in the interim, the Quality Committee should look at the risks		

	regarding medical agency and waiting lists, at its February 2026 meeting. As a result, the Committee is unable to give an assurance rating here.		
Audit and Assurance	<u>Internal Audit Report</u> Assurance was provided regarding the four final reports that had been issues since the last meeting, all receiving either substantial or reasonable assurance. These four reports covered an Assurance Review of Data Quality of Key Performance Indicator (Ligatures), Follow Up of Limited Assurance e-Meds Post Implementation Report, Assurance Review of Waiting List Management (Dementia Patients) and Assurance Review of Patient Documentation in RiO. In addition, all recommendations had been completed. <u>Anti-Crime Report</u> It was noted that an updated Anti-Fraud, Bribery and Corruption Policy would be circulated for approval outside of the meeting.	Reasonable Reasonable	
Internal Controls - Trust	<u>Adequacy of the Policy Process in meeting Legal and Regulatory requirements.</u> The Committee noted the reduction in overdue policies, but remained concerned at the number of clinical policies that remain out of date. The Committee were advised of issues regarding policy overlap, and the need to improve effectiveness. Assurances were given that updating these policies forms part of one of the workstreams of the Quality Improvement Plan and an update will come back to the Committee in May 2026.		

NHS
Kent and Medway
Mental Health
NHS Trust

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**29th January 2026**
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 Mental Health Act Reviews • Bi-Annual Deprivation of Liberty Safeguards Audit Report • Section 136 Breaches • Legislation Update	

Kent and Medway Mental Health NHS Trust

Agenda Items by exception	Assurance narrative by exception. Key items to be raised to the Committee.	None Limited Reasonable Substantial	Actions, mitigations and owners Refer to another committee.
Section 136 Breaches	Following the new implemented process, a significantly reduced number of patients are now not 'breaching' their Section 136 and have a legal framework in place if remaining at the place of safety beyond 24 hours. During the period June to November 2025, only 2 patients breached the policy in the first 6 months of the new process. In both occasions this related to delay in Approved Mental Health Professional (AMHP) availability and were early in the new process. Duty of candour was completed on both occasions.	Reasonable	The Committee agreed to refer this report to the Quality Committee for information.
Legislation Update	The Mental Health Act 2025 was given royal assent in December 2025. The Teams have been attending relevant training and webinars, are awaiting the new code of practice, within the next 12-18 months	Reasonable	The Committee has requested to receive an update on the new Mental Health Act 2025 at each meeting.

Kent and Medway Mental Health NHS Trust

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**29th January 2026**
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**
• NHSP Direct Award	• Linen and Laundry Service	• Planning Update 2025/26 to 2028/29 • Research Investment Update • Strategic Transformation Programmes-Dementia Update • Chief Finance and Resources Officer Report • Finance, Digital and Estates Risks 2025/26 • Finance report for Month 9 (December 2025) • Digital and IT • Digital Plan Update

NHS
Kent and Medway
Mental Health
NHS Trust

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.
Planning Update 2025/26 to 2028/29	The Committee received an update on the draft planning submission and noted the significant financial and operational pressures ahead. These include continued dependence on temporary staffing, high out-of-area placement costs, the need to deliver a 4.5% CIP in 2026/27, and reliance on system partners to address discharge delays, capital limitations and wider mental health investment priorities. The Committee emphasised the importance of robust planning assumptions, clearly stated risks and opportunities, and the alignment of workforce and financial baselines from 1 April. Members also highlighted the need for greater transparency around headcount assumptions within directorate budgets to ensure consistent planning.	**Substantial Assurance**	Next Steps: Management will refine the draft planning submission to ensure risks, opportunities and headcount assumptions are clearly set out and aligned across workforce and financial plans. These refinements will be incorporated into the February submission to provide assurance on deliverability and achievability.
Strategic Transformation Programmes- Dementia Update	The Committee received an update on the Dementia Transformation Programme and noted sustained, significant improvement across Memory Assessment Services. Marked reductions in waiting times and long waits, together with stronger six-week diagnosis performance, indicate a positive improvement trajectory and confirm that recent operational interventions are delivering the intended impact. The Committee also recognised the contribution of	**Reasonable Assurance**	Next Steps: Further assurance will be provided through a detailed assessment of the measurable impact of weekend clinics and waiting list segmentation, including updated long-wait and DNA trends, at the next Committee meeting. This will support continued oversight of sustainability, equitable access,

	weekend clinics and strengthened performance oversight in driving these gains.		and future workforce planning, informed by emerging demand and capacity modelling.
Chief Finance and Resources Officer Report	The Committee received assurance on the current financial position and the key risks facing the Trust. Members noted the continued reliance on non-recurrent mitigations, ongoing staffing and agency pressures within acute wards, and pressures on the capital programme, alongside confirmation that the temporary cash impact from delayed Provider Collaborative payments has now been resolved. The Committee also noted the emerging system support for a mental health investment business case.		Next steps focus on strengthening assurance around the deliverability of plans for delayed discharge, agency reduction and cost controls, and ensuring clear articulation of the Trust's financial risk profile for the Board. The Committee will receive a further update at its March meeting, including capital prioritisation.
Digital Plan Update	The Committee received and noted the update on the Trust's Digital Programme for 2025/26 and the proposed approach for 2026/27 onwards. Members welcomed the strong emphasis on clinical co-production, safety and time-releasing benefits, and recognised that while good foundational progress has been made, the Trust remains at an early stage of digital maturity.	**Reasonable Assurance**	Embed the clinically led prioritisation model: Management will continue implementation to ensure consistent decision-making for digital investment. Align the digital plan with the emerging Trust strategy: The digital programme will be updated to reflect strategic priorities ahead of the final planning submission. Progress preparatory work for 2026/27 digital initiatives:

			Early groundwork will be advanced for key programmes, including ambient voice technology, automation, electronic referrals and electronic prescribing. Report back to the Committee: Further updates will be provided as benefits are quantified and delivery milestones are confirmed.
Note: Business Case NHSP Direct Award was recommended to the board Business Case Linen and Laundry Service was approved by the Committee.			

NHS
Kent and Medway
Mental Health
NHS Trust

Terms of Reference

Name of Committee	**Finance, Business and Investment Committee (FBI)**	
Date	**November 2025**	
Version	**V22**	
Approval	**FBI**	**Date: 27/01/2026**
	Trust Board	**Date: 29/01/2026 (TBC)**
Next review due	**January 2027**	

Review - Document Control

Version	Status	Date	Author	Summary of Changes
V14	Approved	26.05.20	FPC	Reviewed 28.04.20 and Approved 25.05.20
V14	*Approved*	*30.07.20*	*Trust Board*	*Approved by Trust Board 30.07.20*
V15	*Draft*	*23.03.21*	*FPC*	*Review in line with 2021 Governance Refresh*
V16	*Draft*	*20.07.21*	*FPC*	*Update to reflect FPC member comments*
V17	*Draft*	*26.04.21*	*FPC*	Annual review. Updated to reflect the changes included in the Development, Approval and Management of Formal Trust Documents Policy and Procedure.
V17	*Approved*	*27.05.21*	*Trust Board*	Approved
V18	*Draft*	*07.11.22*	*FPC*	Updated for FPC NEDs feedback at committee meeting
V19	*Approved*	*15.12.22*		Reviewed and Approved
V19	Approved	28.11.23	FPC	No changes made.
V20	Draft	11.07.24	Trust Secretary	Review following the governance refresh – approved by Committee members outside of the meeting
V20	Approved	25.07.24	Trust Board	Approved
V21	Draft	13.06.25	Trust Secretary	Reviewed as part of the annual process – approved at the meeting on 24.06.25
V21	Approved	31.07.25	Trust Board	Approved

V22	Draft	27.01.26	Trust Secretary	Updated to reflect the transition of operational performance to Quality Committee, and change of name – agreed at meeting on 25.11.25
V22	Approved	29.01.26	Trust Board	Approved (TBC)

1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Finance, Business and Investment Committee. The Committee is a non-executive Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

The Terms of Reference can only be amended with the approval of the Board.

2. Purpose

The purpose of the Finance, Business and Investment Committee is to support the Trust's strategic direction by providing the Board with assurance concerning all aspects of finance including financial performance relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients.

The committee's role will be to support the Executives with delivery of the overarching efficiency programme, eliminating the Trusts underlying deficit and also to take forward any funding opportunities that may exist to support capital and revenue projects. The committee will draw on the NEDs' experience to support moving forward these agenda items.

Additionally, the Committee has delegated authority to: (a.) Approve Business Cases for capital and revenue schemes within the committee's approval limits as per the Standing Financial Instructions (SFIs) amount; (b.) Approve capital investments and divestments within the committee's approval limits as per the SFIs.

Separation of duties

The roles and responsibilities of the Finance, Business and Investment Committee is distinct from the Audit and Risk Committee who will maintain full oversight of the Annual Accounts process and also Treasury Management policy, as well as areas such as SFIs which are part of the Trust's system of control.

The Executive Management Team will remain responsible for operational delivery and management.

3. Aims

The main aims of the Committee are:

To provide the Board with an independent and objective review of, and assurances, in relation to Financial Performance

To seek assurance that there is adequate organisational oversight of the financial, estates, Clinical Technology and informatics strategies to support the Trust's achievement its strategic plan

To seek assurance that the Trust's efficiency programme is aligned to strategic objectives and is adequately controlled

To seek assurance that the Trust is reducing the underlying deficit aligned to delivery of the Trusts strategic objectives

Monitor and seek assurance over the effective management of significant financial and operational risks which may impact upon the delivery of the strategy and the Trust's financial viability / sustainability. Reviewing the assigned Board Assurance Framework risks are key to undertaking this duty.

The Committee will support the Executive team with delivery of the efficiency programme and funding opportunities that may arise in year.

The Committee may be required to take on additional duties as directed by the Board.

4. Objectives

Review and endorse those strategies relevant to its remit, ensuring their alignment with the Trust's vision and strategic direction and provide assurance to the Board on their ongoing development and delivery.

These include but are not limited to: Financial Strategy; Commercial Development Strategy; Treasury Management; Estates Strategy; Procurement Strategy; Clinical Technology Strategy; Informatics Strategy.

To receive assurances on underpinning policies and procedure, guidelines, protocols and plans to support delivery of agreed strategy.

Providing the Board with an objective review and assurances in relation to major investments/ divestments as classified by NHS England and business cases referred to it by the Board under delegated authority.

Providing the Board with an objective review and assurance in relation to the efficiency programme.

Providing the Board with an objective review and assurance in relation to the underlying deficit and its reduction

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

The Committee holds delegated authority for Investment decisions as defined in the Trust Investment Policy.

5. Membership

Membership
The Committee will be appointed by the Trust Chair and its membership shall consist of the following:
Two Non-Executive Directors, one of whom should be the Chair
Chief Finance and Resources Officer / Deputy Chief Executive and Chief Operating Officer

Attendees – expected to attend all meetings
Deputy Director of Finance
Deputy Medical Director or a nominated Clinical Director (CD) will be a regular attender to represent the clinical voice in Committee discussions

Attendees as required
Director of Contracting, IG and Business Development
Director of Estates and Facilities
Director of Digital and Performance

Nominated deputies will be allowed for Executive Directors and outside appointments on an exception's basis.

The Trust Chair and CEO may attend meetings but are not designated as members.

Frequency of Attendance
Committee members will be required to attend all meetings except in exceptional circumstances when notice is given to the Chair.

6. Quorum

A Quorum will be any two of the Executive and Non-Executive Directors including at least one Non-Executive and one Executive Director.

7. Methodology (Duties, Reporting, Annual Workplan,)

In order to fulfil its duties, the Committee will undertake the following tasks:

Financial Strategy and Plans

- Reviewing on behalf of the Board on an annual basis the Trust's Financial Strategy and Annual Plan

- Review the financial landscape of the wider Integrated Care System, with particular interest on how the other providers are performing financially as this is linked to the new way of working, within the parameters of system control totals

Performance Monitoring

Financial Performance

- Receive and review financial performance reports covering progress against plan, finance forecast and cost improvement programme.

- Receive analysis of significant variation from plan, with due explanation, and assure remedial actions are taken as necessary.

- To receive assurance that the Trust continues to operate as a 'going concern'

Capital Projects & Estates

- To seek assurance on behalf of the Board on the following:
  - That the Estates Strategy is linked to the Clinical and Financial Strategies.
  - Assure major project proposals are robustly prepared and that the implementation plan is deliverable. Monitor the risk individually or collectively of such projects against the Trust's ability to manage its everyday activities
  - That there is a robust disposal policy for redundant estate.

- To oversee the Trust's Carbon Reduction and Sustainability Strategy, reporting as necessary to the Board.
- To seek assurance that the Trust's Environmental Strategy and policies are effectively implemented.

Clinical Technology and Informatics

- Receive and review assurance and exception reports from the Digital Strategy Group

- To oversee the delivery of the Trust's Digital Plan, reporting as necessary to the Board

Procurement Delivery Group

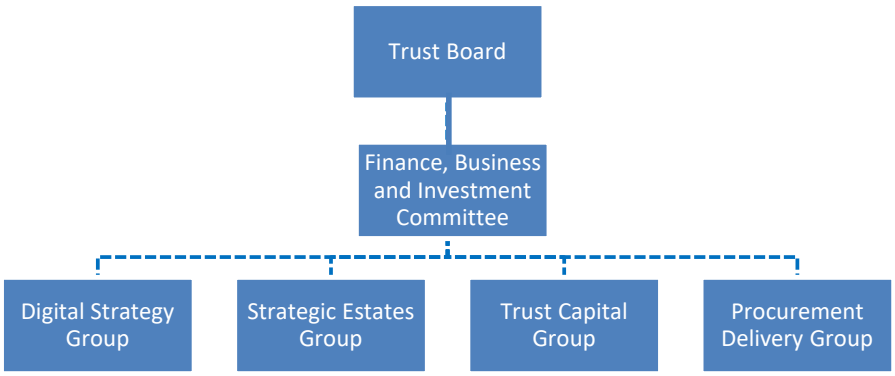
Receive and review assurance and exception reports from the Procurement Delivery Group.

Assurance and Risk Assurance

To assure itself on (i) the identification of principal risks associated with the financial performance and financial management of the Trust, and Digital and Data, (ii) the effective management of those risks and (iii) the escalation to the Board of matters of significance.

NHS
Kent and Medway
Mental Health
NHS Trust

8. Accountability and Reporting – Group Structure



It should be noted that the four groups that report into FBI are Executive led.

Each sub-group will provide a written report to each FBI meeting on any items and/or issues requiring the attention of FBI.

Full Governance Structure is available on the staff intranet.

9. Committee rules and administration arrangements

The Committee is expected to hold 6 meetings in a financial year.

The Committee will be supported administratively by a Secretary, whose duties in this respect will include:

- Agreement of agenda with Chair and attendees and collation of papers.
- Taking the minutes and keeping a record of matters arising and issues to be carried forward.
- Advising the Committee on pertinent areas of governance and procedure.
- Ensuring the agenda, papers and corresponding minutes reflect confidential items.

10. Accountability and Reporting Arrangements (Annual Effectiveness Report)

The Finance, Business and Investment Committee will be accountable to the Board.

The minutes of the Committee meetings shall be formally recorded by the Secretary and made available to the Board.

The Committee will report to the Board following each meeting.

The Committee will consider matters referred to it by other Board sub-committees as an exception and escalation to FBI.

Kent and Medway Mental Health NHS Trust

11. Review and Monitoring

The Committee will undertake and evidence an annual review of its performance against its annual work plans, in order to evaluate the achievement of its duties.

The Committee will undertake an annual review of its Terms of reference. Any proposed material amendments must be approved by the Board.

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**29th January 2026**
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**
• Name and Identity Consultation Plan	• Donor Impact Story • Quarterly Impact Report	• Charity Operational Plan • Charity Risk Register • Finance Report • Approval for Requests over £5000 • Charity Risk Register

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.
Donor Impact Story	The Committee received a positive update on recent charitable activity, highlighting the tangible impact of targeted financial support and strong partnership working. Members noted a powerful case study demonstrating how a small, timely grant supported an individual with lived experience of homelessness to regain dignity, confidence, and re-engage with services through a peer support role. This provided assurance of effective use of charitable funds and clear beneficiary impact. The Committee also received an update on the completion of a significant collaborative capital project at Webb's Garden, delivered largely through in-kind contributions from an external partner, representing a substantial cost saving to the Trust. The new facility has enhanced therapeutic provision for patients, strengthened partnership working, and created early opportunities for income generation, with initial bookings already secured.	**Reasonable Assurance**	The Committee discussed the appropriate use of the facility and received assurance that robust booking arrangements are in place to protect patient access while enabling limited meeting and external use. Members welcomed the proposal to explore holding a future committee meeting at Webb's Garden, subject to these safeguards.
Quarterly Impact Report	The Committee received assurance that the charity continues to deliver a strong impact across volunteering, fundraising and engagement. Performance in Quarter 2 demonstrated significant value through high levels of volunteer contribution, successful fundraising activity, effective communications and targeted grant funding, with evidence that outcomes compare favourably at both system and national level. Members commended the quality and breadth of activity and the positive impact	**Reasonable Assurance**	The Committee noted opportunities to further strengthen assurance and impact, including refining language used to describe value creation, ensuring sustainable management of volunteer growth, and exploring skills-based volunteering to support grant applications. Next steps include embedding these improvements, capturing impact stories to support reporting and the annual report, and maintaining momentum across fundraising and partnership activity.

	achieved through relatively small, well-targeted grants.		
Finance Report	The Committee received and noted the finance report, confirming that the charity's financial position continues to strengthen, with a balanced mix of restricted and unrestricted funds. Income and expenditure remain within expectations, and progress is being made in building unrestricted reserves through fundraising, staff engagement and grant applications.	**Reasonable Assurance**	