NHS
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Mental Health
NHS Trust

Kent and Medway Mental Health NHS Trust

Quality accounts 2025 - 2026

Contents

Chair's Statement

I am pleased to present the Kent and Medway Mental Health NHS Trust Quality Account for 2025–2026.

This has been a year of significant challenge, scrutiny and learning. The trust has operated under two Care Quality Commission (CQC) warning notices, within a context of sustained demand, workforce pressures and increasing complexity of need across our services.

Independent review and regulatory feedback during the year have provided a consistent and clear assessment: while our governance framework is established in design, it has not yet been sufficiently reliable in practice. This has affected the consistency of risk management, safety oversight and the strength of assurance available to the Board. We have been candid in acknowledging these findings and accept that further, sustained work is required to ensure that our systems deliver reliable, evidence-based assurance across all services.

Against this backdrop, the Board has taken focused steps to strengthen oversight, improve the clarity of accountability and develop a more disciplined approach to governance. We have sought to move beyond activity and process towards demonstrable reliability, ensuring that controls are not only in place but are consistently applied and effective.

We have seen early signs of improvement in areas such as crisis response, reductions in self-harm in specific settings, and increased leadership visibility. These improvements reflect the commitment of our staff and the early impact of the Doing Well Together improvement model. However, we recognise that these changes are not yet fully embedded or consistent across the organisation.

Key areas of focus for the coming year include the reliability of risk formulation and care planning, the quality of data and documentation, and the trust's regulatory readiness. The Board is clear that sustained improvement will require disciplined execution, stronger assurance processes, and a continued focus on culture and leadership capability at all levels.

I would like to thank our staff for their professionalism, compassion and resilience during a challenging year, and our patients, carers and partners for their continued engagement and support.

Dr Jackie Craissati
Trust Chair

Chief Executive's Statement

This Quality Account reflects a year of both challenge and important early progress.

During 2025–2026, the trust has operated under sustained regulatory scrutiny, including two CQC warning notices and independent external review. These have provided a consistent diagnosis of our governance maturity. While our governance structures are in place, they are not yet delivering consistently reliable, end-to-end assurance. Independent review has identified weaknesses in the reliability of safety-critical controls, risk formulation, data quality, and the strength of closed-loop assurance.

We have been clear in acknowledging these findings. They are reflected in our Annual Governance Statement and underpin the actions we are taking as an organisation.

In response, we have begun to strengthen our safety systems, improve access in key areas and establish a more disciplined approach to quality governance. The full implementation of the Patient Safety Incident Response Framework (PSIRF), improvements in crisis response, and targeted work to reduce restrictive practice demonstrate the impact of focused improvement activity. However, we recognise that these systems are not yet consistently reliable and require further embedding.

Our staff have shown extraordinary commitment in the face of sustained operational pressure. Their work is reflected in improvements in patient and carer experience and in the growing involvement of lived experience in service design. At the same time, we recognise that patient and carer voice is not yet consistently embedded as a source of assurance within our governance processes, and this will remain a priority.

We are clear that further improvement is required. Risk formulation, care planning, data quality and regulatory readiness remain key areas of focus for 2026–2027. Our priority is to move from improvement activity to demonstrable system reliability—ensuring that controls are consistently applied, outcomes are measurable, and assurance is evidence-based.

We have initiated a trust-wide Quality and Corporate Governance Improvement Programme to strengthen governance architecture, improve assurance flows, and build leadership capability. This programme will be central to our next phase of improvement.

While we have made important early progress, we acknowledge we have further improvements to make to drive consistency. We remain focused on delivering sustained improvement so that our patients receives safe, effective and compassionate care.

"I would like to thank our staff, patients, carers and partners for their continued support and contribution."

Executive Summary

Kent and Medway Mental Health NHS Trust (KMMH) has delivered care during a year of sustained regulatory scrutiny, significant operational pressure and organisational learning. The trust operated under two Care Quality Commission (CQC) warning notices throughout 2025–2026, and was subject to independent review of its quality and safety governance.

These reviews, alongside regulatory inspection, have provided a consistent assessment: the trust's governance framework is established in design but is not yet sufficiently reliable in operation. Weaknesses have been identified in the consistency of safety-critical controls, the effectiveness of risk formulation and care planning, the quality of data and documentation, and the strength of closed-loop assurance.

Independent review and CQC feedback consistently identified:

- Inconsistent reliability of core safety controls
- Fragmented governance architecture and variable governance discipline
- Weak closed-loop assurance, with over-reliance on narrative rather than evidence
- Data quality and documentation issues limiting assurance confidence
- Patient and carer voice not yet embedded as a reliable source of assurance
- Regulatory readiness not yet consistently evidenced

These findings have direct implications for the trust's ability to consistently identify, manage and mitigate risks to patient safety, and have shaped the trust's priorities for improvement.

Against this backdrop, the trust has begun a programme of stabilisation and improvement, focused on strengthening governance, improving access and flow, and addressing key safety risks. While measurable progress has been made in specific areas, these improvements are not yet consistently embedded, and underlying systems require further Improvement to ensure reliability.

The trust also strengthened support for autistic people and people with learning disabilities through a trust wide LD&A programme structured around three evidence based workstreams: immediate need, health inequalities and reasonable adjustments. A new multidisciplinary LD&A Delivery Group, incorporating lived experience, has improved governance and coordination. Workforce capability has been significantly enhanced, with over one third of staff completing Oliver McGowan Tier 2 training and additional role specific learning delivered through co produced Autism Healthcare Webinars.

Quality performance overview

Progress in patient flow remains fragile and highly dependent on external system constraints, particularly housing and social care availability. Despite strengthened daily and twice daily operational processes, a small cohort of patients continues to experience very long lengths of stay, contributing to sustained pressure across the acute pathway.

The trust has begun to strengthen its approach to quality governance, with clearer committee structures, improved reporting and early improvements in the triangulation of data. However, independent review confirms that governance processes are not yet consistently reliable, and further work is required to ensure effective assurance from team to Board.

Implementation of the Patient Safety Incident Response Framework (PSIRF), reductions in self-harm in targeted areas, improvements in crisis responsiveness, and strengthened pathways for dementia and physical health demonstrate the impact of focused improvement work. These represent important early gains, but variation remains and systems require further embedding to ensure consistent delivery.

Patient and carer involvement has increased, with improvements in feedback mechanisms and greater use of lived experience in service design. However, the trust recognises that patient and carer voice is not yet consistently integrated into governance and assurance processes.

Progress in patient flow remains fragile and highly dependent on system-wide constraints, particularly housing and social care. A small cohort of patients continues to experience very long lengths of stay, contributing to sustained pressure across the acute pathway and increasing clinical risk.

The trust remains at an early stage of governance maturity. Risk formulation, care planning, data quality, regulatory readiness, and the reliability of core safety controls remain areas requiring sustained focus. In response, the trust has launched a Quality and Corporate Governance Improvement Programme to strengthen governance architecture, improve assurance flows, and build leadership capability.

Sheila Stenson
Chief Executive

Key improvements in 2025-2026

While the trust has delivered targeted improvements across safety, effectiveness, patient experience and access, independent review indicates that underlying safety and governance systems are not yet consistently reliable across all services. The improvements set out below demonstrate the impact of focused interventions, but variation remains and further work is required to ensure consistency, sustainability and demonstrable impact at scale.

Safety

- Self-harm incidents on **women's wards reduced by 6.44%,** supported by targeted therapeutic interventions, improved observation practice and environmental enhancements.
- Full implementation of the **Patient Safety Incident Response Framework (PSIRF),** including Learning Review Groups, strengthened thematic analysis and real time safety dashboards.
- **New Safety Culture Bundle (Preventative) training delivered** on mandatory Physical Interventions training and simulation de-escalation training delivered on a number of acute inpatient wards, and available for Matrons/Managers to request on away days.
- Digital flagging for **autism and learning disability needs** implemented across all inpatient services, improving visibility and reasonable adjustments.

Effectiveness

- **Dementia diagnosis waiting times improved** from 27.1 weeks to 12.4 weeks, following pathway redesign and improved MDT coordination.
- **Physical health** monitoring for patients prescribed antipsychotics, delivered in line with NICE guidance, **improved with QI pilot sites showing 100% compliance** for 3 month checks post initiation.
- **Medication errors reduced by 26.3%** over the year, decreasing from 38 in April-September 2025 to 28 in October 2025-March 2026.
- **Leadership capability strengthened**, with over 2,000 completed modules of the Leading Well Together programme.

Patient experience

- PREM scores remained strong, with the majority of respondents rating their care as "good" or "very good".
- Carer engagement structures strengthened.
- FFT positive responses increased, supported by improved feedback routes and real-time dashboards.

Access and flow

- **Waiting times** across Mental Health Together (MHT) **improved by 17%.**
- **Crisis Line abandonment rates reduced**, following improvements in staffing and call handling processes.

High Intensity Use (HIU) and system flow

The trust has strengthened system wide flow through the expansion of High Intensity Use (HIU) pathways. Early evaluations demonstrated significant impact, with a small cohort of 14 service users generating 3 inpatient beds a day, 1095 bed days per year, and reductions in average admissions from 11 to 4 per month and average LOS from 127 to 48 days.

These outcomes have informed a whole trust and system wide approach since January 2025, supporting improved crisis responsiveness, reduced readmissions and more personalised, proactive care planning.

Leadership and governance

- Governance redesign implemented following the Quality Governance Review, including clearer committee structures, strengthened risk management and improved closed loop assurance.
- Appraisal completion improved, supporting strengthened accountability and leadership Improvement.
- Early indicators of improved culture, with staff reporting increased leadership visibility and improved psychological safety.

The trust maintained strong emergency preparedness arrangements and was assessed as 100% fully compliant against the NHS England EPRR core standards for 2025. This reflects robust planning, testing and partnership working across the Kent and Medway system, ensuring thetrust can respond effectively to major, critical and business continuity incidents.

Major risks and mitigations

The trust's major risks align with the twelve strategic risks set out in the Board Assurance Framework (BAF).

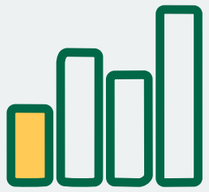
As of 31 March 2026, these included Memory Assessment Service demand; inpatient flow; delivery of the Community Mental Health Framework; organisational management of violence and aggression; CQC regulatory compliance; reduction of self harm in female patients; organisational culture; cyber security; agency usage; delivery of financial targets; underlying financial sustainability; and estate sustainability.

The Independent Quality and Safety Governance Review identified material gaps in assurance that directly affect several risks on the Board Assurance Framework, including quality and safety risks linked to inconsistent reliability of core safety controls; regulatory

compliance risks due to insufficiently evidenced impact of actions; workforce and culture risks associated with change fatigue and variable middle management capability; and governance risks arising from fragmented architecture and data quality issues. The BAF is being refreshed to reflect these findings, with strengthened controls, clearer ownership and enhanced evidence requirements.

These risks have remained relatively constant and are monitored through strengthened governance structures, including ARC, RCQG and the Quality Committee.

The trust also recognises a governance risk relating to policy management. During 2025–2026, several policies passed their review date, increasing the likelihood of operating beyond the trust's stated risk appetite. A targeted programme is underway to review, update and rationalise policies, supported by strengthened oversight from the governance team and executive leads.



a. Inconsistent risk formulation and care planning

- trust wide improvement programme underway with milestones in February and May 2026.
- New templates, audit tools and supervision structures implemented.

b. Regulatory readiness

- Single inspection tracker and evidence library implemented.
- Strengthened closed loop assurance processes.
- Improved triangulation of safety, workforce, experience and performance data.

c. Data quality

- Data quality improvement plan implemented through the Quality Plan.
- New data quality dashboards introduced.

d. Violence and aggression

- Targeted training in alternative restraint techniques.
- Weekly safety huddles in high risk areas.
- Strengthened restrictive practice oversight and accountability.

Progress against 2024-25 priorities

Self-harm

- Improved data capture and thematic analysis.
- Lived experience groups established.
- Pilot interventions delivered on three wards.
- Self-harm incidents reduced by 25% trust wide.

Women's health

- Clinical audit completed.
- Menopause workstream established.
- Staff education gaps identified and training plan developed.

Working with families

- Digital improvements to carer documentation.
- Strengthened carer engagement forums.

Strategic priorities for 2026-2027

The trust's Quality Plan sets out eleven improvement priorities framed under four strategic themes for 2026–2027. These priorities reflect the organisation's regulatory position, the findings of the Independent Quality and Safety Governance Review, and the operational pressures experienced across community, crisis and inpatient services. They also align with the Doing Well Together (DWT) improvement model, ensuring that quality remains the organising principle of the trust's strategy and that improvement activity is focused, coordinated and evidence led.

The priorities were selected through a structured assessment of CQC warning notice requirements, PSIRF learning, patient and carer feedback, workforce insights, and system-wide mental health transformation expectations. This process highlighted the need to strengthen the reliability of core safety controls, improve access and flow, embed personalised care, and build the data and digital foundations required for effective governance and assurance. Each priority is supported by a clear set of standards, measures and expected outcomes, ensuring that progress can be monitored consistently from ward and team level through to the Board.

Overall Summary

The trust has made meaningful progress during a challenging year. While significant work remains - particularly in risk management, data quality and regulatory readiness - the trust has strengthened its foundations and demonstrated early signs of improvement in safety, effectiveness, experience and leadership. The coming year will focus on embedding reliability, accelerating improvement and ensuring that every patient receives safe, effective and compassionate care.

Strategic context and governance framework

About the organisation

Kent and Medway Mental Health NHS Trust (KMMH) provides **secondary mental health services to a population of approximately 1.9 million people** across Kent and Medway. The trust e**mploys around 4,000 staff** and delivers a broad range of services, including:

- Acute inpatient mental health services
- Psychiatric Intensive Care Units (PICU)
- Community mental health services for adults and older adults
- Crisis services and Health Based Places of Safety
- Psychological therapies
- Children and Young People's Mental Health (CYPMH) services
- All Age Eating Disorder (AAED) services
- Forensic and specialist services

KMMH plays a central role within the Kent and Medway Integrated Care System (ICS), contributing to system wide mental health transformation, population health priorities and the delivery of the NHS Long Term Plan.

The trust works closely with acute, primary care, social care and voluntary sector partners to support integrated pathways and improve outcomes for people with complex mental health needs.

During 2025–2026, the trust operated under two CQC warning notices relating to community and crisis services. These notices have shaped the trust's improvement priorities, governance focus and operational delivery throughout the year, with strengthened oversight, accelerated improvement activity and enhanced Board scrutiny.

Quality as a strategic anchor

Quality is the organising principle of the trust strategy and is operationalised through the Doing Well Together (DWT) improvement operating model. This model provides a structured, organisation wide approach to improvement, leadership development and performance management, ensuring that quality is embedded at every level of the organisation.

How quality anchors the trust's strategy, aligned with:

- ICS mental health transformation priorities
- NHSE expectations for safety, access, equity and outcomes
- CQC regulatory requirements, including warning notice actions
- Workforce sustainability, including recruitment, retention and leadership development
- Financial sustainability and value for money
- Digital transformation, including data quality and interoperability

Strategy Deployment Reviews (SDRs) ensure alignment between:

- Trust wide strategic priorities
- Directorate plans
- Team level improvement activity
- Individual leadership objectives

This alignment has strengthened accountability and visibility of progress, with all directorates completing quarterly SDRs during 2025–2026. SDRs have also improved the trust's ability to identify variation, escalate risk and monitor the impact of improvement work in real time.

The Independent Quality and Safety Governance Review, commissioned by the Chief Executive in November 2025, highlighted that the "golden thread between strategic priorities and measurable outcomes is not yet reliable," with quality, risk, workforce and experience intelligence often presented in parallel rather than synthesised into a single view of risk and improvement.

External drivers

The trust's quality agenda has been shaped by several external influences during 2025–26.

Regulatory compliance	• Two CQC warning notices requiring accelerated improvement in community and crisis services. • Increased national focus on sexual safety, ligature reduction and restrictive practice. • Full implementation of the Patient Safety Incident Response Framework (PSIRF).
National policy	• Continued delivery of the NHS Long Term Plan for mental health. • National expectations for improved access to community mental health services and crisis alternatives. • Workforce shortages in psychiatry, psychology and community nursing, consistent with national trends.
Digital and data	• National requirements for improved data quality, digital maturity and interoperability. • Increased emphasis on digital inclusion and personalised care. • Implementation of digital flags for autism and learning disability needs.
Estates and infrastructure	• Estates constraints affecting inpatient and liaison services, including ageing infrastructure and limited therapeutic space. • Increased demand for safe, ligature resistant environments. • Capital pressures requiring prioritisation of high risk areas.
System pressures	• Increased acuity and complexity of presentations across crisis and inpatient pathways. • System wide pressures on social care, housing and primary care impacting flow and discharge. • Growing demand for crisis alternatives and community based support.

These external drivers have required the trust to strengthen its governance, accelerate improvement activity and prioritise safety, access and flow.

CQC inspections during the year identified systemic weaknesses across adult community mental health and crisis services, including failures in legal compliance, risk management, medicines management and governance oversight. These findings have shaped the trust's regulatory response and strengthened the focus on sustainable improvement.

Board oversight

The Board provides oversight of quality through a strengthened governance architecture, including:

- Monthly Quality Committee, supported by a revised subcommittee structure
- Integrated Quality and Performance Report (IQPR), providing triangulated data across safety, experience, workforce and performance
- Quality Plan oversight, ensuring delivery of strategic priorities
- Patient Safety and Mortality Review Group, providing assurance on safety learning and mortality governance
- Risk Register and Board Assurance Framework (BAF), ensuring visibility of key risks and mitigations

During 2025–2026, the Board has focused on:

- Regulatory readiness and delivery of warning notice actions
- Strengthening closed loop assurance
- Improving data quality and insight
- Embedding the DWT improvement model
- Enhancing leadership visibility and culture

Triangulation of safety, workforce, experience and performance data has improved but remains a key development area identified in the Quality Governance Review. The trust has begun implementing a new data quality improvement plan and enhanced reporting dashboards to support this.

The trust continued to experience significant regulatory scrutiny throughout 2025–2026, with multiple inspections across community, crisis, acute and learning disability services, some of which identified systemic weaknesses requiring urgent organisational action. In response, the trust has strengthened closed loop assurance, enhanced RCQG oversight, improved triangulation of quality and performance data, and embedded more rigorous monitoring of improvement plans to ensure sustainable regulatory compliance.

The trust operates an integrated approach to risk management supported by the Audit and Risk Committee and other Board sub committees. Risks are managed through a digital risk application that provides a single point of truth, with clear ownership, escalation routes and oversight. This framework supports consistent identification, evaluation and mitigation of risks across clinical and corporate services. The trust also continued to address the requirements of the Section 29A Warning Notice issued in April 2025. The CQC identified that.

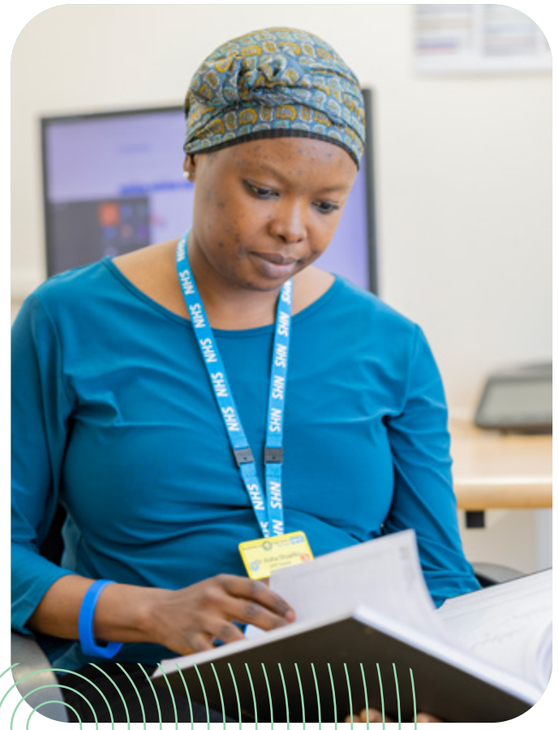
> **the trust had been routinely detaining service users in Section 136 suites… beyond the expiry of their Section 136 detention… without an appropriate legal framework.**

In response, the trust strengthened Mental Health Act governance, implemented revised escalation and oversight processes, and improved legal compliance through targeted training and audit. Re inspections during 2025–2026 demonstrated early signs of improvement, with further work continuing into 2026–2027.

The Independent Quality and Safety Governance Review provided a detailed assessment of the trust's governance maturity. The review concluded that **"the trust cannot yet demonstrate a consistently reliable, end to end assurance system from ward/team to Board"** and assessed quality governance as **"Developing with significant Lagging features".** It identified fragmented governance forums, inconsistent Terms of Reference, weak action discipline, and over reliance on individuals rather than systems.

Regulatory feedback and response

In March 2026, the Care Quality Commission provided detailed well led feedback following its inspection. The CQC highlighted the need to strengthen the trust's risk assurance processes, noting that **"some significant risks did not feature on the trust's corporate risk register, and risk mitigations were not detailed and did not make clear who was accountable."** The CQC also identified the need to improve the consistency of Quality Impact Assessments, strengthen committee workplans, and ensure robust scrutiny of agency staff rostering in inpatient settings.



The CQC also recognised positive progress, however, stating that...

> **there was a strong foundation of motivated staff, emerging leadership capability, and positive examples of learning and collaboration.**

The trust has responded by accelerating improvements to the Board Assurance Framework, strengthening the Regulation, Compliance and Quality Group (RCQG), and enhancing closed loop assurance across all committees.

What this means for quality

The strategic context has shaped the trust's quality priorities by:

- Increasing the focus on safety reliability, particularly ligature risk, self harm and violence
- Requiring strengthened clinical governance and assurance
- Accelerating improvements in access and flow
- Highlighting the need for digital maturity and data quality
- Reinforcing the importance of workforce capability and leadership culture
- Driving greater emphasis on equity, personalised care and inclusion

This context underpins the trust's Quality Plan and informs the priorities for 2026–2027.

The trust has also experienced delays in receiving several CQC inspection reports, which has constrained the pace of assurance and regulatory closure. As the trust set out in correspondence to the CQC,

> **"the length of time that has now elapsed without final inspection reports or clarity on the Section 29A position is significantly constraining our ability to progress assurance, provide clear oversight to our Board and system partners, and move forward from a regulatory governance perspective."**

Mitigations we have adopted include strengthened internal monitoring, enhanced RCQG oversight and increased Board scrutiny of regulatory risks.

Quality performance in 2025–2026

Safe

1. Intent

CQC inspections during 2025–2026 identified systemic weaknesses in adult community mental health and crisis services, including failures in legal compliance, risk assessment and management, environmental safety, medicines management, staffing capacity, and governance oversight. These findings have shaped the trust's safety priorities and have been incorporated into strengthened improvement plans, enhanced oversight through RCQG, and targeted directorate level action.

The Independent Quality and Safety Governance Review reinforced these findings, identifying **"persistent weaknesses in risk formulation, care planning and MHA compliance,"** and concluding that **"safety critical controls are inconsistently reliable."**

The trust aims to deliver consistently safe care through reliable safety systems, a strong safety culture and effective risk management. During 2025–2026, the trust prioritised:

- Strengthening risk formulation and care planning
- Reducing self harm and restrictive practice
- Improving Mental Health Act (MHA) compliance
- Enhancing safety learning through PSIRF
- Improving environmental and workforce safety
- Strengthening safeguarding processes
- Embedding real time safety insight and closed loop assurance

These priorities were shaped by the two CQC warning notices issued in 2025, national expectations for sexual safety and ligature reduction, and internal learning from incidents, audits and reviews.

2. Implementation

Incident reporting and learning

Patient Safety Incident Response Framework (PSIRF) implementation

The trust fully implemented the Patient Safety Incident Response Framework (PSIRF) during 2025–2026, embedding a more transparent, learning focused approach to incident response. Key developments included:

- Establishment of Learning Review Groups for high priority incident categories
- A new triage and prioritisation process for safety events
- Strengthened thematic analysis across self harm, violence and aggression, and ligature related risks
- Introduction of real time safety dashboards providing ward level insight
- Improved feedback loops to staff through Safety Pins and directorate learning forums

During the year, 35 learning responses were subject to an After-Action Review, Patient Safety Incident Investigation, or thematic review. Findings and recommendations of 15 of these were incorporated into existing improvement work. Other findings were either translated into team-level actions or were consolidated into themes to underpin future improvement opportunities.

Thematic analysis key themes identified included:

- Inconsistent risk formulation and safety planning
- Environmental safety risks (ligature points, alarm systems, therapeutic space)
- Communication gaps with families and carers
- Variation in de escalation practice
- Impact of demand pressures on community risk management

These themes informed trust wide improvement programmes and directorate level action plans, with progress monitored through SDRs and the Quality Committee.

Safety improvement programmes

a. Patient flow

Patient flow remains one of the trust's most significant operational challenges and continues to be recognised as a Board level risk. While robust daily and twice daily operational flow processes are in place, including system escalation calls, purposeful admission decision making and seven-day discharge planning, sustained system pressure means demand continues to exceed available inpatient capacity at peak times. This is reflected in consistently high bed occupancy and prolonged waits for admission across emergency and crisis pathways, increasing clinical risk and placing pressure on staff, patients and system partners.

Over the past year, the trust has strengthened its grip on flow through delivery of targeted interventions to improve discharge and reduce clinically ready for discharge (CRfD). These have included expanded step-down capacity, discharge to assess models, closer working with social care and VCSE partners, and focused support for wards with high levels of delayed discharge. These actions have demonstrably released capacity; however, progress remains fragile and highly

dependent on external system constraints, particularly housing and social care availability. As a result, a small but impactful cohort of patients continues to experience very long lengths of stay, contributing to ongoing pressure across the acute pathway.

Looking ahead, inpatient flow and access to acute mental health beds is a clear priority within the trust's Strategy Deployment

framework. Delivery and assurance will be driven through Directorate Strategy Deployment and Quality Reviews (SDQRs), with escalation and alignment at trust Strategy Deployment Reviews (SDRs). For the year ahead, the primary focus will be on reducing the number of patients waiting for an acute mental health bed through tighter alignment of admission criteria, inpatient care and early discharge planning, alongside further development of community alternatives to admission. Strengthening the consistency, clarity and use of flow data within Directorate SDQR and trust SDR governance will be critical in enabling earlier intervention, sharper decision making and sustained improvement in patient safety, experience and system resilience.

b. Self-harm reduction

The Self Harm Steering Group delivered trust wide interventions, including:

- Enhanced therapeutic engagement on women's wards
- Improved observation practice and documentation
- Environmental improvements and ligature risk mitigation
- Staff training in self harm awareness and compassionate response
- Lived experience involvement in co design
- Development of formulation led tools aligned to CRAM

Positive outcomes from the Occupational Therapy led Minimal Risk Activity Packs (MRAP) and Peer Support led Alternatives to Self Harm (ASH) pilots informed wider rollout across inpatient services.

As a result:

Self harm incidents on **women's wards reduced**

Trust wide self harm incidents **reduced by 25%**

c. Violence and aggression

The trust implemented a targeted improvement programme, including:

- Training in alternative restraint techniques
- Enhanced de escalation training
- Weekly safety huddles in high risk areas
- Strengthened restrictive practice oversight
- Implementation of the Respect and Safety Behavioural Accountability Process (RSBAP)
- Heat map pilots to identify environmental triggers

As a result:

Violence and aggression incidents **reduced across priority wards**

Staff confidence in managing aggression **improved through training and supervision**

d. Falls and medicines safety

The trust strengthened falls prevention and medicines safety through targeted actions arising from national clinical audits. A multidisciplinary task and finish group revised the falls risk assessment, embedded a new Falls Management Plan and introduced a simple NICE aligned flowchart for inpatient and community settings.

Medicines safety improvements included strengthened opioid prescribing governance, with automatic review dates and pharmacy confirmation during medicines reconciliation, and enhanced clozapine monitoring through improved patient information, prompts for screening and baseline tests, and strengthened discharge and clinic checks.

These actions have been incorporated into directorate improvement plans and monitored through CEOG and the Quality Committee.

e. Falls, pressure ulcers and deteriorating patients

Pathways were aligned to national guidance, with strengthened investigation and learning processes through InPhase.

Weekly reviews of falls incidents enabled early identification of themes and targeted interventions.

f. Ligature safety

Annual ligature audits were completed across all inpatient areas, with remaining risks incorporated into the Estates Improvement Plan.

A new post audit workshop process ensured:

- Correct application of the audit tool
- Clear documentation of risks and mitigations
- Prioritisation of trust wide capital works

Themes were monitored through the trust Ligature Reduction Group.

g. Learning Disability & Autism (LD&A)

The trust strengthened its approach to supporting autistic people and people with learning disabilities through a comprehensive LD&A programme approved in January 2025. The programme is structured around three workstreams - immediate need, health inequalities and reasonable adjustments - aligned to the Learning Disability Improvement Standards and national guidance for mental health services for autistic people.

A multidisciplinary LD&A Delivery Group, now representing all directorates and incorporating lived experience, has improved strategic oversight and operational coordination.

Work is underway with national partners to develop learning pathways from core training through to advanced and postgraduate study.

Enhanced digital flagging and mapping of over 360 relevant standards have strengthened identification and prioritisation of needs. A pilot Resettlement and Repatriation initiative has demonstrated improved outcomes and system efficiencies, informing a substantive business case to expand community based alternatives and reduce reliance on inpatient care.

Workforce capability has been a central focus, with over one third of staff completing Oliver McGowan Tier 2 training and additional role specific development delivered through co produced Autism Healthcare Webinars.

Safeguarding

Adults	Strengthened adult safeguarding processes included: • Improved learning from statutory reviews • Enhanced multi agency working • Targeted training in domestic abuse, self neglect and MCA • Access to safeguarding experts for advice and supervision
Children	Children's safeguarding processes were strengthened through: • Updated policies • Improved supervision • Enhanced engagement with multi agency safeguarding hubs • Strengthened Think Family practice

Autism and Learning Disability

The trust improved the experience of autistic people and people with learning disabilities through:

- Digital flags implemented across all inpatient services
- Staff training in autism awareness and communication
- Strengthened links with specialist LD&A teams

This work supports compliance with the Equality Act 2010 and national expectations for personalised care.

Workforce safety improvements

- Review of escalation processes following incidents involving nurse call alarms
- Strengthened staffing oversight through the BAF and Risk Register

Staff feedback indicated improved psychological safety and confidence in raising concerns.

Agency workforce safety

The CQC highlighted the need for closer scrutiny of agency staff rostering in inpatient settings, particularly ensuring that temporary staff have the appropriate training to safely restrain patients. The trust has strengthened oversight of agency deployment and is reviewing training compliance requirements to ensure safe practice across all wards.

Infection Prevention and Control (IPC)

IPC compliance was maintained throughout the year, with:

- Hand hygiene compliance at 91%.
- HCAI rates within expected limits for mental health settings

3. Impact

Safety culture - staff feedback through the DWT engagement programme showed:

- Increased leadership visibility
- Stronger confidence in incident reporting

4. Assurance

The Board gains assurance through:

- Monthly Quality Committee oversight
- Safety dashboards and PSIRF learning reports
- Internal audit findings
- CQC engagement and feedback
- Mortality Review Group oversight
- Risk Register and BAF monitoring

Data quality remains a limiting factor for assurance. The trust has implemented:

- A data quality improvement plan
- New data quality dashboards
- Directorate level data quality leads
- Information governance compliance reached 97.4%.

Data quality assurance has been strengthened through the Trust's Data Quality Group, which aims to promote high data quality in order to deliver the best possible care and services to patients. The Group provides a forum for identifying and resolving data quality issues, supported by enhanced reporting, early identification of variances, and improved validation processes. These improvements have increased visibility of data quality across directorates and strengthened the reliability of operational and quality reporting.

Information governance incidents

During 2025–2026, the trust reported five Data Security and Protection incidents in line with national requirements. These incidents were reported to NHS Digital and automatically reported to the Information Commissioner's Office, and related to delayed subject access disclosures, inappropriate access to information, and implementation of a system without appropriate data protection processes. All incidents were investigated and learning has been incorporated into strengthened information governance procedures.

5. Key learning during 2025–2026

Inconsistent risk assessment and safety planning

- New templates and training introduced
- Audit programme established
- Early improvements seen but further work required

Communication with families

- Need for clearer, more consistent communication
- Carer involvement strengthened through working with families

Environmental safety

- Ligature risks and alarm systems require ongoing investment
- Estates Improvement Plan updated

Impact of demand pressures

- Community teams reported challenges in managing risk during periods of high demand
- Flow improvements and crisis alternatives being developed

Coroner and PFD learning

Themes included:

- Physical health monitoring
- Escalation processes
- Documentation quality

Actions have been incorporated into directorate improvement plans.

Effective

1. Intent

The trust is committed to delivering evidence based, clinically effective care supported by strong clinical governance, reliable systems and continuous improvement. During 2025–2026, the trust focused on:

- Strengthening clinical audit and outcomes oversight
- Improving the quality and consistency of clinical documentation
- Enhancing workforce competence in key clinical areas
- Embedding the Doing Well Together (DWT) improvement model
- Reducing unwarranted variation across localities
- Improving physical health outcomes for people with severe mental illness (SMI)
- Strengthening mortality review processes

These priorities were shaped by national expectations, CQC feedback, and internal learning from audits, incidents and reviews.

2. Implementation

National clinical audits

The trust participated fully in the NHSE 2025–2026 Quality Accounts national audit programme, including:

- National Clinical Audit of Psychosis (NCAP)
- Prescribing Observatory for Mental Health (POMH UK) audits
- National Audit of Dementia
- National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)
- National Audit of Anxiety and Depression (NCAAD)
- Learning Disability Mortality Review (LeDeR)

The trust strengthened its audit follow through processes by:

- Introducing a new audit action tracking system
- Requiring directorates to report progress monthly
- Embedding audit outcomes into SDRs
- Linking audit findings to clinical supervision and appraisal

National audit participation and impact

The trust participated in 100% of the national clinical audits relevant to its services in 2025–2026. Key improvements arising from these audits included strengthened falls prevention, safer opioid prescribing, enhanced clozapine monitoring, and improved compliance with NICE guidance across multiple pathways. These actions have been embedded into directorate plans and are monitored through CEOG and SDRs.

Clinical governance

Clinical governance oversight was strengthened through:

- A refreshed Clinical Effectiveness and Outcomes Group (CEOG)
- Improved reporting to the Quality Committee
- A new Clinical Documentation Improvement Programme
- Standardised templates for risk formulation and care planning
- Enhanced mortality review processes aligned to national guidance

The trust also implemented a new Clinical Outcomes Dashboard, providing visibility of:

- Physical health monitoring
- HoNOS outcomes
- Medication safety indicators
- Waiting times for psychological therapies
- Dementia diagnosis performance
- This has improved the trust's ability to identify variation, escalate risk and monitor improvement.

Mortality governance

Mortality governance was strengthened during 2025–2026, with 100% of deaths reviewed, and themes identified in physical health, communication and risk assessment. Actions were monitored through the Mortality Review Group, supporting improved learning and assurance.

Workforce competence

The trust invested in workforce capability through targeted training and competency frameworks.

Risk formulation and care planning

- 2,156 members of staff received some form of training.
- New competency framework introduced
- Audit programme established to monitor quality

Women's health and trauma-informed care

The trust has taken significant steps to improve outcomes for women in inpatient settings. Staff have co designed a suite of learning and development resources to strengthen knowledge of women's health, menopause and gynaecological issues, ensuring care is aligned with NICE guidance.

We are now confident that our environments sensitively cater for women admitted to our inpatient wards, with ongoing work to standardise menstrual and urogynaecology products and health promotion resources. This programme forms part of the trust's Clinical Plan and will expand into pathway level work to create supportive environments that reduce trauma.

Quality Improvement (QI)

The DWT improvement model supported QI projects across all directorates. Examples include:

Dementia diagnosis

- Streamlined assessment pathways
- Improved MDT coordination

RED board process redesign

- Improved discharge planning
- Average length of stay reduced

SMS appointment reminders

- DNAs reduced across community teams

Physical health checks

- SMI physical health check completion improved.

Flow improvements

Patient flow remains one of the trust's most significant operational challenges and continues to be recognised as a Board level risk. Sustained system pressure means demand frequently exceeds available inpatient capacity, resulting in consistently high bed occupancy and prolonged waits for admission across emergency and crisis pathways.

Over the past year, the trust has strengthened its grip on flow through expanded step down capacity, discharge to assess models, closer working with social care and VCSE partners, and targeted support for wards with high levels of delayed discharge. These actions have released capacity; however, progress remains fragile and highly dependent on external system constraints, particularly housing and social care availability.

A small but impactful cohort of patients continues to experience very long lengths of stay, contributing to ongoing pressure across the acute pathway. For 2026–2027, the trust will focus on reducing the number of patients waiting for an acute mental health bed through tighter alignment of admission criteria, inpatient care and early discharge planning, supported by strengthened governance through Directorate SDQRs and trust SDRs.

3. Impact

Clinical outcomes

Dementia diagnosis

Waiting times improved from 27.1 weeks to c12 weeks

Medication safety

Number of prescribing incident reports reduced by 26.3% over the course of the year, decreasing from 38 in April-September 2025 to 28 in October-March 2026

Audit outcomes

Key improvements identified through national and local audits included:

- Better documentation of capacity assessments
- Improved physical health monitoring for people on antipsychotics
- Reduced variation in care planning quality
- Improved compliance with NICE guidance in depression and anxiety pathways

Audit findings informed directorate improvement plans and were monitored through CEOG and SDRs.

Mortality review

The trust strengthened its mortality review processes, with:

- All deaths were reviewed, with 4.1% reviewed through SJR.
- Themes identified in physical health, communication and risk assessment
- Actions monitored through the Mortality Review Group

Learning from mortality reviews informed improvements in physical health monitoring, escalation processes and documentation.

4. Assurance

The Board receives assurance on clinical effectiveness through:

- Monthly Quality Committee reports
- CEOG oversight
- Audit action tracking
- Mortality Review Group
- GIRFT reviews
- Internal audit findings
- External peer reviews

GIRFT recommendations were incorporated into directorate improvement plans, including:

- Improved physical health pathways
- Standardised documentation
- Enhanced MDT working

Data quality improvements supported more reliable clinical outcomes reporting, with:

- Data quality compliance, as measured by Mental Health Minimum Data Set (MHSDS) Data Quality Maturity Index **improving to 91.5%**
- New validation processes implemented
- Directorate level data quality leads appointed

5. Key learning during 2025–2026

Documentation quality	• Variation in risk formulation and care planning • Need for clearer rationale for clinical decisions • Improvements underway through the Documentation Improvement Programme
Variation in clinical practice	• Differences in physical health monitoring across localities • Variation in psychological therapy access • Standardisation workstreams established
Multidisciplinary working	• Need for stronger MDT involvement in care planning • MDT meeting structures reviewed and strengthened
Physical health	• Need for improved escalation of abnormal results • Enhanced training and audit introduced

Caring

1. Intent

The trust aims to provide compassionate, personalised care that respects dignity, equality and inclusion. During 2025–2026, the trust focused on:

- Strengthening patient and carer involvement
- Improving communication and shared decision making
- Enhancing the quality and consistency of personalised care planning
- Embedding trauma informed and culturally competent practice
- Improving the experience of autistic people and people with learning disabilities
- Strengthening equality, diversity and inclusion (EDI) governance

These priorities were shaped by patient and carer feedback, CQC findings and national expectations for personalised care.

2. Implementation

Patient experience programme

The trust's patient experience programme was aligned to national PREMs, the Friends and Family Test (FFT) and local engagement activity. Key developments included:

- A redesigned Patient Experience Dashboard providing real time ward level insight
- Improved feedback routes, including QR codes, SMS links and digital kiosks
- Strengthened thematic analysis of compliments and complaints
- Increased involvement of lived experience partners in service improvement
- Enhanced visibility of patient experience data in SDRs and directorate reviews

During the year, the trust **received 5,881 pieces of patient feedback**, enabling more responsive and targeted improvement.

Carer engagement

The Working with Families priority delivered:

- New carer training for staff
- Updated carer involvement policy
- Improved documentation of carer contact and consent

- Strengthened carer forums
- Co production of new carer information materials
- Improved carer involvement in discharge planning and crisis planning

Carer involvement was embedded into care planning, discharge processes and MDT reviews, supporting more holistic and family centred care.

Communication and personalised care

The trust delivered:

- New personalised care planning templates
- Trauma informed care training across inpatient services
- Improved accessibility of information, including easy read formats and translated materials
- Strengthened processes for capturing patient preferences and reasonable adjustments

These developments supported more consistent, person centred care across services.

Equality, Diversity and Inclusion (EDI)

The trust strengthened EDI governance through:

- Updated Equality Impact Assessment (EqIA) processes
- Improved monitoring of protected characteristics in patient experience data
- Staff training in cultural competence and anti racism
- A new EDI dashboard reporting quarterly to the Quality Committee
- Strengthened oversight of health inequalities through SDRs

EDI considerations were embedded into service redesign, workforce development and patient experience improvement.

Autism and Learning Disability

The trust improved the experience of autistic people and people with learning disabilities through:

- Digital flags implemented across all inpatient services
- Staff training in autism awareness and communication
- Strengthened links with specialist LD&A teams
- Improved sensory support and personalised care planning

This work supports compliance with the Equality Act 2010 and national expectations for personalised care.

3. Impact

Patient experience metrics

Metric	2024–25	2025–26	Change
Positive Mental Health scores from Friends and Family Test	89%	88%	↓ 1%
PREM response rate	3.8%	2.8%	↓ 1%
PREM response count	6,865	5,881	↓ 984

Themes from compliments highlighted:

- Staff kindness and compassion
- Clear communication
- Supportive therapeutic relationships
- Positive experiences of crisis support

Themes from complaints included:

- Communication and information sharing
- Delays in accessing services
- Care planning and involvement
- Discharge processes

These themes informed targeted improvement work across directorates.

Carer experience

Carers reported improved visibility of staff, clearer communication and greater involvement in decision making.

Equality and inclusion

EDI improvements included:

- Increased completion of EqIAs for service changes
- Improved experience scores for people from minority ethnic backgrounds
- Increased accessibility of information in easy read and translated formats
- Improved recording of reasonable adjustments

These developments supported more equitable and inclusive care.

4. Assurance

The Board receives assurance on caring through:

- Monthly patient experience reports to the Quality Committee
- Quarterly EDI reports
- Complaints and compliments dashboards
- PREM and FFT reporting
- Carer involvement monitoring
- Internal audit findings

Regulatory assurance - CQC feedback highlighted:

- Positive staff–patient relationships
- Compassionate care
- Areas for improvement in communication and care planning

These findings informed the trust's improvement priorities and were monitored through SDRs and the Quality Committee.

5. Key learning during 2025–2026

Communication with families

- Need for clearer, more consistent communication
- Improved documentation and consent processes
- Carer involvement embedded into care planning

Personalised care planning

- Variation in quality and consistency
- New templates and training introduced
- Audit programme established

Trauma-informed care

- Need for greater consistency across inpatient services
- Training expanded and supervision strengthened

Accessibility and inclusion

- Need for improved reasonable adjustments
- Digital flags and EDI dashboards strengthened

Patient and carer voice

- Increased involvement in service redesign
- Lived experience partners embedded in QI projects

Patient, family & carer voice

The trust has strengthened its approach to involving families and carers in care planning, risk management and discharge.

Wards that have put in scheduled ward review days and times are getting very good feedback from carers, supported by carer awareness training and a new carer involvement in discharge planning flowchart.

North Kent has enhanced digital inclusion through the Patient Knows Best portal and appointed a co creation facilitator whose role is to seek out and listen to the views of patients, carers, staff and the local community. FFT performance remains strong, with the directorate achieving 89% positive responses from 120 respondents in March 2026.

The Independent Quality and Safety Governance Review found that **"patient, family and carer voice is not yet a dependable source of Board level assurance."** The trust is strengthening experience governance, improving the reliability of PREM and FFT insight, and embedding patient and carer involvement more systematically into quality and safety oversight.

Complaints learning

Learning from complaints has been strengthened through improved thematic analysis, clearer action tracking and enhanced feedback loops to services. Key themes during 2025–2026 included communication, care planning clarity and delays in follow up.

Actions have been incorporated into directorate improvement plans and monitored through the Patient Experience Group to ensure learning is embedded and sustained.

Equality Impact Assessments

Equality Impact Assessments (EqIAs) are embedded across trust decision making to ensure that changes to services, policies or pathways do not disproportionately affect people with protected characteristics.

EqIAs ensure that equality, diversity and inclusion considerations are built into decision making from the outset and provide evidence of compliance with the Public Sector Equality Duty. This strengthens both patient experience and organisational assurance.

Responsive

1. Intent

The trust aims to ensure timely access, effective flow and responsive services that meet the needs of people across Kent and Medway. During 2025–26, the trust focused on:

- Improving access and waiting times across Mental Health Together (MHT) and MHT+
- Strengthening crisis response and reducing Crisis Line abandonment
- Reducing out of area placements and improving bed flow
- Enhancing support for people with complex needs
- Improving discharge planning and community follow up
- Strengthening system wide collaboration to manage demand pressures

These priorities were shaped by rising demand, CQC warning notices and ICS mental health transformation requirements.

2. Implementation

Access and waiting times

The trust delivered a programme of access and flow improvements across MHT and MHT+, including:

- A redesigned waiting list management process
- Weekly access and flow huddles
- Standardised triage and prioritisation
- Increased use of digital and telephone assessments
- Improved MDT coordination
- Enhanced oversight through the Access and Flow Board

The trust strengthened support for people with complex needs through:

- Enhanced MDT reviews
- Improved crisis planning
- Closer collaboration with social care and housing partners
- Increased use of personalised care plans and reasonable adjustments

Crisis services

The trust strengthened crisis response through:

- Improved Crisis Line staffing and call handling processes
- Enhanced training in risk assessment and de escalation
- Strengthened links with police, ambulance and acute partners
- Improved documentation and escalation pathways
- Real time monitoring of call volumes and abandonment rates

As a result:

Crisis Line abandonment improved from in **excess of 35%** in the first six months **to under 25%** in the second half of the year

Response times improved across peak periods

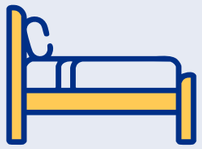
Staff confidence in managing crisis presentations **increased**

Inpatient flow and bed management

The trust implemented a series of improvements to support safer, more effective flow:

- Daily RED Board reviews
- Strengthened discharge planning
- Improved liaison with community teams
- Enhanced oversight of delayed transfers of care
- Increased use of alternatives to admission, including crisis houses and home treatment

These improvements contributed to:



Improved bed availability for local patients

Reduced acute length of stay by **1.1 days**

Discharge and follow-up

The trust strengthened discharge processes through:

- Standardised discharge planning templates
- Improved communication with families and carers
- Enhanced collaboration with social care and housing partners
- Increased use of personalised crisis and safety plans

Follow up within 72 hours of discharge improved to 87.5%, supporting safer transitions and reduced readmission risk.

System-wide collaboration

The trust worked closely with ICS partners to manage demand and improve flow, including:

- Joint escalation processes with acute trusts
- Shared risk management for high intensity users
- Collaborative discharge planning
- Participation in system flow cells
- Strengthened relationships with voluntary and community sector partners

This system wide approach supported more coordinated care and improved patient experience.

3. Impact

Access and flow metrics

Crisis responsiveness and data quality

North Kent has demonstrated strong performance in crisis assessment, with high compliance against the four hour standard. A temporary dip in March 2026 was attributed to data quality issues, reinforcing the importance of accurate recording and validation.

The directorate is also making significant progress in referral to assessment within 4 weeks in MHT, supported by strengthened SDR and IQPR oversight.

Patient and carer feedback

Feedback highlighted:

- Improved responsiveness of crisis services
- Better communication during discharge
- More consistent involvement of carers
- Improved access to community support

Areas for improvement included:

- Waiting times for psychological therapies
- Variation in access across localities
- Delays in accessing specialist services

4. Assurance

The Board receives assurance on responsiveness through:

- Monthly Access and Flow Board reports
- IQPR performance dashboards
- Crisis Line monitoring
- Out of area placement reporting
- Internal audit findings
- CQC engagement and feedback

Regulatory assurance - CQC feedback highlighted:

- Improved crisis response
- Stronger MDT working
- Areas for improvement in waiting times and documentation

These findings informed the trust's improvement priorities and were monitored through SDRs and the Quality Committee.

5. Key learning during 2025–26

Variation in access	• Differences in waiting times across localities • Standardisation workstreams established
Crisis response	• Need for clearer escalation pathways • Improved training and documentation
Discharge planning	• Variation in quality and timeliness • New templates and MDT processes introduced
System flow	• Need for improved coordination with acute and social care partners • Strengthened system escalation processes
Patient and carer voice	• Need for clearer communication during transitions • Carer involvement embedded into discharge planning

Well-led

1. Intent

The trust aims to be a well led organisation with clear strategic direction, strong governance, compassionate and visible leadership, and a culture that supports learning, improvement and accountability. During 2025–2026, the trust focused on:

- Strengthening governance following the Quality Governance Review
- Improving leadership visibility and capability
- Embedding the Doing Well Together (DWT) improvement model
- Strengthening workforce planning, recruitment and retention
- Improving culture, psychological safety and staff experience
- Enhancing data quality, insight and closed loop assurance
- Strengthening regulatory readiness and Board oversight

These priorities were shaped by CQC feedback, internal reviews, workforce insights and the trust's strategic ambition to deliver safe, effective and compassionate care.

2. Leadership and culture

Leadership visibility increased significantly during 2025–2026 through:

- Weekly executive walkarounds
- Directorate level leadership forums
- Increased presence of senior leaders in inpatient and community settings
- Regular staff engagement events aligned to DWT

Staff feedback indicated:

- Improved visibility of leaders
- Greater confidence in raising concerns
- Stronger alignment between senior leadership messages and frontline experience

Leadership capability

The trust invested in leadership development through the Leading Well Together programme, delivering:

- 29 leaders completing core modules
- Coaching and mentoring support for new and aspiring leaders
- Strengthened leadership induction and supervision

Culture and psychological safety

The trust strengthened its culture through:

- Embedding DWT values and behaviours
- Improved incident reporting culture under PSIRF
- Enhanced support for staff following traumatic incidents
- Strengthened Freedom to Speak Up (FTSU) processes

Psychological safety improved, with staff reporting:

- Greater confidence in speaking up
- Improved team cohesion
- Stronger focus on learning rather than blame

The trust has strengthened its Freedom to Speak Up (FTSU) arrangements, with the Guardian undertaking **73 promotional site visits, 43 briefings and 88 meetings during 2025–26.**

FTSU concerns increased by around 15% from 111 to 128 cases, with only two cases requesting full anonymity, which is an indicator of growing confidence in raising concerns. The trust recognises the need to improve timeliness of feedback, as the guardian often reports having to chase or request feedback for extended periods, and has updated the escalation pathway to support more consistent and effective responses.

Research activity

R&I is advancing precision dementia and mental health care - shifting from symptom based models to biologically informed diagnosis and treatment - while expanding equitable access and delivering complex, high impact research at scale.

Dementia leadership:

- COBALT met recruitment target (10) and achieved top national site status for Lewy-body dementia.
- ADAPT co-led nationally, using biomarkers and enhanced diagnostics to enable earlier, more accurate identification beyond symptoms.

Mental health innovation:

- PPiP2 (n=167) identified immunological causes of psychosis in a subset of patients, enabling revised diagnoses and access to immunotherapy pathways.

Scale and delivery strength:

- 1,000+ participants across 15+ studies; >200 in the past year.
- Consistent target achievement, including difficult national studies (CLEAR).
- Delivery of complex, multi-site, clinically intensive studies (imaging, bloods, high need populations).

Inclusion and equity:

- Active recruitment from underserved and coastal communities, improving representativeness and access.

Innovation pipeline:

- UNITE will deploy Hyperfine portable MRI, enabling accessible, patient centred neuroimaging and expanding research capability.

Workforce and co production:

- Strengthened PPIE and lived-experience input (e.g., ADAPT, dementia group).
- Integration of clinical trainees and research fellows improving safety, recruitment, and clinical research alignment.

Research:

- Moves care toward precision psychiatry and dementia, improving diagnostic accuracy and treatment targeting.
- Delivers direct clinical impact, not just research outputs (e.g., identifying treatable causes of psychosis).
- Addresses health inequalities by widening access and improving evidence generalisability.
- Positions the trust as a leader in complex, translational and inclusive research delivery.

The trust is not only delivering more research - it is changing how dementia and mental health are understood and treated, embedding innovation into routine care while scaling capacity, equity, and national impact.

3. Governance and assurance

Governance redesign

Following the Quality Governance Review, the trust implemented a redesigned governance structure, including:

- A clearer committee framework
- Strengthened Quality Committee oversight
- Revised terms of reference for key groups
- Improved escalation and reporting pathways
- Standardised reporting templates
- Enhanced alignment between operational and strategic governance

This redesign improved clarity, accountability and the quality of information received by the Board.

Risk management arrangements have been strengthened through clearer reporting lines, enhanced use of the digital risk application, and more consistent escalation of risks to the BAF. The trust has an integrated approach to the management of risk supported by ARC and other committees, with improved clarity on risk ownership, action plans and oversight mechanisms.

Board assurance

The Board took steps to strengthen its assurance processes through:

- Enhanced use of the Integrated Quality and Performance Report (IQPR)
- Strengthened oversight of the Quality Plan
- Regular deep dives into high risk areas

Board members reported improved confidence in the quality of information and the robustness of assurance processes.

Alignment with the Board Assurance Framework

The trust's major risks align with the Board Assurance Framework, which identifies twelve high impact risks including Memory Assessment Service demand, inpatient flow, violence and aggression, CQC compliance, self harm reduction, organisational culture, cyber security and estate sustainability.

These risks are monitored through strengthened governance structures, including ARC, RCQG and the Quality Committee, ensuring clear ownership, mitigation and escalation.

Regulatory readiness

The trust strengthened regulatory readiness through:

- A single inspection tracker
- A centralised evidence library
- Improved documentation and audit trails
- Strengthened closed loop assurance
- Regular CQC engagement meetings
- Directorate level regulatory readiness plans

This work supported more consistent compliance and improved preparedness for inspection.

4. Workforce

Workforce planning and recruitment

The trust strengthened workforce planning through:

- Improved forecasting and modelling
- Strengthened recruitment campaigns
- International recruitment in priority areas
- Enhanced onboarding and induction processes

Vacancy rates started the year at **10% and ended it at 10.3%, consistently below the 14% target**.

Retention and staff wellbeing

The trust invested in staff wellbeing through:

- Expanded psychological support
- Improved access to supervision
- Enhanced flexible working options
- Wellbeing champions across directorates

Staff turnover reduced from **12.8% to 12.3% across the year, consistently below the target of 16.5%.**

Workforce equality and inclusion

The trust strengthened workforce EDI through:

- Improved monitoring of protected characteristics
- Anti racism and cultural competence training
- Strengthened EDI governance and reporting
- Improved representation in leadership roles

5. Vision, Strategy and Improvement

Strategic alignment

The trust's strategy is underpinned by:

- The Quality Plan
- ICS mental health transformation priorities
- NHSE expectations for safety, access and equity
- Workforce and financial sustainability plans

Strategy Deployment Reviews (SDRs) ensured alignment between:

- Trust wide priorities
- Directorate plans
- Team level improvement activity
- Individual leadership objectives

Improvement capability

The trust strengthened improvement capability through:

- Embedding the DWT improvement model
- Training staff in continuous improvement methodologies
- Directorate level improvement huddles
- Improved visibility of improvement work through dashboards

Over 60 improvement projects were active during the year, with improvements in:

- Dementia diagnosis
- Physical health monitoring
- Discharge planning
- Crisis response
- Restrictive practice reduction

Data Quality and Insight

Data quality improvement remains a key area of focus. Improvements included:

- A trust wide data quality improvement plan
- New data quality dashboards
- Directorate level data quality leads
- Improved validation processes

Insight and analytics

The trust strengthened its use of data and insight through:

- Enhanced reporting in the IQPR
- Real time safety dashboards
- Improved access and flow analytics
- Strengthened use of BI tools in SDRs

This improved the trust's ability to identify variation, escalate risk and monitor improvement.

6. Key learning during 2025–2026

Leadership visibility

- Staff value regular engagement with senior leaders
- Walkarounds and forums strengthened

Governance clarity

- Need for clearer escalation pathways
- Governance redesign improved alignment

Workforce sustainability

- Recruitment and retention remain challenges
- Wellbeing and flexible working support retention

Culture and psychological safety

- Staff value learning focused approaches
- Continued focus needed on consistency across teams

Data quality

- Improved but still variable
- Further investment in digital maturity required

7. Research activity

The trust continued to expand its research activity during 2025–26, with increased participation across professions and strengthened partnerships with local academic and research institutions. The CQC well led inspection noted significant progress in ensuring that published research is undertaken through credible channels and aligned to quality improvement methodologies.

8. Staff survey

Staff survey results showed improvements in leadership visibility and psychological safety, but highlighted ongoing concerns regarding change fatigue, variable middle management capability and confidence in follow through. These findings align with the Independent Quality and Safety Governance Review and are being addressed through the Leadership Development Programme and strengthened governance oversight.

Review of Quality Priorities 2025–2026

Overview

During 2025–2026, the trust delivered improvement across all three domains of quality while operating under two CQC warning notices. Progress was supported by the Doing Well Together (DWT) improvement model, strengthened governance, and clearer accountability through Strategy Deployment Reviews (SDRs). This section provides a consolidated review of progress against the 2025–2026 Quality Priorities, integrating operational detail and evidence from directorates and trust wide programmes.

Priority 1: Reducing Self-Harm

What we said we would do

- Strengthen therapeutic engagement
- Improve observation practice and documentation
- Enhance environmental safety
- Develop formulation led tools aligned to CRAM
- Improve data visibility and thematic analysis

What we delivered

The trust strengthened how it listens to and involves families, friends and carers in self harm improvement work. Trust wide workshops were delivered by the Chief Nurse and Strategic Lead for Allied Health Professionals, complemented by Open Dialogue, CRAM and Carer Awareness training. Carer Champion forums supported awareness raising activity, and new infrastructure was introduced, including the Carer Information form on Rio and the trust's first Family, Friends and Carers SOP.

Feedback mechanisms were redesigned through the "Your Experience Matters" survey, and work is underway to digitise the Triangle of Care self assessment tool to improve oversight and learning.

a. Self harm incidents on women's wards reduced, supported by:
   - Occupational Therapy–led Minimal Risk Activity Packs (MRAP)
   - Peer Support–led Alternatives to Self Harm (ASH) interventions
   - Enhanced sensory support
   - Improved observation practice and documentation

b. BI and InPhase dashboards strengthened data quality and enabled challenge where reporting did not align with clinical experience.
   - Lived experience partners contributed to codesign of principles for supporting people who self harm.
   - Partnership work with acute trusts extended the self harm staff survey to Emergency Departments.

Outstanding work

- Further embedding of CRAM aligned tools
- Continued focus on high acuity individuals whose admission destabilises ward environments

Priority 2: Reducing Violence and Aggression (V&A)

What we said we would do

- Improve de escalation practice
- Strengthen restrictive practice oversight
- Introduce alternative restraint techniques
- Improve reporting and thematic analysis

What we delivered

a. Increased reporting in Q3 within community services reflected improved incident capture rather than increased harm.

b. Key operational improvements included:
- Pre recorded positional statement for telephone services
- Heat map pilots across three services (launching June 2026)
- Zero tolerance posters across wards and community sites
- Implementation of the Respect and Safety Behavioural Accountability Process (RSBAP)
- Establishment of a High Level Multi Disciplinary Panel for repeat/high risk cases
- Consequence cards developed (awaiting executive sign off)
- Allyship training commenced April 2026

Outstanding work

- Embedding heat map learning
- Strengthening MDT oversight of repeat offenders
- Continued focus on staff psychological safety

Priority 3: Reducing Restrictive Practices

What we said we would do

- Reduce seclusion, prone restraint and physical restraint
- Strengthen human rights based physical interventions training
- Improve oversight and accountability

What we delivered

a. Restrictive practices peaked in Q3 due to a small number of high acuity patients (e.g., one patient requiring 226 restraints for personal care/aggression).

b. Improvements included:
- Specialist advice to terminate seclusions earlier
- Search training (person, belongings, room) rolled out across acute wards
- Tiered accountability and Safety Culture Bundle embedded
- Positive Behaviour Support (PBS) working group established
- Health inequality project initiated to address disparities for global majority patients
- Work underway to reduce prone restraint by reviewing IM medication practice and training

Outstanding work

- Embedding PBS framework
- Strengthening alternatives to IM medication
- Continued reduction of variation across wards

Priority 4: Improving Mental Health Act (MHA) compliance

What we delivered

- All MHA related mandatory training areas exceeded the 90% target, with compliance ranging from 95% to 100% across directorates.
- Training extended to CYPMH and AAED services.
- Associate Hospital Managers scheduled for enhanced training (May 2026).
- Preparedness for the new Code of Practice underway, pending national publication.

Priority 5: Strengthening safety learning through PSIRF

What we delivered

a. Full PSIRF implementation, including:
- Learning Review Groups
- New triage and prioritisation processes
- Real time safety dashboards
- Safety Pins for rapid learning dissemination

b. Key themes included inconsistent risk formulation, environmental safety, communication with families, and variation in de escalation practice.

Priority 6: Improving environmental safety (Ligature Reduction)

What we delivered

a. Annual ligature audits completed across all inpatient areas.

b. Post audit workshops ensured:
- Correct application of the audit tool
- Clear documentation of risks and mitigations
- Prioritisation of capital works

c. Capital priorities agreed:
- Door top alarms on Tier 4 doors
- Ligature reduced en suite facilities
- Replacement of nurse on call system
- Courtyard refurbishments
- Ligature reduced windows in Tier 4 rooms

d. TIAA review provided **reasonable assurance** on data quality.

Priority 7: Strengthening safeguarding

What we said we would do

Adult safeguarding:

920
consultations

428
DASH trained staff

140
safeguarding champions

Training compliance above
90%

Children's safeguarding:

100%
supervision compliance

100%
Medway conference engagement; Kent high 90s–100%

Strengthened
Think Family practice and multi agency working

Priority 8: Improving Autism & Learning Disability Support

What we delivered

The trust delivered significant progress against its LD&A priority through a structured programme aligned to national standards. Key achievements included establishment of the LD&A Delivery Group, enhanced digital flagging, mapping of over 360 standards, and strengthened workforce capability through Oliver McGowan Tier 2 training and co produced Autism Healthcare Webinars. A pilot Resettlement and Repatriation initiative demonstrated improved outcomes and informed a business case for expanded community alternatives.

a. Digital flags implemented across all inpatient services.
b. Baseline prevalence analysis identified:

6.5%	9.6%	1.4% autism; 1.65% LD
expected autism prevalence	expected LD prevalence	actual baseline flags

c. Directorate variation highlighted need for improved identification in specialist LD services.

Quality priorities for 2026-2027

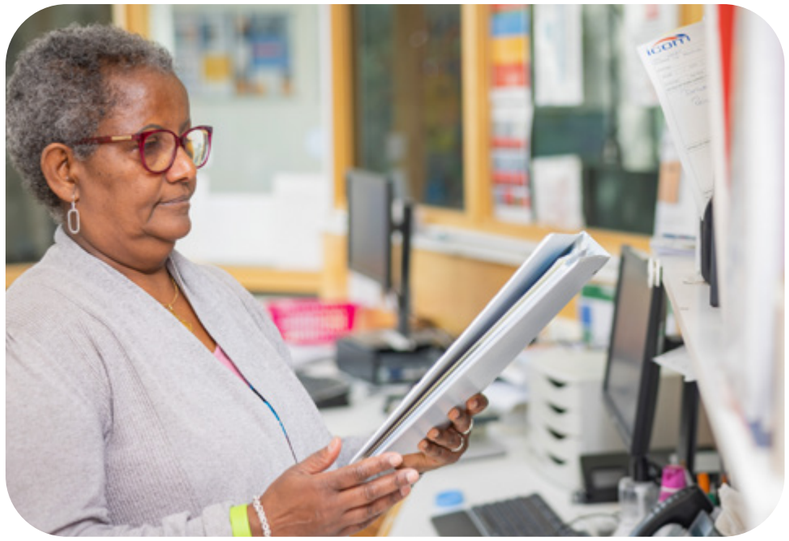
Overview

The Quality Plan for 2026–2027 sets out how the trust will deliver measurable, sustainable improvements in safety, effectiveness, experience and leadership. It reflects the findings of the Independent Quality & Safety Governance Review, CQC warning notice requirements, and the trust's strategic ambition to embed a culture of reliable, evidence led improvement. The plan is structured around four themes - Safety & Risk, Access & Flow, Environment & Experience, and Leadership & Governance Culture - supported by eleven priorities and a single, live action plan.

Delivering these priorities will require a shift from activity based assurance to demonstrable impact. The trust will focus on embedding consistent processes, improving the quality and reliability of documentation, strengthening leadership capability, and ensuring that improvement work is informed by high quality data and triangulated intelligence. The Quality and Corporate Governance Improvement Programme provides the framework for this shift, clarifying accountability, strengthening committee oversight and improving the trust's regulatory readiness.

Collectively, these priorities represent the next phase of the trust's improvement journey. They aim to consolidate the progress made in 2025–2026, address the systemic weaknesses identified through inspection and review, and build a more mature, reliable and learning focused quality governance system. The trust's ambition is to deliver sustained improvements in safety, access, experience and outcomes, ensuring that every patient receives safe, effective and compassionate care.

The plan marks a deliberate shift from compliance driven activity to outcome focused improvement. It establishes a consistent assurance framework, defines "what good looks like" for each priority, and embeds governance structures that ensure clear ownership, reliable escalation and strengthened Board oversight. It also aligns with ICS mental health transformation priorities, national policy expectations, and the trust's Doing Well Together (DWT) improvement model.



How the priorities were selected

The 2026-2027 priorities identified through a multi layered assessment drawing on:

- CQC warning notice requirements, including accelerated improvement in community and crisis services.
- Independent Quality Governance Review findings, particularly the need for stronger assurance, improved data quality, and more reliable safety systems.
- PSIRF learning themes, including inconsistent risk formulation, environmental safety risks, and variation in de escalation practice.
- Directorate level insights from Strategy Deployment Reviews (SDRs), highlighting operational pressures, unwarranted variation, and areas of emerging excellence.
- Patient and carer feedback, including PREMs, FFT, complaints, compliments, and lived experience involvement.
- Workforce insights, including staff survey results, safety culture feedback, and themes from supervision and incident reporting.
- ICS mental health transformation priorities, ensuring alignment with system wide expectations for access, flow, crisis alternatives, and personalised care.
- National policy and regulatory drivers, including expectations for ligature reduction, restrictive practice oversight, digital maturity, and equality.

This approach ensures that the Quality Plan is evidence based, strategically aligned, operationally meaningful and deliverable within the trust's capacity and capability.

The four themes and eleven priorities

Theme 1: Safety & risk

Strengthening the reliability of core safety controls and improving risk management.

Priority 1: Risk and care planning.

Priority 2: Administration of medicines.

Priority 3: Escalation.

Theme 2: Access & waiting

Ensuring timely, equitable access and improving flow across community and crisis pathways.

Priority 4: Caseload management.

Priority 5: Crisis management.

Priority 6: Neurodiverse people.

Theme 3: Environment & experience

Improving the safety, accessibility and inclusivity of care environments.

Priority 7: Work environments.

Priority 8: Responsive services.

Theme 4: Leadership & governance culture

Building a reliable, transparent and learning focused governance system.

Priority 9: Workforce capacity, skills, competence.

Priority 10: Good governance.

Priority 11: Compliance with regulation.

Assurance framework

The Quality Plan is underpinned by a consistent assurance framework that defines:

- Process – policies, SOPs, templates and training.
- Reliability – minimum thresholds for compliance and quality.
- Impact – measurable improvements in safety, experience and outcomes.
- Improvement – trend data over 3–6 months demonstrating sustained change.

Assurance flows through:

- Locality and directorate meetings
- Monthly theme assurance groups
- Quality & Patient Safety Assurance Group
- Quality Committee
- Trust Board

Escalation routes are standardised, with decision making authority delegated to the lowest appropriate level.

Governance and Corporate Improvement Programme

In response to the Independent Review, the trust has launched a trust wide Quality and Corporate Governance Improvement Programme to:

- Strengthen governance architecture and clarify committee purpose.
- Improve the reliability of assurance and the quality of information.

- Embed consistent action discipline and follow through.
- Strengthen regulatory readiness and evidence management.
- Build leadership capability and improve psychological safety.
- Improve data quality, interoperability and digital maturity.

Progress will be monitored by the Audit and Risk Committee, and onwards to the Board.

Measuring success

Success will be measured through:

- Reduced self harm, violence and restrictive practice.
- Improved waiting times, crisis responsiveness and discharge reliability.
- Improved PREM, FFT and carer involvement metrics.
- Improved data quality and audit follow through.
- Stronger leadership visibility and psychological safety.
- Improved regulatory confidence and move towards a rating of good.
- Demonstrable alignment between strategic priorities, operational delivery and patient outcomes.

Assurance, compliance & appendices

Statements of assurance

This section of the Quality Account provides the mandatory statements required by NHS England. These statements offer assurance that the trust has appropriate systems and processes in place to monitor, improve and report on the quality of care it provides.

Review of services

During 2025–2026, Kent and Medway Mental Health NHS Trust (KMMH) provided and subcontracted a broad range of mental health services across inpatient, community, crisis, psychological therapies, CYPMH, AAED and forensic pathways.

KMMH has reviewed all the data available to it on the quality of care in these services. The income generated by the NHS services reviewed in 2025–2026 represents 100% of the total income generated from the provision of NHS services by the trust.

Participation in clinical audit

National clinical audits

During 2025–2026, the trust participated in all relevant national clinical audits and confidential enquiries that it was eligible to join.

These included:

- National Clinical Audit of Psychosis (NCAP)
- Prescribing Observatory for Mental Health (POMH UK) audits
- National Audit of Dementia
- National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)
- National Audit of Anxiety and Depression (NCAAD)
- Learning Disability Mortality Review (LeDeR)

Key findings and actions

- Improved documentation of capacity assessments
- Strengthened physical health monitoring for people on antipsychotics
- Reduced variation in care planning quality
- Improved compliance with NICE guidance in depression and anxiety pathways

Local clinical audits

During 2025–2026, the trust completed audits that informed improvements in:

- Risk formulation and care planning
- Physical health monitoring

- Documentation quality
- Crisis assessment and escalation
- Medicines management

Audit findings were monitored through CEOG, SDRs and the Quality Committee.

Participation in clinical research

The trust contributed to precision psychiatry and dementia research through studies such as ADAPT, which uses biomarkers to strengthen dementia diagnosis, and PPiP2, which has identified immunological causes of psychosis in a subset of patients, informing changes in diagnosis and treatment. The trust has also expanded recruitment in underserved coastal communities to improve equity of access and strengthen the generalisability of research findings.

Care Quality Commission (CQC)

The trust is registered with the CQC and is compliant with all registration requirements.

During 2025–2026:

- The trust operated under two CQC warning notices relating to community and crisis services
- The trust strengthened regulatory readiness through improved governance, documentation and assurance
- A single inspection tracker and evidence library were implemented
- Regular engagement meetings were held with the CQC

The trust continues to work closely with the CQC to deliver sustained improvement.

Data quality improvement

Data quality remains a key area of focus.

Improvements during 2025–2026 included:

- A trust wide data quality improvement plan
- New data quality dashboards
- Directorate level data quality leads
- Improved validation processes
- Strengthened alignment between BI, clinical teams and governance

Information Governance (IG)

The trust completed the Data Security and Protection Toolkit (DSPT) submission for 2025–26 and achieved a rating of Standards met. Information governance training compliance reached 97.4%.

The trust strengthened IG processes through:

- Improved incident reporting and learning
- Enhanced data protection training
- Strengthened oversight of digital and data risks

During 2025–26, the trust reported five Data Security and Protection incidents in line with national requirements. These incidents were reported to NHS Digital on the DSPT and automatically reported to the Information Commissioner's Office, and related to delayed subject access disclosures, inappropriate access to information, and implementation of a system without appropriate data protection processes.

All incidents were investigated, with learning incorporated into strengthened information governance procedures and staff training.

Learning from deaths

The trust strengthened its mortality review processes during 2025–26, with:

- Themes identified in physical health, communication and risk assessment
- Actions monitored through the Mortality Review Group

Learning informed improvements in physical health monitoring, escalation processes and documentation.

A Learning from Deaths action plan has been developed to strengthen the process further, including increasing the number of SJRs completed each month, improving collaboration with the Medical Examiner, and enhancing alignment with PSIRF and Complaints. Progress is monitored through the Learning from Deaths (Mortality Review) Group.

Duty of candour

The trust remains committed to openness and transparency. During 2025–26:

- Staff received training in compassionate communication
- Processes were strengthened through audit and feedback

Freedom to Speak Up (FTSU)

The trust strengthened FTSU processes through:

- Increased visibility of Guardians
- Improved reporting routes
- Strengthened learning and feedback loops

Summary

The Statements of Assurance confirm that the trust:

- Participated fully in national and local audits
- Strengthened research activity
- Delivered against CQUIN requirements
- Improved data quality and IG compliance
- Strengthened mortality review processes
- Maintained regulatory compliance
- Strengthened Duty of Candour and FTSU processes

These systems and processes support the trust's commitment to delivering safe, effective and compassionate care.

Participation in national audits

This section provides the mandatory summary of the trust's participation in national clinical audits and national confidential enquiries during 2025–26. It reflects the trust's commitment to evidence based practice, continuous improvement and national benchmarking.

The trust participated in **100% of the national clinical audits and confidential enquiries** it was eligible for during 2025–26.

Themes from National Audits

Across the national audit programme, key themes included:

- Improved documentation of capacity assessments
- Strengthened physical health monitoring for people on antipsychotics
- Reduced variation in care planning quality
- Improved compliance with NICE guidance in depression and anxiety pathways
- Strengthened MDT involvement in assessment and review
- Improved monitoring of high dose antipsychotic prescribing

These themes informed trust wide and directorate level improvement plans.

Actions taken in response to National Audits

Actions taken during 2025–26 included:

- Introduction of standardised templates for risk formulation and care planning
- Strengthened physical health monitoring pathways
- Enhanced training in medicines optimisation
- Improved documentation standards through the Clinical Documentation Improvement Programme
- Strengthened MDT review processes
- Directorate level audit action plans monitored through SDRs.

Impact of National Audit Participation

Participation in national audits has:

- Improved clinical practice and reduced unwarranted variation
- Strengthened compliance with NICE guidance
- Enhanced the quality of documentation and clinical decision making
- Supported safer prescribing and monitoring
- Improved physical health outcomes for people with SMI
- Strengthened the trust's ability to benchmark performance nationally

These improvements contribute directly to the trust's strategic priorities for safety, effectiveness and personalised care.

Data Quality Statement

High quality data is essential for safe, effective and well led care. During 2025–26, the trust strengthened its data quality governance, improved validation processes and enhanced the reliability of information used for clinical care, operational management and Board assurance.

Data Quality Governance

The trust strengthened data quality governance through:

- A trust wide Data Quality Improvement Plan
- Directorate level data quality leads
- Monthly data quality reporting through SDRs
- Enhanced validation processes within clinical systems
- Improved alignment between Business Intelligence (BI), clinical teams and governance structures

Data quality is monitored through the Digital and Data Quality Group, with oversight from the Quality Committee and Board.

Data Quality Improvement Plan

The Data Quality Improvement Plan delivered:

- New real time data quality dashboards
- Improved completeness of key clinical fields
- Strengthened training for staff on data entry and documentation
- Enhanced audit and feedback cycles
- Improved integration of data quality into performance reviews

Data quality compliance improved to 91.5%, supporting more reliable assurance and regulatory readiness.

NHS Number and GP Practice Code Validity

The trust continues to perform strongly in NHS Number and GP practice code completeness. These metrics support safer care, improved communication and more accurate reporting.

Secondary Uses Service (SUS) Data

The trust submitted data to the Secondary Uses Service (SUS) throughout 2025–26. Improvements included:

- Enhanced validation prior to submission
- Strengthened reconciliation processes
- Improved coding accuracy

These improvements support more accurate national reporting and benchmarking.

Data Security and Protection Toolkit (DSPT)

The trust completed the Data Security and Protection Toolkit (DSPT) submission for 2025–26 and achieved a rating of Standards Met.

This reflects compliance with national data protection, cyber security and information governance requirements.

Information governance training

Information governance training compliance reached 97.4% supported by:

- Improved access to training
- Enhanced monitoring and reminders
- Directorate level oversight

This supports safer handling of patient information and improved compliance with national standards.

Summary

The trust has strengthened its data quality, information governance and digital maturity during 2025–26. Improvements in data completeness, validation and reporting have enhanced the reliability of information used for clinical care, operational management and Board assurance. Continued focus on data quality will support the trust's strategic priorities for 2026–27, including regulatory readiness, digital transformation and improved patient outcomes.

Stakeholder Statements

As required by the NHS (Quality Accounts) Regulations, the trust invited the following stakeholders to comment on this Quality Account:

- Healthwatch Kent and Medway
- Kent and Medway Integrated Care Board (ICB)
- Kent County Council and Medway Council Overview & Scrutiny Committees (OSCs)

Stakeholder statements provide independent commentary on the trust's performance, priorities, and progress. Their feedback is an important part of our commitment to transparency, accountability, and continuous improvement.

All statements received will be included in full in the final published version of this Quality Account.

Healthwatch Statement

[Awaiting formal statement from Healthwatch Kent and Medway]

Healthwatch welcomed the trust's focus on safety, access, and patient experience, particularly improvements in Crisis Line responsiveness and dementia diagnosis pathways. They highlighted the need for continued work on communication with families, personalised care planning, and support for people with autism and learning disabilities.

Integrated Care Board (ICB) Statement

NHS Kent and Medway Integrated Care Board (ICB) welcomes the publication of the Trust's Quality Account and confirms that it has been produced in line with the national requirements for Quality Accounts. The report provides a comprehensive and transparent overview of the quality of services delivered during 2025/26 and openly reflects both the challenges faced by the organisation and the progress made throughout the year.

We particularly welcome the candid reflection within the report regarding the significant regulatory scrutiny experienced during the year and the acknowledgement of the areas requiring further improvement, including governance maturity, risk formulation, care planning, data quality and regulatory readiness. The openness demonstrated throughout the report provides assurance that the Trust has recognised the issues identified through external review and regulatory oversight and is taking steps to address them.

The ICB is pleased to note the progress made against the Trust's quality priorities during 2025/26, particularly:

- The successful implementation of the Patient Safety Incident Response Framework (PSIRF), including the introduction of strengthened thematic learning, learning review groups and real-time safety dashboards to support organisational learning and improvement.
- The reduction in self-harm incidents, supported by targeted therapeutic interventions, improved observation practices and strengthened involvement of lived experience in service design.
- Improvements in access and flow, including reductions in Mental Health Together waiting times, improvements in crisis responsiveness, and the positive impact of the High Intensity Use pathway in reducing admissions, bed occupancy and length of stay for some of the Trust's most complex service users.
- Improvements in clinical effectiveness, including significant reductions in dementia diagnosis waiting times and reductions in medication errors across the organisation.
- The continued development of leadership capability and organisational culture through the Doing Well Together programme and strengthened appraisal processes.

We also welcome the Trust's focus on supporting people with learning disabilities and autistic people through enhanced workforce training, digital flagging and the development of more personalised approaches to care.

The ICB commends the Trust's quality priorities for 2026/27 and supports the continued focus on embedding sustainable improvement across the organisation. In particular, we welcome:

- The emphasis on strengthening the reliability of core safety systems, including improvements in risk formulation, care planning and the management of ligature and violence-related risks.
- The continued focus on improving access and patient flow through strengthened community services, crisis alternatives and reductions in prolonged lengths of stay.
- The commitment to embedding patient, carer and lived experience voices more effectively within governance and assurance processes to support truly person-centred care.
- The focus on improving data quality, digital maturity and evidence-based assurance to support stronger governance and organisational learning.
- The continued development of leadership capability, culture and accountability to support sustained quality improvement.

The Trust has clearly articulated priorities that align with its strategic objectives, regulatory requirements and the needs of the population it serves. The ICB recognises that the next phase of improvement will require continued focus on embedding reliability and consistency across services and demonstrating sustained improvement through robust assurance processes and measurable outcomes.

We welcome the Trust's ongoing engagement through Provider Quality Meetings, Quality Surveillance arrangements and wider system quality governance structures. We look forward to continuing to work collaboratively with the Trust throughout 2026/27 and receiving updates on progress against the Quality Plan and improvement priorities over the coming year.

On behalf of NHS Kent and Medway ICB, I would like to thank the staff and partners of KMMH for their contribution during what has clearly been a challenging year, and we look forward to supporting the Trust as it continues its improvement journey.

Overview & Scrutiny Committee (OSC) Statements

Overall, the report is candid and offers welcome assurance that KMMH is making early progress in responding to the issues raised by the CQC reports and independent review. This is encouraging and demonstrates acknowledgement and recognition that urgent improvements were indeed required. The report is transparent about the need for these improvements to be further embedded, to ensure consistency and address variations in practice.

Most noted are the improvements in data quality dashboards, the focused intervention on LDA programme and dementia diagnosis waiting times, which will have an immediate impact on patient care and outcomes. There is evidence of innovation and applied research being undertaken which has led to demonstrable improvements in diagnostics and onwards care pathways to immunotherapy.

The report is clear and easy to follow. It would have been helpful for the report to elaborate on statements which describe improved collaboration with social care and VCSE organisations.

We acknowledge the pressure on patient flow, often caused by external constraints, such as access to social care and housing, and are committed to working with KMMH to address these systemic issues. Opportunities to mitigate that pressure will also arise from improved integrated working with system partners to prevent crisis, relapse and early intervention for emerging mental health concerns. We would like to see steps towards implementation of the national delivery framework for people with co-occurring conditions referenced in future quality improvement plans.

We note that Trust has expanded stepdown capacity, however, the established community routes are still overwhelmed, and we would like to suggest that the Trust considers creating their own stepdown capacity. In the delivery of care, we would urge the Trust to consider disengagement with care as a red flag, not a reason to remove patients from their books.

We fully support the proposed priorities for 2026/27, particularly improving waiting times, access to community services and strengthening system wide collaboration across the Integrated Care System. These are areas of significant preventative benefit for both patients and the wider system and we welcome the implementation of improvement plans related to these priorities.

Trust response to stakeholder feedback

The trust welcomes the feedback provided by stakeholders and is committed to acting on the themes identified. Key areas of focus for 2026–27 include:

- Strengthening communication with patients, families, and carers
- Improving consistency in risk assessment and care planning
- Reducing waiting times and improving access to community services
- Enhancing support for people with autism and learning disabilities
- Continuing to improve data quality and digital maturity
- Strengthening system-wide collaboration across the ICS

Stakeholder feedback will be incorporated into the implementation of the Quality Plan and monitored through the Quality Committee and Board.

Glossary - acronyms and terms

A concise reference guide to key terms used throughout the Quality Account.

AAED	All Age Eating Disorders service, providing assessment and treatment for people with eating disorders across all age groups.
BAF (Board Assurance Framework)	A structured approach used by the Board to identify, manage and monitor strategic risks.
BI (Business Intelligence)	Data and analytics used to support decision making, performance monitoring and improvement.
CQC (Care Quality Commission)	The independent regulator of health and social care services in England.
CEOG (Clinical Effectiveness and Outcomes Group)	A trust committee responsible for oversight of clinical effectiveness, audit and outcomes.
CQUIN (Commissioning for Quality and Innovation)	A national scheme linking a proportion of provider income to quality improvement goals.
CRAM (Clinical Risk Assessment and Management)	A structured approach to risk formulation and safety planning.
CYPMH	Children and Young People's Mental Health services.
DASH	Domestic Abuse, Stalking and Harassment risk assessment tool.
DWT (Doing Well Together)	The trust's improvement operating model, supporting leadership, culture and quality improvement.
EqIA (Equality Impact Assessment)	A process to assess the impact of service changes on people with protected characteristics.
FFT (Friends and Family Test)	A national patient experience measure asking whether people would recommend services to others.
FTSU (Freedom to Speak Up)	A national framework enabling staff to raise concerns safely and confidentially.

HCAI (Healthcare Associated Infection)	Infections acquired during the delivery of healthcare.
HoNOS (Health of the Nation Outcome Scales)	A tool used to measure clinical outcomes in mental health services.
ICS (Integrated Care System)	A partnership of organisations working together to plan and deliver health and care services in a local area.
IG (Information Governance)	The framework for handling patient information safely and legally.
IQPR (Integrated Quality and Performance Report)	A monthly report providing triangulated data on quality, performance, workforce and finance.
LAT (Long Acting Treatment)	Medication administered via long acting injection.
LeDeR (Learning Disability Mortality Review)	A national programme reviewing the deaths of people with learning disabilities.
MDT (Multidisciplinary Team)	A group of professionals from different disciplines working together to deliver care.
MHA (Mental Health Act)	Legislation governing the assessment, treatment and rights of people with mental health conditions.
MHT / MHT+ (Mental Health Together)	The trust's community mental health transformation programme.
MRAP (Minimal Risk Activity Packs)	Occupational therapy led interventions supporting people who self harm.
NCAP (National Clinical Audit of Psychosis)	A national audit assessing the quality of care for people with psychosis.
NCISH (National Confidential Inquiry into Suicide and Safety in Mental Health)	A national programme reviewing suicides and safety incidents.

NEWS2 (National Early Warning Score 2)	A tool used to identify and respond to deteriorating physical health.
PFD (Prevention of Future Deaths)	Reports issued by coroners identifying risks requiring action to prevent future deaths.
POMH UK	Prescribing Observatory for Mental Health, a national audit programme focused on medicines safety.
PREM (Patient Reported Experience Measure)	A measure of patient experience across key domains of care.
PSIRF (Patient Safety Incident Response Framework)	The national framework for responding to patient safety incidents, focusing on learning and improvement.
QI (Quality Improvement)	A systematic approach to improving services using structured methodologies.
RED Board	A structured daily review process supporting discharge planning and flow.
RSBAP (Respect and Safety Behavioural Accountability Process)	A structured approach to managing violence, aggression and unacceptable behaviour.
SDR (Strategy Deployment Review)	A quarterly review process aligning trust strategy with directorate and team level improvement.
SMI (Severe Mental Illness)	A term used to describe conditions such as schizophrenia, bipolar disorder and severe depression.